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Patient and Prisoner Experiences

Major Mental Illness and Masculinity in the Context of Violent Offending Behaviour

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DECLARATION

I composed this thesis. This work is my own. No part of this thesis has been submitted for any other degree or qualification.

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ABSTRACT

Traditional understandings of violence by the mentally disordered largely look to mental illness to explain such behaviour. More recently, research has begun to examine the role of alternative factors in driving violent offending in this context. Masculinity is one such factor to which little consideration has thus far been given, in spite of a wealth of literature which associates the construction and maintenance of a masculine identity with violence in the non-mentally disordered context. This thesis proceeds from these current understandings, and examines the nature of the relationship between mental illness, masculinity and violent behaviour.

In order to examine this issue, interviews were conducted with a group of 10 male patients diagnosed with major mental illness and with violent offending histories, in a medium secure forensic psychiatric hospital in Scotland. A group of 10 male prisoners serving life sentences in a Scottish adult male prison following convictions for homicide offences were also interviewed, and acted as a comparator group. Following an analysis of these interviews, findings emerged in relation to three key areas of patients' and prisoners' accounts: past experiences of violent offending, present experiences of institutional settings, and future hopes for recovery and desistance. In particular, significant similarities and divergences in the experiences of the two groups were apparent, and this thesis advances two key arguments in light of this.

Considering first the similarities in patients' and prisoners' experiences, it is posited here that for both the mentally ill and non-mentally ill male population the task of constructing and maintaining a masculine identity is a particularly pervasive force in their life histories. It will be demonstrated that for patients and prisoners in this study, masculinity plays a significant role in past violent offending, as well as having important implications for adaptation to present institutional settings, and the creation of a recovered and desisting identity for the future.

Second, in looking to the divergences in patients' and prisoners' accounts, it is asserted that where major mental illness is present it serves to intercede in these three areas of men's lives. Extracts from interviews with male patients will illustrate the interceding role of mental illness in violent scenarios from their pasts. In addition, it will be demonstrated that patients' and prisoners' respective present situations in institutional settings vary, as diagnosis of mental illness leads patients to be placed in a secure hospital rather than the prison, and the differing nature of these environments results in divergences in adaptation to these settings. Finally, in relation to the future, while prisoners focussed on their hopes for desistance from offending, the diagnosis of mental illness led patients to place recovery from such disorders as the primary process at this point.

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INTRODUCTION

This thesis will demonstrate that mental disorder plays a surprisingly minimal role in driving violence, and that the causes of violent offending by mentally disordered and non-mentally disordered individuals are in fact similar. Masculinity will be highlighted as a significant factor linked to violence in both contexts. It will be argued that in spite of such similarities, criminal justice processes separate this population by labelling them as patients or prisoners and treating and managing them accordingly. The removal of this dichotomisation, both in our understandings of these groups and in practice, will be advocated. Ultimately it will be illustrated that what this thesis has termed the 'collaboration of excuse' at work in the secure forensic psychiatric hospital provides patients with a more effective framework for change than those in the prison setting.

This will be done with reference to qualitative interviews with a sample of 20 male[1] patients and prisoners with histories of violence, in a medium secure forensic psychiatric hospital and an adult male prison.

By way of introduction, the development of this thesis and its research questions will be detailed, as well as the development of the empirical element of the project. This section will also illustrate the original contributions this research aims to make to academic study in the relevant areas. Following this, the structure of the thesis will be outlined.

[1] This thesis will argue that gender is an identity which is achieved and constructed rather than biologically given. While it is acknowledged that the terms 'male', 'female', 'men' and 'women' revert to biological reducationsm, these will be utilised at times in this discussion. Where this occurs in the context of reviewing existing research and policy documentation, the terminology utilised in this literature will be adopted. Where this refers to the sample of 'males' or 'men' in this study, it should be noted that these individuals all identified themselves as such, therefore it was deemed appropriate to refer to them in this way.

1. THESIS DEVELOPMENT

The initial main aim of this thesis was to consider the relationship between major mental illness and violence, with a view to understanding the interaction of masculinity with these factors. A literature review of these areas was first conducted. Surprisingly, it indicated that in spite of traditional stereotypes linking mental illness and violence, the role of mental illness in driving such behaviour is comparatively limited. It appears to be less significant than traditional criminogenic factors, such as masculinity. These findings were supported by interviews with patients and prisoners, who detailed similar violent offending histories and general life histories. As such, this initial research focus was examined as intended.

The potential implications of this relationship between mental illness, masculinity and violence for the treatment and management of offenders was at first a subsidiary concern of this project. A literature review of policy and practice in this area was conducted, which revealed that a diagnosis of mental illness results in a significant variation in the treatment and management of this group when compared with the wider offending population. Moreover, while the experience of institutionalisation was not the focus of the interviews, it quickly emerged as a priority in the accounts of both groups. Patients and prisoners detailed their present experiences of hospital and prison, as well as their hopes for the future out with these settings in relations to issues of change. This resulted in an increased focus on treatment and management throughout the empirical element and in the subsequent analysis of this project.

The focus on these two areas – the relationship between mental illness and violence, and the treatment and management of violence – has ultimately shaped this thesis. The research questions addressed by the thesis are therefore: What relationship exists between mental illness and violence, and what is the role of masculinity in this context? How are mentally disordered and non-mentally disordered offenders with histories of violence treated and managed, and does this reflect the causes of offending? And what are the implications of their treatment and management for their future non-offending identities?

2. EMPIRICAL DEVELOPMENT

Just as the overall focus of the thesis changed over time, the empirical element of this project also developed and deviated to an extent from its original structure. One of the main reasons for this was the difficulty of gaining access to the research sites. It was initially hoped that full access would be in place at the beginning of the second year of this project and that the research would immediately commence at this point, however NHS access procedures were particularly lengthy and access to prison was initially denied. As such, gaining access to both settings continued into the second year of study.

Similarly, once access was granted, the interviews did not commence immediately due to difficulties in obtaining a sample of 20 participants. In hospital the induction, sampling and recruitment process, which was dependent on the assistance of consultant psychiatrists, was also time consuming. With a limited number of suitable patients in the research setting, and many patients unwilling to participate, it was more difficult than anticipated to recruit interviewees. The researcher had no role in the recruitment process in prison and sampling in this setting also took longer than expected.

Overall, access and recruitment were more problematic than initially planned for. The empirical element of the research was adapted accordingly and the majority of these obstacles were overcome, as will be outlined in Chapter 4 of the thesis. It was fortunate that with the assistance of practitioners in both settings, interviews were conducted in a shorter amount of time than originally anticipated, and the project has been completed in the allotted time frame. It was a success of the research that 20 interviewees were ultimately recruited and that the project was not scaled down in this respect. Perhaps most importantly, the patients and prisoners who elected to participate largely did so whole heartedly, and a wealth of data was generated from the interviews.

3. ORIGINAL CONTRIBUTIONS

This project hopes to make original contributions to current academic research, in both psychiatry and criminology. These are as follows:

The focus of this thesis aims to fill a gap in existing research. Studies tend to be concerned with the causes of violent offending by the mentally ill, or the treatment and management of this group. This research considers both of these issues simultaneously, examining the reflection of the causes of offending in treatment and management policies and practices. The consideration of masculinity in the mentally disordered context in this project also hopes to address an under-researched area. While some studies consider gender difference in violence perpetration by the mentally ill (Fazel and Grann, 2006; Moran et al., 2003; Link, Andrews and Cullen, 1992), existing research rarely attempts to explain this, and explicit reference to masculinity and femininity is scarce.

The methodological approach of this research seeks to provide an alternative perspective on this topic. Much research into mental illness comes from the field of psychiatry in the form of clinical studies. While such studies are undoubtedly important, it has been suggested that an individual level criminological approach to understanding mental disorder and violence would be beneficial to research in this area, and this supports the orientation of this project (Silver, 2006). The accounts which flow from the interviews conducted here are primary data specific to this project, and represent original information in this area.

The research sample in this project and the comparison of patient and prisoner populations also offers an alternative perspective from traditional inquiry. While much research examines the experiences of offenders in relation to violence and imprisonment, and of the mentally ill in relation to hospitalisation, these groups are rarely compared. This approach not only allows for comparison of the mentally ill and non-mentally ill contexts in relation to the causes of violence, but also illustrates the divergent experiences of patients and prisoners in terms of institutionalisation.

4. THESIS OVERVIEW

This thesis comprises 8 substantive chapters in addition to the introduction and conclusion. An overview of the structure of the thesis, and the argument advanced, will be provided here.

Chapter 1: Mental Disorder and Violence

This chapter will review existing research into the relationship between mental disorder and violence. It will be demonstrated that mental illness has a smaller role in driving violent behaviour than may be expected, and that traditional criminological risk factors appear to have a stronger association to violence. It will be advanced that masculinity may be once such factor.

Chapter 2: Masculinity and Violence

Chapter 2 will consider the nature of masculinity, and how this may relate to violence. It will illustrate that violence is often a resource employed in constructing and maintaining a masculine persona, and that such incidents play out in line with cultural scripts of masculinity.

Chapter 3: The Treatment and Management of Violent and Mentally Disordered Offenders

This chapter will outline the policies and practices in place for the treatment and management of violent and mentally disordered offenders. It will illustrate that the application of the mentally ill label sets an offender apart from the wider offending population, placing this factor at the forefront of treatment and management concerns and clashing with the modest role suggested by the literature review. Conversely, the minimal attention paid to masculinity in practice will be highlighted, in spite of its apparently significant role in driving violence. The contrasting nature of the hospital

and the prison, and how these are experienced by those within, will also be outlined here.

Chapter 4: Methodology

Chapter 4 will detail the methodological approach adopted in this project. It will outline the research process, and will offer some reflections regarding the nature of conducting such research.

Chapter 5: The Past: Violent Offending Histories

This chapter is the first of 4 analysis chapters, providing detailed information from interviews with patients and prisoners. It will focus on the comments of both groups in relation to the causes of their violent offending. It will demonstrate that mental illness has a relatively small role in violent behaviour, while masculinity emerged as a significant factor driving violence for both groups, supporting the findings of the earlier literature review.

Chapter 6: The Past: General Life Histories

Chapter 6 describes patients' and prisoners' general life histories, in areas such as family relationships, education and recreation. The chapter will illustrate the similar nature of both groups in these areas, and the common desire to portray a masculine identity in various areas of their lives. The power of mental illness as a pervasive negative force within this context will also be illustrated.

Chapter 7: The Present: Experiences of Hospital and Prison

This chapter will outline patients' and prisoners' experiences of institutional settings. This aspect of their life histories will be highlighted as a significant divergence, and the differences in the patient and prisoner identities and adaptations to these will be discussed, with reference to their implications for masculine identity. It will be

argued that these negative elements of institutional experience are not recognised in the policies and practices outlined in Chapter 3.

Chapter 8: The Future: Frameworks for Change

The final substantive chapter will detail patients' and prisoners' accounts in relation to their hopes for the future. Specifically, it will focus on the processes of change they perceive themselves to have undergone in order to develop non-offending identities. It will be argued that a mutually beneficial collaboration of excuse exists between staff and patients within the secure hospital, which enables them to attribute their offending to mental illness and create such identities more easily. Therefore, while the focus on mental illness in practice may be unsupported by the causes of offending, it creates a more effective framework for change.

Conclusions

Ultimately, this thesis will argue that the seemingly minimal role of mental illness in driving violence is not reflected in the differential treatment and management of the mentally ill and non-mentally ill. There is conversely little acknowledgement of masculinity in practice, although it has been determined to play a more significant role in driving violence. Regardless of this, it appears that the collaboration of excuse in relation to mental illness facilitates the development of non-offending identities. By way of conclusion, the implications of these findings for policy and practice in this area will be considered, and the possibility of extending a public health model to the non-mentally ill as well as implementing increased recognition of masculinity in practice will be assessed.

CHAPTER 1

MENTAL DISORDER AND VIOLENCE

Misunderstandings surround mental illness, particularly the implications of this for an individual's propensity for violence. This leads the public to be fearful of the mentally ill, and to the perception that this population are dangerous. Such stigma has a negative impact on the wellbeing of the mentally ill and their ability to recover, as well as leading to unreasonable demands on mental health services. Owing to this, it is important to examine the nature of the links between mental illness and violence, as demonstrated by both criminological and clinical literature. This topic has been approached from numerous angles by both disciplines, resulting in a somewhat fragmented research landscape. This chapter will review key research in these areas, in an attempt to draw some broad conclusions about the nature of this relationship. Many studies have examined this relationship generally, concerning themselves with the links between violent behaviour and the mentally ill population as whole. Other studies have instead focussed on specific disorders or specific symptoms, and attempted to determine how these particular characteristics may link to violence. Finally, much research has examined the implications of factors not exclusively related to mental illness for violent behaviour, such as comorbid substance and alcohol abuse or personality disorder, or non-treatable risk factors such as social disorganisation and poverty, a disrupted childhood and family background, and impaired social support while mentally ill. This chapter will argue that the relationship between mental disorder and violence is surprisingly minimal, and that traditional criminogenic factors are more strongly associated with violence.

1. PUBLIC UNDERSTANDINGS OF MENTAL ILLNESS AND STIGMA

Varied perceptions of mental illness exist among the general public, and while many people have an understanding of the nature and implications of a variety of mental

illnesses, others may have gained an inaccurate impression of what it means to experience such a condition. It is important to be aware of the role of the media in shaping opinions about mental illness (Hocking, 2003; Crisp et al., 2007), and highly publicised incidents of violence by members of this population may lead to the belief that the mentally ill are dangerous and to subsequent stigmatisation.

Several studies have sought to gain an understanding of the true nature of public opinion regarding mental illness. In a brief review of this literature Markowitz (2005) highlights that public perceptions of mental illness appear to have changed over time in two key ways. Firstly, since the 1950s an increased understanding of the nature of mental illness and the associated symptoms has emerged, as well as a greater awareness that mental illnesses are varied and not limited to traditional conceptions of psychotic disorders. This is a positive transformation. Markowitz's second observation that "concurrent with these favourable developments… there has been an increase in the proportion of persons who associate mental illness with dangerousness, violence, and unpredictability" (Markowitz, 2005: 3) indicates a more negative impression of the mentally disordered population. This assertion is further supported by findings from a more recent study by Crisp et al. (2007), who cited the common belief among the general public that the mentally ill are dangerous and unpredictable, particularly those suffering from schizophrenia or alcohol or substance misuse. Their research also revealed a general feeling that the mentally ill are hard to talk to and 'feel different' from other people. Crisp and colleagues posit that these negative opinions may be a result of dramatic media coverage of violence by individuals suffering from mental disorder. While understandings of the nature of mental illness itself have improved, there is an enduring notion among the general public that the mentally ill are dangerous and violence prone.

Such negative opinions of mental illness are potentially 'stigmatising'. Stigma, as described by Goffman (1963), is strongly associated with an individual's socially constructed identity and the attributes which 'discredit' this (Goffman, 1963; 3). Therefore, to stigmatise an individual or group is to define them by a distinguishing characteristic and devalue them as a result of this, and mental illness is a

characteristic which may be viewed and interpreted in this way (Goffman, 1963; Dino et al., 2004). In order to understand the nature and extent of stigma, Dino et al. (2004) conducted narrative interviews with 46 community mental health patients, and found that a large majority (41) of these participants had encountered stigma, whether this was indirectly or overtly perpetrated, as a result of their mental illness. This may occur in many social spheres, including work, academic and even treatment settings (Hocking, 2003). It appears from this research that while patients suffer stigma in diverse ways, it is frequently experienced by the mentally ill population.

A reduction in this stigma is desirable for numerous reasons and this thesis argues that this may be achieved through an improved public understanding of the links between mental illness and violence. For the mentally ill population, addressing the negative connotations associated with mental illness would be beneficial. The feelings of distress and isolation produced by stigma have a negative impact on the general wellbeing of the mentally disordered, and may act as a barrier to recovery (Hocking, 2003; Dinos et al., 2004). In addition, tackling stigma may also prove beneficial for the general public. Challenging the notion that all mentally ill individuals are dangerous and prone to violence would serve to assuage the fear this belief promotes in the general population. Such changes in attitude may have positive implications for mental health services as well as the mentally ill. Taylor and Gunn (1999) illustrate that public misunderstandings of violence by mentally disordered individuals lead to a loss of faith in the psychiatric services which treat and manage this population, and a demand for improvements and increased restrictions on the mentally ill. Thus, improving public knowledge may relieve the strain which is often placed on mental health services and promote evidence based practice.

2. PROBLEMS IN RESEARCHING THE RELATIONSHIP BETWEEN MENTAL DISORDER AND VIOLENCE

While it appears important to explore the relationship between mental disorder and violence, this is a problematic task. This section will detail several of the methodological pitfalls of such investigation.

2.1. Defining Mental Illness and Violence

If in studying the relationship between mental illness and violent behaviour one seeks to measure the prevalence of these phenomenon, one must adopt definitions of these terms. It has been acknowledged that these concepts are hard to define, and studies tend to vary in their interpretations (Crichton, 1999; Peay, 2007, 2011). Where mental illness is concerned, studies often include only those disorders which have been traditionally classed as major mental illnesses by clinicians – that is, those forming a subset of Axis I of the DSM-IV-TR (see Glossary) which can be described as "major disorders of thought or affect" (Peay, 2011: 23). Meanwhile, other studies may include individuals suffering from a primary diagnosis of drug or alcohol induced psychosis or personality disorder (see Glossary).

Similarly, what qualifies as violence is often disputed, particularly in light of the fluctuating legal definition. In some studies shouting or threats may equate to violence (Steadman et al., 1998; Coid et al., 2006), while others may only class an incident as violent if blows are struck (Swanson et al., 1996).

2.2. Sampling Difficulties

In researching links between mental health and violence, it is difficult to obtain a representative sample from which findings can be extrapolated to the general population, allowing more general assertions to be made about this relationship.

Studies often sample participants from prison populations or psychiatric inpatient settings. The justification for this approach is that these environments contain a high concentration of mentally ill individuals who have previously engaged in violence. These secure settings also make these populations easy to locate and access. There are difficulties associated with drawing a sample from an institutional environment. Such studies tend to exclude the members of the population who are more moderately ill and who may not have engaged in violence, and instead focus only on those who pose a sufficient risk to require the security of an institutional setting (Taylor, 1998). Friedman (2006) notes that this results in a sample which is not representative of community psychiatric patients or undetected unwell individuals in the general population. Drawing research participants from institutional settings recruits samples from environments containing high concentrations of individuals who "are often from poor, disadvantaged areas where rates of serious street crime and violence are high even for people who do not suffer from mental disorder" (Link, Andrews and Cullen, 1992: 227). Thus, it appears that recruiting participants from institutional settings means that "extrapolating findings from such samples may be misleading" (Chiswick and Thomson 2004: 702).

It may be preferable to draw samples from the community, as these are more representative of the wider population. Sampling individuals in this way also increases the ease of identifying a matched control group, as was achieved in the MacArthur Violence Risk Assessment Study, in which a sample of patients recently discharged into the community were matched to a comparison group of individuals residing in the same neighbourhoods (Steadman et al., 1998). There are also drawbacks to this approach. A sample of this nature is more difficult to identify and recruit. These samples also exclude mentally disordered individuals in psychiatric hospitals or prisons, often resulting in more seriously violent individuals being overlooked (Taylor, 1998). It remains difficult to extrapolate findings to other populations where variations in crime rates and criminal justice practice may affect the relationship between mental illness and violent behaviour (Crichton, 1999; Chiswick and Thomson, 2004).

2.3. Difficulty of Proving a Causal Link

A further difficulty encountered when researching the relationship between mental disorder and violence, even where the already outlined methodological dilemmas are overcome, is that of proving a causal link. Where research results do appear to indicate an existing relationship there are often alternative explanations for its presence. In short, finding an association between mental illness and violent behaviour does not necessarily prove that mental illness causes violence.

One such alternative explanation for associations between mental illness and criminal behaviour generally is the suggestion that there has been a 'criminalization of mental illness' (Link, Andrews and Cullen, 1992: 227). This is the suggestion that the mentally ill are more likely to have interactions with criminal justice bodies, not because of an increased propensity to offend, but through various procedural mechanisms as well as perhaps bias towards this group. Teplin's (1984) research supports this explanation, demonstrating that the mentally ill were more likely be arrested than non-mentally ill individuals even when committing similar offences. If we combine this finding with the likely inability to conceal offending behaviour due to the confusion and disorganisation of mental illness, known as 'inept offending' (Peay 2007: 504), it is perhaps unsurprising that we see increased arrest rates among this population. Moreover, this increased arrest rate is unlikely to be solely attributable to a causal link between mental illness and criminal behaviour.

3. THE RELATIONSHIP BETWEEN MENTAL ILLNESS AND VIOLENCE

Much research seeks to understand the overall relationship between mental illness and violence, in order to determine whether this group are more dangerous than the general population. Research has generally taken one of two approaches in seeking to achieve this aim: measuring the pervasiveness of mental illness in the criminal population, or calculating the prevalence of criminality in the mentally ill population (Chiswick and Thomson, 2004: 703). The results of some key studies in this area adopting both of these approaches will be reviewed in this section.

3.1. Mental Illness in Criminal Populations

Examining the extent of mental illness among the criminal population is often achieved by measuring the prevalence of mental illness in prisons. The implication in such research is that, as prisons contain a high concentration of people charged with or convicted of violent offences, high levels of mental illness in this setting may indicate that the mentally ill are more prone to violence.

Taylor and Gunn's (1984a) study of men on remand in Brixton prison is an influential project in this area. Their sample remanded to prison on criminal charges, 1241 of whom were charged with violent offences. Their prison records were reviewed to determine the prevalence of psychiatric disorder among this group and the relationship between diagnosis and violent offending. The study determined that the rates of mental illness are high among prisoners, with 506 (18.4%) of the 2743 men remanded to the prison during the period of study suffering from symptoms of psychiatric disorder, and 237 (8.7%) suffering from psychosis. These results suggested a relationship between mental disorder and crime, and in particular violence given the high number of individuals in this setting convicted of such offences.

Similar findings have emerged from other research projects investigating mental illness in the prison population. Fazel and Danesh (2002) conducted a systematic review of psychiatric surveys of prison populations in western countries. A total of 62 surveys from 12 countries were included, and the details of 22790 prisoners were reviewed. They found that 1 in 7 prisoners suffered from a psychotic illness or major depression, and that "the risks of having serious psychiatric disorders are substantially higher in prisoners than they are in the general population" (Fazel and Danesh, 2002: 548). Again, these results point to a possible link between mental illness and offending.

While prison based research may posit a relationship between the presence of mental illness and violent behaviour, there may be alternative explanations for any

association such results demonstrate, such as the previously outlined criminalization understanding of mental illness and violence. A subsequent paper by Taylor and Gunn (1984b), which sought to understand the reasons for the prevalence of mental illness in prison utilising the data from their research in Brixton prison, suggested that the tendency of the police to view this group as more dangerous may provide an explanation. The police may use 'mercy bookings' as a means of channelling members of this group into mental health treatment (Markowitz, 2010: 6). The mentally ill population's disproportionate inability to provide a permanent address and to adequately defend themselves in court proceedings was also seen to contribute to the increased numbers of this population in prison (Taylor and Gunn, 1984b: 12). When seeking to explain the high proportion of mentally ill individuals in prison settings, one must also take account of the implications of this environment for mental wellbeing, as the process of prosecution and punishment may induce mental illness or exacerbate already existing conditions (Peay, 2007: 504).

If we consider the results of prison based research projects detailed here, which show that mental illness is particularly pervasive among the prison population, such studies appear to indicate a relationship between mental illness and violent offending. Yet it is important to remain aware of other possible reasons for the association these studies demonstrate between mental illness and violence. Ultimately, high rates of mental illness among prisoners do not prove a causal link between mental illness and violent offending.

3.2. Criminality in Psychiatric Populations

It appears that research into the extent of mental illness in the criminal population is unlikely to yield definitive evidence of a relationship between mental illness and violence. Other studies opted to examine the prevalence of violence among the psychiatric population in order to determine whether this group are more dangerous than the wider society. This section will detail four studies which have adopted this approach: The National Institute of Mental Health's Epidemiologic Catchment Area

Survey; The MacArthur Violence Risk Assessment Study; Link, Andrews and Cullen's (1992) New York Study; and Fazel and Grann's (2006) Sweden Study.

National Institute of Mental Health's Epidemiologic Catchment Area Survey

Data from the National Institute of Mental Health's Epidemiologic Catchment Area Survey (ECA) has often been employed in researching the relationship between mental illness and violent behaviour. The ECA aimed to estimate the incidence and prevalence of mental illness, and to address gaps in the existing research in this area. For example, the project focussed on specific mental illnesses, as defined by the DSM-III, as opposed to 'global impairment ratings' which had been the focus of previous research (Eaton et al., 1981: 320). The project sought to draw approximately 4,000 individuals from each of its five research sites across the USA, aiming for a total of 20,000 participants and resulting in a sample of 18,571. It advanced from previous studies in this respect, as the sample included both community resident and hospitalised individuals and was thus more representative of the general population (Regier et al.: 1984).

While this project itself did not explicitly aim to examine the relationship between mental illness and violence, this data forms the basis for many other studies, and is credited as an accurate assessment of the extent of mental illness in society (Friedman 2006: 2065). Research by Swanson et al. (1990) utilised data from the ECA to examine rates of violence among the mentally ill. The researchers analysed the interview data pertaining to violent behaviour, and discovered that while 2% of participants not diagnosed with a mental illness reported violence, 8% of those diagnosed solely with schizophrenia reported behaving violently. This increased further where schizophrenia was comorbid with personality disorder or drug and alcohol misuse, with 13% of such individuals reporting violence. This was found to be the case even were variables such as gender and socioeconomic status were controlled for. Thus, this research suggests that there are elevated rates of violence among those diagnosed with mental illness, particularly where this diagnosis is of schizophrenia. The methodological rigour of this project is compelling, and "many

studies have done no more – but also no less – than confirm the original findings of Swanson et al." (Maden, 2007: 23).

MacArthur Violence Risk Assessment Study

The MacArthur Violence Risk Assessment Study, conducted between 1992 and 1995, also sought to explain the relationship between mental disorder and violence by determining the rates of community violence among those discharged from acute psychiatric facilities. The study featured many influential academics in the field, and it was hoped that this research would provide definitive evidence regarding the relationship between mental disorder and violence. Seeking to dispel myths about mental illness, and to right the methodological wrongs which compromised previous enquiries (Steadman et al., 1998: 393), the study boasted an impressive research strategy. A sample of 951 patients were interviewed preceding release from four selected psychiatric inpatient units in various locations throughout the U.S.A (Torrey et al. 2008: 147). Patients were then interviewed once every ten weeks over the year following their release, in order to determine whether they had exhibited any violent behaviour. A community control sample, the lack of which was identified as a flaw in previous research, was obtained from one of the sample sites, and consisted of individuals living in the same areas as the discharged patients (Steadman et al., 1998, 395).

A key assertion of this research was that while violence was common among the discharged population, with almost 30% of the sample offending over the course of the follow up year, the mentally ill could not be perceived to be more violent than the community control group. This appears to be a great deal of violence and it is suggested in a critique of the study by Torrey and colleagues (2008) that the prevalence of violence by discharged patients was actually high (Torrey et al. 2008: 148). This is refuted by those in the MacArthur Study Group, who emphasise that this pales in comparison to the levels of violence perceived by the public. In fact, the rate of violence decreased rapidly in the early months of the study. This suggests that, as most of the sample were admitted to hospital for a short period and therefore

were most likely ill at the time of discharge, this violence occurred in the context of enduring acute mental illness and its symptoms. The results therefore indicate that rather than simply a diagnosis of mental illness, it is acute mental illness and its symptoms which increase the risk of violence. A further important conclusion was reached by this project: violence among the mentally ill is associated with the same risk factors which are seen to influence violence in the wider society. Violence was found to be linked to "previous violence, to neighbourhood context, and to anger, as well as the usual demographic variables of age and sex" (Madden, 2007: 35), and a significant role was seen to be played by substance misuse (Steadman et al., 1998: 395). In summation, the results of the MacArthur Study suggest that the mentally ill are not significantly more likely to commit violent acts when we take into consideration the context of these events.

Link, Andrews and Cullen's (1992) New York Study

A study conducted by Link, Andrews and Cullen (1992) also aimed to determine whether the mentally ill population are more violent than the rest of society. They conducted a secondary analysis of data from a previous epidemiological study of the Washington Heights area of New York City, in which official arrest records were collected as well as participants self-reporting their offending behaviour. The project sought to assess the plausibility of alternative explanations for the association between mental illness and violence, including the criminalization theory, asserting that previous arrest-rate studies may have overstated the extent of criminality among the mentally disordered population.

The results indicated a 'modest difference' in the rates of violence exhibited by the populations, with the mentally ill population being more likely to have been violent and to have been arrested for such behaviour. The researchers examined these results in light of the various explanations for such an association, and determined that this must be due to a causal relationship between mental illness and violence. They also note two important qualifications here. First, for such a relationship to exist individuals must be actively experiencing psychotic symptoms, and when these are

controlled for there is no difference in the propensity for violence of the mentally ill and general population. Second, they emphasise that "the excess risk of violence is modest compared to the effects of other factors" (ibid: 290). Thus, while this study appears to indicate a relationship between mental illness and crime generally, the results may be less compelling in light of these observations.

Fazel and Grann's (2006) Sweden Study

Research by Fazel and Grann (2006) also sought to examine the population impact of individuals suffering from mental illness on violent crime rates. They examined high quality national hospital and crime registers in Sweden for the period 1988-2000. All individuals discharged from hospital with a diagnosis of schizophrenia or other psychosis were linked to the crime register, and this data was examined for a wide range of violent offences. This allowed the researchers to determine the violence attributable to this group.

It was found that of an annual 45 violent crimes per 1000 of the population, 2.4 offences were attributable to patients with severe mental illness (Fazel and Grann, 2006: 1400). Given that if we assume a causal relationship between mental illness and violent crime, mental illness can be seen to have caused 5% of all violent crimes in this period, the evidence here appears compelling. The authors themselves highlight that there are limitations to this research, in particular the assumption of a causal link between mental illness and violence, with no account of non-modifiable risk factors such as gender, socioeconomic status and previous criminality. Thus, while this study illustrates that the mentally ill may account for a significant number of violent offences, it does not examine the nature of this association and therefore does not clearly indicate that mental illness itself is the driving factor in these incidents.

3.3 Conclusions

This section reviewed existing research which has sought to understand the relationship between mental illness and violence. In doing so, many studies have examined the extent of mental illness in the criminal population, and of criminality in the mentally ill population. While it was found that mental illness was common in the criminal population, alternative explanations indicated that this association does not necessarily demonstrate a causal link between mental illness and violence.

Moreover, while an examination of criminality in the mentally ill population did show evidence of a modest association between mental illness and violence, evidence here was inconclusive and studies adopting this approach often resulted in more questions than answers. Such research has identified issues which require further study. First, additional consideration must be given to the relationship between the acute mental illness identified by some studies and violence. Second, this research highlights a need to take account of the context in which mental illness and violence occur, and to examine the implications of coinciding risk factors for those suffering from mental illness.

4. MENTAL ILLNESS AND VIOLENCE: DIAGNOSES AND SYMPTOMS

Although we cannot say with certainty that mental illness causes violence, studies have instead sought to investigate the relationship in more detail. Rather than considering mental illness generally, this section will detail the literature pertaining to one diagnosis which has received particular attention – schizophrenia. It will then go further still, examining the influence of the presence of particular symptoms of mental disorder on violence, such as active delusions, 'threat/control-override' symptoms, and positive and negative symptom clusters.

4.1. Schizophrenia and Violence

Stereotypically, those diagnosed with schizophrenia are perceived to be volatile and dangerous (Dinos et al., 2004). Much research has highlighted schizophrenia as a particular diagnosis which may increase the likelihood of violent behaviour, and will be outlined here.

As well as their general findings of the prevalence of mental illness in the prison population, Taylor and Gunn's (1984a) study of Brixton prison gave particular focus to the prevalence of schizophrenia in this environment. Of the sample of 1241, 237 prisoners (8.7% of the total prison population at that time) were found to be psychotic, and the majority of these individuals were suffering from schizophrenia (Taylor and Gunn, 1984a: 1948). There was also seen to be an association between schizophrenia and violence, as 78 (45%) prisoners with schizophrenia were charged with a violent offence. Moreover, 11% of the participants convicted of homicide were schizophrenic, suggesting potential links between this disorder and homicidal behaviour (Anderson, 1997: 245). Although initially the results of this study do appear to illustrate an association between schizophrenia and violence, this may not be the case. Taylor and Gunn highlight that while many of the prisoners diagnosed with schizophrenia were charged with a violent offence, their offences were largely trivial. Additionally, while 11% of homicide perpetrators were schizophrenic, this was not a substantial number and only amounted to 5 individuals. Thus, rather than illustrating a link between schizophrenia and violence, this may suggest that "the population of this remand prison was unnecessarily inflated by the bringing of criminal charges against men who showed minor disturbances in behaviour but were ill and perhaps should have been in hospital" (Taylor and Gunn, 1984a: 1948).

A further study by Taylor and colleagues (1998) also identified schizophrenia as being particularly linked to violence. In conducting this research they examined records of 1740 patients, an entire residential sample for a period of 6 months, in a high security psychiatric hospital. Of this sample, 818 individuals suffered from schizophrenia, making this the most common diagnosis for patients in this setting

(Taylor et al, 1998: 219). Perhaps more significantly, a key finding here was that schizophrenia was determined to be the diagnosis most strongly associated with offences of personal violence. Thus, the findings of this research indicate that there may be an association between schizophrenia and violence.

Schizophrenia has received attention in terms of public concern and research examination. As research into the links between schizophrenia and violence appears to be inconclusive, it is unclear whether this attention is merited. It is crucial to remember the circumstances of individuals suffering from this condition, their lack of an independent life and inability to meet their needs (Chiswick and Thomson 2004: 707). These situations are likely to lead to frustrations and a lower threshold for violence, and may provide an alternative explanation for violence by some schizophrenic individuals. The preoccupation with this illness may relate to a general assumption that the delusions and hallucinations experienced by those suffering from acute schizophrenia influence them to behave violently.

4.2. Symptoms of Mental Illness and Violence

Studies which examine the relationship between mental illness and violence have often found that only those who are acutely unwell and actively experiencing symptoms of mental illness pose an increased risk of violence (Link, Andrews and Cullen, 1992; Maden, 2007). Accordingly, literature in this area has looked to specific symptoms of mental illness in to explain violent behaviour. The presence of delusions, 'threat/control-override' symptoms, and positive and negative symptom clusters have all been posited as explaining violence by the mentally ill.

It is plausible that delusions may lead to violent behaviour, whether this is through their interaction with other features of psychosis; their potential to create further symptoms such as anxiety and depression, which may lower the threshold for violence; or through the detrimental effect they have on the capacity of the sufferer for non-violent interaction with others. The special hospital study conducted by Taylor et al. (1998), referred to earlier in this chapter, examined this relationship. It

was found that many of the serious offences in this sample were motivated by delusional drive, with 75% of those suffering from psychosis offending as a result of the delusions they experienced (Taylor et al., 1998: 224). Appelbaum, Robbins and Monahan's (2000) research has also given attention to the relationship between delusions and violence, with contrasting results. Using data from the MacArthur Violence Risk Assessment Study, a series of follow up interviews with a sample of 1136 patients discharged into the community were analysed in order to examine the nature and prevalence of delusional thoughts among this group and the implications of these for violent behaviour (Appelbaum, Robbins and Monahan, 2000: 567). It was determined that delusional motivations for violence were uncommon, and the presence of delusions did not increase the likelihood of violent behaviour. Variations in the results of these two studies illustrate the problems inherent in comparing community and inpatient research. Perhaps it is unsurprising that community patients were seen to be less likely to engage in violence driven by delusions than inpatients, as they are likely to be those deemed by medical professionals to pose less of a risk to the public when unwell.

It has been posited that a relationship exists between a particular type of symptoms, known as 'threat/control-override symptoms' (TCO), and violent behaviour. Link and Stueve (1994) proposed that TCO symptoms are manifest in a strong perception of threat and a subsequent compromising of internal controls. It is this 'overriding' of internal controls which is perceived to result in violence in some individuals. Swanson et al. (1996) examined this relationship in a community sample, utilising data from the Epidemiologic Catchment Area Study. Participants suffering TCO symptoms were found to be five times as likely as non-mentally disordered individuals to behave violently, and twice as likely as individuals suffering from other psychotic symptoms, such as delusions or hallucinations (Swanson et al. 1996: 311). A study by Appelbaum, Robbins and Monahan (2000) which examined the relationship between delusions and violence generally also gave some attention to TCO symptoms. They found that, like delusions generally, there was no overall increase in violence risk as a result of the presence of TCO symptoms. Importantly, the authors highlight that may be understood as a result of the social withdrawal

which accompanies acute psychosis and delusions, as individuals with these symptoms may be unlikely to engage in the social interactions which lead to violence (Appelbaum, Robbins and Monahan, 2000: 571). This suggests that there is not a direct association between the acuteness of an individual's mental illness and violence, and that instead while some individuals are driven to offend by their symptoms, others may reach a point where their symptoms render them too unwell to engage in offending behaviour.

Further research in this area has focussed on the relationship between violence and positive or negative symptom clusters. Positive symptoms include delusions, hallucinations, and suspiciousness, and can be seen as more 'active' psychotic symptoms in this sense (Swanson et al. 2006 A: 492). Negative symptoms include emotional withdrawal and poor rapport, and can be associated with the isolation experienced by many sufferers of mental illness. Swanson et al. (2006a) examined links between positive and negative symptoms in a sample of schizophrenic patients. Symptoms were assessed using the Positive and Negative Syndrome Scale (PANSS), and violence was measured using the MacArthur Community Violence Interview (see Glossary). The study determined that positive symptoms were present in those who exhibited more violence. It also observed that the relationship between these symptoms and violence is not such that the more symptoms an individual suffers from, the more violence they exhibit (ibid: 496). Rather, individuals suffering from a very high number of symptoms are often so unwell that their ability to offend violently is impaired, leading to the 'inept offending' discussed by Peay (2007: 504).

Investigation of specific groups of symptoms in mentally disordered individuals may explain connections between mental disorder and violent offending. Rather than the presence of a major mental illness being indicative of violence, the specific symptoms associated with this and the extent to which they are experienced may be associated with such behaviour.

5. COMORBID DISORDERS AND VIOLENCE

In addition to the diagnosis of a major mental illness, individuals may also suffer from a concurrent alcohol or substance misuse problem or personality disorder, known as a 'comorbid' disorder. In spite of conflicting views regarding the relationship between mental illness and violent behaviour, the presence of a comorbid disorder is one set of circumstances which most agree increases the likelihood of violence by the mentally ill (Hiday, 1995). Where both of these diagnoses are present, this increases the likelihood of violence even further (Coid et al. 2006: 1203). This section will detail the existing research into the effects of a comorbid personality disorder, or substance or alcohol misuse problem on violence by the mentally ill.

5.1. Comorbid Substance or Alcohol Misuse

In considering the impact of a comorbid substance or alcohol abuse problem on violence, the findings from the MacArthur Study provide some insight. As already stated in this chapter, this research determined that the mentally disordered are not significantly more violent than the non-mentally disordered. Where the mentally disordered did engage in violence, co-occurring substance misuse was often present (Steadman et al. 1998: 399). The one year prevalence of violence for patients with a major mental disorder, but without co-occurring substance abuse, was 17.9%. Where substance abuse was present, this figure rose to 31.1%, almost double that of those not in the comorbid category. Thus, the results indicate that individuals suffering from a mental disorder comorbid with substance abuse are more likely to engage in violence.

Moreover, when offenders themselves are questioned about their criminal behaviour, they often cite drug and alcohol addiction as a driving factor. Junginger et al. (2006) conducted research into the effect of substance abuse and mental disorder on offences. One hundred and thirteen community participants suffering from mental illness and a co occurring substance misuse problem provided explanations for their

offences. These accounts were analysed by researchers who estimated the influence of mental disorder and substance abuse on this behaviour (Junginger et al. 2006: 880). Almost a quarter of participants' index offences were found to stem from comorbid substance abuse, and the results indicated that this was more likely to lead to offending than mental illness. This research illustrates that, according to the accounts of the mentally ill, substance misuse may even play a greater role than mental disorder in causing offences, including violence.

It is possible that this link stems from the negative impact of drugs and alcohol on an already deteriorated state of mental health, destabilising these individuals further and disinhibiting their responses, and ultimately lowering the threshold for violence. This is a particular cause for concern given that the mentally ill are also more likely to succumb to these addictions (Steadman et al. 1998: 400).

It appears that drug and alcohol misuse plays a role in violence by the mentally ill, and indeed where other non illness related factors interact with mental health problems in driving violence, drug and alcohol misuse often complicates the situation further. This is evidenced in research by Swanson et al. (2008 A), which determined an association between childhood behaviour problems and adult violence by the mentally ill. A subsidiary finding of this research was that "those in the conduct problems subgroup were significantly more likely to be violent in the presence of an (even moderate) use of alcohol or illicit drugs" (Swanson et al., 2008 A: 235). This suggests that regardless of whether we view violence as driven primarily by mental illness or other characteristics of this population, drugs and alcohol act as an intervening factor to increase the risk of such behaviour. One could hypothesise that drug and alcohol misuse may have a similar complicating effect on violence by mentally ill individuals suffering from a variety of additional problems. This is an area of concern for both research and treatment and management purposes, particularly as the mentally ill population are more likely to be affected by homelessness, low educational attainment, a lack of familial support and other such problems (Junginger et al., 2006).

5.2. Comorbid Personality Disorder

In addition to mental illness many individuals suffer from a comorbid personality disorder. Kendell (2002) highlights the difficulty of distinguishing mental illness from personality disorder. Personality disorders are defined by the ICD-10 (see Glossary) as "deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations". They are thought to be distinguishable from mental illness owing to their enduring nature, and that they are seen to represent "extremes of normal variation rather than a morbid process of some kind" (Kendell, 2002: 111).

The presence of comorbid personality disorder has implications for the treatment and management of patients. Tryer, Duggan and Coid (2003) emphasise the importance of recognition by clinicians where personality disorder is concerned, particularly as those suffering from a mental illness complicated by a comorbid personality disorder may be difficult to actively engage in the treatment process, which is important for a successful recovery and reduction in violent behaviour (Elbogen et al., 2006).

As well as in practice, in research it is important to be aware of comorbid personality disorder and the implications it may have for the relationship between mental illness and violence. Much research has been concerned with this. For example, Moran et al. (2003) conducted a community study of 670 mentally disordered patients, 28% of whom suffered from personality disorders, in order to determine the impact this has on violence. All participants were monitored in the community over two years in order to record any violence they exhibited. It was found that 19% of the patients not suffering from a comorbid personality disorder went on to offend violently, while 32% of the patients with comorbid personality disorder carried out further violent offences (Moran et al. 2003: 130). Thus, the results here indicate that the presence of a comorbid personality disorder increases the likelihood of future violent behaviour. Such conditions may intercede in the relationship between mental illness and violence as a factor in driving violent offending.

6. THE ROLE OF NON-TREATABLE FACTORS

Fazel and Grann (2006) recognise that assuming a causal link between mental illness and violence without examining other factors is a shortcoming of much research:

> The relationship between severe mental illness and crime is more complex than simple causality, and non modifiable risk factors, such as age, gender, socioeconomic status, and previous criminality are important. (Fazel and Grann, 2006: 1401)

Similarly, Hiday (1995) highlighted that "to understand the relationship, socializing conditions and intervening experiences must be taken into account more fully" (Hiday, 1995: 122). This sentiment is evidenced in a study by Elbogen and Johnson (2009), which analysed data from a large scale two-wave survey of 34,653 subjects in order to identify factors which predict violence in the mentally ill population. The key finding here was that "severe mental illness alone did not significantly predict committing violent acts; rather, historical, dispositional, and contextual factors were associated with future violence" (Elbogen and Johnson, 2009: 155). Research has accordingly been concerned with understanding the implications of these non-treatable factors for violence by the mentally ill. This section will detail three such potential characteristics of mentally ill individuals which may impact upon their propensity to act violently: social disorganisation and poverty, disrupted childhood and family background, and a lack of support while mentally ill.

6.1. Social Disorganisation and Poverty

One factor which may impact upon an individual's propensity for violence is social disorganisation and poverty. In the mentally ill context, this is particularly important if we take into account the downward drift into socially disorganised areas which often accompanies mental illness (Markowitz, 2011).

Hiday (1995) highlights that mentally ill individuals often live in conditions of social disorganisation, and explains how this differs from having low income:

> It is the condition of having extremely low income for a large percentage of one's life and of what that means in today's society: living in constant deprivation, lacking hope of having anything better, and believing in an inexplicable world where external forces arbitrarily determine what outcomes occur, outcomes that are too often negative and painful. (Hiday, 1995: 128)

Her research seeks to devise a causal model for understanding the relationship between violence and mental illness. She affords social disorganisation an important position in this framework, noting that rates of violence are higher among lower socioeconomic groups and in areas affected by poverty. Moreover, her research illustrates that residing in such conditions increases the likelihood of the development of mental illness. Individuals living in poverty areas are also more likely to misuse substances or alcohol and to be personality disordered. Thus, if we follow Hiday's proposed causal framework, we see that in the mentally disordered context, social disorganisation is not only associated with violence as in the general population, but may also induce mental illness and complicate it further with comorbid disorders.

Silver, Mulvey and Monahan (1999) conducted research into the effect of neighbourhood context on the risk of violence posed by the mentally ill. Using data from one site of the MacArthur Violence Risk Assessment Study, ultimately yielding a sample of 336 individuals, they determined that patients discharged into neighbourhoods of concentrated poverty were more likely to commit a further violent offence than those discharged into neighbourhoods with less poverty. This evidence supports Hiday's assertion that a relationship exists between mental illness, violence and poverty and social disorganisation.

6.2. Disrupted Childhood and Family Background

A problematic childhood and family background is a further factor which is often associated with violent behaviour, and may play a role in the mentally ill context. Matejkowski et al. (2008) analysed data relating to mentally ill individuals convicted of murder over a 12 year period, in order to identify factors which are indicative of violence. The majority of this group were found to have disturbed backgrounds, with histories of family dysfunction (Matejkowski et al., 2008: 81). These are problems

which are commonly experienced by those suffering from mental illness, and may be important in explaining their violent behaviour.

The link between a disrupted childhood and family background and violence is also evidenced in research by Swanson et al. (2008 A), which examined the impact of childhood conduct problems on violent offending by the mentally ill. By comparing the prevalence and correlates of violence by a group of 956 patients suffering from schizophrenia who did not have childhood conduct problems, to that of a group of 488 patients who did have antisocial behaviour problems during childhood, this study determined that those with childhood conduct problems were more likely to engage in adult violence over the 6 month study period. Furthermore, it was found that in many instances childhood conduct problems were more influential in driving violence than psychotic symptoms, as for those with childhood conduct problems, psychotic symptoms were seen to have no effect on violence. This research indicates that a disrupted childhood and family background are predictive of future violence by the mentally ill.

6.3. Impaired Social Support While Mentally Ill

It is common for the mentally ill to suffer from impaired social support while battling their mental health problems. This is manifest in a lack of relationships with potentially supportive networks such as the community, charitable organisations, family and friends. These networks may provide two forms of support: instrumental support, where the relationship is a means to an end, for example enabling the individual to access information or financial advice; or expressive support, in which case the love and companionship of the relationship itself is an end (Silver and Teasdale, 2005: 64).

It is probable that in spite of requiring additional support the mentally ill are less likely to be able to easily maintain these relationships. There may be additional strains for those providing support to a mentally ill relative or friend where the individual in question has a history of violence. This is exemplified in research by

Thompson (2007) who conducted a study in order to determine whether violent behaviour by the mentally ill increases the financial burden on their caregivers. Participants from the Duke Mental Health Study, a randomized clinical trial which examined the effectiveness of patient management, were asked to provide a list of caregivers, and these individuals were interviewed about their experiences. The interviews revealed that both the actual financial contributions and perceived financial strain were greater for caregivers supporting mentally ill individuals who have engaged in violence (Thompson, 2007: 329). In light of difficulties such as this it is unsurprising that many mentally ill individuals suffer from impaired social support.

Research suggests that this social support which is so often lacking is important in inhibiting violence by the mentally ill. Basing their suggestions on social bonds theory, Silver and Teasdale (2005) highlight that "having a stake in supportive relationships may decrease the likelihood that disputes with others will escalate into violence. To behave violently is to risk valued support" (Silver and Teasdale, 2005: 65). Thus, they propose that presence of social support prevents violence, while a lack of support frees the individual to engage in violence. This hypothesis was tested using data from the Durham site of the NIMH ECA. The study determined that impaired social support increased the propensity for violent behaviour, and that in fact the relationship between this factor and violent behaviour overshadows that of mental illness and violence. Thus, the lack of social support afforded to mentally ill individuals may increase their likelihood of behaving violently.

6.4. Mental Illness, Violence and Non-Treatable Factors

In summation, research posits that factors which predict violence among the general population also predict violence among the mentally ill, suggesting these groups act violently for similar reasons. The problems listed here are by no means an exhaustive account of the factors which may be detrimental to the wellbeing of this population, and research has demonstrated that such issues are strongly associated with violence.

7. CONCLUSIONS

7.1. Mental Illness and Violence: Research Findings

Following this review of key research which sought to examine the links between mental illness and violence, it is possible to draw some broad conclusions about the nature of this relationship.

An assessment of the literature which examined the extent of mental illness in the criminal population and the prevalence of criminality in the mentally ill population demonstrated that while studies often fail to adequately prove the existence of a causal link between mental illness and crime, others do indicate the presence of a modest association. Moreover, this research identified issues which merit additional concern, in particular the relationship between individual diagnoses or specific symptoms of mental illness and violence, and a need to take account of the coinciding risk factors which shape the context in which mental illness and violence occur, whether these are treatable comorbid disorders or non modifiable risk factors.

Subsequently, research which aimed to address these issues was examined. Research into the links between schizophrenia and violence did not illustrate a causal relationship, yet further studies suggest that the presence of specific groups of symptoms may increase the propensity for violence of mentally ill individuals. It was also found that where personality disorder or substance or alcohol abuse is comorbid with a major mental illness, violence is more likely.

Finally, an examination of non-treatable, traditional criminological factors which may coincide with mental illness, such as poverty and social disorganisation, a disrupted childhood and family background, and impaired social support, determined that these adverse circumstances often increase the likelihood of violent behaviour. The results of such studies suggest that such factors may be more strongly associated with violence than mental illness itself.

Perhaps the most important finding of this review then, is that "An illness and its symptoms do not occur in a vacuum" (Taylor et al., 1998: 224). The results here indicate that mental illness is rarely the sole cause of violent behaviour, and that a simple causal relationship between mental illness and violence does not exist. Rather, a host of other factors intercede in this relationship to increase the likelihood of violence, such as comorbid substance and alcohol misuse problems or personality disorder, or non-illness related risk factors such as a disrupted childhood or low socioeconomic status. Violent acts committed by the mentally ill often occur in a similar context to violence perpetrated by members of the general population, and accordingly this must be taken account of in research and in practice.

7.2. Researching Mental Illness and Violence: A New Approach

While research indicates that the combination of these additional risk factors and mental illness does appear to increase an individual's likelihood of behaving violently, there is little insight into the nature of this interaction. When seeking to understand the functioning of any connection between mental illness and crime, it is important to be aware of the difference between correlation and a causal relationship (Crichton, 1999). While a correlation between mental illness, additional factors and violence is evidenced by research, it is unclear whether this is truly a causal relationship. As Silver (2006) notes, "No clear understanding of the causal mechanisms that produce the associations between mental disorder and violence currently exists" (Silver, 2006: 689). In short, research remains undecided as to how and why mental illness and these factors interact to create violence.

It is perhaps understandable that few accounts of how this association is produced exist. It is difficult to achieve this level of examination in large scale clinical studies like many of those detailed in this chapter. Silver (2006) suggests that by focussing solely on the relationship between mental illness and violence and neglecting additional risk factors, many projects fail to fully examine the intricacies of this relationship:

> A research framework is needed that looks beyond mental disorder as the primary cause of and solution to the problem of violence. Instead, we need research aimed at understanding both the clinical *and criminological* risk factors that might lead to violence either independently or in conjunction with one another. (Silver, 2006: 689)

Thus, an alternative approach to understanding the true nature of the relationship between mental illness and violence is desirable.

If research aims to understand the mechanisms by which mental illness interacts with the particular characteristics and circumstances of individuals to produce violent behaviour, an individual level approach, rather than studies of large populations, may help to achieve this. In the context of the mentally ill, this may prove to be an especially useful means of investigation, as the findings of this review suggest that they are a very diverse group. Given the wide range of possible risk factors affecting this population, it may be that there is no typical picture of a mentally ill person, and thus individual level examination may be required. By conducting a detailed study of the characteristics of an individual offender, it is possible to examine how risk factors interact to produce violence on particular occasions, in particular settings. In doing so, offenders' own accounts of their violence should not be overlooked. If we aim to adopt a criminological approach to investigating this subject, as advocated by Silver (2006), listening to the accounts of offenders in seeking to understand crime and its causes is well established in this discipline (Carlen, 1984; Messerschmidt, 2000; Maruna, 2001). Such an approach would ultimately result in an enhanced clarification of the causal mechanisms driving violence.

7.3. Mental Illness, Violence and Masculinity

Ultimately, the findings of this review indicated both a need to consider the association of additional risk factors to violent offending by the mentally ill, and a need for further understanding of the causal mechanisms which drive this association. It has been posited thus far that this may be achieved by adopting an individual level examination of the risk factors and circumstances surrounding violent offending by the mentally ill. This research has sought to address some of the issues highlighted here, and aims to understand the association between mentally ill

violence and one risk factor in particular, masculinity, through a detailed individual level examination of the mechanisms driving violence in male offenders.

Gender, and the masculine attributes which often characterise maleness, is a risk factor which warrants further investigation in the mentally disordered context. Granted, several studies detailed in this review refer to gender, by noting variations between the sexes in their demonstration of mental illness or perpetration of violence (Link, Andrews and Cullen, 1992; Moran et al., 2003; Fazel and Grann, 2006).Yet research has rarely made variations between genders a priority. Teasdale, Silver and Monahan's (2006) research is an exception here, as this study aimed to examine gender differences in the response to TCO symptoms. Using data from the MacArthur study, they determined that males were more likely to engage in violence at times where they suffered from threat delusions, while females were less likely to be violent during such periods. They suggested that this may be due to a variation in the stress coping mechanisms employed by males, who engage in 'fight or flight' behaviour which may link to violence, and females, who adopt 'tend and befriend' strategies by seeking out support sources (Teasdale, Silver and Monahan, 2006: 656). Yet, "the data required to directly examine these mediating mechanisms were not gathered as part of the McArthur study and therefore could not be tested here" (Teasdale, Silver and Monahan, 2006: 656).

Again it seems that while research remains aware of a correlation between mental illness, being male and violent behaviour, we have no concrete understanding of the cause of this association. Criminology often attributes the increased violence exhibited by non mentally ill males to the concept of masculinity, and there are various competing understandings of the nature of this interaction (Messerchmidt 1993, 1995, 2000; Gilbert, 1994; Polk, 1994; Tomsen, 1997; Brookman, 2003). A consideration of masculinity in the mentally ill context may provide clarification here. Thus, this study aims to examine the causal mechanism by which mental illness, masculinity and additional risk factors lead to violent behaviour by mentally ill males.

CHAPTER 2

MASCULINITY AND VIOLENCE

It is difficult to deny that violence perpetration is an overwhelmingly male activity. Evidence illustrates that violent behaviour is in large part attributable to men (Scottish Executive, 2011). This does not mean to suggest that all males are violent; on the contrary, many males do not engage in violence. Nevertheless, Gilbert (2004) goes so far as to posit that "male violence may even outrank disease and famine as the major source of human suffering" (Gilbert, 2004: 352). This begs the question: why are men violent?

Both early sociological understandings of gender and early criminological explanations for offending have posited masculinity as a possible explanation for this connection between maleness and violence. Such theories have developed over time, particularly through the attention given to this issue in feminist scholarship. This consideration has in turn led to two further questions: what is masculinity, and how does it link to violence?

Thus far in this thesis it has been proposed that consideration of masculinity in the context of violent offending by mentally ill males may serve to illuminate the causes of these incidents. This chapter will explore the role of masculinity in male violence, with a view to answering the questions raised here. It will therefore examine homicide statistics with a view to illustrating the role of male violence; review key literature in the development of our understandings of gender and masculinity; consider the main features of masculine identities; examine various frameworks for explaining male violence; and analyse particular scenarios of male violence in light of 'cultural scripts' based understandings of masculinity and violence. It will be argued that the concept of masculinity does account for a great deal of male violence, particularly when this offence is understood, as suggested by the cultural scripts of masculinity framework, as a resource for the construction and maintenance of a masculine image.

1. THE MALE DOMINATED NATURE OF VIOLENCE

In his analysis of lethal violence in Victorian England, Wiener (2006) highlights that this form of offending "Always has been highly gendered behaviour" (Weiner, 2006: 2). This assertion has become more salient in recent years, as evidenced by Brookman's (2005) review of homicide statistics across England and Wales, Scotland and Northern Ireland for the 1997 to 2001 period, which illustrates the consistently male dominated nature of such offences.

Homicide data is useful in demonstrating the nature of violent crime today. Statistical evidence for this offence is often more accurate than the available information for other violent offences such as assault, where recording is more open to subjective interpretation and many incidents are unrecorded (Archer, 1994: 112). The most recent data set for lethal violence in Scotland is the Scottish Government's Statistical Bulletin 'Homicide in Scotland', which presents statistics on homicides recorded by the police in Scotland in the period 2001/2002 to 2010/2011 (Scottish Government, 2011). The common characteristics of homicides in Scotland are as follows:

In the 95 incidents documented in 2010/2011, 80% (111) of the 138 perpetrators identified and accused were male. Of these 111 male accused, 56% (62) were aged 16 to 30. This suggests that young men are the most common perpetrators of violence. Of the victims in this period, 79% (77) were males. This indicates that most violence is likely to take place between two males.

In the instance of male on male homicide, the most frequent victim-offender pairing, both parties are generally young and are acquaintances(Scottish Executive, 2010). Where a male perpetrator kills a female victim, both parties again tend to be young, and the victims are generally the partner of the accused or have some form of intimate relationship with them.

Statistics also illustrated that homicides are unlikely to be premeditated, and often escalate from rage and fury, or a fight or quarrel. The accused may utilise a sharp

weapon to cause the death of the victim, or where the victim is male the accused may instead beat the victim. Where the victim is female, strangulation is also a common cause of death.

The most common geographical area in Scotland for homicide is the Strathclyde Police Area with 64% (61) of incidents occurring here. Incidents usually occur in residential areas, or in the street. In terms of the role of drugs and alcohol on such incidents, 56% (77) of acused were under the influence of one or both at the time of the offence.

Given that homicide is largely not a premeditated offence, these characteristics are also common to the non-lethal violence from which these incidents stem. Overall, this evidence demonstrates that homicide, and other violent activity, is very much male dominated behaviour.

2. UNDERSTANDING MASCULINITY

In seeking to understand the male dominated nature of violence, scholars have looked to the concept of masculinity. Understandings of masculinity have developed over time, with influences from various fields. This section will review key theoretical frameworks for understanding gender and masculinity, including sex role theory, categorical theory, doing gender and hegemonic masculinity.

It is necessary at this point to highlight the influence of feminism on gender studies. With the emergence of second wave feminism in the 1960s, feminist literature in its various forms placed gender on the sociological agenda (Messerschmidt, 1993: Walklate, 2004). Underpinning feminist research's recognition of the importance of gender in sociological inquiry, is the assumption that gender carries importance in the social world and reinforces men's power over women (Brod and Kaufman, 1994). This attention has resulted not only in greater analysis of women's

experiences, but in a reconceptualisation of male experiences as diverse and complex, rather than merely in opposition to those of females (Mullins, 2006).

2.1. Sex Role Theory

A key concept in seeking to understand gender and masculinity is that of 'role'. Early sociological conceptions of gender which have influenced criminological inquiry, such as the work of Parsons (1937) and Sutherland (1947), are structured around this notion (Walklate, 2004: 56). The sex role framework for understanding gender begins from the assumption that sex differences are biologically designated. These differences then determine which of two sex roles – the male sex role and the female sex role – an individual is socialised into. These roles dictate behaviours and actions for individuals of both genders and are based on stereotypical societal expectations. Thus, the sex role framework asserts that "Biogenic criteria establish differences between men and women and society culturally elaborates the distinctions through the socialization of sex roles" (Messerschmidt, 1993: 15). Masculinity is then a sum of the biological attributes necessary for designation as male, and the male sex role that those designated as male are subsequently socialised into.

The fact that sex role theory remains rooted in the biological category of sex is problematic for many theorists, who perceive this notion as enduring biological reductionism (Connell, 1987; Messerschmidt, 1993). Further criticisms are concerned with the socialization element of this framework. By suggesting that all males are socialised into a single male sex role, and that all females are similarly socialised into a single female sex role, this understanding takes no account of diversity within genders and overstates the polarization of masculinity and femininity. Furthermore, sex role "ignores the fact that men and women are active agents in their social relations" (Messerschmidt, 1993: 28), portraying the individual as a passive recipient of their sex role.

2.2. Categorical Theory

'Categorical theory' is a term advanced by Connell (1987) to group feminist inspired work on gender, which presents both a theory of gender relations as well as a politics for action (Walklate, 2004). It advances from the individual focussed approach of sex role theory, and contemplates broader cultural structures from a gendered perspective. The notion that men and women are two opposing categories in the field of sexual politics is a key feature of categorical theory, which posits that gender relationships should be understood in this way. These categories are related to one another by "power and conflict of interest" (Connell, 1987: 54), and men are perceived to hold this power over women. Thus, key concepts in categorical theory are "patriarchy, domination, oppression and exploitation" (Walklate, 2004: 62). Therefore, through the lens of categorical theory, masculinity is perceived to be the power men wield over women.

While there is a concern that the theory promotes a 'false universalism', as the focus on these two opposing categories generates the notion of a typical individual, the importance of categorical theory should not be undermined. It served to introduce concepts such as power and patriarchy into the field of sociological gender inquiry.

2.3. 'Doing Gender'

As Connell (2002) notes, gender accomplishment can be observed at three levels in society: gender order, gender regime and gender relations. How gender is accomplished at the last of these levels, 'gender relations', is the focus of West, Zimmerman and Fenstermaker's 'doing gender' framework (West and Zimmerman, 1987; Fenstermaker, West and Zimmerman, 1991; West and Fenstermaker, 1995).

The crux of this framework is that gender is constituted through interaction with others. West and Zimmerman (1987) suggest that gender is "the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one's sex category" (West and Zimmerman, 1987: 127). In short,

individuals organise their everyday behaviour to accomplish gender in given situations, and this is a continuous process.

The suggestion that gender is situationally accomplished rather than biologically given and imposed by society represents a departure from sex role theory. The doing gender framework envisions an individual, who plays an active role in defining their gender. Individuals are aware that their actions are ultimately judged by others as indicative of 'manliness' or 'womanliness', and so organise their activities accordingly (Fenstermaker, West and Zimmerman: 1991). They in turn perceive the actions of others as reflective of their gender, and hold them accountable for these representations. The pervasiveness of gender in everyday life is therefore central to this concept (West and Fenstermaker, 1995). Simply put, "Because we believe there are two natural sexes, we attempt to become one of them" (Messerschmidt, 1993: 80). Yet this framework suggests there is scope for this to be achieved in varied ways, rather than positing singular oppositional sex roles. When compared with previous frameworks, doing gender provides one of the most compelling understandings of masculinity thus far.

2.4. Hegemonic Masculinity

One of the most influential conceptualisations of masculinity is Connell's (1987) 'hegemonic masculinity'. Built on feminist understandings, this theory sought to move forward from categorical theory but remained concerned with dominance and patriarchy. Developing alongside the doing gender framework, hegemonic masculinity's expressed recognition of multiple, actively pursued masculinities signified a departure from the conception of a single male role.

Hegemony is described by Connell as dominance achieved through, and embedded in, social and cultural structures. In the context of gender relations and masculinity, the term 'hegemonic masculinity' describes an idealised form of masculinity in a particular cultural and social setting. Connell proposes that hegemonic masculinity thrives through the maintenance of practices which institutionalise male dominance

in the gender hierarchy. This is not necessarily achieved by force, and in fact occurs with the support of a large number of men, in spite of the inability of some to fulfil this persona. As Connell highlights, "Few men are Bogarts or Stallones, many collaborate in sustaining those images" (Connell, 1987: 184). While the nature of` hegemonic masculinity varies across time and settings, there is one characteristic which is enduring: normative heterosexuality. Males who express normative heterosexuality achieve hegemonic power:

> It is found in the dominant notion of the male as breadwinner (from the gender division of labour); it is found in the definition of homosexuality but not lesbianism as a crime (from the gender relations of power); and it is found on the objectification of heterosexual women in the media (from the arena of sexuality). (Walklate, 2004: 64)

The hegemonic masculinity thesis does not suggest the total cultural dominance of one form of masculinity (Connell, 1987: 814). Rather, hegemonic masculinity exists in relation to, and through dominance over, other masculinities and femininities. Alternative masculinities are subordinated but not eliminated. As heterosexuality plays such an important role in hegemonic masculinity, homosexuality is a main form of 'subordinated masculinity'. Other alternative masculinities may act in resistance to hegemonic masculinity and challenge its dominance, these are known as 'oppositional masculinities'. Representations of hegemonic, subordinated and oppositional masculinities can be found in a variety of social settings (Messerschmidt, 2000). Meanwhile, femininity exists in a similarly subordinate position, as hegemonic masculinity is based on global male dominance over women. Owing to this domination, there is no femininity which is the equivalent of hegemonic masculinity (Connell, 1987: 187). A particular form of femininity known as 'emphasised femininity' is perceived to have the greatest cultural and ideological support. It is based on compliance with the subordination of women required by hegemonic masculinity, which requires sexual receptivity in younger women and maternal behaviour in older women.

Overall, hegemonic masculinity represents a synthesis of key feminist insights with sociological understandings of gender roles. By introducing concepts of patriarchy and domination in conjunction with the notion of multiple masculinities and

femininities, it provides a robust framework which forms the foundation for many understandings of masculinity and violence.

2.5. Understanding Masculinity: Conclusions

Understandings of masculinity have changed a great deal over time, and are more complex than simple notions of two dichotomous sexes as defined by biology. The doing gender framework and the hegemonic masculinity thesis represent some of the most influential work to date in the sociological study of gender. Both advance the notion of multiple masculinities and femininities and account for both individual gendered action and larger gender structures. It is from these concepts that many leading understandings of masculinity and violence advance, and when the term 'masculinity' is used throughout this thesis it is these frameworks which are being drawn upon.

3. FEATURES OF TRADITIONAL MASCULINE IDENTITIES

Thus far, competing definitions of masculinity have been critically assessed, and it has been argued that masculinity is an identity which is constructed and achieved. This section will examine how this is carried out in the context of everyday life. The key characteristics of traditional masculine identities will be considered, as will the task of achieving and demonstrating these in various spheres.

3.1. Features of a Masculine Identity

Features such as power, dominance and subordination of others, and normative heterosexuality have thus far been suggested to denote a 'real man'. A more detailed consideration of the facets of masculinity is now necessary.

David and Brannon (1976) suggest that masculinity, or the 'male sex role' has four key elements, 'no sissy stuff', 'the big wheel', 'the sturdy oak' and 'give 'em hell'

(David and Brannon, 1976: 13). Their description of these encapsulates the various important features of a traditional masculine identity. 'No sissy stuff', involves avoiding anything which can be understood as feminine in any way. This applies to all aspects of men's lives, including expressing emotions, maintaining appearances, selecting occupations, and forming friendships. The second of these characteristics is being 'the big wheel'. Broadly speaking, this means achieving success, status and respect, usually in financial terms through employment, but also in other areas of their lives, for example by being successful in recreational activities. Third, the male sex role demands a man to be 'the sturdy oak', an attribute which is demonstrated through "a manly air of toughness, confidence and self-reliance" (ibid.: 23). Both mental and physical strength are important here, creating an image of a formidable male who none would wish to challenge. Finally, men must be able to 'give 'em hell' when necessary. This is the aspect of the male sex role which is most strongly associated with violence. While this does not mean that all males must behave violently, it necessitates an undercurrent of aggression, particularly in the face of challenges. Overall, these four characteristics are at the core of traditional masculine identities, permeating a variety of areas of men's lives, as will be demonstrated throughout the rest of this section.

3.2. Significant Relationships: Family and Childhood

While the characteristics described above are integral elements of the masculine identity, they may not be fully understood or strived for by males during childhood. Masculine identities are beginning to develop at this age, and a male child's family dynamic has an important bearing on how this occurs. Parsons (1937) asserts that when males are socialised into the male sex role, the family is the primary mechanism by which this occurs. Therefore, it is through the family that young boys learn to see the male role as that of "achievement, goal attaining, breadwinning" (Walklate, 2004: 58).

One significant element of the family dynamic which appears to impact upon the development of masculine identities is the absence of a father figure. Parsons

suggests that a complication in the internalisation of sex roles occurs for boys where a male role model is unavailable, as they are over exposed to feminine socialisation. Similarly, David and Brannan (1976) suggest that young boys are particularly focussed on the 'no sissy stuff' element of their masculine identities at a young age, and the lack of a male role model may hinder the development of this feature of masculinity (David and Brannan, 1976: 37). In this scenario, Parsons asserts that boys become conflicted and attempt to rectify this by exhibiting 'compensatory masculinity', a behaviour which involves rejecting feminine 'sissy' behaviour and displaying 'toughness'. Beaty's (1995) U.S. research with a sample of 40 middle school boys, 20 with present fathers and 20 whose fathers were absent, suggested that those without fathers in their households had poorer masculine identities. Similarly, Lynn and Sawrey's (1958) study of children in Norway demonstrated that father-absent boys are more immature and have poor peer adjustment, engaging in more activities that could be considered compensatory masculinity. Overall, the lack of a father figure has strong implications for masculine identity development.

A further feature of masculine identities which may be impacted on by the family situation is violence. Within boys' families, there may be violence directed towards them at a young age, which may in turn lead them to internalise violence as a feature of their masculine identities. Widom's research into the cycle of violence supports this assertion, demonstrating a correlation between childhood victimisation and violence perpetration in later years (Widom, 1989; Maxfield and Widom, 1996). It must be noted that not all children who are victims of violence go on to victimise others, and that such experiences do not guarantee future violence. However, this does suggest that for young boys, experiences of violence may lead them to adopt violence as a feature of their masculine identities.

3.3. Significant Relationships: Female Partners and Heterosexuality

Further significant relationships for males are those with female partners. It was previously suggested that normative heterosexuality and its demonstration are key features of hegemonic masculinity (Connell, 1987). This implies an element of

possession and subordination in relation to females, as they are viewed as a resource for achieving masculinity.

A study by Pleck and colleagues (1993) sheds important light on the attitudes of males to these relationships. Using data from a large scale survey of adolescent males in the U.S., they illustrated that the sexual elements of heterosexual relationships are particularly prized by this group. It was found that males who hold traditional masculine values are more likely to have numerous sexual partners, and to believe that reproduction is an important task for males which validates masculinity. This supports the notion that relationships with females are an important aspect of a masculine identity through which normative heterosexuality can be expressed.

There is a suggestion that masculinity can have negative implications for relationships with females. Pleck's study also found that those who hold traditional masculine values have a greater belief that relationships with females are adversarial in nature. Similarly, research by Shaver and colleagues (1980) found that in couples where traditional gender roles were pronounced, females were likely to experience dissatisfaction within the relationship. One particular source of dissatisfaction traditionally cited by females is the lack of emotion demonstrated by such men in the context of relationships (Balswick and Collier, 1976). This can again be understood as a feature of the 'no sissy stuff' rule which governs masculinity, dictating that a demonstration of a feminine attribute such as emotion is negative.

3.4. School and Education

It is often suggested that school is a significant arena in the formation of early masculinities. This section will consider the various ways in which this setting contributes to and shapes the construction of masculine personas.

One particular feature of school life which may have implications for masculine identities is academic work. Messerschmidt's (1995) account of young boys' experiences of masculinity in school posits strong correlations between success in

this sense, masculinity and social class. For middle class boys such behaviour is in keeping with their goals and conceptions of what it means to be a real man, such as having stable financial income through a 'respectable' professional occupation (Messerschmidt, 1995: 88). Meanwhile for working class boys, studying and performing well in school are understood as emasculating activities and 'sissy stuff', as this group prizes alternative roles for adult males as truly masculine, such as occupations which involve demonstrations of physical strength.

Recreational activities within the context of school also affect masculinities. For Messerschmidt, organised activities such as sports teams are a further arena through which middle class boys may develop and express elements of their masculine identities which are not evidenced through success in school work, such as physical strength:

> Sport creates an environment for the construction of a masculinity that celebrates toughness and endurance, incessantly advocates competitiveness and the shame of losing (Messerschmidt, 1995: 87)

For working class boys, getting into trouble and 'having a laugh' is an alternative means of constructing and displaying masculinities in school (Connell, 1989; Messerschmidt, 1995). This is a recreational activity, but is unorganised and may often take place during lessons. This allows this group to demonstrate attributes such as toughness and daring, while acting against the educational institution which they perceive to be oppressive. It is also noted that fighting is a particular feature of such activities in school for this group, allowing them to further demonstrate elements of hegemonic masculinity such as physical strength.

3.5. Friends and Recreation

Relationships with other males are a key way in which men understand and construct masculinities. Bird (1996) posits that it is through such 'homosocial' interactions that men gain an awareness of the general features of normative masculinity, and establish the boundaries of their masculine identities. Through interviews with males, it was established that such relationships also act as an arena for competitiveness,

allowing the formation of masculine hierarchies within this social realm. Bird suggests that a further key feature of these relationships is the sexual objectification of women, which positions men as dominant in these relationships (Bird, 1996: 123). Hegemonic masculinity is therefore constructed and reinforced through homosocial relations, through the subordination of weaker males and females. Gough and Edwards' (1998) research, which involved discourse analysis of social conversations among a group of males, similarly noted that such interactions were "structured around a key distinction between selves-as-men (positively regarded) and 'other' identities (women, gay men, men of different regions/origins etc.) viewed in pejorative terms" (Gough and Edwards, 1998: 430). Thus, men's social relationships shape and reinforce masculinity.

The lack of intimacy and closeness that often characterises these relationships also denotes masculinity (Bird, 1990). Such a relationship which did entail emotional closeness or any form of dependency would be in contrast with principles of traditional masculinity such as 'no sissy stuff' and 'being a sturdy oak'. Bank and Hansford (2000) conducted research with male and female students which sought to further examine the reasons for the gendered differences which appear to exist in same-sex friendships. Their findings illustrate the negative impact of a masculine self-identity upon intimacy within men's friendships.

As well as friendships, masculine identities are often achieved through particular recreational activities. It has already been mentioned here that in a school setting some males construct masculinities through sports. Such activities are particularly useful for males in demonstrating attributes such as physical strength, reliability, dominance and risk taking at various stages in their lives, and particularly in these early years (Coleman, 1976; Renold, 1997). Parker (1996) asserts that physical activity endures as a priority throughout men's lives for numerous reasons. One of these is the importance to men of maintaining their physical appearance, and the connotations of this for attracting a female partner:

> To be healthy and diet conscious is to have some kind of sexual attraction over and above those who are not (Parker, 1996: 131)

Furthermore, sporting activities allow males to demonstrate hegemonic power, through interaction with other males within this context which is largely characterised by formal and informal separation from females and subordinated males such as homosexuals. Overall, these physical activities allow men to create and reaffirm their masculine identities, and to demonstrate the 'big wheel', 'sturdy oak' and 'give 'em hell' aspects of these.

3.6. Employment and Making Money

Traditionally, within the context of a family, men adopt the leading role in providing financial support. This can be associated with the bio-social goal of obtaining necessary resources for survival in order to provision mates and offspring (Gilbert, 1994). This unequal distribution of labour between the sexes has not gone unnoticed within research, and it is posited that men are socialised to view this to be their key role within the family domain, while women are led to understand family and child care related tasks to be their remit (Major, 1993). Moreover, work is a key source of status and identity for men enabling them to 'be a big wheel' (Brenton, 1976).

As there are a variety of occupations for men, there are also multiple workplace masculinities which men may adopt. These may fall into two categories, as defined by Collinson and Hearn (1996): 'shopfloor' and 'office' masculinities. Shopfloor masculinities are those which are defined by the demonstration of productive manual skills, which not only demonstrate specialist knowledge but are also characterised by freedom and independence (Collinson and Hearn, 1996: 68). In some instances these occupations may not be particularly financially beneficial, yet their nature incurs a sense of status for males (Shostak, 1976). Office masculinities have developed more recently. At their most amplified these parallel a stereotypical image of a business executive, and are characterised by high financial gain, discretionary power in relation to other individuals within an organisation, and risk taking behaviour in relation to professional decisions. While augmenting masculinity, such occupations also require an individual to employ skills which could be understood as feminine,

such as nurturing relationships with others (Collinson and Hearn, 1996: 69). Ultimately, these two realms of employment lead men to do masculinity within the restrictions of these roles.

As employment is a means through which masculinity is constructed, it follows that unemployment may detract from a masculine identity. Willott and Griffin's (1996,1997) research, which involved interviews with a group of unemployed working class males, demonstrated that the inability to meet the needs of domestic provision was an emasculating experience for men. The interviewed men also suggested that the absence of the feeling of productivity which comes from employment led them to feel disempowered. This supports the notion that for adult males masculine identities are often grounded in employment.

4. MASCULINITY AND VIOLENCE

Evidence indicates that men are responsible for the majority of violent offences, and criminology has concerned itself with explaining this. This section will review key research in this area, and provide an overview of the various explanations for the relationship between masculinity and violence. Research with a basis in biological concerns will first be outlined, both in relation to early positivist accounts and more recent evolutionary theories. A multitude of literature also draws on developing sociological understandings of gender in seeking to link maleness and violence and it will be argued that these frameworks present the most compelling account of this relationship.

Feminism has played an important role in developing criminological understandings of male violence, drawing attention to the gendered nature of this crime, as well as introducing concepts such as dominance, power and exploitation (Messerchmidt 1993,2000). For example, much attention was given to male perpetration of sexual violence by feminism, in particular radical feminism. Ultimately, this led to a move away from the positioning of men as the default subject of criminological enquiry,

and to a more critical examination of masculinity as an explanation for male offending (Messerschmidt, 2000: 2)

4.1. Physical and Biological Positivism

Physical and biological positivism represents one of the initial approaches to understanding crime, yet even in these early stages of the discipline males and their affinity for offending were to be the focus of research. In pre-feminist theories such as these, women were largely absent and the majority of attention was focussed on male offending (Heidensohn, 1996: Klein, 1998). While many of these theories are now considered outdated, it is nevertheless important to document their contribution to criminological understandings of male violence.

Positivist ideas postulate links between physical and biological factors and criminality, often with particular attention to violence and aggression. Certain variations in the nature of the male body are seen to predispose groups of men to offending and by measuring these it was seen to be possible to determine which men are likely to commit crimes (Walklate, 2004; Wilson and Hernstein, 1986). Early positivist research by influential scholars such as Lombroso (1876) and Sheldon (1949) focussed on the relationship between male body shape and criminality. More recent accounts have examined the role of genetic disorders such as XYY syndrome and testosterone levels in violence (Turner, 1993; Wayt Gibbs, 1997). Ultimately, while some research in this area has noted correlations between these factors and violence, there is little in the way of firm evidence to prove that they are responsible for driving such behaviour.

4.2. Evolutionary Theories of Male Violence

More recent theories have suggested that evolutionary psychology may provide an explanation for male violence. Evolutionary psychology is founded on the notion that all creatures are predisposed to behave in a way which enhances their 'inclusive fitness': the distribution of their genes in future generations (Brookman, 2005: 79).

Again echoing the conception of gender advanced by sex role theory, this perspective suggests that male aggression stems from a biological foundation and the subsequent socialisation which encourages this behaviour.

Daly and Wilson (1994, 1988) draw heavily on evolutionary psychology in order to explain male violence, with a particular focus on homicide. They suggest that violence is a functional response employed by males to ensure and enhance the effective continuation of their genetic line. They note that "a man has a higher ceiling upon his potential fitness than does a woman, but he also has a greater likelihood of going to his grave with no descendants at all" (Daly and Wilson, 1988: 137). Males are under greater pressure to procure mates for reproduction, and to have the resources to do so, and are accordingly more likely to resort to violence so as to achieve these aims. For example, males may employ violence in order to compete with other males over resources such as female partners, or males may be violent towards female partners so as to deter them from selecting reproductive alternatives (Daly and Wilson, 1994: 268)

Gilbert (1994) also aims to explain male violence from an evolutionary psychology perspective, again focussing on male perpetration of homicide. He begins by positing the achievement of 'biosocial goals' - care of offspring, finding and keeping a mate, forming and maintaining alliances with others, and gaining social status - as the main aim of human activity (Gilbert, 1994: 353). Gilbert sees violence as one of many possible strategies used by males in certain circumstances in order to attain these goals. For example, a common source of conflict between males is social rank struggles, with males often employing violence and physical strength to emerge dominant.

It is difficult to prove or disprove the approach of evolutionary psychology (Brookman, 2005). However, acceptance of this understanding of violence depends on an acceptance of its basis in biology and the debatable notion that passing on healthy genes is truly critical to males.

4.3. 'Cultural Scripts' Understandings of Masculinity and Violence

Other contemporary literature which has examined male violence can be referred to as the 'cultural scripts' framework of masculinity and violence. These theories have many similar features, and are influenced by the doing gender and hegemonic masculinity understandings, including concepts such as power and dominance in their explanations of violence by males. They suggest that men seek to achieve and construct a masculine persona, features of which may include dominance, power and physical strength. They propose that violence is a resource employed by males to display and maintain this image in the face of challenges (Messerschmidt, 1993, 2000; Polk, 1994, 1995). It is a behaviour called on largely by those in lower classes, who have insufficient resources to otherwise 'do' masculinity. Two key frameworks in this area are Messerschmidt's (1993, 2000) "structured action theory" and Polk's (1994) work on homicide.

Messerschmidt's (1993, 2003) structured action theory begins from its conception of gender, which draws heavily from the 'doing gender' and 'hegemonic masculinity' frameworks for understanding masculinity. He notes that while gender is accomplished through everyday action, and this in turn reinforces existing gender structures, masculinity also varies within a given social structure and situation. Therefore, gender is a form of 'structured action', situationally accomplished in relation to social structured circumstances (Messerschmidt, 1993: 84). Within this framework, criminal behaviour and violence are perceived to be a resource employed by men in 'doing' masculinity when more accepted methods of displaying masculinity are not available. Violence in particular is noted for its role in expressing masculinity, as it relates to key features of hegemonic masculinity such as dominance and aggression (Messerschmidt, 2000: 12). It is suggested that males who accept violence as a resource for doing masculinity in this way are more likely to call on this behaviour regularly to do so, particularly in the face of challenges.

Polk (1994, 1995) illustrates his explanation for the male dominated nature of homicidal violence and gives a thorough account of the notion of 'challenges' to

masculinity. He posits that the two key factors which contribute to violence are masculinity and "under or lower class position" (Polk, 1994: 188). Noting that homicide is largely perpetrated by males with lower socio-economic status, Polk proposes that changes in society have led to variations among men in terms of their means for achieving these goals:

> The mature male of established class position , with wealth, recognised status in the community, and power to influence the political mechanisms of community governance, has less need to resort to physical prowess either to subdue his competition or to control his female partner. (ibid.: 202)

Meanwhile, males in lower class positions are less able to accomplish and maintain masculinity in this way. As they have limited means for masculine activities such as achieving a powerful status and attracting females, it is posited that they must instead resort to violence to meet these goals in certain circumstances. In this way his account mirrors Messerschmidt's, suggesting that "physical violence remains a weapon to be employed when other devices fail" (ibid.: 204). Males are said to follow a variety of 'scripts' (Polk, 1994: 206) which guide masculine action in the face of challenges to masculinity. In a given situation there may be a range of available courses of action, and males look to these scripts in order to determine how to behave. This suggestion that males actively engage in behaviours which will enhance their masculinity is an echo of the 'doing gender' framework. For those in lower classes, where a subculture of violence thrives and alternative resources for masculinity are limited, these scripts often – but not always – demand a violent course of behaviour.

There are similarities in the frameworks for male violence proposed by Messerschmidt (1993, 2000) and Polk (1994, 1995). Their understandings of gender as actively pursued and constituted through action draw heavily from concepts of doing gender and hegemonic masculinity. Moreover, their depictions of violence as a means of affirming masculinity in the face of challenges, employed by certain groups of males where no alternative is available, are similar. They account for the male dominated nature of violence, while acknowledging the role of class and explaining variations in violent behaviour. It is from this understanding of masculinity and

violence that this thesis will be advanced. The remaining sections of this chapter will review literature which has adopted a 'cultural scripts' based understanding of masculinity and violence in order to examine particular forms and scenarios of violent behaviour.

5. SCENARIOS OF MASCULINE VIOLENCE

A host of literature has examined specific scenarios of male violence using the cultural scripts approach. This research suggests that male violence is a resource employed by some males in seeking to construct a masculine gender identity, and as such males who behave in this way have followed a cultural script for masculinity which demands violence. This section will review this literature, dividing it into three broad areas based on the victim of the offence: male on male violence, male on female violence, and male on child violence. Much of the research here is concerned with explanations for male perpetration of homicide, but the frameworks suggested can be generalised to explain non lethal violence.

5.1. Male on Male Violence

Male on male violence accounted for a large proportion of homicides in Scotland in 2010/2011, and this is a trend which has remained stable for the last ten years (Scottish Executive, 2011). This section will review research into some of known scenarios of violence where both the perpetrator and victim are male.

Confrontational Violence

Homicide statistics suggest that violence between males usually occurs in the context of a confrontation (Scottish Executive, 2011). In such scenarios, the victim and accused, who are most commonly acquaintances, become involved in some form of conflict. This escalates, often with one or both parties retrieving a weapon, resulting in the death of the victim. This usually happens somewhere in the street, and the

perpetrator is often under the influence of alcohol or drugs. Homicides occurring in this context are known as 'confrontational homicides'.

Polk's (1994, 1995) analysis of homicide incidents in Victoria, Australia between 1985 and 1989 highlights that confrontational homicides accounted for 22% of all cases. The circumstances he details mirror those outlined in Scottish homicide statistics. He describes incidents initiated by an action which is perceived by one male as a threat or challenge. Various provoking comments may constitute such challenges, including insults towards a female companion or a group which the male is part of as well as direct threats, or these actions may even be non-verbal (Polk, 1994: 63). These "precipitating events appear exceptionally trivial when contrasted with the disastrous outcomes" yet to the recipient they represent a substantial challenge (Polk, 1995: 170). This initial exchange often occurs in a public place, with a pub or nightclub being a common location. The "social audience plays a critical role in providing social supports for violence" (ibid.: 173) as a challenged male is reluctant to back down and lose face in front of a group of peers. Following this initial insult, confrontation builds and becomes violent. This may occur very quickly, or over a longer period of time with further verbal threats, and in some cases parties may even leave the scene to procure weapons (Polk, 1994: 69). The conflict moves location as it becomes physical, and the resulting lethal violence is more likely to occur in the street. The scenario escalates into unplanned violence in which one party is killed. Brookman's (2003, 2005) description of confrontational killings, which she notes account for 19 of the 54 cases of male on male homicides in her research, mirrors Polk's. Again, she highlights that while "the particular issues or triggers that gave rise to such confrontations were very diverse" (Brookman, 2003: 39), the incidents spontaneously escalated into lethal violence, often in the context of social alcohol consumption.

In explaining these scenarios, both Polk and Brookman draw on themes of masculinity and class. Polk suggests that the initial insults which incite these events can be understood as challenges to the insulted party's masculine persona, compelling him to defend this image (Polk, 1994: 88). The resulting violence is an

attempt to neutralise the threat to masculine honour. In this sense, often "a man's reputation depends in part upon the maintenance of a credible threat of violence" (Polk, 1995: 185). Brookman also references the part played by 'masculine ego' and the role of honour in these scenarios (Brookman, 2003: 54). Yet, the notion of masculinity alone does not explain why some males do not resort to violence in responding to such conflicts. Polk suggests that social class provides clarification here, as while economically advantaged males secure masculine honour through their access to resources, economically marginalised males cannot and must employ violence as an alternative resource. This understanding of male violence can be extended to non-lethal exchanges which occur in similar circumstances, as males are driven to confrontation as a means of portraying masculinity and 'saving face' where other resources fail (Archer, 1994; Messerschmidt, 2000; Benson and Archer, 2002).

Male Violence in the Context of Alcohol and Socialising

As indicated by homicide statistics and numerous research studies, males often behave violently in the context of alcohol consumption in pub and nightclub settings (Polk, 1994, 1995; Brookman, 2003; Scottish Executive, 2010, 2011). Accordingly much research has been concerned with the effects of alcohol consumption on the propensity for violent behaviour, and the role of bar and nightclubs settings in inciting violence.

As there are instances where males consume alcohol and do not behave violently, it is difficult to posit a statistical association between the two (Homel and Tomsen, 1993). If we consider that confrontational violence generally stems from trivial insults, alcohol may increase the likelihood of such potential challenges being issued. Graham and Hollin (2003) conducted research with a group of males regarding the role of alcohol in violence, and participants suggested that alcohol stimulates young males, making them increasingly aggressive and prone to risk taking while simultaneously impeding their judgement. A young male in this scenario would possibly be more prone to cause offence to others. Alcohol consumption may also increase the likelihood of comments from other males being perceived as injurious to

masculine imagine, by narrowing the drinker's perceptual field and making them more easily offended and sensitive (Archer, 1994; Benson and Archer, 2000). This increases the chances of the initial process of insult and affront occurring, and of confrontational violence. This is particularly important when we consider the often overt competition between males to consume a large amount of alcohol (Tomsen, 1997: 96). It is often suggested that excessive consumption of drugs and alcohol is in itself an indicator of masculinity due to the risky nature of such behaviour (Collison, 1996; Tomsen, 1997).

The bar and nightclub setting also plays a role in male violence. Such venues serve not only as leisure sites, but as social arenas for the appraisal of other males and the demonstration of masculinity (Benson and Archer, 2002: 13). In this context, Graham and Wells suggest that four types of violence are common: honour and face saving encounters, addressing a grievance, impulsive reactions, and fighting for fun (Graham and Wells, 2003: 584). The first three of these categories parallel features of confrontational violence, and in bar and nightclubs provocations are more readily acted upon. The notion of 'fighting for fun' as a masculine pastime is cited by others. Tomsen's (1997) ethnographic study of the culture of drinking violence discovered a level of appreciation for, and pleasure in participating in, violence in the context of male alcohol consumption. He posits that this is a distinctly lower class phenomenon, and attempts to explain this as "a symbolic rejection of middle-class values, leisure habits and lifestyles" (Tomsen, 1997: 99). Canaan (1996) similarly posits that fighting in the context of drinking is a working class means of displaying masculinity. He suggests that this behaviour enables young men to acknowledge masculine strength and power in a leisure context (Canaan, 1996: 123). This is in opposition to the recreational habits of males of a higher socio-economic status, who are unlikely to pursue violence as a pastime. For lower class males then, violence is a pleasurable activity, allowing men to express masculinity through retaliation against the oppressive social regime imposed by the middle class, and the immediate restrictions placed on them by the staff inside these establishments.

Aggression as an Overt Problem Solving Mechanism: Violence as Conflict Resolution and in the Course of Another Crime

In addition to confrontational homicide, Polk (1994) suggests two further categories for male on male homicide: homicide as a form of conflict resolution, and homicide in the course of another crime. In the case of conflict resolution, violence is employed as a means of settling disputes between males who are known to one another. Violence may also occur in the course of another crime, whereby the threat of violence utilised in order to increase the ease with which the original offence is carried out becomes a reality. In both of these instances violence is employed as a resource by males in order to reach various goals, and thus overtly serves as a problem solving mechanism.

Considering violence as a means of conflict resolution, it is necessary to describe some key features of such offences. Polk notes that in these scenarios, the victim and perpetrator are known to one another, and have often had a fairly close relationship (Polk, 1994: 113). Preceding the homicide, a disagreement takes place between the two parties causing this relationship to break down. This may stem from a variety of sources, and some examples seen in Polk's research include resources, such as money or space, and involvement in criminal activity, such as drug dealing or theft. These tensions often simmer between the parties involved for a period of time. Eventually one or both men seek to resolve the problem using violence, often with some degree of planning and the use of a weapon. Ultimately, this results in the death of one of the males involved. Brookman's (2003) description of what she terms 'revenge homicides' is similar. She notes that ongoing tension between two males previously known to one another escalates into planned violence using a weapon which results in death (Brookman, 2003: 43).

Explanations for these scenarios may be applicable to incidents which do not result in fatality, for as Polk notes, extreme violence was expected by the perpetrators in each case but homicide was not necessarily the intended result (Polk, 1994: 129). Polk draws on his framework of masculinity and class in explaining this form of

male violence. It is suggested that these scenarios again represent competition between males and are rooted in conceptions of masculine honour. Men prefer to behave violently so as to resolve this conflict rather than doing nothing and risking damage to their masculine image. He also notes that this form of homicide is particularly common among lower class males and those "farthest from the boundaries of conventional community life" (ibid.: 208), who resort more readily to violence in the face of problems. This may be attributable to the difficulty faced by this group in accessing legal sources of justice in the face of disputes.

As well as serving a function in conflict resolution, violence is often a useful resource for males in the context of other offending activities. These situations are typically high risk forms of crime, such as robbery or drug dealing, which rely on the threat of violence if they are to be successfully accomplished, and in these scenarios this threat becomes real (ibid.: 93). Victims and perpetrators in such scenarios are not necessarily known to one another, although in some instances they may be. Typically, the victim of the original crime becomes the victim of homicide, if, for example, a male being robbed resists and is killed in ensuing violence. The perpetrator may also become the victim of homicide, for example, where the victim of the original crime attempts self-defence and kills the perpetrator. Further variations in this category of homicide included professional killings, the police as victims and killings in a prison setting.

Again, Polk suggests that these incidents are strongly associated with masculinity and class. It is posited that as males are constantly in competition for resources to assert their masculinity, they are often willing to resort to extremely risky measures, including crime, to achieve this. This is particularly true of lower class males, for whom more legitimate avenues for resource accrual are scarce. When faced with a challenge in the course of such dangerous endeavours, these males respond violently so as to ensure that their pursuit of these resources is not jeopardised. Accordingly, "armed robbery can be viewed as a form of competition where males with scarce resources are willing to take enormous risks to seize the riches accumulated by others" (ibid.: 206).

Anti-Homosexual Violence: Expressing Normative Heterosexuality

Violence between males may occur in the context of anti-homosexual behaviour, and it is likely that this again has roots in masculinity. In constructing the hegemonic masculinity thesis Connell (1987) specifically highlights the important role of normative heterosexuality in constructing and maintaining a satisfactory masculine image. In relation to this, homosexuality becomes a key form of subordinated masculinity, generating a "contempt for homosexuality and homosexual men that is part of the ideological package of hegemonic masculinity" (Connell, 1987: 186). Similarly, in citing Freud's understanding of masculinity, Brod and Kaufman (1994) highlight that masculinity involves the avoidance of exhibiting feminine traits, and in this context is inextricably linked to sexuality. As "homoerotic desire is cast as feminine desire" (Brod and Kaufman, 1994: 130), young males are taught to shun and ridicule such behaviours. For young boys, being referred to as gay is the ultimate affront to masculinity, as this also suggests that they are physically weak, feminine and unpopular.

Connell's (1987) work highlights that teenage boys and young men seek to express their normative heterosexuality through the overt violent subordination of homosexuals in a group setting. Contemporary research suggests that this 'heterosexism – the ideological system that stigmatises nonheterosexual forms of behaviour and identity" (Franklin, 2004: 27) remains pervasive in current gendered landscapes. Violent persecution of homosexuals may fulfil a number of functions, including enforcement of societal norms against behaviour which is perceived to be gender deviant, self-defence against perceived sexual advances from other males, expressing heterosexuality to peers, and providing a thrill. The demonstrative purpose of homophobic violence is particularly important for young males:

> It is during the developmental stage in which they are striving to establish their masculine identity that young men are most likely to engage in exaggerated public demonstrations of masculinity. (ibid.: 34)

Franklin also posits that there is a celebratory, recreational atmosphere in such scenarios, with the perpetrators enjoying their shared power over the subordinated male.

5.2. Male on Female Violence

Homicide statistics suggest that females are less likely to be the victims of violence than males (Scottish Executive, 2011). Where this does occur males are generally the perpetrators, and it has long been suggested that violence to women is rooted in masculinity and the patriarchal domination of females by males (Websdale and Chesney-Lind, 1998; Connell, 1987). This section will examine two key areas where this behaviour is carried out: intimate partner violence and sexual violence.

Intimate Partner Violence

Statistics suggest that where females are victimised it is likely to be in the context of an intimate relationship (Scottish Executive, 2011). Dobash and Dobash's (1979) influential research in this area examines violence against wives in more detail, placing this form of offence in its historical and cultural context. They argue that violence against intimate partners has been supported throughout history by patriarchal structures and ideologies within society which position women as subordinate to their husbands. Polk examines such incidents in more detail, looking at individual incidents of intimate partner homicide and their circumstances, and posing the question: "how is it that what begins as a relationship of closeness and intimacy can turn in such a direction that exceptional violence is provoked?" (Polk, 1994: 27). In aiming to understand homicide in this context, such events can be divided into two scenarios: masculine possessiveness, and masculine depression and suicide.

Incidents categorised as 'masculine possessiveness' homicides are those which are motivated by the male perpetrator's feelings of jealousy and possessiveness towards the female victim. Serran and Firestone (2004) advance a 'male proprietariness'

theory of such homicides, highlighting that male possessiveness is at its height when there is a threat of desertion by the female. They posit that this is common among young female victims, as they are more attractive and desired by other men, creating heightened insecurity among their male partners (Serran and Firestone, 2004: 3). These suspicions are exaggerated as "Fuelled by the jealous rage, delusions can build in the minds of these men tormented by the thought of their lovers moving out of their control." (Polk, 1994: 32). In such instances there is often a history of violence in the relationship, with the male employing this as a means of control. It is this desire for control which leads the male to take the life of his partner rather than allow her to leave him, and violence may also extend to any rival male who becomes intimately involved with the female. Themes of masculinity are present in such scenarios, with male domination of females being at the heart of this violence. Female partners in these incidents are viewed as property by the male perpetrators, and abandonment is therefore interpreted as a challenge to the masculine ability to retain a key resource – a sexual partner. This is an especially damaging situation for lower class males, as they have limited means for attracting and keeping a female partner, and are therefore more likely to resort to violence to do so than their economically successful counterparts.

Comparable understandings of non-lethal violence towards women are advanced in other research. In her study of self reported intimate partner violence in a sample of college students, Propspero (2008) notes that this is related to controlling behaviour by males and violent attitudes, whether this is psychological or physical. Totten's (2003) examination of girlfriend abuse by young males found this form of violence to be similarly rooted in masculinity. Young, economically marginalised males in this study were "socialized into a role of dominance, aggression and power, yet were unlikely to ever wield this power" (Totten, 2003: 85). Females, on the other hand, were perceived to be a subordinate group, with many perpetrators of girlfriend abuse demonstrating a firm belief in traditional gender roles which cast them as home makers, sexually receptive, and submissive in everyday life. Totten posits that as males seek resources for the construction of a powerful masculine persona, and

females are seen to be an easily dominated group, abuse of girlfriends is one such resource which is accessible to lower class males.

In considering masculine depression and suicide, Polk notes that in this less common scenario the theme of possessiveness is still present. Possessiveness is expressed in the context of the male's depression, which causes him to end his own life, and to take the life of his intimate partner in the process. This may be due to economic reasons where younger males are concerned, or related to health problems in older males. In either instance, "these events revolve around the decision of the male to take his own life, with the killing of the woman being a secondary consequence of this decision" (ibid.: 33). In this instance, men's domination over women is manifest in the male's perception of the female as his property to be disposed of at will.

Sexual Violence

Although not heavily represented in homicide statistics, accounting for no Scottish homicides in the 2010-2011 period, male sexual violence represents a genuine concern for many females. Like much other violence against women, sexual violence is seen to be rooted in masculinity. Early feminist examinations of male violence suggested that rape is the embodiment of men's domination over women. Through rape and the fear of rape, it was posited that all men keep all women in a state of fear (Messerschmidt, 1993: 37). Understandings of sexual violence advancing from this feminist perspective will be reviewed here.

Cameron and Frazer's (1987) work examines sexual murder, positing that "for certain men, killing is itself a sexual act" (Cameron and Frazier, 1987: 7). Sexual murder occurs where the urge to kill is compulsive, and stems from lust and sadistic sexual desire. The female victims of such offences are depersonalised, serving as objects of sexual gratification. Through examination of prominent themes in several highly publicised incidences of sexual murder, Cameron and Frazer propose a framework for understanding these offences. First, they note that sexual murders are primarily violence against women and are characterised by misogyny. They concede

that these incidents must be understood as men seeking to control women's sexuality and force their lust upon them, yet suggest that this is an incomplete account. Sexual murders, they argue, are also rooted in the desire for 'masculine transcendence', whereby the perpetrator seeks to assert his masculinity through transcendence to something greater than normality and the constraints of everyday life. This is evidenced in "the desire for fame of the serial killer" (ibid.: 166). It is debatable whether most offenders achieve this transcendence, and this aspect of their framework is perhaps less convincing. Yet their conceptualisation of sexual violence contains elements of the cultural scripts understanding of masculinity and violence, describing sexual violence as resource for constructing a masculine identity.

Messerschmidt's (2000) research on the topic of sexual violence provides a similar understanding of this behaviour. Drawing on life history interviews with a small sample of adolescent boys who have perpetrated sexual violence, he too proposes that this is grounded in masculinity. Messerschmidt emphasises that the sexually violent boys had experienced difficulty expressing a satisfying image of normative heterosexuality and sought to remedy this through their actions. This is distinct from the notion that sexual violence simply is male power. Rather, for these males, sexual violence was an achievable means of situationally accomplishing masculinity, in the context of a lack of other resources for doing so. In this way, "all three sex offenders perceived their crime not as rape but as legitimate ways to 'do' heterosexuality and masculinity" (Messerschmidt, 2000: 100).

Sexual violence perpetrated in the context of a group can also be understood as masculine. Group rape involves the devaluation of women through humiliation and domination. Through this devaluation, the masculine power of the participants is strengthened in a number of ways (Messerschmidt 1993: 114). Additionally, through participation in group rape, normative heterosexuality – the keystone of hegemonic masculinity – is displayed in front of a social audience. Franklin (2004) posits that there is an element of social bonding in such activities, as participants engage in this act and gain approval from one another. In light of this, "gang rape is often asexual, or at least not erotic" (O'Sullivan, 1998: 93), and does not generally provide the

sexual gratification described in Cameron and Frazer's (1987) 'lust killings'. Its purpose is social performance and the confirmation of hegemonic masculinity and normative heterosexuality.

5.3. Male on Child Violence

Violence towards children is an emotive topic, and there is a great deal of literature dedicated to understanding this behaviour. It is difficult to measure the extent of such behaviour, as incidents are under-represented in official statistics and self reports. Children represented a relatively small number of homicide victims for the 2010/2011 period, with a total of 7 victims under the age of 15 in this period, yet attention is nevertheless due to the male dominated nature of such behaviour.

Wilczynski's (1995, 1997) research is largely concerned with child homicide, with particular focus on the masculine nature of male perpetration of child homicide. In two key articles she details findings of a research project on child homicide, carried out in England and Wales in the 1980s. This project reviewed 48 cases where a child was killed by a parent, or parent-substitute, seeking to determine the nature and causes of these offences. She emphasises the importance of the context in which they occur, detailing the various stresses which males may experience. For example, males are likely to experience high levels of 'social stress', including perceived financial difficulties (Wilczynski, 1995: 173). It is possible that in this context the child is seen as an additional burden, and that homicide is employed as a resource through which these financial problems can be resolved. Similarly to female partners, feelings of possession and control, and a notion of the child as property to be disposed of when convenient contribute to such violence. Males may also kill their children as a means of retaliating against or controlling an intimate partner, displacing their anger towards this individual on the child (ibid.: 168). Jealousy was also a motivation for many of the male perpetrated child homicides, with several having killed their child due to resentment of the attention given to them by the female partner. Men were also noted to commit homicide out of anger. This generally occurred in the context of rejection by the child victim, or in the context of

discipline, whereby an assault on the child for this purpose escalates and the victim dies. Here we see themes of masculine power and dominance, with male perpetrators lashing out in a state of rage and aggression when the child does not obey their commands. Overall, Wilczynski's understanding of child homicide is characterised by themes of domination, control, and possession. Wilczynski notes that child homicide by males is frequently the culmination of a pattern of abuse, as in 70% of the cases evaluated there was evidence of previous violence to the victim (Wilczynski, 1997: 428). Accordingly, these themes of control and possession can be extended to characterise male non-lethal violence to children.

Alder and Polk (1996) conducted a similar examination of child homicide cases, reviewing cases of the 83 child victims of homicide in Victoria, Australia between 1985 and 1994. They distinguished between scenarios where children were killed by a non-parent, and those where children were killed by a parent or de facto parent, known as filicides. Their research determined that while the explanations for both of these forms of violence were based in masculinity, they were nevertheless different.

Where the offender is not a parent, the most common homicide scenario involves a teenage victim being killed by an older male. Where the victims in these situations are male, this typically occurs in the context of confrontational homicide, as discussed earlier in this chapter (Alder and Polk 1996: 401). Where the victim is a female, there is often an intimate relationship between the victim and accused, and masculine possessiveness may be applicable here. Young females are seen as particularly desirable partners and have more opportunities to defy their current male, an action which is likely to be perceived as a challenge to masculinity and met with violence. Adler and Polk note that homicide was also employed in order to prevent disclosure of this relationship for fear of the legal charges in instances where the victim was particularly young. While the theme of possession is still present here, this is distinct from other intimate partner frameworks, as the female is viewed as a possession and disposed of to resolve a problem rather than in a state of rage.

Alder and Polk propose alternative frameworks for male perpetration of filicide, whereby the victim is killed by a parent or de facto parent. In this context, the most common form of child homicide is that which occurs in the course of an assault, and is known as a 'fatal non accidental injury'. This explained the majority of homicides in the study committed by non biological fathers, and tended to be an attempt on the part of the parent to discipline the child which escalates into homicide. Evidence often suggested that the child had been a victim of previous violence, mirroring Wilczynski's (1995, 1997) findings that child homicide is often the culmination of a pattern of abuse. Child homicides committed by biological parents occurred in the context of the suicide of the father, often accompanied by the murder of the mother and child, with the father perceiving his actions as altruistic (Alder and Polk, 1996: 405). Often this occurred during times of emotional trauma, for example when the couple are separated and custody of the children is in dispute. There is also a suggestion that these actions were intended to control and hurt the female partner. Possessiveness and dominance are again present in this scenario, with biological fathers positioning their children and intimate partners as property to be manipulated and controlled.

A recent study by Cavanagh, Dobash and Dobash (2007) also examined records for child murder, looking at 26 case files which formed part of the 'Murder in Britain' study (Cavanagh, Dobash and Dobash, 2007: 734). Their results indicated that children were more likely to be killed by their stepfathers, with 62% of victims having this relationship to the perpetrator, compared to 38% who were birth children. It was common for children to be murdered in the context of the father or stepfather becoming agitated with their behaviour, or feeling jealous or resentful of them. In seeking to explain this over representation of stepfathers as perpetrators, Cavanagh, Dobash and Dobash theorised that "Some stepfathers are reluctant to invest in other men's children" (ibid.: 742), particularly when they are not accustomed to child rearing. Bringing up another man's child may represent an affront to masculinity, as it is arguably more difficult to exert dominance and control, and challenges may be more frequent in this situation. This is likely to result in the feelings of irritation and resentment described in these cases. It is plausible that in this scenario, stepfathers

resort to violence as a means of exhibiting power and ridding themselves of the perceived burden of the child.

6. CONCLUSIONS

This chapter has sought to determine why males are responsible for such a large proportion of violence, as evidenced by homicide statistics. This has been achieved through an examination of the nature of masculinity and the relationship of this concept to violence.

It was first necessary to examine what the concept of masculinity is, and a review of the development of sociological understandings in this area suggests that most credible accounts of masculinity are those which suggest that this is achieved and constructed, rather than biologically given. This is done through individual action and navigation of gendered social structures, in a variety of spheres of everyday life.

Much literature has sought to link the nature of male violence to these concepts of masculinity, and criminology has advanced many frameworks for this purpose. A review of these understandings has determined that one of the most thorough accounts of masculinity and violence is found in literature which can be grouped as advancing the 'cultural scripts of masculinity and violence' framework. This theory suggests that masculinity and violence are linked, in the sense that violence is a tool for 'doing' masculinity. Violence is seen to be employed by males for the construction and preservation of a masculine persona, particularly in the face of perceived challenges to this. The framework also posits violence as a lower class phenomenon. It is suggested that males of a lower socio-economic status have fewer resources with which to achieve masculinity and are therefore more likely to resort to violence to this end, thus explaining why many males do not engage in violent behaviour.

A variety of scenarios of male violence can be understood in light of this framework. Male on male violence in its various contexts can be seen as the embodiment of masculine competition and challenging behaviour, with males employing violence to defend their masculine honour and subordinate alternative masculinities. Meanwhile, male violence to women must be understood as a means of exerting masculinity through dominance over the female gender, whether this is through possessiveness and controlling violence in intimate partner relationships or the expression of normative heterosexuality and physical control in scenarios of sexual violence. Violence towards children also illustrates male construction of masculinity, with males using violence towards children as a resource for the control of female partners and the domination of children who challenge them with perceived disobedience. Ultimately, male violence must be understood as a resource for doing masculinity which is called upon by males with limited alternatives.

As stated previously, a host of factors may have implications for in the relationship between mental illness and violent behaviour. In light of the strong links between masculinity and violence found this chapter, this thesis suggests that masculinity is one such factor. It will later be demonstrated that that the performance of cultural scripts of masculinity which demand violence impacts upon mentally ill males and non-mentally ill males in very similar ways, both in terms of their propensity for violence, and the nature and circumstances of the violence they perpetrate.

CHAPTER 3

THE TREATMENT AND MANAGEMENT OF VIOLENT AND MENTALLY DISORDERED OFFENDERS

In light of the suggested links between mental disorder and crime and the characteristics of this group outlined thus far, it is unsurprising that some individuals suffering from mental disorder do violently offend. The task of treating and managing mentally disordered offenders with a history of violence is a difficult one, and is the remit of the Forensic Mental Health Services (FMHS) and the Criminal Justice System (CJS), in particular the Scottish Prison Sevice (SPS). Additionally, non-mentally disordered offenders often commit violent crimes, and must be treated and managed accordingly. Unlike mentally disordered offenders, there is not a dedicated service for dealing with this population. Measures are nevertheless in place for the treatment and management of this group in the criminal justice system.

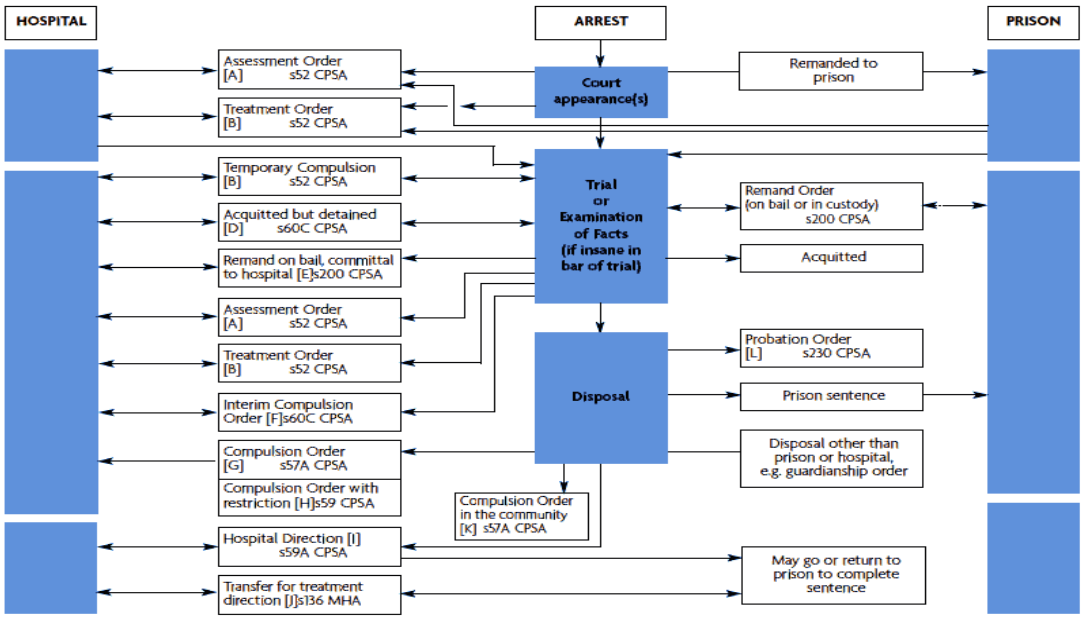
This chapter will review the treatment and management of mentally disordered and non-mentally disordered offenders, with specific attention to the provisions in place for those with a history of violence. As those who commit violent offences are often institutionalised following these incidents, as was the case for all those interviewed in this study, the chapter will focus on the measures implemented in the secure forensic psychiatric hospital and the prison.

It will be argued that where an offender is deemed to be suffering from mental disorder, they are set apart from other offenders for the purposes of treatment and management as a result of this. It will also be demonstrated that treatment and management by the FMHS provides a more effective framework for change than the measures implemented by the SPS. This is due to the variation in the character of these settings, as while the hospital is largely nurturing in nature, the prison is largely punitive. The experiences of patients and prisoners within these settings will also be outlined, and it will be demonstrated that these reflect the respective natures of these

institutions, and are largely negative. It will be argued that these negative experiences stem from the affront posed to masculinity by institutionalisation

1. THE CRIMINAL JUSTICE PROCESS AND MENTAL DISORDER

As this chapter is concerned with similarities and variations in the treatment and management of the mentally ill and non-mentally ill, the processes which separate these groups must first be considered. The criminal justice system itself often creates this separation. It is through the application of formal measures for the identification of mental illness, which are largely set out in the Criminal Procedure (Scotland) Act 1995 and the Mental Health (Care and Treatment) (Scotland) Act 2003, that individuals are categorised as mentally ill. This process sets them apart from the general offending population, dictating that they will receive care and treatment as a 'patient' rather than an 'offender'. The diagram below is taken from a training manual for medical practitioners in Scotland, and outlines the various stages from arrest until final disposal where mental illness can be identified and formally addressed.[2]



Source: Scottish Executive (2005), Appendix 5, pg. 51

[2] It should be noted that while the above diagram details the changes implemented by the Mental Health Act (2003), since this time the Probation Order has been replaced by the Community Payback Order.

As the diagram demonstrates, the measures in place during this process have two functions: to identify mental illness, and to address it. These can be applied at almost any point in the process. The s.52 assessment order is the key provision for the identification of mental illness throughout arrest and prosecution, while the s.52 treatment order and temporary compulsion order, and the s.60C interim compulsion order enable an individual deemed mentally ill to receive treatment for varying lengths of time prior to the final disposal. These measures can be applied where an individual is remanded in prison, enabling them to be transferred to hospital for assessment or treatment.

The diagram also illustrates that once an individual is identified as mentally ill, various final disposals exist which ensure their treatment as patients. A Compulsion Order, under s.57A of the CP(S)A 1995, is a commonly implemented disposal here, dictating that a mentally disordered offender is treated either in the community or in hospital (Thomson, 2006: 424). A compulsion order initially lasts for six months but may be extended for up to twelve months at a time subject to regular reviews, effectively detaining an individual indefinitely for compulsory treatment. A Compulsion Order with Restriction Order (CORO) may also be made, whereby extra scrutiny and control is applied to those considered to be 'high risk'. This order is available under s.59 of the CP(S)A 1995, and can only be implemented if the offence is sufficiently serious, the antecedents of the individual merit this, and they are seen to pose a risk to others (Darjee, 2005: 203). The detention of those subject to a CORO can only be altered a review by the Mental Health Tribunal for Scotland. The CORO is arguably the most limiting and burdensome disposal a mentally disordered individual can receive. Such disposals formally entrench the dichotomisation of the mentally ill and non-mentally ill in terms of treatment and management.

The process of identifying and responding to mental illness through the means outlined above is implemented by professionals. It is their assertion of mental illness which separates this group from the wider offending population and labels them as 'patients'. Becker's (1963) seminal text, *Outsiders*, warns of the implications of

applying labels through formal criminal justice responses to offenders, suggesting that such identities are internalised and reproduced. The effect of the patient label upon identity is significant and will be outlined in Chapter 7 of this thesis. For now it must be noted that the decision of professionals to apply this label to an individual has profound repercussions for treatment and management.

2. THE FORENSIC MENTAL HEALTH SERVICE

Those identified as mentally ill are largely treated and managed by the FMHS as a result of these final disposals. This often takes place in secure forensic psychiatric units where the individual has a history of violence and must be detained for public protection. This section will illustrate the policies and practices at work here.

As well as documentation which lays out policy and practice in this area, research which examines the effectiveness of treatment and management, largely in terms of their reduction of violence, will be outlined here. It should not be forgotten that one of the most qualified groups to consider the effectiveness of their practices are the mentally disordered themselves, and much research examines the 'user experience' of being treated and managed. Taken together, this literature gives an important insight into what is currently in place for the treatment and management of this group, how effective such measures are in fulfilling tasks such as maintaining security, addressing offending behaviour and protecting the public, and how this is experienced by patients. This section will review this literature, which has been divided into four sections: (i) management of violence (prevention); (ii) management of violence (response); (iii) treatment of patients with a history of violence; and (iv) throughput of patients with a history of violence. It will be argued that while the practices in place appear to be effective, they often create negative experiences for patients.

This section will also demonstrate that two leading paradigms dominate practice in this area: risk, as reflected in the concerns of security and assessment; and recovery,

as reflected in the care orientated and nurturing nature of this setting. It will be argued that by setting offenders deemed mentally ill apart for care and treatment in this environment it is ensured that interventions focus largely on mental illness. This conflicts with the minimal role of mental illness in driving violence which was demonstrated in the previous chapter.

2.1. Management of Violence: Prevention

While secure forensic psychiatric units are hospitals, they also must conduct treatment and management of mentally disordered offenders in a secure setting. In large part, maintaining this security involves prevention of violence, whether this is violence towards other patients and staff members, or violence which may potentially occur if a patient is to abscond.

Secure hospitals are categorised in terms of the level of security they offer as high, medium or low secure. A key development of the 2003 Act allows patients to appeal against excessive levels of security under ss.264 – 273, and request to be moved to a lower level institution. Patients should therefore be detained in the least restrictive setting possible, and only be held in high secure settings if they require the levels of security this entails (Thomson, 2006: 429).

Security comprises three forms: environmental security, involving physical measures which ensure security; procedural security, pertaining to practices in place to ensure the effective functioning of the unit and its physical security; and relational security, concerning quality of care provided by staff (Kennedy, 2002: 434). It has been noted that few studies have considered the effectiveness of security, particularly physical and procedural security (Bowers, Alexander and Gaskell, 2002). Largely, these measures are presumed to be effective in maintaining a secure environment where implemented correctly.

Security varies across high, medium and low security. By way of example, the table below details some of the various forms of security at these levels. These are taken

from the *Matrix of Security*, which lays out security standards in Scotland. The full table is available in Appendix B.

		Low	Medium	High
Environmental Security	*Secure perimeter*	No secure perimeter, secure external windows	No secure perimeter, secure external windows, deterrent perimeter fence	Tall secure fence, motion detection perimeter
	Doors	Double locked doors	Electronic airlock	Airport level security
	Staff alarms	Location specific alarms	Location specific alarms, response team alerted by pager	Location specific alarms, security alerted, tannoy to hospital campus and response team
	Dangerous items	Cutlery counted after meals	Cutlery counted after meals	Cutlery counted after meals
Procedural Security	*Communication*	No restriction on phone calls	Phone calls can be monitored or stopped	Phone calls can be monitored or stopped
	Rehabilitative activities	Majority of activities off-site	On and off-site activities	All activities on-site in a secure setting
	Routine pass	Individual risk assessment determines escort	Individual risk assessment determines escort	Minimum of two escorting staff
Relational Security	Required to be of a consistently high standard across all levels of security			

The above table demonstrates that as the levels of security of institutions decrease, the environmental and procedural measures in place tend to become less severe. In certain instances standards are consistent, such as counting cutlery which takes place in all institutions, suggesting that eliminating the potential for violence is a priority at all levels. Concerns here are strongly associated with issues of risk. For example, high security is described as "the level of security necessary only for those patients who pose a grave and immediate risk to others if at large" (Forensic Mental Health Services Managed Care Network, 2004: 21). The maintenance of detention is therefore crucial here, necessitating the increased environmental and procedural provisions outlined above (Forensic Mental Health Services Managed Care Network, 2006 A: 12). In Scotland, the high secure service is provided by the State Hospital at Carstairs.

Risk is also a concern in medium secure institutions, which allow a less restrictive environment, aiming to reintegrate patients into the community (Nelson, 2003). Three such facilities currently exist in Scotland: the Orchard Clinic in the east, Rowanbank Clinic in the west, and the recently opened Rohallion Clinic in Perth. While patients in these facilities may pose a danger to others, this risk is not seen to be as immediate or severe as those in high security (Forensic Mental Health Services Managed Care Network, 2004: 21). Yet the system of escorted pass and the decreased levels of environmental security increase opportunities for patients to abscond, creating additional risk related concerns. Permission for pass is determined in light of the risk patients pose to others should this occur (Scottish Executive Health Department, 2006: 13). Research indicates that enhanced procedural security may be effective in minimising absconding, for example through increased monitoring of patients at risk, and the use of a signing in and out book (Bowers et al., 2003: 421).

There is no dedicated low secure forensic setting in Scotland. Patients requiring this level of management are generally cared for in locked psychiatric wards which also serve non-forensic patients. Environmental and procedural security is again generally less stringent.

Relational security should not vary across the range of levels of security (Forensic Mental Health Services Managed Care Network, 2004: 22). This facet of security pertains largely to the nature and quality of interactions between staff and patients, and the ability of these relationships, if they are of a good quality, to enhance security. This should be ensured at all levels. Although security itself does not appear caring and nurturing, the demand for high standards of relational security illustrates this element of the character of the hospital. James et al.'s (1990) study found that a threefold increase in violence in their research site corresponded with an increase in temporary nursing staff, emphasising the importance of familiar environment and strong staff-patient relationships in preventing violence. Similarly, Beauford et al. (1997) found that the weaker a patient's 'therapeutic alliance', their bond with their therapist and their willingness to work with them, the higher their risk of exhibiting violence during their first week in hospital was. These studies affirm the importance of relational security in reducing violence.

Experiences of Security

In addition to considering the nature of security in hospital, it is also necessary to consider how the secure environment is experienced by patients. While little explicit attention is given to the various forms of security in research, many studies are concerned with service users' overall experience of secure hospitals, and will be outlined here. It should be noted that these studies are largely concerned with general psychiatric hospitals rather than forensic settings specifically, suggesting a gap in the existing literature. However the findings of such research are also relevant to forensic patients, as many of the issues considered, for example staff relationships, are also important in this setting.

Patients may have specific expectations when being treated and managed, and it is important that professionals are aware of these. Hopkins, Loeb and Fick's (2009) literature review asserted that user expectations are high and comprise seven key factors: respect for dignity, involving a safe environment for treatment and good

relationships with staff; confidentiality, in relation to information about their health; autonomy, so as to allow patients some choice in their healthcare; prompt attention, both in crisis and non crisis scenarios; high quality amenities, in terms of hospital facilities; access to social supports, such as family; and a choice of provider, in terms of who administers their care. The prioritisation of information and staff interactions here suggests that relational security is of particular importance to patients.

Studies have focussed on the level of satisfaction felt by patients regarding their treatment and management. Johansson and Eklund (2003) conducted in depth interviews with inpatients and outpatients receiving psychiatric care in order to determine how satisfied they were with the services. Their results indicated that patients were most concerned with their relationships with staff, and that this was an area in which they were highly satisfied (Johansson and Eklund, 2003: 342). Similarly, research in this area by Howard et al. (2003), which surveyed 204 patients from two psychiatric hospitals, indicated high levels of satisfaction with staff relationships, as well as with other aspects of the delivery of service (Howard et al., 2003: 212). Meanwhile, patients were unhappy with the lack of input they had in planning their own treatment and management, and the lack of education about treatment. Other studies further highlighted relationships with staff as generally positive elements of the patient experience, and a lack of information as negative (Kuosmanen et al., 2006; Hanson, 2003). Again this suggests that relational security is important to patients.

2.2. Management of Violence: Response

In spite of the measures outlined in the previous section, patients may still behave violently, and mental health professionals must respond to this. Behr et al. (2005) note that while a policy of zero tolerance to violence by NHS patients has been advocated by the UK Government, these sentiments are often not extended to users of mental health services. This is because such individuals are often very unwell, and are not seen as culpable for such behaviour. Yet, research has suggested that in some instances violence is not looked on with such understanding, particularly if the

aggressor is not seen to be acutely unwell and suffering from active symptoms at the time of the act (Hinsby and Baker: 344). Responding to violence by the mentally disordered is an area fraught with ethical considerations, and research therefore seeks to determine the most effective means of doing so.

In inpatient settings, responding to violence is the remit of nurses. While a variety of options are available - de-escalation, restraint, emergency medication and seclusion - incidents often occur without warning, and nurses may have to decide quickly which method they wish to adopt. Hinsby and Baker's (2004) research indicated that nurses may be more sympathetic in their responses to those who they perceive to be behaving violently due to acute mental illness, opting for less harsh methods of dealing with such individuals. Factors unrelated to mental disorder may also play a role in nurses' decisions. Gudjohnsson et al. (2004) advanced the question of whether racial differences drive nurses' responses to violence, through analysis of recorded violence over three years on 14 general wards. It was determined that decisions to adopt coercive techniques were generally related to the levels of agitation exhibited by patients, rather than race, suggesting that prejudices did not play a role in such decision making. Nevertheless, it is crucial that we are aware of the potential for concerns other than the risk of harm to influence decision making about responses to violence.

Where possible, in practice non-coercive methods are used to tackle aggression and violence (Davidson 2005: 365). This reluctance to employ physical measures reflects the nurturing nature of the hospital setting. These largely involve de-escalation, through talking with the patient in order to calm them, and to identify the cause of their stress and to address this problem. Lewis's (2002) case study of a violent forensic male patient illustrates that restraining individuals may lead to further aggravation and does not address the cause of the behaviour. Instead, he asserts that anger management techniques, which are usually a more long term therapeutic endeavour, can by employed to encourage the patient to assess their behaviour and what triggers their anger, promoting self-awareness and reducing future incidents (Lewis, 2002: 60). As such, this research indicates that what is effective in ensuring

safety is largely being implemented.

In spite of the acknowledgement that non-coercive methods are superior, the primary objective in responding to violence must be the safety of all involved. While nurses are trained in techniques for their own defence, restraint may be more effective in guaranteeing safety. Dickens et al. (2009) conducted a study of 147 people who had undergone extensive training in breakaway techniques, finding that in reality nurses may not be quick to recall these. Thus, if a patient has become physically violent and aggressive, rather than running the risk of placing nurses in a situation which calls for these often forgotten methods of self-defence, the safest option may be to resort to coercive methods.

A commonly utilised method is manual restraint, which involves restraining a patient, often on the floor in the prone position. This is a frequently adopted method, being used up to 5 times per month on an average ward, and even more so in forensic settings which contain a larger proportion of violence prone patients (Stewart et al., 2009: 750). This physical force may pose risks to patients' health, and concerns for patients' dignity are equally important. This process can be humiliating and frightening for patients, and may have psychological consequences (Macpherson, Dix and Morgan, 2005: 411). For agitated patients this is commonly employed in order to allow staff to administer rapid tranquilisation. Macpherson, Dix and Morgan (2005) highlight that these medications can have detrimental side effects, as well as resulting in further embarrassment to the patient, who may have to be restrained while parts of their body are exposed to receive the medication via intramuscular injection. Seclusion, also known as geographical restraint, is a further available method for responding to a violent incident. This involves moving the patient away from others, and into a more isolated area of the ward, for example a dedicated seclusion room (Davidson, 2005: 365). Again, seclusion is associated with risks, such as self–harm and emotional distress, yet in certain instances it may be a preferable option, for example where manual restraint would otherwise have to be used for a prolonged period of time.

Experiences of Restraint

As previously noted, restraint procedures may prove traumatic for patients, and much research is concerned with understanding how this is experienced. This section will outline literature in this area.

In response to a violent incident, professionals often resort to manual restraint. Wynn (2004) conducted qualitative interviews with patients following these incidents. He found that during this process patients felt afraid, angry and vulnerable, and that often this did not help them to calm down, leading them instead to resist the restraint or to disassociate themselves from the event (Wynn, 2004: 132). Moreover, patients believed that restraint was at times unwarranted, or was implemented for the wrong reasons. Research also indicates that experiences of restraint can be reminiscent of abusive events in patients' pasts, and may be like reliving these incidents (Gallop et al., 1999). It can be inferred from this literature that restraint is a negative experience for patients, and this is a deviation from the usually nurturing character of the institution.

Seclusion can be a similarly negative experience for patients. Meehan, Vermeer and Windsor (2000) conducted interviews with 12 psychiatric inpatients in order to understand their perceptions of seclusion. The impact on the patient was seen to be much like that of restraint, inducing feelings of frustration and helplessness in a majority of patients. There was a potential for seclusion to be used wrongly, and often patients were not properly informed why they were secluded, or how long this would last. Holmes et al. (2004) also interviewed patients regarding their experiences of seclusion, and assert that this experience may relate to patients' experiences of social exclusion, intensifying their feelings of isolation.

As coercion is at times necessary, mental health practitioners must endeavour to use these measures with the least amount of distress for the patient. Research indicates that staff have the ability to make this experience less difficult. In a study by Olofsson and Norberg (2000), patients, nurses and physicians discussed their

experiences of coercion. It was found that 'human contact', involving a close and trusting relationship with the staff as a whole and an awareness that they have the best interests of the patient at heart, made the experience of coercion less stressful and made patients feel safer (Olofsson and Norberg, 2000: 95). In this sense relational security remains important here, and attempts to ensure that the caring nature of this institution is upheld are experienced positively by patients.

2.3. Treatment of Patients with a History of Violence

In addition to detention of patients, the main aim of the secure hospital is treatment, with a focus on addressing mental illness. Practice in this area is largely guided by notions of 'recovery', which much research cites as an effective framework of change for patients. This concept has roots in the post WW2 'therapeutic community' approach to the treatment of mental illness, which sought to move away from previously harsh and authoritarian regime and towards a nurturing environment in which patients were active participants. Advancing from this, recovery represents a reconceptualization of the aims of treatment, suggesting that rather than recovering entirely from mental illness and its symptoms, patients should be assisted to recover their lives to the fullest extent possible. It suggests that those suffering from a mental illness may therefore recover without the illness being cured (Anthony, 1993; Jacobson and Greenley, 2001). It is not an end goal, and instead is an on-going process of coping with and adapting to being mentally ill. It also recognises that patients suffer further consequences of illness which must be addressed: 'impairment, dysfunction, disability and disadvantage' (Anderson, 1993: 525). This section will assert that the treatment based elements of the hospital environment convey the implementation of this framework.

The Care Programme Approach

The current model for treatment is the Care Programme Approach (CPA). It aims to assist in treating and managing patients whose cases are complex, and in Scotland is the approved means of regular review for forensic patients subject to a compulsion

order with restriction order, hospital direction, transfer for treatment direction and interim compulsion (Scottish Executive Health Department, 2007). In 2008 the CPA also became compulsory for the management of all patients under MAPPA guidance. As such, patients with histories of violence are largely subject to the CPA framework. However, in 2006 a review of the use of the CPA across Scotland suggested that its application was not uniform for forensic patients (Forensic Mental Health Services Managed Care Network, 2006 C). Furthermore, the CPA was being introduced only where a patient was considered for transfer or discharge from the service, rather than being used from the moment of admission. It was recommended that changes were made to rectify these issues and enhance the CPA's effectiveness.

The CPA process involves a series of meetings attended by various professionals, in order to devise a care package for a patient and to regularly review its implementation. The first of these meetings generally occurs once a patient has been in hospital for 4-10 weeks. Each patient is allocated a Responsible Medical Officer (RMO), generally a consultant psychiatrist, who is charged with their care. It can be suggested that placing a psychiatrist in this role positions mental health issues as the patient's primary need. Also in attendance at CPA meetings are the patient and members of the multi-disciplinary team involved with their care, including psychiatrists, nursing staff, social workers, psychologists and occupational therapists. This group will focus on mental health related needs, but will also seek to address other issues facing the patient. The meetings allow the team to discuss patients' progress, as well as enabling them to raise concerns in relation to their care. A CPA document is created and updated regularly following meetings as a means of recording a patient's care programme. Overall, the CPA is indicative of both the focus on mental illness as a patient's primary need, and the recovery orientated nature of treatment in this setting.

Methods of Treatment

While the CPA represents the framework for treatment, specific methods must also be considered. There is no particular treatment ascribed to violent mentally

disordered individuals. Rather, the nurturing nature of this service advocates that violent patients are treated on the basis of their needs and circumstances in the hope that the risk of violence will be reduced. Again the focus here is addressing mental illness and its symptoms. The recovery paradigm suggests that not all patients can be 'cured', and instead clinicians must work to prevent relapses into acute episodes (Mortimer, 1997: 339). In relation to violence it is important that patients adhere to treatment, as much research has shown that patients who participate actively and willingly in this process are more likely to succeed in addressing such behaviour. (Elbogen et al., 2006; Swanson et al., 2000; Swartz et al. 1998). When individuals with a history of violence do not adhere to treatment, this may cause increased concern among professionals, who may then employ legal leverage in order to ensure compliance (Swanson et al., 2006 B). This section details literature evaluating various measures for treatment.

In treating any major mental illness the "mainstay of treatment is pharmacological" (Travis and Kerwin 1997: 331). The specific medication utilised depends on the disorder a patient suffers from, and the symptoms they exhibit. Where symptoms are psychotic, anti-psychotic medication is utilised, and research has considered the effectiveness of this in reducing violence. Swanson et al. (2008 B) conducted a comparative study of the effects of various antipsychotic drugs on 1445 patients suffering from schizophrenia over a 5 month period. It was found that violence declined across all treatment groups, with prevalence falling from 16% to 9% (Swanson et al. 2008 B: 40). Regardless of which drug is used, it is important that pharmacological treatment begins swiftly once an illness is identified, so as to prevent any further deterioration of the patient's condition (Travis and Kerwin, 1997).

Therapeutic methods are an equally important aspect of the treatment plan, and are strongly associated with the nurturing nature of the hospital and notions of recovery. They suggest that psychological interventions can effect change, and in the case of violent patients this may offer a chance to alter this behaviour pattern. Cognitive behavioural therapy (CBT), which may reduce symptoms of mental disorder

(Haddock et al., 2009: 152), is a commonly used therapeutic measure and involves addressing problematic behaviours and thoughts in order to change these. Yates et al.'s (2005) study compared a sample of 90 mentally disordered inpatients with histories of aggression and crime who participated in a CBT programme, with a sample of 91 similar individuals who did not. It was found that those who undertook CBT to be significantly less impulsive and cognitively impaired and therefore less violent. This group were followed up in the community for 6 months to 4 years, and it was found that 39% no re-hospitalisation or re-arrests (Yates et al., 2005: 221). However, the findings of the study were in conclusive, as those who did not undertake CBT were not followed up. Therapeutic programmes may also be utilised to address problems other than mental illness. For example, Thomson (2000) notes that patients may have a comorbid drug or alcohol abuse problem, which can be addressed through group therapies (Thomson, 2000: 258). These examples are but a few of the existing therapeutic programmes available for mentally disordered offenders, and illustrate that the use of these methods is largely effective.

Experiences of Treatment

It is also essential to examine how users experience and understand these treatments. In general, research suggests that the majority of patients do feel treatment to be effective in terms of its ability to address mental illness and its symptoms. Howard et al.'s (2003) research noted that this is the case, yet patients often receive insufficient information about their disorder and treatment. Thus, it is important to provide patients with the necessary education and include them in this process.

Medication is a key method of treating the mentally disordered and reducing violence in the mental illness focussed hospital environment, yet little literature assesses service users' experiences of medication. Gilbert, Rose and Slade's (2008) study makes reference to medication. Interviews were conducted with 19 individuals who had experience of inpatient mental health care, some of whom reported that patients often suffer overmedication, and severe side effects as a result of the medication. Furthermore, patients felt that they required increased input into

decisions about their medication. Again, this highlights a lack of information and user involvement as a negative aspect of treatment.

Psychological therapies have also been highlighted as a vital part of a patient's treatment plan, and users often agree that these are helpful. In fact, a recent campaign by the leading mental health charity Mind asserted that therapeutic methods are "as necessary as any proven technology for any illness in any part of the NHS" (Mind, 2006: 2). This campaign makes a case for the increased availability of CBT and other therapies on the NHS, recommending a decrease in the waiting time of patients for these services, as well as increases in research into this topic (Mind, 2008). The campaign report includes perspectives of service users who have had positive experiences of these measures. Iqbal and Basset (2008) also conducted a study of the user experience of an aspect of CBT known as 'activity scheduling', whereby patients are engaged in activities in order to prevent negative moods. The majority of participants found that activity scheduling helped to lift their mood and assisted in their recovery. As such, this employment of techniques which reflect the nurturing character of the hospital is positively experienced by patients, and the main problem with this is poor availability and a lack of recognition of their effectiveness in addressing mental illness and its symptoms.

3.4. Throughput of Patients with a History of Violence

Throughput signifies the movement of patients through the forensic mental health service, and their 'progress' in this sense. For example, patients in high security may be moved to a medium secure unit or to a community setting, to continue treatment and management there. Decisions regarding throughput are dominated by concerns of risk, and much research asserts that this is the most effective way for mental health professionals to make these choices (Wong et al., 2007).

When making decisions based on risk, clinicians must determine which factors they will take into account as risk factors. These factors may be static factors which are unchangeable, such as age and offending history, or dynamic factors related to

current changeable features about a patient, for example the extent of their illness and their level of social skills. Existing literature examines which group of factors are more accurate in determining violence risk. Doyle and Dolan's (2006) research tested the validity of the Violence Risk Assessment Guide, a risk assessment scale concerned with many static risk factors. They determined that while these factors are useful in determining risk, consideration of dynamic factors improves the accuracy of this judgement. Similarly, Heap (2003) attempted to identify factors associated with discharge from a medium secure unit, finding that patients who are perceived to be ready for discharge are those who have been involved in less violent incidents in inpatient care and have made progress in this sense, as well as being older. This again indicates that both static and dynamic factors are predictive of risk. It should be noted that static factors have the potential to be stigmatising, as patients cannot change these, but may still be branded as 'risky' as a result (Doyle and Dolan, 2000). As dynamic factors are features of a patient which can be altered, they allow professionals to identify and address patients' needs and to reduce violence in this way.

Literature has also assessed the effectiveness of specific risk assessment instruments designed for managing violence. These allow clinicians to numerically score patients on various risk factors ensuring that decisions are made in a standardised way. Much research has concerned itself with designing an effective scale for predicting violence (Monahan, 2002). Two well known risk assessment instruments are the Violence Risk Assessment Guide (VRAG) and the Historical, Clinical, Risk Management 20 (HCR-20) (Chiswick and Thomson 2004: 710) (See Glossary). Such instruments are commonly cited by research as an effective way of the determining risk of violence a patient poses.

Experiences of Throughput

It has been noted thus far that practices in the area of throughput are heavily informed by considerations of risk. Little research which details users' perspectives on this process exists, however Montgomery and Johnson's (1998) research details

users' feelings about re-entering the community. Involving a series of interviews with 10 patients before and after discharge from an acute psychiatric care hospital, this research indicated a general pattern of feelings about discharge. Patients were optimistic but realistic about their problems at the time of discharge, however as time passed patients become more pessimistic and preoccupied with their problems. Thus, research indicates that the process of discharge is difficult for service users.

Patients' anxieties about the experience of re-entering the community could be somewhat alleviated by increased information about this process. Cleary, Horsfall and Glen (2003) conducted surveys with mental health service users about their satisfaction with discharge planning. Their results indicated that patients did feel that they have enough information relating to the discharge process and the arrangements which had been made for them. However, patients did not feel that they were equipped to understand their medication and its side effects, or their illness and its associated difficulties upon entering the community. Again this indicates a lack of information required by patients to ease their anxiety, particularly in the difficult context of return to the community.

2.5. Conclusions: The Forensic Mental Health Service

This section has reviewed the Forensic Mental Health Service's treatment and management of mentally disordered offenders. Policy and practice has been outlined, as well as research which evaluates these measures. Particular attention has been paid to addressing violence in this context.

Violence is a concern in all areas of practice. The range of secure facilities aims to incapacitate patients, while not unduly restricting their freedom. These settings also implement measures to prevent violence from occurring, and guiding staff responses where it does. In addition to the stringent security measures in place for mentally disordered offenders, they are subject to a comprehensive treatment and management programme under the CPA arrangements. Their progression to lower security

settings and the community occurs gradually and is carefully managed around concepts of risk.

Overall, treatment and management is varied among patients and implemented in individualised ways, and it is encouraging to see that what research cites as effective is also what is implemented in practice. It has also been demonstrated that the somewhat recovery orientated nature of the FMHS translates into a largely nurturing and caring regime within the secure hospital. Yet concerns of risk prevail in this setting, particularly in relation to issues of security. It appears that although research has identified the recovery framework for change as a significant influence it is difficult to suggest that it completely dominates policy and practice in this setting.

The literature describing the experiences of users of the mental health services has also been summarised here. It appears that service users do not generally express objections to the methods utilised, or assert that they are ineffective. Even in the case of coercive measures, the area which users were unanimously dissatisfied with, it was still acknowledged that this was often necessary (Olofsson and Norberg, 2000: 92). Rather, they are dissatisfied with the impact which certain elements of treatment and management have on them emotionally, as they often lead patients to feel helpless and frustrated. In particular, these tend to be the aspects of hospitalisation which move away from the nurturing and caring approach which practices in this setting generally adopt. Research also suggests that this could be overcome by offering more empowerment to users, by way of increased support, information and education regarding the process of being treated and managed, and having a mental disorder.

3. THE SCOTTISH PRISON SERVICE

While the FMHS exists exclusively for the treatment and management of mentally disordered offenders, both groups may also be in the custody of the Scottish Prison

Service (SPS). Policy for the treatment and management of both mentally disordered and non-mentally disordered offenders in prison will thus be detailed in this section.

The specific measures available in prison for those who do suffer from mental health problems will be discussed first. Following this, policies and practices which apply to this group and the wider prison population will be detailed. Particular attention will be paid to risk assessment, addressing the needs of prisoners, and release from prison, with specific reference to how these measures are implemented for violent offenders. It will be argued that in this context there are often flaws with treatment and management practices. It will also be demonstrated that, in contrast with the hospital, the prison is often punitive and harsh in nature.

Much literature is concerned with how prisoners experience the prison, and this will also be reviewed here. It will be demonstrated that the punishing character of the prison is negatively experienced by this group.

3.1. Security in Prison

It is probable that there is greater public understanding of the security in prison than of the measures implemented in the secure hospital. In commencing his influential account of the prison Sykes (1958) details the environment, describing its high perimeter walls, the small space allocated to such a large number of individuals, the searches inmates are subjected to, and the claustrophobic nature of cells. Although writing over 50 years ago, many of the characteristics described by Sykes endure today. These exist in the SPS, and as such the prison retains the punitive character which this suggests.

There are currently 17 prisons in Scotland. Like secure hospitals, there are variations among these institutions in terms of their purpose and security, and the characteristics of the prisoners within. For example, most prisons have a mixture of sentenced prisoners and those on remand awaiting sentence, however HMP Barlinnie's main purpose is to hold remand and short term prisoners. Similarly,

HMPs Glenochil and Shotts have a large number of long term prisoners. Provisions for prisoners in the course of returning to the community also exist, with HMP Greenock assisting those who have served 12 years or more with this process, and Open Estate Castle Huntley providing open conditions for those deemed suitable. Polmont Prison is the national service for young offenders, those aged 16-20. Finally, HMP Cornton Vale is Scotland's only dedicated women's prison.

In the prison setting the main focus in terms of security are the physical and procedural measures in place, and there is little variation between institutions in this area. Many of these are similar to those described as existing in the High Secure hospital. Prisons are characterised by secure perimeters and locked cells which ensure detention, airport level security for those entering and leaving the facility to eliminate dangerous items, and CCTV. Cells and prisoners are regularly searched for banned items, and prison staff navigate the institution using keys. As such, the prison is a particularly restrictive environment. One interesting development in relation to violence in the prison setting is the separation of prisoners convicted of sex offences from other prisoners to ensure that they are not victimised. It should also be noted that maintaining security and preventing violence in this setting may pose increased difficulties to the hospital setting in light of the high numbers of individuals incarcerated in the prison.

Under the Prison Rules 2001, all prisoners must be designated as high, medium or low supervision upon reception. Under Rule 17 these are decided based on the supervision that the prisoner is deemed to require within the prison, and not the risk which they are perceived to pose to the public should they abscond. For those designated as requiring high supervision, "all activities require to be authorised, supervised and monitored by an officer" (SPS, 2011:18). These prisoners are likely to experience this environment as especially punitive and restrictive.

3.2. Provisions for Mentally Disordered Offenders in Prison

The identification of mental illness during the criminal justice process does not necessitate that an individual will receive a final disposal which results in hospitalisation. Research indicates that many prisoners suffer from mental disorder, and that prison itself may serve to exacerbate underlying mental health issues (Peay, 2007; Taylor and Gunn, 1984b). In light of this, the SPS has dedicated measures in place for the treatment and management of mentally disordered offenders under their supervision. However if it is deemed necessary a Transfer for Treatment Direction may be administered, under s.136 of the 2003 Act, to allow prisoners to be sent to hospital (Darjee 2005: 222).

All prisoners are assessed for mental disorder when arriving in prison, and for longer term prisoners a risk and needs assessment is carried out to identify whether specific assistance for mental disorder is necessary (Thomson 2005: 134). The majority of Scottish prisons also have visiting psychiatrists, and certain prisons also have designated mental health teams of psychiatrists, mental nurses, social workers and various other practitioners at their disposal for dealing with these individuals. These teams meet weekly to discuss treatment of specific patients and review cases, encouraging collaboration among the various practitioners involved in the treatment of individual prisoners. Treatment for mentally disordered offenders may take place in the prison health centre, where some prisons have beds available for these individuals (ibid.: 135). Day programmes for mentally disordered offenders are also available in some institutions, such as HM Prison Barlinnie and HM Prison Perth, which aim to facilitate good mental health in the prison.

3.3. Risk Assessment of Violent Offenders in Prison

In recent years, risk assessment has gained a more prominent role in criminal justice system (Feeley and Simon, 1992). For violent offenders in particular, a comprehensive risk assessment determines the risk posed while in prison and to the community upon release, as well as identifying needs which must be addressed.

Effective assessment is expressed as an objective for social work in prisons, whose remit it is to perform such assessments (Scottish Prison Service, 2004: 16).

In considering the nature of the prison as an institution, this development is significant. While the restrictive and punitive nature of the institution has traditionally been understood largely in relation to the physical security in place in this setting, it has been suggested that risk assessment represents an additional and new form of restriction for those in prison (Crewe, 2011).

Generally, there is a perceived lack of consistency across criminal justice bodies in this area. Even within the Scottish Prison Service, there is variation between institutions in their implementation of risk assessment. Research by McIvor, Kemshall and Levy (2002) examined the use of risk assessment tools by various professional groups, including criminal justice social workers in prisons. It was found that the most commonly used of the range of tools were the Risk Assessment Guidance Framework (RAGF) and the Revised Level of Service Inventory (LSI-R) (McIvor, Kemshall and Levy, 2002: 7) (See Glossary). These are widely used across various criminal justice bodies in Scotland (Burnett, Baker and Roberts, 2007; Scottish Executive Justice Department, 2007).

These inconsistencies are important in this context of managing violent offenders, as risk assessment tools used in prison are most often applied to this group (ibid.: 10). Further research highlights that in spite of this, no dedicated risk assessment tools are available in Scotland to assist social workers in determining risk of violent offending (Social Work Inspection Agency, HM Inspectorate of Constabulary for Scotland and HM Inspectorate of Prisons, 2009: 10). This suggests that it may be difficult to effectively assess the risk of violent offending, which could be somewhat of a failing of practice in this area given their significant role in assisting prisoners with the process of release. Yet, additional research into the use of tools specifically for serious violent and sexual offending by MacIvor and Kemshall (2003) indicates that in prison such tools are most likely to be employed by psychologists. Therefore

while these tools do not appear to be utilised by all disciplines, they are used to a certain extent.

3.4. Addressing the Needs of Violent Prisoners

Although the prison is not in itself a treatment orientated establishment due to its concerns with incapacitation and retribution, prisoners nevertheless have specific needs which must be addressed. This section will outline practices in this area which aim to address violence, and associated drug and alcohol problems. These procedures aim to impact upon violence committed by prisoners while in custody, as well as any future, recidivist violence upon return to the community.

It has been demonstrated that treatment in the hospital setting is influenced by the recovery framework. A similar paradigm in the non-mentally disordered context which denotes a process of change in this way would be that of 'desistance'. Yet while recovery has its origins in advances in policy and practice, understandings of desistance have emerged from the somewhat fragmented criminological research which aims to understand how and why individuals cease offending behaviour (Maruna, 1997). As well as conflict over its causes, little effort has been made to fully define how desistance occurs. Maruna's (2001) account of desistance, *Making Good*, has made an influential contribution here, and one which is of particular relevance to this thesis. He asserts that desistance is a 'maintenance process' which offenders are consistently engaged in, rather than a single event. This process of 'making good' is said to be grounded in self-perception, and in order to desist offenders must make sense of their life histories. In doing so, they construct a 'redemption script' which enables them to "recast criminal pasts not as the shameful failings that they are but as the necessary prelude to some new found calling" (Maruna, 2001: 9) and advance an overly positive outlook for the future. While it appears that interventions with offenders should aim to facilitate this process, it has been noted that this paradigm has not been adopted in offender management (McNeill, 2006). Thus, while some of the practices outlined in this section may assist in facilitating desistance, there is little expressed reference to the process.

The majority of measures seeking to address prisoners' needs take the form of offending behaviour programmes. Such programmes generally take place in groups, and are described as "a planned sequence of learning opportunities" (Robinson and Crowe, 2009: 105). This element of prison practice contrasts with the punitive and restrictive character of the institution which has been outlined thus far, demonstrating that although rehabilitative ideologies do not prevail in this setting, their influence is present.

In the Scottish context it is required that programmes for use with offenders are accredited. This task was originally undertaken by the SPS Accreditation programme, which has now been replaced by the Scottish Accreditation Panel for Offender Programmes (SAPOP), as established in 2006 (McIntosh, 2006). The panel has members from various disciplines, and assesses proposed programmes based on their ability to meet certain standards. These standards include whether the programme rationale, target group and intended outcomes are stated and based on evidence, whether the programme uses effective and appropriate methods to achieve its intended outcomes, and whether the programme design ensures the greatest benefit for participants during and after delivery. It should be noted that the availability of these programmes to prisoners depends on sentence length. For those undertaking short term sentences, there may not be sufficient time to find an available place on an appropriate programme and to then complete this in full. In relation to violent offenders, particularly those convicted of homicide, it is possible that they are more likely to engage in such activities than other prisoners as generally their sentences are longer.

A range of programmes are available to offenders in prison which aim specifically to address violence. A recent multi-agency report detailing available programmes available in Scottish Prisons noted the use of the Violence Prevention Programme (VPP) in some institutions (Social Work Inspection Agency, HM Inspectorate of Constabulary for Scotland and HM Inspectorate of Prisons, 2009:17). The VPP aims to address serious violent behaviour by high risk prisoners, 10 of whom may participate in the programme at a time. The programme is made up of 94 two hour sessions, in addition to individual interviews. The demand for the VPP outstrips its

availability, with 40 prisoners in a recent inspection of HM Glenochil identified as waiting to undergo this programme (HM Inspectorate of Prisons, 2007: 32). Additionally, anger management programmes, as available at HM Prison Perth and currently under update at HM Prison Peterhead (HM Inspectorate of Prisons, 2006A: 36; HM Inspectorate of Prisons, 2006B: 33), are likely to reduce instances of aggression by an offender through therapeutic work, ultimately reducing levels of violence. Further dedicated programmes exist for the treatment of perpetrators of sexual violence, such as the STOP programme. This involves 85 sessions and commonly takes between nine months and one year to complete, and can be adapted for offenders with additional needs owing to educational difficulties, and extended if participants require more time to address specific issues (HM Inspectorate of Prisons, 2003: 28). Again, a flaw here appears to be poor availability of the programme to prisoners, with many offenders being unable to participate in the STOP programme in spite of their needs (HM Inspectorate of Prisons, 2006A: 35). Additionally, it should be noted that the implementation of such programmes varies across facilities, thus, while some institutions may offer a programme, others may not. Overall, problems of availability appear to hinder the effectiveness of these programmes, and it appears that treatment in this sense is not necessarily a priority within this setting.

In addition to those programmes which explicitly seek to address violence, other provisions in place in Scottish prisons may address needs associated with violence. A key example here is substance misuse. Drug and alcohol misuse is often linked to violence, and particularly in conjunction with mental disorder (Steadman et al., 1998; Junginger et al., 2006), thus it prudent to detail the measures which seek to combat this problem. The Scottish Prison Service itself has a comprehensive strategy against drug misuse (Scottish Prison Service, 2006), including measures to prevent the transportation of drugs into Scottish prisons, means of assessing prisoners for substance misuse problems, and programmes for treatment of this problem. In terms of assessment, currently, the Common Addictions Assessment Recording Tool (CAART) is utilised to assess and record a prisoner's drug use, whether this is in the community or in prison. Thus, the "nature, the frequency, the quantity and the method of substances used is examined and recorded" (ibid.: 74). In addition to this

rigorous assessment, numerous programmes for the management of substance misuse are in place. These include First Step, a programme which encourages and assists prisoners with drug addiction issues to begin to address these; Lifeline, a programme for individuals close to the end of their sentence, targeting those at risk of relapse upon leaving prison; and a twenty-one hour Drug Awareness course, again for those nearing the end of a sentence, which aims to make prisoners understand consequences of using drugs and relate this to their own addiction (ibid.: 139). The numerous measures in place in this area suggest that tackling substance misuse is a key priority of the Scottish Prison Service, which may ultimately help to reduce violence.

3.5. Release of Violent Offenders from Prison

Finally, it is important to detail the measures in place to facilitate the safe transition of offenders from prison to the community. Again, although risk assessment is of vital importance at this stage, and will be carried out prior to the release of an offender, prisoners may have additional needs at this point, as reintegration into the unfamiliar community environment is often a difficult process. This is particularly true of violent offenders, who may be facing additional stigma upon release because of the nature of their offences.

A key development in this area is the concept of throughcare, which is concerned with providing support for offenders during this period of reintegration. As part of this process, prisoners will develop a Community Integration Plan, which details their needs at this transitional stage and the means of addressing them, while still in custody (Scottish Prison Service, 2004: 10). The plan outlines activities available in prison which help with the reintegration process, as well as linking prisoners to community-based agencies for support on release. Dedicated spaces for throughcare activity in Scotland were established first in 1999 at HMP Edinburgh (ibid.: 9). These areas are now known as ‘LINKS Centres’ across the SPS, and enable prisoners to liaise with approved organisations which offer help in this transitional period, such as SACRO, a charity concerned with the reduction of re-offending. Such

organisations provide guidance and advice to prisoners close to release on a wide range of matters, such as housing, employment, drug and alcohol misuse, and can also be extended to families of prisoners. This process is of particular importance to violent offenders, who may be reluctant to interact with community staff and to disclose their offending histories (ibid: 10).

Given that the prison sample in this project is comprised entirely of life sentence prisoners, it is also relevant here to briefly outline the process of release for this group. A life sentence spans the whole of an individual's natural life and consists of a 'punishment part', a prison term determined by the court, and a 'life licence', which involves monitoring in the community upon release (Scottish Prisons Commission, 2008). It is mandatory that such a sentence is given where an individual is found guilty of homicide and in the case of serious and repeat offenders judges may also use their discretion to impose this sentence. A prisoner can be considered for release when the punishment part of the sentence is completed (The Scottish Government, 2013). This generally occurs as soon as possible, and begins with a referral of a case to the Parole Board by the Scottish Ministers. The Parole Board takes the form of a Tribunal and is conducted as an oral hearing, during which the board must consider whether an individual can be released into the community. It should be noted that "the tribunal will only direct release if it considers that the offender does not present an unacceptable risk to the public" (ibid: 8), and therefore the time an individual serving a life sentence spends in prison can be extended and is somewhat indeterminate. Life sentence prisoners approaching the Parole Board must therefore endeavour to present themselves as changed and low risk. Where a prisoner is perceived to pose too great a risk to permit release, a date must be set for a further hearing within 2 years (Scottish Prisons Commission, 2008). Where the Parole Board elects to release such a prisoner they enter the community under the conditions of a life licence determined during the tribunal, which may include specific requirements based on the perceived needs of the individual, and are monitored by a Criminal Justice Social Worker. The license continues for the duration of the individual's natural life, and if breached will result in their recall to prison.

3.6. Experiences of Imprisonment

The literature detailed thus far in this section has focussed on the policies and practices implemented within the Scottish Prison Service, yet the experience of imprisonment has also generated a wealth of research. This section will consider key literature and recent developments in this area.

In particular, experiences of long term imprisonment have been the topic of much research. Parallels can be drawn between this body of work and the 'user experience' research outlined earlier in this chapter in relation to the secure hospital. Both are concerned with how those incarcerated in institutional settings experience this on a long term basis, whether this is in the context of a life sentence in prison or a mental health disposal for indefinite detention in hospital. It will be demonstrated in this section that, as in hospital, issues such as security and the psychological implications of institutionalisation are also a focus of the experience of imprisonment.

Literature detailing prison experiences is criminological in nature and tends to consider the experience as a whole, rather than focussing on particular aspects of institutionalisation as is the approach of psychiatric service user experience research. This section will mirror this approach, considering first early influential works in this area, followed by recent developments.

Early Accounts of Experiences of Imprisonment

Much literature has stemmed from Sykes' (1958) text, *The Society of Captives.* This study of New Jersey State Maximum Security Prison in the U.S. detailed the functioning of this institution, and is concerned with two key aspects of the prison. The first of these is the issue of power and domination of prisoners by the institution. Sykes argues that although this power is often seen to be complete, in actuality "the power position of the custodial bureaucracy is not truly infinite" (Sykes, 1958: 42). This is suggested to result from both the inability of staff to adhere strictly to the prison regime's rules at all times, and a lack of impetus to conform on the part of

prisoners. Sykes observes that instead, order within the prison is maintained through a situation of compromise between staff and prisoners.

While this first argument focuses mainly on staff and the prison regime itself, Sykes' second argument is concerned with the experience of the prisoner, and is therefore particularly relevant to this research. He highlights that this is characterised by what he describes as the 'pains of imprisonment': "the deprivations and frustrations [which] pose profound threats to the inmate's personality or sense of personal worth" (ibid.: 64). In this sense, the pains go beyond the incarceration and security experienced by prisoners, and include the various psychological implications of imprisonment. Sykes credits these pains with the development of the inmate code, the set of socially constructed norms around which behaviour is organised in the prisoner society, positing its emergence as a response to this experience:

> "If the rigors of confinement cannot be completely removed, they can at least be mitigated by the patterns of social interaction established among the inmates themselves." (ibid.: 32)

This argument will be drawn upon later in this thesis, in relation to the experiences of both patients and prisoners.

Goffman's (1961) *Asylums* is another influential text in this area, and is concerned with further detailing the difficulty of maintaining one's identity within what he terms a 'total institution'. Total institutions are described as those institutions which are all encompassing in nature, and are characterised by physical separation from the wider society (Goffman, 1961: 15). Both mental hospitals and prisons were seen to fit this definition. Building somewhat upon the second element of Syke's argument, Goffman posits that total institutions attack those within psychologically, stripping them of their identities. This is done in the name of rehabilitation, which these institutions aim to effect among the incarcerated through coerced adherence to the rigid institutional regime. Much of Goffman's account focusses on how this is experienced by the inmate, and like Sykes he suggests that the institution is not completely dominant, as those within offer some resistance to this process. Thus, his argument, which ultimately describes a scenario where the encompassing nature of

the total institution is pitted against individual autonomy, is of particular relevance to the investigation of patients' and prisoners' varied experiences of institutions in this thesis.

It should be noted that although Sykes and Goffman's respective theories of institutionalisation offer some generalisations about this process, both suggest that this is individual in nature and will vary among inmates. Cohen and Taylor's (1972) research in Durham Prison, England, goes further still here. Aiming to understand the nature of a long term prison sentence, they posit that prisoners adapt to this in varied ways, which they describe as 'survival' in an extreme situation. Specific features of the prison experience are to be survived, including "the problems of marking time, of making and breaking friends, of finding privacy and avoiding contamination" (Cohen and Taylor, 1972: 112). Their research details how this is achieved, whether this is through active means of resistance such as escape attempts or confrontation with staff, or more passive activities which make the experience more bearable and mark the passage of time such as education or weight-lifting. This research has made a significant contribution to the understandings of both the negative aspects of the process of institutionalisation, and how these are mitigated by inmates. It has also served to focus other research on the significance of long term imprisonment (Sapsford, 1983)

Taken together, these studies raise several important issues in relation to imprisonment. These include the power structures at work in institutions, the 'pains' of institutionalisation experienced by inmates, the implications of institutions for individual identities, and the ways in which those within adapt to this context. All of these issues were referred to in the interviews conducted with patients and prisoners in this project, and this literature is therefore significant in this thesis.

Recent Developments

Thus far some key literature which forms the foundations of our understanding of the prison experience has been detailed. While it is not possible within the scope of this

thesis to review this body of work in its entirety, two more recent developments are significant here: the reconsideration of the pains of imprisonment, and the attention to masculinity in the context of prison.

There has been a recent reconsideration of the pains of imprisonment which is of particular relevance to this project. It has been noted that prisoners experience pains, which go beyond physical punishments and are the psychological implications of being imprisoned and the assault this makes upon one's identity. In the past, it has been posited that different forms of pains can be described in physical terms: 'depth' and 'weight'. King and McDermott (1995) suggest that pains of depth relate to the extent of institutional security they experience, and to which they feel 'deeply' incarcerated in that sense. It implies distance, both from others in a spatial sense, and from release in a temporal sense. 'Weight' encapsulates the psychological ramifications of imprisonment, the extent to which this 'weighs down' upon prisoners. This has connotations of pressure and heavy burden which aptly describe this form of pain. More recently, Crewe (2011) has advanced a third form of pain: 'tightness'. Through this, he acknowledges wider penal changes, specifically the increasingly actuarial and risk orientated nature of punishment (Feeley and Simon, 1992), and accounts for the ways in which these may be experienced by prisoners. Prison is 'tight' therefore, in the sense that its adoption of these methods exerts new pressures upon prisoners to behave in certain ways lest they be deemed 'risky'. The notion of tightness conveys that this pressure is felt as restricting prisoners from all angles. Prison and perhaps institutionalisation generally can therefore be described as 'deep', 'weighty' and 'tight'.

Research has also turned to the role of gender identity in the context of imprisonment. Sim (2006) outlines the key issues in this area, noting that studies have tended to focus on "men as prisoners rather than prisoners as men" (Sim, 2006: 101). He argues that a consideration of hegemonic masculinity within this context reveals this concept forms the foundation of hierarchical structures between prisoners, as males who conform to these ideals are dominant while those who do not

are subordinated. This arrangement also leads to the normalisation of violence within the prison:

> "Violence and domination in prison can therefore be understood as … part of the normal routine which is sustained and legitimated by the wider culture of masculinity: the culture that condemns some acts of male violence but condones the majority of others." (Sim, 2006: 105)

As such, Sim's research suggests that the prison serves to reinforce some of the problematic elements of masculinity, specifically violence. Crewe's (2009) study of HMP Wellingborough, which provides a particularly detailed overview of the power structures at work in this institution and the ways in which prisoners adapt to this, mirrors this notion. In describing relationships between prisoners, he notes that aggression and violence in the prison may be attempts to maintain a masculine persona in the face of peers (Crewe, 2009: 409). Thus it appears that prison reinforces negative aspects of masculinity, by posing such a threat to this identity that prisoners are forced to reaffirm it using extreme measures, including violence. This image of the prisoner varies from the perception of an intrinsically violent individual, illustrating that in actuality this group resort to violence due to the pressures of their environment. Cowburn (2005) notes the implications of these masculine identities as amplified by the prison setting for the successful treatment and management of prisoners. Drawing on research into programmes which aim to change the behaviour of male prisoners convicted of sexual offences he highlights that such a task is difficult when "many of these attitudes and values appear similar to those of the hegemonic masculinity endorsed and actively embodied in the culture of the prison" (Cowburn, 2005: 319). Therefore, as well as reinforcing violence, masculinity in prisons may act as a barrier to positive change.

3.6. Conclusions on the Scottish Prison Service

The Scottish Prison Service has a range of measures in place for the treatment and management of mentally disordered and non-mentally disordered offenders, including those who are violent. This section has reviewed policy and practice in this

area and questioned its effectiveness. Research which outlines the prisoner experience has also been detailed.

Security in prison is largely structured around physical measures, which ensure the detention of prisoners. Dedicated provisions exist for prisoners suffering from mental disorder, although it is not possible to guarantee the same standards of care available in hospital. Violence is also a priority in prison. Measures for risk assessment of violent individuals are readily available, and a range of treatment regimes, largely in the form of accredited programmes, are in place for this group. Facilities are also now in place to assist prisoners with the potentially difficult transition to the community. Overall, while the measures in place appear to be effective in terms of their ability to ensure security, address offending behaviour and its perceived causes, in particular violence, and protect the public, the review illustrated that flaws in their implementation often impede this, particularly in the areas of treatment and risk assessment. Moreover, many of these aspects of the prison regime contribute to its punitive and restrictive character, and there is little reference to the desistance process which the institution should arguably aim to effect.

Key research outlining the prison experience has also been reviewed in this section. This literature has painted a particularly negative process of institutionalisation, in terms of the power structures at work in this setting and the psychological implications of this. More recent research highlights issues of risk and masculinity as placing additional pressures upon prisoners. Thus, as in hospital, the policies and practices in place in the prison may be effective, depending upon their implementation, yet these are negatively experienced by prisoners. This again reflects the harsh and punishing nature of the prison, and illustrates that this is how institutionalisation is experienced by those within.

4. CONCLUSIONS

Several key findings emerged in relation to treatment and management in this study. By way of conclusion, these will be outlined here.

4.1. The Process of Identification

At all stages of the criminal justice process, from the point of arrest to the final disposal, a variety of dedicated measures are available for the identification of mental disorder among those accused of offences. This identification, applied by criminal justice and health care professionals, has important implications for future treatment and management, as a mentally ill offender may be given a disposal which results in their incarceration in the care of the FMHS as opposed to the SPS.

4.2. The Effectiveness of Treatment and Management

Policy and practice for the treatment and management of mentally disordered and violent offenders is implemented in both the FMHS and the SPS. It appears that the secure facilities provided by the FMHS provide adequate care and security for mentally disordered offenders, with a range of facilities offering varied levels of security, and a comprehensive system for assessment, treatment and throughput of patients. The SPS deals with some mentally disordered offenders and all non-mentally disordered offenders given custodial sentences. There are comparable measures in place here to assess the risk and address the needs of these groups. This review has found that while the measures themselves appear to be effective, there are failings in some areas due to problems with implementation.

4.3. Paradigms of Change in Practice

In terms of effectiveness, this chapter has also assessed the extent to which paradigms of change underpin practice in these settings. It was found that in the hospital setting, the recovery framework is the leading process by which patients are

presumed to change, and that practices in this area are somewhat underpinned by this notion. However, concerns of risk detract from this. In prison, it was noted that while the desistance process should be the aim of interventions with offenders, enabling them to change and develop non-offending identities, there is little attention to this process. Instead, there is a degree of attention to rehabilitation, which is largely aimed at reducing re-offending, rather than 'rehabilitation for rehabilitation's sake' (McIvor and McNeill, 2007: 137). There is a far greater emphasis on security, punishment and risk in the prison setting. Both the recovery and desistance frameworks for change will be drawn upon later in this thesis in relation to patients' and prisoners' identities and hopes for the future.

4.4. Institutional Experience

Thus far it is has been suggested that the policies and practices in place in institutional settings are largely effective in terms of their ability to fulfil their desired functions, for example reducing violence by addressing offending behaviour or ensuring security, although this is less true in the prison setting. This review also took account of how these are experienced by patients and prisoners.

In the FMHS, it was observed that while research asserts that the processes in place are effective, those with first-hand experience of being subject to these processes are more critical of the service as a whole. Service users may concede that generally the processes in place are effective, or at least necessary. However, their accounts suggest that this overall process at times engenders feelings of fear, vulnerability, confusion and frustration. In the SPS, the experience was significantly worse. Literature suggested that imprisonment, particularly in the long term, is a profoundly negative experience which serious psychological consequences. This variation in experience reflects the differing natures of these institutions as outlined above. The hospital is a nurturing environment while the prison is a punishing one, and they are experienced as such by those within.

These implications of institutionalisation are largely ignored in policy and practice,

yet the experience of those within institutions can be considered a measure of effectiveness in itself. This is especially true in the context of mental health, where research indicates that negative experiences of treatment and management lead patients to disengage from this process, rendering them less likely to successfully recover (Elbogen et al., 2006). A potential framework for understanding the roots of these negative emotions can be found in the concept of masculinity which is central to this thesis.

4.5. Masculinity in the Context of Treatment and Management

As this thesis is concerned with the role of masculinity in driving violence, positing that it has a significant role in such behaviour, it is prudent to consider the position of masculinity in institutional policy and practice. It can be argued that many of the negative experiences of institutionalisation, when considered from the point of view of males, are linked to the affront that these processes have to masculinity. While masculinity ascribes qualities such as power, dominance, physical strength and independence to males (Connell, 1987), the main features of incarceration involve being dependent on others for basic needs such as food, being told what to do by staff, being physically overpowered, and being restricted inside an institution. These are all in direct conflict with traditional masculine images, and it is therefore perhaps unsurprising that the hospital and the prison are experienced negatively by men.

Yet in spite of the contribution of masculinity to these negative experiences, this is rarely addressed in practice. This is particularly true in the context of mental illness, where even in research the majority of references to gender in this setting relate to the enhanced difficulties faced by females (Gallop et al., 1999; Worrall, 1989). A recent campaign by mental health charity Mind (2009) has made some headway in raising awareness of the difficulties faced by males here. It is emphasised that a feminisation of mental health problems has occurred, resulting in mental health services which are geared towards women (Mind, 2009: 8). The campaign advocates changes in service provision for men, including a recommendation to create a male specific mental health service, as well as calling for recognition of the profound

impact of mental health problems upon males. The inadequacies of the mental health services in dealing with male patients are yet to be addressed. While in the prison context some research does acknowledge the issues related to masculinity in this setting, suggesting that the environment both challenges and reinforces such identities (Sim, 2006; Crewe, 2009) there is little acknowledgement of this in practice. This lack of attention to masculinity can be considered a shortcoming of policy and practice.

CHAPTER 4

METHODOLOGY

In the previous chapters of this thesis, a review of existing research in the relevant fields has established a need to consider the role of masculinity in offending by males suffering from mental illness. This project aims to examine the interplay between cultural scripts of masculinity and major mental illness in the context of violent altercations and the offending histories comprising these incidents, and the implications of this for treatment and management. In order to achieve this, interviews were carried out with male patients in a medium secure forensic psychiatric hospital and prisoners in an adult male prison. This chapter will detail the methods employed in conducting this research.

The first three sections of chapter outline the overall research process of this project, as well as the details of the research setting and interview sample. The following sections reflect on the nature of conducting such research, describing the form of interviewing used in this project, and the dynamics of these interviews. Finally the key ethical issues in this project are described.

1. RESEARCH PROCESS

This section will outline the various elements of the research process followed in this project in the order in which they occurred, and the challenges included in each of these. In some instances these tasks overlapped. This was particularly true in the hospital, where sampling continued while interviews were conducted.

1.1. Research in Institutions: Selecting Sites and Arranging Access

This research was conducted in a medium secure forensic psychiatric hospital and an adult male prison, both in Scotland. These are institutional environments, and as such the traditional methodological challenges of negotiating such settings were present. Gaining acces was a significant challenge encountered in this project. The lengthy and thorough NHS and SPS access processes for these research settings were negotiated, and access was successfully secured.

There are often individuals who have the power to grant or withhold access to institutions, known as 'gatekeepers' (Hughes, 2011: 239). In this project, while formal access processes granted permission for conducting research, staff members at various levels fulfilled this role. It is important to develop strategies for negotiating formal and informal gatekeepers in the research setting (Murphy, Spiegal and Kinmonth: 1992). Forming trusting and communicative relationships with these individuals was an essential aspect of the research process.

Access can be negotiated with the help of a 'local champion', generally a professional individual associated with the research setting, who can facilitate access and progress. It was a particular success of this project that the research was able to be conducted in close consultation with these local champions at both research sites, and to an extent this influenced their selection. This was invaluable in securing access to the research settings and negotiating any problems which arose during the research.

Hospital

The first research setting in this project was a medium secure forensic psychiatric hospital. This clinic holds patients who have committed criminal offences, and accordingly require a secure setting while they receive treatment and care for major mental illness.

Arranging access to the medium secure forensic psychiatric hospital was a particularly difficult process which took almost a year to complete. The first stage involved obtaining informal agreement from the lead clinician at this hospital. Following this, as this institution is part of the National Health Service, NHS research ethics procedures were carried out to gain formal ethical clearance. This was difficult in this project, as it is unusual research in the clinical context. The formal access process is designed for large scale medical studies and drugs trials, and as such is extremely rigorous, but nevertheless had to be completed. It involved submitting detailed applications describing all ethical protocols in this project to a local NHS Research Ethics Committee (REC) and Research and Development Office (R&D). Following a review of the application by these two bodies, a REC meeting was held and the researcher was invited to attend. The result of this process was a favourable ethical opinion by the REC and the granting of research access for this project.

There are several justifications for the selection of a medium secure inpatient setting as the research site in this project. The research was planned in close consultation with a senior clinician in a medium secure setting, therefore it was determined that this particular hospital would be used in this project to facilitate the access process and guarantee the researcher on-going support throughout the data collection phase. There were unforeseen benefits of this. First, an inpatient setting was a preferable interview environment to a community setting, as it allowed the researcher increased control over the physical surroundings during the research. Second, patients in a medium security hospital are in an ongoing process of recovery from mental illness and reintegration into the community following an offence. This is an important stage in the life course of these patients, and is an excellent point for such individuals to be interviewed, as they are able to reflect on their offending histories from their current position, as well as to discuss their aspirations for their futures in the community.

Prison

The second research setting in this project was an adult male prison. The prison held men with a variety of offending histories, and has a large number of prisoners serving long sentences.

The prison setting was also accessed through formal and informal procedures. Initially it was intended that this project would be carried out at a different, more local prison. An application was submitted to the SPS research ethics committee, and the project was not granted access to this setting. As a result of this, a senior staff member within an alternative prison, which became the research site in this project, was approached and agreed to support the research. A second application was then made to the research committee, requesting permission to conduct research at this alternative site and addressing elements of the research protocol which the committee had previously suggested were problematic. Access was granted to the prison setting on this occasion. As two applications were made, this process took a considerable amount of time to negotiate, and it was fortunate that access was secured in spite of these early barriers. This access was also somewhat limited in scope, and the researcher was allocated a short amount of time and resources within which to carry out the interviews.

There were numerous justifications for the selection of the prison setting. Again, the site in question was selected primarily due to ease of access, as a senior staff member willing to accommodate and facilitate the research had been identified here. Although the prison where the research occurred was not the originally intended site, there were benefits of carrying out the research here and it ultimately had some advantages over the initially selected prison. As was the case with patients, it was preferable to interview prisoners in the prison setting for ethical reasons, rather than interviewing ex-prisoners in the community. There were a large number of long term prisoners in this prison who had a range of offending histories relevant to this project. These individuals had also served significant amounts of time in prison, enabling them to reflect on these experiences in the same way as patients.

1.2. Clinical experience

In the hospital setting, by way of induction the researcher was afforded the opportunity to gain some experience of working in a clinical environment. Such experience was not gained in prison. This included a formal induction session in the hospital, involving a tour of the facility with a clinician and an explanation of the day to day running of the hospital; observation of a psychiatrist working with prisoners, conducting mental health assessments in the custody suite at a local police station; and observation of psychiatrists assessing and treating prisoners in a mental health clinic in a Scottish prison. This initial experience was beneficial as it enhanced the familiarity of the researcher with the hospital staff, patients and procedures.

1.3. Sampling

It was stated in previously that the research settings were selected primarily due to the relative ease of accessing the two particular sites in question, and that there were some other unforeseen benefits. The selection of these settings also had implications for the populations from which participants were selected and their characteristics.

The sample in this project consisted of 20 participants. Ten were male inpatients in a medium security psychiatric hospital. These participants were selected firstly because all had been diagnosed as suffering from a major mental illness. This was ensured as such a diagnosis is a requirement for hospitalisation in this setting, whereas the possible alternative approach of sampling individuals with mental illness from a prison setting may have been difficult as many prisoners do not suffer from this condition, or where they do this may be undiagnosed. Selecting patients from a prison setting would also have prevented accounts of the hospital experience from being gathered, an issue which proved to be a significant dimension of this project. Patients in this setting all had documented histories of violent offending. Again, this is a feature of the medium secure hospital, as those warranting this level of security are those who pose some risk of violence to the public, and therefore have committed such offences in the past. Additionally, in spite of this risk of violence, those in the

medium secure setting are deemed to pose a lower risk of violence than, for example, those in the high secure setting. This potential benefit to the safety of the researcher is another reason for the selection of this sample.

The remaining 10 interviewees were adult male prisoners serving life sentences following murder convictions. It should be noted that lifers were not specifically chosen as the desired sample for this project. Rather, due to access issues and the limited involvement of the researcher in the sampling process, this group were selected by the prison staff member involved in this project, whose primary role within this setting involved close contact with the lifer population. This was beneficial in some senses, as it ensured that all prisoners interviewed had clearly documented histories of serious violence, and many of the sample had previous convictions for other offences as well as homicide. The prison sample was intended to act as a comparator group for the patient sample, providing insight into the non-mentally ill experience. The extent of diagnosed and undiagnosed mental illness in prison has already been highlighted in this thesis, as have the significant psychological effects of long term imprisonment, therefore it is questionable whether mental illness could truly be ruled out among this sample. It was made clear to prison staff that no prisoners with mental illness were to be recruited, yet it was difficult to verify this in the absence of access to prisoners' medical records. Many prisoners were also asked about any involvement with prison psychiatric services during the interview and several reported seeking support from this source at some point in their sentence, yet it should be noted that none suggested any history of major mental illness. In light of these circumstances, the absence of mental illness among this sample has been established to the fullest extent possible.

A sample size of 20 was selected in this project. This may appear to be a small number of interviewees, and it could be suggested that 10 patients and 10 prisoners is not a representative sample of these two populations, making the findings of the project somewhat difficult to generalise. However, there are many justifications for this sample size. This sample is appropriate for a qualitative study, as such research aims to gain rich data from individual participants. A sample of 20 therefore allows

an in depth analysis of each participant, but provides enough participants to draw some broad conclusions. Similar sample sizes have been adopted in other criminological research involving narrative interviews (Messerschmidt, 2000; Carlen, 1983). This sample size was also suitable for the scale of this project and the recruitment difficulties involved, and was appropriate for the time constraints involved in doctoral research. It was a success of the project that this number of participants was ultimately recruited, and the wealth of rich data gathered compensates for the seemingly limited sample size.

In light of the samples selected, questions can be raised about the ability to compare the medium secure patient group and the life sentence prisoner group. There were some clear variations in the research conducted with the samples in each setting. The most significant difficulty here was the limited time spent in the prison setting, as the interviews were conducted over a very short period of time, with no real opportunity for follow –up interviews or significant observation, making it difficult at times to comment on the prison regime. Furthermore, to a certain extent it was difficult to compare the offending histories of patients and prisoners, as the samples were not matched here and there was somewhat less variation among prisoners in the nature of their previous violence given that all of their offences directly preceding imprisonment were homicide offences. Nevertheless, both groups did have violent offending histories and gave accounts of a range of violent incidents which showed significant similarities, as will be demonstrated later in this thesis. Although the two settings had marked differences, it was possible to compare institutional experiences, as both groups were experiencing many similar circumstances. The most notable of these was the length and nature of institutionalisation. Patients were in the hospital setting under legislation such as the CORO outlined in the previous chapter and would be discharged based on the assessment of their mental health and risk to others by professionals. Prisoners were serving life sentences and as such had set custodial tariffs, yet these were often similarly indeterminate based on the increasing focus on risk assessment in this setting and the strict monitoring of this group suggested in literature (Crewe, 2009). As such, there were significant similarities and differences

between the two samples which made comparing these groups both challenging and interesting.

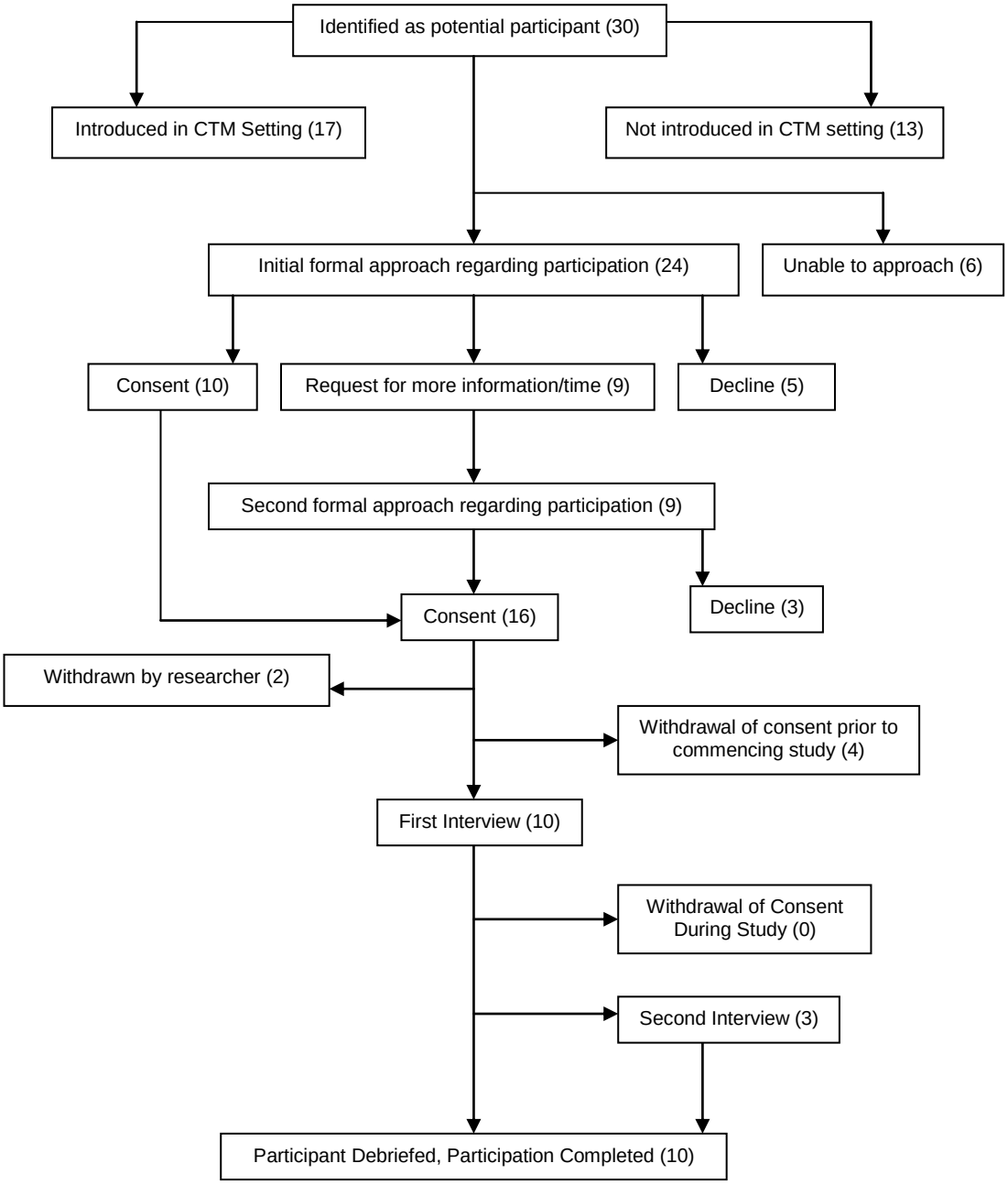
Hospital

During the sampling process in hospital, 30 patients were identified as potential participants. 24 of the identified patients were approached regarding participation and 6 were unavailable. Of these patients, 16 consented to take part in the research, 8 declined. 10 patients ultimately completed the research process. It could be suggested that this is too few interviewees, yet it was a difficult task to recruit even this small number. The hospital research site held approximately 50 patients, some whom were female or were not well enough to take part in the research, and some also declined to participate. Patients had other commitments within the hospital such as their own rehabilitative activities and as such allocating time to research was not a priority. They were also regularly exposed to medical students and interviewed frequently for medical purposes by other staff members, and many were reluctant to commit to further interviews. As individuals suffering from mental illness may also experience paranoia and distrust, the prospect of being interviewed by a stranger may not appeal to patients. Therefore to obtain a larger group, sampling would likely have taken a much longer period of time and would have been dependent on the turnover of patients in this setting. In this context, assembling a sample of 10 was a significant achievement.

Consultant psychiatrists from the research site identified which of their particular set of patients fit the criteria for participation in this research: males, with a diagnosis of major mental illness, and a history of violence. For the purpose of this project, 'major mental illness' included only those with a primary diagnosis of a major mental illness such as schizophrenia and who had experienced psychotic episodes. It did not include those who have a primary diagnosis of drug and alcohol induced psychosis as this is a transient state of illness, or of personality disorder, as this not a major mental illness. A 'history of violence' was defined as a history of aggression, assaultive behaviour, fire raising, sexual violence or homicide, resulting in arrest and

conviction for such offences. The adoption of this definition ensured that participants' violence was a pattern of behaviour rather than a single event, while leaving the scope broad enough to include a range of violent offences Consultants also only selected patients who were well enough to participate in interviews and to provide informed consent to do so. It is acknowledged that the heavy involvement of professionals could create bias in the selection of participants. However, sampling in this environment could not be done more randomly, as practitioners' involvement was essential for ethical reasons.

All of these individuals were then approached regarding participation, and the diagram below illustrates the stages at which they consented or declined to participate, or withdrew from the study for other reasons.



All patients were given a Patient Information Sheet (aee Appendix C) as well as a verbal explanation of the project. Patients were not informed in advance about the focus on masculinity, as it was felt that this may prove to be leading. Patients were informed that the interviews would focus on violence and the factors contributing to this, as it was felt that it would be misleading to omit this (Cavanagh and Lewis, 1996). This disclosure was particularly important as the participants were vulnerable

and it would be unethical to neglect to inform them that the interviews would focus on events which they may be uncomfortable discussing.

Patients who elected to participate were asked to sign a Consent Form (aee Appendix C) prior to interview, confirming that they had the capacity to consent and had read and understood the Patient Information Sheet.

Prison

In the prison setting, the researcher had little involvement in the sampling process due to the restrictions placed on access, and this was carried out by prison staff who selected prisoners with histories of violence for participation, all of whom were serving life sentences. As the prison sample acted as a comparator group, no prisoners who had documented histories of psychiatric conditions or who were currently seeing mental health professionals within the prison were to be included. Little is known about the numbers of prisoners initially approached regarding participation. During the project at least 11 prisoners were approached regarding participation in this research. Of these known individuals, 10 agreed and 1 declined.

Again, 10 prisoners may seem to be a small research sample, however given the restrictions placed on time in this setting it would have been difficult to conduct a greater number of interviews of this depth. The research was accommodated within the strict timetable of the prison, and as such there were large portions of the day where it was not possible to interview prisoners. Additionally, while there were a greater number of prisoners who were able to take part in the research than patients, it is likely that many shared patients' reluctance to take part in interviews. Prisoners also have daily commitments within the prison, and many engage in interviews with professionals such as social workers and psychologists regularly. As such, research participation may again be unappealing to this group, and it would likely be a challenge to generate a larger sample.

The process here was less complex that the sampling methods in the hospital setting. Prisoners were identified and approached by prison staff regarding participation, and were informed about the project with reference to the prisoner information sheet (see Appendix C). Again, they were made aware that the research would involve discussing violent offending histories, and were free to decline to participate, or to take more time to consider. Those who ultimately elected to participate were issued with a consent form at the commencement of the interview, which was signed by the researcher and the prisoner at that time (see Appendix C).

1.4. Clinical Notes Review

Patients who elected to participate in the project also consented to have their clinical notes reviewed by the researcher. No such documentation was reviewed for prisoners. These notes were a good source of background information on the patient in question, allowing for good interview preparation. They contain information about many aspects of the patients' lives, including their forensic histories, their history of interaction with mental health services, information about their families and intimate relationships, employment histories, details of the treatment they have received in inpatient care and information about any violent incidents which have taken place in the inpatient setting.

As these interviews were qualitative in nature, they aimed to "Focus on the informants' understandings rather than checking the accuracy of the interviewers' account" (Arskey, 1999: 33). Although triangulation of data was not of key importance, the clinical notes provided a useful source for checking the accuracy of the interviewees' accounts. Yet it is also important to be aware that these clinical notes are not without their limitations, as there are often inaccuracies in the recording process. Indeed, on several occasions during the interviews, patients corrected or contradicted information recounted to them.

1.5. Interviewing

Hospital

The interviews themselves were arranged between the researcher and the patient. This was done as and when was suitable for the patient in light of other therapeutic and recreational commitments, and routine pass. Arranging a suitable time for interviews was sometimes problematic, and it was essential that the researcher was flexible and accommodating in this respect.

The patients were collected from the main areas of the ward or their individual rooms prior to the interview, by the researcher or a member of the nursing staff, and escorted to a designated quiet room or interview room. The interviews were conducted in this setting, with only the researcher and the patient present. The average interview time was between 1 hour and 1.5 hours, with each patient participating in one interview and some completing a subsequent follow up interview where necessary. The ways in which the interview process was adapted to accommodate the needs of patients will be described in detail later in this chapter, but it must be noted here that this seemingly short interview time was determined by the needs of patients. Many were still suffering from the symptoms of mental illness, and as such were unable to actively participate in interviews for an extended length of time. It was particularly important that interviewees were not pushed to endure longer interview times, as this would risk causing them distress and possible negative implications for their mental health. Therefore, between 1 hour and 1.5 hours was the optimum interview time, and in spite of this limitation a great deal of data was procured during the interviews. Following interviews, patients returned to the main area of the ward and members of staff were notified that the interview was complete. Patients were also given a short debriefing at the end of the interview process, where they were asked if they required support for any immediate emotional distress caused by the interviews.

Prison

Interviews in the prison setting were arranged by members of the prison staff, and the researcher was provided with details of the times at which these would occur. The prison has a strict daily routine which necessitates that prisoners are in certain areas of the institution at certain times. This was a key difficulty encountered in conducting research in the prison setting, as there was a large period of the day during which prisoners were required to be in specific areas of the prison, and as such it was not possible to interview them at this time. The interviews were scheduled to reflect this structure, as were the movements of the researcher within this setting.

The interviews were carried out on the wing where the interviewed prisoners were living. They took place in a staff office in view of staff members. Prisoners were brought to this location from their cells by staff members. The interviews themselves ranged from 45 minutes to 1 hour and 30 minutes. At the end of this time, prisoners were given a debriefing sheet (See Appendix C) detailing sources of support within the prison. They were then returned to the locked areas of the wing by staff members.

1.6. Data Analysis

Qualitative data analysis methods were adopted in this project, and were carried out in several stages. The first of these involved transcribing each of the interviews. At this point, for the purpose of anonymity, patients and prisoners were assigned letters used to identify them where quotations were taken from their transcripts. The process of transcribing these interviews allowed the researcher to become intimately familiar with the research data, which was beneficial throughout the analysis. Following this, the interview material was coded. The process of coding in qualitative research allows data to be linked and grouped so as to aid the interpretation of large amounts of information (Richards and Morse, 2002: 137). The interview transcripts were carefully studied, and significant quotations were coded into their relevant themes based on the interpreted meanings of the participants' comments. In this sense the

coding was 'analytical' in nature, rather than a simple separation of topics (Richards, 2009: 88). Some of these themes were those which were defined as interview topics early in the project, such as childhood and family relationships, while others emerged during the analysis process, such as institutional legitimacy. These sets of coded quotations were then examined for trends and common assertions, which then formed the findings of this project.

2. INTERVIEWS

The interviews in this project were qualitative and initially aimed to take a biographical narrative approach. This style of interviewing was selected as it allows for a fluid discussion and the generation of rich data. However, half of the participants in this project suffered from major mental illness, and accordingly many were unable to talk fluidly as the traditional narrative format demands.The prolonged interviews which are characteristic of the narrative approach were felt to be overwhelming for such individuals. Moreover, the limited time spent in the prison setting prohibited particularly length interviews, and follow up interviews, from being conducted with prisoners. Accordingly, the narrative interviewing style was not fully adhered to in this project, and while some key aspects of this format were retained, the result was the implementation of a life-history focussed semi-structured interview approach

2.1. Narrative and Semi-Structured Interview Approaches

Before the interview format in this project is outlined in detail, this section will outline some of the key features of both narrative and semi-structured interview approaches.

There is a rich tradition of personal storytelling as a research method, and this approach has gained increased popularity since the 1980s (Sandelowski, 1991). Fraser (2002) attributes the growth in the adoption of personal storytelling as a

research method at this time – which she describes as "the rise of narrative research" (Fraser, 2002: 180) – to an overall greater acceptance of postmodern methods in qualitative research. She cites Plummer's (1995) assertion that this period in time can described as the 'narrative moment'. In spite of this popularity, Andrews, Squire and Tamboukou (2008) pose the question "What is narrative research?" While this chapter will not attempt to define this complex area of research, some key features of narrative interviewing should be recognised.

First, personal narratives illustrate the place of events in a life course, and can be considered "Stories that include a temporal ordering of events, and an effort to make something out of those events" (Sandelowski, 1991: 162). This results in a mapping of an individual's life history and the events it comprises, and an overview of the life course. A narrative approach encourages the interviewee not only to detail the facts of these stories they are telling, but to embed their telling in a social and cultural context, as well as their thoughts and feelings at the time and in the present day (Hyden, 2008; Lee, 1993; Maynes, Pierce and Laslett, 2008). This is achieved by allowing the interviewee to weave their own account with little prompting and questioning, and this unstructured style interviewing is a defining feature of the narrative approach. Thus, this approach elicits a fuller account than a mere retelling of events, and this rich contextual telling of a story is another characteristic of narrative research.

Second, through this process narrative interviewing extracts the interviewee's identity and their understanding of the experiences comprising their life – their 'narrative' – from their recounting of these events (Bamberg, 2010; Schachter, 2010). Indeed, it is evident that "The storyteller does not tell the story, so much as he/she is told by it." (Andrews, Squire and Tamboukou, 2008: 3).

Another key feature of this methodology is its interactive and collaborative nature, and the research relationship which forms between the interviewer and participant (Salmon and Reissman, 2008). Everything said by the participant is heard and interpreted by the researcher, and in turn shapes the next comment or question they

ask. The researcher is therefore conceptualised as subjective in the research process (Fraser 2002).

Finally, narrative interviewing is concerned with giving a voice to the speaker, empowering them through the interview process and allowing them to make their experiences and views heard. Narratives are traditionally seen as "modes of resistance to existing structures of power" (Andrews, Squire and Tamboukou, 2008: 4) and are often employed in researching marginalised groups in society whose stories otherwise go unheard. In this role, the aim of the research is often to challenge taken for granted social beliefs about these populations and to provide a realistic insight into the issues surrounding the group in question (Fraser, 2002: 182).

Semi-structured interviewing shares many of these features. It similarly allows participants a voice through which they may express previously unexplored views, and is also an interactive process. It also generates a rich amount of contextual data. However, this approach varies from the narrative style of interviewing as the interviews are more structured, with the interviewer having a greater role in steering the conversation (Mason, 1996). Generally, semi-structured interviews follow a pre-determined schedule or set of themes to be explored.

2.2. Why Choose This Approach?

Narrative and semi-structured interview styles were drawn on in this research for several reasons which will be outlined in this section, and it will be asserted that this was the best methodological approach for achieving the aims of this project.

The level of depth and exploration in eliciting stories which qualitative research offers was crucial in this project as the research aimed to obtain detailed accounts of life histories. In order to understand complex cultural issues such as masculinity, it was also essential to adopt an approach which would allow these stories to be told in their cultural context (Maynes, Pierce and Laslett, 2008: 3). As narrative and semi-structured interviewing results in this richness of data and contextualisation it these

are appropriate methodological approaches for this project, and are more suitable than, for example, a quantitative approach which would not allow participants to provide such a detailed accounts.

Qualitative methods, and particularly the life-history focussed approach, are especially valuable in researching vulnerable populations (Liamputtong, 2007). This allows researchers to take account of the potential emotional stress the interview process has on vulnerable participants, and its flexibility enables the interview to be tailored to their needs. As many of the researched individuals in this project suffered from mental illness, and many had histories including adverse factors such as abuse and drug and alcohol addiction, they were certainly a vulnerable group, and the research methodology in this project has been designed and implemented with their needs in mind. The narrative approach also permits and encourages the formation of a research relationship, which is essential in researching vulnerable populations and seeking to gain their trust.

Presser (2009) notes the frequent use of narrative approaches within criminological enquiry. Such methodologies have proven to be of particular value here, and have been used to obtain offenders' life histories in a range of studies (Carlen, 1983; Messerschmidt, 2000; Sampson and Laub, 1993). In particular, Messerschmidt (2000), whose work has influenced the research design of this project, employed biographical narrative interviewing in his research. His study sought to determine how young men become involved in violence, and how strongly this is linked to masculine identities. Presser also advocates an increased awareness of narratives not just as biographical accounts, but as "vehicle[s] for self-understanding" (Presser, 2009: 191). One study which acknowledges the power of narratives to affect the actor in this way is Maruna's (2001) research into individual narratives and desistance, which will be drawn upon heavily later in this thesis. Similarly, recent accounts of narrative research within criminology advocate a more critical examination of offenders' narratives using a psychoanalytically informed psychosocial perspectives which consider not only the accounts given but also the subconscious motivations for these (Gadd and Farrall, 2004; Gadd and Jefferson,

2007). As this project is concerned with understanding violent incidents and eliciting biographical accounts of offending, a narrative approach has been adopted here.

2.3. The Adaptation of Narrative and Semi-Structured Interviewing Styles for this Project

This section will outline how the biographical narrative interviewing approach has been implemented in this project.

As previously stated, qualitative interviews are traditionally conversational and informal (Mason, 1996). This approach was adopted in this project, and all interviews were carried out as casual discussions between the interviewer and the participant, rather than a formal question and answer format. This allowed for a relaxed atmosphere and aided the researcher in the vital task of building rapport with the participants (Arskey, 1999). This was even more important here, given the vulnerable nature of the research sample and the sensitive nature of many of the interview topics.

The interviews were constructed around a set of themes, a methodological technique which is typical of semi-structured interviews (Kvale, 1996; Mason, 1996). Structuring the interview in this way ensured that the conversation remained focussed on the key areas of interest in this project, while retaining the format of a fluid conversation between the interviewer and participant. The themes discussed included living arrangements, family situation and relationships; school and education; self perception, identity and role models; friendships, relationships and recreation; experience with the criminal justice system and violence; future and aspirations; post-school employment, education or unemployment; and institutional history and mental illness. They were seen to be significant aspects of life histories, as well as having a strong, but at times subtle, links to the concepts of masculinity, violence and mental illness. It was important to structure the interview so as to include ‘safe’ topics. This ensured that the participant did feel not they were consistently discussing distressing issues.

The interviews took a life history focussed approach, retaining this element of the biographical narrative style. As such, the questions asked often encouraged interviewees to respond in the form of anecdotes. An example of this can be seen in the following excerpt from one of the interview transcripts:

> *Researcher:* Going back to the idea of violence and fighting, when would you say was the earliest that you ever were involved?
>
> *A.:* When I was 19, with real violence. Because I was in jail in the YO's [Young Offenders Institution]… the only commodity up there was tobacco, so they're people that take tobacco off you… and I said no. So they started on me and a couple of them hit me. And they said "at lunch time you're going to get done in".

By asking this question so as to request the narrating of a memory, the researcher led the participant to respond with a story about his past. Similar question formats – such as 'Can you tell me about a time when [X] happened?' and 'Can you give me an example of [X] from your own experience?' – were employed to encourage this type of storytelling response. This anecdotal approach proved effective in eliciting the stories of which biographical narratives are comprised.

The flexible nature of the narrative approach was also retained, allowing for what Mason (1996) describes as "tailor making each [interview] on the spot" (Mason, 1996; 40). Interviewees were encouraged to lead the conversation, but the researcher was able to steer the conversation if necessary. This flexible approach was of particular use as throughout the sample there were differences in the levels of education, extent of social skills, personalities of the participants, and particularly the extent of mental illness, and all of these factors may have some bearing on the ability of the interviewee to engage in conversation with a relative stranger. Thus, this flexible format was helpful in allowing for a more structured approach where the needs and abilities of the participant demanded this. It was a particular strength of this project that interview methods were devised which successfully obtained data from a challenging interview sample.

Traditionally, narrative interviewing involves lengthy interviews with participants, yet it was previously highlighted that the interviews in this project lasted approximately 1 hour. In relation to the length of interviews, flexibility allowed was again beneficial here. For those who were unable to be interviewed at length due to problems such as mental illness, the minimum interview duration was implemented. However, many participants did comfortably participate in interviews which lasted for longer and were more similar to traditional narrative interviews. Similarly, in the prison setting there was a limited amount of time for some interviews, and therefore deviated somewhat from the narrative fashion, while for others time was less of a constraining factor .Thus, the interview approach was adapted in this way for the purposes of this research so as to meet the needs and abilities of the sample and the time available for interview.

3. INTERVIEW DYNAMICS

3.1. Interview Co-Construction

Narratives are created through a conversation between the interviewer and the interviewee (Maynes, Pierce, Laslett, 2008: 13). The relationship between the researcher and the research participant has implications for the account given in the interview (Phoenix, 2008; Hyden, 2008). Likewise, the "speaker's intent is always met with the analyst's interpretation" (Salmon and Riessmann, 2008), and thus any prejudices the researcher has will be reflected in their interaction with participants during the interview, and their analysis of the data. This section will reflect on the relationship between the researcher and interviewees. This is of particular interest in this project, as the researcher is a female academic who is somewhat integrated in the research setting but is not a member of staff, while the interviewees are male, some suffering from mental illness, all with violent offending histories, who are patients and prisoners in institutional settings.

3.2. The Researcher as a Participant Observer

The characterisation of the researcher as a participant or an observer, an insider or an outsider, or somewhere between these roles is important for the conducting of the research and the data collected. Researchers rarely act as complete observer or a complete participant in the research setting and instead most exist on a continuum between these two poles as 'participant observers' (Mason 1996: 64). When plotting one's position on this spectrum, Atkinson and Hammersley (1994) posit that four factors must be taken into account: which individuals are aware that the researcher is a researcher; how much knowledge those in the research setting have about the project, and who has this knowledge; which activities the researcher does and does not engage in, in the research setting; and how completely the researcher takes on the orientation of participant or observer (Atkinson and Hammersley, 1994: 249). This section will outline the position of the researcher in this project in both settings.

Hospital

The researcher in this project was a participant observer in the first research environment, the hospital. It is necessary to clarify that while the researcher participated in the general community here, the project sought to access a smaller group within this environment – the patients – and the researcher could not be considered a participant in this sub-community in any way. The researcher was formally granted access to the hospital as an independent research student, and in this way was formally included in the research setting while being acknowledged as an outsider. The perceptions of other individuals in the research setting were equally important to formal access in determining the true position of the researcher, as "Insiderness is no guarantee to avoiding unintended and unanticipated positioning by others and ensuring the establishment of trust with respondents. (Larabee, 2002: 112).

With reference to the first of the four factors previously described by Atkinson and Hammersley (1994), staff in the research setting understood the role of the researcher

and were aware that the researcher was not a staff member, yet they may also have perceived the researcher to be quite integrated in this environment owing to the activities the researcher participated in such as attending clinical meetings and having access to files and keys, known as 'privileged access' (Larabee, 2002: 101). Many staff members formed professional and social relationships with the researcher, and in this way the researcher's orientation was that of an insider. While formally an outsider, in many ways the researcher was sufficiently integrated in the research environment to be perceived and treated by staff as an insider.

Patients had a similar conception of the role of the researcher. The researcher did not command the same authority as staff members, but was introduced to participants by staff members, carried identical keys and identification to staff members, and was able to enter and leave the ward freely. This is an important distinction, as only staff may travel the hospital in this way. Patients were aware the researcher was not formally a staff member and insider, but also saw that the researcher had certain privileges which were generally restricted to staff, and was in close consultation with several clinicians in the setting.

This insider status had many benefits, particularly in terms of access to potential participants and resources, yet there were also drawbacks to being perceived as a staff member by patients. It had implications for the distribution of power during the interview, as in this institutional setting hierarchies position staff as more powerful and this was extended to the researcher. As Larabee (2002) notes, 'status in any number of forms can exude power and this can be perceived as threatening by certain respondents' (Larabee, 2002: 112). Being a participant in the research setting may have posed a threat to potential respondents, leading them to feel pressured to participate or to be more guarded in their comments (Hyden, 2008; Richards and Schwartz, 2002). Insider status actually proved beneficial in this respect, as respondents in this project were aware that the researcher was in close consultation with trusted staff members, encouraging them to participate.

It was crucial that the researcher's role did not become confused with that of staff members in the hospital, as there is a clear distinction between the neutral role of the researcher and therapeutic role of the clinicians in the hospital. The researcher had to refrain from engaging in a more therapeutic form of interview and reporting back to clinicians following interactions with patients, and instead remain focussed on collecting only relevant data for this project. It was possible that interacting with staff, learning their perceptions about particular patients, and reading clinical notes before actually meeting individuals would have implications for the objectivity of the researcher (Larabee, 2002: 108). The researcher also actively sought to remain aware of any prejudices about the research sample which developed in this context.

Prison

In the prison setting, the orientation of the researcher was less complicated, and the researcher was more in the position of an observer. This was due to the limited amount of time spent in this setting and the lack of involvement in activities other than interviews for the purpose of this project.

This status was apparent to staff in the prison. They were aware that the researcher was a student conducting research in this setting. They assisted the researcher in moving around the prison, and arranged for prisoners to be brought to the interview room. As staff members were responsible for the sampling in the project, the outsider status of the researcher was emphasised. Prisoners themselves were also aware that the researcher was an outsider. They did not see the researcher regularly in the prison, and the researcher also did not possess any obvious features of insiderness such as keys for navigating the prison or a uniform as worn by prison staff.

This outsiderness has implications for the interview data collected here. This could be considered beneficial in an institution such as the prison, where there may be negative connotations of association with staff members if prisoners have poor relationships with this group. This outsiderness allowed the researcher to avoid inclusion in institutional power structures, thus balancing the power relationship

within the interview and placing the interview more at ease (Larabee, 2012: 112). Similarly, the lack of a pre-existing relationship with participants allowed the researcher to retain greater objectivity in the research process. There were also negative features of outsiderness. Particularly, a lack of immersion in the research environment may hinder the formation of research relationships with participants, which are particularly important in the context of interviewing on sensitive topics (Larabee, 2002: 104). It was important for the researcher to attempt to build such a relationship even in the short time in which the interview occurred.

3.3. Cross Gender Interviewing

A further factor which may have implications for the relationship between the researcher and participants is gender. Interviews in this research were cross gendered interviews, as all participants were males and were interviewed by a female researcher. As Lee (1997) notes, 'cross gender interviewing is distinct from woman-woman interviewing and is deserving of much more sustained attention' (Lee, 1997: 554).

Such gender difference between the researcher and respondent can have implications for openness in the interview (McKee and O'Brien, 1983: 147). The presence of a female interviewer sets new boundaries for what male participants feel they can discuss. In this project there may have been issues which male participants were embarrassed or ashamed to discuss, such as occasions where they have victimised a woman and may have attempted to deny such behaviour or minimise their violence, so as to avoid incurring the judgement of the researcher (Cavanagh and Lewis, 1996). During the interviews in this project, there were occasions where respondents did employ these techniques when describing shameful behaviour, and participants were particularly evasive when discussing female victims or sexual offences. These difficulties are inevitable in cross gender interviewing, and there is little that can be done to combat this, however it is important to be aware of these issues and the implications they may have for the data generated.

The gender of the participant also has implications for the researcher's perception of them and interpretation of their story. A female researcher's perspective on male interviewees' experiences will differ from the interviewees' own perceptions (Cavanagh and Lewis, 1996; McKee and O'Brien, 1983). This may pose a challenge, as gender differences and the lack of shared cultural norms stemming from this may create obstacles to achieving understanding between the researcher and respondents, and the researcher may disagree with the participant's story (Lee, 1997). Again, little can be done to eliminate these differences. It remains important for female researchers to maintain a balance between challenging inaccurate or even sexist comments made by males during the interview, and conducting interviews neutrally and maintaining rapport (Cavanagh and Lewis, 1996). In this project the tone of the interviews remained neutral throughout, however on occasion a more challenging line of questioning was adopted as a methodological technique to encourage reflection on the part of the respondent.

The cross gendered nature of the interviews also had implications for the power dynamic between the interviewer and interviewee. Traditionally the interviewer is in a position of power, yet traditional gender hierarchies may intercede (McKee and O'Brien, 1983). In this project the interviewees were males with a violent offending history, thus placing the female researcher in a vulnerable position. Men may manipulate or control the interview for their own ends, thus it is necessary to be aware of male respondents' goals in constructing and communicating their identities (Schachter, 2010). McKee and O'Brien (1983) posit that in interacting with female researchers male respondents may have a variety of agendas, which may include seeking to position themselves as superior to a female; attempting to gain sympathy from the researcher; seeking to justify shameful conduct, and subsequently excuse their own behaviour; or simply to converse with a female, which may be rare for the respondents in question. At various points during the interviews in this project all of these goals were evidenced in dialogue between respondents and the interviewer. This domination of the interviews by the participants is detrimental to the research, as it may result in important topics being overlooked and it was important to manage

the power balance and ensure that the interview stayed on topic (Cavanagh and Lewis, 1996).

3.4. Asking Sensitive Questions

This research involved discussing issues which may have been sensitive for interviewees and caused them to feel uncomfortable. This can often impact on the relationship between the researcher and the interviewee, and ultimately affect what is said during an interview. While it is difficult to define what can be classed as a sensitive topic, Hyden (2008) posits that this can be dependent on the relationship between the researcher and the participant.

Where sensitive topics are concerned, the key difficulty is encouraging storytellers to talk about these issues, as often they are reluctant to discuss topics which cause them to feel upset, distressed or ashamed. This is especially true where the interview 'is addressed towards behaviour which is problematic or stigmatized' (Lee, 1993: 103), which was the case in this research as the interviews involved discussing violent behaviour. As well as being hesitant to talk openly about shameful elements of their pasts, respondents may attempt to deny these actions or project them onto another individual. This reluctance may subsequently result in the researcher pressing the respondent for information on sensitive topics, which, as well as causing participants to feel uncomfortable, may compromise the results of the research. Hyden (2008) highlights that often researchers make the error of focussing too intently on sensitive issues during interviews, which limits the range of topics discussed and ultimately affects the research findings.

It is also essential when asking sensitive questions to be aware of the potential for the researcher to be positioned as superior to participants. Hyden posits that when sensitive topics are discussed, participants may reveal themselves to be vulnerable, or guilty of actions which would be perceived by others as shameful. This may lead respondents to believe that they are being judged by the researcher, rendering them in a less powerful position and causing them to feel uncomfortable. In this research,

as participants discussed their own violent behaviour and experiences of mental illness and victimisation, there was a potential for this dynamic to develop.

Owing to the problematic nature of eliciting accountss in relation to sensitive topics, it was important to develop strategies for broaching these subjects during interviews. The interview schedules in this research (see Appendix C) combined topics which were obviously sensitive, such as violent behaviour and experiences of mental illness, with less threatening issues, such as aspirations for the future and employment history. The interviews were generally structured so as to ensure that the discussion never began or ended abruptly by talking about a subject which was likely to be sensitive.

Finally, researchers must address the ethical problems inherent in eliciting accounts of sensitive topics. It is important to be aware of the potential for discussing these issues to lead to anxiety and stress for the participant, and to take steps to deal with this (Richards and Schwartz, 2002: 136). Researchers must take additional precautions to ensure that experiencess relating to sensitive issues are circulated in a way which protects the confidentiality and anonymity of the respondent (Hyden, 2008: 129). Care was taken throughout this project to ensure that sensitive topics were dealt with in an ethically sound way at all stages.

4. ETHICS

It is easy to suggest that qualitative research does not pose a risk of harming those involved, yet ethical issues do exist and must be addressed (Richards and Schwartz, 2002: 135). Three main ethical issues arose: the safety and wellbeing of participants, the safety and wellbeing of the researcher, and data protection. Ethical protocols were designed in consultation with experienced academics, mental health service and prison professionals, and implemented in all three areas to reduce the risks of harm. The main protocols are outlined in the table below. These procedures were particularly important in this project as the sample population included vulnerable

individuals whose wellbeing had to be safeguarded (Liamputtong, 2007). Owing to the detailed planning and preparation which took place during the access process, in advance of the research commencing, no serious ethical problems arose during course of this project.

	Area of Concern	**Protocol - Hospital**	**Protocol - Prison**
Safety and wellbeing of participants	Emotional distress during interview	Participants were able to refuse to discuss upsetting topics Participants were able to request a short break, or to reconvene at a later date if they felt distressed Participants were able to withdraw entirely from the study at any time	
	Emotional distress following interview	Patients remained in a therapeutic and supportive environment following the interview Patients were encouraged to inform clinicians if they required extra support	Prisoners were given a debriefing sheet which informed them of sources of support available within the prison should they be required
	Coercion	Participation was voluntary –no positive or negative consequences of accepting or refusing to participate Those approached were not asked to justify any decision to decline Only patients deemed to have capacity to give informed consent by clinicians were approached	Participation was voluntary –no positive or negative consequences of accepting or refusing to participate Those approached were not asked to justify any decision to decline
Safety and wellbeing of researcher	Physical attack	Environment was designed to ensure the safety of staff Visible through a window	Environment was designed to ensure the safety of staff Visible through a window

		throughout interviews Individuals posing a high risk of harm were not included A location specific personal alarm was carried at all times	throughout interviews Individuals posing a high risk of harm were not included
	Disclosure of personal information about the researcher	Where participants ask for such information, they were informed that institutional protocols prevented the researcher from disclosing such details	
	Emotional distress	Academic and professional support throughout the research process A research diary was kept which proved therapeutic Access to the university counselling service was available	
Data protection	Data storage	Files stored on USB Pen USB pen and any paper documents were stored in a locked cabinet to which only the researcher had access	
	Confidentiality	Data was not shared with professionals	
	Anonymity	Participants were allocated a letter which was used to identify them throughout the writing up of the project The research sites were not named Other identifying details were altered or omitted e.g. names of towns, schools or family members	
	Duty to disclose	Participants were made aware that in certain situations – where information was given in an interview which revealed an on-going risk of harm to an identifiable individual – professionals would be informed	

4.1. Safety and Wellbeing of Participants

In terms of ensuring the safety and wellbeing of participants, the table illustrates that a range of measures were in place. While in all research it is important to guarantee this, extra care must be taken with vulnerable individuals so as to "ensure they will not be adversely affected by participating" (Liamputtong, 2007: 36). This particular project posed no risk of physical harm to research participants, but there was a potential for psychological and emotional distress as a result of research participation (Richards and Schwartz, 2002). This was particularly true of patients, and it is important to emphasise that they were used to participating in interviews with mental health care professionals on a regular basis as part of their on-going assessment and treatment. Similarly, prisoners are often interviewed by psychologists, social workers and other staff within the prison.

It was also essential to ensure that all individuals provided informed consent (Mason, 1996; Richards and Schwartz, 2002). This was of particular importance in this project, as some potential participants suffered from major mental illness their capacity to provide this was therefore in question. In any research project where participants are recruited coercion is a concern, and it is important to be aware that an individual's choice about participation may be constrained (Mason, 1996: 57). As Liamputtong (2007) highlights "some vulnerable groups… often feel disempowered and because of their vulnerability, may unthinkingly agree to participate in research" (Liamputtong, 2007: 33). The table above also outlines measures to ensure informed consent and minimise coercion.

4.2. Safety and Wellbeing of the Researcher

In relation to the physical safety of the researcher, the research settings in this project were dangerous to an extent, as the hospital and prison confine a number of individuals with histories of violence. Owing to this, there are existing measures in place to ensure the safety of the staff who work in these settings on a day to day basis, and this same protection was afforded to the researcher. The hospital in this

research was a functioning teaching facility which regularly trained medical students, and consequently there were provisions in place to guarantee their wellbeing, which were also applied to the researcher. In research "It remains prudent for women interviewers to be realistic about the potential for trouble that any man may present" (Lee, 1997: 555). As all participants had histories of violence, with several having victimised women, this was obviously a concern in terms of physical safety. Protocols were developed in consultation with professionals to ensure the physical safety of the researcher throughout the project.

It is important not to overlook the potential for emotional distress to the researcher. It was uncomfortable in the instance that patients and prisoners asked about the researcher's personal life or commented on her appearance, for example one patient remarked that he was 'always happy to talk to good looking women' when approached about participating in the project. Research indicates that this type of reaction from male participants when confronted with a female researcher is common (Arendell, 1997; Lee, 1997). Indeed, Arendell (1997) emphasises the irony in observing that although research interviewers seek to gain information about participants' lives, they are often reluctant to divulge details of their own in exchange (Arendell, 1997: 335). The interviews may also have caused the researcher to feel distressed and upset, as the topics discussed were sensitive and involved interviewees talking about traumatic incidents in their pasts. Emotional support from a range of sources outlined above was available to the researcher.

4.3. Data Protection: Confidentiality and Anonymity

Data protection was extremely important in this project, as it dealt with vulnerable individuals who require special protection (Hyden, 2008; Liamputtong, 2007). Participants were afforded such protection, through the measures outlined in the above table which ensure confidentiality and anonymity. Conducting research with offenders also poses ethical dilemmas, as they may provide information relating to illegal and criminal activities which the researcher may feel obligated to share with others. Lengthy consideration was given to this issue, and particular scenarios where

the researcher may have a duty to disclose information were identified in consultation with professionals, namely where the information revealed an on-going risk of harm to an identifiable individual, although no such occasions arose.

CHAPTER 5

'THE PAST': VIOLENT OFFENDING HISTORIES

Thus far, the key literature relevant to mental illness, masculinity, and the treatment and management of violent and mentally disordered offenders has been outlined, as has the methodological approach of this thesis. This chapter and the 3 subsequent chapters will outline the findings of this project, using evidence from interviews with patients and prisoners.

Violent offending histories were an important aspect of patients' and prisoners' lives, and if we seek to understand the relationship between mental illness, masculinity and violence, a detailed analysis of these is necessary. Both groups were asked to detail their past violent offending, with particular reference to the context and circumstances of these events.

Much violence described by patients occurred in the context of mental illness. The first section here analyses such scenarios, and will demonstrate that in a small minority of incidents mental illness drove violence during periods where patients were acutely unwell. This supports the literature review in Chapter 1, which suggests that small links found between mental illness and violence may be attributable to the psychotic symptoms which manifest during such periods.

In light of the complex life histories identified by patients detailed thus far, it would be short sighted to suggest that mental illness exits in isolation as a driving force of violence. Accounts of violent behaviour while mentally ill often revealed that such incidents mirrored traditional cultural scripts of masculine violence. Offending which predated mental illness also followed such patterns. As prisoners had no documented psychiatric histories, their previous violence occurred out with the context of mental illness, and was also in keeping with typical circumstances of masculine violence. The remainder of this chapter will be concerned with examining the various scenarios of masculine violence described by patients and prisoners, arguing that it

may play a more significant role in driving violence that mental illness. This again supports the literature review in Chapter 1, which found that non-illness-related factors may be more strongly associated with violence.

1. MENTAL ILLNESS AND VIOLENCE

All of the interviewed patients were diagnosed with mental illness: 6 with schizophrenia, 2 with bi-polar disorder and 2 having experienced acute psychotic episodes directly preceding hospitalisation. All patients described violence which they suggested was motivated by primarily mental illness, and these incidents will be outlined in this section.

While patients' accounts explain these incidents as mental illness driven, it is important to consider whether this is accurate. It will be argued later in this thesis that treatment and management frameworks lead patients to conceptualise mental illness as the cause of and solution to offending, and this may be reflected in comments in this section. This is not to say that their understandings are wrong. Indeed, the violence of one patient in particular, J., did appear to be almost entirely caused by psychotic symptoms and he described no other violent encounters in his life history. The other accounts of violence outlined in this section also demonstrate that it is during such periods of acute illness and psychosis where mental illness is most linked to violence. These were often the incidents that resulted in patients' hospitalisation. Yet although they have been identified as the altercations most strongly associated with mental illness recounted in the study, it was still difficult to eliminate other potential factors driving this violence.

Depictions of such incidents were largely described in relation to the confusion associated with acute mental illness. They were often unplanned and unprovoked:

> I stopped smokin' cannabis in March 2002, started drinkin' heavily, then supposedly one day I went out and I hit this old man, and he hit the ground, and I've walked away, and three or four days later the guy died. And I ended up handin' myself into the IPCU [Intensive

> Psychiatric Care Unit], and they were saying 'What's happened?' and I says 'Nothin'. I had no recall, no memory. (B., Patient, 43)

The patient's confusion here is evidenced as he indicates that he had no recollection of committing this violent act. In describing violent behaviour which led him to be transferred from prison to the medium secure unit, another patient highlighted similar confusion and lack of recollection:

> I still don't understand how it happened… I tried to strangle a doctor to death. But I don't know, I can't remember, they told me that I had been in a really bad state, shakin'… I really can't say anythin' that I have no recollection of. (I., Patient, 19)

Symptoms of acute psychosis were also described by several patients in the context of violent offending. For example, one patient cited overwhelming feelings of 'power and grandeur', a common feature of manic phases of bipolar disorder, the condition with which he was diagnosed. This particular incident appeared to be one of the most strongly linked to mental illness recounted by patients:

> At the time I was ill again, I had this feeling of power and grandeur… I was ill, but I didn't know it, I thought I was normal… And, eh, [Steve] was at the gate – my brother – and this thought came in my head: to prove that I knew the way to god and that I loved god, I had to do this task, and that was to take my brother's life. And that's what I did… I ran him over with the tractor. (J., Patient, 51)

Here, mental illness was not acknowledged by the patient at the time of the incident, who by his own admission did not realise that he was unwell. His seemingly spontaneous use of lethal violence against a family member again indicates volatility and disturbance. The patient also refers to the role of psychotic symptoms in driving his violence, and suggested several times that his delusional thoughts in relation to religion facilitated the commission of this violent offence:

> Interviewer: So what would you say was the cause of you taking your brother's life?
>
> J.: Reading a story out of the bible, about Abraham and Isaac in the Old Testament. And to prove that Abraham believed in god he had to sacrifice his son and take his life, and at that moment before he took his life god told him to stop and said 'yes, you do believe in god'. The thing is, I don't even remember reading that story in the bible.

Other patients' accounts of offences while they were unwell similarly suggested that symptoms of psychosis were a contributing factor. One patient described a serious

sexual assault against his sister. His delusional thought process and feelings of paranoia and suspicion, which are common to schizophrenia, are evidenced here through his beliefs that the individuals closest to him are conspiring against him:

> A. (Patient, 54): I started thinkin' she [my sister] was trying to get me put away… there were a couple of pals too. And eh… I knew there was somethin' wrong, I was thinkin' what to do to them... I went round to my sister's house… and I was just pacin' up and down, these mental thoughts were goin' through my mind.
>
> Interviewer: What kind of things?
>
> A.: Just all sorts, like… me tryin' to reason wi' masel'. And she ran me home… and I just got it in my head and done it [committed the rape]. She left and the polis came that day, and I didn't a hundred percent realise I'd done it.

Another patient described similar suspicion of others, although his delusions were arguably more complex and were associated with strangers. Again, this led him to act violently against this group:

> I thought, well, it was time to maybe 'clean up' [the city], and I was extremely unwell at this time. And took it on my own that I was a 'chosen one' to rid [the city] of heroin dealers and junkies… I'd heard that there were some prostitutes who'd been robbed by heroin dealers… I picked up a girl, because I thought that she was one of the characters who'd been robbing from the prostitutes. But she was a prostitute.... And we had consensual sex. And then she got out of the car… But she'd left her bag and mobile phone and I thought "this is my opportunity to get her bag and her mobile phone and find out more information about heroin dealers" … I pinned her to the ground, basically trying to get her bag off her, I then struck her over the hand and in the knee with the metal bar and eventually pulled the bag free. (F., Patient, 32)

Overall, patients' accounts suggest that psychotic symptoms often play a key role in driving violent behaviour.

In describing offending in this context of acute mental illness, patients' accounts often demonstrated impulsivity. One patient detailed the circumstances of his assault of police officers during arrest, the offence which ultimately led him to be hospitalised. He makes no reference to his violent behaviour, however he does highlight the impulsive nature of his actions at this time, highlighting that his behaviour was 'ill thought out':

> I just lost my composure and I intervened at the – as far as I was concerned it was an unlawful funeral ceremony at this crematorium. It was just a desperate, ill thought out, it wasn't even thought – to be honest I just wanted to… to make a desperate protest at the way

> it was handled, and I intervened at the crematorium and the ceremony. And in the process got myself arrested. (E., Patient, 49)

Similarly, patients also demonstrated that violence while unwell was largely not thought out or perpetrated in a way so as to avoid detection. This was particularly evident in one patient's account of his behaviour following his offence immediately preceding his admission to an inpatient setting as he sought hospitalisation following the incident, and in doing so made no attempt to conceal the crime or to evade arrest and prosecution. The patient's confusion appears to have inhibited his ability to do so:

> I just admitted myself to the IPCU… The nurse came in and said 'B. the police are here to see you', two CID were there, and they said 'You'll need to come with us' and I said 'How?' and they says 'We believe that you've murdered somebody.' And I says 'Aye?'… I was in a trance. So they took me to the police station, charged me with murder. (B., Patient, 43)

This is an example of 'inept offending', whereby mental illness impedes the skills required to successful commit an offence and avoid detection (Peay, 2007: 504). Another patient described violence against police officers. Rather than attempting to evade them he remained in his flat, where officers had already called looking for him. This again suggests a lack of organisation and planning:

> G. (Patient, 54): They [the police] broke into my house when I absconded from hospital. It wasnae until later on that night that they come to my house and I found out they'd kicked the door in lookin' for me.
>
> Interviewer: Okay, so what happened?
>
> G.: I was just sittin' in my flat when they came to the door… I threatened them and that and I ended up fightin' with them.

In contrast to the disorganisation demonstrated by patients, prisoners' comments illustrated some organisation following violence. This was particularly true of where prisoners were facing homicide charges and lengthy prison sentences. In some instances this simply involved going to the police station:

> "I handed myself in." (P., Prisoner, 34)

Two prisoners described attempts to evade arrest, and described their efforts to avoid being found:

> L. (Prisoner, 31): We just fucked off doon tae Dover and sat doon there for about 6 days, then we got the jail.
>
> Interviewer: How?
>
> L.: I got done in a stolen car and they got done a couple of hours later.

Similarly, another prisoner described his actions in seeking to destroy evidence at the location of a violent incident and to conceal his offending behaviour:

> I was gonnae phone the police but I thought 'they're no gonnae believe me'… a couple of grand worth of tablets and jewellery down my pants – they're no gonnae believe that! I made it look as if it had been a break in… I went out the door, locked the door, turned all the cookers on. I was like a zombie. I saw his aftershave bottles so I thought I'd set fire to the place with that… I put a light to all this aftershave, but it must have just went and died away the minute I shut the door over. It never took hold... (M., Prisoner, 39)

As all prisoners were convicted of homicide offences, two recounted their attempts to dispose of the bodies of the victims in order to avoid arrest and prosecution:

> S. (Prisoner, 23): Well there was a missin' person out, and then my cousin obviously said to the polis and that's when they knew that it was a murder.
>
> Interviewer: So did they not have a body at this point?
>
> S.: No.
>
> Interviewer: So where did they find the body?
>
> S.: It was on a golf course.

> We stuffed [the body] in a freezer and locked it in a cellar… But we kindae knew when they found the body that they knew it was us, because they knew that we'd been staying there when he'd disappeared… that was us fucked basically. (L., Prisoner, 31)

Prisoners' somewhat organised behaviour following their index offences contrasts with patients' seemingly disorganised actions during this period. This difference can be attributed to the influence of mental illness, which leads patients' behaviour to be characterised by confusion and disorganisation.

The accounts in this section suggest that acute mental illness and its symptoms may result in violence. In some cases this was due to confusion and volatility. Other accounts illustrated that hallucinations and delusions drove violence. It must be

remembered that this association is only present in periods where individuals are acutely unwell and experiencing such symptoms. Also, although these incidents represented the strongest evidence found of an association between mental illness and violence, it is still difficult to eliminate other factors. Both patients' and prisoners' accounts in this research illustrated masculinity as a driving force in violence. The remainder of this chapter will demonstrate this with reference to common cultural scripts of masculinity.

2. CONFRONTATIONAL VIOLENCE

Male on male confrontation was a common scenario of violence for patients and prisoners, and represented the majority of violent incidents described. Violence which can be understood as 'masculine confrontation' is characterised by seemingly insignificant triggering incidents which are perceived as challenges to one male's masculine honour (Polk, 1994). Challenges are responded to with aggression, and the situation escalates into serious violence. In its most extreme circumstances, confrontational violence can end in fatality. This section will examine both groups' experiences of such incidents, demonstrating the role of masculinity in driving violence.

2.1. Confrontational Violence: Patients' Experiences

Confrontational violence occurred prior to and during mental illness for patients. Many detailed such incidents in their youth, before mental illness was present. These altercations occurred in the context of a trivial disagreement, yet escalated into violence:

> C. (Patient, 34): Up til about 16, I'd go to local pubs in Bathgate and sometimes you'd end up in fights and stuff.
>
> Interviewer: What sort of stuff would happen?
>
> C.: Well, one time there was this tall guy I just didn't get on with… I asked him for a fight, and he said aye and we went to a back alley. And he was tall so he had a bigger reach than

> me and I couldn't get round him, so I jumped and grabbed him and hit his head off a car, and just kept on punchin' him. And then his mates broke it up.
>
> Interviewer: What made you decide that you needed to fight with him?
>
> C.: It was just really, at the time I was more, sort of, markin' out my territory sort of thing, tryin' to make a name for myself.

The presence of a social audience was a key factor in this scenario. The notions of 'marking out territory' and 'making a name for yourself' highlight that this incident was driven by a desire to display masculine attributes such as strength and power in front of this group at a young age, and that violence was a means of achieving this. These characteristics were present in other violent incidents from patients' early years:

> When I was 19, [was my first incident] with real violence. I was in jail in the YOs, there were people that take tobacco off you… and I said no. So they started on me and a couple of them hit me. And they said 'at lunch time you're gonnae get done in'… I went and got a brush, and the two guys… I set about them wi' the brush. Instead of them doing me in, I did them in. And you end up wi' a reputation, but you've got to keep that reputation, know what I mean? I built up a reputation, people were more wary of me and they never bothered me and that. (A., Patient, 54)

Although apparently trivial, if we consider the attempt by other prisoners to take this patient's tobacco in the context of a prison environment where such commodities are scare, this initial affront appears more serious. It is therefore understandable that these actions are perceived as a challenge to his masculine identity, and that the patient is compelled to respond with violence. The issue of reputation is raised again, with the interviewee emphasising the role of physical violence in establishing a sufficiently dominant identity to ward off future challenges.

Escalation is an important feature of confrontational violence, and many such situations stem from these ostensibly minor affronts. One patient asserted that altercations often stem from previous verbal quarrels. While these may not appear serious, when aired in public they are perceived as real challenges to masculinity warranting violent responses:

> It's like past history, like maybe you've had a fall out with somebody and that, or he's done somethin' to you… and the tempers fuse when you see each other and you start arguing with them, and before you know it you're fightin'. It's stupit. But it was mostly guys that wanted

> to fight me as much as I wanted to fight them, it wasn't like I just went up and punched somebody or hit somebody. (A., Patient, 54)

Alcohol was a prominent theme in patients' experiences of confrontational violence in two key ways. First, in recounting violent histories, patients' accounts often focussed on the role of alcohol consumption and its effect on their mental state in driving offending. Second, many incidents took place in the environment of nightclubs and bars, which were perceived to be particularly conducive to confrontational interactions.

One patient suggested that excessive consumption of alcohol increases the likelihood of violence due its effects on the mental state, and that this is true in his own experience:

> Interviewer: How would fights start if you're out getting a drink?
>
> B. (Patient, 43): Probably verbally at first and then it would get into a fight, if you're too drunk you dunno what you're doin', so you cannae blame yourself for it. It's just like, alcohol changes your state of mind so you cannae help how you are… you lose control… When I used to go up the toon, I'd probably have about 8 or 9 pints. And sometimes I'd maybe wonder how I got home… and wakin' up in the mornin' in the police cells and not knowin' how you got there.

He emphasised this point throughout this story:

> Off drink I'm normal and a'right, quite a nice guy, but when I'm on drink, as I say, it affects my mental state, makes me a wee bit funny, you know, different. (B, Patient, 45)

Other patients echoed these sentiments, emphasising the volatile state of mind induced by alcohol consumption, and suggesting that this is likely to play a role in the increased aggression and sensitivity to perceived threats evidenced in this context (Benson and Archer, 2002; Graham and Wells, 2003):

> I was off my heed 'cause ae the drink, I started drinkin' whiskey instead of stickin' to beer. And I started sticking the nut on people and generally making a nuisance of myself. So I got well known to the police from that, and they locked me up. (H. Patient, 49)
>
> I was volatile. I wouldn't, like, go for people I was pally with… it was always something started. A guy would go 'watch who you're bumping' and that, know what I mean? And you'd go 'who are you talkin' tae?' Like a short fuse, no tolerance. (A., Patient, 54)

The second account here suggests that the setting in which alcohol consumption takes place may also be conducive to violence, as it may provide more opportunities for confrontation through small triggering incidents such as bumping into someone. Research also suggests that the setting of the night time economy provides a backdrop for violence (Tomsen, 1997). Again, a key factor in such scenarios is the presence of a social audience. One patient suggested that in the company of peers and in this environment, he felt especially compelled to respond to relatively trivial challenges:

> It was if a guy said something to you in a pub. If you're playing pool with your pals, and a guy goes 'oh you're an idiot, you're an arsehole' and your pals would go 'oh you're not letting him away with that are you?'. (A., Patient, 54)

In this sense, the presence of a social audience appears to 'raise the stakes' of a confrontation. Considered in relation to masculine identity, altercations in this setting pose a risk of a loss of face in front of this group, and damage to a masculine persona (Canaan, 1996; Tomsen, 1997; Benson and Archer, 2002; Graham and Wells, 2003). Both the consumption of alcohol and the setting of the night time economy appear to be conducive to violent behaviour.

Where violence took place in the context of mental illness, the incidents patients described were similarly analogous to confrontational violence scenarios, but were also characterised by the volatile nature of mental illness and its symptoms:

> D. (Patient, 49): I never got charged but I stabbed someone.
>
> Interviewer: What happened there?
>
> D.: I was walkin' along the street and I kicked his car and he shouted at me, I said "are you speakin' tae me?" and he came out and says "aye I'm F-in' speakin' to you!", and then he came out. So I just stood there and he came runnin' out and he grabbed me, and I just panicked and I stabbed him. I don't know if he was goin' to head-butt me in the face or what but he just grabbed me by the back of the scruff that quick.

In this example, the patient's act of disrespect towards the other male's property is interpreted as a challenge, which escalates into a physical altercation. The patient describes his feelings of panic, a trait which he identified earlier in his account as a feature of his mental illness. The patient quickly resorted to violence when

confronted with a situation which he perceived to be threatening, mirroring research which posits a link between 'threat/control override' symptoms and violence. Other patients described similar scenarios, whereby mental illness appeared to intercede in incidents of confrontational violence:

> H. (Patient, 49): Attempted murder. I stabbed my dad. It was the evil tellin' me to do what I didn't want to do but… I blamed that for my father's stabbin'... But it was tryin' to say things like 'you're evil' and I wasn't listenin' to it. Well, I was listenin' to it but I was against it.
>
> Interviewer: And what happened?
>
> H.: I fell out with him the night before because he wouldn't buy me a drink… which was wrong of him, because he was my dad, I expected him to be nice to me, you know… I never questioned him on it because I ended up stabbin' him as my way of getting' him back for being nasty to me.

In this instance, the challenge is advanced by the patient's father, who is perceived to have wronged him in a social setting. There is a lapse in time here before a violent response occurs. This parallels Polk's (1994) account of confrontational homicide, whereby violence may escalate very quickly, or over a longer period of time where patients even leave the scene and resume the altercation at a late time. Issues of mental illness are also present in this scenario, as the patient suggests that he was prompted to respond violently to this situation by auditory hallucinations. This again demonstrates the role of mental illness in these instances.

2.2. Confrontational Violence: Prisoners' Experiences

Masculine confrontation also represented a large proportion of the violence detailed within prisoners' accounts, with half describing confrontational homicides as the offences resulting in their imprisonment. As in the case of patients' accounts, these incidents involved violence between two males originating from a perceived challenge to one party's masculine honour.

Several prisoners detailed early incidents in which they behaved violently towards other males which mirrored situations of confrontational violence:

> On my 16th birthday I was meant to go to the secure home, and my mum had moved because of all the trouble I was getting in... They released me to go and live down wi' her in England, and I only lasted 3 or 4 months. I got into an argument and a guy pulled a knife on me and tried to stab me, I took it off him and stabbed him with it. (R., Prisoner, 28)

While it is unclear what the triggering incident for this altercation was, it is indicated that an initially verbal disagreement escalated in a short period of time into serious violence involving a weapon. This seemingly spontaneous progression to violence is typical of confrontational scenarios (Polk, 1994).

For the 5 prisoners whose offence prior to imprisonment occurred in the context of confrontational violence, the altercations ultimately escalated into the death of one of the parties involved. Again, the origins of these incidents may seem relatively trivial, whereby an initially verbal argument escalates into serious violence:

> K. (Prisoner, 35): We were just in a hoose drinkin' buckfast and stuff and then we just left the hoose and one of the boys that I was with, he started arguin' wi' one of the other guys and just a fight broke oot, and I just went way too far. Obviously the guy died fae his injuries.
>
> Interviewer: Were there weapons involved?
>
> K.: Naw, it was just wi' my hands and that, he was gettin' kicked and punched and that.
>
> Interviewer: And was it just you who was involved in that?
>
> K.: Naw there was aboot 6 ae us or somethin'… But they're all out now.
>
> Interviewer: So were you seen to have the biggest role?
>
> K.: Because I was the ringleader, and 'cause I wasn't that long out ae prison.

The prisoner was not the recipient of the original challenge in this instance. As Polk suggests, in group scenarios the ultimate victim and perpetrator may not be the two parties involved in the initial argument. The presence of a social audience is a factor here, as the prisoner characterises himself as the 'ringleader', creating an image of a dominant male. In a similar scenario described by another prisoner the initial affront was an ostensibly mundane misunderstanding over name calling. Yet the prisoner suggests that the situation 'kicks off' at the moment of this perceived challenge in front of a social audience:

> L. (Prisoner, 31): Basically, I just got oot ae jail and I was 17. And I met my co-accused… And we decided to go down to England, down there 6 days and we were stayin' in a mad

> bedsit 'hing. Then an Asian guy stayed down the stairs and we had up the stairs. And we got on a'right. And basically, we were drinkin' the whole time, know what I mean… And then wi' the accent wi' us being Scottish. So there was that communication 'hing as well… basically it was over a misunderstandin'. My co-accused, was sayin' he'd been stabbed by his father in law or somethin' and that he was a prick. And he [the victim] thought my co-accused was callin' *him* a prick. And that's when it just all kicked off.
>
> Interviewer: What happened, were there weapons involved?
>
> L.: Aye… Me and my co-accused, me [Steve] and [Helen]… he got his head smashed in with a rollin' pin and a bottle, he got stabbed in the chest and in the eye with a screwdriver.

Another incident involved only the victim and the perpetrator. The challenge here was advanced in relation to the prisoner's sexuality, in the form of a perceived homosexual advance from the victim. While there was no risk of 'losing face' in front of peers through withdrawal from a challenge, the prisoner nevertheless responded violently:

> I was walkin' through the town centre and all I heard was [moans] and it was a deaf and dumb guy... And he went like that [mimes drink]... So we went in [his house]... He produced a video with men sitting naked at the side of a pool. So I says 'I don't mind that stuff but I'm no into that' and he's going 'gay pride' like on his heart like that [thumps hand on chest]. And I says 'good for you'. He's poured me a big vodka and that's up to the last thing I can remember… I woke up and he's stood there naked, his face was all red, he was pointing to the door… I said 'Open the door, give me my jacket and bag and I'll go' and he came over and went to head-butt me. So I just put my head down first and come right up with my head on his chin, and that's all I remember in the fight. The next thing I sort of came to, I was on the ground, my arm was stabbed… I went 'oh my god' and I seen his neck, all the way round it was just a red bit. His throat had been slashed all the way from one side. Apparently the pathologist said the blow was so severe there was a mark of the knife on his spine… I felt his pulse, but I knew he was dead, the wound in his neck was so deep he could never have lived. I'd only been out the jail 10 days. (M., Prisoner, 39)

In light of the circumstances described by the prisoner above, the violence employed could perhaps be considered as a form of self defence. It is significant that the prisoner suggests that he cannot remember the incident, as this mirrors the comments advanced by several patients in describing their index offences. Normative heterosexuality is a key feature of hegemonic masculinity, and defence of this is integral to the maintenance of such identities (Connell, 1987). It is possible to infer that the victim's actions were perceived to represent a threat to normative heterosexuality, and the prisoner reacted violently in protection of this aspect of his masculine persona.

All of the confrontational violence incidents described thus far occurred in the context of alcohol consumption, and suggest elements of the increased volatility which this entails. Prisoners' accounts of their pre-institutional recreational habits, which are outlined fully in the following chapter, suggested that they rarely visited bars and clubs due to territorial anxieties in their local areas which prevented them from travelling to these environments. Two confrontational violence scenarios described by prisoners took place in pubs. Again, the pub environment was a key aspect of these offences, allowing for the congregation of groups of males and setting the scene for violence and masculine competition (Tomsen, 1997; Benson and Archer, 2002). The challenge in the first of these instances was not advanced directly to the prisoner, but rather to his father, whom the prisoner felt obligated to defend, following the long period of escalation which led up to the incident:

> We were in the local pub. He [the victim] hadn't been in the pub for years, he was a junkie... He was tryin' tae cause trouble wi' my dad and it went on all day, and me and a few of my mates were there… two ae them came runnin' intae the alcove where we were all sittin' and one ae the guys hit my dad across the head wi' a pool cue, and the guy had smashed me across the head with a bottle, just for no reason, no rhyme or reason. But as soon as they hit my dad – he was dyin' ae cancer at the time – I just jumped the table, punched the guy and tried to drag him out to get it outside. I didn't want to be fightin' in the pub, I didn't want to be fighting at all… I turned round and one guy that was lying on the ground, I punched him about 4 or 5 times, he's knocked out… I found out the next again day that the guy that hit me with the bottle and I had punched … he was lying on the ground when I left and I'd punched him 4 or 5 times. Another guy in the pub had ran over and kicked him square in the head which was nothin' to do with me. But anyway I found out the next again day he had died. That was it, I went to court and I got done wi' murder. (P., Prisoner, 34)

The other account of confrontational homicide within this context bears several similarities to this incident, as again an initially small verbal challenge escalates quickly into violence. This incident also illustrates how pub and nightclub settings provide opportunities for masculinity based challenges between male strangers:

> I went to the bar to get the drinks in, and there's this guy sittin' behind me and I said 'sorry mate', and he went 'wanker' and I heard it but decided to blank it. And I went to the table and put the drinks down and [John], my mate, seen me, I'm chalk white and he knows there's somethin' wrong... So me and [John] went out and [John] tapped the guy on his shoulder to ask, and he turned round and swung and hit him with a punch, and it just kicked off… me and the guy are rollin' about on the floor, I've smashed all his eye and he's burst all my nose, it ended up that he ran out the pub... So, we took knives and walked into the pub and there was about 19 of them sitting all tooled up… This guy's brought out an automatic cosh and hit [John] over the shoulder. We thought it had been a knife or a hatchet. He went down on one knee. The whole place blew, it just went right up in the air. One of them got killed, another 4 or 5 injured, I lost a finger in that fight and got it sewed back on again. (Q., Prisoner, 61)

The break between the initial altercation and the lethal violence is a significant feature of this incident, and parallels Polk's depictions of confrontational situations in which one or both parties leave the scene to retrieve weapons and return for the final violent act (Polk, 1994: 69). In this sense, the pressure to respond to a challenge endures even where there is a lapse in time.

2.3. Confrontational Violence: Conclusions

In summation, the majority of patients' and prisoners' accounts of violent incidents were analogous to scenarios of masculine confrontation. These incidents are rooted in masculine desire to maintain a dominant and physically strong image in the face of perceived challenges. Prisoners' accounts largely referred to incidents of homicide which were confrontational in nature. For patients, their violence was analogous to such scenarios both prior to and during mental illness. Where such incidents occurred in the context of mental illness, features of mental illness such as volatility or active psychotic symptoms contributed to the occurrence of violence, yet the altercations largely adhered to the characteristics of confrontational incidents. This interaction between mental illness and masculinity endured in other scenarios of masculine violence, as discussed in the subsequent sections of this chapter.

3. VIOLENCE AND THE PROTECTION OF WOMEN

Patients and prisoners also described offending in the context of defending females. The circumstances of these incidents varied, but all involved males employing violent behaviour to protect or defend a female whom he perceived to be vulnerable. This image of a male as the protector of vulnerable females is a powerful masculine persona, which is founded in the dominance and superiority of males over females (Connell, 1987). As such, these offences also have roots in masculinity. Where mental illness was present, such cultural scripts were follower, but were carried out

with the confusion and disorganisation which characterised much of patients' actions at this time.

3.1. Violence and the Protection of Women: Patients' Experiences

Three patients gave accounts of violence for the purpose of protecting females. In some instances, this occurred in the context of the defence of known females, for example family members and intimate partners. However, another instance involved the protection of young females who were unknown to the patient.

The desire to protect close females can be understood as a distinctly masculine one. Literature suggests that this desire to protect dependents from danger is a key feature of masculine identity, as males seek to ensure that they remain dominant over other males who advance challenges in relation to female partners and relatives (Gilbert, 1994; Polk, 1994). One patient described his violence towards his mother's partner in an attempt to defend her from his abusive behaviour. The patient characterises himself as the protector of a close female figure, and ultimately a physically strong and dominant male:

> G. (Patient, 39): I assaulted my mum's boyfriend.
>
> Interviewer: Okay what was that for?
>
> G.: He was just being heavy towards me and my mum and that, he was drinkin', takin' money off her, throwin' me out of the house.

Another patient's account demonstrated similar motivations, as he described a need to protect female figures close to him. He characterises such behaviour as a 'vigilante' act, and acknowledges that he is predisposed to such behaviour as he has strong views against the mistreatment of females. Through his actions he ultimately casts himself in a protective and powerful role:

> I was charged with abduction, assault, two counts of robbery, when a con artist, befriended my fiancé at the time and ran up a mobile phone bill for £500 and refused to pay it. So I went round to his house full of drink and drugs and tried to put the door in, ruffled him up a bit, put him in the back of a car, drove down to the bank and told him to withdraw money from

> the bank, and he ran off. And I was charged with abduction, assault and two counts of robbery, and eventually the case was admonished. (F., Patient, 32)
>
> My youngest sister was a heroin addict at the time. So that was why I thought I could really do this [violence against drug dealers] to help my little sister… I've been labelled as a vigilante, but I think it was my morals and beliefs that led me down that path. (F., Patient, 32)

Such behaviour also occurred during periods where patients suffered from acute mental illness. Their accounts suggested an increased willingness to act in the defence of women, even in cases of females who were unknown to them. The same patient described offending behaviour which occurred during acute mental illness, but which nevertheless parallels his pre-illness violence. This demonstrates a continuation of the intention to protect women and position himself as a powerful and righteous male. Mental illness interceded in this scenario, as his actions were carried out in the context of a confused mental state and were ultimately unsuccessful as he directed them towards the wrong individual.

> It was like, the element of, somebody robbing prostitutes for their own gain and drugs, and I thought "right I've got to do something to sort that out"…I thought in that way I was protecting them. And when she [the victim] had said "There's plenty money down there for collecting" I thought "She must be one of the people involved in robbing the prostitutes". (F., Patient, 32)

A similar account was provided by another patient. Through behaviour which could be characterised as violent, arson, he sought to protect females whom he observed to be vulnerable from a perceived threat. The confusion of mental illness is again evident in the execution of this offence, as in this instance the patient mistook police officers as a threat to females, and acted violently against them:

> D. (Patient, 49): I was up the hill walkin' a dog and there was one man exposing himself to two girls, he was hidin' behind a bush. I said to the girls I'd sort him out, and I didn't do anythin' but later I went and saw there were people hangin' about and I didn't realise they were the police, and I set fire to the bushes.
>
> Interviewer: Okay, why set fire to the bushes when you saw them there?
>
> D.: Because I thought they were flashers too. I never knew they were police.

In carrying out such acts, patients characterise themselves as defenders of women in danger, a highly masculine persona.

3.2. Violence and the Protection of Women: Prisoners' Experiences

Two prisoners described violence which was motivated by a desire to protect female partners. As with patients, the masculine desire to protect vulnerable women and cast themselves as dominant and physically powerful males was illustrated in their comments.

The first of these incidents involved a prisoner acting to protect a female with whom he was closely acquainted. He attempted to exact retribution on a male whom he perceived to have sexually assaulted her. Rather than contacting the police, he suggests that he 'blew his top', taking matters into his own hands and ultimately committing a homicide. It can be inferred that he felt compelled to avenge his female friend, placing himself in the role of her protector:

> O. (Prisoner, 45): There was this boy that was meant to be muckin' about with this girl [Elaine] that was the friend of mine, and I just blew my top…
>
> Interviewer: So, she was someone you were seeing?
>
> O.: I wasn't seeing her, I just knew her for being a friend… She said someone tried to rape her. What I should have done is just walked away and just gone to the police station but I didn't. She dropped us off at the flat… I went up to the guy's flat… Well, there was a knife involved but… legs of tables, things like that…
>
> Interviewer: And he died from his injuries?
>
> O.: Eh, he lost a lot of blood and things like that.

A second prisoner also illustrated that the motivation for the homicide offence which led to his imprisonment was the defence of a female, although in this instance she was unknown to him. The prisoner took it upon himself to deliver retribution for a sexual offence against a young girl. By positioning himself as a protector of such a vulnerable individual, he creates a strong and righteous masculine persona through his violence:

> Essentially I killed a guy… the reason I killed him was… This was what was in the paper, he sexually assaulted a young girl at knifepoint, a 12 year old girl or something like that, and that's the reason this happened. This kind of boiled over and I was staying in a small place and you keep bumping into people like that – and I killed him. (Q., Prisoner, 61)

Ultimately, it appears that violence which aims to protect females is masculine in nature.

3.3. Violence and the Protection of Women: Conclusions

In summation, both prisoners and patients gave accounts of violent incidents which were carried out with the motivation of the defence of females. In committing these violent actions, both groups sought to construct a masculine identity rooted in the subordination of females (Connell, 1987). By casting these females as weak and in need of protection, patients and prisoners reaffirmed their own dominance and physical superiority. For patients, while the desire to present a masculine identity through this violence was still present during mental illness, their actions were often perpetrated in confused and disorganised ways which reflected their mental state. Thus, it was again evidenced that mental illness served to intercede in scenarios of masculine violence.

4. VIOLENCE IN THE CONTEXT OF OTHER CRIME

Some violent behaviour described by patients and prisoners appeared to have a more overtly functional role, as it was employed in the course of other criminal activity. In these scenarios, violence was not necessarily the intended result, rather it was a means of facilitating other types of criminal behaviour when challenged by others in this risky situation (Polk, 1994: 93). This violence also contributed to the construction and maintenance of a masculine identity.

4.1. Violence in the Context of Other Crime: Patients' Experiences

Violence taking place in the course of other criminal behaviour made up a very small proportion of the violent incidents described by patients, with only two providing accounts of such situations. The incidents they detailed both took place out with the

context of mental illness. This is understandable in light of the evidence of the disorganisation of mentally ill individuals provided in this chapter. While unwell, patients would likely be unable commit offences such as burglary which often require planning.

One patient described such an incident which took place in his late teens. He engaged in initially non violent crime, breaking into a chip shop to steal money, which ended in violence. As in confrontational incidents, his account illustrated a rapid escalation into violence, demonstrating a readiness to resort to such behaviour in the context of this offending behaviour:

> It was in the mornin', we broke intae the place. And we opened the door… and the [owner] just got a poker and come runnin' at me and I hit him with an iron bar. And the guy just ran away. (A. Patient, 54)

As Polk suggests, the threat of violence employed in embarking on such activities becomes real violence (Polk, 1994: 93).

Another patient's account of the circumstances surrounding a violent incident suggested a wider context of criminal activity, in this case the drugs trade:

> G. (Patient, 39): Two people I was fightin' wi' [in the past] have killed themselves. And I had a lot ae hassle from the police and that, my mates and their mates were fightin' each other over it.
>
> Interviewer: Why were you fighting with them?
>
> G.: To do wi' lassies and to do with drugs at the time. I was takin' drugs off them and money and that, they could look after themselves, so we fought.

Although these scenarios are somewhat dissimilar, both accounts indicated that the patient initially sought to gain financial resources through risky activity, and ultimately felt compelled to resort to violence so as to ensure this was achieved. This willingness to react violently for this purpose can be understood as symptomatic of the wider constant competition for scarce resources between lower class males (Polk, 1994: 206).

4.2. Violence in the Context of Other Crime: Prisoners' Experiences

Three prisoners also recounted violent in the course of other criminal activity. In two instances, the prisoners were involved with the group of perpetrators of the original criminal activity, while in the third the prisoner was the victim.

Several prisoners engaged in lifestyles characterised by association with risky, criminal activities. These situations often escalated into violence. In the instance below, the prisoner himself did not perpetrate the original crime of theft, yet his involvement in a peer group where offending was common appeared to increase his readiness to resort to violence to facilitate these activities:

> When I was 16 I got the jail for attackin' a security guard. Because he'd battered my brother.. He had been caught breakin' into the bread factory... He came round and I says 'what's happened tae your face?' and he says 'that security guard caught us'… And my other mate was in his 30s, he says 'you're lettin' somebody batter your wee brother?'… That day we'd been shopliftin' on a mad spree, and I'd stole this fisherman's blade… And [my brother and the security guard] are arguin' face to face and I just went over his shoulder and slashed the security guard with it. (M., Prisoner, 39)

The presence of a social audience again appears to coerce the prisoner to respond violently to defend his brother, when prompted by a friend on this issue. The threat of violence which is employed in criminal activity was acted upon when faced with the challenge of the security guard. These actions can be understood as masculine in nature, as violence is employed to facilitate activities such as drinking and deviance, through which he seeks to demonstrate a tough, risk taking persona to his peers at a young age.

One prisoner described his index offence in the context of more organised criminal activity – the drugs trade. This incident again contains elements of masculinity, with males using physical violence to achieve dominance, financial success and status in this dangerous sphere of criminal behaviour:

> R. (Prisoner, 28): It was a drug dealer, and the guy got tortured, I was there but I wasn't present when he died... I was only young at the time, and it was [my co-accused] at 39 that done the murder. And him and the guy had argued previously over suitcases ae money, and the other two of us kindae got pulled into it.

> Interviewer: So, when you're saying they tortured him, did you see all that?
>
> R.: Obviously bits of it but he was still alive. He was still alive at that point. But it was afterwards…
>
> Interviewer: Was that not a bit traumatic?
>
> R.: I was a bit shocked. But see, obviously when you think of torture you think of like choppin' him up and things, it wasnae like that. He was just tied up and battered, and maybe he got stabbed a couple ae times. But obviously I've seen that kind of thing over the years…

The above comments suggest that within the context of drug dealing, violence is somewhat normalised, and regularly employed by those involved.

Another prisoner described a scenario in which he was the victim of the original criminal activity rather than the perpetrator. This was the homicide offence which resulted in his imprisonment, where he employed violence to address a pre-existing grievance with another male who had burgled his home:

> He broke into my house… I got a phone call to say the guy that broke into the house was goin' down to sell our stuff. And I phoned the police to say 'he's goin' down there at 10 to sell my stuff'. They said 'we can't do anythin', we get off shift at that time'. So the next day my best pal came in and says 'He's round the corner sellin' your stuff' and I ended up goin'. So my mate says 'this guy's got a lock pick', he was always carryin' it, he was notorious for slashin' people, so he says 'here take this knife' and I says 'look I don't want it', he says 'just take it, he'll end up going for you'. I ended up in a conversation in the car, and he ended up dead. I stabbed him once. He died at the scene. (T., Prisoner, 45)

Rather than the prisoners' expressed intention here being to commit a homicide, the risky situation brought about by the victim's actions escalated into violence over time. It is possible to assert that such an offence is grounded in the masculine need to protect possessions and family members. Lethal violence is employed as a means of protection and of emerging ultimately victorious from this conflict in order to maintain a dominant masculine image (Polk, 1994: 113).

4.3. Violence in the Context of Another Crime: Conclusions

Overall, incidents of violence which occurred in the context of other criminal behaviour made up a small proportion of the violence described by patients and prisoners. The original criminal behaviour in these instances varied from opportunist offending to more organised activity, which are facilitated by the threat of violence.

Their comments suggested that they sought to achieve a masculine identity through the status and financial gain associated with such offending.

5. GANG VIOLENCE

Gang violence represents the final scenario of violent behaviour described by patients and prisoners. While few patients suggested involvement in gangs and gang violence, 9 prisoners described such incidents.

Their accounts demonstrated that gang membership often begins at a young age, and is characterised by frequent and often serious violence. Literature suggests that the gang serves as a means of expressing status frustration, and is an arena for young men to achieve social status and an image of power and strength, often through violence (Cohen, 1955). These incidents mirrored such assertions.

5.1. Gang Violence

Only two patients suggested that they had any involvement in gang violence within their violent offending histories. Their accounts alluded to incidents of serious violence with weapons. The excerpt below implies that gang violence is organised around loyalty to others from a particular area or social group:

> G. (Patient, 39): I've seen stabbin's and slashin's and that. Folk getting' dismantled with pipes and that, folk putting bottles of folks heads…
>
> Interviewer: What were usually the circumstances of that?
>
> G.: Football gangs, football hooliganism… folk coming to the [Aberdeen] community from other areas, they'd come and be trouble.

One patient described a similar context for violence, whereby he ultimately acted against his own gang. This incident is perhaps not typical of gang related violence, as the patient illustrates frustration with the nature of gang membership. It again

highlights that gang involvement was related to the geographical areas where members lived and was characterised by violence:

> H. (Patient, 49): It was a gang called CODY, it stood for Come On Die Young. They were always fighting… this one, the next one. It's all small villages and each small village has a gang.
>
> Interviewer: So, there's lots of areas, and people from one part don't like people from another?
>
> H.: It's like a plague... We met in a pub. And I was there and chattin' up lassies and that, and the rival gang were chattin' up lassies as well, but they never started any fights, so I just thought 'good'. And then the other guys came in and I ended up kind of turning on the [Gorgie] guys for starting on the [Leith] guys, because the [Leith] guys weren't starting any bother. I ended up flingin' tumblers at the [Gorgie] guys. (H. Patient, 49)

The patient was the victim of serious violence by members of the rival gang, resulting in significant injury. Surprisingly, he highlights that he accepts this attack by the rival gang, and was instead angry at the lack of solidarity shown by his own gang members:

> I got blows over the head when I ended up in the gang fight. I ended up fightin' 6 of them [the Leith gang] myself. And I ended up getting taken out and I ended up in an ambulance and coming to the hospital and getting treated and that… I wasn't angry with the [Leith] boys, because it was a gang fight.. I blamed the [Gorgie] guys for leaving me behind. (H. Patient, 49)

The above comments suggest that violence is justified within the context of gang life and the informal social rules which govern this culture. Such acceptance of violence as a means of achieving dominance can be understood as a masculine justification for this behaviour.

5.2. Gang Violence: Prisoners' Experiences

All but one of the interviewed prisoners reflected on their involvement in gangs, particularly in their younger years. Only one prisoner's homicide offence which led to imprisonment occurred within this context, yet gang culture represented an important aspect of prisoners' violent histories.

Prisoners described gang involvement from a relatively young age, suggesting that their local areas were characterised by this phenomenon:

> Q (Prisoner, 34): Just madness, just madness. You couldn't go from area to area…There was gangs 400 strong then fightin' against each other, it was like armies, it was complete madness.
>
> Interviewer: What were they fighting over?
>
> Q.: I don't know. It was areas then…
>
> Interviewer: How old were you when you got involved with that then?
>
> Q.: Young, 14, 13. Right up until I was about 16, 17.

Other accounts further explained that gang violence in Scotland is largely organised around long standing differences between groups of men from rival areas. Within this context, males of various ages engage in regular violence over long periods of time. It is also implied that gang violence is a means of 'showing off' through fighting with other males:

> From generation to generation in Glasgow there's been gang fighting… there's all sorts of gangs … I cannae even remember when it started I was about 8 or somethin'… the older people used to stand at the front and batter each other with poles and knives and whatever, we used to stand flingin' bricks at the back when we were wee boys. And obviously as you get older it gets a bit more serious… From when I was 12 to when I was about 17, 18 I would fight. So it's not a gang really, it's all your pals who you grow up with, so me and about 6 or 7 of my pals we'd all protect each other obviously. So we'd go out there with all the lassies that we used to run about with... It was basically a bit of showing off when you're growin' up, fightin' wi' guys the same age as you or older. (N., Prisoner, 36)

This echoes assertions from literature on gang culture, which suggests that young males seek to achieve status and demonstrate physical strength through gang participation (Cohen, 1955). Involvement in this activity can thus be connected to masculine issues such as power and status.

In discussing gang violence, many prisoners' stories indicated that immersion in this culture led to a normalisation of violence. Violence appeared to be a way of life for these men, and most had experienced victimisation themselves. As a result of this normalisation, two prisoners described being surprised when their own violence resulted in a fatality:

> I grew up in the gang wars in Glasgow. I've had doings when my head's been kicked, it's been ultra violent – I couldn't believe that I kicked that guy in the head and he died, I didn't think that could happen and people could be that weak at that certain part of the body. (Q., Prisoner, 61)

> So, thinkin' back now, see cause of stayin' there I never thought anything of it [violence]. But you'd get heavy kick ins, and if someone battered you you'd go and batter fuck out of them. So it was like a wee cycle, a wee chain, know what I mean? (L., Prisoner, 31)

One prisoner provided an account of a homicide offence which occurred in the context of gang violence, and resulted in his imprisonment:

> N. (Prisoner, 36): [My friend]'s like, "eh, a guy tried to hit us with a belt, thinking I was you". So when I got home, I got a knife and stuck it down the back of my trousers and went up to where he says he was fighting, because I was full of it, the drink and that, I was only 18. I couldn't find that guy, and I ended up walking home... Two of the older mob, have tried to jump me, I chased the two of them and then a guy ran up behind us. And I've turned round and I never really looked at the guy or nothing, just thought he was trying to catch me for them. I turned around and stabbed him, he put his arms up and I stabbed him in the arm… He went to grab us again and I stabbed him in the side, and then that was it. He ran away basically… ran across the [road] and fell on the other side… But this is what happened after this, you'll not believe this. There's two people that he's fell at their feet… At this time, I seen who it was. It wasn't one of the two guys pals who I fought with. It was a guy from my own bit and I was that full of it I've not even realised. It was a guy, an older guy from my bit. I was 18, he was 22 at the time.
>
> Interviewer: So was it a friend?
>
> N.: Aye, basically, aye… It's a wee bit hard talking about it still…

Although this incident took place in the context of gang violence, the above account demonstrates some elements of confrontational violence. The mistaken attack on the prisoner's friend is perceived by him as a challenge here, which he immediately sets out to respond to with violence. This takes place within the specific informal social rules of the gang, which the prisoner ultimately breaks by mistakenly attacking one of his own friends. Again this prisoner sought to maintain his reputation through his initial search for the rival gang member he believed had challenged him, indicating that gang involvement is associated with masculine motivations.

5.3. Gang Violence: Conclusions

There was significant variation in patients' and prisoners' accounts of gang involvement. While only 2 patients referred to gang membership during their life

histories, 9 of the 10 interviewed prisoners confirmed their involvement in gangs. Membership of a gang was closely associated with violence, which involved fights with gangs from other geographical areas. Gang violence also had close associations with masculine identity. Patients' and prisoners' accounts of such incidents suggested that this allowed them to achieve status and portray characteristics such as dominance and physical strength, all of which are important features of traditional masculine personas.

6. CONCLUSIONS

Patients' and prisoners' accounts of violent offending histories served to shed light on the nature and circumstances of violent incidents, and the roles of mental illness and masculinity in driving these. Their accounts made reference to violence occurring in a variety of contexts including mental illness, confrontational violence, violence for the protection of women, functional violence and gang violence.

Considering first the incidents recounted by patients, many of these focussed on violence in the context of mental illness. Their comments evidenced that where patients were suffering from acute mental illness and its associated symptoms, these were often a key factor in driving violent behaviour. Several accounts suggested that the confusion and volatility which characterises acute periods of mental illness serves to increase the likelihood of violence. Similarly, patients often suggested that their offences were carried out in response to psychotic symptoms such as delusions and auditory hallucinations, which motivated them to act in a violent manner. These experiences indicated that violence may be driven by mental illness, but this only occurs during periods where an individual is acutely unwell.

The violent events described by patients and prisoners mirrored traditional cultural scripts of masculine violence, and the accounts provided suggested that violence was often perpetrated as a means of displaying and protecting a masculine identity. In this sense its role appeared to be greater than that of mental illness. This was true of

patient's accounts of violent incidents which occurred prior to mental illness, and prisoners' accounts of violence, as they had no documented history of mental illness. However, where violence occurred in the context of mental illness, this relationship was more complex. In such incidents, violence again occurred in decidedly masculine forms, such as confrontational violence, but was characterised by the confusion, volatility and psychotic symptoms which are specific to major mental illness. Thus, it was evidenced that in these incidents, mental illness acts to intercede in traditional forms of masculine violence.

Patient's and prisoners' accounts provide valuable insight into the roles of major mental illness and masculinity in driving violent offending. Mental illness appeared to have a direct role in violence only during periods of acute illness characterised by psychotic symptoms, while masculinity played a significant and enduring role in violence throughout their life histories. The role of masculinity in driving violence ultimately appeared greater than that of mental illness.

CHAPTER 6

'THE PAST': LIFE HISTORIES

Thus far, it has been demonstrated that masculinity played a significant role in both patients' and prisoners' violent offending histories, while that of mental illness was more limited. In seeking to further understand this relationship, it is necessary to place this violence in the wider context of patients' and prisoners' life histories and the masculine identities which are important features of these. Both groups were asked to reflect on a variety of aspects of their pasts. These accounts centred around several key themes, including family and significant relationships, education, friends and recreation, alcohol and drugs, making money and mental illness. This chapter examines the comments made by both groups in each of these areas.

Similarities and divergences in patients' and prisoners' experiences will be identified throughout this chapter. It will be illustrated that while both groups were largely negative in their comments, patients' life histories were somewhat varied while prisoners' were uniformly adverse. It will be asserted that where patients' experiences were positive, mental illness often interceded in their pasts to the detriment of other aspects of their lives. Throughout this chapter patients' and prisoners' attempts to create and defend masculine personas in a variety of areas of their lives are also highlighted.

1. MENTAL ILLNESS

Patients were interviewed in relation to their experiences of mental illness and its associated symptoms, while prisoners had no documented history of such conditions. Patients' comments in this area represented a significant proportion of their accounts. Although the length of patients' histories of mental health problems varied, depictions of illness were often set within the period immediately preceding the

commission of the offence leading to their hospitalisation, as this tended to be when mental illness and its symptoms were most prominently manifest.

A common thread in patients' accounts was a lack of awareness of mental illness as it began to manifest:

> B. (Patient, 43): I was getting' strange beliefs... I thought there was spaceships landing out the back of my house, I could hear, like, rocketin' sounds. [*Laughs*]
>
> Interviewer: And what's that like? I mean, I know you're laughing now…
>
> B.: You think it's true!
>
> Interviewer: Is it scary?
>
> B.: Aye, you don't know what to do!

Most patients described a similar lack of recognition and the period where symptoms were first experienced were therefore distressing:

> It was torture. I thought I was getting' messages off the radio from songs and that, I thought the songs were about me.... Because I'd ended up scared wi' the paranoia. (A., Patient, 54)

Within this context of distress and lack of recognition of mental illness patients often expressed a conviction that the hallucinations and delusions they experienced were real:

> When I was ill… I thought it was real. I can remember walkin' down the street and thinkin' the SAS were after me and I thought it was real. I didn't say to masel' 'I'm unwell' or 'this is not real' because you cannae tell somebody who's experiencin' things that it's no real. Like, there's a guy in here that would say the water was poisoned. So if I said to him, 'that's no real, the water's no poisoned' he's no going to believe me. He thinks - he *knows* - that the water's poisoned, and I *knew* the SAS were after me, and you couldnae tell me it was any different. (A., Patient, 54)

In light of this, patients' accounts illustrated a reluctance and inability to communicate their experiences to others during this difficult period:

> Not that I took stock and thought 'I have to stop this' and all that. I just didnae have any experience with people talkin' to me about things like that, and I didnae really tell people. (A., Patient, 54)

Similarly, this lack of recognition of symptoms of mental illness discouraged patients from seeking medical help from the appropriate sources:

> You cannae get help, you think it's true and that getting' help isn't going to make anything better. (B. Patient, 43)

Accounts indicated that for patients to admit that they were unwell and required assistance posed a risk of embarrassment and admitting weakness. For one particular patient, maintaining a strong and powerful persona was important:

> It was like tryin' to be brave and tough to try and keep people away from me when you knew the other side of you was scared with the paranoia, of people kickin' your door down and that. (A., Patient, 54)

Demonstrating weakness and expressing emotions such as fear in this way is in conflict with traditional masculine identities. For males seeking to display characteristics such as autonomy and 'no sissy stuff' (Brannon, 1976), admitting mental illness and seeking help is in direct conflict with such identities.

As a result of their lack of willingness to disclose their mental illness, patients' accounts described experiences of isolation:

> I got my own place and started shutting myself off from everybody. (A., Patient, 54)

> I was too isolated… one of the things you get in here is you say 'hi' to somebody every day, and I just needed that basically. (C., Patient, 34)

Overall, patients' accounts of mental illness in the community describe this as an extremely distressing period of their life histories. The rest of this chapter will demonstrate that the features of mental illness outlined here are not self contained. Rather, they spill into other areas of patients' lives with largely negative consequences.

2. SIGNIFICANT RELATIONSHIPS: FAMILY AND FEMALE PARTNERS

Patients and prisoners were asked to reflect on their experiences of significant relationships. The accounts of both groups focussed on their childhood and their

relationships with family members during this period, as well as their experiences of relationships with female partners. While patients' experiences in this area were varied, prisoners' were largely negative.

2.1. Significant Relationships: Patients' Experiences

Family

Several patients gave accounts of close family relationships during early periods of their lives:

> I. (Patient, 19) My mum's a very smart person. She's a good teacher, I've got a lot of love and respect for her.
>
> Interviewer: Did she encourage you at school?
>
> I.: Yeah, my father did as well to be honest… I really do believe that I wouldn't be where I am today if it wasn't for them, well, I don't mean in hospital obviously, I mean as in as I've got a few achievements under my belt and it was all because of them.

> My sister became pregnant, she was living at the family home as well, so he [my nephew] was born while I was there and for the first three years of his life we were all in the family home… So it was even closer than I suppose a normal family would have been. (E., Patient, 49)

For these patients a strong family background represents a key element of their life histories, and was experienced positively.

Patients also detailed negative features of their childhoods, with 5 of those interviewed describing disrupted family backgrounds and turbulent relationships with their parents. Patients' perceptions of the relationship between their parents were a particular focus of these accounts. A turbulent relationship between parents led to a disrupted upbringing, often in the context of separation:

> They split up and they got back together for the sake of the children, that didn't work out, they split up again... (F., Patient, 32)

> Well, before I ended up in prison it [my family] was a broken home but… it's been ups and downs. (I., Patient, 19)

Against these disrupted backgrounds, patients also described poor relationships with their parents which endured into adulthood. In particular, interviewees' accounts highlighted a perceived lack of support from their parents:

> Interviewer: How did you end up homeless if you had been staying with your mum?
>
> C. (Patient, 34): Well she'd forced me to go to university, right, and I'd done the two years… And I didn't have enough money to see me through the year, so I asked her for it and she said no. I felt like she'd set me up for a fall because she'd said 'go to uni' but then 'I'm going to withdraw my help', at this crucial time. So I think that might be why I was…

As well as occurring in the context of educational and financial problems, the period of time referred to here also coincides with the onset of mental illness for this patient. Another patient described similar impaired familial support during this difficult time:

> So, I think in my earlier days my mother and father had more time for me, I think they liked me better in they days. I think that basically they started going off me when I started takin' the drink and the drugs and went unwell and all that.... (B., Patient, 43)

When discussing relationships with their parents, patients focussed particularly on their relationship, or lack of, with their fathers:

> Interviewer: What was it like, not having your dad around?
>
> C. (Patient, 34): Yeah, it made a big difference.

In the above quote, the patient suggests that the absence of a paternal figure throughout his childhood was a difficult experience. For other patients whose fathers were present during their upbringing, their relationships were often problematic. Fathers could be a source of disruption within the household and did not represent a role model:

> I guess that I had a better relationship with my mother than my father, because I could see the destruction that my father was laying in front of himself with alcohol, and to this day he still is an alcoholic. (F., Patient, 32)

In some cases, this negative impression of father figures was more extreme, and some cited their father as a source of persecution:

> He likes to manipulate. He used to manipulate me as a youngster. I think he wanted me to be like him, and I just wasnae like that… Aye, I think it was abusive. I think he was a wee bit too rough, you know… My mum was feart of him, eh, so was I. (B., Patient, 43):

This excerpt asserts that for this patient, his relationship with his father was not a positive experience, as he describes it as volatile, controlling and characterised by violence. For another patient, this violent persecution also extended to other members of the family, in particular his mother:

> Interviewer: What about your mum?
>
> H. (Patient, 49): She was a'right wi' me, she got hit as well.
>
> Interviewer: So [your dad] used to hit your mum as well sometimes?
>
> H.: Aye. He used to hit my mum as well, I got hit by him wi' a chain leash and that one time. I forgave him.

For the two patients who described victimisation by their fathers, these incidents were their first experiences of violent behaviour. Their accounts implied that violent actions were viewed as normal within this context. For example, in describing these events, the patient demonstrated his acceptance of this behaviour which was common in his own home as well as among his peers:

> It was alright, I knew where [my dad] was comin' from. Any laddie my age up in my area got slapped aboot. (H., Patient, 49):

In this sense, violence was normalised and expected from paternal figures. This was evident in comments from another patient who described his father's incitement of violent behaviour:

> Well I'd come in from school and say 'Dad somebody hit me' and he'd say 'Well out this house and go and get him back, and don't come back until you've hit him' and all this crap. He was a violent sort of guy my dad, he was nuts. (B., Patient, 43)

This illustrates that violence was not only presented as an accepted means of responding to challenges during his early years, but was actually encouraged by his father.

Female Partners

Patients also focussed on their experiences with female partners and these were negative in the large part. The relationships they described varied in seriousness, with some describing short term girlfriends, and 3 recounting their experiences of marriage. At the time of interview, no patients were in relationships.

Largely, their accounts focussed on the often volatile nature of such relationships, and relationships with women involved frequent arguments and even extended to violence:

> So she was about 21... I started goin' out with her and it was nothin' but trouble… And she was like, hell, all she wanted to do was party, drink, drugs, arguments all the time. She was so possessive of me… When she told me she'd got another boyfriend it was a relief, I swear to god it was a relief! Auch god, she was trouble. (A., Patient, 54)

> I slapped [Amy] in the face one day, she was dain' my heed in though, she was screamin' at me and I was like 'Calm doon!'. (B., Patient, 43)

The assertion here is that the female partner is the main source of the problems within these relationships. While this stance was true of most patients, they also consented that arguments within this context were attributable to their own behaviour on occasion:

> We'd [my wife and I] fall out every now and again.... My pals used to come down for me and I used to go out with them and she didnae like that, and she'd go to her maw's and that if I didn't come back, after me promisin' no to drink again. (A., Patient, 54)

Drug and alcohol misuse were highlighted by several patients as sources of strain within intimate relationships. One patient stated that his relationship, which was serious and long term, broke down as a result of his drug taking:

> She says 'It's me or the drugs' and I said 'Ok, the drugs then'. (B., Patient, 43)

Thus, while problems in relationships with female partners were largely attributed to the perceived volatile behaviour of these women, there was also a suggestion that drug and alcohol misuse exacerbated these issues.

Within this turbulent context, several patients described infidelity on the part of their female partner:

> She did a few nasty things but I forgive her. Sleeping with other men… The love's gone away, there's no love now... (B., Patient, 43)

As this extract suggests, infidelity was described as a particularly difficult experience for patients. They detailed a wide range of emotions in this context, in particular anger:

> Interviewer: What happened with [your marriage]?
>
> H. (Patient, 49): She was playing about.
>
> Interviewer: What was that like for you?
>
> H.: I didnae know what I was feelin'. I was upset and I was angry and…

Similarly, in one particular scenario, a patient described experiencing extreme emotions and suggested that the incidents impacted on his mental health:

> I.: It's just a thing that, being a man, when you think or you're reminded of these kinds of things it just [*breathes deeply as if calming himself down*].
>
> Interviewer: Makes you annoyed?
>
> I.: Yeah… I was betrayed in the worst way possible… And not only through cheating, through my possessions… There were a lot of factors contributed to the thing that happened to me [a psychotic episode]. I was beyond rage and anger.

For this patient, infidelity is described as an ultimate affront by a female to a male, and he cites feelings of rage. If we consider this in relation to issues of masculine identity, such defiance by a female partner challenges a masculine identity, which is founded on dominance over females (Connell, 1987). Viewed in this way, these feelings of rage can be understood as a response to this injury to masculinity. There is also an insinuation here that this patient's reaction to this incident was so severe that it may have played a role in the development of his mental illness. Another patient gave a similar account of infidelity:

> J. (Patient, 51): 2001 was my first [episode of mental illness]. I think the trigger was I found out my wife was going on chatrooms on the computer. And this affair she was havin'…

> Interviewer: And how did you find out about that?
>
> J.: Her sister told me, so I found out, and then I confronted her about it and she suggested she was going to be leavin' me.

It is difficult to assert that mental illness was induced by infidelity in any of these instances. Indeed it is possible that these events merely coincided, or that paranoia and suspicion, as well as other symptoms which characterise acute mental illness, had a negative impact on this aspect of patients' lives. This again illustrates the ubiquitous nature of mental illness as a force in other areas of patients' life histories.

For most patients, because of the severe emotional impact of such experiences, their partners' unfaithfulness led to the termination of the relationship. One patient described the feelings of relief he experienced when the relationship ended:

> And then we split up… it was like a weight off my mind. It was like "she's no mine now, I don't need to worry about who she's with or what she's done." (A., Patient, 54)

The patient's description of his partner alludes to his feelings of ownership of this woman during the relationship, through the suggestion that she was 'his'. Again, when viewed in the context of masculinity, this is in keeping with hegemonic ideals of dominance over females (Connell, 1987). In light of this it is possible a female partner who is perceived to have persistently defied the male represents a particular affront to masculinity. The feelings of relief described at the termination of this relationship could be interpreted as relief that this threat to masculine identity is now gone.

2.2. Significant Relationships: Prisoners' Experiences

Family

Only one prisoner provided an overwhelmingly positive account of his childhood and family life. He remembered his childhood fondly, and felt that he was brought up in a nurturing family environment:

> My childhood, I loved it, it was brilliant. I had a great childhood and my mum was brilliant, my stepdad was brand new. (P., Prisoner, 34)

While the remaining interviewed prisoners did suggest that there were some positive features of their childhoods, these appeared to be overshadowed by varying degrees of negative experiences. In a few instances these were extreme, with prisoners' childhoods being overwhelmingly characterised by disruption and poor family backgrounds:

> The very first time I got any tablets was from my sister, she gave me tamazepam, 10 jelly babies… I was on the run from a children's home, I was stayin' wi' her and her pal hiding out, never left the hoose for aboot a year… from 11 to 13, durin' them two years naebody had seen me and up until then I had been gettin' lifted every weekend for doing stupit things… I didnae want to be in a home either, no. It was a weird upbringing, my da' was the first one to introduce me to thievin', he took me out thievin', so that's how I got introduced to that way of life. (M., Prisoner, 39)

Many important issues are raised here, including early experiences of drug use, a history of institutional care, involvement in criminal activity from a young age, and the influence of the father during this period. While the experiences of prisoners were diverse, these factors were common to the majority of this group with others revealing similar experiences:

> I went into children's homes, and I was runnin' away fae them every night and for the weekend and that, and the police were crashin' my ma and da's door in. (L., Prisoner, 31)

For the three prisoners who shared experiences of institutional care settings as described above, separation from their parents was an important feature of childhood. Several of those who had not experienced institutional care also highlighted that one or both parents were absent during their childhood:

> S. (Prisoner, 23): I stayed with my gran and my granddad from when I was about 6, 'cause my mum was on drugs.
>
> Interviewer: So do you see your mum at all now?
>
> S.: Nah, I dinnae really keep in touch wi' her.
>
> Interviewer: So what was that like growing up with them?
>
> S.: It was probably better. A lot of people were like that, you know, there were probably about 6 or 7 folk I knew stayin' with their grans and granddads.

> My ma' and da' were divorced when I was 11, so I stayed with my ma' basically. My ma', my sister, and my brother. (N., Prisoner, 36)

As with patients, for prisoners the father and his role in their upbringing was an important aspect of their childhoods. Many described situations whereby their father was absent:

> My dad, when I was young, he's never been part of it, he was an alcoholic so my mum didn't want him around the house, so he left and they divorced when we were young. I suppose the fact that my real dad chose alcohol… you know. (R., Prisoner, 28)

In total, 5 of the prisoners described separation from their fathers in some form, indicating they did not have a male role model in their early years. As outlined in Chapter 2, this has negative implications for masculine identities (Lynn and Sawrey, 1958; David and Brannan, 1976; Beaty, 1995).

Where fathers were present, prisoners generally described poor relationships with them. For two in particular, they were cited as violent:

> L. (Prisoner, 31): See if we ever done anythin' my da' was strict and he'd punch fuck out of me…
>
> Interviewer: Would you say it was just a smack or was it more?
>
> L.: No, it was more of a kickin'. To this day I've still never had a kickin' like the ones wi' my da', it was always that I'd done somethin', skived school again or somethin'…

The above excerpt provides an important insight into prisoners' understandings of violence from a paternal figure. Although severe, the prisoner suggests that violence was in some way warranted as a response to his misbehaviour. It could be said that violence was accepted from a young age by this prisoner, and was understood as normal. Similarly, one prisoner described violence directed not only at himself but also at his mother, leading him to cast himself as her defender from a young age:

> Q. (Prisoner, 61): My dad shot me when I was 9 years old.
>
> Interviewer: What? He shot you?
>
> Q.: With an air rifle. He aimed it and pulled the trigger. He was a nutter, he thought it was funny to do somethin' like that, you know what I mean. My dad wasn't right in the head. He was fightin' with my ma', a lot of the fights with me and him were because he was batterin'

> my ma'. I remember shoutin' at my dad with a poker when I was 10 years old, threatenin' to stab him. I was protectin' my mum.

As a result of this violence, this prisoner was keen to highlight the differences between himself and his father, in spite of the fact that the prisoner himself went on to engage in serious violence:

> But my dad at that time, I'm nothin' like him, he was muscles and dark hair. My father was one of the violent street fighters. (Q., Prisoner, 61)

Thus, accounts suggest that in prisoners' experiences, an absent father results in the lack of a male role model, while a present father's behaviour may make him a negative paternal force during childhood.

Prisoners made reference to the areas in which they grew up, often highlighting the difficulties associated with a childhood in such an environment. There were often characterised by crime, including violence:

> It was a rough area, it's notorious… The place we came from, if you'd have said to people years ago "aye I'm going down there" a lot of people wouldn't want to go through it, they'd be scared to walk through it. (T., Prisoner, 45)

> Interviewer: What was the area like?

> S. (Prisoner, 23): Bad, just bad.

> Interviewer: A lot of crime?

> S.: Aye, maybe 5 or 6 stolen motors a night… Violence, drugs, everything.

These comments were pronounced where prisoners grew up in areas characterised by gang culture:

> Interviewer: So these gang battles, what is that over?

> R. (Prisoner, 28): Well where I was from in Glasgow there was a little area next to it, and there was the low end and the top end, and they'd fight each other. Just because they didn't like that area because they're not from there, so they fight… People just come into different areas and fight each other

While gang violence was outlined in detail in the previous chapter, it is important to note at this stage that many prisoners' childhoods were spent in such circumstances,

and that this may further serve to normalise violence. Overall, prisoners demonstrated negative opinions of the areas where they grew up.

Female Partners

Prisoners' accounts illustrated a range of experiences of relationships with female partners, with some prisoners describing particularly serious relationships, and others describing less serious relationships. Five prisoners described long term relationships with women, with 3 who had begun their life sentences later in their adulthood referring to their experiences of marriage. One prisoner was still with his wife at the time of interview, and his comments were positive:

> We've always been strong, we've always been there for each other… The two of us are solid. (T., Prisoner, 45)

Other prisoners described similar relationships. One went so far as to imply an association between desistance from offending and a relationship with a female partner:

> And when I came out of borstal, I met my wife, my ex-wife, I got married and had kids, I was out of prison, and that just kind of took me away from it [offending]. (Q., Prisoner, 61)

This comment echoes the assertions of social bonds literature, which proposes that forming connections with female partners or long term employment often encourage offenders to desist (Sampson and Laub, 1993).

Other prisoners described less serious relationships. These were generally shorter in duration and did not involve marriage:

> Well the girl I was with I had been with about a year [before my prison sentence] but it wasn't *serious* serious. (P., Prisoner, 34)
>
> K. (Prisoner, 35): Aye when I was out I had girlfriends and that, I had one when I got the life sentence.
>
> Interviewer: Was it a serious relationship?
>
> K.: Nah. We were only goin' wi' each other for about 6 months.

Interviewer: So when you got your life sentence did she say to just leave it?

K.: Aye, you're better off no havin' a girlfriend when you have a life sentence

Both of the above excerpts describe relationships which were not perceived to be serious by the prisoners when they were in a community setting. This may in part explain why both ended these relationships when commencing their prison sentences.

Several prisoners described turbulence in the context of their relationships, with two describing experiences of marital separation prior to imprisonment. The experience of divorce was particularly difficult for one prisoner, and although he was reluctant to divulge further details of the circumstances, he suggests that he was in some way wronged by his wife:

Interviewer: Do you think getting divorced was a turning point?

Q. (Prisoner, 61): Biggest turnin' point in my life. Comin' out of prison, comin' out of the borstal, I was a grafter, and then somethin' happened in the marriage, I don't really want to go into it, and I came out the marriage, and the layer told me she was suing me for divorce, and it was going to cost me so much money so I chucked my job.

Interviewer: Why?

Q.: I was just stoppin' her, I wasn't going to pay her, because it was her fault. That's when I started doin' robberies and that.

There are again connotations of masculine dominance over women here, as the prisoner's angry reaction to the separation can be interpreted as a response to the affront this perceived defiance by his female partner poses to masculine identity. Significantly, this interviewee suggested that this represented a turning point for him, and that his divorce re-engaged his criminal career. In contrast, another prisoner proposed that his wife's decision to end their relationship was justifiable in the context of his alcoholism:

O. (Prisoner, 45): Well [my wife] met somebody else and things like that, I had a drinkin' problem and she gave me plenty of chances and I blew it. I went to rehab to try and dry out and that, to get back with her, she took me back 3 or 4 times, but I ruined it myself.

Interviewer: Is that something that you regret?

O.: I do regret it aye, but I can't blame her for giving me those chances and then…

Both of these accounts suggest that where a relationship ends, the male in the scenario prefers for this to be initiated by his own behaviour and expects that this be justified in his eyes. Thus, the notion of masculine possessiveness is again present here.

2.3. Significant Relationships: Conclusions

Patients and prisoners were asked about their experiences of significant relationships. In constructing their responses, they commented on their early experiences of family life, their relationships with particular family members, and female partners later in life.

In relation to family life, the accounts provided by patients indicated that their experiences were varied, with some describing happy and settled childhoods, and others detailing turbulent family situations and relationships. Prisoners' accounts were more uniformly negative, with almost all depicting their family lives as troubled. Particular attention was paid to fathers as a negative feature of family life by both groups. This was strongly associated with masculinity, both in terms of the difficulty of forming a masculine identity without a male role model, and the demonstrations of violence which communicated that such behaviour is befitting a dominant male figure where fathers were present. Patients' accounts also referred to difficult relationships with parents in later lives during the onset of mental illness, demonstrating the destructive force mental health problems posed in other areas of their lives. For prisoners, the area where they grew up was also often strongly linked to violence, which was normalised in the context of gang culture.

There were several similarities and divergences in patients and prisoners' comments on their experiences of relationships with females. In describing the reasons for the termination of these relationships, patients' accounts illustrated that mental illness often coincided with the breakdown of intimate relationships, again demonstrating its destructive nature. Meanwhile prisoners suggested that the commencement of a prison sentence led them to leave their partners. Patients and prisoners also made

reference to infidelity in ending relationships, and patients focussed particularly on this issue. While their accounts may also illustrate the suspicion which often characterises mental illness, both groups' comments illustrated the affront which this poses to traditional masculine personas which are rooted in dominance over females.

Overall, significant relationships were important features of the pasts of both of these groups, which demonstrated their pre-institutional masculine identities.

3. EDUCATION

Patients and prisoners were also asked to describe their experiences of school and education. Both groups reflected on two main areas: their educational attainment and behaviour in the school setting. Their accounts indicated generally low educational attainment among both groups, with some variation among patients. Both patients and prisoners described misbehaviour in school, illustrating that such behaviour is a resource employed in constructing a masculine identity in this setting.

3.1. Education: Patients' Experiences

Considering first educational attainment, some patients described success in this area, with two patients describing experiences of further education:

> I went to college and I did my HNC in Business Admin, then I did my HND, then I went to university and I was in the third year of my degree when I fell out of that with being not well. (C., Patient, 34)

Here, the patient highlights that he did not complete his final qualification, as his mental health problems began to manifest during this period. This again illustrates the negative implications of mental illness for other aspects of patients' life histories.

The majority of patients cited poor educational attainment. Various explanations were provided in accounting for this, and some accounts state that distraction and low motivation resulted in poor performance:

> I did get distracted and consequently from 3rd year and into 4th year when I took my O-Levels my grades were starting to slip… I was so disappointed in myself with my O-Levels, that had an even worse effect and I just thought 'I'm just wasting my time' so my Highers went down even more. (E., Patient, 49)

> Just couldn't be bothered with school anymore…My mum and dad just says, and the headmaster says 'He'll probably do fine anyway' instead of sittin' the O Grades. (B., Patient, 43)

The second quotation here also highlights that for patient 'B.', little emphasis was placed on the importance education by his parents. Owing to this lack of coercion he left school at an early age with no qualifications. This was echoed by other patients who indicated a lack of parental encouragement:

> I used to play truant quite a lot… I had the worst attendance in my year at school. At the time I could work wi' my dad in the chuck wagons and the vans and that, and he let me stay off from school. (G., Patient, 39)

Patients' accounts of education also focussed on their perceptions of their behaviour during school. Almost all described poor behaviour at some stage, with some detailing more serious histories of truanting and exclusion:

> Interviewer: What did you do to get expelled from school?
>
> D. (Patient, 49): Shout at the teachers, swear at the teachers, not do work, not do lessons and that…

There was a suggestion that misbehaviour in the context of school was common among male pupils, and that this is typical behaviour to be expected of young boys:

> That's a funny question [laughs]. I was in trouble a few times in school or that, I mean, youngsters, you know, boys will be boys. (I., Patient, 19)

This echoes sentiments in literature which notes that misbehaviour in school is common among young boys, and that such acts are perpetrated as a means of establishing a masculine identity within this context at a young age (Messerschmidt, 1994).

More than half of the patients described violence in the school setting. Where incidents occurred in the context of a fight, they appeared to represent attempts to save face and maintain a tough reputation in this setting. One patient emphasised that it was not possible to avoid such incidents, which occurred frequently, and that 'showing face' was a primary concern in this environment:

> A. (Patient, 54): I was only in one fight at school. A guy picked a fight with me and I fought him and I beat him. That was it I never fought again.
>
> Interviewer: Why would he want to fight you?
>
> A.: Ach I cannae remember, it was just one of those things, like in the classroom something was said and then he was like "right, square go". That's what it was like at school … people would just say square go for the sake of it. And you couldn't really back down. You had to show face like standing up for yourself.

These comments imply that from a young age it was important for the patient and his peers to respond to challenges violently if necessary. This notion of demonstrating strength and guarding a reputation through physical violence is a key feature of the construction and maintenance of masculine identity detailed in much literature, and violence in the context of school can be understood in this way (Polk, 1994; Gilbert, 1994).

Rather than perpetrating violence in this context, several patients described being the victims of bullying:

> I started skiving in 3rd year because I was getting bullied – so I stayed away, I didn't go to school at all because I was too frightened. (B., Patient, 43)
>
> In primary I stuck in, but as soon as I went to high school they threatened me. I was scared to go, I never went… I ended up not going for months and months and months. (H., Patient, 49)

The above comments highlight that this had a detrimental effect on their perceptions of school and education, and ultimately resulted in them avoiding school.

3.2. Education: Prisoners' Experiences

Prisoners' accounts of education overwhelmingly suggested that their overall educational attainment was poor. Only one prisoner illustrated that he had performed well in school:

> I was a rogue at school, I just mucked about… I just wanted to leave school. But they had a meetin' wi' my mum and the maths teacher and all that... So I ended up staying to 6th year, they talked me into it. I got like 9 highers or something, or 8 and an O-grade. So I done well… (P., Prisoner, 34)

It is important to note that the success detailed above took place in the context of the poor behaviour and lack of motivation which characterised the school experience of the majority of other prisoners.

The remaining 9 prisoners described leaving school with few qualifications if any, and suggested that their educational attainment was low overall. Several described problems in this area and for some school work was challenging due to issues such as learning difficulties:

> I went to a private school. It was a school for my reading and writing and that, there was a bus that picked you up but I kept disappearin' from there as well. (O., Prisoner, 45)

> It was a special needs school, I wasn't the best at spellin' and all that. I spell a bit better since I've been in the jail. (S., Prisoner, 23)

Such problems may in part explain the poor educational attainment of this group, and at the time of interview numerous prisoners had enduring literacy and numeracy needs. One highlighted that a lack of achievement in school was expected among his peers in his local area:

> Interviewer: Did you leave school with any qualifications or anything?
>
> T.: No, I don't think many people did from my area.

In light of such circumstances, several prisoners described leaving school early:

> See back in Ireland you could leave school when you were 12, as soon as you made your confirmation you could leave school, so I was just at primary school and then that's it. I left school when I was 12. (K., Prisoner, 35)

This ultimately led the above prisoner to miss most of secondary school. As in this excerpt, other prisoners suggested that they left school at the earliest opportunity:

> Basically in second year I left school… [I got] suspended a few times, and I just stopped going. (L., Prisoner, 31)
>
> Q. (Prisoner, 61): I didn't go to a lot of secondary school, I didn't like authority. I didn't like getting told what to do.
>
> Interviewer: When did you leave?
>
> Q.: When I was 12. Leaving age when I was young was 15, so you're only talkin' about a 3 year period.

Ceasing education at such an early age resulted in many prisoners leaving school with no qualifications, and contributed to the overall low educational attainment which characterised this group.

Thus far, excerpts have highlighted that prisoners left school at a particularly early age. In addition, the previous two accounts suggested that prisoners also left school due to behavioural issues. Most prisoners cited such activities in this environment, including misbehaviour and truancy:

> I got kicked out of high school for somethin' stupid, know what I mean… I ended up doggin' school and as I said I got expelled. (T., Prisoner, 45):
>
> I was always suspended and that. Just daft stuff, tossin' things about. In primary school really. (S., Prisoner, 23)

Although the incidents described above are relatively trivial in nature, in some instances they were more serious, with one prisoner recounting a theft in the context of school. The shame of this incident and its repercussions discouraged this prisoner from attending school:

> I went in and not knowing anybody, and within a week I got caught stealing another boy's food money, for his lunch. The police got called in and they shouted us out in front of everybody in the class. They had a suspicion it was me, and they said 'come out here now' in front of the class. They said 'take your shoes off' and the money fell out in front of the class,

> and I always remember the embarrassment of that. And I got expelled right away, and I left school after that really, every school I went to after I just dogged it… (M., Prisoner, 39)

Other prisoners also described more serious misbehaviour in school, including violence:

> I think I went wrong in first year [of school], I got suspended 3 days into it for fightin'. I ended up fightin' with the rest of my pals. (L., Prisoner, 31)

Ultimately, prisoners' accounts appear to connect poor behaviour with poor educational attainment, as many prisoners described avoiding school or being formally excluded due to this.

Although much misbehaviour in school could be characterised as trivial, one prisoner illustrated a pattern of misconduct so severe that he was forced to attend an institutional school:

> I was out of control. I started high school, I got expelled, went to another high school, got expelled. They put me into a school for people who've been expelled and I got kicked out of that, none of my family and my mum couldn't control us, I was right out of control. And so they put me into a residential school for 5 year, and once I went in there I got punted from one to one, they couldn't control me. (R., Prisoner, 28)

This quote indicates that poor behaviour in educational settings had implications for other aspects of prisoners' lives. For this prisoner, his behaviour led to a series of school placements and upheavals and again led to low educational attainment.

In a similar vein to the patients' comments, one prisoner highlighted that misconduct in the school environment was typical behaviour of young boys:

> R. (Prisoner, 28): I would have been on my own really [if I had stuck in at school].
>
> Interviewer: Were other people in your school sticking in and keeping their head down?
>
> R.: It was girls… It was all girls doing that.
>
> Interviewer: Why do you think particularly boys?
>
> R.: I don't know, boys are always gettin' into trouble.

The affinity for 'trouble' and low attainment detailed here can again be understood as a means of demonstrating attributes such as toughness and risk taking (Meesserschmidt, 1994). Thus, such behaviour can be understood to derive from the need to present a masculine image in this setting.

Few prisoners described being victims of bullying, and none suggested that they had bullied others in school. One prisoner's account of victimisation is particularly illuminating. He describes an early encounter with violence whereby he was initially the intended victim, but reacted with force and emerged as the dominant party:

> R. (Prisoner, 28): But with me, I was quite a stubborn little guy… I think… it was mainly the bullyin'part I think, I can't stand bullies, I just can't accept it.
>
> Interviewer: What happened?
>
> R.: He was trying to bully me in the class.
>
> Interviewer: In what way?
>
> R.: He told me I was getting it after school for no reason, so I picked up one of those meter sticks up and skelped him.

Thus, through this experience with bullying, this prisoner learned to respond to challenges with extreme violence at a young age, a pattern which would endure throughout the rest of his life. Again, the interpretation of such challenges as threats to masculine persona is implied here, and therefore this incident can be understood within this context.

3.3. Education: Conclusions

In summation, patients' and prisoners' accounts of education and school revealed their experiences in two key areas: educational attainment and behaviour in the school setting. Overall, their accounts illustrated that their performance in both of these areas was poor, and that school was largely a negative experience for this group.

In terms of educational success during school, while patients' experiences were somewhat varied, prisoners' comments demonstrated overwhelmingly poor

performance in this area. Both groups gave accounts of leaving school with few qualifications at the earliest opportunity. In particular, prisoners' accounts indicated that this was normal behaviour among their peers. While patients' experiences were better in many instances, it is important to note that the onset of mental illness was shown to be detrimental to the pursuit of educational attainment. This again demonstrates the omnipresent and often destructive nature of such conditions.

Poor behaviour in school was described by both groups. Again, this was more serious for prisoners with numerous prisoners describing serious misconduct, with consequences such as suspension, exclusion from school, or even institutional schooling. In its most serious forms, misbehaviour in this setting involved violence. Such activities must be understood in the context of masculine identity, and the desire of young males to construct dominant, physically strong, risk taking identities in this setting.

4. RECREATION AND FRIENDS

Recreation and friendships was another significant area of patients' and prisoners' life histories. They were asked to provide information of both their recreational habits and the nature of the friendships they formed. Their accounts demonstrated variation in this area, with patients detailing everyday recreational habits such as frequenting clubs and bars, while prisoners' accounts suggested involvement in criminal activity within this area of their lives.

4.1. Recreation and Friends: Patients

In the context of recreation and friendship, most patients described active social lives:

> Aye, my mates would always take me out if I had no money, I had a good social life. (G., Patient, 39)

The social lives they described in their adolescence, and continuing into adulthood, revolved largely around the bar and nightclub environment. This represented a significant element of patients' recreational pasts:

> F. (Patient, 32): We used to go to those marquees to take drugs and dance all night and smoke cannabis and stuff. So that's what I was basically doing, and then going clubbing into the city and sometimes we'd maybe sit at home at the weekend if we didn't have enough spare money and we'd just take loads of drugs and just sit around going 'wheeey' and being totally wasted.
>
> Interviewer: What sort of things would you do when you were at nightclubs and stuff?
>
> F.: Drinking, dancing and chatting up women.

Consumption of alcohol, and in some cases recreational drug use, was of primary importance here. The above quote evidences the sense of 'carnival' which literature suggests is present in these settings (Tomsen, 1997). Within this context, violence was also a key feature of recreation:

> Interviewer: What would you do when you were out at clubs?
>
> G. (Patient, 39): Dancin' and meetin' other folk, sometimes there would be trouble and that too. Too much to drink and someone kickin' off.

This issue was outlined in detail in the previous chapter, yet it is worth noting again that violence and recreation were associated activities for many patients.

Within this recreational context of nightclubs, alcohol consumption and violence, patients also described the nature and quality of their friendships during this period. Their comments in this area were generally positive:

> I got on great wi' my pals. Never fell out with them. If they had no money I'd take them for a drink, if they had no money for fags I'd give them money, I was quite a generous person. I got on great with guys (A., Patient, 54)

Other patients indicated that loyalty was an important aspect of these relationships. In some instances, this extended to loyalty in relation to physical violence:

> Interviewer: So you were saying you're the kind of guy who would jump in [in a fight]?
>
> G. (Patient, 39): Aye, I would. So were my mates though. They wouldn't let you get a kick in, they'd back you up to the teeth.

This willingness to intervene in violent incidents appears to be reciprocal, with both parties being prepared to defend each other where necessary:

> If I was out with a guy and he'd get bother off of somebody I'd help him out, so generally people… I had a big network of pals, people got on alright with me. (A., Patient, 54)

These notions of the importance of displaying physical strength, as well as the desire for social status are key features of traditional masculine identities (Brannon, 1976; Gilbert, 1994). Where violence acts were committed in this context, they can be understood as a means of asserting a masculine persona to peers.

Although pubs and nightclubs were the mainstay of recreational pastimes for most patients, others described more organised hobbies:

> I had racin' greyhounds and I used to train them for other people and that. I went to the dog track for about 10 years. And every meetin' I went to, and I was friendly with everybody in the dog track, and there was all sorts of people. Policemen had dogs, millionaires had dogs, you name it… At that dog track you could have got anythin' you wanted. Because you got that friendly with them all and that, and if you never had a job you'd be guaranteed to get a job off somebody there, because there were loads of them had businesses and that. I was well spotted and that and people used to come to my house to check dogs out. I got on brilliant at the dog track. (A., Patient, 54)

It is implied in this quote that the patient enjoyed this pastime thoroughly, yet his comments are concerned with the relationships he formed and his standing in this social circle rather than the activity itself. He emphasises his own status within this sphere and the connections and possibilities which were available to him in this environment. Other patients gave similar accounts of hobbies:

> Interviewer: Why do you think you were drawn to boxing?
>
> G. (Patient, 39): It was just a way ae life to me at one stage. It was ma bread and butter and that. It I had to do what I could do when I was 24, I was fit as a fiddle. I trained every day, I kept a proper diet, I was fit. The attention I was getting from everybody when I was doing it was amazin'.
>
> Interviewer: Is that what you like about it?
>
> G.: It's the thrill of fightin' the person, I used to get excited. People would wonder why you're doin' it but you get excited. I liked the actual fight.
>
> Interviewer: Okay, so it was the reputation for you, and then you liked the thrill of it as well?

G.: Aye. And I was good at it, I was winnin' all the time.

Again, this account indicates that the status and reputation achieved through participation in this pastime, in this case boxing, were particular attractions and benefits of this activity. This pastime also involved violence, albeit within a sanctioned environment. Violence and dominance were seen to be appeals of boxing, as the patient emphasises the importance of 'the thrill of the fight' and 'winning'. Additionally, the physical nature of boxing was also highlighted. Ultimately, it appears that for these interviewees, hobbies were means of achieving status. This can be associated with the need to establish a public masculine persona.

4.2. Friends and Recreation: Prisoners' Experiences

Prisoners also described their experiences of recreation and friendship. For this group, this aspect of their life histories was often characterised by offending behaviour and involvement with the criminal justice system.

The childhood recreational habits described by prisoners often included criminal behaviour. As a result, many prisoners described interaction with the police from a young age:

> The very first time I was in trouble was 11 or 12, [it was] when I was still at school, and I went to the market… I stole stuff. I got caught and sent to a young Sherriff court. (M., Prisoner, 39)

> I was just getting into trouble, smashin' windows, stealin' cars. I was stealin' cars from a young age. Shopliftin'.... (R., Prisoner, 28)

This behaviour resulted in both individuals becoming known to the police and involved in the criminal justice system in their youth. Other prisoners illustrated parallel situations:

> Interviewer: How old were you when you started getting in trouble with the police?
>
> L. (Prisoner, 31): 11.

> Interviewer: What were you doing?
>
> L.: Stealin', we smashed a window, things like that.
>
> Interviewer: What would you say was the first sort of serious thing?
>
> L.: I got caught shopliftin' but that's no really serious is it? When I was in the children's homes I started stealin' cars and that… I was about 13 or somethin', I was out of control.

Involvement in deviant behaviour at such a young age can be understood as a means of asserting masculinity, through the demonstration of a risk-taking and tough persona (Messerschmidt, 1994).

For most prisoners, this offending behaviour continued into adulthood. While much of this was for financial gain, one particular account illustrates the nature of such behaviour within the context of recreation:

> We broke into a glazin' factory to steal some glue, me and this other guy. We heard a big loudspeaker, 'this is the police, we know you're in there, come out'... We were just on the roof throwin' slates at them. And all the dancin' and the discos were comin' out then, in 1990 this was. This hamburger van drew up and started selling to all the people watchin' us! That's what I'm sayin', it's funny now, but… (M., Prisoner, 39)

This account highlights that for this prisoner, recreational habits which included offending and deviant behaviour endured in his later years. The above example illustrates how such behaviour could be understood as 'fun' by prisoners during this period of their lives.

When describing offending, prisoners were keen to emphasise that they were not alone in this behaviour, particularly in their youth. They believed themselves to have been 'following the crowd' at the times of these incidents:

> When I was younger… They [my friends] were doin' the same things that I was doin' really, you know. We were all just doing the same thing. (K., Prisoner, 35)
>
> I've always had wee bits of bother with the police, just stupid things like shopliftin', followin' my brother here and there and everywhere and he's doin' things and I'm just joinin' in and things like that. (O., Prisoner, 45)

Older friends often proved to be a negative influence and were highlighted as a source of incitement for offending:

> But in the '90s and that when I was only a young boy I was jumpin' about wi boys that were 21 and that, and you're doin' what they're doin' and you think it's right. (S., Prisoner, 23)
>
> I was jumpin' about wi older people and that, and I went down the wrong path more or less, you know. (K., Prisoner, 35)

Other prisoners made similar comments, yet also that suggested such relationships may also serve a protective function:

> L. (Prisoner, 31): Well my pal that I used to jump about with, he was 17 and I was 13 at the time.
>
> Interviewer: How do you think that affected you, having an older group of friends?
>
> L.: It toughens you up really… I was an angry wee bastard, always wantin' to fight.
>
> R. (Prisoner, 28): When I started jumpin' about wi' my older mob I was pals wi' guys in their areas, and then once I got into the residential schools I was making friends from all over. It was all the worst in this one school.
>
> Interviewer: What do you think looking back on it now, is it good your older friends took you away?
>
> R.: I suppose, the thing with my older friends, they schooled me in a sense where if I got into a situation I'd know how to handle myself, but obviously that path isn't a good one.

The prisoners here imply that they benefited from these friendships, particularly as they assisted them in negotiating a violent environment and the situations which arise within this. Prisoners' attempts to gain approval from these older males, as well as to demonstrate qualities such as daring and power, again appear to drive these situations and suggest a desire to construct a traditional masculine identity in the context of recreation.

4.3. Friends and Recreation: Conclusions

In summation, both patients and prisoners described their recreational habits and their experiences of friendship. Their experiences in these areas were dissimilar in many ways, yet two key similarities were present in their accounts: the allusion to

criminal behaviour, including violence, within this context, and the desire to project a masculine identity within this sphere of their lives.

Patients' recreational habits involved socialising within the night time economy or more organised activities. Conversely, prisoners' experiences of recreation largely involved offending behaviour, often from a young age and enduring into adulthood for some. Both groups noted that violence was often part of these experiences, whether this was in the context of confrontations in bars and nightclubs described by patients, or other deviant behaviour illustrated by prisoners.

Both groups also described their relationships with their peers. It was shown that for patients and prisoners, friendships were an important feature of their pre-institutional lives. Prisoners' comments illustrated the role of peers in encouraging them to become involved in crime, and in some instances violence.

It was also evidenced that patients and prisoners both sought to gain social status within this sphere of their life histories, and to display characteristics such as risk taking, courage and physical strength. In this sense, their approach to recreation and friendships can be viewed as attempts to establish a masculine identity.

5. ALCOHOL AND DRUGS

Both patients and prisoners were asked to detail their histories of drug and alcohol consumption. Almost all patients and prisoners had engaged in alcohol and drug misuse at some stage, and they referred to the extent and effects of this. For both groups, this appeared to have negative implications for interviewees' mental states, and often resulted in dependency. For patients, alcohol and drug misuse in combination with mental illness resulted in a disoriented mental state.

5.1. Alcohol and Drugs: Patients' Experiences

Patients indicated that social use of these substances started from a young age, particularly in the case of alcohol:

> Interviewer: How old were you when you started drinking and that?
>
> G. (Patient, 39): I was about 14, just at nights up the street, Saturday nights after the football and that.
>
> H. (Patient, 49): It started when I was young, when I was 13. I started drinking, and that was because I was at high school at the time and I ended up getting a carry out to go to the disco. Because I thought I would get a bird easier [laughs]. Dutch courage and that.
>
> Interviewer: And then what happened that night?
>
> H.: I ended up getting' lifted by the polis 'cause I was drunk.

As patients grew older, alcohol consumption increased in volume and frequency. In some instances this escalated into dependency:

> Aye, I got to the stage, it was a half bottle, then it was a bottle, and cans of beer, I ended up on crates of beer at the end, and I was drinking 3 and a half litres of vodka a day. (H., Patient, 49)

Others described similar escalation in relation to drug use:

> At 35, I started off with cannabis. [My friends] kept going on at me to try it so I tried it, and I just kept dabblin', and before I knew it I was smokin' with groups of people and that and goin' to people's houses and smokin' it, and it just progressed. (A., Patient, 54)

This quote suggests that recreational cannabis use can develop into habitual use, as the patient began smoking cannabis at a relatively late age and soon after was regularly using the substance. This sentiment was echoed in the accounts of other patients, who detailed dependency in relation to cannabis:

> Yeah I would have said I was dependant on drugs, especially at the weekend, and definitely dependant on smoking cannabis. I wouldn't go a day without smoking a joint. (F., Patient, 32)
>
> I would say at my peak my habit was about an ounce a week, that's about an eighth a day, which is about £100 a week on dope. (B., Patient, 43)

These accounts describe the pervasive nature of these patients' cannabis misuse, illustrating the frequency with which they used this substance, and the financial implications of this.

Consumption of alcohol and drugs may also have implications for mental health. Literature suggests that alcohol and drug misuse interacts with mental illness to exacerbate this problem and to destabilise mental health further, in some instances leading to violence (Steadman et al., 1998; Junginger et al., 2006; Swanson et al., 2008 A). Patients' accounts indicated that drug and alcohol misuse often coincided with mental illness:

> Interviewer: When was the first time you took drugs?
>
> I was just smokin' [cannabis], somebody would just say 'Here's a joint' and I'd say 'Alright'. But it wasn't big scale. It didn't happen big scale until I first went ill. When I went ill for the first time, I was smokin' a lot of drugs. (B., Patient, 43)

While it is difficult from this account alone to determine whether drug misuse preceded and induced mental illness, or vice versa, the connection here is nevertheless significant. Other patients similarly suggested that cannabis use may have exacerbating effects on mental health, in this case resulting in increased feelings of paranoia, and generally disordered behaviour:

> I was 18. I took a smoke of cannabis. Whatever kind it was, I can't remember, but it made me feel alright. But, it was as the years grew on that I started getting' paranoid wi' smokin' dope and takin' drink. (H., Patient, 49)
>
> I basically became a little bit more unwell, started smoking more cannabis, became more unwell, started smoking more cannabis, so it was gradually building up and building up, to the point that this irrational behaviour and erratic behaviour set in. (F., Patient, 32)

Patients also made parallel comments in relation to alcohol misuse, suggesting that in conjunction with mental illness this had implications for their mental state:

> I was a binge drinker, that was the worst about it. I maybe was aff it months and that, then binge drinkin' and away wi' the birds again. (A., Patient, 54)
>
> B. (Patient): The drink doesn't agree with me. I don't drink anymore… I'd just get a wee bit aggressive and that, lost the plot a wee bit. Maybe not start trouble but if there was trouble there…

In the second extract, the patient suggests that this resulted in increased volatility and aggression. Moreover, he implies that this change in his mental state led to 'trouble' in this sense, which may allude to criminal activity and even violence.

5.2. Alcohol and Drugs: Prisoners' Experiences

As in the case of patients, prisoners also suggested that alcohol and drug misuse was a feature of their life histories. Few prisoners suggested that this took place within the context of night clubs and bars, although one prisoner highlighted that this environment was where his drug misuse began:

> I started going to the dancin' – going out – and takin' ecstasy, that's when I was about 18, and to come off the ecstasy at the weekend on the Saturday I used to take a couple ae tamazepam - jellies - and basically it ended up I was takin' more jellies than I was ecstasy, I ended up wi' a habit wi' the jellies, takin' them every day, every couple of days or whatever. (N., Prisoner, 36)

This quote suggests that this prisoner's drug use escalated after his initial experimentation, as he attempted to deal with the symptoms through further drug use.

Unlike patients, for prisoners the setting of drug and alcohol consumption tended to be their own homes, or the homes of friends:

> Interviewer: What did you do with the boys who were older?
>
> K. (Prisoner, 35): Kind of just sat about the house drinkin', smokin' dope and stuff.
>
> Interviewer: You were taking drugs outside prison then?
>
> K.: I smoked dope, sometimes I took Es and acid and stuff but that was it.

This excerpt illustrates that drug and alcohol consumption were largely confined to residences rather than public social areas during prisoners' younger years. One prisoner suggested that due to the context of gang culture which characterised his up-bringing and restricted his movements it was not possible to visit bars and clubs, and

it is likely that this experience was shared by other prisoners. Owing to this, he adapted his socialisation habits to remain within these distinct territories:

> Interviewer: So it wasn't going to clubs or pubs?
>
> S.: No... you cannae really go out your area without fightin' with anyone, so it's just…
>
> Interviewer: There's no option to go to a pub or anything?
>
> S.: No, not really.

Accounts also focussed on the effects prisoners experienced when taking drugs and drinking alcohol, including the addictive nature of these substances:

> Tamazepam's a downer, but I was takin' them that long, I had a kind of immunity, I was havin' to take more and more and more building up a tolerance like. I thought I was alright but obviously people seen me and were like "god, he's in some state" but I thought I was alright. (N. Prisoner, 36)

In this instance it appears that drug use escalated into dependency, and had a particularly negative impact on the prisoner's behaviour. Others described similar scenarios where drugs and alcohol were concerned, suggesting that these substances changed their behaviour and made them more aggressive:

> K. (Prisoner, 35): Every time when I drank buckfast or somethin' I would change, I was a completely different person.
>
> Interviewer: What were you like?
>
> K.: I was out of control when I was full of buckfast, I just kept getting' into fights and stuff.
>
> Interviewer: So it made you feel more aggressive?
>
> K.: Aye definitely.

Thus, the effects of drugs and alcohol experienced by prisoners are also important features of their life histories.

5.3. Alcohol and Drugs: Conclusions

Both patients and prisoners provided comments in relation to drug and alcohol misuse. Their accounts illustrated similar experiences, with interviewees from both groups recounting escalation into dependency in this context. Both groups also

asserted that this altered their mental state and increased their volatility. This was especially significant for patients, as alcohol and drug misuse served to further exacerbate their mental health problems.

The context in which both groups used drugs and alcohol was markedly different. While patients' accounts indicated that often this took place socially in bars and nightclubs, prisoners' activities were almost always restricted to their homes or the streets of their local areas. This may be explained by the difficulty these prisoners faced in visiting shared social spaces within the context of gang violence.

It is important to note that interviewees from both groups alluded to the role of alcohol and drug misuse in encouraging volatility and aggression, and even leading to violence. This supports the accounts of violence in this context provided in the previous chapter.

6. EMPLOYMENT AND MAKING MONEY

Employment and making money represented a significant aspect of patients' and prisoners' pasts. They detailed their experiences of legitimate work as well as means of making money through criminal activity, and it was demonstrated that the wealth and status associated with employment were important features of a masculine identity.

6.1. Employment and Making Money: Patients' Experiences

Patients were asked to describe their experiences of employment and means of earning money. There were variations among this group in relation to the types of jobs and the levels of income they experienced in their pre-institutional lives. Two patients described affluent lifestyles prior to their hospitalisation:

> I got into business and that quite young… I got a taste for that, and got into business systems, computer systems. So I spent about 17, 18 years in business systems that way, and for

> probably 10 years I was self employed… So most of my working life was in computers and businesses. (E., Patient, 49)

For those patients who had prosperous careers, these generally ended due to the onset of mental illness and their ultimate hospitalisation. The difficulty of maintaining a successful career in conjunction with mental illness, particularly in relation to the stress that such occupations often pose, was highlighted.:

> I was working for an engineering company… I started to become slightly unwell, so… I say unwell, when I look back, I was suffering from sleep deprivation, thought disorder, you know, racing thoughts and getting stressed... Basically, at that time, because of everything that was going on and problems at home and certain family issues, I started to smoke cannabis… I walked out of my job. I didn't go back… I just cut off all communication with my company, and I left a major project open and I feel bad about doing that but I was really unwell. (F., Patient, 32)

Most patients were not working at the time of their offence and hospitalisation as a result of this. Thus it appears that mental illness again intercedes in other areas of patients' lives with negative consequences.

For those who had experienced a successful career in the community, this appeared to be associated with issues of status and an affluent lifestyle:

> I went out and bought nice cars and nice suits. You know, I'm not like that now, I look back and almost laugh at some of the ways we went about things... It was good while it lasted and it was an experience but it was all at the time, it was the 'yuppie' thing, getting on in business and having money. (E., Patient, 49)

While the patient implies that he now views this behaviour as foolish, it is proposed that in his earlier life his career was closely associated with a sense of wealth and status. These comments suggest that employment contributed to these patients' masculine identities, as characteristics such as financial success and 'being a big wheel' (Brannon, 1976) in this way are important features of traditional male personas.

The remaining 8 patients described less financially lucrative careers, with many giving negative accounts of their experiences of employment. Such employment was characterised by long hours, poor pay and 'hard graft':

> I left school and got a job as an apprentice butcher… It was hard graft. You were workin' from about 7am to 7pm through the week and working a Saturday. And I was only getting 6 pound odds and I was giving my maw a fiver, and I was only left with one pound odds. Aw it was torture. (A., Patient, 54)

Where interviewees described less financially rewarding occupations, there was nevertheless a sense of status which came with employment:

> I worked for this guy and he employed labourers and I was in charge of the labourers. Because I had worked in buildin' sites since I was 22 and knew the ins and outs and that. And eh, it was all jack the lads, guys that's come out the jail and looking for money, getting' a shift and all that. So he needed somebody, I was quite tough when I was younger, and that's why I was in charge because I could keep a tight rein on them. If it was somebody else at the top they would have just made a fool of him. (A., Patient, 54)

Concepts of leadership, knowledge and being needed were all features of this occupation which the patient viewed positively. For those whose jobs involved physical work, this element of the occupation was similarly prized:

> I worked on the building sites almost all my life. It was a hard physical job which I enjoyed and it got me super fit. (A., Patient, 54)
>
> B. (Patient, 43): I was really fit at the time, I was strong and fit and young, and I'd just finished the paras, I'd completed the parachute regiment then, I'd done the course it's a very hard course.
>
> Interviewer: Physically demanding?
>
> B.: Very. Mentally demandin' as well. I joined the paras at age 17 and a half, I passed my parachute course when I was 18, you've got 6 months to do the course and get you fit for it. So I got myself my red beret and I had my wings, I was a fully trained para by the age of 18.

Overall, patients' comments demonstrated that a sense of status was associated with their various occupations. In some instances this stemmed from financial success and wealth, while in others this was derived from the physical nature of their work. Again, the achievement of status, wealth and physical strength through these actions can be interpreted as 'doing masculinity' (West and Zimmerman: 1987) within the context of employment.

In addition to legitimate employment, patients also described engaging in criminal behaviour as a means of making money:

> It was when I lost my job, [I had] nae money for fags and things like that, and I got involved with older guys, saying 'c'mon we'll steal a bag of coal, we'll get this and that' and then… the next couple of nights 'Oh, we'll do this', you know what I mean Christine, and I just fell along wi' it. (A., Patient, 54)

For this patient, offending behaviour such as theft was a means of achieving financial wealth in situations were this was not possible through regular employment. Other patients' accounts of this form of offending were associated with drug and alcohol misuse and the need to fund this:

> Auch, we were dodgy at the time, well it wasn't *dodgy*, but we were lookin' for money and I says 'Look we'll use this guy's ID and we'll get some stuff off it'. So we went to Dixons - and this was years ago when I was in my mid 20s, again - and we bought a video camera in this guy's name. We went down to a place that used to buy second hand stuff and sell stuff, and the guy gave us £120 for the video camera. So we went and got drugs off it. See that was the different part, you steal money for drugs. (B., Patient, 43)

> Interviewer: What about when you were younger, were you ever in trouble with the police from a young age?
>
> D. (Patient, 49): Aye.
>
> Interviewer: Can you tell me a wee bit about that?
>
> D.: Breakin' into houses. We never got much, just if there was any money lyin' around.
>
> Interviewer: What were you going to use the money for?
>
> D.: To buy alcohol.

For some patients there was a more obvious link between drugs and offending, as several recounted involvement in drug dealing. One patient indicated that when he began using drugs this escalated into selling drugs:

> F. (Patient, 32): It all started off when I was about 17, 18, I started dabbling, I was smoking cannabis at the time, I would just buy it in bulk and sell it to my friends. And the same with ecstasy... So that was basically the kind of dealing that I got involved in. It wasn't on a major scale.
>
> Interviewer: Did you ever get caught by the police for that?
>
> F.: Yeah, there was a time when I was caught with a reasonable amount over a score, I received a £50 fine and that was it…

While this particular experience is not considered serious at this point, the patient suggested that it soon evolved to more organised drug dealing:

> Yeah well I was involved with drug dealers, collecting money for drug dealers, getting involved in drugs, selling drugs, yeah… (F., Patient, 32):

Another patient described serious involvement in drug dealing, and the financial benefits of this:

> I. (Patient, 19): You would think that it [drug dealing] was not as dangerous when [mephedrone] was legal, but believe me I've been through a lot. And as it turned illegal the prices became illegal.
>
> Interviewer: So did it become more valuable once it became illegal?
>
> I.: Yeah. I don't want to get too into that because what's done is done. But let's just say I knew how to play the game.

Although reluctant to divulge details of the monetary benefits, this patient's account insinuates that his experience of this activity was profitable. He is also keen to emphasise his success and knowledge within this context. The patient also described negative aspects of drug dealing:

> I. (Patient, 19): One thing led to another obviously, but I mean, you know how it starts. It starts from… one friend to another, one crazy thing to the next… You see, like, danger was a big part in [drug dealing], because the things that I was having to go through were dangers. I don't like to say much about it but… been there, done it.
>
> Interviewer: So did you like the danger element of it?
>
> I.: I never used to do it for the fun of it, I used to do it because I had to.

It appears that issues such as the threat of detection by police, or danger from other criminals involved in this activity detract from the benefits of this activity.

6.2. Employment and Making Money: Prisoners' Experiences

The interviewed prisoners were also asked to detail the ways in which they survived financially in the community. For some, this involved legitimate careers, and for others, this involved criminal activity.

Half of the prisoners described the jobs they held in the community, illustrating a range of professions and levels of income. Two of these prisoners described financially secure lives where they were making 'good money' in a 'decent job'. Again there was a sense that status is associated with such achievements:

> I grafted all my life, realised I had a wee bit of a brain at one point and used it. Went away to university, done quite well for myself, got a decent job… I worked down in London and in America. (P., Prisoner, 34)

> I worked as a landscape gardener. Me and my wife worked for a computer company buildin' up the computers, she'd work one shift and I'd work the other. We were makin' good money. It's the best money I've seen. If you worked all weekend they were giving you a bonus of £500. The money we were pullin' in was good. We had our holidays, two holidays a year and that. (T., Prisoner, 45)

Other prisoners described occupations which were perhaps less financially lucrative and were temporary:

> I went into a job just after school, working with the milk, I was a van boy. I liked going to my work and that. (Q., Prisoner, 61)

> I was working with my brother doing window cleaning for a bit, he had his own business, but we got in trouble for not tellin' social security… It was shop windows and things like that. (O., Prisoner, 45)

In addition to such casual work, most prisoners described periods of unemployment, with the remaining 5 stating that they had never worked at all. For these individuals there was little importance placed on having a job. Moreover, the sense of status attached to employment which was suggested by many patients, as well as prisoners who had successful careers, did not appear to be present here:

> Interviewer: And you didn't go back to school when you came back to Scotland [after leaving school at age 12]?
>
> K. (Prisoner, 35): No.
>
> Interviewer: So what did you do, did you work?
>
> K.: No, I just sat about the house and that.

> I was 17 when I got the jail, I was in and out of children's homes until I was 16. After that it was… I never even considered workin' to be honest. L. (Prisoner, 31)

Half of the prisoners described offending behaviour as a means of making money through crimes such as robbery. Some such offences were one off incidents which did not appear to have been planned and appeared to be opportunistic offences:

> When I was 15 I got done for an armed robbery. So I got 5 years when I was 16… It was just one of those ones, we were just out for a walk and we just came across it, and they just did it and I went along with it. It wasn't planned, it was just like we were out and about walkin' about and we saw it. It was a hospital, like a mental hospital, it was for the drugs and that. (K., Prisoner, 35)

Other prisoners described crimes which were more organised, and represented a pattern of sustained offending for financial gain. One prisoner had a particularly extensive history of such crimes and supported himself financially through criminal activity for an extended period of time:

> Q. (Prisoner, 61): I was a hold up man, I used to rob bookies back in the day when bookies had money… You'd hear of a manager that was down on his takin's and he was happy for a guy to come in and be tied up and the guy to take the money.
>
> Interviewer: How many times did you do that?
>
> Q.: 5 or 6.
>
> Interviewer: Did you get a lot of money out of that?
>
> Q.: Yeah, 18, 20 thousand pound a time. A lot of it was all managers that wanted money took off them so it was set up.
>
> It ended up that shoplifters used to come to me and sell me their stuff and then I'd sell it on at a higher price. And I found out I was making more sittin' on the phone doin' that with the connections I had, and it was less risky. (Q., Prisoner, 61)

These excerpts demonstrate how the prisoner modified this behaviour so as to minimise the risks for himself. Emphasis is again placed on the financial benefits of such activity, as he highlights that in both instances he was able to make a substantial amount of money. Thus, the status associated with financial success can also be achieved through criminal activity. Other prisoners described similar activities, such as drug dealing which had similar monetary benefits:

> I was in with a gang at a young age, but my older mob pulled me aside and said 'you don't want to be doing that, come on with us', so instead of getting into fights with gang violence I was workin'. They took me away from that into makin' money, sellin' drugs and makin'

> money, rather than standin' with guys my own age fightin'. That wasn't me, so I got took away from that and into, I suppose, the start of my criminal path. (R., Prisoner, 28)

This prisoner highlights that his drug dealing stemmed from his involvement with gang culture. In this sense, his criminal behaviour escalated into less violent activities, and more organised crime as he got older. Other prisoners made similar assertions:

> Then I was older… I started meetin' up with boys I was in the gang with when I was younger. And they were all doing robberies and things, it was all robberies for gain then. It was more an older crime, it was to get money, it wasn't to act out. And it got serious then. (Q., Prisoner, 61)

It appears that that early involvement in gang culture led to involvement with criminal individuals in prisoners' later years.

6.3. Employment and Making Money: Conclusions

Patients and prisoners were asked about their means of making money and experiences of employment in the community. The accounts they gave detailed a range of options, from successful employment to criminal activity.

In terms of employment, few interviewees recounted having jobs which were particularly financially lucrative. The majority of both groups described lower paid occupations and casual work. Both also described periods of unemployment. In many cases patients' accounts suggested that they had been unable to manage employment in the context of mental illness, although all had experienced work at some point. 5 of the 10 prisoners interviewed had never been employed.

Interviewees from both samples – 4 patients and 5 prisoners – described alternative means of making money, largely through criminal activity. In some instances these were one off incidents which could be characterised as opportunistic, while some detailed more sustained criminal behaviours, such as drug dealing, through which they supported themselves financially for extended periods.

Employment also appeared to have a bearing on masculine identity. Patients' accounts implied that financial success and the status associated with employment were a key aspect of a masculine image. Additionally, where employment did not generate a significant financial status, reference was made to the physical nature of these endeavours, again communicating a masculine person, but this time through physical strength. For prisoners, greater emphasis was placed on financial success and the status associated with this, rather than masculine status through employment itself. Ultimately employment and financial stability had strong associations with masculinity.

7. CONCLUSIONS

To conclude, both patients and prisoners were asked to comment on various areas of their lives prior to hospitalisation and imprisonment. These included significant relationships, education, recreation and friendship, drug and alcohol use, and employment and making money. Patients were also asked to discuss experiences of mental illness in the community.

Overall, the accounts provided by both groups revealed adverse experiences and circumstances in a variety of areas of their pre-institutional lives. Patients and prisoners illustrated childhoods involving turbulent family situations and poor relationships within this context, as well as negative experiences of school and low education attainment during this period. Relationships with females during adulthood were also characterised by turbulence, including frequent arguments and infidelity. Subsequently, most developed recreational habits involving drug and alcohol misuse from a young age, and often violence. As they left school and were faced with the task of financially supporting themselves, they experienced jobs with low income, and several described resorting to criminal activity to make money.

Patients' accounts demonstrated some variation among their experiences. While all described situations analogous to the negative circumstances detailed above, most

patients also gave positive accounts in relation to some of these aspects of their life histories. Patients also endured the development of mental illness, which was portrayed as a particularly destructive force. Even where patients' experiences of their early lives were positive, once such conditions were manifest they were shown to intercede in other aspects of patients' lives, by disrupting relationships with families and intimate partners, placing strain on the pursuit of education and employment, and interacting with alcohol and drug misuse with further negative implications for mental health. In this sense, major mental illness was illustrated as a pervasive negative force in patients' life histories.

Prisoners' accounts were more uniformly negative, and the circumstances they described were more severely adverse than those of patients. The majority of this group described extremely difficult experiences, demonstrating long histories of disadvantage and chaotic lifestyles. For most, their experiences included adverse circumstances such as turbulent relationships with families and intimate partners, low educational attainment, alcohol and substance misuse, and involvement in offending from a young age with substantial institutional histories. Within these contexts it is perhaps unsurprising that these individuals ultimately committed serious offences resulting in long term prison sentences, a sentiment which was acknowledged by one prisoner:

> It's just madness. But for me it [the life sentence] wasn't anything. My lifestyle was chaotic at that time, I know for a fact it was. I'd been in and out of jail, I'd done about 3 sentences and 3 remands, every remand I got, I got a sentence at the end of it… It was always jail for me, 'go to jail, go to jail', it was like monopoly… (M., Prisoner, 39)

Violent behaviour was a significant feature of both patients' and prisoners' lives in the community. Many described experiencing violence in the home from their fathers from a young age, as well as in school. Similarly, they recounted recreational habits and means of making money to which violence was intrinsic. In many respects, it appears that violence was omnipresent in interviewees' pre-institutional lives.

Within the context of these experiences of turbulent life histories, there was consistent evidence of patients and prisoners seeking to construct and maintain a

masculine identity. This was apparent in many areas of pre-institutional life, for example in misbehaviour at a young age in educational settings which sought to demonstrate risk-taking behaviour, in recreational practices which involved a display of physical strength or status, and in views expressed in relation to intimate partners which illustrated notions of dominance over these women. Ultimately, masculine identity was demonstrated as particularly important to both patients and prisoners, and their past behaviours were often aimed at the creation and protection of such an image.

Overall, patients' and prisoners' accounts of their life histories portrayed their experiences of particularly adverse circumstances, as well as demonstrating the damaging nature of mental illness and the consistent desire to portray a masculine identity.

CHAPTER 7

‘THE PRESENT’: EXPERIENCES OF HOSPITAL AND PRISON

This chapter will provide an overview of patients’ and prisoners’ accounts of ‘the present’. For the ten patients who participated in interviews, these revolved around their experiences of a medium secure psychiatric hospital, while the accounts of prisoners detailed their experiences of imprisonment. There are numerous similarities in the nature and function of these institutions. Both are institutional settings, tasked with the management of populations which are perceived to be dangerous, and settings share the aim of reducing recidivism, often through long periods of incarceration.

Patients’ and prisoners’ experiences share many similarities. As such, 3 key areas of experience emerged from these accounts: institutional identities, the nature of being mentally ill and being a lifer; adaptation to this setting, through compliance and rebellion; and institutional power structures. However, their comments also demonstrate significant divergences in their experiences.

Through these accounts, the distinct ways in which masculinities are achieved and maintained in these environments are revealed. It will be argued that the nature of these settings and the implications they have for masculine identity shape the experiences of patients and prisoners in these environments. While the prison reinforces traditional masculine identities, the secure hospital challenges and diminishes these.

1. INSTITUTIONAL IDENTITIES

Institutionalisation posed a challenge to patients’ and prisoners’ individual identities. For patients, this involved being labelled mentally ill and receiving a patient identity. As all interviewed prisoners were serving life sentences, the ‘lifer’ identity was

applied to them. This section will detail the key features of these new identities, as well as patients' and prisoners' responses.

This will be done with reference to the 'pains' of institutionalisation which are central to these identities for both patients and prisoners (Sykes, 1958; Crewe, 2009, 2011). These include the 'weight' of confinement in this setting, the psychological burden, and the 'depth' of confinement, the physical security and restriction experienced (King and McDermott, 1995).

It will be demonstrated that patients focus on mental illness in developing institutional identities, and while some accept that they are unwell, others seek to deny mental illness. This denial, it will be argued, represents an attempt to cling to a traditional masculine identity, and eschew the patient label and its connotations of weakness and instability which threaten such a persona. Conversely, prisoners' comments demonstrate that their conception of a 'lifer' is a hyper-masculine image which serves to reinforce pre-institutional masculinities.

1.1. Patient Identities: Being Mentally Ill

As stated in Chapter 3, the identification of mental illness by professionals during the criminal justice process sets those deemed mentally ill aside for treatment in hospital. Patients' stories revealed that the hospitalisation process forces a 'patient' identity upon individuals. This identity has strong connotations of vulnerability and weakness. Two distinct stances towards this persona emerged among the 10 patients interviewed: those who accepted that they suffered from mental illness, and accordingly identified themselves as mentally ill; and those who rejected the assertion that they were mentally ill did not accept this label.

This section will detail the experiences of both of these groups of patients, and will argue that acceptance of mental illness departs from masculine identities, and denial of mental illness can therefore be understood as a defence of this persona. It will be

demonstrated the pains of 'depth' and 'weight' are intrinsic features of hospitalisation for all patients.

Acceptance and Experiences of Mental Illness in Hospital

Of the interviewed patients, half accepted that they were suffering from a major mental illness. They reflected on being unwell in institutional settings and their experiences of symptoms of mental illness. An additional 2 patients suggested that, while they did not perceive themselves to suffer from a major mental illness, they had experienced at least one psychotic episode preceding their hospitalisation, and their comments on these experiences will also be included here.

Patients who accepted that they suffered from mental illness provided details of their psychiatric history, and demonstrated a recognition of their present diagnosis:

> Interviewer: What are you diagnosed with?
>
> C. (Patient, 34): Well for a long time I was undiagnosed. And then it was schizophrenic, then schizo-affective, and now it's paranoid schizophrenia.

Patient's accounts often focussed on the challenges of being unwell in a hospital setting, and the psychological trauma or 'weight' of this experience. Their accounts of entering a secure psychiatric hospital while acutely unwell following an offence highlighted the distressing and confusing nature of this experience. The image they portray of a hospitalised individual is that of a vulnerable and fearful male:

> I ended up in the IPCU when I was 20 years old… And when I was in there I thought they were tryin' tae poison me... It was hard to cope, the illness and the meds were coincidin' with each other and making you very disorientated and confused and all the things that go wi' it. (B., Patient, 43)

For most patients this period was understood to be the time when they were most unwell and their accounts often conveyed symptoms of active psychosis:

> I kept goin' on about the devil, god, that I was supposed tae do it and that, and that I can't remember doin' it, I was forced tae do [commit the offence]… I just was that unwell, Christine. (A., Patient, 54)

> Well, the last time I was really unwell was 2006 – 2007 in the State Hospital. And I was makin' shrines, and doin' things like that. I would have fits. (J., Patient, 51)

Hallucinations, delusions and volatile behaviour such as that illustrated above was described by several patients, and their accounts support that notion that experiencing positive symptoms of mental illness is very distressing (Appelbaum, Robbins and Monahan, 2000; Swanson et al., 2006 A). At the time of hospitalisation, most patients had recently committed a serious violent offence, and had been arrested and prosecuted for this, the aftermath of which was a further factor adding to their distress:

> I have to say it was probably one of the worst times of my life… I was just overwhelmed with disgust at my actions and what I did, but then having that [illness] on top of my own disgust, it just made it really difficult time in my life to cope with, you know. (F., Patient, 32)

In light of the issues outlined above, it is to be expected that the initial period of hospitalisation is difficult for patients. The patient identity appears to have connotations of weakness and helplessness. The psychological burden of mental illness and hospitalisation are also demonstrated through these accounts, indicating the 'weight' of hospitalisation.

Two patients recounted that they were not immediately transferred to hospital following their offence, and instead were remanded in prison. Much research posits that levels of mental illness are high among prisoners, possibly in part due to the exacerbation of underlying mental health issues by this environment (Peay, 2007: 504). In keeping with this, both patients described being acutely unwell in this setting as an especially distressing experience:

> Yeah I was very unwell at the time as well, so, it was just windin' me up even more, and more, and more, and my lawyer could see that things weren't… I wasn't in a good situation, and I think most of the prison officers agreed with that, and they said they'd transfer me to the State Hospital. (F., Patient, 32)

One went so far as to imply that his experiences of prison may have played a role in the onset of his mental illness. Although it is difficult to confirm its origins,

imprisonment appears to have further negative implications for the wellbeing of an individual suffering from mental illness:

> I was put in pressure in a place like that things, let's just say, things just build up inside your head… And even though I have no recollection of what happened, I can understand how my mental state went the way it did. (I., Patient, 19)

Overall, the comments of patients who accepted their diagnosis of mental illness demonstrated that this is a particularly distressing and challenging experience in the context of an institutional setting.

Rejection and Denial of Mental Illness

While most patients were willing to admit that they had suffered from mental illness and recounted these experiences, others were keen to dismiss such suggestions. Research documents the rejection of mental illness, and suggests that individuals may deny this for varying reasons such as shame and fear of stigma (Hocking, 2003; Dinos et al., 2004; Jones and Crossley, 2008; Saks, 2009). It will be argued here that the denial of mental illness by males represents an attempt to avoid identities which demonstrate weakness and neediness in order to maintain a masculine identity. As Matza suggests, 'The idea of being sick or mixed up seems incongruous with the delinquent's traditional self-image of manly toughness and precocious independence' (Matza, 1964, 83).

As the diagnosis of mental illness is a label applied by professionals, it is somewhat refutable. Like the 'deviant' label described by Becker (1963), it is possible to argue that in spite of its scientific basis the 'mentally ill' label is to a certain extent socially constructed. Patients' accounts demonstrated a level of awareness of this. Of the 10 patients interviewed, 3 stated that they did not agree with the diagnoses of made by clinicians and did not perceive themselves to suffer from these conditions. This section will describe these accounts. Comments from those 2 patients who consented that they had suffered from a psychotic episode but did not believe that they suffered from major mental illness are included here.

In denying mental illness, several patients in this study sought to claim that the interpretation of particular past behaviour as symptomatic of mental illness was inaccurate:

> I've been consistent in this all the way through, I didn't really think I was delusional, how I acted – all I was trying to do was to highlight my grievances. (E., Patient, 49)

A key way in which patients in this study attempted to negate diagnoses of mental illness was through the suggestion that any symptoms they experienced were isolated incidents rather than an enduring mental health problem. Through such explanations, patients sought to demonstrate that the loss of autonomy and weakness they displayed during their period of mental illness were short lived and no longer a feature of their masculine identities. One patient asserted that his experience of a mental health problem was a single episode brought about by the stressful experience of imprisonment:

> Well, I can't say it's an illness because I've only had one psychotic episode – but everything that was happening on the outside, while I was inside, that's what gave me too much pressure and led me to break down. (I., Patient, 19)

A similar explanation for any apparent mental health issues was drug and alcohol misuse, with many patients suggesting that this brought about a disturbed mental state. Again, patients portrayed this not as a long term problem, but as a transient state which has since been remedied:

> Dr. [Smith] says paranoid schizophrenic but I don't believe that. I panic and things but I don't think I've got an illness. I took alcohol, in the past I had alcohol [issues], but I don't anymore. (D., Patient, 49)

> I believe I was maybe a drug induced psychosis, maybe like a short term schizophrenic but I'm alright now. (A., Patient, 54)

One patient posited that his denial of mental illness was a conscious decision due to the expectations of his peers. His comments indicated that these feelings are associated with the affront that an admission of mental illness poses to masculinity, and more specifically, the masculine identity which he has established among his peers:

> If I was to fully accept that I'm a psychiatric patient… I don't do that because it's not part of the character that my friends would know. (C., Patient, 34)

Unlike those who accepted their mental illness, patients who sought to reject mental illness often displayed a lack of understanding in relation to their diagnosis. Several implied that they were unsure of the relevant medical terms relating to the illness from which they suffered. For example, one patient was keen to take the opportunity to minimise the extent of his condition, by highlighting that it was a vague diagnosis of mental disorder:

> Delusional disorder, or mental disorder, I think, has also been the description. But I think that's basically it, it's nothing more than that as far as I'm aware. (E., Patient, 49)

Patients' confusion regarding individual illnesses also stemmed from changes over time, as many patients' diagnoses altered during the course of their treatment. Such fluctuations left them with a poor understanding of their condition, and a lack of conviction that their current diagnosis was accurate:

> "I'm not really sure myself. They diagnosed me with something else before, but this is what they're saying now, that I'm paranoid schizophrenic. (G., Patient, 39)

> Interviewer: What's your diagnosis?
>
> H. (Patient, 49): Paranoid schizophrenia. That was the first thing but I reckon it's changed now.
>
> Interviewer: What's it changed to?
>
> H.: A mental attitude.

It is possible to interpret many patients' demonstrated lack of understanding as a further feature of their resistance to acknowledge this diagnosis as valid.

Overall, patients' accounts demonstrated that mental illness may be denied in a variety of ways, and that this often represents an attempt to maintain a masculine identity.

The Nature of Hospitalisation

In describing the nature of being diagnosed with a mental illness, regardless of their acceptance or rejection of this, those interviewed in the hospital setting all reflected on the nature of being a patient in a secure institution. Many were detained following the application of a Compulsion Order, or a Compulsion Order with Restriction Order (CORO) where they were deemed to pose a particular risk to the public. While these measures are outlined in greater detail in Chapter 3 of this thesis, it is important to note here that these orders allow for detention in hospital for the purpose of treatment for an indefinite amount of time. As a result of this, patients' reflections here largely focussed on the indeterminate nature of their time as an inpatient, and the pains they described here were related to the length of stay and security they experienced, or the 'depth' of hospitalisation.

Patients' accounts implied that indefinite hospitalisation led to feelings of confusion. One highlighted that the indeterminate nature of his time in hospital left him uncertain about the future and his progression within the forensic mental health service. The depth of hospitalisation is increasingly problematic in this sense, as there is no definite distance from release:

> It is a bit in limbo… It's hard for me to sort of really see how long that piece of string is. (E., Patient, 49)

This was experienced as frustrating by many patients, and one went so far as to assert that owing to this lack of clarity he would prefer to be in prison:

> At least in prison you know when you're gettin' out, you don't know when you're gettin' out in a hospital. (D., Patient, 49)

Other patients suggested that the indefinite term of inpatient care is particularly difficult to adjust to at the time of admission, and contributes to the problematic nature of this period. One noted that, as he had no expectation of when he would be discharged, this led him to feel depressed:

> When I was first in, because I had so much time before I was going to get out, I didn't know [when], it was a problem, it was depressing me. (C., Patient, 34)

Overall, it appears that the indefinite duration of time as an inpatient in the secure hospital is a very difficult aspect of hospitalisation for these patients, and enhances the pain of depth. The final quote here suggests that when faced with this long stretch of time, patients may find it difficult to adopt a positive attitude to their inpatient status, combining the pains of depth and weight.

1.2. Prisoners' Identities: Being a 'Lifer'

As all of the interviewed prisoners were serving life sentences following a murder conviction, when reflecting on imprisonment they described the distinctive experience of being a 'lifer'. Their accounts again made reference to the pains of imprisonment, and were structured around three key aspects of this: the unique nature of a life sentence and the particular challenges of this; survival of a life sentence, in relation to behaviours which help or hinder this; and the challenges posed by forming and maintaining relationships with others in this context.

Prisoners all appeared to have adopted the lifer label and commented openly on their experiences. This section will demonstrate that lifer identity reinforces and amplifies traditional masculine identities. The accounts of the nature of long term imprisonment here are a reflection of the harsh and traumatic nature of this setting, and both the 'depth' and 'weight' of this experience.

It should be noted that these assertions refer specifically to the interviewed sample, all of whom were convicted of homicide offences where other males were the victims. Others serving indeterminate sentences for offences against children or the elderly, or for sexual offences, may already be perceived by themselves and others as having deviated somewhat from traditional masculine identities due to the stigma associated with such offences. This is particularly true in a prison setting where, as will be demonstrated later here, enhanced stigma is attached to such behaviours. Therefore, comments on the lifer identity here refer to those convicted of killing

other males, and the experiences of these other offenders in relation to masculine identity is perhaps an avenue for further research.

Nature of a Life Sentence

In describing their experiences of prison, prisoners described the unique nature of a life sentence. Their accounts often focussed on the length of the custodial element of this type of sentence, or the pain of depth which they experienced. They illustrated that while a life sentence has a set custodial tariff, the amount of time a spent in prison may be longer if a prisoner is recalled for a breach of their license conditions:

> I done 11 and a half year of my lifer… I got out, and I was out for 3 months and got caught with a knife, and I've been in ever since. (N., Prisoner, 36)
>
> Just from failing a drug test in the jail, I got 16 months (N., Prisoner, 36)

For this prisoner, persistent drug use was a barrier to his progression out of the secure setting. These breaches of license and failure to adhere to the regulations in a semi open prison resulted in an additional 8 years of incarceration, and what was described as an almost indefinite sentence length:

> Since that's been done I've just been comin' back and forward between here and semi-open. (N., Prisoner, 36)

Another prisoner described more serious incidents in the prison which led to additional sentences being added to his original life sentence:

> It's a 13 year tariff I've done, and that's done. I'm now startin' a 7 and a half year sentence for tyin' two reliance guys up and lockin' them in the cubicle in their van and escapin' for a day. And I got 3 years consec' for attempt' murder on a beast, a guy that had done sex offences. I got 8 year for takin' two nurses hostage. (M., Prisoner, 39)

While prisoners facing shorter sentences often complete their custodial term in one prison, the nature of a life sentence increases the likelihood of prisoners being moved around. Several prisoners also recounted spending their sentences across a variety of institutions:

> I've been in a lot of prisons, my sentence started in England, I started off in England. I've been in Gartree, Parkhurst, Belmarsh, Norwich, Canterbury… It's just their system. (Q., Prisoner, 61)

> I've done two sentences, this sentence I've been in Shotts and Kilmarnock and I've been in the YOs at Polmont and that. (K., Prisoner, 35)

In some instances, prisoners described lengthy institutional histories dating back to childhood. For many a life sentence was a further addition to an already significant amount of time spent in secure settings, whether these were prisons or institutions for children:

> R. (Prisoner, 28): I was in residential schools from when I was 12 to when I was 16, I got out, I got a sentence, I got out, I come back to Scotland, and then I got this. So I've only been out 18 months from when I was 12.
>
> Interviewer: Did you not have much time out then, for your teenage years?
>
> R.: It's all been spent in places like this.

> I went to borstal. I came here when I was 16, detention… then I went to borstal from here. (Q., Prisoner, 61)

In light of the length of time in prison denoted by a life sentence, which may add to already substantial institutional histories, it follows that this experience was described by prisoners as emotionally overwhelming. Again, the pains of depth and weight appear to combine here, and the initial phase of the life sentence is posited a one of the most challenging periods of the custodial tariff:

> K. (Prisoner, 35): I was seeing Dr. Smith for a wee bit…At the start of the sentence I was findin' things hard wi' the life sentence, I started takin' drugs and things like that, I just started losin' control...
>
> Interviewer: Why do you think it was so hard at the start?
>
> K.: Just tryin' tae get used to your life sentence and that. You see no end of it… You don't see a light at the end of the tunnel.

> When you're looking at a long time and you've got a big number in your head, there's not a thing you can do, you're angry, everybody else is to blame, know what I mean. It's hard. (L., Prisoner, 31)

Prisoners suggested that the emotional weight of imprisonment is felt strongly during other periods of the life sentence, such as the context of frustration with other prisoners and bereavement. This is particularly difficult to handle in the prison environment where it is not possible to have time alone to deal with these feelings. One prisoner described being so emotionally overwhelmed that he purposefully sought to be segregated so as to ensure a period of time away from other prisoners:

> You're in there with 40 people and you're no always gonnae get on. Sometimes you don't need to say anythin', you just wake up in the mornin' in a mood. The majority of us know – you know when that mood's coming on – so you try just to avoid people. (L., Prisoner, 31)

> My dad died a couple of years ago and I don't know if I had time to grieve about it, I think about a month ago it just hit me… I just felt as if everything was on top of me with everything outside. I went to speak to the manager and explain, and says was there any chance of getting a couple of days out down in segregation. And she knocked us back eh. I ended up smashing a telly in the section so I could go down. That was the only way I could deal with it because they wouldn't let me have the time out. (P., Prisoner, 34)

Overall, accounts indicate that the nature of a life sentence is a particular challenge facing prisoners, and the pains of depth and weight are strongly felt throughout.

Survival

In light of the pains associated with the life sentence, prisoners described a need to 'survive' (Cohen and Taylor, 1972). Comments here focussed on activities which help or hinder survival and the navigation of these pains, and were illustrative of the harsh and punishing nature of the prison experienced outlined in Chapter 3. Overall, this notion is a masculine one, and prisoners' accounts serve to cast the lifer identity as one of great strength and courage in the face of what is understood as an extreme challenge.

Accounts suggested that survival was achieved in various ways, and prisoners often took an active approach, filling their time with meaningful activities. Having a structured and full routine made it easier for some to endure the lengthy sentence:

> My first instinct was to survive the 12 year life sentence – I had to switch my head around and stay with a routine. I go to the gym 2 or 3 times a day. And just do my education, I've

> done quite a bit of open university… So basically, I've got a set routine and I stick to that all the time and that's what gets me through. (P., Prisoner, 34)

Physical activity was a common means of filling time, with several prisoners stating that they regularly used exercise facilities within the prison. As well as passing time, these activities are a means of marking time through changes and improvements in physical appearance (Cohen and Taylor, 1972: 95). One prisoner's comments evidenced his focus on this:

> Interviewer: Yeah, you're a big guy, do you go to the gym a lot in here?
>
> R. (Prisoner, 28): Aye, and this is me lost weight, you shoulda' seen me before.

The same prisoner suggested that in addition to the obvious physical benefits of such activity, camaraderie among groups of men who share similar interests is a further positive aspect of exercise:

> There's me, and my big pal, all of us that sit together, we're all big boys… You've got your gym heads that'll just go to the PT all the time, it's all different little groups of guys that you've got in jail. (R., Prisoner, 28)

Rather than surviving in this active sense, other prisoners employed alternative methods such as drug use as a means of coping with a long term custodial sentence. Drug use served a retreatist function in the prison setting, as its effects prevented prisoners from dwelling on their current situation and facing the pains of imprisonment:

> Taking drugs is just to make it easier for yourself. It stops you even having to think about it. (L., Prisoner, 31)

By some, drug use was seen as a problematic approach to survival, due to the implications this has for an individual's health. One prisoner suggested that resorting to drug use represented weakness and a lack of the mental fortitude necessary for survival:

> Part of doing a big sentence, if you're strong minded you'll get through it. If you're weak minded you'll not get through to the end of the sentence. You get guys who come in and start

> taking drugs and all that, and that's just a way of ending your life quicker isn't it? So, that that's weak minded. (R., Prisoner, 28)

Overall, it is suggested that mental strength and the ability to adapt to the difficult nature of the life sentence is vital for survival. There are connotations of masculinity here, as the issues of fortitude and endurance referred to here are particular features of traditional masculine identities (David and Brannon, 1976: 12).

Whatever approach prisoners took to surviving a long sentence, this was perceived as an individual task. This sense of autonomy and self reliance further contributes to the masculinity of the lifer persona. Several communicated that in surviving a long sentence it is important to place your own wellbeing as your primary concern. It was vital to avoid entanglement in other prisoners' 'troubles', as this had negative consequences which could jeopardise survival:

> I just try and avoid it all really, it's easy really to get into trouble if you're out and about. There's always something happening, so I just try and keep myself away from it. (K., Prisoner, 35)

It is for such reasons that long term prisoners in particular suggest that they must 'look out for number one'. In some instances, the implications of association with such issues can be severe, with one prisoner describing a physical attack as a result of helping a friend with a problem:

> K. (Prisoner, 35): I was up at education and these two lads, one of them stabbed me three times in the back and one in the side.
>
> Interviewer: So what was the reason for that?
>
> K.: I don't really know… it could be somethin' to do wi' my last cellmate. He got himself into a lot of debt wi' drugs, he was movin' on and a lot of people came into the cell and they were going to give him a beating. So I said I'd sort it out, but he hadn't told me how much he owed…. People came lookin' for him, all sayin' 'he owed me £300' and I was like 'fuck that I'm no paying it'.
>
> Interviewer: So is that an example of how you can get involved?
>
> K.: Aye, because I just done him a favour and it backfired on me.

In addition to avoiding the problems of other prisoners, interviewees suggested that attachments outside the prison may also have negative implications for survival.

Relationships with women were highlighted as problematic, acting as barriers to survival, as imprisonment brings about the physical separation of intimate partners causing frustration and anxiety:

> You're better off no havin' a girlfriend when you have a life sentence, because it's hard enough. (K., Prisoner, 35)

In this context, perceptions of sexual infidelity were seen to be particularly troubling for prisoners:

> You get guys lyin' in here thinkin' about what they're doin' outside. (K., Prisoner, 35)

> You see that many people sittin' in here like that 'what's she doin'?'. They're on the phone first thing tryin' tae catch the boyfriend and see if she's sleepin' wi' someone and all that. It messes with your head, comin' off the phone smashin' stuff up, all paranoid thinkin' she's cheatin' on them and all that. I couldnae stand it. (L., Prisoner, 31)

These excerpts provide a variety of insights into prisoners' impressions of intimate relationships. First, it appears that prisoners believe that females are likely to be unfaithful while their male partners are in prison. Second, worrying about this – as opposed to other numerous difficulties surrounding separation from an intimate partner – appears to be the most distressing aspect of continuing a relationship while in prison. The idea of showing emotion in relation to female partners is understood to be negative, possibly because this represents the 'sissy stuff' which males should avoid if they aim to present a truly masculine identity (David and Brannon, 1976: 12). Third, it indicates that for some prisoners, relationships with women are not perceived to be worth enduring this anxiety. Thus, prisoners' comments illustrate again that for those serving a life sentence, survival in prison is an individual task.

Maintaining Relationships

For most prisoners, a key part of survival was 'going it alone', as they perceived relationships to be a hindrance to this task. However, even where prisoners did seek to maintain relationships with others this was difficult in the context of a life sentence, and isolation appeared to be a significant feature of the pains of imprisonment (Cohen and Taylor, 1972: 67).

While friendships were a source of unwanted aggravation for some prisoners, others described attempts to form bonds with other prisoners. These were often difficult to maintain in the context of a life sentence:

> I've had that many friends that move on. And what lifers say is 'it's like ships in the night', they're there and then they're not. And you don't really keep in contact with people outside… In 16 years I've never stayed in touch with anybody and I've met a lot of friends. (Q., Prisoner, 61)

Due to the length of a life sentence, where lifers did form friendships, it proved difficult to sustain these as other prisoners were released after shorter periods of time. For many, adjusting to the loss of this relationship was particularly upsetting, and it was accordingly not seen to be worth forming such relationships. As with female partners, it appears that the emotions and vulnerability which stemmed from these relationships were undesirable for those adopting a masculine lifer identity:

> L. (Prisoner, 31): Don't get me wrong, you don't sit with people because they're doing lifers, but you tend to gravitate towards each other. I wouldn't go and sit with somebody that's only in for 6 months. I'll maybe say 'alright' and that, but I'm not going to become best pals, because you'll probably never see them again.
>
> Interviewer: Is it hard if you make friends with someone and they leave?
>
> L.: Aye, it devastates you. When you're a lifer… if you're best pals with someone and then they go it devastates you.

Prisoners face similar problems in attempting to maintain existing relationships with family members outside prison:

> Sometimes you feel a little bit helpless. Like my granddad's got Alzheimer's, my nana's took a stroke. There's nothing I can do for them, I'm helpless. (R., Prisoner, 28)
>
> With me getting this long sentence a long time ago I didn't bring [my children] up. So they're not used to me being there. (Q., Prisoner, 61)

Their accounts largely suggested that while it is important to remain in contact with family while serving a life sentence, it is often difficult to find common ground for conversation. One prisoner emphasised that differences between life in prison and life in the community quickly become apparent:

> You get visits and you ask what's happening and they say nothing. They don't want to tell you because they're no wanting to upset you or don't want to make you jealous. So it's kind of hard, they ask me what's happening in the prison and I say nothing, because I'm not wanting to worry them or let them know what happens in prison. (Q., Prisoner, 61)

At times, these stark variations between prisoners' own experiences and those of their family members can be a source of frustration, as everyday problems are perceived to be banal:

> They all talk about their problems and that and I can't relate to it, they'll say they've been decorating the back room or whatever, you feel like just saying 'shut the fuck up, it doesn't even matter', but that's a big thing for them, you know. (L., Prisoner, 31)

Again, prisoners sought to avoid this and survive the life sentence alone, sacrificing close family relationships in the interests of self preservation:

> And as time goes on that slowly – not through their part but through your own part, because to survive in here you can't have all the everyday problems, because every time I talk to my mum there's problems – you gradually pull away from that to survive. (P., Prisoner, 34)

> There's only a couple of people that visit me and that's the way I like it… [My children] don't want to visit me because they don't like visiting. I've got nothing to say to them anyway. (Q., Prisoner, 61)

It was previously stated that many prisoners often ended with female partners at the start of their life sentence. Where they attempted to maintain these relationships in prison, this was problematic as it is not possible to maintain the levels of intimacy that were present in the community:

> In this prison they've got the policy it's one kiss when you come in the place and one kiss when you go out the place. And if you try and hold your wife's hand over the table… Fair enough a lot of guys would abuse that, but a lot of genuine guys and their missus are trying to keep that relationship there, and you're kind of separated. (T., Prisoner, 45)

Overall, prisoners' accounts of life sentences in prison suggest that it is particularly difficult to maintain relationships in this context. Friendships, relationships with families, and with intimate partners are all under pressure, and the emotions they entail threaten masculine identities. Prisoners therefore allow these relationships to fail or refrain from forming bonds with others..

1.3. Conclusions on Institutional Identities

Similarities and differences emerged in patients' accounts of being mentally ill and prisoners' accounts of being lifers. Both groups noted that patient and prisoner identities are fraught with the pains of the process of institutionalisation. Patients' comments reflected the nurturing nature of hospitalisation suggested in the literature outlining policy and practices in this setting which was reviewed in Chapter 3, yet also highlighted some of the problems faced by individuals in this setting which were suggested in the literature outlining service users' experiences of hospitalisation. Meanwhile, comments regarding imprisonment were very much in line with previous studies of the prison experience reviewed in Chapter 3, which describe the harsh psychological implications of the process of imprisonment. Patients and prisoners reacted differently to these challenges to identity, but ultimately their responses demonstrated the implications of hospitalisation and imprisonment for masculine identity.

Patients' accountss demonstrated that while many acknowledge that they suffer from mental illness and address these challenges accordingly, others deny any experience of mental illness. Explanations for this denial can be understood through the implications that acceptance of mental illness has for patients' masculine identities. For those who acknowledge mental illness, this acceptance translates into the adoption of characteristics such as vulnerability, emotional instability, and an inability to meet one's own needs, which contravene traditional masculine personas. Thus, attempts to deny mental illness can be understood as actions to avoid this label and protect the masculine identity. This begs us to consider, given the suggested importance of a masculine identity and the efforts to establish such a persona which were outlined in the previous chapters, why all patients did not attempt to deny mental illness and retain this identity. Or rather, we are pushed to consider why some patients sacrificed this persona and accepted mental illness. It is possible that this is associated with issues of change and recovery which are outlined later in this thesis. It will be highlighted that some patients perceived themselves to have gained 'insight' into their mental illness, which is described as both a recognition of the

problem of illness and a desire to change and recover. Acceptance of hospitalisation and illness is a significant part of this process. Therefore it may be the case that those patients who recognise and accept mental illness in spite of masculinity do so as part of a process of engaging actively in their own recovery, while those who do not cling to masculinity and may also lack such an insight.

Conversely, prisoners' accounts suggested that the challenges associated with being a lifer reinforce traditional masculine identities. A life sentence was described as a challenge of mental and emotional fortitude, which must be survived and endured, largely through self-reliance. In this sense, the identity of the lifer is a hyper-masculine portrait of a man facing the ultimate challenge and responding to this with strength and courage.

Thus, while being mentally ill can be seen to weaken patients' masculine identities, being a lifer strengthens prisoners' masculine persona.

2. ADAPTATION TO INSTITUTIONALISATION

It has been demonstrated that patients and prisoners must manage the new identities attached to them through institutionalisation. In addition, both groups must also adjust to the regimes within the hospital and the prison. This section will demonstrate that patients' and prisoners' adaptation to institutional life is shaped by their responses to these labels, as well as the nature of the institution itself.

Thus far, the two key pains of institutionalisation, depth and weight, have been described in relation to patients' and prisoners' experiences (King and McDermott, 1995). More recently, Crewe (2009, 2011) advanced a third notion of 'tightness' as a pain of imprisonment. He posits that this is a feeling of suffocation within the institution, as a result of 'pressured rehabilitation', which forces prisoners to self-regulate conduct and to work at rather than endure long term confinement (Crewe, 2011: 522-523). In describing their adaptations to the institutional regime, patients'

and prisoners' comments illustrated their responses to the specific pains in their settings. For both groups, adaptation takes two forms: compliance and rebellion.

It will be argued that the tightness of the hospital setting serves to effect compliance from patients, as well as posing a threat to masculine identities. Therefore, rebellion in this setting can be understood as an attempt to challenge this tightness and retain a masculine identity. In prison tightness is a less pronounced pain with accounts focussing more on depth and weight, and a level of compliance and engagement being ensured through the strict nature of the institution. Where rebellion did occur in this setting, it took more concealed forms between prisoners, and reinforced masculine power.

2.1. Compliance and Rebellion: Adaptation to Life in Hospital

Thus far it has been proposed that the application of the patient label is met by acceptance or rejection of mental illness. This section will demonstrate that these issues of identity impact upon patients' willingness to embrace institutional life, as their responses to the mentally ill identity are mirrored in their adaptations to the hospital regime. Patients adapted in two key ways: compliance with and rebellion against the institutional regime.

Compliance

For patients who accepted mental illness, adaptation took the form of compliance through engagement with the therapeutic activities on offer in this setting. It will be argued that the institution effects such compliance through 'tightness', and ultimately this process 'infantilises' patients. To comply with hospitalisation is therefore a diversion from traditional masculinities.

Compliance entailed participation in a care oriented programme of recovery which addresses a variety of needs, and is implemented by a multi-disciplinary team. Patients were involved in creating this routine, and were able to participate in a wide

range of therapeutic recreational activities. The result was a care and treatment plan which was individually tailored to suit the needs and interests of the patient in question. As such, the somewhat recovery orientated hospital regime outlined in Chapter 3 was evidenced here. Several patients described particularly full and active lives in hospital:

> I do different things so there's not an average day really – but I tend to keep active exercise wise. I do a bit of running, I play football… I've been doing a bit of art once a week… I was doing quite a bit of music, just messing about with different instruments. I do quite a bit of reading, I keep in touch with my folks back home… Hopefully I'm going to get into a bit of cooking once a week. And I do a few courses at the moment, evening classes in business. (E., Patient, 49)

Although patients were encouraged to engage in these activities in the interests of passing time and as rehabilitative endeavours, participation was not compulsory. Patients were aware that it was up to them to engage with the regime, and an element of responsibilisation was demonstrated in their comments here:

> You've got to take the onus on yourself to get yourself up in the morning, get washed and shaved, do activities in general, like it's in your hands. (F., Patient, 32)

As compliance with the institutional regime was optional, engaging in this way was understood as 'making the most' of their present situation:

> I like to try to get as much quality as I can in a place, if you know what I mean. (A., Patient, 54)

The flexible nature of day to day activities in the medium secure environment was appreciated by patients. They described it as a nurturing environment, with one patient suggesting a conscious participation in the process and an awareness of the institution's orientation:

> You can get involved in things when you want and how you want. You're living a more normal life and that's the best way, it relieves a lot of the tension. (E., Patient, 49)

> It's kind of like you shape your own destiny here because the onus is on you, because they're so recovery focussed here. (F., Patient, 32)

Thus far, it has been demonstrated that routines and therapeutic activities were highly individualised. In a similar vein, patients noted that the decision to grant particular freedoms and benefits was based on individual assessments. This reflects the concerns of risk which often drive practice in this setting. While on the surface there is flexibility in the decision to comply, there was a pervasive undercurrent of tightness as patients were aware of this scrutiny from various angles:

> They do individual self assessments for people and they say 'Right okay, this can happen and that can happen, you can have a laptop'… It's like 'We'll investigate it and we'll come back to you and see what's the best way. (F., Patient, 32)

It is this process of subtle coercion which serves to infantilise patients, as their actions are guided by concerns of gaining permissions from staff members who adopt roles not unlike those of parents. For example, one patient's account highlighted that in this context of assessment and monitoring, privileges were understood to be earned. He suggested that that if he took it upon himself to demonstrate his engagement then these privileges would continue. The situation he described also conflicted with features of masculine identities such as autonomy and self reliance:

> It's just like bein' in here, you take advantage of what you have, like privileges and things like that. Like, you can go away on passes and that and you get out yoursel' and you go tae town and you go tae the pictures and that. It's like you try your best. (A., Patient, 54)

The 'passes' referred to in the above extract – time out of the locked hospital building, either in the grounds or in the local community – were particularly understood as privileges in this way. Another patient emphasised the importance of gaining the permission of staff for such freedoms, even where this was limited to 15 minutes outdoors:

> They're trusting me to go out 15 minutes a day on my own. (H., Patient, 49)

Overall, these accounts suggested that individual compliance was in patients' interests in the medium secure facility where this coul lead to increased freedom out-with the hospital. The feelings of tightness this created among patients gently coerced them to comply. In doing so, professionals cast patients in childlike roles.

This sense of having to earn trust and freedom again conflicts with masculine identities, which traditionally would be characterised by self-determination. The same patient highlighted that while he was encouraged to engage with the regime, this pressure to comply was not infallible and other patients did elect not to engage:

> Some guys just prefer to sleep all day and sit on the ward. (A., Patient, 54)

In spite of the pains of tightness demonstrated in the above comments, interviewees' present medium secure inpatient setting was experienced as preferable to high secure conditions. Those who had previously been treated in the high secure environment of the State Hospital described the institution as oppressive. Their accounts focussed on two key aspects related to depth rather than tightness: the structures which secure the hospital, and the strict institutional routine. It was understood to be reminiscent of prison:

> You had to do everything you were told to do… If you have to work to work they make sure you're out to work, you can't just ay 'Oh I'm not well'. Basically there's a fence around it as well so you feel locked in... I'd say it's more of a punishment being in Carstairs, it's a wee bit like the jail. (B., Patient, 43)

> In any sort of institution like the State Hospital – which is a hospital, but it has to inevitably run a bit like a prison because it's high security – there's stresses and pressures and frustrations inevitably, that's just the way these places are. (E., Patient, 49)

In summation, for those who accepted mental illness and sought to comply, the medium secure hospital offered a variety of activities tailored to the needs of the individual patient. Yet assessment and permissions were a key feature of hospital life. This tightness served to effect compliance among patients, which poses a threat to masculine identities. Nevertheless, the medium secure hospital was experienced as preferable to the high secure hospital.

Rebellion

Patients who denied mental illness were unlikely to engage with treatment and management regimes. Such poor engagement hinders the likelihood of successfully

preventing future violence (Elbogen et al., 2006). Violence served as a further means of rebellion within this setting, with patients behaving violently towards staff members. These responses were attempts to avoid the tightness of the institution and the infantilisation process, and to cling to pre-institutional masculine identities.

Rebellion involved a general lack of engagement with the treatment and therapeutic activities on offer in this setting. Such an approach to inpatient life tended to be synonymous with a generally negative view of the institution and was common among those who did not believe that they were unwell, and accordingly did not perceive their hospitalisation to be legitimate. It may also represent an attempt to avoid the challenge to masculinity posed by compliance:

> There's no much to do. I sit and play games, or you can go to a group. It's a long borin' day it is, eh? (G., Patient, 39)

> Interviewer: Is there anything you think is good about it?
>
> D. (Patient, 49): Not really, no. It's not a life, you're best being out of the hospital, in the community.

As these patients did not engage with treatment, they tended not to take advantage of freedoms available in the hospital or earn privileges like other patients. Yet assessments which determine freedoms such as escorted pass give much consideration to the risk posed by the patient and their level of illness. Therefore, while these patients fail to demonstrate the level of engagement deemed necessary for certain freedoms, it may also be the case that they are simply too unwell or pose too high a risk to be granted these liberties, which in turn may contribute to the lack of insight these patients demonstrate.

Traditionally, violence is a means of rebelling in institutions, and some patients provided accounts of such incidents in hospital. Due to the closed nature of this environment, victims tended to be other patients or hospital staff. Patients suggested that this was not frequent and appeared reluctant to discuss these scenarios. While 5 of the interviewed patients' clinical notes indicated that they had behaved violently in institutional settings, only 2 described perpetrating violent acts in hospital. A few

patients gave accounts of victimisation. Where violence did take place and patients victimised fellow patients this was generally accepted as a product of the volatility which often characterises mental illness and its symptoms:

> When I went into the State Hospital there was a guy - he was quite unwell - he sort of attacked me a couple of times… I think it was just unfortunate that I was there at that time, you know. (E., Patient, 49)

> He's [the patient who attacked me] just no well, he just attacks people all the time, and it was just oot ae the blue, he just instantly like, *whoosh* tryin' tae throw punches. (A., Patient,54)

In this sense, it is difficult to suggest that violence between patients represents a form of rebellion against the secure hospital. Rather, it is understood as a result of the close proximity of acutely unwell and volatile individuals in this setting. This may explain the lack of retaliation to violence, as by excusing challenges from cohabiting males as products of mental illness, there is less pressure to respond to these as legitimate threats to masculine identity.

In a further two incidents of violence perpetration described by patients, the victims were clinical staff members. Both incidents occurred in the context of patients' unhappiness with institutional management. Violence was employed as a response to this situation, and can therefore be understood as rebellion:

> G. (Patient, 39): It just aboot came tae a head. All ae the inmates and that, all the patients faced up tae the staff. They didn't run it too well and there was a bad atmosphere.
>
> Interviewer: Okay, so what was the background to that?
>
> G.: They were pinnin' folk doon and injectin' them eh?
>
> Interviewer: So that was the restraint procedures, you weren't happy with them?
>
> G.: Aye.

A particular aspect of hospital practice which comments suggested provoked much violence were restraint and emergency medication procedures described here. As outlined in Chapter 3, this involves staff members manually restraining an individual and administering medication via injection (Davidson, 2005). Research suggests that patients find such experiences distressing and controlling (Macpherson, Dix and Morgan, 2005). Although it is often necessary in the instance that a patient poses a

risk to the safety of themselves or others, it is likely to be experienced as an act of hard power which creates pains of depth and weight. Restraint procedures threaten masculine identity, as they involve complete physical domination of the patient, and it is to be expected that violence should be employed as a resource in responding to this situation. This was confirmed in the accounts of patients in this study, who expressed a sense of injustice in relation to these procedures:

> They said 'we're going to inject you, we're going to do it', it wasn't 'you can have it if you want', it was 'we're going to do it', and that's why I went against them. (H., Patient, 49)

Violence in hospital therefore appears to be a means of regaining the independence and control which is denied to them, and which are integral to masculine image. In this sense, violence towards staff members within this context can be understood as rebellion.

Overall, it appears that while rebellion against the tightness of the regime may take more passive forms, such as disengagement, rebellion against more obvious pains of depth and weight is often violent. In both instances, rebellion also serves to reaffirm masculine identity.

2.2. Compliance and Rebellion: Life in Prison

It has been posited here thus far that prisoners adopted a hyper-masculine lifer identity within the institution. This also impacted upon their responses to institutional life. This section will detail how prisoners adapted to this setting, and will demonstrate how this identity and the nature of the prison itself shaped this adaptation. It will be demonstrated that compliance and rebellion were the key responses to life in prison.

Compliance

Compliance in prison occurred in two key ways. First, some prisoners complied willingly with the institutional regime, through engagement with the activities on

offer in this setting. Additionally, all prisoners were forced to comply with the strict routine in this setting, which involved a rigidly enforced timetable and was characterised by extreme security. Accounts here reflected the nature of the regime, as while some rehabilitative measures were available, overall the harsh punitive nature of prison prevailed. This further reinforced the masculine lifer identity, as the hard power of this setting enhanced the pains of depth and weight.

Compliance was generally acted out through involvement in the various rehabilitative activities within the prison. These were understood as a constructive means of passing time and surviving the life sentence:

> I've taught myself to read and write since I come in here. And I'm a fully qualified personal trainer, I've done my level 3 gym instructor's qualification, so I've used this place to my advantage a little bit and I've got a few qualifications out of it. (R., Prisoner, 28)

It was stressed that that these activities were optional, and it was prisoners' own responsibility to become involved. Compliance in this way was again understood as making the most of their present situation. This compliance was not a threat to masculinity, as it did not involve a loss of autonomy, and was instead a demonstration of fortitude and survival. One prisoner highlighted that it was possible not to participate in education or work:

> You pick what you do really, there's hundreds of other jobs, I'm just waiting to progress so I'm taking it easy. (L., Prisoner, 31)

It is significant that prisoners' accounts in this area did not suggest the experience of tightness implied in patients' comments. The pressure to comply through engagement in the institutional regime in order to proceed to lower security settings did not appear to be present to the same extent in prison. Particularly in relation to work, it was asserted that such activities are optional:

> I was on the pass for a wee while but I jacked that in. (O., Prisoner, 45)

This conflicts with existing literature which indicates that a sense of tightness is present in the contemporary prison environment (Crewe, 2009, 2011). Given the

monitoring which characterises the process of release from prison for the lifer population, as outlined in Chapter , it would be expected that this group in particular would be compelled to engage with the institutional regime in this sense. In notable contrast with this were comments on psychological activities, which appeared to be more compulsory in relation to the process of release, giving support to Crewe's (2009, 2011) account of tightness:

> They do psychology courses, one to one psychology before they'll move you on. (P., Prisoner, 61)

Overall, prisoners made little specific reference to more subtle forms of power such as monitoring in relation to the release process which may lead them to comply. Instead they referred more to the more obvious security and routine in the prison setting as problematic.

Even where prisoners did not illustrate compliance with the prison regime in the sense that they participated in work or education, they were nevertheless subjected to the rigid daily structure in place in this setting. One prisoner described adhering to this routine, in spite of his lack of structured activity:

> Routine… You get opened up, talk to other prisoners or lie and watch the television, then you get locked up, get your dinner, get locked up… So it's mundane. (Q., Prisoner, 61)

In this sense, the strict routine of the prison ensures compliance in terms of their adherence to a daily structure, which applies uniformly to all prisoners. Such a lack of freedom is in conflict with key features of masculine identity such as power and strength, and it is unsurprising that this was experienced as particularly difficult by males. This was true in relation to the hours they spent locked in cells. One prisoner described the rigidity of this aspect of prison life, in spite of his engagement with activities available in this setting:

> We shut up at 9, like locking up time you mean, we're back [from work] at half 6 and we're locked up at half past 9. That's us in our cells until the morning and it's just basically the same routine every day. Nothing really varies or changes. (T., Prisoner, 45)

Ultimately, this rigid and controlling routine leaves no option other than compliance. The depth of imprisonment was felt here by prisoners, as the security of the institution and a long stretch of time spent in this regime is one of the difficulties of prison life. Several described the monotony of their routine, suggesting that this also has a psychological impact and creates pains of weight:

> Jail's like groundhog day, like that film, that's what it is, wake up, do the same thing, go to sleep, wake up, do the same thing. (R., Prisoner, 28)
>
> After 16 years it's all the same thing. (Q., Prisoner, 61):

Overall, compliance in prison varies among prisoners. For some prisoners, compliance includes institutional activities as a positive way of passing time, while others choose not to engage. However, compliance is still elicited from these individuals, as all prisoners are subject to the rigid structure of daily life in the prison environment.

Rebellion

In prison no overt rebellion against the established hard power of the regime was described, suggesting an awareness of the established authoritarian power of the institution. Rebellion instead took more subtle forms, as the large scale of the prison appeared to present more scope for such disobedience, making it easier to conduct these activities in more covert ways. These included drug use and violence between prisoners. Both of these activities reinforced traditional masculine identities, as they allowed prisoners to take control of their lives in prison.

In the prison setting violence was described as a fairly common occurrence. In contrast to patients' accounts, prisoners recounted no violence towards staff members. This is likely to stem from a reluctance to openly challenge the power of this institution. Instead, violence occurred between prisoners and was largely trivial. This mirrors violence in the community taking confrontational forms, with small challenges to masculinity escalating into violent altercations. Considering the nature

of prison life, with numerous men cohabiting in a small space, it is perhaps unsurprising that tensions occur from time to time:

> Yeah, you get [fights]. Some of the boys usually just talk it out like, and it's all about stupid things you know. Next day you see them all pally and that again. (O., Prisoner, 45)

Other violence recounted by prisoners was more serious. This was true where incidents stemmed from existing grudges between prisoners. These were akin to traditional masculine situations of violence, as violence was employed as a resource for resolving these conflicts and righting perceived wrongs against masculine image. One prisoner described a violent act perpetrated by himself in prison which he perceived as just punishment for the victim's wrong behaviour:

> My co-accused was in that jail as well. So when I landed there… See the one that done the murder, he got told that if he owned up to the murder I would have got out and my other co-accused would have got out. So I skelped him with a claw hammer. (R., Prisoner, 28)

Some accounts of violent incidents suggested that they may have been planned. One altercation took place several years following the initial disagreement. This implies that among prisoners, even where a large amount of time has passed, it was still felt to be necessary to settle grudges through violence. Violence was organised so as to be undetected by prison staff:

> N. (Prisoner 36): Aye, eh well about a month ago… I was in a cell and that's when that happened [points to scar on his face].
>
> Interviewer: And what was that in relation to?
>
> N.: I was here about 4 year ago, and there was a boy in that section there. And him and my friend had had an argument in the hairdressers in here… I shouldnae have gotten involved… And that was about 4 or 5 year ago that happened... Anyway, he's supposed to have paid two guys in that section in there [to attack me]. They shouted us intae a cell about a month ago, like "Aye, what do you think of this?"... As I walked in, it was as if they were pointin' at somethin' they wanted us to look at, I just went to look at the paper, wonderin' what they were talkin' about. And then bang, they grabbed my two arms and he slashed us.

In addition to planning and subversion, another important issue highlighted by this account is the role of weapons in a prison setting. The same prisoner noted the ease with which such items may be obtained in prison, in spite of institutional efforts:

> N. (Prisoner, 36): I seen him pulling a knife out his pocket, a big thing like that [gestures].
>
> Interviewer: How would you get that in here?
>
> N.: Very easy, you can make it in one of the shops. A lot of knives in here are made in the sheds, and the laminators, it's just bits of plastic and all they do is sharpen them up and they can go through the metal detectors. The only way they can catch them in here the now is doin' random searches… They just come in to the hall and they get planted everywhere, so if you want one you can get one.

Overall, it appears that violence is relatively common, and takes place covertly between prisoners rather than involving staff. Whether this occurs in the context of trivial quarrels, or as a means of resolving long standing disagreements, it appears that violence in prison follows traditional cultural scripts of masculinity, supporting the notion that this environment and the lifer identity amplify masculine personas.

Resistance to the prison regime was also demonstrated through prisoners' accounts of drug use. Thus far it has been posited that drugs are a means of escape from the difficult experience of prison life, and the use of drugs, particularly heroin, was cited as common in prison:

> It's quite easy to get drugs in prison if you want. If you want drugs, there's drugs there. (K., Prisoner, 35)

Another prisoner described the measures in place within prison which attempt to address this problem, and posited that drug use is a means of maintaining choice and control in an otherwise restricted existence. Drugs may also serve a rebellious function, allowing prisoners to regain the autonomy which characterised their pre-institutional masculine identities:

> L. (Prisoner, 31): [Staff] just want to get everyone on methadone.
>
> Interviewer: Have you got the option of doing that?
>
> L.: It's a control thing, you know. I don't think I ever would.
>
> Interviewer: Why?
>
> L.: They're on you from when you get up to when you go to bed. You've only got a wee, small bit of control in your life. And I think if you go on methadone you give that last wee bit of control up.

Overall, drugs, as well as violence, appear to be a further means of rejecting and rebelling against the institutional environment. Moreover, these actions are means of protecting and enhancing masculine identities within the context of the prison.

2.3. Conclusions on Adaptation to Institutional Life

Significant similarities and divergences emerged in patients' and prisoners' adaptations to their respective institutional settings, but for both groups adaptation took the form of compliance or rebellion.

In both settings, compliance generally meant engagement with the institutional regime and the activities available. On this surface, this was optional in hospital and in prison. In hospital, a flexible, nurturing approach was evidenced. However, the monitoring and assessment which characterise this setting and govern progression within this system lead to pains of tightness and elicited compliance from patients. In prison this pressure was less pronounced, and engagement was more optional. Nevertheless, prisoners were forced to comply to a certain extent, due to the rigid regime and security in this setting, which created pains of depth and weight for this group. In both settings, the control and pressures to comply, although exerted and experienced in different ways, challenged features of masculine identities such as autonomy and dominance. Overall, while both institutions effected compliance, this was achieved in arguably more subtle ways in the hospital, as demonstrated by interviewees' comments:

> Prison is a lot worse, worse than here [the secure hospital]. Prison is a punishment, hospital is a care area, as you say. They're different things and different types of places for different types of people, for patients and for criminals. (I., Patient, 19)

In light of this, rebellion in these settings also took different forms. In the hospital, rebellion was acted out through confrontation with staff members, often involving violence, in an attempt to regain autonomy and act against the tightness of this setting. Meanwhile, in the prison setting, rebellion took more subtle forms of disobedience which sought to avoid detection by staff, and was commonly manifest in violence between prisoners and drug use. Although carried out in concealed ways,

it was also a means of acting against the controlling nature of this setting. In both institutions, rebellious behaviour protected masculine identities by allowing patients and prisoners to regain a degree of power.

3. INSTITUTIONAL POWER STRUCTURES

Within secure institutions power structures are said to exist. The majority of literature detailing such constructs refers to prisons, and suggests that these consist of various elements including social hierarchies and moral codes (Sykes, 1958; Crewe, 2009). Such structures are grounded in masculinity, as they involve issues of dominance and power and the struggle to achieve these in these settings. This section will detail the power structures at work in the medium secure hospital and the prison. These structures are determined both by the nature of the institutions themselves, and the identities and adaptations of those within.

3.1. Institutional Power Structures in the Secure Hospital

Thus far it has been demonstrated that the secure unit is an institution characterised by tightness, and patients adapt to this accordingly. In light of this power on the part of staff to grant permissions and impose restrictions, it can be said that they are in a position of dominance in this setting. This dominance jeopardises patients' masculinity by placing them in a position of submission and weakness. This section will examine further levels of social and power structures existing in this setting. It will be illustrated that there was little evidence to indicate that established hierarchies or institutional moral codes exist between patients in a medium secure forensic ward. Moreover, their accounts indicated that any existing power structures at this level did not appear to be enforced through violence, and that relationships between patients often diverged from the traditional masculine relationships with peers in the community.

Patients' accounts suggested that they shared some of the views traditionally held by prisoners regarding certain groups within the institution. An example of this was present in one patient's comments on his experiences of interacting with others convicted of sex offences in a high secure setting. Traditionally, in prison sex offenders are a stigmatised group and are victimised by the wider prison population. While the patient shared these negative impressions of sex offenders there was no expectation of violence between this group and other patients, and the two were not segregated from one another in secure psychiatric hospitals as was the case in prison:

> I would call them lowlives, because it's a terrible thing to put a female through or a child through. But there were actually several heavy child paedophiles in my ward and communicating with them on a daily basis didn't really occur to me, you know, I just, like, stayed out of their way and never really bothered them. (F., Patient, 32)

It appears that while patients may have agreed with aspects of the moral code present in prison, it was not enforced in the hospital.

Rather than particular groups of patients acting as the lower levels of patient to patient social hierarchies, accounts suggested that they related to one another as individuals in this context. Particular patients were suggested to be trouble makers, generally as a result of behaviour which was disruptive to the atmosphere within the hospital. These patients had lower social status among their peers, and tended to be those who were particularly unwell, as their volatile behaviour resulted in them being disliked. For example, one interviewee highlighted that the accusations of another patient were regularly frustrating for himself and others on the ward, resulting in him confronting this patient:

> A patient the other night, he was sitting shouting his mouth off at us all that somebody has been in his room slashing his CDs and that. And I'd heard enough of it, pointin' the finger and accusations, and shoutin' what he's goin' to do to people and that, and I says 'Who the hell's going to go into your room and touch your CDs? It's all in your mind.' So I ended up frustrated and saying, because I was listening to him... But sometimes things can frustrate you, Christine, when you're listening to unwell people. (A., Patient, 54)

It is significant that the patient did not respond with violence in this instance, but instead reacted verbally, indicating that social structures were not enforced through violence in this setting. The frustration of living with others who are acutely unwell

appears to be a particular challenge of hospitalisation. Similarly, another patient described organised group action against such a patient rather than employing violence. In this instance, the disruptive behaviours of a patient who was disliked by many others on the ward were reported to staff members formally:

> F. (Patient, 32): It was just a petition that somebody wanted to put together… because people were strongly against the behaviours of this individual patient, and eventually came round to me and asked if I wanted to sign it. And I kind of did agree with what was on the petition, so I said yeah I'll sign it… And I thought it was the right way to go about it, his behaviours were absolutely atrocious, I don't know if you need to know, but things like inappropriate sexual comments about children … we really needed to voice our opinion against this and see if somebody could take action, because complaints had been made to staff but nothing seemed to be getting done…
>
> Interviewer: What happened to the patient, people wanted to get him moved away?
>
> F.: It wasn't really to get him moved away, it was more to really try and correct his behaviour because it was atrocious, the things that he was doing, there was a big long list… But you just have to tolerate it you know, but it's difficult when you're living in such a close environment with guys 24/7 and you've got to put up with bad habits and irrational behaviour. But nothing else came of it.

In this sense, the tightness of the hospital setting shaped social relationships between males, as organised reporting of misdemeanours mirrors the assessment based nature of this institution. This is a divergence from masculine peer relations which characterised patients' pre-institutional lives, in which violence was a means of resolving conflicts. The notion of addressing disputes non-violently in consultation with staff members which is suggested here is also in contrast with accounts of moral codes in prison. Traditionally, prisoners resolve these matters themselves, and individuals who collude with staff members are perceived to be untrustworthy and are known as 'grasses', and accordingly such individuals are in a subordinate position to other prisoners. In hospital involving staff in these incidents was common. For example, one patient described being attacked by another patient, and indicated that rather than responding violently to this incident, he instead restrained the individual until staff members were able to intervene:

> He attacked me, but I beat him, I just got him down and restrained him, I had him in a like a hold until [staff members] came… The staff commended me...said 'well done' and that, for what you done. (A., Patient, 54)

Overall, the social structure outlined here diverges from traditional accounts of institutional power, and signifies a move away from typically masculine peer relations.

3.2. Institutional Power Structures in Prison

Traditional accounts of prison and similar institutions reveal the existence of underlying power structures in these settings (Goffman, 1961; Sykes, 1958). Prisoners' experiences also alluded to these frameworks, reflecting on their own positions within such hierarchies, and the negative consequences of breaking this community's informal social rules. Explanations particularly focussed on the perceived 'moral code' within the prison, which dictates that certain groups of prisoners are subordinate, and that certain behaviours are not tolerated. This section will describe this element of prisoners' stories, and will demonstrate that the institutional power structures in this setting serve to reinforce traditional masculinity.

In terms of the power structures existing between staff and prisoners, accounts indicated that, as would be expected, staff members were understood to be in a position of power in opposition to the prisoners:

> In prison, you've got the officers on one side. (R., Prisoner, 28)

In addition to relations between staff and prisoners, power structures also existed at a prisoner to prisoner level. A key facet of these informal social rules was a lack of tolerance of sex offenders. This group were housed in a separate area of the institution so as to avoid victimisation by mainstream prisoners. Prisoners' accounts demonstrated an extreme dislike of this population, who were characterised as 'beasts':

> Interviewer: What is it about the sex offenders that other prisoners have against them?
>
> L. (Prisoner, 31): Put it this way, lifers are the bottom of the social ladder because we've taken a life and I agree with that. But I've got sisters and that… I wouldn't hit a woman, when I was younger I've been stabbed and slashed by women but I just took it, I didn't do anything back…

Interviewer: So it's from drawing on your own experiences?

L.: We're not just scumbags, we've got our morals. Don't get me wrong, we're as warped and twisted as they come but… [Long pause]

Interviewer: …There's certain things that just aren't appropriate?

L.: Aye.

The above account establishes that even as a group of individuals who have broken societal norms and committed offences, a moral code does exist among prisoners. The actions of sex offenders are perceived as breaching this code of conduct, leading this group to be ostracised by other prisoners. More specifically, the notion of victimising vulnerable groups such as women and children is highlighted as unacceptable. Attaching stigma to such behaviour is in line with traditional masculine identities which promote the protection of these groups:

> It's just their crimes. I mean, to do that to a kid, even a woman, it's just the lowest of the low. In prison, we've got our kinds of rules as well, you know what I mean. You'll know yourself, every community's got their own rules and it's always been the rule – kiddie fiddlers, rapists, it's just liberty taking. (Q., Prisoner, 61)

Prisoners who were perceived to be 'grasses' were viewed with similar disdain. Interviewees' comments highlighted that individuals who informed staff of other prisoners' behaviour, particularly where doing so would result in disciplinary action, were generally disliked. Such behaviour conflicts with masculine ideals, as it signifies an admission of a need for assistance and an inability to resolve ones own conflicts. Consequently, one prisoner recounted an incident of violent victimisation in which he was aware of the identity of his attackers yet he elected not to inform staff members:

Interviewer: So what happened with the people who attacked you?

K. (Prisoner, 35): No, they've not been caught for it or that.

Interviewer: Have you not told anyone who it was?

K.: No I never says who it was.

Similar extracts from another interviewee's story demonstrated a genuine fear of the repercussions should he be labelled a 'grass'. He highlighted that the ramifications of informing staff of such incidents were often extreme, and may include violence:

> Interviewer: Why would you never say?
>
> N. (Prisoner, 36): Because, I can't… Well I'm living my life in here, and grasses aren't well liked, know what I mean?
>
> Interviewer: So if they found out that you had given their names…
>
> N.: It wouldn't look too clever. My family's out there, and my ma' lives herself, my sister lives herself, these guys could maybe get somebody out there to see my family or something, know what I mean? So, I would never put them in that position.

The above quote suggests that the threat of violence may not necessarily be directed at the prisoner himself, but at those close to him. Therefore, the majority of prisoners choose not to 'grass' and tell staff about disorder within the prison. In this sense, adherence to these informal social rules can be understood as another aspect of survival.

In a similar vein, prisoners highlighted that it was not appropriate to intervene in other prisoners' disputes. An interviewee described his experience of intervening in what he initially perceived to be an unfair fight as only one prisoner had a weapon. This intervention turned out to be a grievous error, and resulted in his subsequent victimisation. He explicitly refers to this as a feature of an informally established, commonly respected system of 'jail politics':

> So this wee guy's got [a knife] anyway, and as soon as I've seen that I've ran over, and I've grabbed his arm that he had the knife in… Then I've seen Robert my pal that's in the cell, and he's got a knife, I didn't think the two of them were going to be fighting with knives, I thought it was going to be a square go. So I shouldn't have grabbed this wee guy, I should have just let the two of them get on with it. Jail politics says don't get involved, if it's a square go with knives don't get involved. (N., Prisoner, 36)

As a result of these informal rules which dictate the subordination of particular groups of prisoners, a power structure existed not only between the staff and prisoners, but also at the level of prisoner to prisoner relations. Certain categories of prisoners were positioned as subordinate to others. This traditionally includes

'grasses' and 'beasts', as evidenced thus far, but comments suggested that more generally prisoners who were perceived to be 'weak' also adopted this position in the hierarchy. Accordingly, prisoners sought to develop a tough and dominant masculine image:

> R. (Prisoner, 28): If you let your emotions show it's a weakness in prison. So that's the way I've been brought up anyway, because I've been brought up in places like this.
>
> Interviewer: Do you think that's an image you need to have?
>
> R.: I'd say at the start it was maybe an image, but it's just second nature now. That's the way I am… I'd just say, you have maybe 700 dangerous guys in this jail and maybe 500 of them are criminals, like professional criminals. And everybody's trying to outdo everybody. So you've got to be strong minded, it's just that kind of environment.

Even during periods where prisoners experienced personal problems, it was nevertheless important to maintain a 'brave face':

> When you're in prison and there's deaths and that, you can't deal with it. You've got to show face out there, know what I mean. You show a lot of weakness in the jail and people try and take advantage of it. So, all they kind of feelings, you have to put up a wee barrier to the outside. (T., Prisoner, 45)

Again, integral to this sentiment was the notion that expressing emotions is a form of weakness. Similarly, physical vulnerability and avoidance of conflict was perceived as a weakness. Accounts suggest that that it is essential for prisoners to respond to challenges to masculinity from other prisoners, and that violence was the most effective means of doing so:

> This is the thing, see if someone walked up to me and squared into my face, see if I walked away, then what's to say the next person's not going to come in and go "right, I want your canteen, I want your dinner" know what I mean? So that's why, when that happens I've stopped it right away. (R., Prisoner, 28)

Simply put, showing weakness harms a masculine persona, and results in a low position in the existing institutional power structure.

3.3. Conclusions on Institutional Power

This section has detailed the institutional power structures at work in the medium secure hospital and the prison. It has been highlighted that in both the hospital and

the prison environment, staff members are in dominant positions, while patients and prisoners have subordinate roles.

Power structures within these settings are further complicated by inter-patient and prisoner relationships. Within the hospital, a significant lack of a hierarchy among patients was evidenced, with little violence being described among this group. Instead, patients with lower social status tended to be those who posed a disruption to others, and the tightness of the hospital caused patients to resolve such conflicts in non violent ways. In contrast, prisoners' accounts illustrated an informal power structure in this setting, which was governed by a collectively accepted set of informal social rules and often enforced by violence.

Again, this contrast in power structures can be explained through the differences in masculine identities within this setting. The hierarchies illustrated by prisoners can be understood as a product of the reinforcement of traditional masculine identities within this setting. Conversely, the lack of such structures within the hospital appears to stem from the challenges to hegemonic masculinities which this setting poses, and represents a move away from such identities.

5. CONCLUSIONS

In conclusion, patients' and prisoners' experiences of hospital and prison offer many similarities and divergences. Both groups made comments in relation to 3 areas of their experiences: institutional identities, adaptations to institutional life, and institutional power structures. Their accounts served to illuminate the particular pains – depth, weight and tightness – experienced in these settings, and the varied ways in which men do masculinity in light of this.

Patients' accounts suggested that both experiences of mental illness and hospital posed a threat to the maintenance of a traditional masculine identity. In particular, the connotations of weakness and vulnerability associated with the mentally ill label, as

well as the tightness of this setting jeopardised such personas. As a result, while some patients accepted this to the detriment of their masculinity, others attempted to maintain powerful and masculine images through rejection of mental illness and rebellion within the hospital setting. In light of this, accounts of institutional power structures in this setting reflected this move away from traditional masculinity.

The accounts of prisoners contrasted with this. Their experiences suggested that the lifer identity and its associated qualities of resilience and strength, as well as the authoritarian prison environment, reinforced masculine values and identities. The institutional power structures in this setting therefore reflected traditional masculine values and hierarchies.

Overall, patients' and prisoners' present experiences in the medium secure hospital and the prison were shaped by the nature of these settings, and the effects they had on pre-institutional masculine identities. Ultimately, the secure hospital challenged these personas, while the prison reinforced them.

CHAPTER 8

'THE FUTURE': RECOVERY AND DESISTANCE

A significant proportion of patients' and prisoners' stories focussed on the future. In particular, patients and prisoners referred frequently to issues of recovery and desistance. The interviewed patients were all recovering from mental illness, while both patients and prisoners were desisting from offending. Both recovery and desistance are understood to be enduring and often life-long processes (Anthony, 1993; Jacobson and Greenley, 2001; Maruna, 2001). In this sense, individuals may often never truly 'recover' or 'desist', and are instead constantly 'recovering' and 'desisting'.

Concepts of recovery and desistance are closely associated to individual identity. In engaging in these processes, individuals seek to a construct identities which both facilitate and communicate their progress. It is important to stress here that patients and prisoners in this project were still incarcerated in institutional settings at the time of interview, and were preparing to be released into the community. As such, it was not possible to predict whether they would be successful with these endeavours in the future. Therefore, it is not asserted here that the comments of interviewees guarantee no recidivism among the group. However, it is argued here that such a change in identity and the development of a persona which is optimistic and committed to a future free from crime is an end in itself. Moreover, other longitudinal research does indicate the development of such identities is associated with the maintenance of desistance from crime outwith institutional settings (Maruna, 2001).

This chapter will detail patients' and prisoners' attempts to advance recovering and desisting identities through three main aspects of their accounts: neutralisation of the past, acceptance of the present, and optimism about the future. Overall, it will be argued that while prisoners are engaged in the process of desistance, for patients the situation is different. They are engaged in both recovery and desistance, and rather

than positioning these equally, recovery is perceived to be the main process here and desistance is seen to follow naturally.

1. RECOVERY AND DESISTANCE

At the time of interview all patients were in a medium secure hospital. The role of this setting is to provide a transitional environment which enables individuals to move on to lower security settings or the community. It was also noted in the previous chapter that the medium secure unit facilitates engagement with the recovery process. Prior to this, many patients had spent long periods of time in institutions, and although their individual institutional histories varied all were at some stage of recovery and desistance at the time of interview. Therefore, they were well placed to reflect on their experiences to date and to consider their futures out with inpatient care:

> The experience in the State Hospital did give me a lot of time to think about things and really re-prioritise my life, so I decided quite early on that when I do get out of here and get back into the community, I know far more certainly what's going to be important to me. (E., Patient, 49)

Their accounts were organised around the construction and communication of desisted and recovered identities. In describing the process of desistance, Maruna (2001) illustrates that those seeking to abstain from criminal behaviour must construct a non-offending persona. A key feature of such identities is the ability to 'make sense' of the past, by accounting for previous offending behaviour in a coherent way. Such accounts which both explain past offending and demonstrate change are known as 'redemption scripts'. In the recovery framework, mental illness is similarly positioned as an experience which the individual is in the process of overcoming and through which they have changed. Attempts to construct such accounts were evident among patients where they described their experiences of offending and of mental illness:

> I lived an extremely stressful and dangerous lifestyle… I realise now, I see things in a different light because I lived a life of crime and violence. (I., Patient, 19)

> I can see it was like paranoia and delusions an' that… Misinterpretin' whit people were sayin' and thinkin' they were plottin'. That's what I mean, that's what happened. (A., Patient, 54)

Overall, patients' accounts illustrated the unique relationship between recovery and desistance, suggesting that these processes occurred simultaneously and were intricately linked.

Prisoners were also well placed to reflect on their pasts and look to the future, as many had served significant lengths of time in prison, with some having been incarcerated for almost 20 years. Similarly to patients, several were set to be released from prison in the near future, and all discussed their hopes for returning to the community. As such, all prisoners were engaged in the desistance process to some extent. The account of one prisoner demonstrates this well, referring to both past mistakes and his hopes for the future:

> K. (Prisoner, 35): See years ago at the start ae the sentence I wasnae really tryin', I didn't want to do nothin' or do courses, I was failin' drug tests. But in the last 4 or 5 years I think I've changed. I've grew up a bit.
>
> Interviewer: In what way?
>
> K: I think I just realised that I wasnae doin' masel' any favours, I don't want to spend all my life in jail.

This was particularly true where violent behaviour was concerned. Prisoners' accounts indicated that their perceptions of such behaviour have changed over time. They often suggested that they presently held a more realistic understanding of these events than they did in the past:

> L. (Prisoner, 31): All the circumstances were there [leading to the offence]. And just that wee spark that one night… if any one ae these wee things hadnae happened the whole thing wouldnae have happened. It's easier to think back now… but if it hadnae happened then, it could have happened a week later, or a month later, or a year later.
>
> Interviewer: Why do you say that?
>
> L.: Because I was runnin' about like a fuckin' idiot. I didn't care about nothin'. Mad wi' it all the time and if you wanted somethin' you just robbed it. Aye, so it's no really a surprise. But at the time you're all like 'oh, how did this happen?'

Prisoners' experiences varied in many ways from the accounts provided by patients, but were similar in their demonstration of the engagement of this group in the desistance process. Overall, both groups were well placed to provide insights into the nature of the recovery and desistance processes.

2. NEUTRALISING THE PAST

Neutralisation of the past was a key feature of recovery and desistance for patients and prisoners, as will be demonstrated throughout this section. As the term 'neutralisation' suggests, this aspect of interviewees' accounts represented their attempts to explain past offending behaviour. The notion of neutralisation was originally advanced by Sykes and Matza (1957), and such statements are described as "justifications for deviance that are seen as valid by the delinquent but not by the legal system or society at large" (Sykes and Matza, 1957: 666). It is suggested that such statements enable individuals to ease their conscience regarding offending, and ultimately facilitate the 'drift' in and out of deviant behaviour. Therefore, the concept of neutralisation is generally a negative one. Yet for those interviewed in this project, neutralisation appeared to serve an alternative function, and one which may ultimately be positive. In the context of long term institutionalisation, reoffending was not generally possible for patients and prisoners while in this setting, therefore neutralisation was not enabling the drift in and out of crime at the time of interview. Rather, it seemed to be an important aspect of developing non-offending identities. While again it should be stressed that there was no firm evidence of a reduction in offending, given that individuals had not yet re-entered the community, neutralising past offending behaviour appeared to be very important to patients and prisoners in explaining how and why they had committed serious violent acts, and in illustrating how they had changed for the better and 'made good' as Maruna (2001) suggests.

There are also conflicts between neutralisations and hard facts, and it is important to be aware of these. On one hand, neutralisations tend to be employed and dispensed by patients and prisoners in a way which shows them in a more favourable light. This

is a particularly important point when we consider the process of release from the hospital and the prison outlined in previous chapters, and the potential for patients and prisoners to attempt to neutralise past behaviour in order to facilitate and expedite this process. Yet, explanations cannot be disregarded as false on the sole basis that they are attempts at neutralisation, and often give insight into an individual's thoughts and feelings about the event in question.

This section will demonstrate the techniques of neutralisation utilised by both groups in this study. It will be argued that while both patients and prisoners offered explanations in line with traditional techniques of neutralisation, patients had access to a second more powerful set of neutralisations based on mental illness, and more readily employed these where possible. It will be highlighted that patients' and prisoners' use of techniques of neutralisation shed light on the role of masculinity in their previous violence. Finally, the role of neutralisation in recovery and change will be described here.

2.1. Neutralising the Past: Patients

Patients had varied histories, but all had committed violent offences in the past. In order to progress with recovery and desistance, patients sought to neutralise these actions. In doing so, they employed traditional techniques of neutralisation, but also relied heavily on explanations based in mental illness. Patients demonstrated that they understand their offending to be a product of mental illness, and believe that desistance will follow naturally once this is treated. Their comments also illustrated that many offences were committed for the purpose of constructing and maintaining a masculine identity.

Traditional Techniques of Neutralisation

Patients regularly employed traditional techniques of neutralisation when reflecting on past offending, as originally advanced by Sykes and Matza . These take 5 key forms: denial of responsibility, denial of the victim, denial of injury, condemnation

of the condemners, and the appeal to higher loyalties. The employment of such explanatory devices is common within accounts of offending behaviour. One example of their use can be seen here as one patient suggests that he was led astray by his peers and that his behaviour escalated within his context, suggesting a 'denial of responsibility':

> I was the innocent guy that got mixed up wi' the older guys and people kindae – I don't mean sympathy – they kindae said 'he was alright until he got mixed up with that crowd'. 'Cause I was that naïve that I got involved, it just spiralled out of control, and I didn't know what was goin' on, and then I got the jail and it hit me, know what I mean? (A., Patient, 54)

Such traditional justifications for offending behaviour were regularly employed by patients in describing their violence. Another patient stated that the victim suffered no significant harm, representing a form of 'denial of injury':

> They said I assaulted a policeman, but I never. He wasn't injured in the slightest bit. (D., Patient, 49)

Similarly, another patient highlighted that the victim of his violence was a sex worker. Although it is not explicitly stated, it can be inferred from his repetition of this fact that he perceives this to have some bearing on her status as a victim in this case, and can be understood as 'denial of the victim':

> She was a prostitute, she was a known prostitute… (F., Patient, 32)

In other instances, particularly where offences took place during periods of acute mental illness, the neutralisations proposed by patients were more complex and often spoke to the disordered thought processes which may characterise mental illness. For example, one patient gave his opinion of the seriousness of an arson offence he previously committed which resulted in significant damage to property but no injury to himself or others in his building. His account implied that as nobody was hurt, little harm was caused by his actions. He also asserted that if harm had occurred, he would not have been entirely culpable due to the precautions he perceived himself to have taken. These comments indicate a 'denial of responsibility':

> C. (Patient, 34): I had thought about the layout of the flat, I thought there wasn't really a problem with it [the fire I set] spreadin' or harmin' someone else.
>
> Interviewer: So you weren't worried about that?
>
> C.: Especially with phonin' the fire brigade after it happened, I thought that nothin' would go wrong.

This account may be unsatisfactory as a justification for such reckless behaviour, and it is difficult to assert that sufficient precautions were taken here to ensure no harm was caused. What is important here is that the patient himself perceives this to be a sufficient explanation, echoing Sykes and Matza's assertion that neutralisations are not always accepted by the wider scoeity. Overall, patients' accounts regularly demonstrated their employment of traditional techniques of neutralisation.

Mental Illness and Neutralisation

Thus far it has been advanced that in explaining previous offending behaviour, patients employed techniques of neutralisation similar to those advanced by Sykes and Matza. In addition to these, patients also advanced neutralisations for violence which were grounded in mental illness. Matza himself has noted the legal power of mental illness in neutralising deviant behaviour:

> The act is not criminal because the mental element is lacking. Extenuation is granted because the actor did not cause the act. Thus, the accused is released from criminal responsibility. (Matza, 1964: 82)

He also asserts that excuses for criminal behaviour couched in notions of insanity may appeal to offenders as they are "augmented by elements from within the law itself" (ibid.: 83). A level of awareness on the part of offenders is implied here, as they are seen to understand that mental illness may serve to neutralise violence to themselves, and in the eyes of the wider society and legal system. Consequently, neutralisations which rely on mental illness may be particularly attractive to offenders. Again, this does not suggest that claims of mental illness are untrue simply because they are attempts at neutralisation, and many patients were suffering from acute mental illness and its symptoms at the time of their offences.

Matza's account does not mention the inherent utility of such excuses for those charged with the treatment and management of forensic psychiatric patients. By conceptualising offending as a product of mental illness and its symptoms, patients are provided with a framework of understanding for their previous behaviour. Where violence is concerned, this framework is appealing for professionals in practice as it encourages patients to engage in the recovery process and eliminate such behaviour, and for patients in terms of their identities as it enables them to knife off past offending as a feature of their illness. Overall, the mutually beneficial collaboration of excuse which emerges between patients and professionals gives effect to desistance in conjunction with recovery.

In light of this, when describing offences which took place while unwell, patients employed a unique set of neutralisations based around mental illness. One patient emphasised that his violence was attributable to the volatility which characterised his mental illness and drug misuse. This explanation appeared to have more 'neutralisation purchase', as it removed notions of intent and culpability to the extent that it was felt to be an acceptable defence by his legal representatives:

> As my lawyers said to me 'It's not murder that you did. You didn't get out of bed that day and say to yoursel', 'I'm goin' to get this guy'. You were drunk, you weren't well, you were walkin' down the road, you hit the guy for no reason, and the guy died.' (B., Patient, 43)

This also supports Matza's assertion that mental illness has the power to remove criminal responsibility. Thus, while the patient's justifications here are based in fact, the focus on mental illness as the cause of this incident proves an effective means of neutralisation.

Similar justifications were advanced by other patients, who also focused on the role of acute mental illness as the cause of violence. One patient's explanation stated that his targeted victims were those involved in the drugs trade, as his delusional thoughts were focussed on this:

> I thought, well, it was time to maybe 'clean up' the city, and I was extremely unwell at this time. And took it on my own that I was like a 'chosen one' to go and rid the city of heroin dealers and junkies. (F., Patient, 32)

The emphasis that his victims were involved in other criminal activity is similar to traditional neutralisations taking the form of 'denial of the victim'. Yet the patient highlights the context of delusional thoughts, and the neutralisations he chooses to employ in explaining the event are focussed on mental illness.

Another patient suggested that his feelings of paranoia and fear of persecution from the victim of his offence drove his violence towards her. These are common symptoms of schizophrenia, and the explanation of his offence is again a neutralisation based in mental illness:

> Interviewer: And were you thinking that about your sister [the victim] before the offence happened? That she was up to something?
>
> A. (Patient, 54): Well, she was the one that was most in my mind, because she was the one that was helpin' me, she was the one that was takin' me to locals. And I started thinkin'… If people are tryin' to help you when you're unwell, you don't think they're tryin' to help you, you think they're plottin' against you.

While the focus on mental illness as a means of neutralisation was largely unconscious, patients did demonstrate some awareness of its power. One highlighted that such explanations are often accepted by the wider society, and evoke a level of understanding from others:

> [Patients] have maybe done a horrible crime but people stick by them because they don't seem them as that person who's done the crime, there must have been a reason. (Alan Anderson, Patient)

Overall, patients implied that were it not for the symptoms of mental illness which led them to behave in this way, these incidents would not have taken place. Their accounts demonstrated the perceived neutralisation purchase of mental illness in accounting for previous offending, due to the implication that they were not fully culpable for their actions within this context, supporting Matza's assertions.

Masculinity and Neutralisation

As techniques of neutralisation illustrated the role of mental illness in violent incidents, the accounts provided by patients also illuminated other driving factors. In particular, their explanations for violence suggest that the desire to perpetuate a masculine identity was an important aspect of these incidents. One patient justified his behaviour by suggesting that this was normal within his social group:

> That's just the way it was in those days. There's nothin' I was doin' that was different from what the rest of my friends were doing. So if you're all in the same boat… you fly with the crows, you get shot with the crows. (A., Patient, 54)

The patient's account here illustrates a desire to conform to the prevailing masculinity scripts within this group. It is implied that offending behaviour was accepted among these peers, and thus to deviate from this may have compromised his masculine identity. Similarly, another patient suggested that his offending behaviour was rooted in his desire to defend females, and was in this sense justified:

> I don't like seein' [women] bein' hard done by and bein' cheated… That's why I think I took those matters into my own hands. (F., Patient, 32)

While the patient suggests that his actions in these instances were based on his personal moral values, they also speak to masculine ideologies which demand the protection of females. Ultimately, such sentiments were frequently present in patients' explanations for their offending behaviour, suggesting that masculinity played a role in these incidents.

Neutralisation and Change

Maruna (2001) suggests that desistance is a process whereby the past must be understood and made sense of through such scripts, in order to allow the offender to construct a new desisting identity. In a deviation from this form of narrative, patients seeking to neutralise the past often emphasised that they were 'a different person' and not 'the real me' while unwell:

> People can do [bad] things and be good people, even though they've done things. (A., Patient, 54)

> I'm more interested in trying to be myself - and you lose some of the things about you when you were younger that really weren't you. (E., Patient, 49)

It has thus far been suggested that mental illness based neutralisations are powerful in excusing previous violence. Accordingly, rather than suggesting that patients needed to change in some way, accounts such as those above implied that this was not necessary as their behaviour during this phase was not their true nature. One patient's account illustrated this notion as he asserted he has reverted to his true non offending identity, or 'the real me', through the process of recovery from mental illness and alcohol misuse:

> I didnae really need to change, cause the original [B] was meant to be alright anyway. It's just like drink changed it all… I think the doctors know that off drink I'm normal and alright, quite a nice guy, but when I'm on drink as I say it affects my mental state, makes me a wee bit funny, you know, different. But I realise what it does to me now.
> (B., Patient, 43)

Such comments are at odds with the accounts of violence given in Chapter 5 of this thesis. Most patients had violent histories which predated their mental illness, and as such to suggest that their identity at this point was non-violent would be inaccurate. Such suggestions are symptomatic of patients' tendency to conceptualise violence while unwell as entirely a product of mental illness rather than a continuation of a pattern of violent behaviour.

2.2. Neutralising the Past: Prisoners

In constructing desisting identities, prisoners sought to explain their previous offending behaviour. All interviewed prisoners were serving life sentences following convictions for murder, a crime which attracts a particular level of censure from the wider society. Prisoners demonstrated an awareness of the the particular difficulty of neutralising such behaviour, and their justifications reflected this. This section will detail prisoners' attempts to neutralise their past offending behaviour.

Traditional Techniques of Neutralisation

In spite of the difficulties of justifying such behaviour, prisoners did endeavour to provide neutralisations for these acts. In doing so, they often advanced explanations in line with Sykes and Matza's (1957) original 5 techniques of neutralisation. Some sought to neutralise their offences through 'denial of responsibility', for example one prisoner suggested that he may not have been responsible for his index offence, which he claimed to have no memory of and asserted was beyond his capabilities:

> So if you were to say to me that he knocked me out and somebody came in and done that to him I could quite believe that. Cause even now, I never in a million years thought it would be possible for me to do that. (M., Prisoner, 39)

While this explanation may be unconvincing to some, it is again important to highlight Sykes and Matza's assertions that the techniques represent justifications which are accepted by the offender, but not necessarily the wider society (Sykes and Matza, 1957: 666). Others similarly suggested that the incidents were almost out with their control:

> It's through circumstance eh? (P., Prisoner, 34)

Some prisoners explained their offences by 'denying the victim', for example by suggesting that they were dangerous, and that their use of force against them was justified:

> Fair enough I punched the guy 4 or 5 times and I maybe went a bit far but it was a very like high [pressure] situation, the guy was a very dangerous guy, he carried blades and that. (P., Prisoner, 34)

Others sought to explain that they had not intended to cause significant harm through their violent behaviour, and did not aim to kill the victim of their offence. This is 'denial of harm', another traditional technique of neutralisation:

> The violence I've seen compared to the violence of that one kick, I couldn't believe it that he could die from that one kick. (Q. Prisoner)

One prisoner justified his offence by suggesting that failures by the police may have contributed to his actions. A dispute with the victim over the theft of his belongings led to a violent altercation in which the victim died. He emphasises that he had the police taken action on the matter, the homicide would not have occurred. This amounts to 'condemnation of the condemners', whereby the criminal justice bodies which would seek to condemn him are portrayed in a negative light through his account:

> I've always said to myself, I wish the police had said to me 'we'll go down'. I'm not tryin' to say they're not doin' their job or blame them, I took the guy's life, but I often wonder why, if they'd gone down at 10 o'clock that night they'd have caught him sellin' my stuff. And it would have been finished wi'. (T., Prisoner, 45)

Finally, in some instances prisoners advanced an 'appeal to higher loyalties' in neutralising their behaviour. One stated that his violence took place in protection of his father. While his account suggests that under other circumstances there would be some level of moral sanction for this behaviour, he implies that this justifies this act to himself and others:

> If any of my mates thought that I was out of order they would never have spoken to me again, but in everybody's eyes I was protectin' my dad. And that's how I feel as well. (P., Prisoner, 34)

Ultimately, prisoners regularly employed traditional techniques of neutralisation in accounting for past offending behaviour and establishing a desisting identity.

Neutralisation and Masculinity

Much like patients' comments, prisoners' attempts to neutralise the past demonstrated the role of masculinity in their offending behaviour. The explanations and justifications they provided frequently suggested that their violence was an attempt to display and protect a masculine identity. In one prisoner's explanation for the homicide offence he committed prior to imprisonment, he states that he did not set out to use force which would result in the death of his victim. His comments also indicated that the incident had roots in masculine concepts of dominance and power as he states that he needed to incapacitate his opponent:

> There was no way I meant to kill the guy, I just meant to keep him down. That's how I was brought up, when you put somebody down don't let them back up again. (Q., Prisoner, 61)

Similar accounts emerged in explaining previous violence. Another prisoner attempted to justify his behaviour as a response to persecution from another male. Violence appears to be his common response to perceived challenges from other males in the past, suggesting that his previous violence occurred as a means of defending his masculine identity:

> I suppose it [my violence] started, a guy tried to bully me and I just wasn't acceptin' it. And I think it was just like a light switched off, and any time I was gettin' into any situation I was just goin' right into violence because that guy bullied me. So, I wasn't lettin' that happen, so I stuck up for myself. (R., Prisoner, 28)

Other prisoners suggested that homicidal violence often escalated from small triggering incidents. They attempted to neutralise this by asserting that they did not expect or intend the incident to develop in this way:

> I realise now that any time in that day I could have walked away from the potential situation. But I still wasn't thinkin' it was ever gonnae get to that level. (P., Prisoner, 34)

Such descriptions of escalation are common in scenarios of masculine 'confrontational homicide', whereby challenges between males develop into serious violent altercations (Polk, 1994). Thus, this prisoner's neutralisation revealed that his offence occurred in the context of a traditionally masculine scenario of violence.

Neutralisation and Change

Overall, through their comments which neutralise past violence, prisoners sought to construct a desisting identity. In doing so, they were keen to emphasise that they had changed, and demonstrated an awareness of the difficulties associated with doing so. One prisoner suggested that to return to his hometown upon release from prison would be problematic:

> Q. (Prisoner, 61): I don't want to go to [my hometown] wi' all the old faces and that.

> Interviewer: With temptations and things?
>
> Q.: Well not temptation, but people think you're the same person but you've changed. I don't have the time to sit and convince people that I'm not the same guy.

In the context of serious offences such as homicide it is difficult to convince others that sufficient changes have been made in relation to past offending and its causes. Nevertheless, prisoners were keen to express that they had changed:

> I'm not that person anymore, what I was. (Q., Prisoner, 61)
>
> I hope I could say that I'm a changed… That this has changed me. (K., Prisoner, 35)

Particularly, prisoners suggested that they had progressed from their offending identity, and this perception of change is integral to the construction of a desisting identity. One prisoner described his own attempts to address his volatile personality. He highlighted that understanding his own anger has enabled him to control himself and to change in this way:

> I know about my anger now, I don't get angry like I used to. I think I'm burnt out, I've used it all up or grown up, but I don't let my emotions control me. (L., Prisoner, 31)

Another prisoner suggested that he had made similar changes in relation to his previous violence, in this instance by addressing his drug and alcohol misuse:

> Aye, I think I've changed, I think my attitude's changed a good bit. I've had help wi' the alcohol and things like that as well. (O., Prisoner, 45)

Both of these prisoners have implied that these changes enable them to refrain from violence and hence advance the desistance process. Overall, change is a significant feature of a desisting identity for this group.

2.3. Neutralising the Past: Conclusions

Both patients and prisoners sought to neutralise their past violence in constructing recovering and desisting identities. In doing so, they employed traditional techniques of neutralisation. The explanations they offered also often illustrated that much offending was motivated by a desire to construct and maintain a masculine identity.

For patients, a further set of techniques of neutralisation which were grounded in mental illness were available. These explanations for violence, which suggested that such incidents were driven by mental illness and its associated symptoms, proved to be more powerful than traditional techniques in neutralising offending.

In light of this, while prisoners were keen to suggest that they had changed and developed desisting identities, patients asserted that their offending identity was never their true nature as their violence was driven by mental illness. Consequently, they proposed that they did not need to change, and instead had reverted to their true non offending identity.

3. ACCEPTANCE OF THE PRESENT

Acceptance of their present situation was recognised as another important feature of the recovery and desistance processes by patients and prisoners. It will be demonstrated that for patients, acceptance of hospitalisation was contingent on their acceptance of their diagnosis of mental illness. While they did not accept culpability for their previous offending, they did express remorse for their actions. For prisoners, acceptance of imprisonment was based in their acceptance of culpability for the offence which led them to be there, which all expressed, as well as feelings of remorse. This section will detail the comments made by both groups in this area.

3.1. Acceptance of the Present: Patients

As stated in the previous chapter, some patients acknowledged that they were unwell yet others rejected their diagnosis and their resulting placement in hospital. While this confirmation or denial of mental illness has thus far shed light on the experiences of this group in institutional settings, these comments also had implications for their recovered identities, as will be demonstrated here.

Acceptance of Mental Illness and Hospitalisation

Engagement with the recovery process was shaped in part by patients' acceptance of their illness, and accordingly their hospitalisation. Patients' accounts were therefore more varied here than prisoners'. A belief of innocence may usually have implications for acceptance of institutionalisation, yet little reference was made to notions of culpability for the offence which led patients to be placed in hospital. Rather than guilt for the offence, hospitalisation was accepted or rejected based on a perceived need for treatment for mental illness.

One patient described a change in perspective regarding his illness. It was implied that in order to 'progress', it was essential to accept the diagnosis of mental illness and to proceed with the process of recovery:

> My behaviour was so out of character, and I think many people thought I'd… I had flipped, you know, I had lost the plot.... So it took a while in the State Hospital for me to sort of buckle down and just accept and say 'look that's how it's been interpreted, you have to just go on with it and try and make some progress.' (E., Patient, 49)

Other patients similarly suggested that it was necessary to accept detention in hospital in order to move on, and several described a change in attitude over time in relation to their hospitalisation:

> G. (Patient, 39): I think you can have a bad attitude towards it [hospital].
>
> Interviewer: Is that what you had?
>
> G.: Aye, at first when I was in hospital in [Glasgow] I was in a lot of bother and that, it was nothin' but bother. But here I like the staff, I'm gettin' on fine.

Similarly, patients' statements indicated that the gradual nature of reintegration into the community or lower security settings must be accepted and complied with:

> I appreciate that they prefer to do that in stages, you know… You don't like having to come back and being locked up, but I'm not inclined to go against that or challenge that. (E., Patient, 49)

Overall, patients' accounts suggested that hospitalisation, and procedures within the hospital must all be accepted by the patient as features of his present situation in

establishing a recovering identity. This is also in keeping with the comments in Chapter 7 which suggested that patients must engage with the hospital regime if they wish to progress through this sytem. Mental illness and recovery are again placed at the forefront, as acceptance of hospitalisation is defined in relation to acceptance of mental illness rather than previous offending.

Remorse for Previous Violent Behaviour

In constructing recovered and desisted identities, patients also gave reference to their previous offending behaviour, demonstrating acceptance and remorse. Patients did not suggest that they viewed themselves as culpable for these actions. This section will detail the complex emotions described in this area.

Almost all patients described feelings of guilt and remorse in relation to their previous offending, particularly violence which had seriously harmed others:

> The anniversary of my brother's [the victim] death can be a trigger. Yeah, I had a real guilt. (J., Patient, 51):

> I regret quite a lot of things. (G., Patient, 39):

Tensions appeared to exist between patients' expressions of remorse and the neutralisations for violence described in the previous section of this chapter. Yet the two did not seem entirely incompatible, as although feelings of regret were expressed they did not equate to an admission of culpability. One patient described such feelings which were particularly strong as the victim of his offence was elderly. Yet was also keen to emphasise the victim's physical vulnerability, in a sense suggesting that he is less culpable for his death:

> [My lawyers said] 'The reason he died is because he was old, if it had been a guy your own age the guy would have been fine. The guy was old.' Which brings it all worse to me, you know, it was terrible what I did. (B., Patient, 43)

Overall, few patients discussed issues of culpability in relation to acceptance of their present situation. This can be associated with their ability to employ mental illness as

an almost complete neutralisation for violence, to the extent that there is no impetus to accept responsibility for their actions while unwell.

3.2. Acceptance of the Present: Prisoners

Prisoners' accounts also demonstrated their acceptance of their present situations. This included acceptance of their imprisonment, as well as acceptance of culpability for their offences and the feelings of remorse associated with this.

Acceptance of Imprisonment

It is not uncommon for prisoners to feel frustration in relation to their imprisonment, and it is likely that these sentiments were particularly pronounced in the context of a life sentence. It has already been suggested that patients must accept their mental illness and hospitalisation in order to progress on to lower security settings, and for prisoners this appears to also be the case, albeit to a lesser extent. As prisoners were placed in prison solely as a result of the crime for which they had been convicted, an acceptance of imprisonment was in direct conflict with the neutralisations for offending advanced earlier in this section. Prisoners' highlighted that in spite of neutralisations it is nevertheless important to accept this situation, as part of the task of survival and demonstrating mental fortitude:

> I worked my arse off to do well and I did and it all got thrown away because of they two idiots in the pub. And that really annoys me, aye. But what can you do? You just need to deal with it. (P., Prisoner, 34)

Other prisoners made similar comments, accepting their imprisonment as legitimate in light of their offences:

> At the end of the day I've admitted that I've done wrong and I've been punished. (T., Prisoner, 45)

> But the way I see it, you do the crime you do the time. (L., Prisoner, 31)

In this sense, acceptance of imprisonment is an important feature of a desisting identity. Although not explicitly stated this could also be associated with the process

of release from prison for lifers. It is possible that prisoners must accept their current situation and comply with the prison environment, or at least must not behave in a disorderly or overtly unaccepting manner, in order to be deemed suitable for release.

Remorse for Offending Behaviour

Particularly in relation to offences of homicide, notions of guilt and regret characterised prisoners' feelings in relation to these incidents and many were still affected by these emotions in the present:

> I've took somebody's life, I've got to live with that the rest of my life. And… sometimes I sit and think about the guy. I've done wrong. (T., Prisoner, 45)

Other prisoners described similar feelings regarding their index offences, suggesting that they regularly experience feelings of guilt and shame in relation to their actions:

> I didn't like myself for a long time, you know what I mean. I still don't like myself for what I done, but it was, I don't know, it was just outtae the norm. (Q., Prisoner, 61)

> There's a picture of him [the victim], and he's got a big smile on his face, and that haunts me that does… That could have been me in the coffin and the one stabbed. Would I rather be the one in the coffin? No, but I wouldnae ever again rather live with the guilt. (M., Prisoner, 39)

While the above quotations refer specifically to the prisoners' feelings in relation to the victims of their offences, these sentiments extended to others. Prisoners demonstrated an awareness of the wider implications of their offences, and the effects of this not only on the immediate victim, but also the victims' families and their own:

> I regret it, for a lot of reasons, family reasons. A lot of people think you kill somebody and that's you, that you feel alright, and you don't, you think about the effects it's had on his family, on my family. (Q., Prisoner, 61)

> That really got to me, and thinkin' about my family and his family. I killed someone's son or brother, someone's future father. Nobody can give you that authority. (Q., Prisoner, 61)

Prisoners described feeling remorse for their violence even where the victim of the offence was seen to be less deserving of sympathy. For example, one prisoner described his feelings in relation to his index offence, in which he fatally stabbed a

man who had previously burgled his home. Although he suggested that the victim was of poor character, he emphasises that his actions were nevertheless wrong:

> T. (Prisoner, 45): I should never have took his life. You know what I mean?
>
> Interviewier: Even if he was a thief and all that stuff you said?
>
> T.: Even with what he was, that's not for me to decide… that doesn't give me the right to take his life.

Another prisoner gave a similar account of his feelings in this area:

> Interviewer: Even though he had a history of being a sex offender, you still feel remorseful for that?
>
> Q. (Prisoner, 61): Oh, totally. Totally. I mean, who gave me the right to take this guy's life, who gave me the authority? Who gave me the authority to kill somebody?

Although these prisoners would seek to neutralise their actions through a 'denial of the victim', they continues to express remorse, again demonstrating that techniques of neutralisation are not necessarily incompatible with feelings of remorse.

Acceptance of Culpability

Prisoners' accounts went further than those of patients, and as well as remorse they demonstrated their acceptance of culpability for their offences. This is at odds with the excuses they provided for previous violence and at times it may be difficult to ascertain whether these admissions are genuine. Yet in the absence of a strong neutralisation such as mental illness for such serious violence prisoners were therefore unable to eschew culpability. There is a general moral expectation that offenders take responsibility for their behaviour, and this aspect of prisoners' accounts may initially appear preferable to those of patients in this sense. Yet this poses a potential barrier to change, as the psychological process of taking ownership of past violence in the desistance process is likely to be significantly more difficult than patients' experience where this is not required.

One prisoner asserted that although he did not intend to commit murder or seriously injure his victim, he nevertheless accepted responsibility for the consequences of his actions:

> I take responsibility for what I done. I punched the guy 4 or 5 times, I never thought I'd seriously injure him, but I'm no gonnae complain, that's done and dusted now. (P., Prisoner, 34)

Other prisoners also took ownership of their violent behaviour by accepting responsibility for such incidents:

> L. (Prisoner, 31): When I was on remand, they sent psychologists and that but most of them are just fuckin' hacks… he was tryin' tae make excuses for me and all that. Like 'see when he went to attack [Sarah] did you see your da' hittin' your ma'?' and I said 'aye, aye', but it's just a lot of shite, people tryin' tae put labels on me.
>
> Interviewer: So you'd rather just take responsibility?
>
> L.: Aye… And see sayin' 'my da' beat me when I was young'… I believe in takin' responsibility.

Again, the prisoner here asserts that he is culpable for his index offence, emphasising that he does not wish for others to diminish this sense of responsibility in any way. This suggests that an acceptance of responsibility for violence is particularly important to prisoners. In this sense, it can be understood as an integral feature of a desisting identity.

3.3. Acceptance of the Present: Conclusions

Acceptance of their present situations also represented an important aspect of patients' and prisoners' recovery and desistance identities. This was seen as a key element of being able to move on from institutional settings and engage with recovery and desistance processes.

Both groups accepted their present statuses of hospitalisation and imprisonment. For patients, this was based in an acceptance of mental illness, while for prisoners this stemmed from their acceptance of guilt for their offences.

Patients and prisoners also referred specifically to their present emotions concerning their offending histories. Both groups expressed remorse for their violent actions. There are tensions between these feelings of remorse and the neutralisations which were advanced by patients and prisoners earlier in this chapter, which are further pronounced where culpability was concerned. While prisoners accepted culpability for their offences in spite of the explanations they had previously offered, patients had employed stronger techniques of neutralisation focussed on mental illness, and therefore did not feel that they were responsible for these incidents.

The comments made here once more highlighted the intricate relationship between recovery and desistance processes. Patients' accounts focussed on mental illness as the key issue which must be accepted, and the key cause of past violence. Accordingly, it appears that recovery is again positioned as the most important process here.

4. OPTIMISM ABOUT THE FUTURE

Optimism about the future was common among patients and prisoners, in spite of the possible barriers both groups might face upon returning to the community. This positive outlook represented the final element of their recovering and desisting identities. This section will outline their comments in this area. It will be demonstrated that patients were particularly optimistic about their recovery and prospects for the future, but made little reference to desistance and the means by which this would be maintained. Prisoners were also optimistic, both in relation to their plans for desistance from crime and their general lives in the future. However, they also exhibited elements of trepidation in relation to the future.

4.1. Optimism About the Future: Patients

In establishing a recovering and desisting persona, patients also discussed the future. Their comments were overwhelmingly positive in nature, and they described a

variety of personal goals and aspirations for their return to the community. Such feelings were expressed in relation to their overall recovery from mental illness and desistance from offending, as well as specific issues such as employment, relationships and 'giving back' to the community.

Optimism about Recovery from Mental Illness

Patients largely considered themselves to be making inroads to recovery from mental illness, following a recognition that they suffered from such a problem. This was described as 'insight':

> It took me about six months, I started thinkin' straighter and started to realise 'Christ, that was all in my mind'. I did a lot of thinkin' and that. It's called insight. (A., Patient, 54)

> I can only say now, when I look back I think "Jesus, that's what I was doing", that it was mental health difficulties. (F., Patient, 32)

Patients indicated that they were well situated to continue with the recovery process from their current position of insight, which represented a key feature of a recovering identity. Their awareness of the negative experiences of acute psychosis often served as a motivation to engage with treatment in the future:

> I can guarantee a hundred percent that I never want to ever get those things in my head, like paranoia, delusions and things like that. I don't get things like that. It's all real I've got now. I've got good insight, I'm a real person. (A., Patient, 54)

Ultimately, patients' accounts expressed confidence about their recovery from mental illness to date and in the future.

As well as maintaining mental health, patients also expressed optimism about their hopes for abstaining from alcohol and drug misuse. Their accounts of their pasts detailed the role of alcohol and substance misuse in exacerbating mental illness and contributing to offending behaviour (Steadman et al., 1998; Junginger et al., 2006, Swanson et al., 2008 A). Their descriptions of their hopes for the future suggested that these issues were closely linked. As with mental illness, they expressed an understanding of the implications of drug and alcohol misuse. They suggested that

they were presently making inroads into issues of addiction and intended to continue this:

> I didn't know at the time it was the drink and drugs that was causin' me all the paranoia and delusions... And that's what keeps me a hundred percent away from it. Because I know if I ever touched them again it will come back. (A., Patient, 54)

> The situation is with cannabis, it's an illegal drug, so you're better no getting' involved wi' it all. (B., Patient, 43)

Access to these substances within the community was highlighted as a particular temptation anticipated by patients:

> That was the concern, that I would take drinks or drugs, with the opportunity. (A., Patient, 54)

In spite of such concerns, patients were optimistic regarding their ability to abstain from future drug and alcohol misuse. They appeared absolute in their determination to avoid drugs and alcohol, implying that there was no possibility of them returning to these habits:

> I'm no' gonnae take a drink, I can control it. (H., Patient, 49)

> In the last 7 years I've touched [cannabis] once. I'm no' takin' it again, I'm 40 now, I've got responsibilities. (G., Patient, 39)

Overall, recovering patients sought to avoid drugs and alcohol, which for many characterised their pre-institutional lives.

Patients' accounts of recovered identities also referred to their ability to mange their personal care out with their inpatient setting. They appeared confident in their abilities to meet needs such as personal hygiene, cooking, cleaning and shopping:

> I eat well, I'll make sure I always have nice food. I'll make sure I've got decent clothes to wear. (B., Patient, 43)

> I like to keep myself in order and keep my flat tidy and clean, I'll be all sorted and that. (G., Patient, 39)

This optimism about their ability to manage their day to day lives and to continue to do so in the community was a feature of recovering identities.

Optimism about Desistance from Offending

As patients were in a secure setting where opportunities for offending were limited, the desistance process was underway for the majority of patients. Patients made little reference to their hopes for future desistance. Where they did touch on such issues, patients highlighted that they were already taking measures to avoid confrontations and situations conducive to violence, communicating an actively desisting identity:

> If [guys] did anythin' nowadays I'd just go 'alright, sorry mate', and just walk away and that. (A., Patient, 54)

One patient specifically detailed his enthusiasm for a future free from offending behaviour and the difficulties associated with this:

> I'm not goin' to have to look over my shoulder all the time, be close to dying all the time and live dangerously, I won't have to deal with all that shit. It's somethin' to look forward to. (I., Patient, 19)

The above patient gives little insight into how desistance should be achieved or the measures which he will take to avoid crime, although he presents a desisting identity. Patients' sparse references to techniques of active desistance from crime again demonstrate the close association between recovery and desistance processes. As desistance is understood by this group to be a natural side effect of the recovery process, it follows that they would give little consideration to ways of actively pursuing desistance in the community.

Optimism about Employment

Accounts of patients' future hopes for employment were also optimistic. In spite of the potential barriers to gaining legitimate employment posed by a diagnosis of major mental illness and convictions for violent offences, many detailed their career

plans for entry into the community. This lifestyle posed a welcome change from the criminal activity which characterised patients' pre-institutional lives:

> I could do the management side of the family business… I wouldn't mind doin' that, and retirin' from a life of all that other shit [drug dealing]. (I., Patient, 19)

> I'd like to make some money for myself and live a comfortable life. (H., Patient, 49)

Other patients described similar goals for future employment. Many detailed multiple options for jobs within the community, suggesting optimism about the possibilities in this setting:

> I've got a drivers license but it's been revoked at the moment because of me being not well… So I would like to get that back and eventually I'd like a job maybe drivin'... I mean there's jobs you can do that's in your house and you get paid for it as well. Maybe like data input or word processin' of some kind. (B., Patient, 43)

> G.: Anythin' I could turn my hand to really. (G., Patient, 39):

This optimism often extended to a perception that patients would be able to be selective in pursing employment in this context:

> I'm waitin' for an IT job. They wanted me to do gardenin' but I said to them I'm not doin' it. I don't want to work hard like that, I can't be bothered with hard work. (B., Patient, 43)

> I think, one, I wouldn't work unless I was getting paid some decent money and, two, say I used my HND and got a clerical job or somethin'. (C., Patient, 34)

In order to achieve such aims, several patients made references to their hopes to continue their education upon leaving the inpatient setting. Again, patients' accounts here indicated that, in spite of the likely barriers facing them in hoping to achieve further educational qualifications and employment, they are optimistic regarding their options for the future:

> I mean, I've got highers and I could go to university hopefully, and if I can't do that I'm hopefully I'm going to still try and aim high and do something with my life. (I., Patient, 19)

> I could end up as a mature student studying at college or something like that. (H., Patient, 49)

Ultimately, optimism regarding future employment was common among patients, and was an important feature of their overall aspirations for life in the community.

Optimism about Intimate Relationships

Several patients also expressed their hopes for relationships with female partners in the future. Many patients were hopeful that in spite of their experiences, in the future they may have a serious relationship:

> Eh, well I'm in the last year of my 40s but I hope I'm not too old to find somebody to settle down with… I still want to meet somebody, like a soul mate. (E., Patient, 49)

Here, the patient implies that his age may be a barrier to this, a common sentiment among those re-entering the community in the later years of their life following long periods of time in inpatient settings. In spite of such difficulties, other patients demonstrated similar hopes for their future relationships with females and starting families:

> I want to get a girlfriend and that and settled down, and have a family and that. (G., Patient, 39)

> If I meet somebody special I'd definitely be willing to commit to a new relationship… I'd like to get involved with a female and maybe settle down and have kids. (F., Patient, 32)

Patients acknowledged that the traditional problems and 'stresses' of relationships with female partners may also be present in future relationships they may have:

> I've not been put off, but it can be a lot of stress having a girlfriend… (B., Patient, 43)

> I don't think I've got the capabilities and the maturity to keep a relationship goin'. (C., Patient, 34)

> I wouldnae get involved [with a female] again. Duckin' and divin' and all that, no. (Patient., A., 54)

In the context of readjustment to life in the community, developing and maintaining an intimate relationship may be seen as an added pressure for patients. Patients showed a rare glimpse of pessimism in relation to this particular issue. A further barrier to future relationships was disclosure of past mental illness and violent offending:

> Aye, you can meet somebody and disclose everythin' to them and then fall out wi' them and they go and tell the whole neighbourhood. (Patient, A., 54)

> Interviewer: Your past, how do you think that will affect future relationships with women?
>
> F. (Patient, 32): It all comes down to being open and honest… You've got to explain, 'I'm bi polar, I got involved with the police, I had some trouble when I was younger'.

While the second patient here feels that this can be overcome through honesty, others were less hopeful. Some felt that the issue of disclosure was an insurmountable problem:

> If I met a woman I'd have to disclose everythin' about mysel' and I don't wannae do that. So I'd rather no do that. (A., Patient, 54)

This sentiment was not necessarily common among patients, who were optimistic in this area. The above patient's offending history included a conviction for rape, and the stigma attached to sex offences may explain his reluctance to disclose his past. Overall, while most patients were optimistic that the future held stable relationships with females and the promise of starting their own families, others were more reserved in their expectations in this area.

4.2. Optimism about the Future: Prisoners

Optimism about the future was common among prisoners, with many giving overwhelmingly positive accounts of their hopes and goals upon release. Prisoners provided evidence of their optimism about their future desistance from crime. In addition, they were positive in relation to areas of their futures such as employment, relationships, and giving back to the community. Prisoners also demonstrated a level of trepidation in relation to their release from prison, and an awareness of the challenges which this may pose. Their comments in these areas demonstrated their construction of desisting identities.

Optimism About Desistance from Crime

Prisoners demonstrated particular optimism in relation to their hopes for desisting from future offending. Comments indicated, with near certainty, that they would not be engaging in violent or other offending behaviour once in the community:

> I'm not goin' back [to criminal behaviour]. I mean I could, but I wouldn't, I'm not that guy now. (Q., Prisoner, 61)

> I know once I'm out I'll be able to cope with the life. I know because I'm that kind of person. It's the getting out and doing it… (Q., Prisoner, 61)

Peers were cited as a source of temptation, suggesting that once out of prison it would be possible to be 'easily led' into offending, but most prisoners held strong convictions that this would not happen:

> I'll be alright, I can go out and about and talk to people and it would never tempt me to go back to the life I had. (P. Prisoner, 34)

For most prisoners, avoiding these negative influences was a strategy which they intended to employ in order to maintain desistance. This extended both to previous acquaintances from the community, and those encountered while in prison:

> I'll just make sure I stay away from the people that I used to jump about wi'. (K., Prisoner, 35)

> Interviewer: Do prisoners keep in touch with each other?
>
> O.(Prisoner, 45): It's part of your license that you should keep away from any criminals…
>
> Interviewer: It's maybe not good to meet up then?
>
> O.: You're not wantin' to go out and get mixed up in somethin' and then sent back in the jail again.

Prisoners highlighted that their experiences of prison thus far serve as a motivation to avoid future offending. Many suggested that the knowledge that any criminal behaviour in the community following release from prison would result in their return to this setting, is sufficient to deter them from such behaviour:

> I've just got to keep myself away from everythin'. I know the consequences…I'm back in there for another however long. (N., Prisoner, 36)

> I don't want to spend the rest of my life locked up wi' other guys, I don't want to spend the rest of my life in this place. (R., Prisoner, 28)

Some prisoners had experienced recall from the community setting following a breach of license. One described being found in possession of a knife, asserting that he had learned from this experience which resulted in a significant period of further incarceration:

> When I got done with the knife that was in 2004. So that's 7 or 8 years… So it's no' worth it. (N., Prisoner, 36)

Overall, prisoners were aware of the implications should they fail to meet their license conditions while in the community.

For most prisoners their index offences occurred in the context of drug and alcohol misuse, and they would be required to attend regular tests once released into the community. They stressed their commitment to avoid misuse of these substances, and the implications should they engage in such behaviour:

> I know for a fact, if I drink that's one of the biggest things, downfalls, is the drinkin'. (K., Prisoner, 35)

> It's really gonnae test it when I go to open conditions, see if I do hit the drink, if I do hit it it's straight back to the mainstream. (O., Prisoner, 45)

As the interviewed prisoners had not yet been released into the community it was not possible to determine whether their assertions in this area were accurate, and if they would be able to avoid drug and alcohol misuse in this setting. However, it appears that prisoners were optimistic regarding this endeavour, and had strong hopes for success in this area and that prison would potentially act as a deterrent here.

Trepidation About the Future

While prisoners were optimistic regarding their prospects for success in the future in relation to desistance, they nevertheless expressed some trepidation regarding their

release from prison. Their comments detailed the uncertainties and changes associated with this transition, which were significant for lifers.

As lifers, many prisoners had spent periods of almost 20 years in institutional settings, and were unaccustomed to life in the community. As such, they expressed that adjusting to changes which have taken place in the community over this period of time would be particularly difficult:

> I canne plan for the future… I dunno what it's like out there. You can sit and tell me everythin' about the place I stay but it doesn't mean anythin' because I've not got a reference to it. People tell me it's changed and all that, but I can't remember what the fuckin' place looked like to start wi'. (L., Prisoner, 31)
>
> Q. (Prisoner, 61): I'm more scared of getting' out than I am of stayin' in. I've only got 2 and a half years left and I'm brickin' it, I'm no lookin' forward to that.
>
> Interviewer: Why?
>
> Q.: Because I'm gonnae be out in the big bad wide world again and I'm scared… Since I've been in prison the streets have changed.

Overall, a lack of familiarity with local areas and the wider community represented one of the key anxieties experienced by prisoners in relation to their future release.

Prisoners also expressed trepidation regarding the change in lifestyle which awaits them in the community. The responsibilities of everyday life were a daunting prospect after an extensive period of time in an institutional setting:

> Aye I think it will be a challenge basically. It's easy to live in here, you get everything done for you, you don't need to worry about anythin'… You need to look after yourself basically, that's the hard thing. (N., Prisoner, 36)

It is suggested here that prison effectively removes these problems, and that being reintroduced to these tasks is a further cause for anxiety among prisoners. There was a sense that leaving prison represented a move away from prisoners' normality:

> Interviewer: What will be difficult about being released?
>
> Q. (Prisoner, 61): Wakin' up in the morning and there being only you in the house, and not here where there's at least 60 bodies goin' by you. Just being outside, coping, dealin' with real life. Dealin' wi' money.

Overall, prisoners often suggested that their current institutional setting was in stark contrast with their expectations for the future, and that the change and readjustment which will characterise their move to the community will be challenging.

Often, prisoners are unsure of their immediate circumstances on release from prison. For lifers in particular, who are returning to the community setting following a long period in prison, avenues of social support may have diminished. This was highlighted by prisoners, who noted the unsuitability of measures in place for them during this period:

> K.(Prisoner, 31): I've seen a few people getting lumped to hostels and that because they don't have anywhere else to go to, they don't have any family that will have them staying.
>
> Interviewer: What about hostels, is that a good environment?
>
> K.: I don't think it is a good environment. Because people in hostels all drink and take drugs and stuff.

This again highlights the insecurity which appears to characterise the transition to the community for many long term prisoners. It appears that overall that release from prison was fraught with insecurity for life sentence prisoners.

Optimism about Employment

In describing their opportunities for future employment, prisoners were optimistic about the variety of opportunities available to them upon return to the community. However, prisoners did acknowledge the challenges facing those with convictions for murder in seeking legitimate employment.

Prisoners regularly reflected on their hopes for legitimate employment on returning to the community. Many expressed a willingness to work upon release from prison:

> O. (Prisoner, 45): You can get help from the social work department and that, places take lifers on, like community service stuff and things like that. I'll give it a bash anyway and see what happens…
>
> Interviewer: Would you quite like to work?
>
> O.: Oh, aye. Keeps your mind occupied, keeps your mind going…

Prisoners illustrated their hopes for employment upon return to the community, detailing particular courses of action which they seek to pursue:

> I've got a lot of things going for us… And with the job situation I've got a lot of pals that still work in [the scaffolding] industry that would be able to get us a job. (N., Prisoner, 36)

> When I get out I can be a personal trainer, and it's an honest living, know what I mean, so… There's good money in that. (R., Prisoner, 28)

Prisoners' accounts here were optimistic in relation to the success of these intentions, and suggest that various options are available in this situation. Similarly, others illustrated their plans to return to education in the community:

> I'm hoping to go to university, because I know lifers that have done that, so I would actually like to go to university and finish whatever I do here. And actually start thinking about a career again. (P., Prisoner, 34)

Ultimately these accounts imply that even where prisoners have served long sentences following serious offences, they believe that options still exist for those who wish to pursue legitimate employment. One prisoner demonstrated an optimistic sense of choice in relation to this issue, suggesting that he was in a position to pursue a career which suits his interests:

> I wouldn't go back into an office, it was too boring in my eyes… I really want to concentrate on something that I'm interested in. (P., Prisoner, 34)

In spite of their apparent optimism, prisoners did acknowledge the obstacles they faced in relation to obtaining future employment:

> A job? Eh… It's not easy for a lifer is it. (O., Prisoner, 45)

It was suggested that this is a particularly difficult task for life sentence prisoners, given their histories of violent offending, and the length of time which they are likely to have spent in prison:

> I'll be 62 when I get out. I've been in prison twice for killing someone. There's not a lot of opportunities. (Q., Prisoner, 61)

> I'm a little bit nervous just because of the length of time that I've done. (R., Prisoner, 28)

Accordingly, prisoners expressed feelings of trepidation in relation to this aspect of his release from prison. In some instances, prisoners' awareness of the unique barriers they face in procuring employment led them to develop alternative strategies. For example, one prisoner asserted that that, owing to the difficulties facing him in relation to his offending history, he intended to become self-employed in the community rather than seeking work through an established employer:

> I've looked into it, and with me havin' the criminal record for murder, imagine sittin' in a job interview and saying that, it's hard enough wi'hout that. You need disclosure Scotland for everything. My only option is startin' up my own business. (P., Prisoner, 34)

In summation, prisoners were optimistic in relation to their hopes for future employment, and in particular the variety of opportunities available to them. However, it was acknowledged that their offending histories may place them at a disadvantage in seeking to procure employment, and accordingly they also expressed feelings of trepidation in this area.

Optimism about Relationships

Several prisoners were looking forward to the opportunity to rebuild relationships with female partners and children upon return to the future, as long periods of imprisonment had significantly diminished their capacity to maintain these bonds. Their comments illustrated optimism regarding their future relationships with partners and children:

> I need to work on these relationships. My wife's up to see me every week, she has done for the last 7 years, but to get back to livin' together in a relationship, you need to build on that after this. And the same with my daughter, I need to try and build the bridges that have not been there since she was 13. (T., Prisoner, 45)

> My main priority when I get out will be my daughter. (Q., Prisoner, 61)

Rebuilding these relationships represented a significant feature of prisoners' ambitions for their release. Similarly, where prisoners did not have partners or families, they were keen to pursue this once in the community:

> Really I just want to get out and get my own place and maybe a girlfriend. (K., Prisoner, 35)
>
> I want to settle down, have a family… a house, kids. (R., Prisoner, 28)

Developing a stable family background in this sense appeared to be a key aspect of the desistance process.

Prisoners did face challenges in this area, and these were acknowledged in their accounts. One prisoner noted that while he was optimistic about the prospect of a future intimate relationship, it may be difficult for female partners to accept his offending history:

> My attitude is that I understand it would be hard for [a girlfriend] but I think if I'm just straightforward and tell the truth she'll accept it or she won't. (P., Prisoner, 34)

Similarly, he noted that the length of time he has spent in prison may hinder his chances of starting a family upon release from prison, as he will be approaching late adulthood at the time of his release:

> That's the only thing I want to do to be honest, have kids... I'll be 39 or 40 by the time I'm back on the street. Don't get me wrong, I know you still can at that age but it's pushin' on a bit. (P., Prisoner, 34)

The prisoner is less positive here, and it appears that this particular challenge is especially daunting for him. Overall, rebuilding damaged relationships with intimate partners and children, or meeting a female partner and starting a family, were particularly important goals for the future for many prisoners. However, prisoners also acknowledged the challenges facing them in this area, with some exhibiting pessimism in relation to this issue.

Optimism and Giving Back

A final important feature of prisoners' comments in relation to the future focussed on the notion of 'giving back'. They expressed their hopes that others could learn from their own mistakes, and that they could use their experiences to their advantage in this way. For some, this meant providing guidance to members of their own families,

in particular children. For others this extended to ambitions to become involved in voluntary work. Recent attention has been given to such issues of generativity, a term coined by Erikson which signifies "a passing on of care, attention and support to future generations based on one's own experiences" in the context of criminal justice (Barry, 2006:143). Commitments to generative activity are said to provide offenders with a sense of purpose and fulfilment, while simultaneously offering 'proof' of professed individual changed and offering legitimacy to such claims (Maruna, 2001; Maruna and McNeill, 2008). Ultimately, "the sense of higher moral purpose that accompanies generative commitments might be necessary for sustaining desistance" (Maruna and McNeill, 2008: 233). The comments of prisoners in this study supported such assertions.

One prisoner asserted that he seeks to build a relationship with his estranged son in the future. He was hopeful that through this relationship he can divert his son from involvement in criminal activity:

> I've just started talkin' tae my son, he's 17 in April… His ma' says to me 'He hero worships you, 'cause you're in the paper.... He thinks you're something to look up tae'. I says 'Please believe me I'll make it known that I'm no' anythin' to look up tae' and I have made it known… I want to stop him from turnin' tae jail, I'd give my two legs for that tae happen, I wouldnae want tae wish this on anybody, especially my own son. (M., Prisoner, 39)

Other prisoners expressed similar desires for the future. Many also sought to 'give back' through involvement with more organised avenues of engagement with young people in similar situations to themselves upon release from prison:

> Q. (Prisoner, 61): But young people ask me for advice and I try tae keep them straight, I'd like to do a bit of that, work wi' young guys comin' outtae prison.
>
> Interviewer: That's positive, you might give something back.
>
> Q.: That's the way I think of it, if I can help anybody, I'd like to do that, and then it's no' just been a waste, it's not been a 'put him in prison, throw away the key' carry on. There's some benefit from it.

The prisoner here suggests that using his experiences in this way would provide meaning and purpose to his past, as others would 'benefit' from his advice. Similar intentions were described by other prisoners:

> I want to go out and I want to help young people, that's what I'm going to do, to go out and maybe catch a couple… I want to help as many as I can. (M., Prisoner, 39)

> Maybe I could talk to the younger boys, you know, and tell them that that's no' the right way to go about it, you know. (S., Prisoner, 23)

Overall, a strong desire to give back was common among life sentence prisoners. Whether this was through engagement with the prisoner's own family members, or through more organised endeavours such as voluntary work, such activities served a symbolic function. In terms of constructing a desisting identity, the desire to give back represented an important feature of such personas.

4.3. Optimism about the Future: Conclusions

Optimism about the future was the final feature of patients' and prisoners' recovering and desisting identities. This was expressed in relation to their success in the context of recovery and desistance, and to their hopes for happy and settled lives after leaving institutional settings.

Patients and prisoners expressed their hopes for recovery and desistance. Patients again focussed on recovery from mental illness as the key process here, and made little reference to desistance. Meanwhile prisoners detailed the strategies they intended to employ in effecting desistance. This again suggests that patients position recovery as the key process here, as rather than suggesting that they will need to work at desistance, they perceive it as something which will naturally follow from recovery.

Both groups were very optimistic about their hopes for a happy and settled life in the future, commenting on issues such as employment and relationships. Patients in particular were very positive in this area. While prisoners were optimistic, they also expressed trepidation regarding release from prison, largely as a result of their serious offending histories and the stigma attached to these, and the lengthy periods they had spent in institutional settings.

One final important difference which also emerged in this area was the notion of 'giving back'. This is a common element of traditional redemption scripts, and prisoners regularly suggested that they wanted to help others avoid offending. Conversely, patients made no reference to this. This can be understood in terms of the lack of culpability patients feel for their offending, which subsequently removes the necessity of making amends in patients' recovering and desisting identity.

5. CONCLUSIONS

Throughout this chapter, it is been advanced that where patients' and prisoners' accounts are concerned with the future, they give reference to recovery and desistance. More specifically, they illustrate engagement with these processes and subsequent attempts to construct recovered and desisting identities. In providing these accounts, both groups focussed on three key areas: neutralisation of the past, acceptance of the present, and optimism about the future. While there were many similarities in the accounts of both groups, significant differences also emerged.

In neutralising the past, both patients and prisoners employed traditional techniques of neutralisation. However, patients also advanced a second, and potentially more powerful, set of techniques based on mental illness. Their neutralisations of the past can be seen as more persuasive than those advanced by prisoners. This has significant implications for the identities of these groups. For patients, it was suggested that there was no need to change, and that their offending identities were never their true identities. Rather, because their previous offending behaviour was understood to be largely motivated by mental illness, it was implied that recovery from mental illness would facilitate a natural desistance from crime. Conversely, as prisoners were unable to employ these techniques, their justifications did not completely neutralise their past offending. In light of this, prisoners recognised a need to demonstrate that they had changed, and advanced comments to this effect.

Prisoners and patients expressed their acceptance of their present situations, and variations in their accounts were also apparent here, particularly in the area of culpability. Both groups described their present feelings of remorse for their offences. However, while prisoners tied this remorse to strong feelings of responsibility for their violence, patients made no clear reference to this. This can be understood again in relation to the perceived causes of offending. While prisoners suggest that they were violent of their own free will, patients characterise their violence as a product of mental illness and subsequently do not perceive themselves to be entirely culpable for these actions. Again this demonstrates the strong association between recovery and desistance processes for patients, as unlike prisoners it is not necessary for them to construct a desisting identity through an admission of responsibility, and desistance is once more seen as a by-product of recovery.

In accounting for the future, patients and prisoners were both largely optimistic regarding their hopes for recovery and desistance, as well as issues such as employment and relationships. However, there were several variations in their accounts in this area. First, while prisoners made particular reference to the means by which they sought to maintain desistance, patients did not. This again reflects the assumption on the part of this group that desistance is a natural occurrence in the context of recovery from mental illness, and that therefore there is no necessity for any specific endeavour to avoid offending. Secondly, unlike patients, prisoners expressed a level of trepidation in relation to their release from prison. This may be explained by the differences in the institutional settings where these interviewees were located. Patients were in a medium secure setting and were therefore accustomed to going out on pass into the community. The feelings of uncertainty which prisoners associated with life in the community were therefore not present in patients. Finally, while prisoners demonstrated a desire to 'give back' to others and to create something positive from their experiences, patients did not express such notions. It is possible that prisoners' intentions in this area stem from their feelings of culpability in relation to their offences, and a desire to make some form of symbolic reparations for their actions through these endeavours.

In conclusion, patients' and prisoners' accounts of the future demonstrated many similarities and divergences in relation to recovery from mental illness and desistance from offending. While prisoners' accounts of desistance were in line with the traditional 'redemption script' accounts advanced by Maruna (2001), patients' situations were more complicated. They were simultaneously engaged in the recovery and desistance processes. In constructing these identities, patients demonstrated that they position recovery as the primary process here, while the desistance process is seen to follow naturally from this. Thus, patients understand their future recovery from mental illness to be more important than their desistance from offending.

CONCLUSIONS

This thesis has sought to advance from existing understandings of the relationship between mental illness and violence. In particular, it aimed to move away from the focus on mental illness and its symptoms as the primary cause of such behaviour, and to look to criminological risk factors in seeking to understand such behaviour (Silver, 2006). Masculinity is one such factor which criminological literature has found to be strongly linked to violence, but has not yet been considered in the mentally disordered context. Accordingly, this research has aimed to examine the roles of mental illness and masculinity in driving violent offending.

If rehabilitative pursuits aim to reduce violent offending, it follows that they should endeavour to address the causes of such behaviour. This complex relationship may therefore have implications for the treatment and management of male psychiatric patients and prisoners convicted of violent offences. A further aim of this project was to examine the treatment and management of these groups, both in terms of the policy and practices implemented for this purpose, and how this is experienced by these individuals.

This concluding chapter will outline the key findings of this project, and their implications for mental health and criminal justice practice. It will be demonstrated that violence by the mentally ill and the wider population is similar in nature and origin, and that mental illness has a surprisingly modest association with violence. Masculinity plays a comparatively prominent role in driving violence for both groups, as violent incidents they described paralleled typical scenarios of masculine violence and were rooted in the desire to construct and maintain a masculine identity. Yet this is not reflected in treatment and management. For those deemed mentally ill, mental illness is perceived to be the cause of and solution to violent offending, rather than these non-illness related factors which may be more influential. Patients' and prisoners' experiences in this area are therefore divergent, both in terms of their time spent in institutional environments, and the processes of rehabilitation and desistance which these settings seek to effect, which have further implications for masculine

identities. Masculinity is not always acknowledged in criminal justice and mental health service practice which deals with such individuals. Ultimately, this dichotomisation of the two groups leads to variations in their ability to change and construct non-offending identities, with patients achieving this more effectively. The findings of this project have subsequent implications for the institutions and processes which treat and manage these groups.

1. FINDINGS FROM PATIENT AND PRISONER EXPERIENCES: MENTAL ILLNESS, MASCULINITY AND VIOLENCE

The findings of this project illustrate the similarities and divergences in patients' and prisoners' experiences in the areas of their past violent offending and life histories, present institutional settings, and future processes of recovery and desistance. If we consider these findings as a whole, they demonstrate significant disconnections between the causes of offending for these groups and the treatment and management which follows these offences.

1.1. The Past: The Causes of Violent Offending

It is first important to note that the causes of offending for both the mentally ill and the non-mentally ill are similar. Surprisingly and in contrast with existing stereotypes, the literature review in Chapter 1 and patient's accounts of their previous violence in Chapter 5 illustrated that mental illness has a somewhat modest role in driving such behaviour. It should be noted that a small minority of violence may be attributable to acute psychotic symptoms, and such exceptions were noted within this sample. Yet broadly speaking, mental illness plays a relatively small part in driving violence. In fact, throughout their life histories these groups are similarly affected by traditional risk factors for violent offending, as outlined in Chapter 6. As such, this thesis advocates a removal of the dichotomisation of these populations in terms of our understanding of their offending.

One factor which has strong links to violence is masculinity. Chapter 2 demonstrated that existing criminological literature posits masculinity as a cause of violence by males, suggesting that violent incidents occur where males seek to demonstrate or defend masculine identities. These assertions were supported by patients' and prisoners' accounts of previous violence, which indicated that these incidents played out in line with common masculine scenarios.

1.2 The Present: Experiences of Institutionalisation

It was also found that these similarities in the causes of offending are not reflected in the subsequent treatment and management of these groups. A review of policy and practice in Chapter 3 highlighted that throughout the criminal justice process individuals may be identified as mentally ill, impacting upon their subsequent treatment and management. While those deemed to be mentally ill are hospitalised in what research suggests to be a nurturing and caring environment, other offenders are incarcerated in the harsh and rigid setting of the prison. This does not correspond to the somewhat limited role of mental illness in driving violence, and instead positions it as the most significant factor in such behaviour for this group. It was also demonstrated that as well as the policies and practices in place in institutions, the experiences of those within are equally significant. An examination revealed that both institutions were experienced negatively, in particularly the prison. While this in part reflects the contrasting nature of these environments, it also relates to the affront to masculinity posed by institutionalisation, and the lack of acknowledgement of this in practice.

Chapter 7 illustrated that the two groups have differing experiences of treatment and management in the context of processes of institutionalisation. Patients were those who had been diagnosed with mental illness therefore hospitalised for treatment. This process imposed a vulnerable and dependent 'patient' identity upon them, which undermines traditional masculinities. Prisoners interviewed for this project were serving life sentences, and were accordingly labelled 'lifers'. The autonomous and resilient lifer identity reinforced and amplified elements of masculine personas.

Much reference was made to the nature of these institutions, and the varied ways in which they asserted control challenged patients' and prisoners' masculine identities. Patients' accounts illustrated that the hospital setting was characterised by consistent assessment and monitoring which constrained their actions, known as 'tightness', coercing them to comply and engage. The experience of long term imprisonment was seen to be more 'deep', in terms of the physical security and distance from release experienced by prisoners, and 'weighty' in terms of its oppressive and emotionally distressing nature, and the issue of 'tightness' was less prominently cited. This strict and vicious regime effected compliance from prisoners, but did not force them to engage. In both instances rebellion can be understood as an attempt to retain some of the control and autonomy which is integral to masculine identities.

1.3. The Future: Recovery and Desistance

Chapter 3gives attention to the aims of the secure forensic psychiatric hospital and the prison, noting that they aim to effect different processes. Patients in the hospital setting appear to engage in the recovery process, which again focuses on mental illness as the key obstacle which must be overcome, and is therefore in contrast somewhat with the process of desistance which is concerned with offending. This is in spite of the comparatively modest role mental illness appears to play in offending. For prisoners, desistance from offending is the desired outcome of treatment and management, whether this is to be achieved through rehabilitative practices or punishment.

The accounts of patients and prisoners in relation to this in Chapter 8 of this project have shown that the recovery framework appears to be a more effective framework for individual change. Findings indicate that this process did not lead patients to believe that they needed to change in order to address offending, rather they merely needed to revert to their pre-illness identity or 'the real me', which it was believed would happen naturally when mental illness subsided. While this model of understanding for their previous offending was willingly adopted, it also seemed to be a result of and learned through the institutional prioritisation of mental illness.

Thus, while the identification of mental illness as the cause of violence may be questionable, this facilitates a perceived change in identity. This 'collaboration of excuse' which developed between patients and staff in relation to violence seemed to facilitate the adoption of a non-offending identity, and as a result patients were particularly optimistic about their futures out with institutional care. While it should again be stressed that this optimism was in advance of release from the hospital setting, and therefore it was not possible to determine whether this would ultimately result in reduced or no future recidivism, it has been argued in this thesis and elsewhere that this is an important factor in avoiding future offending (Maruna, 2001). It appears that the commitment to avoid deviance and the adoption of an identity which conflicts with such behaviour is a significant factor in the success of such endeavours.

This framework of understanding was not available to prisoners seeking to make sense of their pasts. Prisoners were keen to emphasise that they had changed, by taking ownership of their offending and constructing a new identity within this context. In this sense, their accounts followed more traditional discourses regarding desistance, distinct from recovery in the sense that they focus on future offending behaviour rather than illness. This process of desistance is arguably a more difficult one owing to this responsibilisation, which appeared to require this group to actively demonstrate change. Again, this was prior to release from prison, and while it was not possible to determine whether prisoners were more likely to reoffend that patients upon returning to the community, but nevertheless this process did appear to be more difficult and could possibly have such implications.

1.4. Key Findings

Ultimately, this thesis has found that while both patients and prisoners have similar violent offending histories, as well as broader life histories, they are treated and managed in contrasting ways which do not reflect the causes of offending as a result of the prioritisation of mental illness. This appeared to create a variation in their capacity to change in institutional settings and their hopes for the future, both as a

result of their divergent experiences of institutionalisation itself, and the contrasting processes which the settings in which they find themselves aim to facilitate. This finding has implications for the existing policies and practices in place for the treatment and management of both of these groups.

2. RESEARCH FINDINGS: IMPLICATIONS FOR POLICY AND PRACTICE

The findings of this project have implications for mental health and criminal justice policy and practice. First, as it has been demonstrated that current treatment and management does not fully reflect the causes of violent offending, it could be suggested that adjustments could be made so as to address these factors in policy and practice. A second, and potentially conflicting, implication relates to the finding that the recovery process which mental health policy and practice appears to seek to facilitate is a somewhat easier framework for change and the development of non-offending identities. This implies that engagement in this process may also be beneficial to the wider population of offenders.

2.1. Addressing the Causes of Violence in Policy and Practice

Removing the Focus from Mental Illness

As this research and many other studies have demonstrated, mental illness plays a surprisingly small role in driving violent offending. These findings suggest that the current emphasis placed on mental illness in policy and practice may be unwarranted, and that it perhaps should not the leading factor which treatment and management seeks to address.

It has been noted that the role of mental illness in violence can be attributed to the presence of active psychotic symptoms (Swanson et al., 1996; Taylor et al., 1998; Swanson et al. 2006 A). As such, where mental illness is to be addressed in practice,

treating these symptoms should be the focus of such endeavours. At present mental health practice does seek to treat these symptoms, largely through medication, and as such little change can be recommended in terms of its practices in this area. However, it could be suggested that psychotic symptoms should be viewed as one of many needs which must be addressed for this group of offenders, rather than the most significant issue facing these individuals which sets them apart from other offenders in some way.

A further finding of this project is the wide ranging impact of mental illness as a destructive force in patients' life histories. As well as treating mental illness itself, treatment and management should endeavour to address the damage which this causes in other areas of individuals' lives. For example, practice may endeavour to assist patients in rebuilding relationships with families and partners which are damaged by mental illness, or to enable patients to re-enter employment or education which was interrupted by mental illness. Again, such measures are in place to an extent within current mental health institutions, which adopt a multi-disciplinary approach and include input from professionals such as social workers and occupational therapists who assist patients with some of these issues.

Recognising Similarities

While it cannot be refuted that the patients interviewed for the purposes of this research had such particular needs resulting from their mental illness, these were shared by many of the prisoners participating in this project. As outlined in Chapter 7, both groups had similarly disrupted life histories, including experiences of abuse, low educational attainment, involvement in gang culture and many other factors which are traditionally associated with offending. Therefore, these needs should be addressed for both groups. The review of policy and practice in Chapter 3 determined that while measures for this are in place in both the mentally disordered and non-mentally disordered contexts, these are more comprehensively implemented by the mental health service across the institutional and community settings. As such

the results of this research suggest that these standards should be mirrored within the criminal justice system.

As well as addressing these shared needs in equally effective ways, more generally it could be inferred that as patients and prisoners are similar, they should be similarly dealt with in practice. This thesis has highlighted that a dichotomisation of these groups exists in terms of our understandings of the causes of their violence, and this was also reflected in practice. Criminal justice processes currently identify individuals as suffering from mental illness, and subsequently incarcerate them in a setting which aims specifically to address this issue (Darjee, 2005; Thomson, 2006). This sets them apart from the wider offending population. Due to similarities in the causes of offending by patients and prisoners identified by this research, this dichotomisation appears somewhat unwarranted. The findings of this thesis therefore advocate its removal.

Yet how can this be achieved in practice? As this thesis has suggested that mental illness may not be the most significant factor which must be addressed, it could be said that treatment and management in the prison setting would be more reflective of the causes of violence. Yet it has been demonstrated here and in other studies that the prison setting may have a negative impact on mental illness and is an inappropriate environment for this group (Peay, 2007: 504). The prison has also been shown to be a harsh and distressing experience for those not diagnosed with mental disorder, both in this study and significant criminological literature (Sykes, 1958; Goffman, 1961; Cohen and Taylor, 1972). As such, it would conflict with other findings of this project to suggest that imprisonment be adopted for both groups here, and this thesis does not propose this approach. The alternative option here is the treatment and management of both those designated as mentally ill and the wider offending population in hospital, yet this option may be similarly unsuitable. For the mentally ill, this would maintain the current potentially unwarranted focus on mental illness as the solution to offending behaviour. The nature of intervention here may also be excessive in relation to the needs of non-mentally disordered offenders, and would remove the moral sanction for offending behaviour implied by imprisonment. It is

therefore difficult to suggest that one of these institutional settings, as currently functioning, could serve both groups. Yet it should be noted that the hospital setting appeared to be more effective in its facilitation of non-offending identities. This was in part due to the recovery based approached adopted but largely as a result of what has been termed the 'collaboration of excuse' which this approach appears to facilitate, and as such a means of adapting this element of treatment and management for both populations will be outlined in a subsequent section here.

In addition to being more reflective of the causes of offending, conceptualisation of the mentally ill and non-mentally ill as similar in policy and practice also has the potential to contribute to a reduction in stigma for this group. It was noted in Chapter 1 that stigmatisation of the mentally ill stems from notions that they are somehow different from others, and that these misunderstanding have a negative effect on this group (Markowitz, 2005; Crisp et al., 2007). If, rather than separating these individuals from other offenders, they were treated and managed in similar ways and by the same service or even within the same institution, this would communicate to the mentally ill as well as the public that this group are not significantly different from others and that this stigmatisation is unwarranted.

Masculinity in Policy and Practice

This research has also highlighted a lack of recognition of the role of masculinity in patients' and prisoners' experiences, both in terms of the role it plays in violent offending and the implications it has for experiences of institutional settings. Accordingly, an implication for policy and practice stemming from the findings of this research is an increased focus on this in practice.

In terms of addressing the causes of offending, it is important to make patients and prisoners aware of the role of masculinity in driving violence. For both groups, this could be achieved through therapeutic work. Group or individual psychological treatment could assist them in understanding the common scenarios for masculine violence, and could attempt to equip these individuals with means of responding to

challenges other than violence. At this point it should be noted that therapeutic measures aiming to address violent behaviour are already in place in both the hospital and the prison setting, for example the cognitive behavioural therapy referenced by patients or the violence groups described by prisoners. However, this research did not identify any such groups which gave an expressed focus to masculinity or male gender issues, and given the significant role that this factor has been shown to play in offending this can be considered something of an oversight. Such an intervention could prove to have important benefits for both groups in relation to reducing future offending.

Additionally, a heightened awareness of the implications of institutionalisation for traditional masculine identities would be beneficial in practice. Educating practitioners in the hospital and the prison may assist them in understanding and managing patients' and prisoners' adaptations to these settings. In the hospital setting, clinicians should be made aware of the ways in which hospitalisation and particular practices in this setting, for example restraint procedures, are perceived by patients as challenges to masculinity. This would leave them better equipped to negotiate potentially volatile situations which could lead to violence. Prison service practitioners should also understand the propensity of imprisonment, especially long term imprisonment, to reinforce problematic elements of masculine identities. This may provide staff with an increased understanding of the origins of conflicts between prisoners, therefore improving their ability to resolve these.

2.2. Adoption of the Recovery Model for Patients and Prisoners

The Effectiveness of the Collaboration of Excuse

Thus far in this thesis policy and practice has been criticised for its present propensity to treat patients and prisoners differently in spite of the demonstrated similarities between these groups. For patients, treatment and management appears to be grounded in the notion of recovery. This focuses on mental illness as the key issue which must be addressed in order to allow patients to recover their lives in spite of

their diagnoses. It also assists patients to neutralise violence as a product of mental illness which is out with their control. It should be noted at this point that neutralisation is traditionally a concept with negative connotations, as the advancement of such justifications is perceived to facilitate the drift in and out of deviant behaviour (Sykes and Matxa, 1957; Matza, 1964) Yet in this study, neutralisation of past offending appeared to be an important element in the development of non-offending identities and moving on from a history of serious violence. The process of change is therefore facilitated by a mutually beneficial 'collaboration of excuse' between staff and patients. This is effective in terms of enabling patients to develop non-offending identities by reverting to what they refer to as 'the real me'.. While it is questionable whether these non-offending identities truly existed for patients prior to the onset of mental illness given that many had violent offending histories which predated this, it is this element of the recovery framework, the ability to explain away previous violence, which appears to enable patients to move on in a positive and optimistic way.

Meanwhile, prisoners are unable to conceptualise offending in this way and are therefore unable to fully neutralise violent behaviour. The development of a non offending identity through the process of desistance appears to be a more difficult one, as the non-mentally ill must accept responsibility for their offending and develop a redeemed identity (Maruna, 2001). Therefore this thesis argues that although the causes of offending for both groups are similar, the variations in their treatment and management leave patients with a more effective means of constructing a non-offending identity than prisoners. As such, the findings of this research have further implications for policy and practice. It has already been posited here that both groups should be dealt with in similar ways, and the question was raised as to how this may be achieved. In addressing this, it could be suggested that such a framework of excuse in relation to violence should be available to both groups, therefore aligning their treatment and management more closely with one another. This could effectively involve the adoption of a public health model in criminal justice.

While this approach to treatment and management is hypothetically valid given its support from the findings of this project, in practice the implementation of policies and procedures which enable this could prove problematic. The key reason for the effectiveness of the recovery process in this sense is the unique nature of mental illness and its function as a complete neutralisation for serious offending behaviour (Matza 1964, 82). In order to extend this framework to the non-mentally ill, this group would have to be provided with a similar excuse, one which is more powerful in neutralising violence than the techniques currently available to them. It is important to remember at this point that for those identified as mentally ill such excuses are powerful primarily because they develop in collaboration with staff, and are therefore endorsed by an official source. For prisoners then, if such an excuse were to be made, professionals in this setting would be required to similarly affirm such justifications, and overlook the traditionally negative aspects of neutralisation, in order for them to be successful. It may then be possible to advance more powerful neutralisations in relation to criminological risk factors for violence, and for these to have a similarly powerful impact to mental illness, provided that this support from staff was forthcoming.

Recovery in the Non-Mentally Disordered Context: Pragmatism vs. Principles

It could be suggested that this approach is not entirely reflective of the causes of offending, a principle for treatment and management which was advocated in the previous section of these conclusions. Given the seemingly modest role of mental illness in driving violence which this thesis has demonstrated, it is difficult to suggest that this should be a central focus of policy and practice. Yet in this instance, the capability of treatment and management to meet its aims – the cessation of violent offending behaviour – does not correspond to its reflection of the causes of offending. This thesis argues that the ability of the recovery framework to create positive change found in this research is difficult to ignore, and it would be undesirable to depart from this model for patients. Moreover, if in the context of the non-mentally disordered offending population recovery were to be implemented with traditional criminological risk factors as a means of excuse, this would in fact mirror

the roots of violent behaviour, as such issues have been shown by this research to play a more significant role in driving offending. It should also be noted that enabling both groups to conceptualise their offending in this way would reflect the similarities in the causes of their violence, as well as giving them equal ability to develop non-offending identities. As such, the implementation of the recovery model in this way would not conflict entirely with the assertion that policy and practice should address offending's driving factors.

A potential barrier to the implementation of such an approach would be the public reaction to this framework, as it would not involve the retribution which is often perceived to be an appropriate and justified response to offending (Ashworth and Roberts, 2012). Nor would it serve the expressive function of many current punishments, which involve "an essential element of condemnation" of the act and the offender (Duff and Garland, 1994: 13). Moreover, it is likely that the public would recoil at the removal of culpability which is at the heart of such a framework, particularly in relation to violent offences. In this sense, neutralisation would be likely to be recognised as a negative process, in line with its description in much criminological literature, rather than a potentially necessary process which assists change. Such a public health inspired model would conflict with recent popular criminal justice trends which endeavour to responsibilise offenders and to offer reparation to victims, such as restorative justice (Gray, 2005).

Furthermore, it has been stressed here that the evidence in this thesis cannot confirm that the presence of desisting and recovering identities will guarantee a complete abstinence from offending when an individual is released into the community. The public may be similarly aware that the adoption of recovery and neutralisation for both groups is not a complete 'cure' for offending, and would therefore be sceptical of such an intervention. They may hold the view that, as has been noted here, patients and prisoners could simply demonstrate recovered ad desisting identities without being fully committed to change, in order to meet the requirements for release. Indeed, were such a model implemented it would be difficult to ensure that the identities demonstrated were genuine rather than constructed for this purpose.

In this sense, it is probable that the principles of the public would be at odds with this pragmatic approach. If such policies and practices were implemented, it would be necessary to ensure that those out with the medical and criminal justice professions were made aware of the potential for this collaboration of excuse to assist individual change which may prevent future offending. Overall, it is difficult to gauge how such policies would be received, yet it is probable they would be met with resistance.

2.3. Research Findings: Key Implications for Policy and Practice

Ultimately, two key insights which may prove of use in policy and practice stem from this research. First, an increased correlation between the causes of offending and its subsequent treatment and management was highlighted as desirable. This was suggested both in terms of a move away from the current emphasis placed on mental illness in this context, and towards a recognition of the similarities between the mentally disordered and non-mentally disordered population, such as the role of masculinity in offending. This may assist in reducing future offending, as well as aiding the treatment and management of these individuals in institutional settings. Second, as the collaboration of excuse which exists in the hospital setting appears to facilitate the construction of recovering and desisting identities, and may reduce recidivism, the extension of this element of the recovery framework to prisoners may help this group to develop non-offending identities in similar ways. Further research in this area which examined individuals both prior to and following release from institutions may be useful in providing an insight into the extent to which such identities do ultimately result in a lack of future crime and violence.

APPENDIX A: PATIENT AND PRISONER BIOGRAPHIES

A. (Patient, 54)

A. was transferred to the medium secure hospital in 2008 from the State Hospital, and had been diagnosed with paranoid schizophrenia since 1996. He was admitted to the State Hospital in 1997 on a CORO following the rape and assault of his sister, who was his primary carer. At this time he was acutely unwell and suffering from paranoid delusions about the victim of the offence, and had a drug and alcohol misuse problem. He had convictions for breach of the peace which also occurred in the context of mental illness, and an assault and robbery which took place in his adolescence and resulted in him serving time in a young offenders' institution. His childhood was unremarkable, but his adolescence was characterised by violence in the context of recreation. Prior to the onset of mental illness he worked on building sites in his local area, and he was divorced from the mother of his two children.

B. (Patient, 43)

B. was transferred to the medium secure hospital in 2008 from the State Hospital. He was diagnosed with paranoid schizophrenia since the late 1980s and had numerous periods of prior institutional care. He was admitted to the State Hospital in 2002 on a CORO following the culpable homicide of an elderly man, who he pushed resulting in his death. He was acutely unwell at the time, and was drinking heavily and had been habitually using cannabis for an extended period of time. Prior to this, he had several convictions including theft, fraud and housebreaking, which were generally committed to enable him to purchase drugs or alcohol. B. was also convicted of assault and housebreaking. During his childhood he performed well in school, but experienced bullying and left early. He experienced physical abuse from his father. His mother committed suicide in 1990, and there is a history of mental illness in his family. Prior to hospitalisation he was largely unemployed, but had a successful period of military service. He had several long term relationships but never married.

C. (Patient, 34)

C. was transferred to the medium secure hospital in 2009 from his local psychiatric hospital on a CORO. He had a psychiatric history dating back to 1998 with numerous

periods of institutional care, and his most recent diagnosis was paranoid schizophrenia. He was also described as having a difficult personality which included several psychopathic traits, but was not diagnosed with a personality disordered. He presented himself at his local hospital after setting fire to his flat in supported accommodation, and was charged with breach of the peace and possession of knives. He was suffering from schizophrenia at this time, and stated that he aimed to be hospitalised through these actions. Prior to this he had numerous criminal convictions including breach of the peace, assault, robbery and housebreaking. His childhood was partly spent overseas, however he returned to Scotland with his mother when his parents separated and was raised by her while his father remained there. He described difficulties of being a mixed race individual raised in a white family, and had no contact with his father who recently passed away. He had a history of recreational violence and drug use. He gained some qualifications, and attended university but left when his mental illness interfered with his studies, and his not worked since this time. He had casual relationships with females but no long term partners.

D. (Patient, 49)

D. was transferred to the medium secure hospital in 2001 from a non forensic ward on a CORO. He had a psychiatric history dating back 1983 with numerous periods of institutional care. He was diagnosed with paranoid schizophrenia, which was complicated by limited intelligence. He was transferred to the medium secure unit following assaults on staff members and posing a general management difficulty in other wards. He had a history of such behaviour, including sexual assaults on female staff members. In 1993 he started a serious fire outdoors, claiming that there were homosexuals hiding in the area, resulting in his imprisonment and transfer to the State Hospital. He had a series of criminal convictions dating back to 1974 including breach of the peace, theft, assault and arson. He was brought up by his grandparents and his childhood was characterised by misbehaviour including some criminal behaviour. He was disruptive in school and attended a secure school at one point. He

had no long-term employment prior to institutionalisation but had odd jobs in the community, and had no relationships with females.

E. (Patient, 49)

E. was transferred to the medium secure hospital in 2004 from the State Hospital on a Compulsion Order. His diagnosis was abnormal grief and adjustment, prior to which he had no psychiatric history. He was admitted to the State Hospital in 2003 after a breach of a peace at his sister's cremation, during which he assaulted police officers attempting to arrest him. He had a series of delusional beliefs surrounding his sister's death. He had one previous conviction for breach of the peace. His childhood was happy and settled, and he had a close relationship with his family. He was raised as a Christian. He performed well in school and was successful in business in his later life, and had casual relationships with females.

F. (Patient, 32)

F. was transferred to the medium secure hospital in 2009 from the State Hospital on a CORO. He was admitted to the State Hospital in 2008 following a serious assault on a sex worker, during a period in which he was acutely unwell and experiencing delusions. At this time he was diagnosed with bi-polar affective disorder, and had also been habitually using cannabis. He had no history of hospitalisation until this incident. Prior to this he had convictions for assault and theft. He had a generally happy child, although his parents' relationship was turbulent and ultimately they divorced, and his relationship with has father became problematic. His adolescence was characterised by recreational drug use. He performed well in school, and was professionally successful and worked overseas prior to developing mental illness. He had a series of long term relationships with females.

G. (Patient, 54)

G. was transferred to the medium secure hospital in 2010 from his local psychiatric hospital on a Compulsion Order. He was diagnosed with paranoid schizophrenia, in relation to which he demonstrated no insight, and also had a history of alcohol misuse and some drug use. Prior to this he had absconded from hospital and seriously assaulted one of the police officers who attempted to return him to hospital. He had a history of violent and threatening behaviour in inpatient settings, and had been an hospital several times in the past. Prior to hospitalisation, he had been convicted of assault and car theft, and had served sentences in prison for some of these offences. His childhood was happy, and while he performed poorly in school he was a successful amateur boxer. His parents are now divorced, and he had a poor relationship with his stepfather who was the victim of one of his assaults. He was largely unemployed prior to hospitalisation and described no serious relationships.

H. (Patient, 49)

H. was admitted to the medium secure hospital in 2011 on an Assessment Order. He was diagnosed with paranoid schizophrenia, and had upwards of 20 hospital admissions including a previous admission to the same medium secure hospital. Prior to admission he had absconded from his local psychiatric hospital to England where he was found and returned to hospital, and had a history of violence and aggression in an inpatient setting. He had a history of offending, including assault and theft. In 1993 he attempted to murder his father while unwell. His childhood was settled, although he performed poorly in school. He was also heavily involved in gang violence from a young age, and obtained a serious head injury in once incident. He described a history of serious alcohol misuse. Prior to hospital admission he was unemployed other than occasional casual work. He married at 25 but divorced from his wife soon after.

I. (Patient, 19)

I. was transferred to the medium secure hospital from prison in 2011. He was diagnosed as having suffered a schizophreniform episode as a reaction to imprisonment and additional personal problems at this time. During the episode he attempted to strangle a doctor in prison. He was in prison following a conviction for offences related to drug dealing. Prior to this he had no history of criminal behaviour or psychiatric disorder. His childhood was settled, although he was raised in an Islamic household and describes his upbringing as strict. He performed well in school and gained several qualifications at higher level. It was in the later years of high school that he began selling drugs. Prior to his imprisonment he was engaged, and the relationship ended while he was in prison.

J. (Patient, 51)

J. was transferred to the medium secure hospital from the State Hospital in 2011 on a CORO. He was diagnosed with bipolar affective disorder and had been in contact with psychiatric services since 2001, including several inpatient stays. He was admitted to the State Hospital in 2004, after killing his brother, who was his primary carer at the time, while at work on a farm. At this time he was acutely unwell and in a manic phase of his illness, and experiencing hallucinations and delusions. Prior to this he had no history of criminal behaviour. His childhood was happy and settled, although his father died in 1994. He performed poorly in school, and went on to work as a farm labourer until he was hospitalised. He was married in 1993 and divorced in 2004, which he cited as a source of his mental illness.

K. (Prisoner, 35)

K. was a life sentence prisoner who at the time of interview had served 14 years of his sentence, including time in a young offenders' institution at the start of his sentence and 11 years in the prison in question. He was convicted of murder following an incident at age 21 in which he and several friends killed another man in a confrontation while drinking socially in a friend's home. He was under the influence of the alcohol at the time of the incident and described binge drinking at

weekends. He also described a past heroin addiction in prison. Prior to his sentence at the time of interview, he had also served 5 years for an armed robbery which he committed with friends at the age of 15. He spent part of his childhood in Ireland, but left at age 12 when his dad died and did not return to school. Prior to imprisonment he never had a job and described involvement in gang culture. He described several short term relationships, including one which ended when he received his life sentence.

L. (Prisoner, 31)

L. was a life sentence prisoner who at the time of interview had served 14 years of an 18 year sentence, including 4 years in an English prison and 10 years in the research site. He was convicted of murder following an incident at age 17 in which he and two friends killed a male neighbour over a misunderstanding while drinking socially in their shared flat. He was under the influence of alcohol at the time of the offence and described serious alcohol misuse. At the time of interview he was using heroin in prison. Previously he had convictions for car thefts at a young age and had served a sentence in a young offenders' institution for this offence. His childhood was turbulent, as his father was violent towards him. He performed poorly in school, and had poor behaviour resulting in suspension and his eventual placement in a children's home. He described violent and criminal behaviour from a young age and involvement in gang culture. He had never worked and described no serious relationships.

M. (Prisoner, 39)

M. was a life sentence prisoner who at the time of interview had served 13 years of his life sentence, the tariff of which was 13 years. However, due to incidents while in prison, including taking nurses hostage in the prison, absconding from transportation to court and restraining staff, and attempted murder of a sex offender, an additional 18 years had been added to his sentence. He was convicted of murder following an incident in which he killed an elderly man in his home. He was drinking heavily at

the time of the incident and described a history of drug misuse. Prior to this sentence he had a long history of prison sentences dating back to 1998, for offences including breach of the peace and theft. His childhood was particularly turbulent, including time in institutional care, drug misuse and offending from as young as 10. He didn't attend school after primary school, and had never worked prior to being arrested. His offending and drug and alcohol misuse endured into adulthood. He described a serious long term relationship prior to imprisonment.

N. (Prisoner, 36)

N. was a life sentence prisoner who at the time of interview had served approximately 16 years in prison. This included 2 years in a young offenders institution, followed by 11 years in the research site, at which point he was released and then recalled for carrying a knife. Since that incident, he had failed drug tests in semi-open conditions and been returned to the research site as a result several times. He was convicted of murder following an incident at the age of 18, in which he mistakenly stabbed and killed a male friend in the context of gang violence. He was under the influence of alcohol during this offence, as well as dependency on vallium, and at the time of interview he was using heroin in prison. Prior to this he had no convictions for other offences. His childhood was largely settled, although his parents were separated, and it was characterised by involvement in gang culture. He gained some qualifications at school and left at 16, going on to work in construction until his offence. He had no serious relationships before coming to prison.

O. (Prisoner, 45)

O. was a life sentence prisoner who at the time of interview had served approximately 10 years in prison. He was convicted of murder following an incident at age 34 in which he and a friend assaulted and killed another male who they believed to have sexually assaulted a close female friend. He was under the influence of alcohol at the time of the offence, and had a history of alcohol misuse. Prior to this he had one other conviction for a violent offence, in which he had seriously assaulted

his brother-in-law. His childhood was settled, although he described absconding from school regularly from a young age, and did not attend secondary school, resulting in him being unable to read and write as an adult. He was largely unemployed before prison apart from some occasional casual work. He was married and had divorced from his wife, with whom he had one child.

P. (Prisoner, 34)

P. was a life sentence prisoner who at the time of interview had served approximately 6 years in prison of a 12 year life sentence. He was convicted of murder following an incident at age 28 in which he assaulted and killed another male in the context of an altercation in a pub. He was under the influence of alcohol at the time but described no history of dependence. Prior to this he had no criminal convictions. He described his childhood as happy and settled, and his relationships with his family as positive. He did well in school and went on to study at university and had a successful career as a stockbroker. He described several long term relationships prior to imprisonment, including one which he ended as a result of his life sentence.

Q. (Prisoner, 61)

Q. was a life sentence prisoner who at the time of interview had served 16 years of an 18 year sentence. He was convicted of murder following an incident at age 44 in which he assaulted and killed a sex offender who lived in his local area. Prior to this, he had served a 9 year sentence in various English prisons for manslaughter following involvement in a bar fight in which a man was killed, and had also served time in borstal around the age of 17. His childhood was turbulent, as his father was physically violent to him and his mother, and he had a close relationship with his grandfather. He left school early after behaviour problems, with no qualifications. He worked as a milkman for many years after leaving school, but left and supported himself through criminal activity, including armed robberies of betting shops and selling stolen goods. Had several long term relationships, including one marriage which ended in divorce, and had three children with different mothers.

R. (Prisoner, 28)

R. was a life sentence prisoner who at the time of interview had served 9 years of a 12 year sentence, including two years in a young offenders' institution before coming to the prison in question. He was convicted of murder following an incident at age 18 in which he and two other men involved in drug dealing tortured and killed a man. Prior to this he served a 2 year sentence in a young offenders' institution for stabbing another male in an altercation. His childhood was turbulent, as his father was absent and he was excluded from several schools and eventually placed in an institutional school. His local area was characterised by gang culture, which he broke away from as a result of older peers. He was then involved in drug dealing from a young age and never worked prior to imprisonment.

S. (Prisoner, 23)

S. was a life sentence prisoner who at the time of interview had served 8 years of a 12 year sentence, including some time in a young offenders' institution prior to his transfer to the research site. He was convicted of murder following an incident at age 15 in which he killed a man who had smashed a window in his female cousin's home. Prior to this he had not spent time in prison. His childhood was disrupted, and he was brought up by his grandparents as his parents were drug addicts. He performed poorly in school, and had additional learning needs as well as being badly behaved and regularly being suspended. He did some part time work for his father prior to coming to prison, and had no significant girlfriends.

T. (Prisoner, 45)

T. was a life sentence prisoner who at the time of interview had served 7 years of an 11 year sentence, including 2 in another prison and 5 in the research site. He was convicted of murder following an incident at age 38 in which he stabbed and killed a man who had previously burgled his home. Prior to this he had spent a short sentence

in prison for driving offences but described no other offending. His childhood was settled, although he was raised in an area characterised by crime. He performed poorly in school and was excluded for truanting. He worked in full time employment for all of his adult life. He had a wife of 23 years, who he was still married to at the time of interview, and one daughter.

APPENDIX B: THE MATRIX OF SECURITY

THE MATRIX OF SECURITY IS AN EXCERPT OF THE DEFINITIONS OF LEVELS OF SECURITY REPORT

Table 7 The Matrix of Security

ENVIRONMENTAL SECURITY					
Delineator	**LOW**			**Medium**	**High**
	Open ward	**IPCU/locked rehab**	**Locked forensic unit/ward**		
DESIGN AND CONSTRUCTION					
Perimeter (e.g. fence)	Standard hospital specifications		No secure perimeter, but secure outside area. Secure external windows	No secure perimeter, but secure outside area. Secure external windows. Deterrent perimeter fence with motion sensors	5.2m secure fence, additional motion detection perimeter
Control of access to the site	Standard hospital specifications	double locked doors		electronic airlock	Airport level security
Building design to deter escape	Standard hospital specifications - not specifically designed to deter escape	Specifically designed to deter escape		robust construction able to deter and delay determined escape	robust construction able to withstand determined escape with tools
Window / door security	Standard hospital specifications	Window restrictors / reinforced windows	Doors opening outward (interview room and bedroom), window restrictors / reinforced windows	Keypad entry, internal doors reinforced. Communicating doors alarmed if kept open. Two way opening (interview room and bedroom) doors, reinforced windows with anti-smuggling grid on external windows.	Prison service approved locks, airlock systems some break-proof windows, some use of electronic control of doors. No external windows
Furniture design	standard hospital furniture			Heavy and robust	
EQUIPMENT					
X-ray / metal detector / ion detector	None routinely used	Hand held metal detector			xray machine, arch and handheld metal detector, ion detector, sniffer dogs from partner organisations if required
Personal alarm systems	Standard personal alarms	location specific		location specific - response team alerted by pager	location specific security alerted and tannoy to hospital campus and response team
Physical restraints	None used				handcuffs for exceptional leave
Campus observation (CCTV)	Limited to specific locations			Complete external, point of access, air locks, kept 2 weeks	complete campus and perimeter, kept 3 weeks
Availability of additional secure area for behaviourally disturbed patients	None	normal bedrooms used		Individual additional secure area available with bedroom and living area	A range of individual secure areas with bedroom and living space

Table 7 The Matrix of Security (cont.)

PROCEDURAL SECURITY					
Delineator	**LOW**			**Medium**	**High**
	Open ward	**IPCU/locked rehab**	**Locked forensic unit/ward**		
COMMUNICATIONS					
Patients phone calls	No restriction except in "exceptional circumstances"			Can be monitored or stopped	
Patients letters/mail	Can be monitored in a limited way – Section 117 MH(S) A 1984				All post X rayed. Can be monitored - Section 117 MH(S) A 1984 - with additional statutory powers
Patients electronic mail / access to the internet	Not supervised if available		Supervised access on site unsupervised off site		no access
Staff communications	unrestricted received mail				received mail is x-rayed
ITEMS – RESTRICTED (or prohibited)					
Searching patients	As warranted by individual risk assessment	On admission including possessions and as warranted by individual risk assessment - random searches following LOA		On admission, following LOA, regular personal – and regular room searches.	
Searching visitors, official visitors, staff	none routine			None routine – but secure lockers available for bags (not allowed in patient areas)	Searched if metal detectors are set off and random entrance and egress searches. Bags searched if suspicious item seen in x-ray imaging.
Drug access/screening	Screening dependant on clinical need	Urinary drug screening on basis of clinical need and on admission & random screening			
Alcohol access/screening	Access to alcohol on leave approved by MDT. Alcometer available				No access to alcohol permitted
Access to pornographic materials and/or materials portraying violence	MDT discretion, individual patients			Routine screening and controlled access	
ITEMS – Daily living equipment					
Cutlery	supervised meals	Restricted metal cutlery - counted after use, supervised meals			
OT equipment (e.g. kitchen)	MDT approval			graduated access following individual risk assessment and MDT approval	
Fire setting materials (e.g. cigarette lighters)	Dependant on individual risk assessment	Controlled/ limited access, no fire setting material with patients			
ITEMS - Access to money, valuables and belongings					
Access to belongings	At MDT discretion			Limited number of items and limited access	

Access to money/valuables	Dependant on individual assessment of capacity	Dependant on individual assessment of capacity. May be restricted	Dependant on individual assessment of capacity. May also be restricted on LOA to reduce absconsion risk	Dependant on individual assessment of capacity. Money and valuables are also restricted on site and on LOA for security reasons

Table 7 The Matrix of Security (cont.)

PROCEDURAL SECURITY					
Delineator	**LOW**			**Medium**	**High**
	Open ward	**IPCU/locked rehab**	**Locked forensic unit/ward**		
PEOPLE- visitors					
Visitor ID and approval	Not generally required			Identification required. Prior approval by MDT, Unit policy. Visitors must agree code of conduct	Identification required then special ID provided and checked on exit. Prior approval by MDT. Visitors must agree code of conduct
PEOPLE- Child Visitors					
Child visiting policy	Nursing staff discretion	approved by MDT		Social work assessment required, approval via MDT	
Visiting arrangements procedure	Specified visiting areas (other restrictions dependant on risk present at time)			Special family visiting room away from clinical area	Special family visiting suite away from clinical area
PEOPLE- Internal Movement between clinical areas in a psychiatric facility					
Patients	may be escorted			Escorted within Unit – no access to administrative areas	Grounds access for some patients - monitored by CCTV, some escorted, prohibited areas in the campus
Visitors / official visitors	may be escorted	Escorted			Escorted - bussed to location of visit
Staff	None			Not limited, but electronically recorded	electronically recorded and restricted access to some areas
Provision of recreations/therapies	Range – with majority off ward			On Unit wide range of secure activities. Range off-site available	On campus range of secure activities

Table 7 The Matrix of Security (cont.)

PROCEDURAL SECURITY					
Delineator	**LOW**			**Medium**	**High**
	Open ward	**IPCU/locked rehab**	**Locked forensic unit/ward**		
PEOPLE- Patient absence from the hospital					
Routine pass (e.g. "testing out")	Standard hospital policy		Unit policies including individual risk assessment		Usually a minimum of two escorting staff
Exceptional LOA (e.g. court, hospital)	Standard hospital policy		Unit policies including individual risk assessment.	Unit policies including individual risk assessment. Local police informed.	handcuff meeting, police liaison, more escorting staff
Prevention and management of absconsion	Standard hospital policy			Unit policies – description card (ID) completed every time a patients leaves clinic and returns, key information and risk assessment given to police in case of absconsion	Individual risk assessment for each LOA, usual to have 2 or more staff escorting. Individual risk assessment of grounds access. Range of multi-agency contingency plans, network of sirens
Prevention and management of escape	Standard hospital policy			Unit policy. Key information and risk assessment given to police	Contingency planning, liaison with police, siren
Miscellaneous					
Policies	General hospital policies	General hospital policy. Some unit policies	General hospital policy. Some forensic unit policies	Detailed forensic unit policies	High secure forensic hospital policies
Contingency planning	limited contingency planning		Multi-agency planning for evacuation, escape and absconsion		range of multi-agency contingencies for hostage, riot, escape, barricade, rooftop

APPENDIX C: ETHICAL DOCUMENTATION

1. PATIENT INFORMATION SHEET:

Understanding the causes of violent offending behaviour by males suffering from a major mental illness. *Christine Haddow, University of Edinburgh*

Information for Participants

Aim of this Project

This project aims to explain violent offending by mentally ill males, by considering factors which they feel have contributed to their violent behaviour. Mentally disordered males with a history of violence will be interviewed in depth about their life histories.

Taking Part

If you agree to take part, you will be interviewed, possibly more than once, about your past and times when you have behaved violently. The interview will take place in the clinic, and will be one on one with the researcher. This will be a chance to talk informally and openly about your past and why you think you have been violent, and you will be able to lead the conversation. Topics which might be discussed include:

- Family and Childhood
- School and Adolescence
- Employment
- Relationships
- Mental Illness
- Violent Crimes
- Identity and Role Models
- Future Plans and Aspirations

Volunteering

If you decide to take part, you are volunteering to do so. Whether or not you decide not to take part, this will have no effect on your care and treatment.

<u>If you agree to take part in the study:</u>

- You can change your mind and stop taking part in the study at any time.
- You can refuse to answer any questions or discuss any issues which you do not want to discuss.

<u>If you change your mind and decide you want to withdraw from the study:</u>

- You do not have to give a reason for deciding to do this.
- It will not have any effect on the following care and treatment you receive.

Support

The interviews will involve talking about things which might be upsetting for you. Because of this, patients taking part will be in a supportive environment during and after the interviews. Your treatment will continue and it has been agreed in principle with medical professionals that you will receive continuing support and care. If you feel distressed during an interview you can refuse to answer any questions that are upsetting, or you can ask to stop and the researcher will arrange to come back another day to carry on the interview.

Confidentiality and Anonymity

All interviewees will be guaranteed confidentiality and anonymity throughout this project. Any information you provide will be private, and you and the clinic will not be named in the write up of the study, which may be published. The information collected in interviews will be securely stored at all times, no copies will be made or distributed, and only the researcher will have access to the data.

There are certain situations where the researcher would have a duty to report to other people about information which you have provided. The researcher would disclose information in the following situations:

1. **If information you give shows that there is an immediate risk of harm to yourself or others** – e.g. if you give information which clearly identifies someone who you say is currently being victimised or harmed in some way, or if you give information which shows you are in danger.
2. **If you show a clear intention to cause harm to yourself or others in the immediate future** – e.g. if you talk about plans to attack members of staff or other patients, or clear plans to commit an offence upon release from the institution.
3. **If information you give shows there is a current risk to security in the clinic** – e.g. if you talk about a weapon, mobile phone or other prohibited items you have in the clinic, or if you talk about plans to abscond from the clinic.

If you start to give information like this during the interview, you will be reminded that the researcher will have a duty to tell someone about it if you go on. If you continue to give the information, the researcher will keep recording the information and will pass it on to the relevant people in the clinic, who will decide on the appropriate steps to take.

2 .PATIENT CONSENT FORM

Understanding the causes of violent offending behaviour by males suffering from a major mental illness. *Christine Haddow, University of Edinburgh*

Participant Consent Form

- ☐ I consent to take part in the above named project, by participating in interviews.

- ☐ I have read and understood the patient information sheet provided, and know who to contact if I require further information.

- ☐ I understand that by consenting to participate, I may still refuse to answer any questions, or withdraw at any time, without providing reason, and that this will have no detrimental effect on the treatment and care provided to me.

Participant Signature:_____

Date:_____

Witness Signature:_____

Date:_____

3. PATIENT INTERVIEW SCHEDULE

Living Arrangements, Family Situation and Relationships

- Quality of home life and family relationships in early years
- Early experiences of discipline
- Opinion of the local area

Institutional History/Mental Illness

- Experiences of mental illness and its symptoms
- Experiences of hospitalisation and inpatient care
- Violence in hospital settings

Experience of the Criminal Justice System/Violence

- Contact with the criminal justice system – police
- Violent behaviour over the life course
- Insights into the causes of violent behaviour

Friendships, Relationships and Recreation

- Recreation - habits and activities
- Significant relationships and the nature and quality of these – intimate partner, children, other.

Self Perception/Identity/Role Models

- Heroes and role models, and living up to these
- Perceived identities in close social networks – family, friends
- Identity and 'the real you' – impact of mental illness on this

School and Education

- Social relationships/status in the context of school
- Behaviour and conduct in a school setting – bullying, fighting, truancy
- Successes and challenges with schoolwork

Post School – Employment/Unemployment/Study

- Experiences of employment/unemployment/study after leaving school
- Aspirations at this age

Future/Aspirations

- Feelings about returning to the community
- Short and long term aspirations
- General reflections on their life history

4. NHS ETHICAL APPROVAL

Lothian NHS Board

South East Scotland Research
Ethics Committee 03
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 536 9000
Fax 0131 536 9088

www.nhslothian.scot.nhs.uk
Date
Our Ref
Enquiries to Joyce Clearie
Extension 35674
Direct Line 0131 465 5674
Email joyce.clearie@nhslothian.scot.nhs.uk

29 July 2010

Miss Christine Haddow
4/3 Tytler Court
Edinburgh
EH88HJ

Dear Miss Haddow

Study Title: **Understanding the Relationship Between Major Mental Illness and Masculinity in the Context of Violent Offending Behaviour**
REC reference number: **10/S1103/37**
Protocol number:

Thank you for your letter of 27 July 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by the Chair and Vice Chair of the committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Investigator CV	CI Haddow	26 May 2010
Protocol	1	26 May 2010
REC application		26 May 2010
Covering Letter		
Interview Schedules/Topic Guides	1	26 May 2010
Participant Information Sheet: PIS	2	27 July 2010
Response to Request for Further Information		27 July 2010
Participant Consent Form: PCF	2	27 July 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/S1103/37	**Please quote this number on all correspondence**

Yours sincerely

Dr Christine West
Chair

Email: joyce.clearie@nhslothian.scot.nhs.uk

Enclosures: "After ethical review – guidance for researchers" *[SL-AR1 for CTIMPs, SL- AR2 for other studies]*

Copy to: *Gemma Watson, The University of Edinburgh*
[R&D office for NHS care organisation at lead site]

5. PRISONER INFORMATION SHEET

Understanding the causes of violent offending behaviour by males suffering from a major mental illness. *Christine Haddow, University of Edinburgh*

Information for Participants

Aim of this Project

This project aims to explain violent offending by mentally ill males, by considering their life histories and experiences of violent behaviour, and comparing them to experiences of non mentally ill males. In the prison setting, male prisoners with a history of violence who do NOT suffer from a mental illness will be interviewed in depth about their life histories.

Taking Part

If you agree to take part, you will be interviewed, possibly more than once, about your past and times when you have behaved violently. The interview will take place in the prison, and will be one on one with the researcher. This will be a chance to talk informally and openly about your past and why you think you have been violent, and you will be able to lead the conversation. Topics which might be discussed include:

- Family and Childhood
- School and Adolescence
- Employment
- Relationships
- Violent Crimes
- Identity and Role Models
- Future Plans and Aspirations
- Institutional History

Volunteering

If you decide to take part, you are volunteering to do so. Your decision about taking part will have no effect on your management and care in prison.

<u>If you agree to take part in the study:</u>

- You can change your mind and stop taking part in the study at any time.
- You can refuse to answer any questions or discuss any issues which you do not want to discuss.

<u>If you change your mind and decide you want to withdraw from the study:</u>

- You do not have to give a reason for deciding to do this.
- It will not have any effect on your management and care.

Support

The interviews may involve talking about things which might be upsetting for you, and support will be available if this should happen. Because of this, if you feel distressed during an interview you can refuse to answer any questions that are upsetting, or you can ask to stop for a break, or the researcher will arrange to come back another day to carry on the interview.

Confidentiality and Anonymity

All interviewees will be guaranteed confidentiality and anonymity throughout this project. Any information you provide will be private, and you and the clinic will not be named in the write up of the study, which may be published. The information collected in interviews will be securely stored at all times, no copies will be made or distributed, and only the researcher will have access to the data.

There are certain situations where the researcher would have a duty to report to other people about information which you have provided. The researcher would disclose information in the following situations:

1. **If information you give shows that there is an immediate risk of harm to yourself or others** – e.g. if you give information which clearly identifies someone who you say is currently being victimised or harmed in some way, or if you give information which shows you are in danger.
2. **If you show a clear intention to cause harm to yourself or others in the immediate future** – e.g. if you talk about plans to attack members of staff or other prisoners, or clear plans to commit an offence upon release from the prison.
3. **If information you give shows there is a current risk to security in the prison** – e.g. if you talk about a weapon, mobile phone or other prohibited items you have in the prison, or if you talk about plans to abscond from the prison.

If you start to give information like this during the interview, you will be reminded that the researcher will have a duty to tell someone about it if you go on. If you continue to give the information, the researcher will keep recording the information and will pass it on to the relevant people in the prison, who will decide on the appropriate steps to take.

6. PRISONER CONSENT FORM

Understanding the causes of violent offending behaviour by males suffering from a major mental illness. *Christine Haddow, University of Edinburgh*

Participant Consent Form

- ☐ I consent to take part in the above named project, by participating in interviews.

- ☐ I have read and understood the prisoner information sheet provided, and know who to contact if I require further information.

- ☐ I understand that by consenting to participate, I may still refuse to answer any questions, or withdraw at any time, without providing reason, and that this will have no detrimental effect on my management and care.

Participant Signature:_____

Date:_____

Witness Signature:_____

Date:_____

7. PRISONER INTERVIEW SCHEDULE

Interview Headings and Themes

Living Arrangements, Family Situation and Relationships

- Quality of home life and family relationships in early years
- Early experiences of discipline
- Opinion of the local area

Institutional History

- Experiences of imprisonment
- Violence in the prison setting

Experience of the Criminal Justice System/Violence

- Contact with the criminal justice system – police
- Violent behaviour over the life course
- Insights into the causes of violent behaviour

Friendships, Relationships and Recreation

- Recreation - habits and activities
- Significant relationships and the nature and quality of these – intimate partner, children, other.

Self Perception/Identity/Role Models

- Heroes and role models, and living up to these
- Perceived identities in close social networks – family, friends
- Identity and 'the real you' – impact of offending on this

School and Education

- Social relationships/status in the context of school
- Behaviour and conduct in a school setting – bullying, fighting, truancy
- Successes and challenges with schoolwork

Post School – Employment/Unemployment/Study

- Experiences of employment/unemployment/study after leaving school
- Aspirations at this age

Future/Aspirations

- Feelings about returning to the community
- Short and long term aspirations
- General reflections on their life history

8. SOURCES OF SUPPORT IN HM PRISON X

While these interviews are not expected to cause you distress, if you would like access to sources of support within the prison following the interviews it can be provided by one of the following organisations:

- **Mental Health Service**
- **Prison Chaplaincy Team**
- **Prison Listeners Service**

These organisations all provide effective support and you may contact them at any time.

APPENDIX D: GLOSSARY

Care Programme Approach (CPA)
The framework in place for the treatment of forensic psychiatric patients in Scotland. It is characterised by a collaborative and multidisciplinary approach.

Comorbid Disorder
An additional mental health condition occurring in tandem with mental illness. Generally these are either comorbid personality disorders, or comorbid drug and alcohol misuse problems.

Drug and Alcohol Induced Psychosis
A transient rather than enduring mental health problem caused by excessive misuse of either or both of these substances.

Diagnostic and Statistic Manual of Mental Disorders (DSM-IV-TR)
This is a text published by the American Psychiatric Association which provides standardised definitions of mental disorders. DSM-III refers to an earlier version of this manual.

Historical, Clinical, Risk Management 20 (HCR-20)
A clinical risk assessment tool which considers the presence of 20 factors relating to an individual's history, clinical state and risk management in relation to violence.
International Classification of Diseases, 10th Edition (ICD-100: A publication produced by the World Health Organization, which provides standardised criteria for the diagnosis of diseases and contains a specific section on mental and behavioural disorders.

Major Mental Illness
Major disorders of thought or affect which cause significant impairment and require treatment. For example schizophrenia or bi-polar disorder.

MacArthur Community Violence Interview
A methodological tool which measures violent behaviour via self-reports over a period of 6 months.

Personality Disorder
An entrenched and constant pattern of behaviour and responding to situations. This does not amount to a major mental illness.

Positive and Negative Symptom Scale (PANSS)
This is a tool used to rate individual psychotic symptoms on a 7-point scale from 'symptom absent' to 'extreme'.

Revised Level of Service Inventory (LSI-R)
Instrument which examines risk factors for re-offending. This information is used in addition to details of a prisoner's history to assess the likelihood of re-offending.

Risk Assessment Guidance Framework (RAGF)
Instrument for the identification of relevant risk factors. These may be static factors which are unchangeable, such as age and offending history, or dynamic factors related to changeable issues, for example socio-economic status or educational attainment. These framework also suggests a level of service which will minimise the risk of re-offending in light of risk factors.

Violence Risk Assessment Guide (VRAG)
A clinical risk assessment tool which aims to assess the risks of violence by considering patients in light of 12 factors which are collectively most predictive of violence.

BIBLIOGRAPHY

Agar, M. (1980) 'Stories, Background Knowledge and Themes: Problems in the Analysis of Life History Narrative' in *American Ethnologist, Vol. 7, No. 2, 224-236.*

Alder, C.M. and Polk, K. (1996) 'Masculinity and Child Homicide' in *The British Journal of Criminology, Vol. 36, No. 3, 396-411.*

Anderson, A. (1997) 'Mental Illness and Criminal Behaviour: A Literature Review' in *Journal of Psychiatric and Mental Health Nursing, Vol. 4, No. 4, 243-250.*

Andersson, K. (2008) 'Constructing Young Masculinity: A Case Study of Heroic Discourse on Violence' in *Discourse & Society, Vol. 19, No. 2, 139-161.*

Appelbaum, P.S, Robbins, P.C. and Monahan, J. (2000) 'Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study' in *American Journal of Psychiatry, Vol. 157, No. 4, 566-572.*

Archer, J. (1993) 'Violence Between Men' in J. Archer (ed.) *Male Violence*, London: Routledge.

Arendell, T. (1997) 'Reflections on the Researcher-Researched Relationship: A Woman Interviewing Men' in *Qualitative Sociology, Vol. 20, No. 3, 341-368.*

Arskey, H. and Knight, P.T. (1999) *Interviewing for Social Scientists: An Introductory Resource With Examples,* London: Sage.

Ashworth, A. and Roberts, J. (2012) 'Sentencing: theory, principle, and practice' in M. Maguire, R. Morgan, and R. Reiner (eds.) *The Oxford Handbook of Criminology,* Oxford, Oxford University Press.

Balswick and Collier (1976) 'Why Husbands Can't Say "I Love You"' in D.S. David and R. Brannon (eds.) *The Forty-Nine Percent Majority: The Male Sex Role,* Philippines: Addison-Wesley

Bamberg, M. (2010) 'Who Am I? Narration and its Contribution to Self and Identity' in *Theory & Psychology, Vol. 21, No. 1, 3-24.*

Bank, J.B. and Hansford, S.L. (2000) 'Gender and friendship: Why are men's best same-sex friendships less intimate and supportive?' in *Personal Relationships, Vol. 7, No. 1, 63-78.*

Barry, M. (2006) *Youth Offending in Transition: The Search for Social Recognition,* London: Routledge.

Beaty, L.A. (1995) 'Effects of paternal Absence on male Adolescents' Peer Relations and Self-Image' in *Adolescence, Vol. 30, No. 120, 873-880.*

Beauford, J.E., McNeil, D.E. and Binder, R.L. (1997) 'Utility of the Initial Therapeutic Alliance in Evaluating Psychiatric Patients' Risk of Violence' in *American journal of Psychiatry, Vol. 154, No. 7, 1272-1276.*

Becker, H. S. (1963) *Outsiders: studies in the sociology of deviance,* New York: Free Press

Behr, G.M et al. (2005) 'Zero Tolerance of Violence by Users of Mental Health Services: The Need for an Ethical Framework' in *British Journal of Psychiatry, Vol. 187, No. 1, 7-8.*

Benson, D. and Archer, J. (2002) 'An Ethnographic Study of Sources of Conflict Between Young Men in the Context of the Night Out' in *Psychology, Evolution and Gender, Vol. 4, No. 1, 3-30.*

Biller, H.B. (1970) 'Father Absence and the Personality Development of the Male Child' in *Developmental Psychology, Vol. 2, No. 2, 181-201.*

Bird, S.R. (1996) 'Welcome to the Men's Club: Homosociality and the Maintenance of Hegemonic Masculinity' in *Gender and Society, Vol. 10, No. 2, 120-132.*

Borland, K. (1991) ''That's Not What I Said': Interpretive Conflict in Oral Narrative Research' in S.B. Gluck and D. Patai (Eds.) *Women's Words: The Feminist Practice of Oral History,* New York: Routledge.

Bowers, L. et al. (2003) 'A Trial of an Anti-Absconding Intervention in Acute Psychiatric Wards' in *Journal of Psychiatric and Mental Health Nursing, Vol. 10, No. 4, 410-416.*

Bowers, L., Alexander, J. and Gaskell, C. (2002) 'Safety and Security Policies in Psychiatric and Secure Admissions Wards: A Result of a London Wide Survey' in *Journal of Psychiatric and Mental Health Nursing, Vol. 9, No. 4, 427-433.*

Brod, H. and Kaufman, M. (eds.) (1994) *Theorizing Masculinities,* Thousand Oaks, CA: Sage.

Brookman, F. (2003) 'Confrontational and Revenge Homicides Among Men in England and Wales' in *The Australian and New Zealand Journal of Criminology, Vol. 36, No. 1, 34-59.*

Brookman, F. (2005) *Understanding Homicide,* London: Sage.

Burnett, R., Baker, K. and Roberts, C. (2007) 'Assessment, Supervision and Intervention: Fundamental Practice in Probation' in L. Gelsthorpe and R. Morgan (eds) *Handbook of Probation,* Cullompton: Willan.

Cameron, D. and Frazer, E. (1987) *The Lust To Kill,* Cambridge: Polity Press.

Canaan, J.E. (1996) '"One thing leads to another": Drinking, Fighting and Working-Class Masculinities' in M. Mac an Ghaill (ed.) *Understanding Masculinities,* Buckingham: Open University Press.

Carlen, P. (1983) *Women's Imprisonment,* London: Routledge.

Cavadino, M. and Dignan, J. (2002) *The Penal System: An Introduction,* London: Sage.

Cavanagh, K. and Lewis, R. (1996) 'Interviewing Violent Men: Challenge or Compromise?' in K. Cavanagh and V.E. Cree (eds.) *Working With Men: Feminism and Social Work,* London: Routledge.

Cavanagh, K., Dobash, R.E and Dobash, R.P (2007) 'The Murder of Children by Fathers in the Context of Child Abuse' in *Child Abuse & Neglect, Vol. 31, No. 7, 731-746.*

Charmaz, K. (1994) 'Identity Dilemmas of Chronically Ill Men' in *The Sociological Quarterly, Vol. 35, No. 2, 269-288.*

Chiswick, D. and Thomson, L.G.D. (2004) 'The Relationship Between Crime and Psychiatry', in E. Johnstone, et al. (eds.) *Companion to Psychiatric Studies,* 7th Edition, Churchill Livingstone.

Cleary, M., Horsfall, J. and Hunt, G.E. (2003) 'Consumer Feedback on Nursing Care and Discharge Planning' in *Journal of Advanced Nursing, Vol. 42, No. 3, 269-277.*

Cohen, S. and Taylor, L. (1972) *Psychological Survival: The Experience of Long-Term Imprisonment,* Middlesex: Penguin.

Coid, J. et al. (2006) 'Violence and Psychiatric Morbidity in a National Household Population – A Report from the British Household Survey' in *The American Journal of Epidemiology, Vol. 164, No. 12, 1199-1208.*

Coleman, J.S. (1976) 'Athletics in High School' in D.S. David. and R. Brannon (eds.) *The Forty-Nine Percent Majority: The Male Sex Role,* Philippines: Addison-Wesley

Collinson, D. and Hearn, J. (1996) ''Men' at 'work': multiple masculinities/multiple workplaces' in M. Mac an Ghaill (ed.) *Understanding Masculinities,* Buckingham: Open University Press.

Collison, M. (1996) 'In Search of the High Life: Drugs, Crime, Masculinities and Consumption' in *British Journal of Criminology, Vol. 36, No. 3, 428-444.*

Connell, R.W. (1987) *Gender and Power: Society, the Person and Sexual Politics,* Cambridge: Polity Press.

Connell, R.W. (1989) 'Cool Guys, Swots and Wimps: the interplay of masculinity and education' in *Oxford Review of Education, Vol. 15, No.3, 291-203.*

Connell, R.W. (2002) 'On Hegemonic Masculinity and Violence: Response to Jefferson and Hall' in *Theoretical Criminology, Vol. 6, No. 1, 89-99.*

Connell, R.W. (2002) *Gender,* Cambridge: Polity Press.

Cowburn, M. (2005) 'A Man's World: Gender Issues in Working with Male Sex Offenders in Prison' in D.M. Britton *Gender and Prisons,* Aldershot: Ashgate.

Crewe, B. (2009) *The Prisoner Society: Power, Adaptation, and Social Life in an English Prison,* Oxford: Oxford University Press.

Crewe, B. (2011) 'Depth, weight, tightness: Revisiting the pains of imprisonment' in *Punishment and Society, Vol. 13, No. 5, 509-529.*

Crichton, J. (ed.) (1995) *Psychiatric Patient Violence: Risk and Response,* London: Duckworth.

Crichton, J. (1999) 'Mental Disorder and Crime: Coincidence, Correlation and Cause' in *The Journal of Forensic Psychiatry, Vol. 10, No. 3, 659-677.*

Crisp, A.H. et al. (2007) 'Stigmatisation of People with Mental Illness' in *The British Journal of Psychiatry, Vol. 117, No. 1, 4-7.*

Croall, H. (2006) 'Criminal Justice in Post-Devolutionary Scotland' in *Critical Social Policy, Vol. 26, No. 3, 587-607.*

Daly, M. and Wilson, M. (1993) 'Evolutionary Psychology of Male Violence' in Archer, J. (eds.) *Male Violence,* London: Routledge.

Daly, M. and Wilson, M. (1988) *Homicide,* New York: Aldine Transaction.

Darjee, R. (2005), 'Legislation for Mentally Disordered Offenders', Chapter 7 in McManus, J. and Thomson, L.D.G. (Eds), *Mental Health and Scots Law in Practice,* Edinburgh: W. Green & Sons.

David, D.S. and Brannon, R. (eds.) (1976) *The Forty-Nine Percent Majority: The Male Sex Role,* Philippines: Addison-Wesley

Davidson, E. (2005) 'The Management of Violence in General Psychiatry' in *Advances in Psychiatric Treatment, Vol. 11, No. 5, 362-370.*

Dickens, G. et al. (2009) 'An Audit of the Use of Breakaway Techniques in a Large Psychiatric Hospital: A Replication Study' in *Journal of Psychiatric and Mental Health Nursing, Vol. 16, No. 9, 777 - 783.*

Dino, S. et al. (2004) 'Stigma: The Feelings and Experiences of 46 People with Mental Illness' in *British Journal of Psychiatry, Vol. 184, No. 2, 176-181.*

Dobash, R.E. and Dobash R. (1979) *Violence Against Wives,* London: Open Books

Dolan, M. and Doyle, M. (2000) 'Violence Risk Prediction: Clinical and Actuarial Measures and the Role of the Psychopathy Checklist' in *The British Journal of Psychiatry, Vol. 177, No. 4, 303-331.*

Doyle, M. and Dolan, M. (2006) 'Predicting Community Violence From Patients Discharged From Mental Health Services' in *British Journal of Psychiatry, Vol. 189, No. 6, 520-526.*

Duff, R.A. and Garland, D. (1994) 'Introduction: Thinking About Punishment' in R.A. Duff and D. Garland (eds.) *A Reader on Punishment,* New York: Oxford University Press.

Eaton, W.W., Regier, D.A., Locke, B.Z, Taube, C.A. (1981) 'The Epidemiologic Catchment Area Program of the National Institute of Mental Health' in *Public Health Reports, Vol. 96, No. 4, 319-325.*

Elbogen, E.B. and Johnson, S.C. (2009) 'The Intricate Link Between Violence and Mental Disorder' in *Archives of General Psychiatry, Vol. 66, No. 2, 152-161.*

Elbogen, E.B. et al. (2006) 'Treatment Engagement and Violence Risk in Mental Disorders' *in British Journal of Psychiatry, Vol. 189, No.4, 354-360.*

Fazel, S. and Grann, M. (2006) 'The Population Impact of Severe Mental Illness on Violent Crime' in *American Journal of Psychiatry, Vol. 163, No. 8, 1397-1403.*

Feeley, M.M. and Simon, J. (1992) 'The New Penology: Notes on the Emerging Strategy of Corrections and its Implications' in *Criminology, Vol. 30, No. 4., 449-474.*

Forensic Mental Health Services Managed Care Network (2004) *Definition of Security Levels in Psychiatric Inpatient Facilities in Scotland.* http://www.forensicnetwork.scot.nhs.uk/documents/previous_reports/LevelsofSecurityReport.pdf

Forensic Mental Health Services Managed Care Network (2005) *Community Services for Mentally Disordered Offenders in Scotland.* http://www.forensicnetwork.scot.nhs.uk/documents/reports/commuityservicesconsultation%20with%20addendum.doc

Forensic Mental Health Services Managed Care Network (2006 A) *High Secure Standards.* http://www.forensicnetwork.scot.nhs.uk/documents/reports/High%20Secure%20Standards.doc

Forensic Mental Health Services Managed Care Network (2006 B) *Low Secure Standards.* http://www.forensicnetwork.scot.nhs.uk/documents/reports/Low%20Secure%20Standards.doc

Forensic Mental Health Services Managed Care Network (2006 C) *Review of Care Programme Approach Guidance for Restricted Patients in Scotland.* http://www.forensicnetwork.scot.nhs.uk/documents/reports/CPA%20Consultation/Draft%20for%20Consultation%20_inc%20appendices_.pdf

Franklin, K. (2004) 'Enacting Masculinity: Antigay Violence and Group Rape as Participatory Theater' in *Sexuality Research & Social Policy, Vol. 1, No. 2, 25-40.*

Fraser, H. (2004) 'Doing Narrative Research: Analysing Personal Stories Line by Line' in *Qualitative Social Work, Vol. 3, No. 2, 179-201.*

Friedman, R.A. (2006) 'Violence and Mental Illness – How Strong Is the Link?' in *The New England Medical Journal, Vol. 335, No.20, 2064-2066.*

Gadd, D. and Farrall, S. (2004) 'Criminal careers, desistance and subjectivity: Interpreting men's narratives of change' in *Theoretical Criminology, Vol. 8, No. 2, 123-156*

Gadd, D. and Jefferson, T. (2007) 'On the defensive: A psychoanalytically informed psychosocial reading of The Jack Roller' in *Theoretical Criminology, Vol. 11, No. 4, 443-467.*

Gallop, R. et al. (1999) 'The Experience of Hospitalization and Restraint of Women Who Have A History of Childhood Sexual Abuse' in *Health Care for Women International, Vol. 20, No. 4, 401-416.*

Gilbert, H., Rose, D. and Slade, M. (2008) 'The Importance of Relationships in Mental Health Care: A Qualitative Study of Service Users, Experiences of Psychiatric Hospital Admission in the UK' available at http://www.biomedcentral.com/1472-6963/8/92

Gilbert, P. (1994) 'Male Violence: Towards and Integration' in Archer, J. (eds.) *Male Violence,* London: Routledge.

Goffman, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates,* Middlesex: Penguin.

Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*, New York: Simon & Schuster Inc.

Gough, B. and Edwards, G. (1998) 'The beer talking: Four lads, a carry out and the reproduction of masculinity' in *Sociological Review, Vol. 46, No. 3, 409-435*

Graham, K. and Wells, S. (2003) '"Somebody's Gonna Get Their Head Kicked in Tonight!" Aggression Among Young Males in Bars – A Question of Values?' in *British Journal of Criminology, Vol. 43, No. 3, 546-566.*

Gray, P. (2005) 'The Politics of Risk and Young Offenders' Experiences of Social Exclusion and Restorative Justice' in *British Journal of Criminology, Vol. 45, No. 6, 938-957.*

Gray, P.S. (2007) *The Research Imagination: An Introduction to Qualitative and Quantitative Methods,* Cambridge: Cambridge University Press.

Gudjonsson, G.H., Rabe-Hesketh, S. And Szmukler, G. (2004) 'Management of Psychiatric In-Patient Violence: Patient Ethnicity and the Use of Medication, Restraint and Seclusion' in *British Journal of Psychiatry, Vol. 184, No. 3, 258-262.*

Haddock, G. et al. (2009) 'Cognitive-Behavioural Therapy v. Social Activity Therapy for People with Psychosis and a History of Violence: Randomised Controlled Trial' in *The British journal of Psychiatry, Vol. 194, No. 2, 152-157.*

Hagendorn, J.M. (1998) 'Frat Boys, Bossmen, Studs, and Gentlemen' in L.H. Bowker (ed.), *Masculinities and Violence*, Thousand Oaks, C.A.: Sage.

Hanson, M. (2003) 'Evaluating User Experience of an NHS Mental Health Service' in *International Journal of Healthcare Quality Assurance, Vol. 16, No. 7, 342-346.*

Heap, M. (2003) 'Difference in the Progress of Discharged and Undischarged Patients in a Medium Secure Unit: A Pilot Study' in *Journal of Psychiatric and Mental Health Nursing, Vol. 10, No. 5, 534-542.*

Heidensohn, F. (1996) *Women and Crime, 2nd Edition,* Basingstoke: Palgrave MacMillan.

Hiday V.A. (1995) 'The Social Context of Mental Illness and Violence' in *Journal of Health and Social Behaviour, Vol. 36, No. 2, 122-137.*

Hinsby, K. and Baker, M. (2004) 'Patient and Nurse Accounts of Violent Incidents in a Medium Secure Unit' in *Journal of Psychiatric and Mental Health Nursing, Vol. 11, No. 3, 341-347.*

HM Inspectorate of Prisons (2003) *Report on HM Prison Peterhead* http://www.scotland.gov.uk/Resource/Doc/47102/0025122.pdf

HM Inspectorate of Prisons (2006A) *Report on HM Prison Perth.* http://www.scotland.gov.uk/Resource/Doc/169877/0047332.pdf

HM Inspectorate of Prisons (2006B) *Report on HM Prison Peterhead.* http://www.scotland.gov.uk/Resource/Doc/149669/0039858.pdf

HM Inspectorate of Prisons (2007) *Report on HM Prison Glenochil* http://www.scotland.gov.uk/Publications/2007/03/13165417/0

Hocking, B (2003) 'Reducing Mental Illness Stigma and Discrimination – Everybody's Business' in *Medical Journal of Australia, Vol. 178, No. 9, S47-S48.*

Holmes, D., Kennedy, S.L and Perron, A. (2004) 'The Mentally Ill and Social Exclusion: A Critical Examination of the use of Seclusion From the Patients' Perspective' in *Issues in Mental Health Nursing, Vol. 25, No. 6, 559-578.*

Holt, D.B. and Thomson, C.J. (2004) 'Man-of-Action Heroes: The Pursuit of Heroic Masculinity in Everyday Consumption' in *Journal of Consumer Research, Vol. 31, No. 2, 425-440*

Homel, R. and Tomsen, S. (1993) 'Hot Spots for Violence: The Environment of Pubs and Clubs' [Conference Presentations] in H. Strang and S. Gerull (eds), *Homicide: Patterns, Prevention and Control,* Canberra: Australian Institute of Criminology

Hopkins, J.E., Loeb, S.J and Fick, D.M. (2009) 'Beyond Satisfaction: What Service Users Expect of Inpatient Mental Health Care: A Literature Review' in *Journal of Psychiatric and Mental Health Nursing, Vol. 16, No. 10, 927-937.*

Howard, P.B et al. (2003) 'Consumer perspectives on Quality of Inpatient Mental Health Services' in *Archives of Psychiatric Nursing, Vol. 17, No. 5, 205-217.*

Hurwitz, B., Greenhalgh, T. and Skultans, V. (2004) *Narrative Research in Health and Illness,* Malden, Mass: Blackwell Publishing.

Hutton, L. (2009) 'Implementation of the Community Sex Offender Groupwork Programme in Scotland: Programme Evaluation' *Criminal Justice Social Work Development Centre for Scotland, Towards Effective Practice, Paper 6, March 2009.*

Hyden, L.C. (1997) 'Illness and Narrative' in *Sociology of Health & Illness, Vol. 19, No. 1, 48-69.*

Hyden, M. (2008) 'Narrating Sensitive Topics' in M. Andrews, C. Squire and M. Tamboukou (eds.), *Doing Narrative Research,* London: Sage.

Ian McIntosh (2006) 'Accredited Programmes & Some Challenges to Effective Practice' (Presentation) *Criminal Justice Social Work Development Centre for Scotland, Resources.* http://www.cjsw.ac.uk/cjsw/files/Ian%20McIntosh_Accredited%20programmes.ppt

Iqbal, S. and Bassett, M. (2008) 'Evaluation of Perceived Usefulness of Activity Scheduling in an Inpatient Depression Group' in *Journal of Psychiatric and Mental Health Nursing, Vol. 15, No. 5, 393-398.*

James, D.V. et al. (1990) 'An Increase in Violence on an Acute Psychiatric Ward: A Study of Associated Factors' in *British Journal of Psychiatry, Vol. 156, No. 6, 846-852.*

Jefferson, T. (1997) 'Masculinities and Crimes' in M. Maguire et al. *The Oxford Handbook of Criminology, 2nd Edition,* Oxford: Oxford University Press.

Jefferson, T. (1998) 'Theorising Masculine Subjectivity' in T. Newburn, and E. Stanko, (eds.) *Men, Masculinities and Crime: Just Boys Doing the Business,* London: Routledge.

Johansson, H. and Eklund, M. (2003) 'Patients' Opinion on What Constitutes Good Psychiatric Care' in *Scandinavian Journal of Caring Sciences, Vol. 17, No. 4, 339-346.*

Jones, A. and Crossley, D. (2008) '"In the Mind of Another" Shame and Acute Psychiatric Inpatient Care: An Exploratory Study. A Report on Phase One: Service Users' in *Journal of Psychiatric and Mental Health Nursing, Vol. 15, No. 9, 749-757.*

Jordan, E. (1995) 'Fighting Boys and Fantasy Play: The construction of masculinity in the early years of school' in *Gender and Education, Vol. 7, No. 1, 69-86*

Junginger, J. et al. (2006) 'Effects of Serious Mental Illness and Substance Abuse on Criminal Offenses' in *Psychiatric Services, Vol. 57, No. 6, 879-282.*

Kemshall, H. and Wood, J. (2007) 'High-Risk Offenders and Public Protection' in L. Gelsthorpe and R. Morgan (eds.) *Handbook of Probation,* Cullompton: Willan.

Kendall, P.C. and Clarkin, J.F. (1992) 'Introduction to Special Section: Comorbidity and Treatment Implications' in *Journal of Consulting and Clinical Psychology, Vol. 60, No. 6, 833-834.*

Kendell, R.E. (2002) 'The Distinction Between Personality Disorder and Mental Illness' in *British Journal of Psychiatry, Vol. 180, No. 2, 110-115.*

Kennedy, H.G. (2002) 'Therapeutic Uses of Security: Mapping Forensic Mental Health Services by Stratifying Risk' in *Advances in Psychiatric Treatment, Vol. 8, No. 6, 433-443.*

King, R. and McDermott, K. (1995) *The State of Our Prisons,* Oxford: Clarendon Press.

Klein, D. (1998) 'The Etiology of Female Crime' in F.P. Williams and M.D. McShane, *Criminology Theory: Selected Classic Readings, 2nd Edition,* Cincinnati: Anderson.

Kuosmanen, L. et al. (2006) 'Patient Satisfaction With Psychiatric Inpatient Care' in *Journal of Advanced Nursing, Vol. 55, No. 6, 655-663.*

Labaree, R.V. (2002) 'The Risk of Going 'Observationalist': Negotiating the Hidden Dilemmas of Being an Insider participant Observer' in *Qualitative Research, Vol. 2, No. 1, 97-122.*

Lee, D. (1997) 'Interviewing Men: Vulnerabilities and Dilemmas' in *Women's Studies International Forum, Vol. 20, No. 4, 553-564.*

Lee, R. (1993) *Doing Research on Sensitive Topics,* London: Sage.

Lewis, D.M. (2002) 'Responding to a Violent Incident: Physical Restraint or Anger Management as Therapeutic Interventions' in *Journal of Psychiatric and Mental Health Nursing, Vol. 9, No. 1, 57-63.*

Liamputtong, P. (2007) *Researching the Vulnerable,* London: Sage.

Link, B. and Stueve, C. (1994) 'Psychotic Symptoms and the Violent/Illegal Behaviour of Mental Patients Compared to Community Controls' in J. Monahan and H. Steadman (eds.) *Violence and Mental Disorder: Developments in Risk Assessment,* Chicago: University of Chicago Press.

Link, B.G., Andrews, H. and Cullen, F.T. (1992) 'The Violent and Illegal Behaviour of Mental Patients Reconsidered' in *American Sociological Review, Vol. 57, No. 3, 275-292.*

Lynn, D.B. and Sawrey, W.L. (1958) 'The Effects of Father Absence on Norwegian Boys and Girls' in *Journal of Abnormal and Social Psychology, Vol. 59, No. 1, 258-262.*

Macpherson, R., Dix, R. and Morgan, S. (2005) 'A Growing Evidence Base for Management Guidelines' in *Advances in Psychiatric Treatment, Vol. 11, No. 6, 404-415.*

Maden, T. (2007) *Treating Violence: A Guide to Risk Management in Mental Health,* Oxford: Oxford University Press.

Maguire, M. (2007) 'Crime Data and Statistics' in Maguire M. et al. (eds) *The Oxford Handbook of Criminology, 4th Edition,* Oxford: Oxford University Press.

Major, B. (1993) 'Gender, Entitlement, and the Distribution of Family Labor' in *Journal of Social Issues, Vol. 49, No. 3, 141-159*

Markowitz, F.E. (2011) 'Mental Illness, Crime and Violence: Risk, Context and Social Control' in *Aggression and Violent Behaviour, Vol. 16, No. 1, 36-44.*

Maruna, S. (1997) 'Desistance and Development: The Psychosocial Process of 'Going Stright'' in *The British Criminology Conferences: Selected Proceedings, Vol. 2,* http://www.britsoccrim.org/volume2/003.pdf

Maruna, S. (2001) *Making Good: How Ex-Convicts Reform and Rebuild Their Lives,* Washington DC: American Psychological Association.

Mason, J. (1996) *Qualitative Researching,* London: Sage.

Matejkowski, J.C. and Solomon, P.L. (2008) 'Characteristics of Persons With Severe Mental Illness Who Have Been Incarcerated for Murder' in *Journal of American Psychiatry and the Law, Vol. 36, No. 1, 74-86.*

Matza, D. (1964) *Delinquency and Drift,* New York: Wiley and Sons.

Maxfield, M.G. and Widom, C.S. (1996) 'The Cycle of Violence: Revisited 6 Years Later' in *Archives of Paediatric and Adolescent Medicine, Vol. 150, No. 3, 390-395.*

Maynes, M.J., Pierce, L.J. and Laslett, B. (2008) *The Use of Personal Narratives in the Social Sciences and History,* Ithaca, N.Y.: Cornell University Press.

McIvor, G. and McNeill, F. (2007) 'Probation in Scotland: Past, Present and Future' in L. Gelsthorpe and R.Morgan, *Handbook of Probation,* Cullompton: Willan.

McIvor, G. and Kemshall, H. (2003) 'Serious Violent and Sexual Offenders: The Use of Risk Assessment Tools in Scotland' available at http://www.scotland.gov.uk/Publications/2003/02/15704/12502

McIvor, G., Kemshall, H. and Levy, S. (2002) 'Serious Violent and Sexual Offenders: The Use of Risk Assessment Tools in Scotland' *Scottish Executive Social Research* http://www.scotland.gov.uk/Resource/Doc/47007/0025217.pdf

McKee, L. and O'Brien, M. (1983) 'Interviewing Men: 'Taking Gender Seriously'' in E. Gamarnikow et al. (eds.) *The Public and the Private,* London: Heineman.

McNeill, F. (2006) 'A Desistance Paradigm for Offender Management' in *Criminology and Criminal Justice, Vol. 6, No. 1, 39-62.*

McNeill, F. and Maruna, S. (2008) "Giving Up and Giving Back: Desistance, Generativity and Social Work with Offenders" in G. McIvor and P. Raynor *Developments in Social Work With Offenders,* London: Jessica Kingsley

Meehan, T., Vermeer, C. and Windsor, C. (2000) 'Patients' Perceptions of Seclusion: A Qualitative Investigation' in *Journal of Advanced Nursing, Vol. 31, No.2, 370-377.*

Messerschmidt, J.W. (1993) *Masculinities and Crime: Critique and Reconceptualization of Theory,* Lanham, MD.: Rowan and Littlefield.

Messerschmidt, J.W. (1995) 'Schooling, Masculinities and Youth Crime by White Boys' in T. Newburn and E. Stanko (eds.) *Men, Masculinities and Crime: Just Boys Doing the Business,* London: Routledge.

Messerschmidt, J.W. (2000) *Nine Lives: Adolescent Masculinities, the Body and Violence,* Boulder, CO: Westview Press Inc.

Miles, M.B. and Huberman, A.M. (1994) *Qualitative Data Analysis: An Expanded Sourcebook,* Thousand Oaks, CA: Sage.

Mind (2006) 'We Need To Talk: The Case for Psychological Therapy on the NHS' *Campaign Report, www.mind.org.uk.*

Mind (2008) 'While We Are Waiting: Experiences of Waiting for and Receiving Psychological Therapies on the NHS' *Campaign Report, www.mind.org.uk*

Mind (2009) 'Men and Mental Health: Get it Off Your Chest' *Campaign Report, www.mind.org.uk*

Mishler, E.G. (1986) *Research Interviewing: Context and Narrative,* Cambridge: Harvard University Press.

Monahan, J. (2002) 'The MacArthur Studies of Violence Risk' in *Criminal Behaviour and Mental Health, Vol. 12, No. S1, S67-S72.*

Montgomery, P. and Johnson, B. (1998) 'Chronically Mentally Ill Individuals Re-entering the Community After Hospitalization' in *Journal of Psychiatric and Mental Health Nursing, Vol. 5, No. 6, 497-503.*

Moran, P. et al. (2003) 'Impact of Comorbid Personality Disorder on Violence in Psychosis: Report from the UK700 Trial' in *British Journal of Psychiatry, Vol. 182, No. 2, 129-134.*

Mortimer, A. (1997) 'Treatment of the Patient With Long-Term Schizophrenia' in *Advances in Psychiatric Treatment, Vol. 3, No. 6, 339-346.*

Mullen, P.E. (2006) 'Schizophrenia and Violence: From Correlations to Preventive Strategies' in *Advances in Psychiatric Treatment, Vol. 12, No. 4, 239-248.*

Mullins, C. (2006) *Holding Your Square: Masculinities, Streetlife and Violence,* Cullompton: Willan.

Multi-Agency Public Protection Arrangements (2009) 'Protecting the Public' *Lothian and the Scottish Borders Multi-Agency Public Protection Arrangements Annual Report 2008-2009.*
http://www.scotland.gov.uk/Resource/Doc/289100/0088484.pdf

Nelson, D. (2003) 'Service Innovations: The Orchard Clinic: Scotland's First Medium Secure Unit' in *Psychiatric Bulletin, Vol. 27, No. 3, 105-107.*

O'Sullivan, C. (1998) 'Ladykillers: Similarities and Divergences of Masculinities in Gang Rape and Wife Battery' in L.H. Bowker (ed.), *Masculinities and Violence*, Thousand Oaks, CA: Sage.

Olofsson, B. and Norberg, A. (2000) 'Experiences of Coercion in Psychiatric Care as Narrated by Patients, Nurses and Physicians' in *Journal of Advanced Nursing, Vol.* 33 *No. 1, 89-97.*

Parker, A. (1996) 'Sporting masculinities: Gender relations and the body' in *Mac an Ghaill, M. (ed.) Understanding Masculinities,* Philadelphia: Open University Press

Peay, J. (2007) 'Mentally Disordered Offenders, Mental Health and Crime' in M. Maguire et al. (eds) *The Oxford Handbook of Criminology, 4th Edition,* Oxford: Oxford University Press.

Peay, J. (2011) *Mental Health and Crime*, London: Routeledge.

Peplau, L.A. et al. (1993) 'Sex Role Attitudes in Dating and Marriage: A 15-Year Follow-Up of the Boston Couples Study' in *Journal of Social Issues, Vol. 49, No. 3, 31-52*

Pleck, J.H. et al. (1993) 'Masculinity Ideology: Its Impact on Adolescent Males' Heterosexual Relationships' in *Journal of Social Issues, Vol. 49, No. 3, 11-29.*

Polk, K. (1994) *When Men Kill: Scenarios of Masculine Violence,* Cambridge: Cambridge University Press.

Polk, K. (1995) 'Masculinity, Honour and Confrontational Homicide' in T. Newburn, and E. Stanko (eds.) *Men, Masculinities and Crime: Just Boys Doing the Business,* London: Routledge.

Presser, L. (2004) 'Violent Offenders, Moral Selves: Constructing Identities and Accounts in the Research interview' in *Social Problems, Vol. 51, No. 1, 82-101.*

Presser, L. (2009) 'The narratives of offeders' in *Theoretical Criminology, Vol. 13, No.2, 117-200*

Prins, H.A. (2005) *Offenders, Deviants or Patients,* London: Routledge.

Prospero, M. (2008) 'Effects of Masculinity, Sex and Control on Different Types of Intimate partner Violence Perpetration' in *Journal of Family Violence, Vol. 23, No. 7, 639-645.*

Regier, D.A. et al. (1984) 'The NIMH Epidemiologic Catchment Area Program: Historical Context, Major Objectives, and Study Population Characteristics' in *Archives of General Psychiatry, Vol. 41, No. 10, 934-941.*
Renold, E. (1997) '"All They've Got on Their Brains is Football." Sport, Masculinity and the Gendered Practices of Playground Relations' in *Sport, Education and Society, Vol. 2, No. 1, 5-23.*

Richards, H.M. and Schwartz, L.J. (2002) 'Ethics of Qualitative Research: Are There Special Issues for Health Services Research?' in *Family Practice, Vol. 19, No. 2, 135-139.*

Robinson, G. and Crow, I. (2009) *Offender Rehabilitation: Theory, Research and Practice,* London: Sage.

Rubin, H.J. (1995) *Qualitative Interviewing: The Art of Hearing Data,* Thousand Oaks, CA: Sage.

Saks, E.R. (2009) 'Some Thoughts on Denial of Mental Illness' in *American Journal of Psychiatry, Vol. 166, No. 9, 972-973.*

Sandelowski, M. (1991) 'Telling Stories: Narrative Approaches in Qualitative Research' in *Journal of Nursing Scholarship, Vol. 23, No. 3, 161-166.*

Sapsford, R.J. (1983) *Life Sentence Prisoners: Reaction, Response and Change,* Milton Keynes: Open University Press

Schachter, E.P. (2010) 'Narrative Identity Construction as a Goal-oriented Endeavour: Reframing the Issue of 'Big vs. Small' Story Research' in *Theory & Psychology, Vol. 21, No. 1, 107-113.*
Scottish Association for Mental Health (2006) 'What's It Worth? The Social and Economic Costs of Mental Health Problems in Scotland' *Campaign Report, www.samh.org.uk*

Scottish Executive (2005) *Approved Medical Practitioners: Mental Health (Care and Treatment) (Scotland) Act, 2003, Training Manual*
http://www.scotland.gov.uk/Resource/Doc/924/0011799.pdf

Scottish Executive (2010) *Statistical Bulletin, Criminal Justice Series: Homicide In Scotland 2009/10*
http://www.scotland.gov.uk/Resource/Doc/334452/0109352.pdf

Scottish Executive (2011) *Statistical Bulletin, Criminal Justice Series: Homicide In Scotland 2010/11*
http://www.scotland.gov.uk/Resource/Doc/365275/0124207.pdf

Scottish Executive Health Department (2006) *Forensic Mental Health Services,* HDL (2006) 48. http://www.sehd.scot.nhs.uk/mels/HDL2006_48.pdf

Scottish Executive Health Department (2007) *Guidance for Forensic Services,* CEL 13 (2007). http://www.sehd.scot.nhs.uk/mels/CEL2007_13.pdf

Scottish Executive Health Department (2008) *Multi Agency Public Protection,* CEL 19 (2008). http://www.sehd.scot.nhs.uk/mels/CEL2008_19.pdf

Scottish Executive Justice Department (2007) 'Implementation of the Multi Agency Public Protection Arrangements (MAPPA) in Scotland' *Community Justice Services Division, Circular 15/2006*
http://www.scotland.gov.uk/Resource/Doc/1099/0047856.pdf

Scottish Prison Service (2004) *Inclusion Policy.*
http://www.sps.gov.uk/multimediagallery/E51BD556-DB9A-49A1-8A08-D96E9EE9DCE2.pdf

Scottish Prison Service (2005) *Act 2 Care: Suicide Risk Management Strategy.*
http://www.sps.gov.uk/multimediagallery/AB49BF61-06C1-4915-9D62-F3FA754C871C.pdf

Scottish Prison Service (2006) *SPS Strategy on the Management of Drug Misuse: Pathways and Progression: An Evaluation of Referral, Assessment, and Intervention.*
http://www.sps.gov.uk/MultimediaGallery/a8143eae-9f0a-4ac6-832f-74722f5ffa11.doc

Serran, G. and Firestone, P. (2004) 'Intimate Partner Homicide: A Review of the Male Proprietariness and Self-Defense Theories.' in *Aggression and Violent Behavior, Vol. 9, No. 1, 1-15.*

Shaver, P. et al. (1980) 'Report on the LHJ 'Intimacy Today' Survey' Private Research Report to the *Ladies' Home Journal*

Shostak, A.B. (1976) 'Blue-Collar Work' in David, D.S. and Brannon, R. (eds.) *The Forty-Nine Percent Majority: The Male Sex Role,* Philippines: Addison-Wesley

Silver, E. (2000) 'Race, Neighbourhood Disadvantage, and Violence Among Persons with mental Disorders: The Importance of Contextual Measurement' in *Law and Human Behaviour, Vol. 24, No. 4, 449-456.*

Silver, E. (2006) 'Understanding the Relationship Between Mental Disorder and Violence: The Need for a Criminological Perspective' in *Law and Human Behaviour, Vol. 30, No. 6, 685-706.*

Silver, E. and Teasdale, B. (2005) 'Mental Disorder and Violence: An Examination of Stressful Life Events and Impaired Social Support' in *Social Problems, Vol. 52, No. 1, 62-78.*

Silver, E., Mulvey, E.P and Monahan, J. (1999) 'Assessing Violence Risk Among Discharged Psychiatric Patients: Towards an Ecological Approach' in *Law and Human Behaviour, Vol. 23, No. 2, 237-255.*

Sim, J. (2006) 'Tougher than the Rest? Men in Prison' in Y. Jewkes and H. Johnston (eds), *Prison Readings: A Critical Introduction to Prisons and Punishment*, Cullompton: Willan

Snowden, P. (2001) 'Substance Misuse and Violence: The Scope and Limitations of Forensic Psychiatry's Role' in *Advances in Psychiatric Treatment, Vol. 7, No. 3, 189-197.*

Social Work Inspection Agency, HM Inspectorate of Constabulary for Scotland and HM Inspectorate of Prisons (2009) *Multi-Agency Inspection: Assessing and Managing Offenders Who Present a High Risk of Serious Harm.* http://www.scotland.gov.uk/Resource/Doc/275852/0082871.pdf

Sparks, R. (1996) 'Masculinity and Heroism in the Hollywood Blockbuster. The Culture Industry and Contemporary Images of Crime and Law Enforcement.' In *The British Journal Of Criminology, Vol. 36, No. 3 Special Issue, 348-360.*

Squire, C., Andrews, M. and Tamboukou, M. (2008) 'What is Narrative Research?' in M. Andrews, C. Squire and M. Tamboukou (eds.), *Doing Narrative Research*, London: Sage.

Steadman, H.J. et al. (1998) 'Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods' in *Archives of General Psychiatry, Vol. 55, No. 5, 393-401.*

Stewart, D. et al (2009) 'Manual Restraint of Adult Psychiatric Inpatients: A Literature Review' in *Journal of Psychiatric and Mental Health Nursing, Vol. 16, No. 8, 749-757.*

Swanson, J.W. et al. (1990) 'Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys' in *Hospital and Community Psychiatry, Vol. 41, No. 7, 761-770.*

Swanson, J.W. et al. (1996) 'Psychotic Symptoms and Disorders and the Risk of Violent Behaviour in the Community' in *Criminal Behaviour and Mental Health, Vol.Vol. 6, No. 4, 309-329.*

Swanson, J.W. et al. (2000) 'Involuntary Out-patient Commitment and Reduction of Violent Behaviour in Persons With Severe Mental Illness' in *British journal of Psychiatry, Vol. 176, No. 4, 324-331.*

Swanson, J.W. et al. (2006 A) 'A National Study of Violent Behaviour in Persons With Schizophrenia' in *Archives of General Psychiatry, Vol. 63, No. 5, 490-499.*

Swanson, J.W. et al. (2006 B) 'Violence and Leveraged Community Treatment for Persons With Mental Disorders' in *the American Journal of Psychiatry, Vol. 163, No. 8, 1404-1411.*

Swanson, J. W. et al. (2008 A) 'Alternative Pathways to Violence in Persons with Schizophrenia: The Role of Childhood Antisocial Behaviour Problems' in *Law and Human Behaviour, Vol. 32, No. 3, 228-240.*

Swanson, J.W. et al. (2008 B) 'Comparison of Antipsychotic Medication Effects on Reducing Violence in People With Schizophrenia' in *The British Journal of Psychiatry, Vol. 193, No. 1, 37-43.*

Swartz, M. et al (1998) 'Violence and Severe Mental Illness: The Effects of Substance Abuse and Nonadherence to Medication' in *American Journal of Psychiatry, Vo. 155, No. 2, 226-231.*

Sykes, G. (1958) *The Society of Captives: A Study of a Maximum Security Prison,* Princeton, NJ: Princeton University Press.

Taylor, P.J. (1998) 'When Symptoms of Psychosis Drive Serious Violence' in *Social Psychiatry and Psychiatric Epidemiology, Vol. 33, Suppl. 1, S47-S54.*

Taylor, P.J. and Gunn, J. (1984a) 'Violence and Psychosis I: Risk of Violence Among Young Psychotic Men' in *British Medical Journal, Vol. 288, No. 1, 1945-1949.*

Taylor, P.J. and Gunn, J. (1984b) 'Violence and Psychosis II: Effect of psychiatric Diagnosis on Conviction and Sentencing of Offenders' in *British Medical Journal, Vol. 289, No. 1, 9-12.*

Taylor, P.J. and Gunn, J. (1999) 'Homicides by People with Mental Illness: Myth and Reality' in *British Journal of Psychiatry, Vol. 174, No. 1, 9-14.*

Taylor, P.J. et al. (1998) 'Mental Disorder and Violence: A Special (High Security) Hospital Study' in *British Journal of Psychiatry, Vol. 172, No. 5, 218-226.*

Teasdale, B., Silver, E. and Monahan, J. (2006) 'Gender, Threat/Control-Override Delusions and Violence' in *Law and Human Behaviour, Vol. 30, No. 6, 649-658.*

Teplin, L. (1984) 'Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill' in *American Psychologist, Vol. 39, No. 7, 54-67.*

Thompson, M.S. (2007) 'Violence and the Costs of Caring for a Family Member with Severe Mental Illness' in *Journal of Health and Social Behaviour, Vol. 48, No. 3, 318-333.*

Thomson, L.D.G. (2000) 'Management of Schizophrenia in Conditions of High Security' in *Advances in Psychiatric Treatment, Vol. 6, No. 4, 252-260.*

Thomson, L.D.G. (2005) 'Psychiatric Systems and Services for Mentally Disordered Offenders', in McManus, J. and Thomson, L.G.D. (Eds) *Mental Health and Scots Law in Practice,* Edinburgh: W. Green & Sons.

Thomson, L.D.G. (2006) 'The Mental Health (Care and Treatment) (Scotland) Act 2003: Legislation for Mentally Disordered Offenders', in *Psychiatric Bulletin, Vol. 30, No. 11, 423-429.*

Thomson, L.D.G., Galt, V. and Darjee, R. (2007) 'Professionalising the Role of Appropriate Adults' in *The Journal of Forensic Psychiatry and Psychology, Vol. 18, No. 1, 99-119.*

Tomsen, S. (1997) 'A Top Night: Social Protest, Masculinity and the Culture of Drinking Violence' in *The British Journal Of Criminology, Vol. 37, No. 1, 90-103.*

Torey, F.E. et al. (2008) 'The MacArthur Violence Risk Assessment Study Revisited: Two Views Ten Years After Its Initial Publication' in *Psychiatric Services, Vol. 59 No. 2, 147-152.*

Totten, M. (2003) 'Girlfriend Abuse as a Form of Masculinity Construction among Violent, Marginal Male Youth' in *Men and Masculinities, Vol. 6, No. 1, 70-92.*

Tracie Shea, T., Widiger, T.A and Klein, M.H. (1992) 'Comorbidity of Personality Disorders and Depression: Implications for Treatment' in *Journal of Consulting and Clinical Psychology, Vol. 60, No. 6, 857-868.*

Travis, M.J. and Kerwin, R.W. (1997) 'Pharmacological Treatment of the Newly Diagnosed Patient with Schizophrenia' in *Advances in Psychiatric Treatment, Vol. 3 331-338.*

Tryer, P., Duggan, C. and Coid, J. (2003) 'Ramifications of Personality Disorder in Clinical Practice' in *British Journal of Psychiatry, Vol. 182, Suppl. 41, S1- S 2.*

Turner, A.K. (1993) 'Genetic and Hormonal Influences on Male Violence' in Archer, J. (eds.) *Male Violence,* London: Routledge.

Walklate, S. (1995) *Gender and Crime: An Introduction,* London: Prentice Hall.

Walklate, S. (2004) *Gender, Crime and Criminal Justice 2nd Edition,* Cullompton: Willan Publishing.

Wayt Gibbs, W. (1997) 'Seeking the Criminal Element' in *Scientific American, 1997 Special Issue*.

Weaver, T. (2001) 'The Prevalence and Management of Co-Morbid Substance Misuse and Mental Illness: Results of a Screening Survey in Substance Misuse and Mental Health Treatment Populations' in *Drug and Alcohol Review, Vol. 20, No. 4, 407-416.*

Websdale, N. and Chesney-Lind, M. (1998) 'Doing Violence to Women: Research-Synthesis on the Victimization of Women' in L.H. Bowker (ed.), *Masculinities and Violence,* Sage.

West, C. and Zimmerman, D.H. (1987) 'Doing Gender' in *Gender & Society, Vol. 1, No. 2, 121-151.*

Widom, C.S. (1989) 'The Cycle of Violence' in *Science, Vol. 244, No. 4901, 160-166.*

Wiener, M.J. (2006) *Men of Blood: Violence, Manliness and Criminal Justice in Victorian England,* Cambridge: Cambridge University Press.

Wilczynski, A. (1995) 'Child Killing by Parents' in R. Dobash, R. Dobash and L. Noaks (eds.) *Gender and Crime,* Cardiff: University of Wales Press.

Wilczynski, A. (1997) 'Mad or Bad? Child-Killers, Gender and the Courts' in *The British Journal of Criminology, Vol. 37, No. 3, 319-346.*

Willott, S. and Griffin, C. (1997) 'Men, masculinity and the challenge of long-term unemployment' in *Mac an Ghaill, M. (ed.) Understanding Masculinities,* Philadelphia: Open University Press

Willott, S. and Griffin, C. (1997) '"Wham Bam, am I a Man?": Unemployed Men Talk about Masculinities' in *Feminism & Psychology, Vol. 7, No. 1, 107-128.*

Wilson, J. and Herrnstein R. (1986) *Crime and Human Nature,* New York: Simon and Schuster.

Wong, S.C.P. et al. (2007) 'Assessment and Treatment of Violence-Prone Forensic Clients' in *British Journal of Psychiatry, Vol. 190, Suppl. 49, S66-S74.*

Worrall, A. (1989) *Offending Women: Female Lawbreakers and the Criminal Justice System,* London: Routledge.

Wynn, R. (2009) 'Psychiatric Inpatients' Experiences With Restraint' in *Journal of Forensic Psychiatry and Psychology, Vol. 15, No. 1, 124-144.*

Yates, K. et al. (2005) 'A Cognitive, Behaviorally Based Program for Patients With Persistent Mental Illness and a History of Aggression, Crime, or Both: Structure and Correlates of Completers of the Program' in *The Journal of the American Academy of Psychiatry and the Law, Vol. 33, No. 2, 214-222.*

OTHER SOURCES

Home Office Crime Reduction, *Working With Offenders: Offending Behaviour Programmes.*
http://www.crimereduction.gov.uk/workingoffenders3.htmrl

Forensic Mental Health Services Managed Care Network (Forensic Network)
http://www.forensicnetwork.scot.nhs.uk/regional.html

MacArthur Violence Risk Assessment: Executive Summary
http://www.macarthur.virginia.edu/risk.html

Scottish Government, *Accreditation of Offending Behaviour Programmes*
http://www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/community/16910/14735