TITLE

A discourse analysis of staff and patient accounts of pornography in a high-security hospital

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor of Philosophy by

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DECLARATION

This thesis is the result of my own work. The material contained in the thesis has not been presented, nor is currently being presented, either wholly or in part for any other degree or other qualification.

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GLOSSARY OF TERMS

Cat B:	Category B prison
CCC:	Central Control Centre
DA:	Discourse analysis
DGH:	District General Hospital
DSPD:	Dangerous and severe personality disorder
ECC:	Effective care coordination
EDR:	Earliest date of release
EMI:	Elderly mental illness
ETS:	Enhanced thinking skills
ICC:	Internal care coordinator
LREC:	Local Research Ethics Committee
MHRT:	Mental Health Review Tribunal
MI:	Mental illness
MSU:	Medium Secure Unit
NA:	Nursing assistant
PACIS:	High security services clinical information system
PCT:	Patient Care Team
PCTM:	Patient Care Team Meeting
PD:	Personality disorder
PDS:	Personality Disorder Service
PDU:	Personality Disorder Unit
POA:	Prison Officers Association
RMN:	Registered Mental Nurse
RMO:	Responsible Medical Officer
RNMH:	Registered Nurse for Mental Handicap
SOTP:	Sex offender treatment programme
RSU:	Regional Secure Unit
VPU:	Vulnerable Prisoner Unit

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ABSTRACT

Title: A discourse analysis of staff and patient accounts of pornography in a high-security hospital

Aim: The study was designed to explore how forensic mental health nurses and mentally disordered sexual offenders, with a diagnosis of personality disorder, constructed accounts of pornography in a high-security hospital.

Background: The special hospitals of England and Wales were formally established under section 97 of the Mental Health Act (1959) for individuals deemed to require 'treatment under conditions of special security on account of their dangerous, violent or criminal propensity'. The history of these institutions, though, is much longer, dating back to the nineteenth century 'criminal lunatic asylum'. In the context of secure provision, the nursing role combines care with custody. Therapeutic engagement with detained sexual offenders is one component of clinical practice. The Fallon Inquiry Report (1999) highlighted particular concerns about pornography in the context of treatment services for personality-disordered sexual offenders, and contributed to larger NHS reforms and legislative change. Debate about pornography and sexual violence in the wider scientific community, based on diverse evidence, has produced little consensus about a 'causal' relationship, but strongly suggests a 'correlation'. The intellectual nursing community has shown little professional, or research, interest in pornography as an issue in healthcare delivery.

Methods: This research adopted a discursive approach to the collection and analysis of data based on the approach of Potter and Wetherell (1987). Semi-structured interviews with eighteen nursing staff, and nine patients, were used to co-construct accounts of pornography, sexual offending, and treatment within the institutional context of one forensic hospital. Interviews were audio-taped and transcribed. The data was coded to identify theoretical and conceptual themes and sub-themes representing the discursive repertoires, or collective talk, of respondents. Particular attention was given to textual variation in the construction of accounts, which positioned respondents in relation to each other and the institutional context of high-secure care. Analysis and data collection were undertaken concurrently.

Findings: An analytic focus on discourse identified a series of themes which constructed particular versions of the hospital, and of the staff and patient groups who participated in the study. Most notably, they revealed a gendered use of language, and contextual construction of otherness. Male nurses and patient participants shared an overtly masculine discourse that promoted gendered inequality and discrimination, and contradicted therapeutic goals. The hospital ward emerged as a central construct, and male space, that framed respondent talk. A sense of alienation, and isolation, permeated respondent accounts of daily life that centred on a routine and repetitive regime. Female nurses were marginalised within a dominant culture that defined men in terms of physicality, and women in terms of sexuality. Though there were restrictions on patient access to sexual media, talk

about pornography illustrated the masculine texturing of the treatment environment. The different use of language by male and female respondents embodied gendered knowledge and experience, mediated by institutionalised sexism. In the accounts of men, sexual pleasure and sexual offending coalesced in a shared discourse of male sexuality. To assert a clinical identity, male nurses invested in a distinction between 'normal' and 'deviant' men, while female nurses adopted a discourse that positioned them in relation to dangerous men.

SECTION I

CHAPTER 1

Introduction and Aim

Introduction

This chapter introduces the subject of pornography, as a research question, in the context of a secure psychiatric service for the treatment of the personality disordered sexual offender. The study design draws upon larger debates about the relationship between sexual imagery and behaviour, but the rationale is situated in the practice domain of mental health nursing. The personal involvement of the researcher, in selecting this topic is acknowledged; a former employee of the special hospital system who lived through two high-level public inquiries into the care and management of the disordered offender. In contrast to a large body of experimental studies, striving to establish a cause-effect link between pornography and male sexual violence, much less attention has been paid to the way that perpetrators talk about pornography and sexual offending. Forensic mental health nurses have a professional role in the care and treatment of sexually abusive men, part of which might involve the management of sexual media in the clinical environment. The research project outlined below is an attempt to develop the knowledge base of this, relatively new, branch of nursing science by focusing on the discourses of staff and offender-patients in relation to pornography

The autobiographical context of the research question

A product of time, place and person, the study is interwoven with the autobiography of the researcher. The theoretical and professional perspectives that informed the project require an introduction that draws on experience and anecdote. Between 1985 and 1997 the researcher worked as a mental health nurse in one of the three English special hospitals, maximum-secure institutions providing custodial treatment for those deemed to be, both, mentally disordered and dangerous. Over time and in various roles, responsibilities and professional practice changed, but the care and management of the sexual offender remained an enduring interest. Many of these men were diagnosed as 'psychopathic' or 'personality disordered', and lived ordinary lives in an extra-ordinary environment. In the former Park Lane Hospital (renamed Ashworth in 1989 when it merged with Moss Side Hospital) there was no diagnostic distinction in ward allocation; patients broadly categorised as 'personality disordered', and 'mentally ill', were housed on wards defined in terms of 'high', 'medium' or 'low dependency'. It was commonly noted, though, that enforced proximity did not

extend to positive social relations, or shared sense of identity, between these two groups of detained men.

'PD' patients, as they were usually referred to by professional staff, and each other, generated a series of conflicting emotional responses from those around them. They were not marked out by the visible stigmata of psychosis; their offences were not the result of command hallucination or paranoid ideation; they were not in receipt of psychiatric medication because they had no symptoms to control. Collectively, they were defined by their offences and perceived dangerousness. Not unusually, the personality disordered sexual offender was intelligent, articulate and litigious, confronting the system and its agents in ways that produced fear, and earned contempt, from nurses working on the wards. Shunning the less able, less vocal, patient population, the 'psychopath' would typically re-invent himself as a 'political prisoner'. This spirit of resistance was portrayed in '*Notes from a waiting room: anatomy of a political prisoner*' (Reeve 1983), described as the revolutionary tract of a special hospital detainee. However, to men with non-sexual offending histories, they became euphemistic 'bank robbers'; a reference to the concealment of sexual offending, and public presentation of a macho type crime. For many of the nursing staff, grievances of this patient group would be dismissed as the 'narcissism' of the 'nonce' who had 'nutted off'; that is, feigned mental illness to escape the harsh privations of a prison sentence. So, what of treatment?

Treatment is a nebulous term, and one that is difficult to define. But in the context of involuntary and indeterminate detention, under mental health legislation, the concept of some form of intervention, freely chosen and based on consent, becomes problematic (Pilgrim 1988a, 1988b). The idea of working therapeutically with offenders is rooted in the nineteenth century asylum for the 'criminally insane', reflecting an optimistic faith in criminological science; a philanthropic-positivism that invested in, and initiated, an ongoing quest to seek out an d remedy human deviance by focusing on the individual offender (Sapsford 1981, Young 1981). Debate about the ideological construction and management of human difference has featured in a compelling critique of contemporary techniques and technologies of social control, as 'therapeutic state' (Kittrie 1971, Conrad & Schneider 1980) and 'carceral society' (Foucault 1977). When Broadmoor Hospital, built by convict labour, opened in 1863 it represented the birth of the 'special hospital'. An architecturally austere structure, set atop a hill in rural Berkshire, its isolation mapped out the physical and symbolic segregation of those labelled, both, mad and bad. The design of the institution, though, enshrined a treatment philosophy as much as a concern with containment (Cohen 1981), the aspiration of Victorian morality in the service of medicine. Accommodation was

described as clean and spacious, fresh air plentiful, with recreational and sports facilities provided. Park Lane, the most recently built special hospital opened in 1974, to relieve overcrowding in the older institutions. Massive financial investment witnessed the creation of a state of the art forensic facility. Single-storey wards looked out onto bowling greens and tennis courts; all patient side-rooms were fitted with integral sanitation; sporting facilities included a well-equipped gymnasium, swimming pool and squash courts; and the rehabilitation centre boasted workshops devoted to a wide range of occupational skills, from fine art and pottery to carpentry, metalwork and upholstery, with an emphasis on industrial training rather than individual therapy. Beyond locks and keys, the traditional symbols of custody, the hospital was a centrepiece of surveillance security. Within the 'perimeter compound' surrounded by a twenty foot concrete wall, high-mast lighting illuminated shadowy recesses, and infra-red CCTV cameras made all internal activity visible. A 'high-tech' central control centre [CCC] monitored all staff-patient movements via portable UHF radio receivers/transmitters allocated to each ward.

For nurses who worked in this insular world, there was an assumption that treatment and containment were indivisible; public-safety and professional obligations interwoven in the figure of the special hospital nurse. Echoing the tradition of 'milieu therapy', just 'being there' constituted the health component of the hospital function for the patient population. For much of its history, the special hospital system was centrally managed, alongside the prison service, by the Home Office. Nursing staff were required to sign the Official Secrets Act, classed as civil servants, and in most cases were members of the Prison Officers Association [POA]. In the late 1980s and early 1990s, though, a series of structural changes, and professional developments, had a profound impact on the secure hospital and its nursing workforce. Nationally, there were incremental attempts to bring the special hospital system within the NHS framework of policy and provision (Deacon 2004). One, small, component of this reorganisation was the introduction of systematic care planning and individualised patient care, embodied in the nursing process. Mental health services had been speaking this language for a number of years, but it was a culture shock to those working in secure psychiatry. A longstanding debate about 'therapeutic custody' (see for instance Burrow 1991, 1993a, 1993b, 1993c) was replaced by a search to identify the unique constituents of a skills-base for mental health nurses caring for the disordered offender (Tarbuck 1994). Educational provision, like the English National Board course '*Nursing in Controlled Environments*' (the ENB 770), were approved in parallel with the setting up of the *Forensic Psychiatric Nurses Association* [FPNA] in the UK, and the American dominated *International Association of Forensic Nurses* [IAFN] (Lynch 1995). If 'forensic nursing'

had established a professional identity, and collegiate membership, it could be argued that there was little change at the grass roots.

The expectation that nursing staff would therapeutically engage with the sexual offender, or any client group, was linked to the introduction of individualised care planning onto the wards; an intervention that became illustrative of larger tensions involved in managing medicalised offending. Documentation, imported from a local District General Hospital [DGH], was distributed without any guidance on how it might be implemented with a unique population who were characterised by diagnosis and index offence (Mason & Chandley 1990). Mason and Chandley (1992) described nursing practice as a 'hyperreal' exercise, where an abundance of administrative paperwork constructed a reality very different from the day-to-day existence of life on the wards. A cursory glance at most of the care plans revealed problem areas such as 'poor personal or environmental hygiene' (which translated as 'body odour and an untidy room'). In contrast, progress was measured in terms of patients 'interacting well with staff and peers, or regularly attending social events' (which translated as 'friendly, not disrupting life on the ward, and disappearing in the evenings'). Nurse-patient interaction may have been plentiful; together the two groups would play snooker, read the newspapers, watch television, kick a football around in the garden area, and generally engage in banter and gossip. While these shared activities might have had some therapeutic value, there was scant evidence of planned programmes of care. Given the lengthy duration of patient detention in special hospitals, with few temporal markers, Richman (1989: 23) talked about a 'deep freeze of time', where those resident on the wards would "'turn off' and 'go' into their heads to become private people". In this cultural context, Richman and Mason (1992) caricatured the nursing role as a combination of entertainment and policing, of filling time and containing trouble.

Pornography, patriarchy and professional practice

If one attribute characterised the sexual offender on the wards, it was invisibility. There was good reason to mask the nature of their offending to peers, but little incentive or opportunity to address this in any kind of therapeutic forum. Responsible medical officers [RMOs] collected perpetrators of extreme and bizarre sexual crimes, but appeared less interested in undertaking interventive work with the men. A handful of clinical psychologists pioneered some innovative, individual, input with sexual offenders, but were outnumbered by demand. Sadly, nursing staff, the largest professional grouping in the hospital workforce, claimed neither expertise nor interest in offence-focused work with patients. This was disturbing, because the ratio of qualified to unqualified nurses was a luxury beyond the budget of

general mental health services. In retrospect, it is hard to accept that there was no systematic approach, or investment, in t reating the sexual offender within a hospital that claimed rehabilitation as a commitment to public safety.

In the early 1990s my being appointed as a lecturer-practitioner provided an opportunity to promote practice development. With a group of like-minded individuals, from a range of disciplinary backgrounds, it was decided to initiate the first group-work treatment approach for sexual offenders in Park Lane. Borrowing from work pioneered in the US (e.g. Laws 1989) and the UK (e.g. Cowburn & Wilson 1992) a relapse-prevention model was adopted. Based on cognitive-behavioural principles, the aim of the programme was directed at challenging individual and institutional denial, and promoting non-offending lifestyles through identification and management of risk factors. Despite the motivation of facilitators and participants, the group struggled to survive and fell victim to sabotage and obstruction at different organisational levels. Staffing and funding became management issues, because separate escort arrangements were required to transport patients to the therapy suite, avoiding their being identified as 'sex offenders'. Nursing assistants allocated this duty were reluctant to co-operate. Instructed to carry out the request, one of these men announced, loudly, in the ward day-area "Anyone for the sex offender group?" The naming of the group had been an important issue from the outset. If men taking part were to acknowledge their sexually abusive behaviour, it was felt this needed to be reflected in the identity of the group. However, to maintain confidentiality, and patient safety, the project became known generally as the 'Friday Group'.

For two hours each Friday afternoon, with considerable stress for all involved, efforts were made to confront and address the denial, and defences, characteristic of the sexual offender (Marshall 1994, Cooper 2005). There was little in this process that has not been reported widely in the literature (Marshall et al 2005, Marques et al 2005, Marshall & Serran 2000), but of greater import was the cultural context within which the treatment was enacted. There was a sense that any therapeutic advances, made in the brief period of intervention, were offset by the institutional culture into which the patient was returned. The findings of the Blom-Cooper Inquiry (Blom-Cooper et al 1992), would later indict Ashworth Hospital for sexist and racist ideologies that were deeply embedded in its organisational fabric. In brief, the therapeutic message that there were other ways of understanding women than 'sexual objects', was contaminated by an institutional miasma that reinforced denigratory and discriminatory attitudes and practices. One dimension of this was a saturation of pornographic imagery, throughout the hospital, that symbolised a lack of sensitivity toward women, gender, and sexual stereotyping. Some examples from practice will suffice to

explicate these concerns. Notwithstanding definitional difficulties about what constitutes pornography, attention will be directed toward a range of representations in the context of the types of offences committed by the detained men.

At that point in time, there was little restriction in terms of what patients could access, and commercial pornography was available in the hospital shop. Displayed on the counter, men would peruse magazines, and discuss the contents, as they queued to pay for their purchases. Female nurses would, usually, be responsible for checking 'restricted items' (lighters, batteries, blu-tack, etc), and sexually explicit images of women offered a ready source of unwanted attention and harassment. Similarly, it was not unusual for patient bedrooms to be wallpapered with pictures cut from sex magazines. This public display of women's bodies, as 'flesh' or 'meat' (see Adams 2003) represented a powerful text, about sexual-status, for female nurses undertaking random-routine room searches. In art classes, held in the central rehabilitation complex, pictures of women taken from publications like *Mayfair* or *Fiesta* were used as 'models' for patient paintings. Often, the final product would depict some form of hurt or distress, but artistic merit took precedence and precluded discussion of meaning or symbolism. Other kinds of materials precipitated concerns in relation to specific individuals or specific offences. One patient, claiming to be representing himself at an MHRT, requested scene of crime photographs from his case-files. Another man tried to order a series of photographs depicting female nurses in sexually suggestive poses. A member of staff from the hospital library questioned the request, from a patient with a history of paedophile offences, to order *Immediate Family* (Mann 1992). Dominated by images of the photographers' children, this portfolio had attracted considerable media controversy and condemnation, with some critics labelling the work as child pornography. The patient maintained, however, that he was considering taking up photography as a hobby. Examples such as these illustrate the complexi ty involved in a clinical consideration of relations between imagery, ideas, and behaviour (Mercer & Mckeown 1997, Mercer 2000).

The professional press paid little attention, but Orr (1988) offered one early commentary on the need for nursing staff to engage with pornography as a political concern in healthcare; from sexualisation of nursing as a genre of the industry, to gendered inequality in the NHS. Likewise, pornography received minimal coverage in psychiatric literature, though Drake (1994) drew attention to the lack of awareness, among educators, about health risks associated with pornography consumption. In relation to forensic mental health, Duff (1995) noted the lack of policy to address patient access to commercial pornography in secure services. It could be suggested the public and political outrage which greeted the publication of the *Fallon Inquiry into the Personality Disorder Unit at Ashworth Special Hospital*

(Fallon et al 1999) was framed within an organisational failure to take the subject of pornography seriously. The report was a direct response to allegations made by a former PDU patient about organised paedophile activities in the hospital, including grooming and photographing a child and trading children's underwear, availability of pornography, misuse of drugs and alcohol, and financial irregularities (Warden 1999). The appointment of an inquiry panel by the Secretary of State (February 1997) to investigate these claims represented the most recent investigation in the troubled history of the special hospital system (e.g. Boynton 1980, NHS Advisory Service 1988, Blom-Cooper et al 1992).

A research rationale for nursing practice

The emergence of pornography as a clinical concern (Fallon et al 1999), in the care and management of the sexual offender, suggested the need for an appropriate professional response. Forensic mental health nursing, as part of the multi-disciplinary team, is invested with a professional responsibility to, both, the client group and the public. Current mental health policy (DoH 1999, DoH 2006) aims to reduce service level restrictions within a larger agenda of inclusion and citizenship, and regulation of certain items, legally available outside secure settings, does not sit comfortably within a philosophy of normalisation. Political and professional anxieties about pornography, inevitably, filter down to the clinical team, where nursing staff play a central role in decision-making about literature or imagery that might be considered inappropriate for patient consumption. A number of questions emerge as a result of the hybrid role of the forensic nurse as carer and custodian, where practice is integrated with a security function. How, for instance has pro-feminist and critical thinking impacted on the dominant discourse of psychiatry? How is pornography understood in relation to the commission of sexual offences? How, given the range of textual and mediated imagery, are decisions made about what constitutes pornography? How is hospital policy interpreted and enacted in the context of care planning and risk management? And, equally important, to what extent would these accounts be shared by a patient population subjected to long-term detention?

Despite the existence of a vast body of literature documenting attempts to identify a causal link between pornography and sexual crime, results are contested and disputed (Donnerstein et al 1987). The bulk of this work has adopted an empirical approach to the measurement and quantification of particular variables (e.g. hostility toward women) following exposure to sexually explicit and/or sexually violent imagery. Research participants in experimental design studies have, typically, been recruited from non-offender populations such as undergraduate students (Carter et al 1987). Much social scientific inquiry developed as a

response to the singular focus that pornography assumed in feminist accounts of sexual violence, where survivor testimonies and public hearings (Everywoman 1983) provided a basis to campaign for censorship. Likewise, ambiguity is characteristic of clinical work with sexual offenders. While some therapists argue pornography is instrumental in developing and reinforcing fantasy as a prelude to offending (Wyre 1992) and others attribute a cathartic function in reducing dangerousness (Abel & Becker 1984) evidence regarding the use of pornography by sexual offenders is less convincing (Langevin & Curnoe 2004, Langevin et al 1988).

An alternative approach to the vexed issue of pornography is contained within a critique of new cultural forms, accompanied by the fragmentation and breakdown of established categories of meaning. One dimension of this relates to the sexualisation of late modern society (Plummer 1995), where the sexual story, gaining power and prominence, has turned personal narratives into public property. Sexual story-telling is diverse in terms of content, context and technology, from counselling and psychotherapy to television chat-shows and telephone sex-lines (Moorti 1998). Representing a mass-produced set of stories and images, pornography is cited as a prime example of the sexual story, a genre constructed specifically by the erotic. It is noted: "every invention – mass print, the camera, the film, the video, the record, the telephone, the computer, the 'virtual reality' machine – has helped, bit by bit, to provide a veritable *erotopian* landscape to millions of lives. The media has become sexualised" (Plummer 1995: 4). This theorising is prominent in the work of McNair (1996) where pornography as sexual discourse, rather than reified commodity, invites both positive and negative interpretations. Here, the relationship between pornography and viewer is more complex than the stimulus-response model that has greatly influenced the methodology of behavioural science research. Instead, the focus of inquiry shifts toward "the *meaning* of media images of sex, rather than their content taken in isolation; on the *uses* made of those images by those individuals who consume them, rather than on what they *do* to people; and on the context of their reception, as opposed to their instrumental effects on behaviour, attitudes, and values" (McNair 1996: 6 original emphases). From this perspective, dominant traditions in defining pornography, and understanding its effects, can be understood as competing discourses, with shifting ideological and political allegiances (Russo 1987).

There have been few attempts, by qualitative researchers, to access the institutional domain of the prison or high-security hospital and engage with male sexual offenders specifically in terms of pornography. From a feminist perspective, Scully and Marolla (1984, 1985) presented an early insight into the experience of undertaking critical inquiry with sexual offenders in the American penitentiary system; interview accounts where pornography

emerged as an unanticipated theme in relation to men's talk about offending. Challenging the medicalisation of rape, they offer an understanding of sexual crime as learned behaviour where cultural and social scripts enabled the offender to negotiate a 'non-deviant identity' and diminish responsibility: "The images projected in pornography contribute to a vocabulary of motive which trivializes and neutralizes rape and which might lessen the internal controls that otherwise would prevent sexually aggressive behaviour. Men who rape use this culturally acquired vocabulary to justify their sexual violence" (Scully & Marolla 1985: 253). Urging for a move from the laboratory into a broader social context, it was suggested of research into male sexual violence that: "it is necessary to explore the motives and rationalizations of men who rape, and their beliefs about men, women, and sexual violence in general, as well as their own victims and crimes in particular" (Scully 1990: 59).

The work of Scully (1988, 1990) initiated an interest in exploring how sexual offenders, and the nurses who worked with them, used language to talk about pornography in the context of secure mental health care. Recent work by Mann and Hollin (2007), in the UK, exploring sexual offenders' explanations for their crimes has replicated the finding that sexual gratification is a 'reward of rape'. The latter study, though, relied on a content analysis of written responses that were coded according to pre-existing categories, and related to dynamic risk factors such as 'schema-driven thinking' and 'cognitive distortion'. In stark contrast, Auburn (2005) using a discourse analytic approach to explore language use in a prison sex offender treatment programme [SOTP], described the concept of 'cognitive distortion' as a 'social resource' rather than a 'pathological mental entity'. Therapeutic concepts and categories, here, are understood in terms of a discursive practice that positions people, within institutions, in terms of identity and pathology. Of the value of engaging with talk in a custodial treatment setting it is noted: "To date, little work has focused specifically on the institutional discourse of prison settings and so this study opens up a novel strand of inquiry particularly as prisons are conventionally regarded as highly coercive regimes. By focusing on the interaction of those involved in prison institutional life, a richer understanding of how such regimes are accomplished can be gained" (Auburn 2005: 698).

The research study described in the thesis drew inspiration from this body of work, in seeking to access and critically explore the accounts of staff, and offender-patients, in relation to talk about pornography in one high-security hospital. The aim was to explore the ways that pornography was spoken about in the institutional environment where nursing staff and patients shared space and time. Semi-structured interviews were undertaken with forensic mental health nurses, and offender patients diagnosed as 'personality disordered'. A discourse analytic design (Potter & Wetherell 1987) informed the philosophical framing of

the question, style of interview, and analysis of data. Hopefully, it offers a challenge to a dominant research tradition within social science which has uncritically accepted, and reproduced, particular versions of the 'truth', where the objects/subjects of scientific knowledge are assumed to have a pre-discursive existence (Rolfe 2000, Hardin 2001).

The structure of the thesis

The thesis is divided into three sections, each of which contains a number of chapters. The first section introduces the background, and aim, of the study. This is followed by a review of literature that identifies the political and ideological debates that frame any discussion of pornography and harm. Attention is given to diverse forms of evidence that attempt to establish, or disprove, a relationship between consumption of pornography and male sexual violence. In a field of social science research that is riven with dispute, it is noted that textual approaches afford an alternative way of understanding 'pornographies', and sexualities, in a negotiated cultural context. Th ough it is rarely addressed in the professional literature, consideration is given to the relevance of pornography as an issue for nursing practice and research.

Section two, chapter three, outlines the theoretical framework and design of the research study. The approach to discourse analysis developed by Potter and Wetherell (1987) informed data collection and analysis. Recorded and transcribed interviews with nursing staff and sexual offenders, described as co-constructed accounts, provided a wealth of discursive data. Coding and analysis focused on the construction and variability of accounts, and the function of language in positioning participants in relation to each other and the institution.

Section two, also, contains four chapters which present the findings of the study, the content of which are organised according to the distinctly gendered language that constructed respondent accounts. By analytically integrating male nurses and patient accounts, chapter four explores how the talk of men constructed the hospital ward as male territory and variously textured relations between detained men and staff. Similarly, chapter five explores how a shared male discourse permeated respondent talk about pornography and sexual offending. In contrast, chapter six focuses on the accounts of female nurses who worked in the hospital, and the way that they used language to position themselves, in relation to male colleagues and sexual offenders, within the densely masculine culture of an oppressive and discriminatory environment. Chapter seven retains a focus on the accounts of female nurses,

by looking at their uniquely gendered talk, and experience, of pornography as a part of life on the wards, and sexual violence as a feature of women's lives.

Section three, chapter eight, draws together the findings of the research in a discussion of discursive themes that illuminated the function of language in constructing versions of the institution, and of the nurses and patients who participated in the study. Particular attention is given to the centrality of gendered discourse, contextual positioning through talk and a fluid construct of otherness that was continually re-worked in respondent accounts

CHAPTER 2

Literature Review

Introduction

Published literature relating to pornography constitutes a vast and diverse body of work. For the purpose of this thesis, the chapter reviews only material that is central to the research question. The rationale for reviewing a broad range of literature is rooted in the clinical component of the research question which seeks to understand how pornography is spoken about, and managed, in a treatment setting for detained male sexual offenders. There is a large body of scientific research which has attempted to identify a causal link between particular forms of sexual media and male sexual violence towards women. However, the clinical experience of the researcher would suggest that the findings of such scholarly work are rarely accessible to mental health practitioners, and have little impact on decision-making regarding the care and treatment of offenders. Nursing staff, in particular, play an important role in monitoring sexual media on the wards of secure facilities, and in assessing what constitutes 'clinically inappropriate' material, but typically lack any guidance in undertaking this role. Traditional experimental studies into the negative effects of pornography are problematic in a number of ways: the 'subjects' are often volunteers from a student body; researchers operate with different definitions of what constitutes the pornographic; and, most importantly perhaps, the studies look at short-term results in a controlled setting. The findings from such work, it can be argued, have intellectual value but less direct relevance for health care practice.

Interest in the subject of sexual representation crosses boundaries of disciplinary scholarship, but here the focus is restricted to debate about the relationship between imagery and behaviour; in short, the extent to which sexual crime, and sexual violence, can be attributed to the influence of a specific category of material. It is difficult, though, to disentangle the epistemological traditions that construct an intellectual engagement with pornography, which makes it difficult to classify or define materials in a way that has universal meaning. Ideas about pornography are historically and culturally constructed, and the subject has provoked debate in moral philosophy, politics and policy making, alongside a range of academic disciplines. In the context of this study, pornography is approached from the perspective of ethical nursing practice in forensic care, where the decision to restrict certain items can be interpreted as a positive therapeutic intervention, or a breach of the human rights of the disordered offender. Typically, it is a contested topic area, attracting

polarised and ideologically located critique. It is interesting for instance that much of the behavioural science research into the harmful effects of pornography grew out of feminist scholarship and activism; yet, though they may share a common interest in 'harm', their philosophical approaches would be markedly different. In the UK, pornography as a criminal issue has been typically dealt with under the Obscene Publications Act [OPA], but this clearly embraces a notion of indecency that offends community standards. In contrast, the feminist critique of pornography has generally focused on oppression, rather than offensiveness, with calls for legislative reform.

The material covered in this review acknowledges wider debates about pornography and engages with the ideas of Kingston and colleagues (2009) who explore individual differences in pornography use in relation to offender treatment. Noting theoretical diversity, and definitional difference, they make a distinction between 'pornography' as a commodity purposefully designed to sexually arouse the user, and 'embedded sexual media'. The latter would include a diverse range of mediated imagery, particularly televised entertainment that, if not sexually explicit, can influence people's desires and behaviours. As well as bodies of disciplinary knowledge, contributions to this debate can be understood as discourses, which respondents might draw upon in constructing their accounts. As Jensen (1998a: 5) notes: "...rather than constraining the discussion with simplistic notions about how mass communication causes specific behavior, we can think about how pornography cultivates certain views about sexuality". Concerns about the effects of pornography on society, particularly women and children, have prompted its recognition as a global public health issue effecting populations around the world (Perrin et al 2008). It is, further, suggested that the huge expansion of cyber communication and Internet technology has contributed to the mass marketing of exploitation and abuse.

The organisation of the review follows what might be described as a conventional structure in recounting the key debates in this area (e.g. Diamond 2009), and the chapter is divided into six sections which identify these. The first section introduces pornography as a contested and culturally constructed category. The second section focuses on a feminist, political, critique which identifies pornography as an instrument of male power, contributing to a patriarchal system in the oppression and subordination of women. The third section extends this debate into a discussion of child pornography, noting how technological advances have created a global market for the sexual exploitation of young people. Such debates have relevance for forensic practioners, where the misuse of IT, and child pornography, figured prominently in criticism of the secure hospital system (Fallon et al 1992). Pornography and sexual crime are discussed in the fourth section, giving attention to

the attempts of researchers, over a long period of time, to establish some relational measure between types of sexual materials and negative attitudes or behaviours toward women. It is suggested any evaluation of research claims invites a critique of the dominant research tradition, where methodological issues complicate the attempt to explain complex human behaviours in terms of a single determinant. Section five focuses on what has been referred to as the 'pornographication' of contemporary culture, and perspectives on pornography that emphasise discourse, text and context. The idea that human agency and experience offer an imaginative and analytic approach to sexuality and sexual offending has resonance for this study, where respondent language permits an understanding of how talk about pornography features, and works, in respondent discourse. Finally, section six considers pornography in relation to healthcare generally, and nursing in particular, in terms of promoting sexual health and addressing sexual offending.

Introducing pornography: a contested category

Debates and concerns about the societal role of pornography have a long tradition (Kendrick 1987, Hunt 1993, Cocks, 2004), embracing a history of written and pictorial representations of the sexual sphere of human relations. Any definition of what constitutes pornography is constructed and constrained by cultural conditions, from artistic expression and freedom of speech to moral panics and political polemics (Semonche 2007, Vadas 2005, Rea 2001). In the context of ever expanding and increasingly sophisticated technologies, commentators have described the contemporary world as a postmodern pastiche of sexual images, and icons, with a multiplicity of messages (McNair 1996). Across diverse disciplines in socio-cultural studies, interest has converged on the power of metaphor as a way of understanding human meaning (Plummer 1995). This theoretical perspective accords the 'story' a central role in interactions that characterise the social world. Furthermore the 'sexual story', as an emergent but specific set of discourses, is seen as a feature of western industrial societies, from TV chat shows to therapeutic exchanges (Plummer 1995). The commercial pornography industry has readily adopted mass communications systems and global media in the manufacture and distribution of its products (Cole 1989). At the same time, illicit use of Internet technology as a 'deviant technicway' (Durkin & Bryant 1995) provides an almost unregulated marketplace for a 'culture of sex talk' that blurs the boundaries between private and public spheres (Wallace & Mangan 1996).

During the 1970s, political campaigning against pornography became a central issue in the wider struggle of the women's movement for sexual and social justice (Green 2000). This introduced the experiences of women into a debate previously dominated by the "happy

triumvirate of pornographer, moralist and consumer" (Cole 1989: 17), suggesting the misunderstanding, and misrepresentation, of feminist perspectives on pornography reflected difficulties in redefining a masculine discourse. Bart and colleagues (1985) suggested that attitudinal differences between men and women, who had viewed an 'anti-pornography documentary', could be explained in terms of 'different classes' with 'different interests'. The last three decades have witnessed a burgeoning number of, experimental design, studies exploring the connections between pornography and sexual violence (Langevin et al 1988, Nemes 1992), typically informed by three competing models of rape that focus on psychopathological, physiological and socio-cultural factors (Cowan & Campbell 1995). Derived from evidence of correlation, activists and campaigners for reform have emphasised 'harm', rather than 'obscenity', as an appropriate target for legislation (Itzin 1992). Some radical feminist commentators, though, have questioned the value of collecting empirical data, to identify pornography as a causal factor in sexual crime, maintaining that the production and consumption of pornography in eroticising power relations and gender hatred *is* violence against women (Dworkin 1974, 1981, Russell 1993).

Behavioural science, and feminist, research might concur about the contribution of specific types of materials to gendered inequality, but share little in common regarding the scientific status of what constitutes evidence (Fukui & Westmore 1994). Likewise, Fisher and Grenier (1994a, 1994b) claim the field of research is marred by a lack of methodological and conceptual clarity, where inconsistencies in study design can profoundly affect results; where a body of evidence can both 'confirm' and 'disconfirm' the association of violent pornography with negative attitudes and abusive behaviours toward women. If there is broad convergence, in recognising an association between pornography and sexual aggression, it is suggested by leading social scientists in the field that the collection and interpretation of data cannot be understood outside of the cultural setting of research (Hald & Malamuth 2008). Whether focused upon the (typically male) subject of laboratory inquiry, or (typically female) victim of sexual abuse, ideologically located perspectives produce different ways of thinking and speaking about pornography. These approaches are outlined in more detail below, and direct attention to the centrality of language in constructing, as much as defining, their subject.

Feminism, pornography and sexual violence

Conflicting internal debates about pornography, within the sexual-political arena of the women's movement make it rash to suggest a unified feminist perspective (Cowan 1992). Theoretical engagement and pragmatic action have developed, over time, with marked

tensions between sexual-political accounts of structural division; from a liberal feminist emphasis on gendered discrimination to the radical variant of patriarchal oppression. In the United States, early objections to pornography, from the Women's Liberation Movement, focused on institutionalised sexual exploitation such as the beauty pageant. Two decades before Dworkin (1988) would link 'inequality' and 'intercourse', Millet (1969) identified a heterosexist hatred of women inscribed in contemporary literature. Understanding rape as the exercise of power, rather than an extreme expression of sexuality, Brownmiller (1975) placed violence against women on the centre stage of political activism. Like rape, pornography became a male cultural invention, without any female equivalent, where there could be no sexual equality. Perhaps, the best remembered campaigning slogan, coined by Morgan (1980), articulated the relationship with enraged clarity: 'Theory and practice, pornography and rape'.

In the context of personal and political consciousness, collective struggle shifted from an exclusive focus on violent and physical crime to embrace all areas of life where women experienced coercion and harassment. Feminist attention to popular culture was accompanied by an iconography that threatened women's rights and freedoms: "and who could look at *the new pornography* without being reminded of rape, of violence, and even of death, even when the images themselves were highly symbolic or contrived?" (Valverde 1985; 141 emphasis added). Twin concerns of changing content and backlash politics (Faludi 1992, French 1993) have lost little relevance for the pornography debate. Fuelled by the counterculture of the nineteen sixties, pornography entered mainstream corporate business, like the *Playboy* empire (Dines 1998), selling sexual liberation as recreational sex and chic hedonism. A study by Cowan and colleagues (1988) looking at the 'debasement' of women in pornographic videocassettes available from rental stores, commented on the fusion of sex and aggression in portrayals of rape, bondage and female submission.

More recently, exposure to video-tapes portraying women being 'degraded' was found to foster rape-supportive attitudes in male viewers (Golde et al 2000). Lovelace (1982) painfully recounted the relentless brutality that kept her imprisoned within the sex industry, while earning the public status of celebrity. The movie, *Deep Throat*, entered language and popular culture, earning in excess of $600 million, but the autobiography of the woman behind the camera lens recounted a dehumanised existence of physical assault, forced prostitution, gang rape and bestiality: "every day I either got raped, beaten, kicked, punched, smacked, choked, degraded or yelled at" (Lovelace 1982: 41). In this context, the late Andrea Dworkin (1981) initiated a powerful counter-offensive that identified pornography as a manifesto of male-supremacist ideology, historically rooted in the reality of women's

oppression; pornography was enshrined in art and literature, protected by law, and invested with the power to name and define: "male power is the raison d'être of pornography; the degradation of the female is the means of achieving this power" (Dworkin 1981: 25). Situating pornography within patriarchal culture, as "the undiluted essence of anti-female propaganda" (Brownmiller 1975: 394), radical feminism made an explicit connection between sexualised representations and sexual violence; an intertwining of male sexual arousal, male sexual hatred and male sexual aggression. Developing these ideas into a causal model, Russell (1988) outlined how pornography could predispose men to rape, diminishing internal and social inhibitions against using sexual violence.

Where pornography became symbolic of the eroticisation of female suffering for male entertainment and gratification, the question of causality, and search for scientific evidence to support a relationship between stimulus and behaviour, became an illusory and redundant exercise (MacKinnon 1986). Russell (1993: 113) more recently commented: "when addressing the question of whether or not pornography causes rape, as well as other forms of sexual assault and violence, many people fail to acknowledge that the actual *making* of pornography sometimes involves, or even requires, violence and sexual assault". Refuting the 'catharsis model' of pornography, findings from a study by Silbert and Pines (1984) supported an 'imitative model' where men learned how to become aroused in response to the suffering of women. Open-ended interviews with street prostitutes supported the idea of rape as an act of control and power, rather than sex. In respondent accounts, pornography was a feature of sexual violence and juvenile sexual exploitation, with 10% of women reporting that they had been used in pornographic films and magazines as children. The authors comment: "many of the references to pornography noted by the subjects indicated that their abusers were imitating the abusing males in pornographic materials, and believed that, as the victims in pornography, their victims must enjoy the abuse" (Silbert & Pines 1984: 866).

The massive growth, and commercial success, of 'cyber-porn' is a relatively recent development within the pornography industry, with Internet access rivalling travel and business sites in popularity (Stack et al 2004). Kramarae and Kramer (1995) note that an estimated 85-90% of users of electronic-mail and Net tools are male, suggesting that feminists need to shape the legal contours of cyberspace. Addictive use of Internet pornography, as a masturbatory stimulus, has been clinically diagnosed as a variant of 'pathological sexuality' (Fitzpatrick 2008, Stein et al 2001). Particular concern has been expressed about visual depictions of real, or simulated, rape, where women who initially reject sexual attention eventually respond to the ill treatment of their aggressors. Gossett and Byrne (2002: 703) comment on the ease of access, range of choices, and interactive options

that enable the viewer to 'see through the eyes' of the rapist and manipulate the content: "Connected to the notion that a woman really wanted the rape are the rape ideas that women are deviant sexual creatures and that all women are whores who deserved the rape".

Beyond examples such as pornography, or the analysis of narrative accounts of convicted rapists (Kellett 1995), it is contended that feminist scholars and discourse analysts have consistently failed to present an argument that sexist discourse in the broadest sense constitutes 'hate-speech' (Lillian 2007). Pornography sites, conventionally referred to as 'infotainment', are described as hate-speech, harassment, and sexual aggression against women. It is remarked that newsgroup postings: "make clear that at issue are not 'just' pin-ups of naked, large-breasted women, but also high-resolution, anti-female, racist pictures of women and children whose breasts and labia are, for example, pierced and trussed" (Kramarae & Kramer 1995: 16). Regarding pornography, the standard test of 'obscenity', as items that shock prevailing community standards, is impossible to operationalise where there is no local community (Spencer 1999, Wallace & Mangan 1996).

Eco-feminists have incorporated pornography, as pollutant, within emerging discourses of global environmental destruction (Hynes 1990), making a connection between 'meat' as consumable product and commercial trading of the female body as 'flesh' (Adams 2003). It is suggested that globalisation and the expansion of multinational capital has created a planetary marketplace, where the pornography industry (legal and illegal) has exploited opportunities for child exploitation, pornography and prostitution (King 2004). If pioneering contributions to the feminist literature on sexual violence identified rape as a terrorist weapon in national conflicts (Brownmiller 1975, Vogelman 1990), contemporary cultural critics make reference to a 'pornography of war' that, in an age of digital communication, transcends local and state conflicts. Film footage of the destruction of the World Trade Centre is juxtaposed with the ill treatment of inmates in a Baghdad prison, as images that 'thrill' and 'shame' (Baudrillard 2005).

Dean (2003) notes how the association of pornography with pathological sexuality has transcended the erotic domain, in non-sexual contexts, where human suffering generates 'eroticised objectification' rather than 'empathic identification'. With specific reference to the 'marketing' of genocide in Nazi Germany, she comments on the 'cultural work' of pornography as a metaphor that describes atrocity while obscuring horror: "Peep shows and snuff films are metaphors for both the secondary degradation of the victims – for the violence perpetrated by the exhibit on the memory of the Holocaust – and for the eroticization of violence and the presumed excitement it evokes" (Dean 2003: 103).

Commenting on film and camera recordings of war-time atrocities, Bovens (1998: 207) identified conflicting values characterised by the "puzzling resemblance between photojournalism and pornography". As with material designed to sexually arouse the viewer, concern is focused on 'bad consequences'. These include desensitisation to content and a diminished ability to empathise, misuse and misappropriation of images, and the status, and intent, of the photographer (pornographer) as participant.

Morrison (2004) contrasted the differential value of the term 'pornographic' as applied to holocaust images with amateur photographs confiscated from soldiers. The former illustrate the 'power' to systematically exploit and exterminate those deemed sub-human, while 'genocidal tourism' more closely parallels sexually extreme variants of violent pornography. With reference to pictures taken by Japanese militia at Nanking, where it is estimated that 80,000 Chinese women were raped, it is remarked: "They are photographs of the victims of rapes, many of whom were mutilated and killed afterwards. In one, three naked women lie distressed before the camera, the shadow of the soldier taking the photograph falls just before them intruding into the image" (Morrison 2004: 353). Technological development has meant that systematic rape as ethnic cleansing in the former Yugoslavia and Rwanda (Hynes 2004, Price 2001, Seifert 1996) has been made available via the Internet, stimulating further controversy about the function of pornography in sexualised racial hostility.

For Catherine MacKinnon (1994), the promotion and product of sexual violence becomes one and the same thing: "In that war, pornography pervades the rape/death camps in which Serbian fascist forces have interned Muslim and Croatian women to rape and kill them. Women in those camps report that what they see done to women in pornography is also done to them. They also report pornography being made of sexual atrocities committed against them" (MacKinnon 1994: xiii). Post-apartheid South Africa provided Teboho Maitse (1998) an opportunity to explore the sexual roles, and gender relations, of a newly democratised country. Despite introduction of progressive legislation, and significant representation of women in Parliament, levels of sexual violence are reported as escalating. Pornography is identified as an important factor in reinforcing misogynistic culture, where formerly illegal and exploitative representations of women enjoy the protection of 'free speech' under the Bill of Rights.

Pornography and the abuse of children

Feminist theorising has linked the commodification of children's sexuality, where desire and fantasy are interwoven, to the promotion of exploitation and abuse: "The implication is that

children are available sexually and that youth is the most desirable form of sexuality" (Elliot 1992: 219). Indicting empirical research into pornography and harm for prioritising adult sexual behaviour over the experiences of children, it is remarked: "there is no reason to believe that there is a distinction between how pornography in general, and child pornography in particular, affects the user" (Barnen 1996: 18). For Kelly (1992), scientific neglect is mirrored in feminist anti-pornography campaigns that paid little critical attention to the experiences of children. In a climate where sexual, physical and emotional suffering is dismissed as 'kiddie porn', she notes: "it seems that a percentage of the general public finds these forms of sexual violence plausible enough for 'fiction', but unbelievable and unacceptable in reality, regardless of the testimony of child and adult survivors" (Kelly, 1992: 114). Abramson and colleagues (1997) discuss one case study of child pornography and sexual abuse, in a day care centre, to illustrate how investigative difficulties undermined allegations and diminished victim credibility. Police discovered over 3000 pornographic slides of pre-school children, but criminal conviction was hampered by the prevailing social climate.

The centrality of language-use in exploring the social construction of multiple forms of child sexual exploitation has generated concerns about 'textual abuse' and 'lexical redescription' that minimise the specific experiences of young people (Goddard et al 2005). Exploring legal and social discourses that construct child pornography, Ost (2002) suggests that the content of the material, and status of the child, require separate attention. Academic and legislative assumption that possession of child pornography equates to child abuse is seen as problematic, where sharing fantasy is different from sharing an offending lifestyle: "in operating upon the assumption that a causal relationship exists between using child pornography and committing child sexual abuse, the academic discourses...may inadvertently provide actual child sex abusers with a convenient excuse for their behaviour" (Ost 2002: 450). For Itzin (2001, 1997, 1996) the dominant discourses of psychiatry, and clinical research, construct typologies and classifications of the sexual offender that make it difficult to conceptualise the relationship between pornography and intrafamilial or extrafamilial abuse. The term 'paedophile', it is suggested, pathologises some men/offenders and shifts attention away from the cultural sexualisation of children. In opposition to the scientific quest for clinical taxonomies, it is posited that sexual violence and child sexual abuse need to be seen as a continuum of behaviours (Itzin 2001).

An early contribution to the literature on child pornography (Tate 1991, 1990) alerted health professionals to a 'largely hidden' form of child abuse and challenged the stereotype of the child molester as alienated outcast. Attention was directed to domestic and international

markets that traded sexualised images of children, facilitated by advances in information technology. This remains a central concern regarding the sexual traffic of children in the U.K. (Chase & Statham 2005) and globally. At an international policy level, it is suggested, two developments have contributed to child sexual exploitation; the growth of affordable holiday destinations where young boys/girls are available for sexual purposes, and digital technology permitting the production and cross-border distribution of pornography involving children (Alexander et al 2000). Child pornography on the Internet takes many forms - pictures, anime cartoons, video, sound-files and stories - with assorted routes of distribution (Burke et al 2002). Quayle and Taylor (2005) note that if paedophiles were a relatively isolated group prior to the IT revolution, they can now form 'virtual communities' where few external controls operate. The complexity of defining what constitutes child pornography, it is argued, has created problems for clinical practitioners; where a singular focus on illegal materials limits comprehension of the way that a wide range of 'seemingly innocent' pictures might function for the sexual offender. Noting that most risk assessment instruments are based on prediction rather than explanation, they comment: "These inevitably focus on the role of fantasy in relation to offending behaviour, but make little reference to the use of pornography as an aid to fantasy" (Quayle & Taylor 2005: 865).

With regard to the interpretation of images as sexual, distinct from their original intent, Zurbriggen and colleagues (2003) comment on conditions under which children engaged as photographic models can be harmful; where child protection has to be balanced with artistic creativity. Making recommendations about the artistic use of child models, and the distribution of images, they note: "using current computer technology one can take an innocuous picture of a child (for example, a school portrait) and digitally modify it so as to create child pornography. Although no harm came to the child during the photographic session, one would want to consider the harm that would result from the dissemination of these pictures" (Zurbriggen et al 2003: 317). The introduction of internet censorship and regulation, to protect minors, requires proof of a causal link between the consumption of child pornography and predatory sexual behaviour (Catudal 1999).

Technological 'filtering' allows for the automatic detection of 'human nude' imagery (Forsyth & Check 1999), but there are difficulties in estimating the age of young girls whose photographs appear on sex-tourism sites (Stathopulu et al 2003). Citing the *Child Pornography Prevention Act* [CPPA] in the U.S., Catudal (1999) raises concern about definitional criteria and the categorisation of images. These include 'young looking adults' and 'computer generated simulations', which, it is argued, only become child pornography as a product of context. Commenting on a Supreme Court ruling that 'virtual' child

pornography enjoyed the protection of free speech, because 'actual children' were not hurt, is contested by Levy (2002). Acknowledging sparse empirical evidence of harm, to support a ban, opposition is framed in terms of imagery that reinforces unequal gender relations: "child pornography, actual or virtual, necessarily erotizes inequality; in a sexist society it therefore contributes to the subordination of women" (Levy 2002: 319). Prompted by definitional difficulty, and legal-moral conflict, in defining digital child pornography, Enemen (2006) proposed that non-technical research be complemented by systematic and empirical information systems [IS] research.

From a critical feminist perspective, Adam (2002) urges an exploration of Internet technology in terms of new and liberal forms of sexual expression, and the promotion and reinforcement of abusive behaviours. Understanding how technology is related to 'desire', and functions as a 'trigger' for some perpetrators, is identified as a worthy topic for gendered analysis. Rather than a simplistic assertion that criminality is a male pursuit, constructing female children as 'victims', attention is directed toward "topics such as privacy, where bodies are watched, looked at, or subject to surveillance or indeed where bodies are actually violated and the violations are watched on-line" (Adam 2002: 133). For Dombrowski and colleagues (2007), these concerns redirect attention toward the protection of children from online hazards including sexual solicitation and accessing pornography. It is suggested that the increased use of websites, chat rooms and instant messaging by young people in search of friendship and romance, needs to be balanced with recognition of considerable emotional and psychological harm; where supervision and intervention by carers requires technological and educational strategies. Similarly, Richardson and colleagues (2002) expressed concerns that software products, designed to block pornography access, might have adverse effects by screening out online health information sites. A study design, simulating adolescent Internet searching, revealed poor technological discrimination between pornographic and non-pornographic Web sites. This became particularly problematic where young people might be seeking information on sensitive topics such as sexuality, contraception, or abortion.

Pornography and sexual crime:

Evidence of a relationship between pornography and sexual crime is based upon diverse forms of data, from macro-level analyses of crime rates, (Gentry 1991, Court 1984, 1976) to individual victim testimony (Everywoman 1983). Bauserman (1996) reviewed correlational research with regard to the experience of sex offenders and pornography compared to non-offenders, sex crime rates and circulating pornography. Findings did not support the

argument that sexually explicit materials contributed to sex crime, but it was noted that a 'minority of offenders' reported using pornography prior to, or during, offending. Experimental research into harmful effects of pornography usually focuses on two discrete categories of sexually explicit materials, the 'violent' and 'non-violent' (Check & Guloien 1989). Consistently, social and behavioural science studies have linked the use of these kinds of pornography to sexual aggression and negative attitudes toward women. Though findings support a feminist critique, disagreement exists between researchers as to what has been 'proved', particularly in the longer-term (Dines, Jensen & Russo 1998). Donnerstein and colleagues (1987) argue that only pornography combining sex and violence can be shown to be harmful, and then only in terms of immediate effects. A third grouping, the 'erotic', depicting consensual and mutually pleasurable sexual relations, did not produce similar results.

An early investigation into concerns about pornography and sexual violence was undertaken with male sexual offenders, and non-sexual offenders, in the American penitentiary system (Cook et al 1971). Rating-scales and questionnaires, rather than physiological measures, were used to assess arousal levels as a product of viewing pornographic stimuli. Overall, little difference was noted between the two groups, but non-sexual offenders reported greater exposure to pornography during adolescence. Against a backdrop of moral panic about a 'permissive society', 'sexual repression' in youth was identified with anti-social behaviours later in life. Normative social values, likewise, framed research into relations between early use of pornography and development of 'abnormal' sexual behaviours (Goldstein et al 1971), with 'homosexuals' and 'transsexuals' placed alongside 'rapists' and 'paedophiles' in a discussion of 'sexual deviance'. It was reported: "Generally the reports of frequency during the adolescent years indicate that institutionalized sex offenders, homosexuals, transsexuals, and users of pornography report less frequent exposure than the control groups" (Goldstein et al 1971: 13).

From the perspective of sex-therapy, Gayford (1978) reviewed the content of seventy-two 'sex magazines', categorised in terms of 'erotic', 'sexual deviance', and 'sado-masochistic'. Assumptions about sexual desire and sexual behaviour are conveyed in the gendered language of the report, with sexual materials described as 'girlie magazines'. The recommendation, that such literature offered a therapeutic/masturbatory resource for young men, is consistent with other sociological work dating from the period. Berger and colleagues (1973), for example, presented pornography as a 'normal' social process of adult life within friendship and dating networks. Two decades later, Scott and Cuvelier (1993), undertook a content analysis of *Hustler* magazine (1974-1987), given social concerns that

linked an increase in violent pornography to a reported increase in rape rates. It was suggested that sexually violent portrayals were infrequent in 'adult' magazines and videos. Analysis indicated there had not been an increase in either violent, or sexually violent, cartoons or pictorials, and that a greater volume of pages/pictorials represented a decrease in the number of such items. These findings were consistent with public opinion, about the attribution of rape to pornography, based on general survey data for the same time period (Sharp & Joslyn 2001).

Padgett and colleagues (1989) explored the effects of viewing 'non-violent erotica', suggesting this to be more representative of commercial pornography. A questionnaire study of 'adult movie theatre' patrons did not support the hypothesis that viewing pornography invariably produced negative attitudes toward women. It was posited: "This finding may suggest that erotica portraying equal male-female interpersonal power roles and free from depictions of abuse is benign and may perhaps serve socially beneficial needs" (Padgett et al 1989: 489). Kearns and colleagues (1988) investigating pornography, masturbatory, and sexual practice in 'non-incarcerated sexual offenders' and 'paraphiliacs', maintained that adult exposure to sexual materials did not differ from the general population. Expressing reservation about the reliability of self-report data from sexual offender populations, they concluded: "sexual activity by paraphiliacs and sex offenders had begun prior to exposure to pornography...supported by this study's findings that 91% of paraphiliacs and 63% of the sex offenders experienced masturbation before they were exposed to pornography" (Kearns et al 1988: 296).

In North America the experimental research studies of Malamuth and colleagues, over an extended time period (e.g. Malamuth et al 1977, Malamuth & Huppin 2005), have combined clinical and theoretical strands. This body of work has attempted to develop objective assessment techniques, for the treatment of rapists, which take account of feminist theorising about pornographic media promoting gender hatred. Incorporating an 'exposure-arousal-fantasy-behaviour' process to explain sexual violence, attention is given to disinhibitory conditioning that might result from prolonged exposure to pornographic type depictions of sexual aggression. Using penile tumescence as a response measure, Malamuth (1981) noted that male undergraduate subjects, identified as 'force-oriented', created more arousing fantasies after exposure to depictions of 'rape', compared to 'mutual consent'. It was commented: "Taken together, the arousal and content data during the fantasy period suggest that exposure to rape stimuli may stimulate in some subjects arousing rape fantasies" (Malamuth 1981: 43). Further, in those subjects described as 'non-deviant', arousal levels were not significantly affected by manipulation of 'consent' as a variable. Thus, while

depictions of suffering and trauma had an inhibiting effect, certain portrayals of rape stimulated high-levels of arousal.

Zillmann and Bryant (1982) reported how, under controlled conditions, exposure to pornography resulted in reduced levels of compassion for women as rape victims. Subjects exposed to greater amounts of pornography found the material less offensive, trivialised sexual violence, and recommended shorter sentences for perpetrators. It was concluded: "massive exposure to pornography clearly promoted sexual callousness toward women" (Zillmann & Bryant 1982: 18). Revisiting the work of Malamuth, on rape myth acceptance as a determinant of rape proclivity, Bohner and colleagues (2006, 1998) sought to introduce clarity regarding 'correlation' and 'causality'. Recognising the limitations of generalising from an experimental design, it was noted that data approximated to 'real-life' within the ethical constraints of research. Initial findings supported the hypothesis that male proclivity to exert sexual force is 'causally' affected by individual and collective acceptance of rape myths. They noted: "Specifically, feedback about a high level of rape myth acceptance in their peer group led students to report somewhat higher rape proclivity compared to feedback about a low level of rape myth acceptance" (Bohner et al 2006: 290).

Critical of the recruitment of college students in empirical investigation into pornography and sexual aggression, Carter and colleagues (1987) reviewed physiological evidence that suggested different arousal patterns in rapist and non-rapist populations. Studies of adult sexual offenders indicated higher levels of sexual arousal in response to descriptions and representations of sexual violence. However, there was little evidence they had greater exposure to pornography than non-sexual offenders, and sexual offenders often reported less use of pornography than other offender groups or controls. Commenting that such findings ignored the heterogeneity of sexual offending, they postulated a complex relationship between pornography and behaviour, moderated by sub-type differences in offences. Volunteer subjects from a 'Treatment Centre for Sexually Dangerous Persons' were used to examine possible differences, between 'rapists' and 'child molesters', in terms of exposure to, and experience of, pornography. It was reported both groups had similar exposure to pornography in the home and during their early years. For child offenders, though, the use of sexual materials persisted into adulthood, prior to and during offences, or to relieve an impulse to offend. This was considered a significant finding, given that most previous work had been interested in pornography as a 'trigger' to rape. It was concluded that for offenders with high arousal levels, and limited capacity for adult relationships, pornography might represent an intermediary step between fantasy and acting out.

Malamuth and McIlwraith (1988), similarly, shifted from behavioural and attitudinal effects, to explore the relationship between frequency of exposure to sexually explicit magazines and fantasy, particularly those combining sex and hostility. Following exposure to two high-circulation, sexually-explicit, publications (*Playboy* and *Penthouse*) the 'imaginal processes inventory' was used to assess 'fantasising' and 'daydreaming' in male undergraduate students. The authors concluded that "data reported in the present research suggests some connections among consumption of certain sexually explicit media, sexual fantasies and hostility" (Malamuth & McIlwraith 1988: 768). In this tradition, Bogaert (2001) explored individual preference for sexual media in relation to personality characteristics, where men of lower intelligence, and a high-rating for anti-social tendencies, were more likely to select sexually violent films. Two recent Canadian studies (Kingston et al 2008, Seto & Eke 2005), exploring pornography consumption as predictive of future offending, each produced comparable results. Longitudinal data analysis of official records suggested a positive correlation between prior sexual offending, use of child pornography and rates of recidivism. Work undertaken by Webb and colleagues (2007), in the UK, focused on personality characteristics and risk in relation to matched groups of internet sex offenders and child molesters, as representing distinct types of offending. Across a range of psychometric measures, the two groups of men shared social and psychological characteristics, but significant differences emerged in terms of sexual recidivism. Noting that 'contact' offenders present an increased risk of reoffending in the community, they commented: "despite the small numbers there is some indication to suggest that there is a sub group of internet offenders who pose a risk of repeated internet pornography offending, but not an escalation to contact sex offending. Nevertheless, as yet, by far the largest subgroup of internet offenders would appear to pose a very low risk of sexual recidivism" (Webb et al 2007: 463).

Societal concerns about youth consumption of movies with sexually violent and degrading themes prompted Linz and colleagues (1988) to investigate 'emotional desensitisation' as a product of prolonged exposure. Assigned to experimental groups/conditions, college-age men viewed two versions of a rape trial re-enactment and one of three types of film: R rated (violent), R rated (non-violent), and X rated (non-violent/sexually explicit). Questionnaire and self-report data indicated that desensitisation to film violence occurred rapidly, where sexually violent images initially provoked anxiety and depression that reduced with repeated exposure. Viewing sexually violent media also correlated with lower levels of sympathy for the rape victim. Of equal gravity, they noted: "More robust was the finding that the R-rated violent-film subjects were less able to empathize [sic] with rape victims in general when compared with no-exposure control subjects and subjects exposed to other types of film"

(Linz et al 1988: 766). If most studies focused on changes in attitude and behaviour under specific (experimental) circumstances, less emphasis was given to predicting the propensity to commit rape or other sexually violent acts. It was suggested that there was a lack of clarity, in published studies, between 'pornography effect' and a 'pre-existing attitudes effect' (Demare et al 1988: 142): "For example the current literature cannot rule out the possibility that sexually violent attitudes and beliefs might create interest in both pornography and sexually violent behavior, such that any relationship found between pornography use and sexual violence would be spurious". In this context, the latter authors conducted a survey amongst college males to explore self-reported likelihood of rape, or use of force. Results revealed pornography use was widespread in the sample, with half the men consuming materials that depicted violence against women. Findings suggested the fusion of sex and violence, as a feature of specific types of pornography, combined with conservative sexual attitudes to promote a proclivity for sexually abusive behaviours (Demare et al 1988).

Research into 'degradation', as a damaging component of pornography, was reported by Cowan and Dunn (1994), noting methodological problems surrounding definition, and the varied materials used as stimuli in experimental studies. Linking feminist theory with an empirical design, the study aimed to test-out feminist concepts of 'subordination' and 'inequality' as constituents of 'degrading pornography'. Previous inquiry, it was observed, had been initiated by male academics, and operationalised with masculinist constructions. It is noted: "When the degradation of women is associated primarily with their display of sexuality, rather than by the ways in which sexuality portrays their subordination, not only is a double standard of sexuality being used, but also subordination is discounted" (Cowan & Dunn 1994: 12). After viewing clips from commercial 'X-rated videos', reflecting 'blatant' and 'subtle' themes of gendered inequality, subjects were required to complete a series of rating scales. Results supported a feminist perspective that 'subordination', not 'sexuality', degrades women; discrepant with predictions, 'submission' was an ambiguous theme that rated, alongside 'equal sex', as the most arousing content for male and female participants.

Commenting on the contradictory findings of two US federal commissions (1986, 1972), Boeringer (1994) attempted to investigate rape proclivity in relation to different types of sexual stimuli. These included 'soft-core pornography', 'hard-core non-violent pornography', 'hard-core consensually violent pornography', and 'hard-core rape depictions'. Self-report data from male students, focused on 'sexual aggression/coercion' and 'likelihood of rape/force', identified pornography as a significant correlate with sexually aggressive behaviour. This, though, was not the case with 'non-violent' and 'soft-core' materials. Consumption of 'rape pornography' also correlated with the use of alcohol or

drugs to obtain sex. It was noted: "It is probable that, for some persons, violent pornography not only presents techniques for sexual assault, but also provides justifications for violence and rape" (Boeringer 1994: 299).

Other studies have focused on the role of social factors in mediating responses to violent pornography, and how this might contribute to the process of becoming a sexual offender. Norris (1991) considering how an interest in sexually violent materials developed, used an experimental design to explore the social context of arousal in a sample of men and women. Questionnaires were completed, by participants, after hearing two versions of a sexually explicit/violent 'story', where 'outcome' varied in terms of the woman/victim experiencing 'pleasure'/'distress'. Prior to responding, subjects were given false information regarding a fictitious set of individuals who, it was claimed, had taken part in the study. Reporting the results, it was contended that 'normative information', rather than the female characters emotional state, played a significant part in constructing arousal.

Becker and Stein (1991) interviewed adolescent males charged with, or convicted of, sexual offending, where attention was given to their experience of 'erotica'. Though only 11% of respondents reported not using some form of sexually explicit media, they disclosed high levels of alcohol consumption, and histories of physical and sexual abuse. Only two of the (160) interviewees claimed pornography could be implicated in their offending, and none reported viewing video material that contained sexually violent themes. Accepting the retrospective nature of the data, and possibility of self-serving and selective responses, it was concluded that no single factor could be held responsible for sexual interest and sexual offending. Noting that pornography and alcohol had been, individually, identified as precursors to male violence, prompted Norris and Kerr (1993) to explore a possible relationship between these two issues. The study aimed to investigate mechanisms by which alcohol consumption might increase 'positive reactions' to 'violent pornography' with adverse behavioural changes. Recruiting campus students, classified as 'social drinkers', an experimental design manipulated variables (alcohol/no alcohol) in combination with two different versions of a 'story' detailing heterosexual acts. Results indicated that 'alcohol effects' occurred for subjects of both sexes. In particular, alcohol consumption by men produced negative views of the female character, and a greater willingness to behave like the male character. For women subjects, alcohol was associated with a more favourable appraisal of the male character, and a self-reported likelihood of adopting the role of the woman in the script.

Cowan and Campbell (1995), noting the commonality of rape in the lives of young women, argued that little was known about adolescent understanding of the causes of sexually abusive behaviour. Contending that the cognitive development of young people precluded abstract reasoning, and supported the attribution of individual blame, pornography as a communicative media became worthy of investigation in relation to the propagation of rape myths. It was conjectured that adolescents who had been exposed to pornography, viewed it frequently, and stated that it had informed their learning about sex would believe more strongly in victim precipitation. Findings revealed that if adolescent respondents invested in individual, rather than structural accounts, attitudes to rape were gender specific, and each gender group explained rape in terms of the perceived characteristics of the other. In conclusion it was noted: "Although causal relations between exposure to pornography and rape myths cannot be drawn from correlational findings, the possibility that large numbers of adolescents are adversely affected by exposure to pornography is worth considering" (Cowan & Campbell 1995: 151). Focusing on the scale of forcible sex experienced by female students in the U.S, Carr and VanDeusen (2004) discussed the need to develop theory-based risk assessment to inform campus rape-prevention programmes. Attention was directed at the value of attempting to understand the 'unidentified rapist' as representative of the majority of sexually aggressive men who evade conviction. Survey and rating-scale data supported the identification of factors predicting sexual aggression in a high percentage of college males. Of pornography, in particular, it was observed that: "A significant proportion of the sample reported using some form of pornography on at least a monthly basis in the form of magazines (42%), videos (34%), and Internet sites (39%). In addition, 9% attended strip clubs" (Carr & VanDeusen 2004: 284).

Expanding the debate beyond pornography as a health concern for young people in terms of coercive sexual behaviour, Haggstrom-Nordin and colleagues (2005) explored pornography consumption in relation to sexually transmitted diseases and HIV/AIDS. Survey data, from male and female high school students, revealed gendered responses in relation to experience, and use, of pornography. Young men consumed more pornography, were more likely to report high-levels of sexual arousal as a result, and claimed to incorporate the ideas of viewed material into their fantasies and sexual acts. Supporting theories of pornography offering a male sexual script, certain acts were rated in different ways according to the sex of the respondent: It was noted: "It seems obvious that most women do not appreciate being anally penetrated, contrary to the idea that is spread through pornographic films" (Haggstrom-Nordin et al 2005: 106).

Shifting the definition of pornographic, within contemporary popular culture, St. Lawrence and Joyner (1991) explored the effects of 'sexually violent rock music' on male subjects, noting the lack of attention given to such media. Experimental manipulation consisted of exposure to one of three conditions - 'sexually violent heavy metal', 'Christian heavy metal', and 'classical music'. Results based on a series of rating-scales, indicated that even brief exposure to rock music increased male sex-role stereotyping irrespective of the lyric content. In terms of sexual arousal, classical music rated highest, explained as a cultural construction. The authors suggested that "the relationship between classical music and sexual arousal has been part of folklore for years, and this finding is consistent with the view that pornography arouses aggression rather than sexual arousal" (St. Lawrence & Joyner 1991: 59). Barongan and Nagayama Hall (1995) reported on a laboratory study to investigate 'misogynous messages' in rap music reinforcing cognitive distortions about women. Borrowing the 'causal model of rape' (Russell 1988, 1993), it was conjectured that regularly listening to negative language might have the same effect, on men and women, as viewing negative imagery. They note: "Some musical lyrics express negative and sexist attitudes about women that are very similar to the messages found in pornographic movies and magazines, including the idea that coercive sexual activity is enjoyable for women" (Barongan & Nagayama Hall 1995: 197). Male students, assigned to control groups, listened to music and watched videotaped vignettes graded in terms of sexual violence, one of which was selected to be shown to a female confederate. That a significantly greater number of men chose sexually aggressive vignettes, after being exposed to misogynous rap music, offered support for the hypothesis. More recent commentators, though, have suggested the attribution of 'social content' to music, as violence against women, needs to be approached with caution, particularly where critical commentary focuses on advertising campaigns and album sleeves (Clarke & Dibben 2000).

Pornography, discourse and text

If pornography emerged as a 'problem' of 'sexual revolution', boundaries of singular interpretation and categorisation have been eroded by unprecedented cultural change in terms of a mediated, or sexualised, society (Beaver 2000, McNair 1996). A change in the sexual marketing of 'men's magazines' has witnessed the emergence of weekly publications with titles such as *Zoo* and *Nuts*, interpreted by some as a chic replacement for 'soft-porn'. Exploring the discursive construction of male heterosexuality in 'lifestyle' weeklies, Attwood (2005) noted the re-cycling of traditional signifiers of masculinity, described as "tits and ass and porn and fighting" (Attwood 2005: 97). Without denying some connection between pornography and violence against women, the 'effects' debate that has dominated

feminist discourse is seen as 'damaging', over-investing in messages rather than the medium, and reifying a set of images as a historical and unchanging (Boyle 2000). Ciclitira (2004), noting the dissatisfaction of many women with the anti-porn movement, equating it with 'anti-sex', comments on the way that 'interactive sex entertainment' has opened a technological space for women to produce and distribute their own, non-profit, pornography to explore sexual desire and sexual identity.

Challenging feminist campaigns against pornography as deterministic, Wilkin (2004) argues for an analysis of pornography that accounts for economic and social relations. It is noted: "Its meaning has to be situated in the social context in which it is produced and used, and how it is understood will reflect the concrete narrative of particular groups and individuals in particular times and places" (Wilkin 2004: 354). For Attwood (2004, 2002), the 'binary' feminist definitions of pornography, in terms of misogyny and harm, are limited and limiting, signalling a need to re-contextualise pornography as visual representation, sexual excitement, and sexual practice. It is noted: "The lines drawn between porn and other forms of sexual representation also seem much less clear than they did in the past; mainstream representation has become more explicit and 'perverse' and imagery and language, which would have been classed as pornographic not very long ago, have become part and parcel of popular culture" (Attwood 2002: 94). Traditional social-scientific research is seen as a product of constructing pornography through 'definition', exploring the 'links' between 'low culture texts' and 'effects'; pornography as an 'outlaw discourse' that signifies a range of social ills and anxieties. Instead, an ethnographic shift is recommended, with intellectual attention directed from 'pornography' to 'pornographies', in terms of the reader, the text, and the context.

Benwell (2005) adopted a textual-culture approach to explore the construction of masculinity, and masculine discourses, in relation to 'men's magazines'. Co-constructed, focus-group, interviews were used to replicate the reading experience of young men, enabling analysis of local moral orders that reflected broader cultural values. A request from school-age boys, to incorporate pornographic material into sex-education classes, led Allen (2006) to focus on the 'discursive limits of respectability' that symbolised masculine sexual subjectivities within the 'hetero-normative space' of the classroom. Congruent with a social constructionist perspective, sexuality is seen as a negotiated, and competitive, performance, rather than an innate and immutable human characteristic. She notes: "The struggle is for the achievement of a particularly powerful form of masculinity that is heterosexual, virile, competitive and predatory. This regime is conceptualised as hegemonic masculinity, a configuration of practices that create the ascendancy of one group of men over others (and

women)" (Allen 2006: 74). It is suggested that critical engagement, with pornographic content, can minimise its power in dominant sexual discourses.

While a body of research into pornography and harm has utilised psychological style experiments, less attention has been given to investigating leisure and gender in relation to a multi-billion dollar entertainment industry (Shaw 1999). Undertaking inquiry into the role of pornography in women's lives, accounting for agency, the latter author reported both positive and negative responses to viewing sexually explicit materials [SEM]; where representations were interpreted in relation to 'self-image' and 'body-image'. If pornography could be instructional, in terms of new experiences or heightened arousal, the imagery could also be framed by threat and fear. In conclusion, it was noted: "The views expressed by women in this study are clearly consistent with the notion of gender reproduction. They provide confirmation of the role that pornography plays in reproducing hegemonic femininity (and masculinity), through the objectification and inferioization of women" (Shaw 1999: 209). Similarly, Boynton (1999), reported on focus-group discussions, with women, in relation to their viewing of 'top-shelf magazines' aimed at a heterosexual market, positioning participants in a traditionally, male-gaze. Analysis of discursive themes revealed a reflexive reading of visual texts, of comparison with, or distancing from, the model. Attractiveness was equated with being 'natural', while 'good-looking' women could still be described as 'tarts'. Beauty was associated with a slim figure and youthful appearance, with a rating and delineation in terms of 'proper models', 'glamour models', and 'amateur models'. Significantly, viewing women's breasts in a magazine was considered more socially appropriate than breastfeeding in public, suggesting a contextual difference between 'pictures' and 'women's bodies'. Noting that empirical research studies, in this area, rarely access ways of speaking, women respondents were able to move beyond a narrow remit on imagery and sexual crime: "Such discourses are not found in experimental studies of SEM – because women participants are largely absent, and also because an experimental (quantitative) design means participants rarely discuss what they are viewing in detail" (Boynton 1999: 459).

Discourse analytic critiques of tabloid coverage of anti-paedophile demonstrations revealed the ideological function of language in constructing 'otherness', pathologising crowd protest, and delegitimating collective political action (Drury 2002, Cowburn & Dominelli 2001). Against a backdrop of real risk, and moral panic, around child abuse and child pornography, the paedophile has emerged as an icon of evil in contemporary reporting of sexual crime (Silverman & Wilson 2002, Spargo 1999). Similarly, Evans (1993) and Simon (1996) refer to the 'postmodern condition' in relation to competing scripts of sexual

citizenship, where the obscurity of the 'sexual outsider' has been lost through social discourse. It is posited that: "their appearances are not merely sanctioned severely, but their dangers advertised and their potential suspected, and actual practitioners are aggressively pursued" (Simon 1996: 125). For Boutellier (2000), the strong consensus about protecting children from paedophile risk, reflects a crisis in late-modern sexuality, described as a 'schizophrenic' moral situation where permissiveness and equality conflict. He remarks: "In my opinion, the vehemence of the rejection of these products arises from the fact that child pornography is the culmination of a sexualised culture" (Boutellier 2000: 455).

Pornography in a healthcare context

Pornography, as an issue worthy of professional consideration, has received scant attention in the nursing press. Until recently the whole area of sexuality as a component of holistic caring was neglected in the literature, and remains an issue largely focused on the needs of particular client groups such as the elderly or learning disabled (Wheeler 2001). Where attempts have been made to include sexual health within nursing curricula, humanistic professional values tend to divest the subject matter of any sexual-political specificity. Thus, Crouch (1999: 671) is able to proffer of 'sexual fantasy': "This is reflected in past literature such as the Kama Sutra, and Renaissance pictures, Indian and Egyptian wall paintings and statues, as well as current fictitious novels such as those written by Jackie Collins, and soft pornography magazines such as Club, Penthouse, White House and Asian Babes, where explicit sexual activity is discussed and pictured".

One, exceptional, early claim that the nursing profession, and healthcare staff, ought to engage with the issue of pornography (Orr 1988) was grounded in a set of concerns arising from service provision. These focused upon the thematic content of sexual violence, objectification of women, representations of nursing roles, workplace harassment, and gendered inequities in NHS career structures. Latterly, Regan (2005) drew attention to the blatantly sexist portrayal of nurses in a high-profile advertisement campaign for a cellular phone service. It was noted: "Without any subtlety whatsoever, the imagery portrays the age-old idea of women as the weaker sex in need of protection and nurses as exemplary instantiations of the Madonna-whore phenomenon" (Regan 2005: 210). Despite important implications for health promotion, such issues continue to be poorly addressed in generalist professional publications. Psychiatric nursing literature, likewise, reveals a lack of reference to either health risks associated with pornography consumption, or the perceptions of educators toward possible effects (Drake 1994). Indeed, when pornography does receive some meagre coverage, this is typically a newsworthy response to disciplinary action,

suspension, or the dismissal of individual nurses as a result of criminal actions and/or professional misconduct (Anon 2004a, 2004b, Castledine 2002).

The emergence of forensic nursing as a discrete area of practice further highlights pornography as a clinical dilemma, and positions academic questions firmly in the clinical domain (Mercer 2000, Mercer & McKeown 1997). If few effective policy statements have been formulated, access to legally available pornography by detained patients is recognised as a national concern amongst practitioners and managers (Duff 1995). Recent public inquiries into high security provision have raised related concerns about 'macho' cultures and the availability of pornography in rehabilitative environments (Blom-Cooper et al 1992). Particular attention has been directed at the clinical and institutional management of personality disordered patients at the 'severe-end' of the diagnostic spectrum (Fallon et al 1999). Specific concerns related to pornography being brought into treatment settings, unsupervised patient access to VCRs, sophisticated computer equipment permitting illicit materials to be copied, and trading in pornographic materials.

An interesting contribution, from within the Psychology Department at Ashworth Hospital, is made by Steward and Follina (2006) who review empirical evidence on behavioural effects of violent media in relation to developing policy for forensic practice. Timely as this attention might be, in raising awareness, the discussion rehearses rather than revisits methodological problems identified in this chapter. In short, results from study samples, drawn from the general population, are applied to the disordered offender. While acknowledging cross-cultural factors, imprecise terminology and ecological validity that compromise generalisation, this discussion paper fails to discriminate between 'violence' and 'sexual violence', collapses diagnostic categories, and makes no reference to pornography as a discrete type of material. Though cognisant of the difficulties this generates, uncritical assumption allows the authors to make broad claims: "We do not claim that media violence *causes* the offences, but it is reasonable to assume that media exposure is one of the influences on the expression of violence in the forensic population, just as in any other population" (Steward & Follina 2006: 35, original emphasis).

Institutional vigilance, restriction and searching might fulfil the function of security, but takes little account of individual care planning. With regard to sexual crime, an important issue relates to the use and circulation of legally available materials with a sexually explicit content, or more mundane products featuring sexualised images of women and children (Kelly 1992). Hynes and colleagues (2007) note, in particular, the recent involvement of mental health professionals in assessing and treating individuals who enter services as a result of using the internet for sexual purposes. Recognising the implications of an

expanding medicalisation and criminalisation of emerging modes of sexual activity, it is suggested a spectrum of practitioners need better preparation to undertake a highly specific role. They comment: "A much wider group, including nurses and social workers, is likely to have most frequent contact with people with histories of a range of online sexual behaviours, perhaps for the first time. The legal framework around this area is complex, largely because online sexual activity is a relatively novel phenomenon and includes such a disparate range of activities, paralleling offline, or 'real world', sexual behaviour" (Hynes et al 2007: 20).

Sex-offender treatment programmes in psychiatric (Nelson et al 1989) and penal (Grubin & Thornton 1994) settings, that attempt to balance therapeutic integrity with public safety, need to incorporate these issues in the context of the therapeutic environment. In this sense, ideas and talk about pornography represent an important element of care planning, nursing management and risk assessment. It has been suggested that the limitations of experimental research, with the potential to under- or over-reach the role of pornography in promoting sexually aggressive attitudes and behaviour, should lead to alternative avenues of inquiry. Derived from a larger critique, of the objectivity and neutrality of traditional social science research methods, is the idea that behaviour patterns can be understood through the 'stories' that people tell about their lives (Dines et al 1998). This approach complements the clinical practice of offender-focused therapists, where pornography use can be implicated at each of the key stages of offending behaviour, from fantasy and predisposition to grooming, planning, and the commission of sexual crime (Wyre 1992).

Summary

The chapter has reviewed diverse forms of data that contribute to an understanding of the relationship between pornography and harm, revealing the difficulty of reaching any definitive statement. As Jensen (1998b: 101) notes: "Some advocates of regulation, both feminist and conservative, commonly cite studies showing links between pornography and violence, while opponents of regulation point to other studies that show no links or are inconclusive". Though there is great uncertainty between the findings of research studies, and their interpretation, some tentative conclusions have been proposed. Donnerstein and colleagues (1987) suggest it is the combination of sex and violence, in certain types of pornography, which produce anti-social attitudes. This, though, is qualified only in terms of immediate, rather than longer-term effects. Russell (1988, 1993), reviewing the experimental evidence, posits a 'causal link' between pornography and sexual crime, while Itzin (1992) argues that the 'correlation' between pornography and negative attitudes/behaviours is

sufficient to warrant legislative change. For others, this disagreement demonstrates methodological shortcomings of the dominant experimental design, and privileging of 'science' in contemporary culture (McNair 1996, Jensen 1998). An alternative approach has been suggested that draws upon experience, and language, in situating pornography within the social context in which it is consumed. The proposed study shares that philosophy, and the next chapter outlines a research question, and methodological design, to explore staff and patient discourse, about pornography, in a high-security hospital for the treatment of sexual offenders.

SECTION II

CHAPTER 3

Theoretical Framework and Study Design

Introduction

This chapter maps out a methodological approach which was congruent with the aims of the research question. The study adopted a discourse analytic [DA] design focused on language-use and verbal data to explore how pornography was spoken about in relation to the nursing management of personality disordered sexual offenders. In contrast to a large body of experimental work that, arguably, has little direct relevance for nursing practice, the study design shifted the research agenda to the institutional discourse of the forensic setting. Sympathetic to the idea of forensic nursing as a discursive-practice (Perron et al 2005, Holmes 2002), the study adopted a constructionist version of discourse analysis developed by Potter and Wetherell (1987) that enabled staff and patient accounts to be understood as talk in action.

The selection of a discourse analytic design reflected the clinical construction of the study and the need to address the issue of pornography, and sexual offending, in a different way from the dominant research tradition in this area. As noted in the literature review, a large body of empirical evidence exists to suggest certain types of sexual, or sexually violent, materials can be linked to aggressive and abusive male behaviours. However, these findings are not consistent between studies and, if the field is intellectually rich, there is little of value for forensic mental health nurses who are more involved in practical decision-making than theoretical debate. Research using an experimental design is, typically, decontextualised; taking place in a laboratory setting, recruiting student subjects, and measuring particular responses in relation to a pre-determined set of stimuli. In contrast, this project intends to explore the issue within the context of a high-security service for men who have already demonstrated their dangerousness through serious sexual offending. The high-security hospital system represents a unique cultural environment, with a distinct patient population, and critical reports have identified institutionalised sexism (Blom-Cooper et al 1992) and pornography (Fallon et al 1999) as problematic. It is difficult to imagine how one might develop, or enact, a strategic approach to the management of sexual media in such settings without taking account of power relations that characterise institutional life. Likewise, personality disorder (Pilgrim 2001) and pornography (Hardy 2008) are contested categories, where the theoretical insights of constructionist theory have utility. Academic and professional attention has recently shifted toward a critical analysis of therapeutic discourse

of sex offender treatment (Auburn 2005). Writing about constructive work with male sexual offenders, Cowburn (2006) has noted the need to consider how masculinities are constructed through language. The design of this study acknowledges early, critical, analysis of gendered talk in custodial settings (Scully & Marolla 1985, 1984), and adopts the contemporary interest in discourse.

Though it was an early development in discursive socio-psychology, the approach of Potter and Wetherell (1987) has remained a popular methodology for exploring performative aspects of language. It provides a broadly constructionist perspective on self and identity (Edley 2001, Edley & Wetherell 1997) where speaker accounts are produced in context-specific ways, and accomplish social actions; a focus on what people do with talk, as much as what they actually say. It is also a form of discourse analysis that easily accommodates the research interview and socially generated data. Wood and Kroger (2000) note that in research areas characterised by 'private, secret or non-normative activities', DA has to rely on non-naturally occurring talk. It is hard to conceive of an ethical way of gaining access to offender-patients talk about intimate, and closely guarded, aspects of their lives. In contrast, co-constructed accounts of pornography, and sexual offending, are possible, and will situate respondent talk in the institutional environment.

The chapter is divided into four sections that map out the philosophical approach which informed the aim, and conduct, of the study. The first section identifies complex definitions of discourse analysis, as a series of approaches rather than a distinct method in social science research, that focus on talk and text in context. The second section introduces an accessible, and influential, model of discourse analysis (Potter & Wetherell 1987) that has gained prominence in nursing and health-related research (e.g. McCloskey 2008, Seibold 2006, Stowell-Smith & McKeown 1999). Adhering to the tenets of social constructionism, this approach to discourse is interested in the variability of accounts, and performative aspects of language as a social practice. In the third section, attention is given to the practicalities of data collection in the institutional context of a high security hospital. Interviews with nursing staff and detained sexual offenders were seen as co-constructed accounts, rather than a search for facts. The final section looks at the analysis of data, from initial reading and coding to the identification of themes and patterns within, and between, respondents talk. A discourse analytic orientation revealed how respondents constructed accounts by drawing on cultural resources in, contextually, variable ways that positioned them within the institution.

A Discourse Analytic Design

Discourse analysis as theory and practice: the 'turn to language'

Discourse analysis [DA] is described by Silverman (2001: 177) as a "heterogeneous range of social science research based on the analysis of interviews and texts as well as recorded talk". In broad terms, it treats the social world as a series of texts, or interwoven discourses, that have an existence independent of those who use them. Beyond *individual voices*, discourse analysis can be seen as a way of understanding *social voices*, as collective and communal ways of talking that are shared between people in a way that makes social life possible. The origin and development of discourse analysis, across a number of social science disciplines, such as psychology, sociology and linguistics, means that it cannot be understood as a unified or unitary approach (Cheek 2004, Traynor 2004). The emergence of the 'discursive turn' in psychology and the humanities marked a rebellion against entrenched scientific orthodoxy and the rejection of exclusively experimental approaches to research design; a paradigm where individuals described as 'subjects' would be administered 'treatments' in an environment that controlled and measured, respectively, independent and dependent variables. Harré (2004: 689) captures well the disenchantment, with a search for generalisable laws, in reflecting that: "It was widely assumed that the real cultural and historical contexts of social action could be ignored, since the laboratory was deemed to be a culturally neutral place". This dissatisfaction, it is suggested, provided fertile intellectual territory for the development of approaches to social interaction that prioritised talk, mediated by meaning, as part of a collective social process.

As a perspective on the nature of language and its relationship to the central issues of social science, it is argued that discourse analysis transcends strictly methodological concerns (Potter 1997). Wood and Kroger (2000: x) concur with this sentiment when they note: "More specifically, we see discourse analysis as a related collection of approaches to discourse, approaches that entail not only practices of data collection and analysis, but also a set of metatheoretical and theoretical assumptions and a body of research claims and studies". In contrast to the search for singular truths, characteristic of modernist theory, the emphasis is upon competing realities and representations (Banister et al 1994). The approach is, typically, described as complex and confusing (Cheek 2004), where the 'label' of discourse analysis has often been applied as a generic term for almost all research that makes a claim on the study of language in a social or cognitive context (Potter & Wetherell 1987). The theoretical underpinnings, and variant forms, of discourse analysis can be explicated

through a brief review of the way that the concepts of 'discourse' and 'discourse analysis' have been interpreted and applied.

What is meant by the term 'discourse' evades any easy definition. Variability in the way that the concept is understood, and used, reflects epistemological differences in approaches to socially-situated language; a theoretical and methodological umbrella under which there is both consistency and conflict. These divergent perspectives embrace those primarily affiliated to linguistics, as well as scholars in academic disciplines that share an interest in language (Schiffrin et al 2004). The latter authors posit that, considering the abundant definitions of discourse, most of these fall within three categories: Language above the sentence, language use, and a broader range of social practices. The former refers to the search for linguistic patterns in language-use where the units of analysis are extended texts, while the latter relate to talk as a source of evidence about other aspects of people's lives (Cameron 2001). Critical theorists in particular, employ the term 'discourses' with reference to a broad range of linguistic and non-linguistic social practices and ideological assumptions that construct and mobilise power inequities (e.g. Fairclough 2001, 1995). Fundamentally, this is a distinction between the analysis of discourse as an end in itself, or some other end where larger disciplinary questions are addressed through methods that generate discursive data. Thus, it is noted: "Interviews, focus group discussions and ethnographic studies using participant observation all involve verbal interaction between a researcher and research subjects, and/or between research subjects themselves. At least some of the analysis carried out by researchers who choose these methods will involve listening to talk, transcribing it, and reflecting on its meaning and significance" (Cameron 2001: 8).

In this sense, White (2004) discusses discourse analysis as an orientation toward research, rather than a prescriptive recipe about how to undertake inquiry. With particular reference to healthcare and nursing research, Stevenson (2004) argues, that two forms of discourse analysis have gained prominence, social consructionist DA, exemplified by Potter and Wetherell (1987) and Foucauldian DA represented by Parker (1999) focusing on the way discourses position individuals in relation to the reproduction of power relations. Though there are discrete differences, it is noted that these approaches operate on common philosophical ground: "There is not a fracture between the two positions, as they share some social constructionist ideas, for example, in the potential for multiplicity in the accounts, and in the rejection of straightforward representationalism" (Stevenson 2004: 19). The first of these approaches has been adopted in the design of the present study, and will be discussed in more detail below.

In common with other types of qualitative research, discourse analysis adopts an inductionist approach by collecting and reviewing data prior to any theory development (Holloway & Wheeler 2002). Noting discourse analysts understand language as a cultural resource that, beyond simple depiction, creates and sustains reality, Denscombe (2008) describes the task of DA as a focus on the 'implicit meaning' of texts rather than their 'explicit content'. The organisation of texts, written or spoken, achieves more than the transmission of facts or representation of the social world; distinct from description, the selection and use of particular words involves a complex set of relations between the speaker and the object of speech. It is suggested that the task of the researcher is to 'unpack' any text to explore what people are attempting to do through talk, and to identify the domain assumptions that permit this to be done. In summary, it is noted: "Discourse analysis generally approaches the analysis of talk, text and images on the basis that they should never be taken 'at face value' but, instead, should be investigated to reveal the hidden messages that they contain and the kind of thinking that needs to be going on in the background – implicit and unspoken – in order for them to work" (Denscombe 2008: 308). Intrinsic to this analytic process is the recognition of an association between thought and behaviour, where the topic of interview data can be interpreted and studied as potential courses of action (Atkinson & Coffey 2002). Thus, a deconstructive approach to data analysis requires the researcher to engage in an active, rather than passive, interpretation of text in search of how individual meaning is constructed within, and reflective of, broader socio-cultural discourses.

Study design: doing discourse analysis

This study adopted a discourse analytic design derived, chiefly, from the work of Potter and Wetherell (1987), who employ the concept of 'discourse' in an 'open sense' to embrace all spoken interaction and written texts. In contrast to an interest in 'discourse per se', they emphasise the contribution that the study of discourse can make to an understanding of social life; where the study of data is concerned with the performative aspects of language as a fundamentally human practice. Thus, their description of language as a complex representational system for communication, and the organisation of thought, provides an analytic bridge between 'culture' and 'self'. Describing the 'principal tenet' of this philosophy and application, they remark: "what is required is an analysis of discourse which focuses on variability and the construction of accounts" (Potter & Wetherell 1987: 43). Discussion, in this chapter, is supplemented by the intellectual insights of Wood and Kroger (2000) who offer a, pragmatic, contemporary re-working of this approach in their text *Doing Discourse analysis: methods for studying action in talk and text.* The latter authors suggest

that one distinct advantage of this version of discourse analysis resides in the accessibility, and commonality, of its central principles.

Drawing on Foucauldian and neo-Marxist theories of discourse and power, the approach understands discourse as constitutive of both social and psychological processes (Wodak & Reisigl 2004). As Hammersley (2003) observes, transcribed audio-recordings provide data, where there is a central concern with discourse as action. That is, the generative power of discursive acts in constructing, and reifying, phenomena in such a way as to appear to be objective and non-discursively given features of the world; a position which moves the perspective closer to critical discourse analysis. It is commented: "from the constructionist point of view, discourse analysis not only captures something important about the social world, but also plays a key ethical and political role in showing how social phenomena are discursively constituted: it demonstrates *how* things come to be as they are, that they could be *different*, and thereby that they can be *changed*" (Hammersley 2003: 758 original emphases). The approach is congruent with healthcare research which has integrated theoretical and methodological approaches in exploring the relationship between language and the body (e.g. Mills et al 2007, Burck 2005, Seibold 2002). It has been noted that: "contrasting and conflicting philosophies and methodologies can be disquieting for some. However, as the underpinning of DA is a contested area there are fewer constraints in how DA might be conducted. There is an opportunity for tailoring a DA approach to specific research areas in nursing" (Stevenson 2004: 22).

Beyond understanding social interactions in terms of interpersonal exchanges, or talk, Potter and Wetherell (1987) focus on all forms of verbal and textual materials. The object of analysis is to explore the construction of discourse, and relate specific discursive constructions to larger social functions (Wooffitt 2005). Developed principally in social psychology, this perspective has contributed to a broader sociological critique of knowledge and culture that adheres to the tenets of social constructionism (Gergen 2000, Potter 1996). Recognising the social construction of reality and meaning, discourse analysis explores the complex and dynamic functions of language in shaping, rather than simply describing, social life (Georgakopoulou & Goutsos 1999). The contribution of Potter and Wetherell (1987), which retains a prominent place in contemporary scholarship, is accredited with a pivotal place in the 'linguistic turn' that provided a space for those interested in undertaking non-positivist research (Banister et al 1994). Similarly, Lupton (2001) identifies their body of work, in relation to discourse analysis and other types of interpretive research within medicine and healthcare, as playing a central part in the recognition of inter-relationships between discourse and social practice. It is noted: "Indeed, it is becoming recognised in all

areas of social research that texts are important items of analysis as sensitive barometers of social process and change (Lupton 2001: 18).

It is suggested that related concerns about the construction of scientific knowledge, mechanisms of talk, and sense-making crystallised in the 1970s around the relationship between language and culture. Banister et al (1994: 94) remark: "These are all approaches in sociology that privilege the 'ordinary' understanding people produce about the world over researchers' theories of what is going on". Rather than fetishise consistency, Potter and Wetherell (1987) advocate researchers into language should focus on functional variations, or 'interpretative repertoires', that construct a sense of meaning within shared cultural traditions. More specifically, they describe these as: "broadly discernible clusters of terms, descriptions and figures of speech often assembled around metaphors or vivid images...systems of signification and...the building blocks used for manufacturing versions of actions, self and social structures in talk...some of the resources for making evaluations, constructing factual versions and performing particular actions" (Wetherell & Potter 1992: 90). In this context, discourse analysis has been invested with an 'emancipatory potential' in exploring the ideological nature of language that, in privileging some groups and denigrating others, subtly maintains power relations (Gergen 2000). Potter (2005), for example, reflected on the exploration of racism and prejudice experienced by minority groups, through open-ended interviews, as characteristic of early critical work in the area.

Based on interview data, the focus of analysis in this study was socially generated text. The aim was to explore data from interviews with forensic nurses and offender-patients, not only in terms of content, but of how they organised their accounts; a focus on interpretive processes rather than the collection of facts. It is suggested that one advantage of this method is that it produces data by asking people to do something (talking) that is familiar to them, as opposed to presenting an unusual or artificial task (as with standardised instruments). It is noted that: "Life may or may not be 'in many ways a series of conversations', but it is in no way a series of box-checking exercises" (Cameron 2001: 15). Rather than following a prescribed format, the discourse analytic approach was led by the issues and problems that needed to be addressed and, where possible, by the participants themselves. Using a discourse analytic design with interview-generated data, the project adopted an approach that is gaining recognition, and popularity, within health care research (Crowe 2005, White 2004). Unlike the work of discourse analysts whose primary affiliation is to the discipline of linguistics, this application was more interested in the idea that people's talk could be a source of evidence about other aspects of their lives; a means to an end, rather than an end in itself.

In discourse analysis generally, and the work of Potter and Wetherell (1987) in particular, the rejection of more orthodox approaches to psycho-social inquiry meant that methodological decisions needed to be justified within a larger critique of the philosophy of science. The research question, which sought to explore respondent talk about pornography in a specific healthcare setting, was premised on an attempt to understand language as action oriented and performative. Departing from abstract theorising about the grammatical composition of discourse, based on a distinction between linguistic rules and everyday speech, discourse analysis is concerned with language as a human practice; notably, how individuals use language in particular contexts to achieve particular outcomes. Incorporating intellectual developments in ethnomethodology and semiotics, it is suggested that language can be conceptualised as a bridge between self and culture (Potter and Wetherell 1987). Using a discursive approach to frame the research design meant that attention could be given to respondent accounts in their own right, rather than seeing them as a conduit to access things that are, typically, accepted as existing beyond the text; secondary constructs such as attitudes or cognitive processes.

This study differed from much of the previous research into pornography and sexual violence in two main, though related, ways. It rejected the search for the sort of incontrovertible 'facts' that have assumed the status of a Holy Grail in experimental inquiry into correlation and causation; collecting measurable types and traits that, within an idealised conception of science, signify particular men as different, dangerous, and more predisposed toward abusive behaviours. Rather than uncritically accepting respondent descriptions of pornography or rape, for instance, the analytic focus concerned itself with the way that their talk was constructed, and how it functioned within the institutional setting. This entailed an interrogation of data that prioritised indexicality and reflexivity as dimensions of sense-making and meaning as a contextual and collective undertaking.

Borrowing from Potter and Wetherell (1987), the core components of discourse analysis that informed an understanding of language in this study required recognition of function, construction and variation within, and between, respondent accounts. It is noted: "All language, even language which passes as simple description, is constructive and consequential for the discourse analyst" (34). Shifting away from the reified concepts of traditional psycholinguistics is the idea of individuals constructing variable versions of the social world, and the self, at particular times; where the possibility of 'self-concept' is inextricably dependent on linguistic practice in everyday life. As in the classic contribution of Goffman (1963, 1961) the individual social actor, inhabiting a range of roles and role expectations, is seen as a performer where discordant identities and selves coexist. It is the

constructive, functional and flexible nature of language-use that for discourse analysts make it a worthy topic of investigation.

The next section of this chapter explores the practical aspects of data collection and analysis but, here, it is worth commenting on the impact of philosophical debate on decision-making about key stages in the research process (Zajacova 2002). Sample size in discourse work, for example, is usually small as a result of labour intensive scrutiny directed at linguistic patterns, rather than individual speakers. However, it is acknowledged that certain areas of inquiry warrant a larger number of participants. The present study would fall within that grouping as it represents a pioneering journey into a relatively unexplored cultural domain to explore interactions and speech episodes that are far from commonplace. There is nothing in the published literature to indicate the systems, or patterns, of language use that characterise patient and professional talk, about pornography, in high-secure psychiatric provision within the United Kingdom.

The choice of interviews as a data collection resource developed from the intellectual aims of discourse analysis. Unlike traditional interviewing, where questioning a sample population on specific issues permits an estimation of comparability in responses, the emphasis was on a greater degree of 'active intervention' (Potter & Wetherell 1987: 163). Here, it is incumbent on the researcher, in conversational encounters, to generate a series of 'interpretive contexts' that promote variability; where consistency is about identifying regular patterns within participant talk. It is the exhaustive exploration of diverse themes, rather than descriptive accuracy, that characterise the value of these discursive episodes. Similarly, gross coding and categorisation of data, from a discourse analytic perspective, is problematised as a potentially limiting technique that can diminish or disguise linguistic variation within respondent accounts. Selective reading and the imposition of narrow codes, it is suggested, can decontextualise language-use and conceal discursive difference. Of the much vaunted rigour of the scientific method it is observed: "...experiments are situations where the value placed on consistency of behaviour in our culture is made particularly salient to participants. In general, experiments are designed to wipe out variability of interpretation and response, indeed, that is supposedly their strength and rationale, although they may be obscuring one of the most interesting and important features of social life in the process" (Potter & Wetherell 1987: 40).

It is hopefully apparent from the above discussion that the topic of pornography as a concern in forensic mental health practice might benefit from the type of discourse analytic inquiry which has been proposed. In the area of gendered violence, and institutional responses,

critical and feminist inspired research has begun to invest in the concept of discourse as a way of exploring relations between the powerful and the powerless (Skinner 2005, Corcoran 2005). As noted in the literature review, there has also been a more general trend in researching pornography to look at how sexual texts are read, and interpreted, rather than set up a binary relationship between a reified object and a resultant effect (Attwood 2004, 2002). An influential body of work derived from studies using a psychological design has replicated the idea that pornography can be readily known, defined with relative ease, and administered uniformly in controlled environments. Less attention has been given to the variable language used by researchers to describe sexual media, or the assumption that male and female respondents will utilise a shared discourse that transcends gendered experience. Language, here, is treated as a neutral category where it is assumed that enduring cognitive constructs, such as sexist attitudes, can be captured by the indices of a decontextualised rating scale.

If discourse analytic inquiry has initiated a compelling ideological critique of dominant research designs in terms of limitation and inconsistency, it remains to consider how proponents of DA offer a validation of their own findings. Discussing the place of discourse analysis in nursing research, Crowe (2005) argues for methodological and interpretative rigour where multiple and subjective interpretations of talk as text are possible. Likewise, Smith (2007) advocating the adoption of discourse analysis in nursing inquiry notes the need for investigators to acknowledge the possibility of bias that can be attributed to any form of qualitative project, while actively seeking to reduce this through methodological consistency. Many published articles based on discourse analysis fail to make such quality checks explicit, but those that do typically return to four analytic techniques outlined by Potter and Wetherell (1987). These are described as *coherence, participants' orientation, new problems* and *fruitfulness*. Each of these is described below.

It is proposed that analytic claims ought to give 'coherence' to a body of discourse, in such a way that function and effect are evident in the discussion. An important part of demonstrating rigour involves accounting for exceptions and alternative claims in the data set, where coherence relates to the analytic process rather than the discourse: "We might say that there is no 'error' variance in discourse analysis, only variability that needs to be accounted for" (Wood & Kroger 2000). Coherent claims should connect the detail of individual sequences of text within a broader pattern of language use, so that they fit together in a unified argument. If coherence is about the claims that are made by the analyst, 'participant orientation', as warranting resource, is described as a feature of the discourse itself. Here, the researcher needs to be sensitive to the subtlety of respondent talk, as distinct

from abstracted meaning, and the way that interaction has implications for social practice. Potter and Wetherell (1987: 170 original italics) remark: "When looking at variability and consistency, it is not sufficient to say that *as analysts* we can see that these statements are consistent and these dissonant; the important thing is the orientation of the participants, what *they* see as consistent and different". At tention, thus, has to be given to the way that utterances are treated by the speaker, asking how similar utterances might be treated differently within an interaction, and exploring how this has procedural consequences.

The observance of similarity and difference is an important component of the final two warranting devices, though it is noted that these have invited diverse interpretations (Wood & Kroger 2000). 'New problems' refers to the identification of contradictions between discursive repertoires, that independently might function effectively, and the linguistic strategies employed by speakers to repair such tensions. 'Fruitfulness' moves from respondent handling of talk as text to claims made by the analyst, and how these might relate to, or inform, future research. It is anticipated that findings from the present study, for example, will reveal interpretive repertoires that reframe professional and academic approaches to the treatment of sexual offenders in the secure psychiatric system. Lastly, discourse analysts give prominence to reader evaluation (Wood & Kroger 2000, Elliott 1996), with warrantability seen as a co-construction that rests on shared knowledges. Potter (2004) notes that a distinctive feature of discourse research, setting it apart from traditional approaches, is the presentation of extended materials which permit the reader to evaluate the interpretations that are proffered.

Data Collection

Practicalities of doing the research

Before discussing the process of collecting data, some attention needs to be given to the unique environment within which the research actually took place. In this sense, the research question, itself, has to be contextualised within the physical structure and ideological construction of one secure psychiatric service. There is a body of literature which attests to the inherent difficulties of undertaking research, particularly of a critical nature, in secure settings and state institutions. Much of this work relates to variant forms of detention within the criminal justice system, such as prisons and youth detention centres (Liebling 2001, 1999, Sim 2001), and has identified a series of common concerns. Typically, these relate to accessing research sites, organisational impediments, and the neutrality of independent

investigators within the power relations of state institutions premised on social control. These issues were resonant for the present study, particularly the entrée and data collection phase, and are discussed more fully in appendix 1.

Sample selection and sample size

For the purpose of data collection, interviews were undertaken with two different sample populations (18 staff and 9 patients) recruited from the Personality Disorder Service [PDS] in a high-security hospital. These individuals were selected in relation to inclusion/exclusion criteria [see Boxes 1 & 2]. The ethical requirements of the LREC demanded that care was exercised to ensure there was no conflict of professional, or clinical, interest between staff and patients agreeing to take part in the study. This strategy was intended to protect patient interests, and maintain academic rigour, by precluding any interpretation of therapeutic intent on the part of the researcher.

Box 1: Inclusion criteria

Patient population	Staff population
Male patients	First level registered nurses
Patients with a diagnosis of personality disorder and a recorded sexual offence	Staff with clinical and/or therapeutic experience of working with a sexual offender client group

Box 2: Exclusion criteria

Patient population	Staff population
Female patients	Staff without clinical, or therapeutic, experience of working with a sexual offender client group
Patients with an index offence of sexual offending and a diagnosis of mental illness or learning disability	Nursing staff with a direct clinical, or therapeutic, responsibility to individual patients consenting to take part in the research study

From the perspective of more conventional qualitative research, sample sizes in discourse analytic inquiry are sometimes criticised as being too small to allow generalisation beyond the specific group of participants (Wood & Kroger 2000). Discursive work, though, operates with a different set of goals where interest in language-use directs the choices of the researcher (Potter & Wetherell 1987), and the 'crucial determinant' of sample size is the specific research question. Of spoken discourse, in particular, Cameron (2001: 29) similarly notes: "It is impossible to present a set of invariant rules about data collection (how much data, what kind of data, obtained through what method or in what situation) because choices

have to be made in the light of the investigator's goals". Discussion of sampling, in handbooks on DA, often pays little attention to the interview, focusing instead on the selection of text (e.g. Titscher et al 2000). If the sample needs to be relevant and representative, the interest of discourse analysis is in language-use rather than language-users; where the units of analysis are texts produced by the respondents, rather than the respondents themselves (Wood & Kroger 2000). Likewise, Potter and Wetherell (1987) focus on the richness and depth of linguistic data, rather than sample size, in research aimed at exploring discursive formations: They note: "Because one is interested in language use rather than the people generating the language and because a large number of linguistic patterns are likely to emerge from a few people, small samples or a few interviews are generally quite adequate for investigating an interesting and practically important range of phenomena" (Potter and Wetherell 1987: 161).

Information about staff and patient respondents is contained in boxes 3 and 4 below. It is worth noting, with regard to the patient sample, that the intent of the initial research proposal had been to interview men who had been detained for three years or less. This was because the sexual offences would have been relatively recent, and patients would have limited exposure to the institutional discourses and cultural domain of the hospital. A glance at the 'period of detention' column in Box 3 indicates this aim was not achieved, and all of the participants had lengthy careers within the forensic system. This reflected changes in the admission policy of the PDS, and the selection of suitable patient-respondents by their responsible medical officer [RMO].

Box 3: Patient respondents

No.	Diagnosis	Institution(s)	Period of detention	MHA (1983)	SOTP attendance
1	PD	Moss Side & Ashworth	33 years	37/41	Yes (adapted)
2	PD	Broadmoor & Ashworth	25 years	37/41	No
3	PD	Broadmoor & Ashworth	33 years	37/41	No
4	PD	Ashworth	25 years	37/41	Yes
5	PD	Moss Side & Ashworth	40 years (recall)	37/41	Yes
6	PD	Ashworth	25 years (recall)	37/41	Yes
7	PD	Ashworth	16 years	37/41	Yes
8	PD	Cat B prison & Ashworth	12 years	47/49	No
9	PD	Dispersal prison & Ashworth	20 years	47/49	Yes (prison)

The final composition of the nursing sample, listed in Box 4, differed from the criteria of the research proposal in two ways. These revisions reflected both organisational constraints and methodological decisions. Originally, the intent was to interview nursing staff with an RMN qualification, and exclusive experience of working with patients diagnosed as having a personality disorder. Nurses with an initial RNMH qualification, and professional background in learning disability, were to be excluded. However, structural changes (the closure of, both, an adjacent secure hospital for patients with a learning disability, and the women's service) meant that a considerable number of nursing staff had been deployed within the study site. A 'conversion course', run in the Staff Education Centre, offered a shortened route to mental health nursing registration. At the point of commencing research, the larger implications of these changes could not have been anticipated. In terms of methodology, the original aim had been to recruit ward-based nurses who worked with personality disordered sexual offenders. As the interviews proceeded this was widened to include unqualified staff and managerial grades.

Box 4: Nursing staff respondents

No.	Sex	Qualification	Job title	Secure hospital experience	SOTP facilitation
1	M	RMN	Team leader	Ashworth & Moss Side	No
2	M	RNMH/RMN	Team leader	Ashworth & Moss Side	Yes
3	M	RNMH/RMN	Staff nurse	Ashworth & Moss Side	No
4	F	RNMH/RMN	Staff nurse	Ashworth & Moss Side	No
5	M	RMN	Staff nurse	Ashworth	No
6	M	RMN	Team leader (acting)	Ashworth	Yes
7	F	RMN	Staff nurse	Ashworth	No
8	M	RMN	Team leader (acting)	Ashworth	No
9	M	RMN	Team leader	Ashworth	No
10	M	RNMH/RMN	Team leader (acting)	Ashworth & Moss Side	No
11	F	RMN	Team leader	Ashworth	No
12	F	Unqualified	Nursing assistant	Ashworth	No
13	F	RMN	Clinical manager	Ashworth	Yes
14	M	RMN	Clinical educator	Ashworth	No
15	M	RMN	Staff nurse	Ashworth	No
16	M	EN/M RMN	Staff nurse	Ashworth	No
17	M	RMN	Staff nurse	Ashworth	No
18	M	RMNH/RMN	Staff nurse	Moss Side & Ashworth	No

Preparing for the interviews

Kvale (1996) comments that a significant part of any interview needs to take place before the tape recorder is switched on, allowing time for the integration of conceptual and theoretical concerns. He writes: "Just hanging out in the environment where the interviews are to be conducted will give an introduction to the local language, the daily routines, and the power structures, and so provide a sense of what the interviewees will be talking about" (Kvale 1996: 96). It was considered important to situate each interview within the context and culture of the institution, and only one interview was arranged for a single day. While field-notes could not be included in discourse analysis itself (Wood & Kroger 2000), these did offer invaluable insights into the occupational, and organisational, life of the hospital and helped frame the interview process. No time limit was set on the duration of the interviews, and these were thorough and exhaustive of the subject matter. The average length of each interview was two hours, though some lasted in excess of three hours. Prior to interviews taking place it was necessary to secure informed consent. If conventional ethical procedures informed this process, an additional dynamic related specifically to the legal status of the patient population as a product of their detention under the Mental Health Act (1983).

In '*After the Interview*', Warren and colleagues (2003) discuss the phenomenon of leave-taking rituals, where respondents offered further comments once it was perceived that the interview had been completed. This may be a common theme in qualitative research, where participants feel they have something to contribute, or issues to raise, but prefer to do this 'off tape'. The experience of doing this research suggested that one could, similarly, define a stage of the research process as '*before the interview*'. The experience of interviewing detained sexual offenders warrants consideration beyond routine procedures for 'consenting' potential participants. Aside from institutional and clinical impediments to accessing an incarcerated population was the incentive, or lack of, for these men to take part. Hospital representatives, at a number of preparatory points, suggested the diagnostic classification of the patient group ('PD') meant they would share a collective hostility toward forensic services, and be unlikely to engage. The researcher was issued with a, generic, statement from the Patient Council, regarding participation in research, to support and legitimate the lack of enthusiasm predicted by hospital employees.

Although a number of patients made contact with the researcher, independently, and expressed an interest in being involved in the study, this was not possible within the existing arrangements for undertaking research in the hospital. In accordance with the requirements of the Hospital Authority, *Research Consent (RMO) Forms* (see Appendix 2) needed to be completed by the responsible medical officer of each potential participant, prior to them

being approached by the researcher. This, effectively, meant that a psychiatrist selected those patients who could take part in the research; an 'approval' that *their* patient could participate, based on *their* 'satisfaction' that the individual was 'capable of giving consent'. Ethical management of the study was underpinned by the principles of self-determination and informed consent. Potential participants were made aware of the nature of the research and their role within it. Each was supplied with an information sheet (see Appendix 3) enabling them to make an informed choice regarding whether they wanted to be included. At least one week was given for this decision to be made, and longer if required. Agreement was formally documented in consent forms for patient and nurse respondents (see appendix 4), though there was a distinct difference between the rhetoric of clinical support for research in the hospital and the experience of the researcher.

Attempts to promote a non-threatening and informal interactional style had to be achieved within the routine of the hospital. Usually, the researcher was allocated an interview-room on the ward, and patients would be directed to this venue by a member of the nursing staff. This meant that the first interpersonal interaction was not with the researcher and, for those who declined to attend the meeting, follow-up was not possible. On a number of occasions, patients informed the nurse that they did not wish to be included, but would ask to meet with the researcher to explain their reluctance to participate. These sessions often developed into discussions beyond the planned scope of the project, and raised interesting ideas about patient perceptions, and experiences, of research that were later recorded as field notes. For other patients, agreement to participate was a protracted and gradual process, negotiated over days or weeks, in what felt like a 'testing out' of the researcher. Similarly, given the longevity of the recruitment phase, patients who had been involved in the interviews would recommend possible candidates in a 'snowball' sampling effect. If these individuals were included in the patient group that had been identified by the RMO this afforded credibility, and confidence, as the project developed.

Another important factor in the pre-interview recruitment stage of the study related directly to the inclusion criteria. The RMO, and care team, had been asked to facilitate access to a group of men with a diagnosis of 'personality disorder', and a history of 'sexual offending'. This requirement, reiterated in the patient information sheet, had two main ramifications for recruitment. Firstly, the master status of 'sexual offender' not only described a patient in terms of offending; it constructed a particular type of person within the informal institutional hierarchy. The category of 'rapist', or 'paedophile', could invite threat and harm if the confidentiality of the respondent was breached. Participating in the study, regardless of ethical safeguards and researcher discretion, signalled attention that could be dissuasive.

Secondly, the designation of 'sexual offender' was not always shared by individuals who were interested in participating.

Conducting the interviews

In broad terms, the purpose of the interviews was to explore a particular set of discourses, the conditions under which they were used, how they functioned, and what they achieved (McCloskey 2008, Potter & Wetherell 1987). It is suggested that in discourse analysis, the style of an interview differs from other qualitative approaches in three significant ways: "First, variation in response is as important as consistency. Second, techniques which allow diversity rather than those which eliminate it are emphasized, resulting in more informal conversational exchanges and, third, interviewers are seen as active participants rather than like speaking questionnaires" (Potter & Wetherell 1987: 165). Part of this process involved giving attention to interviewer questions, as well as participant responses, which shaped the functional context of the interview and needed to be included in the analysis. The interviews were undertaken in two stages:

Stage 1: Eighteen interviews with nursing staff who worked on the PDS
Stage 2: Nine interviews with patients who lived on the wards of the PDS

Nurses working on the wards were interviewed, while on duty, at a convenient time. Where possible, one of two interview-rooms on each ward was used, but due to the pressure of demand on these facilities there were a number of occasions when hasty improvisations had to be made. If, for instance, the room needed to be requisitioned for impromptu clinical sessions (e.g. counselling) or scheduled visits (e.g. legal representatives) the interview was delayed, or interrupted, while alternative locations were identified. During the data-collection stage with nurses, the shortage of interview space was accommodated by 'borrowing' the staff room, lounge area, ward manager's office and, on one occasion, an empty patient side-room. Each of these proved satisfactory, but acoustic quality was variable in terms of the quality of recording. On only one occasion was an interview recording [S16] sufficiently poor to make transcription difficult, and this was a strong reminder of the security function of the hospital. The interview had taken place in an interview room on the PDS 'admission ward', where institutional arrangements to minimise risk were evident in the design, and physical structure, of the ward. The room itself was stark, and bereft of décor or furnishings that might convey any ambience of equality. There was no carpet, and the functional table, and uncomfortable chairs, were bolted to the floor.

All of the patient interviews were conducted in ward interview-rooms, and in most cases these provided a comfortable and relaxed environment conducive to talk. This was a space where patients were allowed to smoke and, bringing a hot beverage with them, made the request for breaks less of a problem. As with the staff, an attempt was made to put people at ease before the interview commenced. Part of this involved the researcher organising the environment in advance; armchair style seats, separated by a coffee table, were positioned at angles to avoid a direct face-to-face interrogative posture. It was felt important to reduce, as far as possible, the visibility of technology, as a constraint on conversation and source of distraction. Though the purpose of the recording device was explained at the consent stage, and introduced prior to the interview, efforts were made to conceal wires, by using magazines, and make the microphone less obtrusive (Holloway & Wheeler 2002).

Given the risk of untoward incidents, or hostage-taking situations, interview-rooms had been designed with a window in the door to permit the visibility of occupants at all times. During patient interviews it was hard not to be aware of the immediate presence of nursing staff, and other patients, on the ward outside. In all but one interview this created minimal disturbance. Respondent [P3], though, in venting his anger, attracted closer surveillance by ward staff. One male nurse adopted an imperious posture outside the room which was interpreted by the respondent as an exhibition of power and control. During longer interviews a break was taken if the respondent requested it. On the day of the interview, the researcher spent time on the ward observing the patterns and rituals of daily life, chatting informally with staff and patients. Field-notes, written contemporaneously and typed up at the end of the day, often contributed to particular lines of questioning.

The interview style needed to be appropriate for discourse analysis, with interviewer and respondent interrogating particular ideas and co-constructing accounts of emerging topics and themes. It is suggested that interviews in DA differ, theoretically and procedurally, from their equivalent form in other types of qualitative research. Adopting the recommendation of Potter and Wetherell (1987: 164), called for an interview style that gave 'theoretical primacy' to the 'talk' of respondents, where variation between accounts was more interesting than consistency. They suggest: "Analyses which identify only the consistent responses are thus sometimes uninformative because they tell us little about the full range of accounting resources people use when constructing the meaning of their social world and do not so clearly reveal the function of participants' constructions". To achieve this, it is recommended that the interview be seen as a 'conversational encounter' rather than a 'research instrument', with the interviewer generating 'interpretative contexts' to fully explore the accounting practices of the respondent (Potter & Wetherell 1987). Situating

interviews in the institutional context, and developing a degree of emotional engagement, made the interactive episode a partnership for sharing ideas, rather than a tool to extract information.

The interview style avoided any use of leading questions, including the less obvious constraint of framing discussion around pre-selected abstract categories. Of interviewing in DA, Wood and Kroger (2000: 73) have noted: "Whereas other types of interviewing involve attempts to get the interview 'back on track' or assume that relevance will emerge in the analysis, discourse-analytic interviews require pursuit of the relevance of the contribution with the participant at the time of the interview, an activity that requires not only careful listening but also ongoing interpretive work". What is described as permitting 'discursive rambling', yielded a wealth of rich data, but reviewing the transcripts indicated a diversionary discourse in relation to the topic of sexual materials. In response, four further interviews were undertaken [P6-P9] with a more structured remit to explore patient understandings of pornography, pornography in the context of sexual offending, and the management of pornography, or sexual media, in the hospital. At the consent stage of recruitment it emerged that two patient respondents [P8 & P9] had been transferred into the hospital from the prison system. Given that the other patient participants had been admitted directly into the secure hospital system, this afforded an opportunity to explore the possibility of alternative discourses in relation to identified themes.

In undertaking interviews, the guidance of Kvale (1996) was particularly helpful in linking the methodological practice of data collection to philosophical concerns about the constructive nature of knowledge. From the perspective of an 'inter-view', the idea of 'subject matter' as 'objective data' that can be 'quantified' is replaced with a recognition of 'meaningful relations' to be 'interpreted'. It is noted: "There is no longer a unique self who uses language to describe an objective world or to express itself; it is the structures of language that speak through the person" (Kvale 1996: 43). As mentioned previously, Liebling (2001) emphasised the importance of empathy in prison research generally, but suggested that it has a particular contribution in the management of the interview. She noted: "The capacity to feel, relate, and become 'involved' is a key part of the overall research task. Research is after all, an act of human engagement. To achieve criminological Verstehen – subjective understanding of situated meanings and emotions – researchers have to be affectively present as well as physically present in a social situation" (Liebling 2001: 474). An interview structure covering the main areas of interest was abandoned after the two pilot interviews, where the philosophy of the study required an approach that was probing without being prescriptive.

Rather than representing a distinct stage, proceeding from the completion of data collection, analysis became part of an ongoing reflective process, and an integral component of interviewing and transcription. This is congruent with the comments of Wodak and Meyer (2005), who note that, in discourse analysis, the distinction between 'elicitation' (data collection) and 'evaluation' (data analysis) is an artificial imposition on the research process.

Recording and transcription

Transcription requires that the spoken word is translated, or converted, into a written document, to facilitate analysis, and different rules of language-use need to be reconciled (Kvale 1996). Edwards (2004), commenting on the need for accurate and detailed transcription, describes this as an insufficient, if essential, component of discourse analytic work. The transcript is understood as a representational artefact, attempting to 'freeze in time' the fleeting and multidimensional events of interaction, that is inherently selective and interpretive: "The researcher chooses what types of information to preserve, which descriptive categories to use, and how to display the information in the written and spatial medium of a transcript. Each of these choices can affect the researcher's perceptions of the interaction" (Edwards 2004: 321). This perspective is a reminder that data, as linguistic sounds technologically preserved through the medium of recording, should be revisited and listened to throughout the period of study. Likewise, Coates and Thornborrow (1999: 596) offer an emphatic reminder that it is the original audio-tapes which constitute data, and that any transcription will always be partial and never perfect: "What we as researchers and transcribers have failed to do is to make explicit the fact that we are continually revising our transcripts and that we offer any particular transcript as the best we can do at that moment, not as a finished product. Transcription is a never-ending process".

Transcriptions of audio-taped interviews are a public record, can be replayed and transcripts improved, and allow aspects of speech to be preserved (Silverman 2001). For the majority of interviews a small cassette-recorder, with omnidirectional microphone, recorded interactions, but in the final four interviews [P6-P9] this was replaced with a digital recorder. This technology contributed to an enhanced reproduction of the interviews in terms of sound quality and fidelity. All tapes, digital files, and transcribed data were assigned a code, to ensure anonymity and safeguard the confidentiality of respondents. During transcription (done by the researcher) identifying words and cues [e.g. names of staff and patients, or specific wards within the PDS] were replaced, in square brackets, with an anonymous signifier. If this represented ethically good practice, Kvale (1996) suggests that it is particularly apt when researching with individuals, or in settings, that could be described as

sensitive. He comments: "In sensitive cases, it may be advantageous as early as the transcription stage to mask the identities of the interviewed subjects, as well as events and persons in the interviews that might be easily recognised" (Kvale 1996: 172). Prior to each interview the equipment was checked and batteries replaced. The location of the interviews, in a secure setting, generated contextual issues; permission had to be granted for recording equipment to be taken into the secure compound; the approval documentation listed the specific items (recorder, microphone and batteries) that could be carried into the hospital (spare batteries were not included); and, once checked into the institution, there was no facility for exchanging faulty equipment.

If there are no standard conventions for transcription, there are standard choices to be made in terms of style and presentation (Kvale 1966, Cameron 2001) that relate to the nature, and design, of the particular project. The final transcription, in this study, aimed to produce a verbatim record of the verbal interaction that approximated, as far as possible, to the actual interview, where the "nuances and the differences, the transformations and discontinuities of meaning become the very pores of knowledge" (Kvale 1996: 168). A recognised system of notation symbols, used in conversation analysis (Jefferson 1984), was loosely adapted to indicate speech characteristics such as repetition, unfinished words, utterances, pauses, pitch, or laughter, while avoiding the imposition of grammatical features [see appendix 5]. Potter and Wetherell (1987: 165) comment on the importance of transcribing the 'whole' interview, where the interviewers' questions and responses are seen as "active and constructive and not passive and neutral". Interruptions and disruptions were noted as they related to the interview context, or institutional impediments. It was not unusual when interviewing nurses for members of staff to knock on the door, and enter the interview room, if they needed to contact respondents. Reasons for these intrusions included personal calls, a request for specific keys, the offer of refreshments, or an urgency to requisition the room.

Transcription was a time-consuming process that commenced on the day of the interview. Initially, the tape was played to check for clarity and reorient the researcher to the subtle nuances and tone of the interview. The first-draft of the transcription, made while the interview remained fresh in the mind of the researcher, was a verbatim record of the spoken material, and indicated non-verbal and paralinguistic aspects of the interaction. Despite close attention to the transcription of audio-recordings, it is suggested the process is diminished, and meaning compromised, by an emphasis on the content, rather than context, of speech and voice. It is noted: "Reading the written-word version of an interview, even when faithfully transcribed, you can sometimes feel (especially if you conducted the live interview) that it has somehow been de-natured" (Gillham 2005: 88). Wood and Kroger

(2000), referring to discourse as the actual words spoken in an interaction, note the ephemeral quality of any speech event, and the methodological rigour needed to produce a version that is accessible to repeated exploration and examination.

Field-notes, written prior to departing from the hospital, were used as an aide memoir to insert into the transcription those features of communication that were significant, if silent, on the tape; where recollection involved interpretation as much as reproduction (Edwards 2004). It is suggested that such observations complement recorded data and inform future areas of investigation. An identification of respondents 'ordering' and 'phrasing', through active listening, enabled emergent themes to retain the 'meaning frame' of participants (Hollway & Jefferson 2000). The completed version of each transcript represented a painstaking process of repeated listening, and annotation, which evolved over weeks. This was of immense value in terms of the formal, as distinct from immediate, process of discursively coding data in two ways. Firstly, it generated an intimate familiarity with the data, described better as gestalt, than content and, secondly, led to the experience of 'hearing', rather than 'reading' the transcripts. This phenomenon is described well by Wood and Kroger (2000: 84) when they comment on the 'trick' of appraising 'disfluent' text: "The process is similar to what happens when you try to read a foreign language that you have learned orally, through conversation, television, and so forth. This may be possible only if you sound out the text. When the issue is approached this way, we can say that the talk does indeed sound like it does on the transcript". In accordance with Cameron (2001), transcription in this study was conducted as 'artfully' as possible, recognising the pragmatic, technical and theoretical components of the process; an engagement with, and means of representing, the details of talk in a way that was both authentic and analytic.

In general terms, Holloway and Wheeler (2002) suggest that analysis in discourse work adheres to commonly accepted rules within the sphere of qualitative research, where immersion in data precedes analytic coding and the search for patterns, regularities and relationships. Cameron (2001) notes that transcription represents the first stage of analysis and interpretation, and what follows is very much shaped by the research question. It is further suggested that the fundamental principles of analysis can be summed up in terms of a balance, between 'description' and 'explanation'. Accepting that discourse analysis refers to a hybrid field of inquiry, or set of approaches to the exploration of text, written and spoken, there is no single formulaic method or analytic tool for managing and interpreting a corpus of data. Indeed, a common criticism of discourse analytic research is the failure to adequately describe method, beyond broad theoretical principles (Seibold 2002). Discourse analysis is associated with recent post-structural developments in interpretive theory.

Methodological reading and interpretation required the researcher to explore the relationship between the texts and the social context that framed them. The following section outlines the process of organising and analysing transcribed data in line with the theoretical principles of the adopted approach to discourse analysis.

Data Analysis

Though drawing on broader ideas and academic debate, this section is informed chiefly by Potter and Wetherell's (1987) discussion of coding and analysis. Analytic attention focused on the constituent parts of this particular approach to discourse; namely function, construction, and variability of language use within, and between, respondent accounts. The aim of the analytic process was to explore how nurses, and patients, constructed versions of their social world. Discourse, here, became a topic in its own right, requiring the researcher to identify how respondent accounts were constructed from pre-existing linguistic resources, and the way these were actively deployed, omitted, or manoeuvred during interview. Ultimately, as presented in the four findings chapters, variability in the construction of accounts permitted an understanding of the way participants used language in a performative, and purposeful, way to position themselves in relation to each other, and the secure context within which they lived or worked.

Initial reading

Preparatory to commencing the analysis, Wood and Kroger (2000) recommend that time is spent reading through transcripts, and listening to audio-taped interviews, with an 'open mind'. They remark: "Although, like transcription, the initial reading does involve theoretical, interpretive, or analytical activity, its point is to make the data manageable for formal analysis. So, like transcription, the initial reading is both part of and necessary for analysis" (Wood and Kroger 2000: 87). This exercise was undertaken, but diligent application to the transcription process meant the researcher already had a good 'feel' for the data. Another purpose of initial reading is to consider interview discourse in relation to the original question, where unanticipated discursive features can lead to a re-focusing of analysis. The value of scrutinising accounts from an early stage was intellectually profitable in indicating areas of commonality between respondent accounts, and identifying unique or individual contributions worthy of further investigation.

Broad discursive domains were informed by the research question and interview structure which focused on eliciting accounts of pornography, sexual crime and offender treatment. As interviews were transcribed, coloured highlighter pens were used to mark 'chunks' of text that identified emergent themes and issues. Adopting Potter and Wetherell's (1987) discussion of this process, it was not considered a preliminary stage of data analysis. Rather, selective coding was seen as an analytic preliminary in preparing for a much more intensive study of the data.

Coding

There is a degree of ambiguity in the published literature relating to how much of the total corpus of discourse should become the focus of analysis (Wood & Kroger 2000). For Potter and Wetherell (1987), coding is an 'analytic preliminary', distinct from 'analysis', that selectively identifies material for more intensive interrogation. They note: "The goal is not to find results but to squeeze an unwieldy body of discourse into manageable chunks" (Potter and Wetherell 1987: 167). Before the advent of technological software, this approach required multiple copies of transcribed material being 'sorted' into 'relevant instances' and assigned to boxes, where sections of transcripts might, initially, be categorised in a number of ways. For this study, the entire body of transcribed interview data was systematically coded prior to the analytic task of identifying 'interpretative repertoires'; that is, relatively stable or coherent ways of talking about objects or events.

The process of coding was undertaken, manually, by the researcher. As with transcription, it was considered important to remain 'close' to respondent accounts. Computer-assisted text analysis software, such as NVivo, was not employed in the analysis of data, though it is acknowledged that increased levels of technological sophistry have meant that 'rich data' and 'rich text' are no longer incompatible concepts (Richards 1999, Stubbs 2001). Working through, and retaining engagement, with the transcribed versions of twenty-nine interviews was an exhaustive undertaking that lasted approximately six months. Each account (transcript) was approached in a similar way to that described by Walker and Myrick (2006: 551) in relation to grounded theory: "In open coding, analysts immerse themselves in the data through line-by-line analysis, coding the data in as many ways as possible and writing memos about the conceptual and theoretical ideas that emerge through the course of analysis". More than reading the accounts, this required an emotional response to the words, and the context within which they were spoken. As mentioned above, familiarity with the recordings meant that the voice of the respondent was resonant throughout the interpretive exercise. Not wishing to replace pragmatism with poetry, the process could be described as

meditative rather than mechanical. In the first instance, notes, comments, and thoughts were annotated on each transcript. There was no attempt to formally organise these, or impose any kind of structure.

Having systematically worked through each transcript in this way, notes about recurrent themes, contradictions, and shared language, were organised with regard to the question, and what appeared to be relevant contextual issues. Potter and Wetherell (1987: 167) suggest that: "All pages of transcript coded as containing relevant instances are then photocopied and placed in a file of their own. This file serves eventually as the basis for detailed analysis". Rather than using multiple photocopies, files, or boxes, each transcript was converted into a separate Word document, where sections of text could be 'cut and pasted' into categories; these groupings would eventually be used to construct 'discursive repertoires' outlined in the findings section of the thesis.

Adopting a discourse analytic orientation

Completion of coding enabled approaching the data with, what Wood and Kroger (2000) refer to as, a discourse analytic 'frame of mind', where the idea of 'specific steps' is dismissed as 'prescriptive' and 'overly restrictive'. In short, Potter and Wetherell (1987) summarise the, elusive, analytic process as twofold; firstly, a search for 'patterns' within the data and, secondly, recognition of the function and consequences of talk. They note, though, that there are no formulaic rules, or methods, to elicit 'findings' from 'data': "Words fail us at this point, it is not a case of stating, first you do this and then you do that. The skills required are developed as one tries to make sense of transcript and identify the organizational features of documents" (Potter & Wetherell 1987: 168). Central to a 'complete', as opposed to a 'technical' analysis of data, within 'broadly critical' versions of DA, is the identification of 'interpretive repertoires', 'ideological dilemmas', and 'subject positioning' (Wetherell 1998).

Theoretically, 'interpretive repertoire' relates to relatively coherent discursive resources, used by speakers, to construct accounts of events, actions or individuals; a lexicon of, culturally available, terms, metaphors and figures' of speech (Potter 1996, Potter & Wetherell 1987). The concept of 'ideological dilemma' overlaps with the idea of shared (cultural) ways of speaking, in terms of the contradictions and inconsistencies within any 'common-sense' explanation of the world (Edley 2001). Finally, the concept of 'subject positioning' permits understanding, and exploration, of the relations between individual (identity) and language (text). Edley (2001: 210) succinctly comments: "In a sense, it is this

concept that connects the wider notions of discourses and interpretative repertoires to the social construction of particular selves. Subject positions can be defined quite simply as 'locations' within a conversation". Analysis, then, is concerned with the way that individuals position themselves through 'talk', and how this sense of self/identity can shift with discursive manoeuvring.

To discuss and illustrate the pragmatic, and intellectual, process that permitted the data to be organised and presented in this way relies on two, key, complementary sources (Wood & Kroger 2000, Potter & Wetherell 1987) that focus on discourse as 'topic'. Each of these texts, as noted above, avoids outlining a series of discrete steps carried out in a predetermined order. Rather, the shift from initial interpretation to analysis is guided by a series of strategies and concepts, responsive to the research aims, undertaken through multiple, cyclical, readings of a text. It is noted: "it is unfortunately not the case that one can simply look at a piece of text, generate an interpretation, and move on" (Wood & Kroger 2000: 99). With regard to the transcribed interviews, with nursing staff and patients, these strategies were firstly enacted on segments of data, such as 'definitions of pornography', within individual accounts. This activity was guided by the fundamental premise of discourse analysis that the intent of the exercise should be an exploration of how accounts were constructed, and not an attempt to recover specific events or beliefs in a literal sense. For each respondent, a table was constructed to illustrate themes and sub-themes, with accompanying notes to indicate the interactional context, and contingencies, of the interview (as talk) encounter. For Rapley (2001: 307 original emphases), this reveals the importance of understanding interview-talk as a form of social action, where language is not a neutral carrier of information: "central to this analytic perspective is an awareness of the *accounting work* of interview talk, that speech-acts are *performative*, used to 'present the self' (cf. Goffman 1959) in a morally adequate light". Thus, when looking at interview accounts of pornography, for instance, it has to be remembered that the talk and positioning of respondents represents only one, possible, moral trajectory. In other local situations with different interlocutors, such as friends or colleagues, it is easy to imagine that other ways of talking, or presenting the self, might be adopted.

In the final stage of analysis, and report writing, guidelines offered by Wood and Kroger (2000) were adopted, emphasising the need for disciplined, sensitive and creative analysis. They note: "The first task is to recognise that discourse analysis requires the ability to examine discourse creatively in all of its multifarious aspects and an open-mindedness to entertain multiple possibilities" (Wood & Kroger 2000: 91). In addition to pattern analysis, interpretation is informed by the research question, and recognition that speakers both

produce, and are produced by, discourse. Similarly, Hardin (2001) conceptualises the 'environment' as language, and the interview as 'performance'. Of introducing this methodology, and analysis, into healthcare research she comments: "This move makes it possible to construct a bridge between individual life stories and the cultural, social, and historical discourses from which those accounts emerge" (Hardin 2001: 11). In analytic terms this required looking beyond the immediate roles of respondents, to consider discursive devices that positioned 'self' and 'others' within the accounts.

Summary

This chapter introduced the concept of discourse analysis as a series of interdisciplinary approaches to language that can be understood as, both, methodology and method, defined in terms of principles rather than rigid rules. The version of discourse analysis developed by Potter and Wetherell (1987) has been outlined as providing a theoretical framework and study design to address the research question. The following four chapters of the thesis present the study findings, where analysis of textual data illustrates how the variability of respondent talk constructed accounts that positioned them within the cultural context of a secure hospital.

CHAPTER 4

Men's talk: The discursive texturing of male space

Introduction

This chapter looks at how male respondents used language to position themselves in relation to the hospital, and to each other. The accounts of nursing staff, and patients, have been analytically integrated to permit an exploration of gendered discourse that transcended the institutional, or professional, location of the speakers. The chapter is divided into three sections that explore the effects of masculine discourses on the way that secure care, and nursing practice, was constructed through the talk of men. The first section looks at similarities in the accounts of male respondents when talking about the hospital, where they shared a common discourse centred on a restrictive, and regulatory, regime defined in terms of 'security'. Each group of men maintained that the security function of the Personality Disorder Service [PDS] had expanded to such a degree that it exerted influence over what had previously been the domain of the clinical care team. There was a concern that these changes signalled the emergence of a prison-type culture, and the prediction that this would have a negative impact on staff-patient relations. More broadly, the language of the respondents sketched out an autonomous institution which was experienced, by those who lived and worked on the wards, as remote and oppressive.

This idea is developed in the second section of the chapter, which focuses on the way talk textured relations at, what was constructed as, the lowest level of a hierarchically ordered system. Characterised by the monotony of an unvarying routine, and the temporal rhythm of a rigid shift system, the physical space of the ward framed interactions between the nurse and patient. The professional identity of the nurse was shaped by mundane and routine labour, while detained men described an uninteresting existence in a rule-structured environment. However, the accounts of the respondents illuminated a much more complex set of discourses that mediated the mutual antagonism of the carceral setting, and defined the ward as male territory. The concept of 'otherness' is borrowed to explain the cultural dynamic that permitted men to position themselves in context-specific circumstances, while female nurses were largely marginalised. If men were defined in terms of masculinity, female nurses were defined by their sexuality. Inseparable from talk about risk, women who worked in the hospital were spoken of as needing to be *protected*, or needing to be *policed*. The sexualisation of female staff, in demarcating male territory, is given further attention by

observing the way that men understood the display of pornography as a commonplace form of communication.

The final section of the chapter draws together these findings in discussing how gendered language informed talk about treatment, risk and nursing practice. Each of these issues had vital import for secure mental health care, but respondent talk was based around informal, and cynical, interpretations of therapeutic engagement. Indeterminate detention was described as compromising the credibility of the sex offender treatment programme [SOTP], and each set of respondents alluded to ritualised game-playing. Nursing staff talked about a commonality of interests on the wards, which helped in getting through the day, by using masculine metaphors of sport and sex. In contrast, they withdrew from work which involved reflecting on the sexual-self, where talk about sexual fantasy and sexual offending threatened to erode the boundary between normal and deviant. Nurses talked of managing the patient population in terms of *knowing them* or *being like them*, as a product of long-term-exposure and intuition. Patient respondents challenged the competence of professionals to estimate risk in an artificial environment, but they also eschewed the legitimacy of scientific measurement, locating sexual violence in a male understanding of the world. Lastly, attention is given to the way that gendered speech embodied risk in the female nurse, where talk about sexuality and sexual crime defined them in terms of vulnerability, and compounded their exclusion from a macho culture.

A dominant discourse about security: regulation, restriction and rules

When they talked about the organisational management of the hospital, male nursing staff and patients produced similar accounts that constructed the institution in terms of control. Typically, they focused on an increasingly restrictive regime, and the enforcement of security procedures that undermined the treatment ethic of a secure mental health service. Articulating a recurrent theme, patient [P5] claimed that the Security Directorate had moved from an advisory function to 'actually running' the hospital:

> "Oh yeah...they're involved in treatment as well [pause] you have to go through them [pause] the same as...erm parole or anything [pause] security...security...security [pause] it's all security (.) it is in fact...security running this hospital now [pause] no longer are they advisory...they're actually running it" (P5: 622-625).

Frequent reference was made to inflexible regulations, codified in *Type Approval Committee* guidelines, governing the everyday life of the patient. Collective frustration was articulated in numerous examples of, what was perceived as, the excessive and petty application of institutional rules. Nurse [S3], for instance, talked about the storage of a musical instrument,

belonging to a patient, which failed to meet specific criteria, and illustrated a division between care team members [PCTM] and the security directorate:

> "Security are now saying that...that erm...everything that patients have...possession wise has got to go through the Type Approval Committee [pause] and the Type Approval Committee have...er approved patients with PCTM approval to have one acoustic guitar with six strings [pause] and this is an electric guitar with six strings [laughing] and they're saying 'Well it's not Type approved it'll have to go'" (S3: 946-951).

Both sets of respondents referred to the current situation in terms of a blanket imposition of rules that were applied to everyone. Patient [P5] used the phrase 'security rules' when talking about the restrictions that were applied to the type, and number, of domestic items a patient was permitted to keep in his own living space:

> "Security...everything goes through security [pause] if it's not...erm (.) what is it they use now? [long pause] Erm? [long pause] Well let's take...a bedside lamp from Argos...you can only buy one particular type...of bedside lamp [break] and this is because...security have deemed this...it's the only one you can buy...you can't buy any others [pause] if you want a television...you can only get fourteen inch (.) these days they're doing away with fourteen inch televisions [pause] if you want to buy er a recording DVD...there's only one type you can buy [pause] security rules" (P5: 384-395).

The function of security was described as being enmeshed in the operational, managerial, and clinical resources of the hospital, described by [S3] as an autonomous 'empire' that had expanded territorial control within the hospital. Like many other respondents, this nurse suggested that the escalating number of security personnel, and procedures, could be explained as a response to previous criticism of the Personality Disorder Service (Fallon et al 1999). The emergence of a new grade of security liaison staff was interpreted [S8] as an infiltration of the care team, where the autonomy of clinicians had been compromised by the function of security being extended to embrace decisions about patient treatment:

> "Oh security is a huge empire and it...it's built its foundations...are on...on Fallon [pause] we used to have a few security [pause] people that you could contact didn't we? We now have...security liaison for every ward (.) y'know the...the Security Department has...has...erm it...it...it must be about eight hundred percent bigger than it ever was...y'know [pause] so yeah it's got a lot bigger" (S3: 976-981).

> "we have security liaison erm people...on the care teams now so erm a lot...a lot of the stuff that we do now as regards like patient treatment is...is governed by whether Security will pass it" (S8: 140-142).

In his scathing reference to security as 'God', [P5] intimated an all powerful organisational deity enacting and enforcing laws that interfered with treatment. Here, nursing staff had to do as they were instructed, and patients felt 'the pinch'. Likewise, respondent [P2] suggested that the nursing profession was impoverished by the rigidly applied rules of a controlling

institution. The next section of the chapter explores the complexity of staff-patient relations on the ward in terms of otherness, but in these accounts the nurse was talked about as a relatively powerless, and unthinking, conduit for the instructions of others:

> "But having said that they [nursing staff] are still restricted...by security...which we call God (.) God says...and these [nurses] have got to do...and we feel the pinch [pause] er security interferes with ...everything...including treatments" (P5: 366-368).

> "they've [nurses] got to...abide by the rules of the hospital...same as we have to abide by the rules of the hospital" (P2: 243-244).

This disjuncture was particularly acute when treatment plans involved, or recommended, individual patients leaving the secure compound. Security, as a faceless and mechanistic bureaucratic body, was spoken about as the power-broker in mediating patient contact with the outside world. For respondents [P5 & S3], the agents of security stipulated who could 'come in', and who could 'go out' of, the hospital. Decisions formerly made by the care team were described as having become the province of a Security Directorate that acted as the gatekeeper between *secure space* and *social space*:

> "They [security] say who comes in and who doesn't [pause] they say what happens...they say who goes out...the hospital and who doesn't [long pause] they dictate how many escorts you have [pause] not the team (.) it used to be the team [pause] not any more" (P5: 630-632).

> "[Security] challenge a lot of things y'know...they'll challenge a lot of stuff that we send in there...y'know...i.e. we think maybe somebody needs to go here...needs to go there ...whatever (.) er and we think that therapeutically it would be worth them going and...and they tend to come from the security angle and say 'Oh hang on...erm I don't know whether this is appropriate'" (S3: 1010-1015).

For patient [P4], the term 'security', acted as shorthand for an oppressive and disempowering environment that diminished any ambition of personal growth. The organisation was accused of infantilising its inhabitants, fostering dependency, and creating a culture inimical to the successful achievement of treatment goals:

> "if you treat people like children...by restricting them heavily they will react...like children [pause] because it's...the security is like a parent...you can do this...you can't do that...you will do this and we've changed our mind and you can't do that now [pause] y'know or we restrict you on what you can buy and you can't...go anywhere or do anything y'know (.) well [pause] what's that going to create? Is that creating an adult in me? It's for me to be motivated...in an adult way to...to deal with therapies and deal with my problems" (P4: 188-196).

The language of respondent [S5] connoted a relationship with security that was founded on conflict and struggle. Rather than one component of a secure mental health service, security was spoken about as an anonymous and ubiquitous force that threatened to undermine a

philosophy of care. Here, the concepts of 'hospital' and 'nursing' were conjoined as potential casualties of an imbalance within the system:

> "I think they [security] need to realise that it's a hospital (.) y'know it's...no matter whether they agree or they don't agree...it's a hospital...and if we don't...if we lose that balance and security becomes more [pause] overwhelms the nursing aspect then (.) I mean we're not in trouble because I suppose it's still...we still function...but to what degree we function at is questionable then" (S5: 535-541).

A related discourse, that revealed similarities between male staff and patient accounts, resided in claims that the restructuring of the organisation was at risk of creating an environment that more closely resembled a prison. Patient [P6], for instance, described the institution as a 'hospital type prison', as distinct from a 'hospital per se':

> "it's like going into erm...a hospital type prison now rather than a...hospital per se" (P6: 12-13).

Respondents attributed this trend, in part, to the negative impact of an increased number of individuals being admitted from prison, and talked about men transferred from prison as being qualitatively different from the traditional patient population. There had always been traffic between these institutions, but it was predicted that an increase in the prison transfer population could have a major impact on the culture of the hospital:

> "So it's...in time there's going to be a more...particularly on the PD side...there's going to be more of a...prison transfer population than...patient population" (P6: 31-33).

> "I mean if you're gonna take an awful lot from prison as we move on...is each ward gonna have a few from prison? And we'll see the culture change [pause] and that's...could be a...a major impact" (S10: 384-386).

It was suggested [P5] that men admitted from prison enjoyed a greater degree of freedom as a result, but that longer-term patients would suffer from the importation of a predatory penal culture based on exploitation and gang membership. Evidence of an embryonic prison culture, though, was not restricted to a changing inmate mix or corresponding increase in security. The attire and demeanour of some nurses was interpreted as an overt display of authority, where custodial relations were mirrored in the adoption of a dress code that aped the uniform of prison officers:

> "there are a few prisoners in here at the moment [pause] and they're quite happy to be in here (.) because they've got a lot more freedom...here than they...had in prison [pause] alright they can't rule the roost...as much as you can in prison [pause] like tobacco baron's...and drug baron's...and money baron's and god knows what else [coughs] if they could...they would [break] you can see it...a lot of the staff...er you see them coming in wearing the black trousers and white shirts [pause] getting ready [pause] I don't like that at all [long

pause] I mean if they're going to treat me like a prisoner then as far as I'm concerned...they're screws...end of story" (P5: 600-611).

Similarly, respondent [P3] conjectured how a hostile and incendiary environment would radically transform staff-patient relations. Though it was not overtly expressed, denigratory language hinted strongly at a racist construction of the new type of offender who posed a threat within the hospital; described as the 'prisoner of today', this man was a stereotyped composite of the gangster rapper:

"but until somebody sits up and listens...to what we're saying [pause] and recognises it's going on [pause] by the time the prisoners come here...they'll burn the place down [pause] strongly predicted ...staff are wanting to leave...'cos they're now getting scared [pause] because the prisoner of today isn't the prisoner...like me who will talk to you [pause] the prisoner today is a crack addict who doesn't give a fuck...listens to rap...and goes about with a big four five in his hand...'Fuck off you [pause] you just dissed me'" (P3: 1065-1072).

Two patient respondents [P8 & P9] had been transferred into the hospital from the prison system. Their accounts of security were similar, but the language that was used worked to establish a distinct identity. In another variant of otherness that demarcated individuals within the organisation, they dissociated themselves from men who were detained under mental health legislation. Respondent [P8], for instance described himself as a 'prison transfer', which connoted a different status to the hospital patient who was defined by a section of the MHA (1983):

"Yeah...but I'm still a prison transfer [pause] we are still...are are still different to the hospital patients...and they're...they're something like a thirty seven? [pause]" (P8: 271-272).

Respondent [P9], likewise, placed himself in a different category of containment from individuals who came from the courts. Each might be serving a similar amount of time in custody, and offences might be comparable, but the identity of the 'prison transfer' resided in his experience of doing 'hard time' in the penal system. There was no denial that security systems were stringent, but the hospital was characterised by a regime of comfort and privilege; typified in the distinction between 'having it easy' and 'constant abuse':

"Yeah well y'know those that came from the courts and got a section thirty seven forty ones...for erm whatever offences (.) erm most of them are serious anyway because...y'know the fact that they got section thirty seven forty one which is like life under the Mental Health Act [pause] They have had it easy...they've had it easy in lots of ways [pause] I mean the privileges that...that are available in a special hospital system...er [pause] they're very comfortable er y'know they've...they've not had a hard time in the prison system [pause] they've not been through like the abuse that...that's constant in...in...in prison (P9: 3-10).

Changes in the use of physical space within the hospital, to complement security and surveillance measures, were presented as additional evidence of a custodial function. Respondents [P5 & P4] suggested that centralised visiting facilities resembled media images of the penitentiary. It was reported that the building in which visits took place, referred to in the hospital as the Exchange, had been refurbished in a way that compared to the physical security of a prison. This claim was allegedly supported by men with first-hand experience of prison life:

> "You've only got to look at [pause] in visiting areas in a prison...we know what it's like (.) we've seen it on the television...we've heard it from prisoners who are here [pause] they've done the Exchange...like a prison" (P5: 419-421).

> "Even the visits are so poor now...that people are stopping coming [pause] and we're supposed to be in contact with family because it's good" (P4: 205-206).

The visiting hall, representing physical and social space shared by patients, their family and friends, was described as an unwelcoming and uncomfortable venue, where Spartan conditions and furniture exerted the pall of institutional living, and diminished the value of the occasion:

> "Visitors...and patients [pause] have complained left right and centre about it...because the seats are hard...and the tables you've got to lean right over...if you're writing anything or...if you're playing bingo (.) and if you have a bad back...I mean I have a bad back [pause] a lot of the visitors and the patients are standing up...having their visit for those two hours" (P5: 422-426).

> "Same with visits...they don't want people visiting you here...and that's been exemplified by the new Visits Hall...there's so many complaints about it [pause] you're sat this far apart from your visit [indicates with his hands] on seats that are uncomfortable...plastic [pause] they're not bothered...they don't want it" (P3: 1390-1393).

It was commonly reported that a growing emphasis on security had been accompanied by a corresponding increase in the volume, and visibility, of surveillance technology. The introduction of new camera and alarm systems, discussed as a by-product of admitting 'violent hardcore criminals', was described [P6] as 'prison oriented measures':

> "they've had to bring in...like prison orientated measures er security er extra staff etcetera etcetera...and of course some of the people that have been coming in are...hardcore violent criminals and there's been staff assaulted and various aspects i.e. results of all these kinds of things and whatever...so (.) and...and millions were spent since the Fallon Inquiry...extra cameras...extra cameras...extra roadways...new type of alarm system...so it's a major increase" (P6: 37-43).

> "It's just ridiculous [pause] wherever you go the cameras are watching you [pause] and now...I don't feel as though...I'm a patient anymore...I think I'm a prisoner...because of all the security around me" (P1: 392-397).

It was further claimed that restrictions had a detrimental impact in terms of physical space being incorporated into a policing strategy on the wards. If the disruptive behaviour of those unwillingly admitted from prison was unpleasant and frightening, management based on observation and control involved reducing room access. Closure of communal parts of the ward day area in the interests of safety might be a managerially effective strategy, but took no account of the unsettling effect of this on small personal choices that gave meaning to daily life in a large institution:

> "there's been major incidents there's been staff assaulted er seriously assaulted...all the rooms are locked off...now at one time I could come up here and you've got the library...you could sit in the library...I could read me books in peace and quiet...go and make a cup of tea when you want...go in the dining room...do a snack or whatever...and because of...various incidents by prisoners over the last few months...the library was locked off because...there was never any staff supervision in there [pause] and at that time it was the smoke room...where you had a smoke [pause] these prisoners were going in there...threatening patients...bullying patients...taking tobacco off 'em" (P6: 64-72).

The respondent suggested that sexually exploitative or inappropriate behaviour had, similarly, been addressed by limiting the opportunity for intimate contact on the wards. Because patients were not permitted access to side-rooms other than their own, ward toilet areas had been designated as a high-risk venue for improprieties. Throughout the following chapters it will be noted how the institutional management of behaviours, interpreted as problematic, would replicate this tension between collective and individual responses:

> "the toilets are open now but when the rooms are open...the toilets are locked off because there's been improprieties taking place in there in the cubicles [pause] so it's [pause] it's sad in a way that other people's behaviour [pause] has...denied me...facilities that I've not abused" (P6: 84-87).

Living with the 'other': defining the ward as male territory

Male nurses, without exception, explained their role on the wards as an amalgam of security and therapy. Direct questioning about a typical day, though, invariably generated a recital of rigidly structured routines, where talk about management of the immediate environment took priority over any discussion of care. Discussing the tasks that comprised an early shift, the account of respondent [S15] illustrated two themes that featured prominently in interviews with male staff, and organised the way they talked about relations with the patient population. Firstly, the shift system represented the smallest unit of organisation within the hospital, and it was with members of their own team that nurses expressed the strongest affiliations. Secondly, the focus of 'getting ready for the day', in terms of supervision and

dealing with 'issues that arise', sketched out an expectation that nurses would have minimal patient contact unless they were required to intervene in resolving problematic situations:

> "I'll start from an early where you come in at seven o clock and do all your security checks...do the hand over...and then the...the morning shift usually go off around half seven erm...and then that time between half seven and eight thirty is...the patients are sort of given time to...to get up at their leisure really (.) they have to be up before half past eight er but the ones who are on medication [coughs] usually need to be up by ten past...and then it's...between ten past eight and eight thirty it's breakfast time...erm it's just er...it's just getting ready for the day really...it's get up get washed and we're just sort of around to...to supervise and...and deal with any issues that...that arise" (S15: 16-24).

In talking about crisis intervention as opposed to care, respondent [S6] offered a similar account of life on the wards that constructed nursing interventions in terms of managing, controlling and maintaining order when faced with interruptions to a predictable routine. If the ward was described as a community, it was not one based on integration, and the patients were seen as responsible for planning their own day. When nurses were required to encourage motivation this was described in the language of sorting out a problem; talking about the need to 'step in', accompanied by laughter, connoted a prescriptive style of intervention. The 'hope' was for limited engagement in terms of supporting work done by others, based outside the ward, in a rhythmic passing of time. The idea of social interaction mentioned by this respondent will be developed, later in the chapter, when considering how nursing staff and patients constructed, and negotiated, identity and otherness in the confines of the ward environment:

> "I don't know if <u>there is</u> a typical day...I mean a typical day's fairly quiet [pause] hopefully erm [pause] I think the nursing staff <u>on here</u> [pause] or the <u>staff on here</u> generally...you're almost like a community crisis intervention team really [pause] on a day to day basis hopefully you don't have that much input [pause] you'd have say somebody who [pause] people who are doing therapy...you might be involved in a supporting role around the therapy [pause] <u>but day to day</u> erm [pause] <u>hopefully</u> you're not <u>that involved</u>...it's more social interaction and [pause] <u>passing the time of day</u> (.) erm [pause] hopefully most of our [pause] patients are [pause] reasonably capable of planning their own day [pause] carrying on with their day [pause] motivating themselves mostly...every now and again obviously we'll have to step in where the motivation's [laughs] slipped and encourage them (.) but it's...it's more a sort of [pause] erm...<u>bit more</u> like a community <u>really</u>" (S6: 30-42).

Patient respondents seldom spoke about the contribution that nursing staff made to any treatment pathway. The responsibility of the nurse as an Internal Care Co-ordinator [ICC] to prepare case conference reports, or make representation to the care team, meant weekly meetings were a scheduled event. Beyond this, though, therapeutic work and recreations were centralised, and life on the ward was described as a series of uninteresting, repetitive and solitary activities. Echoing the language of the nurses, they made reference to pastimes as a way of passing time:

> "Get up in the morning [pause] get our med's [pause] then we just...some go to work...those who don't go to work just stay on the ward and just...watch television...play on the Play Station [pause] read books...read magazines" (P2: 127-129).

Discussing his perception of the role of the nurse, patient respondent [P1] suggested that involvement was restricted to basic duties, such as dispensing prescribed medication, or trivial pursuits that represented an unimaginative approach to working with a challenging client group. Similar pedestrian interactions were described by nurse [S8], but presented in terms of using communication skills that were appropriate to the level of the patient group. This superficial engagement with the detained men was framed by talk about dangerousness, but as a contextual rather than a clinical concern. Common interests or environmental cues, such as the television, offered a platform for basic exchanges with individuals who were set apart from the staff:

> "Well [long pause] they play...they play games with you...like snooker...cards or...scrabble or...talk to you [long pause] give you medication and [pause] I suppose take you out...shopping trips or...wherever and [pause] I suppose (.) in their sense they're helping" (P1: 779-782).

> "you've got to be able to communicate with these people on their level [coughs] that's [pause] not...not totally disregard what they've done [pause] erm [pause] or how dangerous they are...or how dangerous they may be (.) you've got to be able to communicate...on a basic level...maybe have a laugh and a joke with them about something that's on TV or...whatever" (S8: 423-427).

Respondents [P5 & S8] discussed micro-level interactions between patient and nurse, where staff could be categorised according to a series of fluid social relations. Within the temporal ordering of the shift system, collective identities were allocated to small teams of nurses that were quite distinct from the ward, of which they were constituent parts. Each respondent referred to particular nursing groups being designated as the 'shit shift'. Individual nurses might be valued according to merit, while negative characteristics were attributed to the larger team:

> "and there's one shift [pause] which is...everybody calls it the shit shift [pause] there are patients who won't go into the dining room for their food when that shift is...is on [pause] they have problems [long pause] it seems to be the whole shift [pause] that's why they call it the shit shift [pause] I don't particularly like it meself [pause] the staff are polite with me [pause] 'Hello [name of respondent] you alright?'...'Yes thanks' (.) Er...but I don't like 'em [pause] because of their attitudes [pause] in general (.) individually...not too bad" (P5: 662-672).

> "there's a sense of community on the ward (.) I wouldn't say family's probably the right word...but there is a sense of community on the ward with the patients and the staff [pause] you'll always get a situation where you've got like three...three day shifts where you'll get different atmospheres on the ward...when each shift's on...and that's down to...that's down to relationships that the staff have got with the patients [pause] and the old adage of 'Well...there's the shit shift coming on'" (S8: 95-101).

The physical space of the ward emerged as a dominant construct in shaping the accounts of patient and staff participants. It represented the shared world within which these two groups of men lived and worked. When nurses talked about their role it was usually in the context of the ward, a location that defined their function, interactions with patients, and organisational status. This set of relations conjoined to suggest an overwhelming sense of professional alienation and invisibility. The ward conferred collective identities to the people who inhabited its geo-spatial confines. For respondent [S1] patients could be described as a 'collection', and named in diagnostic shorthand ('PD'), but nursing staff seemed trapped within the repetitive patterning of the shift system. The ward was symbolically constructed as the lowest level of an institutional hierarchy, with senior management dismissed as an undifferentiated structure of remote and authoritarian figures:

> "I'm a team leader...erm I work on one of the PD wards erm...the way it works is that erm...there are a lot of erm...for each PD ward there are...erm three shifts of nurses and erm...a collection of patients...on each ward (.) above the wards erm...there's a management structure...we don't see very much of those managers...erm [pause] perhaps once every couple of weeks er we see our...our Matron (.) and then after that...like once a year we see...see managers above that...and it seems to sort of tick over on a week...day by day...week by week basis [pause] erm [pause] and that's about it" (S1: 17-24).

There was continuity within the nursing accounts that, explicitly or implicitly, conveyed the idea of formal and informal relationships that constructed the ward in different ways at different times. For respondent [S1] this was articulated as analogous to drama, or acting, where people had become skilled at moving between roles. Just as working on the ward conferred inclusive membership to nurses, other professionals could be referred to as 'visitors' in a way that connoted outsider status. It was claimed that the arrival, and departure, of these individuals produced different presentations of the self in line with organisational expectations; the ward, temporarily transformed, to accommodate the business of the other, before 'relaxing back down' to its natural state:

> "when there's visitors on the ward Dave [pause] everybody changes...everybody on the ward changes and it's almost as if they're on stage (.) and so what you see then is...is what we're supposed to erm...what we're supposed to present [intake of breath] when er these visitors go...and of course they're not there very often erm...then everything relaxes back down...so that there are informal relationships that just aren't mapped in the organisation" (S1: 36-41).

Making reference to the ward as seen through the eyes of the other, and delineating between the outsider and the insider, respondent [S14] invoked an inverted institutional logic. He talked about a failure to value those staff that had the closest relations with the patient population and reinforced a sense of distance between hospital personnel:

> "I'm saying that in other people's eyes the status of somebody outside of the erm...the wards is probably higher than somebody inside and it's like an inverted triangle it...it should be the other way round...we should be...we should be supporting that at the expense of anything else but I think...big institutions end up running erm for the sake of the institution and the structure rather than what they're there for" (S14: 356-361).

These nurses each provided accounts of everyday interactions between nurse and patient in relation to the concept of a 'family'. The language-use of respondent [S1] made a distinction between official terms and a more honest version of life on the wards. This analogy was supported by the comments of [S14] about the way nursing staff relied on their personality to survive in the secure setting. In contrast to connoting a harmonious domestic sphere, the family became a shared living space where problematic elements could produce instability. The patient might, simultaneously, be identified as a sibling and labelled dysfunctional. Personality, here, mediated the normal (nurse) and the ('scary') deviant. When 'down' or 'out' on the wards it was maintained that individual attributes represented everything in getting by, and getting on, with the patient group; family membership that was wrapped in a survivalist, rather than therapeutic, use of self:

> "that's the way it is...er in official terms and then there's...you know...to be honest on the wards it's more like erm [sighs] it's more like erm...a family...in many ways" (S1: 30-32).

> "it felt like erm sometimes a...a scary family y'know...'cos they can be scary places and...it's like erm...erm one of the siblings sort of...being dysfunctional in the family...and I sort of think that...erm your personality down there is everything...when you're out...on the wards...your personality...sort of gets you through and I think there is a sense of family" (S14: 451-456).

In the complex organisational matrix of the ward, it was suggested that loyalties and allegiances, between patients and staff, grew more cohesive as the unit of nursing organisation became smaller. Since neither group benefited from any disruption to the equilibrium of the ward, individuals who threatened this fragile and volatile social system became problematic; a mutual alliance between keepers and kept, motivated by self-interest, to manage the delicate fabric of life on the ward. Each group could be classed as a separate 'entity', while understood in terms of the need for cohesion. To be 'valued', as a nurse, carried the expectation of being looked after:

> "families stick together and I had...I do see that the erm...on a lot of wards that the staff and the patients are a kind of erm...they are an entity in their own right (.) er and they are looking out for one another as well erm...and that's always been the case erm y'know...patients will look out for staff...they'll look out for staff...particularly if they value them" (S14: 471-475).

A pervasive theme in male nurse accounts centred on the way they negotiated daily interactions with a group of patients who were *spoken about* as other, and *spoken to* as men.

This discursive disjuncture was illustrated, particularly, by respondent [S1] when describing 'lad's talk' as an informal feature of life after five-o-clock at night; where the inclusivity of common male interests replaced difference in upholding the masculine culture of the ward. Reminiscent of his talk about family relations, the respondent suggested that the usual distinction between these two groups of men was replaced by talk about casual interactions rooted in shared values. Women became a focus for male-bonding, with sport and sex serving as metaphors of masculinity, yet female staff were invisible within the account. It was suggested that a crude, and commonplace, discourse about sexual activity was a component of conversation between a 'group of fella's' that dissolved professional boundaries:

> "and what people don't see is...sort of after five o clock at night Dave we're sat there...very often in small groups talking about...y'know values we share...about erm the hospital...about football...about women (.) about those types of...things that men talk about [break] I call it lad...lad's talk [pause] but I've seen it that often that erm...erm...male staff will be talking about erm...who they...who they were shagging last night...what their sexual activity was...I've even heard people talking about how they...how they erm...how they erm...what their sexual habits are with their wives (.) now I correct that...but I've...I've seen it that often...in various places that you know...that's what...that's what seems to be of value...erm conversation on the wards that I've worked on...over a long time [pause] there aren't qualified and unqualified and patients...there's a group of fella's talking about whatever they...whatever erm takes their fancy...prompted by TV programmes maybe" (S1: 368-388).

In stark contrast, the respondent outlined a completely different set of nursing discourses that took place in the privacy of the staff room. Here, it was alleged, the patient was spoken about in a way that diminished any humanity, and became the subject of cruel jokes. Being 'inadequate' and 'ugly', for example, set these individuals apart from society, and informed a crude understanding of the motivation to sexually offend. Retreat into a 'fantasy world' represented refuge from rebuke and ridicule, but it was ironic that this treatment should be replicated in a mental health setting. Shifting from reported speech, the nurse contributed a personal observation to this construction of the other. The patients, collectively dismissed as 'these people', were marked out by the stigma of being 'very odd' which invited the denigratory label of 'pervert':

> "say we go into the staff-room and we have our tea [pause] the jokes are...are quite telling I think because erm [pause] someone will be taking the piss out of him [pause] this fella erm...saying he couldn't get a...he could [unfinished] inadequate...he couldn't get a woman anyway...that's why he's raping erm...or that's why he's got fantasies to rape (.) er they'll say he's ugly...or they'll say that erm you know he...he couldn't cop off in a brothel erm...and that's it really...that what's happened with this fella is that he's erm [pause] been erm [pause] you know er a...a social inadequate at school...that's...that's what people think...social inadequate at school he's erm...been erm...not able to engage erm...socially...he's erm been probably the brunt of ridicule and he's probably withdrawn from there into a fantasy world...and then eventually become a rapist (.) that's what people think in a...as a crude way erm and y'know from what I've seen...these people are...are

> always very odd anyway...they're either erm...there's something about them that you...you...if they were walking down the road you'd think...you'd think pervert" (S1: 494-508).

In response to this narrative, the respondent was asked whether nurses, commonly, had different ways of speaking that were context specific. This produced an elaboration of the type of talk that would take place if the men on the shift went 'for a pint' [865]. In contrast to the 'lad's talk' of the ward, this was described as a script that was reserved for off duty interactions. Described as a 'different level' of talk, the language expressed contempt and condemnation for the patients. Conjecturing this might reflect the demands of working with difficult people, and the opportunity to 'let some steam of', did little to assuage the vitriol of the commentary; a version of events that was credited with being 'the truth':

> "it goes to a different level then because of course we're off duty...we're not on stage at any level and then they're talked about as being erm [pause] sick...horrible...perverted...should never get out...throw away the key...bastards erm...they're erm [pause] should er cut his genitals off...should erm [pause] we'll set him up...those types of things Dave erm...and I don't know whether that's about people working with...working with...you know quite difficult people...who have to let some steam off but there's a different level of erm...they're talked about at a different level when...when we're out at the pub y'know...quiet...having a few drinks and stuff erm [pause] and that's remarkable for me...I think it's [pause] erm...that's when the truth comes out" (S1: 863-875).

If women, in general, were identified as a feature of lad's talk on the wards, the female nurse was subsumed within a shared male discourse that combined ideas about *sexuality* and *risk*; outside of this limited construction, the women who worked on the PDS were seldom mentioned. Male nurses talked about having a protective function and an obligation to ensure the safety of female staff, particularly with regard to the sexual offender. Making a distinction between aggression and sexual behaviour, respondent [S15] talked about managing the risk to female staff as a basic part of his work on the wards; an environment where women were expected to have minimal, unsupervised, patient contact:

> "obviously it's...everyone's aware of the facts y'know...of what the offence is...y'know if it's against women and stuff erm [long pause] I think that's to say basic...where you sort of look after the female staff anyway on the ward y'know for the...for the...for the aggression as well as like the sexual behaviour erm...y'know a female member of staff would never see one of the patients on her own" (S15: 588-593).

These accounts were typically framed by comments about the relocation of female staff following closure of the Women's Services Directorate. Discussing this redeployment in negative terms [S15] talked about women coming from the 'other side'. As in most staff accounts, adverse events were presented in relation to the safety of the ward, so a perceived imbalance in the male-female ratio was discussed as a problem that needed to be, informally, addressed at that level. Implying tension between ward staff and service managers, the

account defined the working environment as male space, and women as unwanted and unwelcome commodities that could be bartered:

> "since the other side...since the East closed we're like swamped with women [pause] there's too many too be honest...and er y'know it does create problems on the ward...the mixed staff erm y'know supposed...we're supposedly to run on er four males...two females but more often than not we end up on three and three [pause] and you'll have three females [pause] but there isn't anything you can do about it other than recruit male staff...because you're ringing all the wards up saying 'Can we...y'know can we swap a male for a female? We've only got two males on and four women' and stuff y'know and it should at least be three and three...so it's really difficult" (S15: 606-621).

The risk to female nurses who chose to work in the hospital was described, by male colleagues, in gender specific language that emphasised the possibility of sexual attack. Patient respondent [P5] described an altercation with a female nurse, over room access, which introduced the possibility of physical harm. It will be noted, in chapter six, that becoming the victim of physical assault more closely resembled the concerns of female respondents. Here, though, a shared idea of women, as weak and vulnerable, was expressed as a code that invited connotations of honour, where *restraint* equated with *respect*. This presentation of himself, in a favourable light, was combined with a dissociative strategy in terms of other men referred to as prisoners. As noted earlier, language functioned to construct a changing culture typified by a distinct category of inmate who could be portrayed as lacking, either, consideration or conscience:

> "she's as thin...thin as a rake [coughs] if you blew on her you'd probably break...break every bone in her body...and I thought to meself...who the hell does she think she is? [pause] I thought [pause] if I wanted to get in there...there's no way on this earth she'd stop me [pause] but I don't...attack females ...I never have done [pause] but [pause] if that'd been one of the prisoners...they'd say 'Ahh get out...the fuckin' way woman'" (P5: 645-653).

Women were defined as sexual beings in a way that was never questioned for male staff, where ideas of risk incurred a responsibility to dress and behave in what was described as an appropriate manner. Respondent [S15] articulated an account of gendered risk which identified the sexuality of female nurses as inherently dangerous; if this was something men *knew*, it was something which women needed to *know*. Externalised, and accentuated by clothing that reflected fashion rather than function, certain cues were seen to signal sexual possibilities; where interpreting sexual codes had as much to do with *male behaviour* as *offending behaviour*. That women could, to a degree, be trusted in managing their personal conduct, did not replace a need for regulation, policing and, if necessary, discipline. Folkloric stories permeated the culture of the wards to remind women of punitive sanctions that could be invoked for perceived transgressions. Ultimately, though, regardless of adherence to risk-reduction, victimhood was inscribed in gender. If women disguised or

concealed their sexuality, and presented themselves in a prescribed way, they earned male approval and protection. It was suggested that women invited dangerous sexual interest by exciting men, which included some of the 'fuckin' male staff', in a way that was difficult for them to control; where the presence of a female was sufficient to provoke male sexual interest:

> "women are to be really aware of their...their own sexuality and how they...how they present themselves really [pause] I mean to be honest I've never come across a female staff on any of the wards I've worked on who've like dressed inappropriately y'know...they might have er skirts too short or [pause] too tight I mean it's just as well...some of the fuckin' male staff [laughs] some of the male staff on here y'know what I mean (.) I don't think any of them would dream of coming in stuff like that but erm...yeah I mean y'know they need to be aware of [pause] stuff like that obviously [pause] erm about how they dress and how they present themselves [pause] I mean you do hear stories from time to time around the hospital and y'know female staff being bollocked for [pause] y'know wearing a low cut top or pants too tight or y'know that sort of stuff [pause] and I think that's y'know [pause] that sort of needs er watching and as again y'know make sure that they...the female staff don't get isolated with these patients" (S15: 645-658).

The attribution of stereotypical qualities permitted patient respondent [P7] to claim that the hospital was an unsuitable, male, environment for women to work in, and placed female staff in a difficult and dangerous situation. Specific types of attire could identify them as sexually provocative, and was directly linked to fantasy as a component of risk in certain men. The possibility of their offering a counter-balance to the male-dominated ward culture, defusing volatile situations, was rooted in the gendered characteristics of femininity. At the same time, in an account that compared to a victim-blaming ideology, female nurses were, to some degree, seen as responsible for attracting predatory male attention:

> "they do defuse [pause] certain volatile situations [pause] because they're non-threatening aren't they? But by and large they're not...they tend to like...to want to defuse the situation rather than having a...a macho...approach to things [break] but on the other side...er [long pause] the way some of them dress [pause] a bit provocatively [pause] erm...can only fuel certain peoples...fantasies [break] the most recent thing that [pause] has become quite prevalent amongst er the female staff...I'm not saying they do it deliberately...erm I think it's unintentional [pause] is that [long pause] their thongs...tend to ride up out of the backs of their trousers...and are on full display...to quite a lot of people...now [pause] I don't think that's appropriate [pause] in an all male environment like this" (P7: 420-446).

Reflecting on his nursing career in the hospital, respondent [S16] recalled the naiveté with which he had engaged in speech-acts, with young personality disordered sexual offenders, which demeaned and exploited female colleagues. The language, powerfully, embodied an account of staff-patient relations where the construct of otherness was negotiated in relation to gender. His description of socialising with a group of patients, referred to as 'lads', centred on a female nurse variously referred to as 'a girl' and 'eye candy'. The sense of what

constituted appropriate behaviour was fluid in a sex-specific way, where the female nurse could be seen as culpable for male comments about how she might be used sexually:

> "I'd sit with all the young lads on [name of ward] and a girl [nurse] who we've just mentioned would walk past...dressed inappropriately...right (.) but because I thought it was appropriate for me to...to be a bit of eye candy and pleasure...I'd talk about her with these young patients and say 'Whoa' y'know 'what would you do with that?' And y'know [laughs] but I thought that was common practice Dave" (S16: 421-426).

Another dimension to the construction of the ward, as male space, was illustrated in men's talk about pornography as a visual symbol that textured masculine territory. Historically, pin-up pictures on the walls of side-rooms and cells were a standard feature of secure psychiatric and penal institutions. In all-male environments that prized masculinity, but afforded limited sexual opportunity, the overt display of pornography emerged as a way of signalling sexual interest and orientation. For respondent [P9] this represented a form of fitting in, where it was considered necessary to conceal sexual aspects of the self that could incur sanctions. It was implied that there was risk involved in disclosing any sexual interests outside of norm, especially where this might connote a feminised sexual status. For heterosexual men, though, exhibiting pornography made a statement and signalled membership:

> "Maybe it's trying to make a statement y'know that 'I am heterosexual' (.) Maybe a guy who's in the closet and he's really gay...erm but he doesn't want his mates to know will put it up...maybe guys who are <u>really heterosexual</u> y'know and do fancy women wanna make that statement that 'I do...and she's got great tits or whatever...she's got a great arse'" (P9: 698-702).

Though respondent accounts were framed by an organisational imperative that prohibited the display of sexual images, personal opinion was more ambiguous. Nurse [S15] talked about the enforcement of a prohibitive policy, where the rationale for restricting sexual media could be vaguely explained in terms of external criticism of the hospital (Fallon et al 1999). However, his comment that the walls of patient bedrooms had previously been 'plastered with stuff' connoted sexual imagery without making any reference to the gendered nature of the materials:

> "It's [pornography] not allowed at all [break] no [pause] not even as much as erm [long pause] in fact...I'm not [pause] y'know erm like...sort of page three stuff...I mean even that's pretty much frowned on [pause] I can remember going back years ago before the Fallon and everything...and you'd go in some patients rooms and the walls would be plastered with...with stuff [pause] erm [pause] and again it's difficult to say what should be allowed and what shouldn't (.) it's always something that you're never really...you're never really sure of" (S15: 743-757).

Respondent [P7] claimed that he had a picture of a topless model on the wall of his room, but that there had been no request to remove it. This had been taken from *Fast Cars* magazine that, while targeted at a male readership, would not fall into a narrowly defined category of pornography. If not a personal preference, pin-up decor was a familiar and unquestioned component of the occupational sub-culture of men [P6], whether private or public space:

> "Do you know I've never thought of that [the reason for displaying pin-up pictures] I've never thought of it...I've never thought of it [pause] I've worked in environments outside where there's like...a nudie calendar on the wall" (P7: 492-494).

> "Well I mean to say the sailors...in the navy have got pin ups on their lockers [pause] er garages...you can go in and see a calendar on the wall in a garage" (P6: 842-843).

It was notable that when they talked about displaying sexualised representations of women, none of the male respondents made any reference to female nurses who worked in the hospital. Male language defined *male space*, and pornography defined *male pleasure* in a way that permitted nurse [S15] to describe the prohibition of pin-ups in patient rooms as an invasion of men's privacy. A comparison between patient rooms, and the factory floor, signalled a taken for granted part of working-class life and manual labour, where sexist or exploitative imagery was too commonplace to question, and too trivial to worry about. Immersed in the values of male popular culture, women were seen as little more than a decorative distraction, invisible in their exposure:

> "y'know you think well...if it's in...if it's in the privacy of y'know their own room and that [pause] their room's not really any different to...you can go in any sort of work hut in the country and they've got pictures like page three (.) I mean the factory I used to work in before I went into nursing...there was y'know...our dining room was like plastered with page...page three out of the *Sun* and [pause] and stuff like that (.) I don't...look in the newspaper...and you see all this stuff and you don't...I don't even bother looking at it anymore y'know it's just...just a picture of a woman with her boobs out...I mean y'know so what like? But y'know some people can get a kick out of it...and it makes you wonder erm y'know...if people are in their own rooms what real harm are they doing" (S15: 757-767).

Respondent [P7] moved from considering the pin-up as a decorative picture to recognition of its symbolic value in asserting a collective masculine identity, token of entitlement, visual extension of fantasy, and territorial marker. The male occupant of an office, for example, became a ridiculous figure by association with what were taken to be feminised objects ('fluffy cats'). However, replacing these with an image that enhanced the masculinity of the meeting place restored a sense of balance and (male) order to the environment:

> "if you're a male and you go into someone's office...and the male behind the desk has got a picture of fluffy cats [laughs] you would...you'd think fuckin' hell...what's up with him like...but if you went in...and there was a picture of...I don't know...somebody half naked sprawled across the bonnet of a car [pause] you'd [mmh] that's alright and then you'd get on

with the interview...with the person [pause] but you wouldn't think he was weird" (P7: 523-528).

This account organised a discourse about how men relate to each other through a shared sense of belonging in a world imagined, and defined, through male language. It connoted male recognition and reconciliation via an image that expressed masculine drive, ambition, power and desire. The woman 'sprawled' across the bonnet of a car seen as an accoutrement of success. Aware that this functioned as a marketing strategy, and commodification of women in advertising, the product on offer was more than a material object. It represented fantasy, aspiration and lifestyle. More than this, it was unattainable and double-edged:

> "in terms of that kind of thing I think car manufacturers...and manufacturers in general tend to use women more...to sell things [break] this is a beautiful car [pause] you're not gonna get this woman [pause] but because of this beautiful car...this wonderful new car you might get a woman like this" (P7: 533-540).

For respondent [P3] the hospital policy of restricting what could be displayed on side-room walls, and removal of particular images from the ward environment, was interpreted as an extreme and foolhardy measure. The pin-up was defended as a part of inmate culture, where staff interventions were seen as policing the personal space of the patient. Censorial invasion of the ward was described as counter-productive in terms of rehabilitation and preparation for life outside. Reinforcing the physical, and symbolic, distance between the 'real world', and what was implied to be the artificial world of the hospital, carried an implicit suggestion that controlling access to sexual media was about masking rather than managing risk:

> "do you know what is silly because y'know people put pin up's on their wall they're not allowed to now [pause] er they rip...magazines...you know like...er catalogues with anything that's a bit saucy [whistles] rip it out...on some wards [pause] that's a bit stupid [break] it's taking you away from the real world [long pause] but that patient's got to go out somewhere and some time and see something [pause] what's he gonna do then?" (P3: 2348-2359).

Gendered talk: treatment, risk and nursing practice

Though the physical and human impact of security was clearly expressed in all the male respondent accounts, a philosophy of treatment was less clearly articulated. For staff, the terminology was problematic, and concepts such as treatment, therapy, and nursing care were used uncritically and interchangeably. If this hinted at an ill-defined professional persona for nursing, it represented part of a larger semantic conflation about interventive work with medicalised offenders. That only two of the male nurses [S2 & S6] had direct experience of facilitating sex offender treatment groups suggested an institutional division of

labour. Respondent [S15] articulated a routine distinction that was made between the generic practice of forensic nursing and the expertise of offence-focused work:

> "y'know as someone's ICC you wouldn't...you wouldn't discuss their offending but you'd tend...from a personal point of view...and I think for most people you tend not to get too deeply involved...just on the one to one basis [pause] it's...it is mostly preferred if it's...if it's done off the ward where you might [coughs] psychologists may well be involved in it...but they tend to erm...they tend to frown on er sex...certainly sexual index offence work on like one to one basis...it's...it's geared up towards the er y'know the group work" (S15: 571-577).

Given the involuntary and indeterminate detention of the patient population, therapy was described, by nurses, in terms of coercion. For respondent [S6], attending a treatment programme was not seen as a 'freedom of choice thing', but as a strategic gesture to demonstrate the capacity to accept and deal with offending behaviours. If the treatment goal was to reduce offending, the patient goal was to promote a new image and improve the chance of their being moved to a less secure unit. Patient participation in the SOTP was, in this sense, interpreted as an instrumental and grudging gesture, motivated by self-interest rather than self-help:

> "the only reason...the majority of them [pause] attend any of the therapy...or take on any of the therapy that's offered to them is because it's the only bloody way they'll get out [pause] they know that...and I hope we know that...really [pause] so it's not a sort of...it's not a freedom of choice thing is it...it's (.) erm [pause] 'You're here...and unless you do something to improve your [pause] er chances of not offending [pause] you'll be here for a very long time'" (S6: 395-400).

Patient [P7] talked about the dilemma of truth-telling in treatment, where it was claimed that honesty carried little incentive. The account suggested a collusive and ritual enactment where attendance had greater import than meaningful participation; that a game was being played, for which there were formal and informal rules. To the frustration of the respondent, fair play had a high cost. Within the forensic system, therapy was described as an administrative exercise that transformed the patient into a marketable commodity. The process of SOTP as an agent of change, like the allegedly feigned participation of patients, was dismissed as superficial and fraudulent:

> "I've said to them 'Look I'm struggling with this SOTP...I'm being really honest...I'm telling people that I still get these fantasies' And yet I sit there and I hear other people say 'I don't get that anymore' And I know they're lying [pause] not everyone might be lying...but a good proportion of them are [the nurse said] 'Doesn't matter whether you've changed at the end of it [pause] as long as you can tick that box we can then sell you to an RSU' [pause] And I really think that is wrong [pause] I do because [pause] I think it's wrong that the system is set up that way" (P7: 1106-1122).

The issue of fantasy ran through the male respondent accounts, as a medium for understanding how thinking translated into offending. Nurse respondent [S6], likewise, saw little incentive for patients to reveal any cognitive ideation if this would, likely, result in their being constructed as more dangerous. Using the example of a fantasy about rape, it was suggested in direct language that disclosure would prevent the individual from ever getting past the 'front gate' of the hospital. In the following chapter, these ideas will inform respondent talk about policing and regulating pornography, where sexual media was understood as a bridge between the internal and external world of the sexual offender:

> "you can't measure it y'know (.) it's self reported and who in their right minds...if they know they're never going to get out the front gate if they're still having the fantasy about rape (.) 'I'm still having that fantasy' They're going to come up and go 'Well I've sorted that...it worked...thank you'" (S6: 703-707).

Utilising the metaphor of game-playing, nurse respondent [S10] also offered a critique of therapy as something that had to 'be done' in order to 'move on'; where the *content* of the programme was less important than the *consequences* of having attended. The 'therapeutic game' rehearsed ideas about the personality disordered client as duplicitous, where newly acquired 'jargon' enabled them to present a more credible persona; learning a new way of speaking, rather than a new way of being:

> "they play the therapeutic game...it's not the content [pause] it's the 'I've done this therapy now...so I move on now' And we have patients on this ward who have done this...have done that...and they're involved in the therapeutic jargon [pause] rather than 'Well I've learned from it' it's 'I have done that...so I can move on now' [pause] Yeah and that's...they're playing the therapeutic game" (S10: 281-286).

For nurse [S1] the therapeutic process, as described above, resembled an organisational charade, or no-win situation, where the game was rigged. If the patient adhered to the rules of the 'game' and accepted therapy it confirmed the symptomatology of a manipulative and untrustworthy psychopath. Conversely, rejection of therapy invited other forms of negative attribution. This was a discourse that conjured up an image of service-losers rather than service-users:

> "they're told they're psychopathic [pause] erm if they erm...play the game...engage in therapy they're said to be manipulative...if they don't engage and erm [pause] take therapy they're said to be erm...deviant" (S1: 120-122).

It was not unusual for respondents to retell a story from the perspective of another person, or to use the reported speech of another. Respondent [P3] augmented personal reservations about therapy with the alleged experiences of a fellow patient, in suggesting that patients undergoing treatment mobilised different discourses according to the audience. The

respondent was keen to stress that no therapeutic boundaries had been violated, but therapeutic disclosure appeared to have an unofficial variant, where offence-specific details were shared with peers. The anonymous offender referred to in this account emerged as a skilled and intelligent performer, who graduated from the SOT programme with merit. At the same time as winning approval from the group facilitators, it was suggested the man felt angry and betrayed. In contrast to therapeutic talk as way of demonstrating reduced risk, here it was indicted as a dangerous farce; 'rape therapy' rebuked as a form of 'torture'. Rather than equip offenders with the skills to prevent recidivism, it was suggested that offending techniques had been refined by sharing new or novel acts of abuse within the group:

> "he went on the SOTP [pause] now he's kept the confidence of the group...he hasn't told me about the group...but what he's told me is about himself [pause] I've read his papers so I know his history...I know all his rapes...all the gory details [pause] this guy...is so fuckin' angry...he's clever too...he went in there...he became at the end of the SOTP the star patient [pause] 'Look what we've done for him...look how well he's done' [pause] He said to me 'I could go out tomorrow cut their fuckin' throats and hack the fuckin' heads off these motherfuckers...who've tortured my fuckin' mind with this sick fuckin'...rape therapy thing' He said 'I've learned more over there about fuckin' sexual offending than I even knew before I went in'" (P3: 2000-2015).

Previously, the respondent had talked, angrily, about the motivation of nurses who chose to work in a forensic setting. Talking about treatment, he had positioned patient participants as victims of the therapeutic process, but nursing staff were portrayed as parasitic on the inmate population, deriving vicarious pleasure from their stories. Like some of the nurses when they talked collectively about the patients, the term 'these people' was used to signal difference between the two groups:

> "these people [nurses] I've come to learn...actually enjoy people killing because if I hadn't...hadn't killed they would not be in a fucking job for Christ's sake [pause] they almost come off on it...some of them...talking to them [pause] and it makes me sick" (P3: 971-974).

Nurse [S16] also talked about the emotional cost of information transacted in therapy groups, but in terms of staff who facilitated the sessions. It was conjectured that the effect of prolonged exposure would challenge coping strategies, and impact on home life. The general reluctance of male nurses to become involved in sex offender treatment was implicit in the account, where tangible embarrassment accompanied the admission of having watched from the periphery:

> "Right but can they cope with the information they're getting? 'Cos it's hard Dave isn't it? I've watched...as I say I've probably seen a bit more SOTP than I like to let on y'know being honest and er I've...the hot chair etc...and lads y'know...and all that...and I think if you're facilitating that day in day out and reflecting on it...feedback...you take it

> home...don't care what anyone says Dave...you take the job home...can they handle that?" (S16: 1050-1055).

As with [P3], above, respondent talk shifted toward questioning why some nurses would elect to undertake this kind of work. The discussion was framed by the oppositional ideas of 'helping' or 'enjoyment', where the person who worked with sex offenders was measured against a *normal individual* with a *normal job*. Contact with an unpopular and outcast group was portrayed as shameful in comparison with the simplicity of manual labour:

> "Do they feel like they can help? Or do they enjoy it? 'Cos what average man...there's a stereotype scouser isn't there? Works on a building site...does whatever...talks to you in a pub and you say 'What do you do for a job?' 'Building site'...whatever...you say 'Oh I work with sex offenders' (.) A normal man's instinct...I say 'normal' loosely...a normal man's instinct...wouldn't it? It'd be 'Why the fuck do you work with them?'" (S16: 1070-1076).

This uncertainty, and doubt, contributed toward the respondent's explanation for refusing to be involved in offence-specific work with this client group. Rather bravely, though, it developed into a rarely articulated theme that emerged within some male nurse accounts. This related to a fear of identifying with the fantasy lives of men routinely designated as other. When the nurse talked about being scared of seeing something during his observation of the SOT groups, it was a reference to the dangers residing in self-knowledge. Ensuring that his meaning could not be interpreted in relation to 'kids', or any association with the paedophile offender, he carefully crafted a comment about male sexuality. Speaking, as 'a man', permitted him to hint at the attraction of 'older schoolgirls':

> "I am sometimes scared that you might see <u>something</u> in other offences that...now I don't mean obviously...about kids...young y'know and that...but y'know sometimes I've been over to them [SOTP groups] like and a fella's talking about like <u>older schoolgirls</u> like (.) <u>I'm a man</u>...you go past a school sometimes...so there's a bit of that as well Dave y'know <u>I don't want</u>...<u>I don't like</u>...<u>I wouldn't like to</u> [pause] <u>see something</u>" (S16: 702-707).

Similarly, respondent [S6] reflected on the relationship between the *sexual-self* and the *sexual offence*. As noted earlier, nurses often talked about a lack of incentive for patients to make honest disclosures that might imply risk. The same challenge was extended to group facilitators, with fantasy discussed as a component of male sexuality, where boundary violation was perceived as a lapse in clinical and custodial judgement. The format of the treatment group was premised upon an ideological difference between two sets of men who represented the normal and the deviant. In this context there could be no, overt, recognition that their respective sexualities might overlap:

> "I'm not going to go into my sexual fantasies...<u>but</u> I'd like to think they're fairly <u>normal</u> (.) erm...<u>I mean this is one of the</u>...one of the things I noticed <u>about</u> erm [pause] <u>sex offender</u>

> therapy is talking with...certainly [pause] again it's...it's like the sort of demonising normal behaviour [pause] if you're involved in it [pause] from a sort of staff point of view [pause] erm [pause] nobody is going to admit in public...as a member of staff....that 'I had the same fantasy the other night as he's just described...'cos he's an offender' [pause] If I was sat there...as a patient was describing some sexual fantasy about a young girl...we're not gonna go 'Oh I've had the odd one like that...I was fantasising about this fourteen year old'" (S6: 921-929).

In the discussion so far it has been noted how a concept of risk was fundamental to nursing talk, and assumed profound importance in the lives of detained men. Given the centrality that it occupied in the discourses of both sets of respondents, though, there was little talk about a shared approach to the assessment or management of risk. Rather, institutional culture, and relations, informed how risk was spoken about. Male nurses discussed an understanding of risk in terms of the amount of time which they spent in close proximity with the patient population, and the longevity of their relationships; where good nursing relied upon knowing the patient:

> "I've known people in here longer than I've known people outside [pause] it's incredible [break] so when it comes to assessing the risk that they pose...that [laughter] longevity of experience goes a long way in determining whether...whether or not you believe seriously that they're gonna do something which is a risk" (S17: 462-469).

The identification of risk was described, by most nurses, as 'gut instinct'. In contrast to the use of formal rating-scales or measures, these accounts saw risk as an unconsidered part of daily life on the ward. Calculating risk was seen as intrinsic to interpersonal interaction, where potential aggression could be signalled by changes in patient behaviour. Rather than a planned approach to predicting future dangerousness, it was spoken about as a way of coping with the present, requiring the nurse to be familiar with the personality traits and idiosyncrasies of their charges:

> "And they're the small things you pick up...and it's just knowing them...and it's just learning that gut instinct...and personality traits [pause] I mean that (.) when you work with people [pause] and you know their idiosyncrasies...and it's just [pause] it's a very hard one to put into words" (S10: 663-666).

It was not unusual for the male nurses to make casual reference to validated violence prediction tools, such as the HCR 20, but they seldom expanded on the utility of these instruments in relation to the PDS client group. Alongside the construction of risk as a visceral process, these accounts demarcated formal assessment strategies as the property of 'psychologists'; knowing through experience replaced by knowing through science:

> "there are scales that they use...er...psychopathy scales and this kind of thing which the psychologists get themselves involved with and erm that's another way of measuring that risk" (S17: 266-269).

Patient respondents were sceptical about ability of professionals to accurately assess risk. There was also agreement in disputing that such an exercise could be undertaken inside the hospital. Respondent [P5] expressed the opinion of a number of interviewees, articulating the contradiction of preparing individuals to lead a 'normal life' within the confines of an 'abnormal environment'. Combining the artificiality of his surroundings with a dismissal of research, positioned speaker [P4] as a subject of scientific interest, to be studied and tested:

> "It's [risk assessment] not realistic at all [pause] you're asked to live [pause] a normal life in an abnormal environment...it can't be done at all" (P5: 1569-1570).

> "I mean you've got to start somewhere [pause] and you can't do it [assess risk] in here [pause] it's no good doing these tests...and monitoring...and research and stuff inside here...that does no bloody good whatsoever" (P4: 630-633).

As with nursing accounts, patient respondents shared a discourse that understood risk in terms of experience, and sensitivity to subtle signs and signals. Patient [P3] portrayed his RMO as unable to relate to the lives of the men for whom he had clinical-legal responsibility. The account positioned the professional as different in terms of background, social class and education, where expert status was diminished by lack of familiarity with a male world defined in terms of toughness and physicality. To *speak* of violence was to *know* violence, which was only possible by *doing* violence; a discursive device which validated the account, while constructing a macho identity. Acknowledging the 'horrendous' impact of violence permitted him to assume the role of both victim and perpetrator:

> "'Have I been shot?' 'Yes I have there's a bullet hole in that fuckin' leg' [pause] So 'Have I been stabbed?' 'Yes I have...doin' me karate' [pause] and when I talk to people like [RMO] about violence [pause] who's never been in a punch up in his life...at school...quote him...hasn't got a [pause] well I can't pull these up [indicates trousers] a scar on his knee like most boys have...fall down playing...in my day [pause] I think 'Well where've you been living? You can't talk to me about violence...I've been there [pause] it's horrendous...I've had it done to me and I've done it to others" (P3: 1860-1868).

His suggestion that patients were better placed to identify risk drew upon an understanding of interpersonal relations that contrasted sharply with nursing talk of the ward as a family. The account, though, shared the idea that instinctive qualities aided survival in an unpredictable environment. Co-existence demanded winning trust, gaining familiarity, and asserting mastery. Real indicators of risk were non-verbal and, unlike language, could not be concealed or controlled. Nursing staff might manage the wards, but they could not be described as living there. Unseen aspects of patient sexual lives were used to illustrate how the professional remained ignorant of factors that might contribute to risk assessment. The inmate group, in contrast, had an informed and reliable network that derived from living in a confined institution with few secrets, and minimal privacy:

> "it's the same [dealing with patients] with an animal...you go up to an animal and you don't...and he'll come and you'll do something...and he'll sniff...and let him fuckin' sniff...let him lick...and you gradually go near...you don't grab hold of 'em...or whatever [pause] it's about body language [break] and there's another thing you see...in here as a peer group...we live here...you don't [pause] and I know...if he's shaggin' arse in that room down there...you'd never know [pause] a doctor won't know...but I'll know...'cos I'll see it...or hear of it...or something...or find it [pause] so I'll know more about you...if you're in here with me...than I would if I was living next door to you outside" (P3: 2041-2157).

Another variant of staff discourse [S1] saw risk prediction as an intuitive construction that informed the discourse of the care team. Here, the nurse functioned as a script-writer, chronicling events and re-telling stories, to produce one interpretation of life on the ward. Removed from any systematic interactions with the patient group, gathering information was akin to 'picking up' litter; caution informed clinical judgement, and observations informed assumptions which were then enshrined as facts in the text of clinical notes. The account illustrated how the opinion of unqualified members of the team, through institutional osmosis, was reconstructed as 'real risk' in the ward documentation. While there might be alternative explanations, these were unheard or drowned out by the 'noise' of a perceived 'high-risk' scenario:

> "they [nurses] would be involved at...at...at a couple of levels [in assessing risk] the first level is that erm [pause] they write the clinical notes most frequently...and they write what they intuitively feel very often Dave...they write what they erm...they've erm picked up across the ward (.) and what they pick up across the ward doesn't fall into what I'd call science or art...it falls into what I would call lay language [sigh] if a couple of nursing assistants think somebody's a high risk they'll make a lot of noises about that...those noises become quite erm [pause] difficult to resist...and that's the way that people on the ward will start to view...view the patient and so that's what gets written into the clinical notes on a very frequent basis [pause] 'He's doing...he's er perhaps sitting in a peculiar place in the day room' 'He's er...he's now stalking the females on the ward' erm 'He's sat in er...in er...in er...on a seat where he can view through the mirrors and the doors of the ward and the reflections on the ward' People in various activities...and really he could just be sat there reading a book...so we become hypersensitive...and then that becomes...that goes into the clinical notes...and those become real risks" (S1: 312-326).

Two interwoven themes in this account of risk, as an adjunct of maintaining order on the ward, are indicative of how nursing practice was talked about on the PDS; where lay language positioned the patient as a potential stalker, and females as potential victims. In the context of informal relations and a shared male discourse, women were constructed as the embodiment of risk, while their bodies embellished crude techniques of risk assessment. For nurse respondent [S6], working with detained men, identified in terms of diagnosis, was talked about as an art. Rather than specific nursing skills, or personality, it was 'personality disorder' that defined nurse-patient relations. Traits that were typically described as negative aspects of the patient population became the foundation for interaction that suggested a pathological, rather than therapeutic, interpretation of engaging the other. The idea that nurses needed to act in a similar way to the patient, framed life on the ward as a constant

struggle to prevent the 'PD' from 'getting one over on somebody'; an account that reinforced the construction of the ward as male space, and nursing as a masculine activity:

> "I would say there's an art to working with PD's [pause] erm [pause] I suppose you almost have to be one yourself...well you certainly have to understand enough to be able to be one [long pause] there's...there's always got [unfinished] the PD's generally...will always...it's part of their nature...they will always try and get one over on somebody [pause] there's always something going on...and it's a case of knowing what's going on...and knowing when to stop it [pause] and when not to" (S6: 241-247).

Inverting the usual interpretation of empathy in the care process, respondent [S16] shifted from talk about *being* like the patient, to suggest that he had *lived* like them. Couching this comment in terms of coping, again, implied survival and competition:

> "At times Dave I feel like I cope like...I can cope like them because I've lived like them" (S16: 403-404).

Situating the account in retrospective disclosure, he hinted at previous involvement in a criminal sub-culture that repositioned patient-professional relations. Past wrong-doings conferred a certain status on the wards, where professional identity could be reconfigured around the attributes of his *Jack the lad* reputation:

> "before I come here I was...thought I was jack the lad y'know what I mean (.) I was down south and all that so...and I feel like...one of the last admissions who come in [pause] erm worked for one of my cousins [pause] drug dealer [pause] y'know stuff like that which is [pause] totally wrong...y'know what I mean...but that's the way it is y'know" (S16: 412-416).

This masculine language framed the account in terms of knowing a type of *person*, as opposed to caring for a type of *patient*, and permitted the respondent to consider the use of threat as an effective nursing strategy. Rather than physical coercion, this equated to a contest, or mind-game, where mastery could be asserted through prescience and prediction:

> "sometimes it does them no harm to be talked to and to feel threatened by you (.) but not physically threatened (.) they're...they're threatened because [pause] this sounds mad but it's as though y'know you're one little bit ahead of them...you know what they're planning you know what they're thinking" (S16: 469-474).

A paradox in the way that they were spoken about meant women were constructed as the embodiment of risk, while their bodies embellished informal techniques of risk assessment. The same respondent [S16], who had spoken about his casual conversations with patients about female staff, offered examples of non-verbal signals that might have predictive value in relation to the potential dangerousness of a sexual offender. The behaviour of one patient,

while playing a wooden block game, for instance, alerted him to risk that was subsequently seen to confirm the suspicions of the care team:

> "I was made up because it come out that they [the care team] were worried...they were worried about his history of females and that [pause] and it just totally...it's hard to explain [laughs] y'know Dave but he went for the bottom one [block] and just made it topple because he couldn't concentrate while this girl was in the room" (S16: 145-149).

Elaborating on these sorts of behavioural cues, the respondent drew on the idea discussed earlier of an intuitive response or gut feeling. Here, though, the talk positioned the speaker, as a man, in relation to the other. This advanced beyond the claims of knowing the patient as a product of time, to knowing the sexual offender as a product of being male:

> "say a female staff's bending over picking something up and a patient's looking at her arse...I'm looking at her arse Dave...y'know what I mean Dave...being honest...right [pause] it's just y'know this is the first thing...it's the look and the...I don't know...gut feeling...my first impressions are non verbal shall we say" (S16: 658-662).

Beyond unspoken clues, one team leader [S8] outlined his expectation that nurses on the ward should exercise great care in recording, precisely, the comments of sexual offenders as they might relate to risk. Alongside accurate record keeping and staff safety, the account situated female nurses as a central resource in monitoring patient risk. The language used to illustrate sexual risk in this account was imagined verbal abuse, presented as though spoken by a patient, constructed sexual and physical attributes of women in terms of contempt and revulsion:

> "they [nurses] should record down...I think specifically...exactly what they say...when they say it to people...particularly female staff (.) like er if it...if it's quite sexual or...they call someone a...I don't know 'a fucking slut' or something like that...it's not enough to say well [pause] or if...someone's...I know it's a bit embarrassing but if someone...say...say someone's quite obese...a female staff or whatever and they say 'You fucking horrible...fat slut' or something like that...whatever...that should be recorded down verbatim" (S8: 568-574).

In patient interviews, women who worked in the hospital were talked about in gender specific ways. Typically, this related to feminine characteristics as a component of the professional role, or their sexual attributes in an all-male environment. For respondent [P6], though, interaction with female staff of all disciplines had been actively avoided because of the 'discomfort' it generated. If this man could exert some internal control by deliberately avoiding physical or verbal contact, he claimed that early attempts at therapy had provided no escape from the intensity of his enmity towards women. One-to-one sessions with a female psychologist had been terminated because of extreme levels of distress generated by enforced proximity with a woman. Attempts to deal with misogyny, or discuss offending,

were abandoned because the treatment process itself was likened to cruel infliction of suffering. Refusal to engage with women intensified, it was claimed, by the arrival of a female nurse who resembled a previous victim, identified only as a prostitute. In a rigidly dichotomised construction of women, physical appearance demarcated those worthy of respect, and those deserving punishment:

> "Miss [psychologist] said that...it's not as though [respondent] doesn't want to try...it's not as though he doesn't want to get in therapy or whatever but...it would be a cruelty for our sessions to continue...the discomfort he has...with a female therapist...the discomfort and unease he feels in a female's presence [pause] so that was certainly majorly still there...I wasn't speaking to female staff...I ignored female staff when I was on the wards [pause] if I wanted a telephone call done...or anything...what it was...I was always requesting male staff...if a female staff come up and said 'You've got a visit'...'Yeah ok fine' (.) It was abrupt and this kind of thing...and then when that female staff started on the ward...bore a striking resemblance to the prostitute that I'd just assaulted [pause] so no way was I...did I speak to her...and that went on for five years...not a good morning or nothing" (P6: 415-426).

Respondent [P3] named a number of women who worked in the hospital as being willing to attest that he was no longer a risk; an assertion based on his having not sexually assaulted them when there had been the 'opportunity'. One particular female nurse, though, became the central figure in an imagined scenario that conjoined sex and violence, and the account contained an anecdote that completely sexualised the concept of a nurse-patient relationship. As metaphor, the rhythmic cadence of the language used to describe the woman resembled a pornographic script, with the listener invited to imagine the events of a hot summer's day; where the dress, perfume and posturing of the nurse was sufficient to produce an erection. Here, male arousal defined masculinity, and set the normal man apart from the 'queer':

> "I can produce right here and now...women in this hospital who'll say 'Bollocks' [pause] Who...where there's opportunities been...and [name of a female nurse] is one of them [pause] the times I've fuckin' sat there with an erection and said 'Oh fuckin' hell [name of female nurse] get out of here'...'Why?'...'I've got a fuckin' hard on'...'Have you? Ooh I'm flattered'...'Yeah bollocks you might be but...' 'Cos we had a good relationship [pause] I could have grabbed hold of her in that room [break] find me somebody more attractive...sexually [pause] back in eighty four than [name of a female nurse] [pause] that'd wind any anybody up [pause] right there...I'm talking about...as it was [pause] imagine a hot summer's day [pause] she comes in...see through skirt...you can see everything...plonks herself down...hitches her skirt up...da de da de da de da...it's...fuckin' hell that perfume's nice [pause] stuck out [indicates nipples] like chapel hat pegs [pause] and I'm sat on me bed...come on you'd have to be queer not to get an erection" (P3: 1871-1889).

If desire proved difficult to temper, restraint was exercised, and the nurse was asked, or instructed, to leave his side-room. She was described as responsible for his arousal, but he took responsibility for managing the situation. The attribution of her being flattered, further, constructed the nurse as a passive sexual being. Though prominent in the account, she was silent, and there was no reported response aside from laughter and an intimation that she delighted in her sexuality. If the nurse was *powerless*, the patient was *powerful* and exerted

control where offending would have been easy. Framing the facade of good humoured banter, that permeated the account, was the possibility of a more sinister course of action; where the female nurse was portrayed as vulnerable in an environment controlled by the respondent. In this scenario, 'force' served as euphemism for sexual aggression, consent was irrelevant, and the nurse became a hostage. Sexually violent assault was discussed as a sexual act, and the likelihood of the victim reporting this was interpreted as vengeful, where rape did not involve the victim being hurt:

> "Now if the desire was there [pause] I could have shut that door [pause] or anywhere in the hospital in those days 'cos there was all sorts of occasions...and she could have been forced...or I could have said 'I'm going to give you one whether or not' [pause] Right? [pause] And she'd have had no choice...she'd have to lay there and cop it...and then scream when she got up to the office...if you like [pause] if you follow me point...without her being hurt [pause] but nonetheless she'd have gone up there and said 'He just...forcibly had sex with me'" (P3: 1896-1902).

Using almost identical language, patient [S1] highlighted the interwoven discourses about sexuality and sexual offending which permeated the masculine culture of the hospital; so that sex and rape could be used interchangeably. It is conceivable that, for detained men in a strictly controlled environment, women staff could easily attract sexual attention. Arguably, though, the marginalisation of female nurses compounded, and reinforced, a commonly held perception of their vulnerability. In the rigidly gendered world of the institution, talk about relations between male patients and female nurses evinced the ever-present threat of violence, and the collective fear of women. Sex, in this account, was equated with the obligation and ownership conferred by marriage, so that rape became the violation of male property. The 'law' and hospital 'rules' were spoken about as synonymous constructs that imposed penalties on men, and offered protection to women. For the respondent, the possibility of *committing rape* within the hospital was easy to imagine, but the *inclination to rape* was extended to 'anybody'. Ideas about female nurses 'consenting' to 'have it', and 'complaining' about 'rape', positioned men as potential victims to the duplicitous accusations of women:

> "I think 'Well yeah she's [a female nurse] nice [pause] I wonder what she'd be like to have sex with?' [break] But she's married...so [pause] fair enough [pause] and then I'll think 'I can't have sex with her [pause] because [pause] they wouldn't allow it [pause] she wouldn't...let me [pause] and it's against the rules...and against the law' [pause] And even if she turned round and said 'Yeah...you can have it' [pause] What's to stop her from going...and complaining after that I've raped her...even though she said 'Yes' [pause] If she said ' Yeah I can...have sex with her' Then if she goes and says I raped her...I'm in more trouble then [break] and I think 'Well it must be frightening for them' [pause] Fair enough...there's an alarm there [indicates the panic button] but [pause] if there was a blind on that window [pause] I sat there...female sat here [pause] what would there be to stop me...jumping up...pushing her over onto her back...and raping her? [long pause] Well not just me but anybody" (P1: 1344-1349).

Summary

The chapter has introduced an unanticipated, though central, finding of the study which is further developed in the remainder of this section of the thesis. Analysis of male accounts, both nursing staff and patient, revealed how the discourse of men about life in a secure hospital contributed to the construction of a masculine culture. Most notably, it established how an informal alliance between these two groups of men defined institutional space, particularly the hospital ward, in male language; where the concepts of 'family' and 'security' symbolised male bonding in a macho world. Female nurses featured little in the way that male respondents talked about everyday life in the hospital. Typically, female nurses were spoken about only in terms of sexuality or risk, two themes which conjoined to accord women staff a marginalised status on the wards.

In an environment where male staff and patients described themselves as isolated within the institution, the ward represented a shared territory talked about in terms of, both, commonality and discord. But, this was a male space, textured by talk and gendered ideology, which framed discussion about formal and informal aspects of nurse-patient relations. Within a rule-driven and ritualised regime, men talked about passing time, playing games and game-playing, where otherness was contextually mediated through language. It was suggested that male staff used talk about the ward as a 'family' to identify with a group of patients as men, but could initiate a stigmatising discourse to maintain a social, and symbolic, distance. Male accounts constructed the hospital as a tough world, where risk was something men instinctively knew about, and presenting a macho identity defined a way of working for the staff, or a way of surviving for the patient.

Overall, the chapter discusses the way that language plays an important role in managing and maintaining distance in a secure and highly regulated environment. It suggests that the affiliations and groupings that characterise the micro-level interactions of the ward are far more subtle and, precarious, than the duality between the staff group and those who are locked up for treatment. This is different to much of the published literature on therapeutic custody that talks about these roles as fixed and enduring, reified in the power relations of forensic psychiatric practice and predicated on a legislative practice of indeterminate detention. Rather, an analysis of discourse provides an understanding of the way that identity and status (as patient, prison-transfer, nurse or health professional) is fluid and renegotiated. This is important because it has a direct impact on the discursive practice of nursing, so that concepts such as 'care' and 'treatment' cannot be uncritically accepted outside of the environment in which they are spoken about.

The next chapter is, again, focused on the shared discourse of male respondents in relation to pornography as a healthcare issue in a treatment environment for detained sexual offenders. Building on the ideas discussed above, of gendered exclusion and discrimination, male talk about sex and sexuality offers a way of exploring the construction of female nurses working in high-security care as 'other'.

CHAPTER 5

Men and pornography: Discourses of sexuality and sexual deviance

Introduction

This chapter explores how male respondents talked about pornography, and the commonalities in language-use between nursing staff and detained sexual offenders. Previously it was noted that these two groups of men, who could define each other in terms of difference, shared a common discourse that reflected the patriarchal culture of the hospital. Here, it is suggested that while talk about pornography-use within the hospital operated as a discriminatory device, delineating the normal and the deviant, it embodied a set of assumptions about male sexuality that permeated the accounts of men who participated in the study. The chapter is divided into three sections that focus on the way respondents spoke about their understanding of pornography, how mediated imagery might relate to sexual offending, and the management of sexual materials in the hospital.

The first part looks at how respondents defined pornography as something that they knew about as men. The accounts were constructed around talk of gratification and arousal, which focused on the function of sexual media as much as the content. If pornography could be seen as facilitating a healthy male need to masturbate, this was compromised within a secure setting by what were described as unhealthy sexual interests, where a range of mundane items and objects were inscribed with erotic value. Normal men might use pornography to enhance their sexual lives, but another group of consumers were portrayed as susceptible to negative effects; a distinction that constructed the personality disordered sexual offender in terms of deficit and dysfunction. Respondent talk about commercial sex magazines representing the subordination of women, and deviant pornography purveying more harmful images, was permeated by a masculine discourse that understood heterosexual relations in terms of gendered inequality; where male sexual arousal was linked to the exploitation, or suffering, of women.

The second section of the chapter looks at how respondents used language to position pornography in relation to sexual offending. As a product of experience, the construction of the accounts differed between the two groups of men. Patients were not required to talk about specific crimes, but often alluded to their own offences, while nurses conjectured on the basis of having worked with the perpetrators of sexual violence. Staff tended to describe the detained men in terms of chaotic lives, sexual abuse, and histories of institutional

confinement; where the use of pornography compounded a range of social or emotional problems. Patients did talk about pornography as a feature of custodial settings, but exposure and access was about belonging to a larger male community; where obsessive interest in specific types of sexual media could blur the line between fantasy and reality. Fantasy was talked about as an unquestioned aspect of male sexuality, but the ability to exercise self-restraint enabled nurses to normalise pornography-use while dissociating themselves from the men in their care. However, a shared discourse permitted men to talk about women as property, or commodity, and to discriminate between deserving and undeserving victims of sexual violence. By constructing the child as emblematic of innocence, nurses depicted the child-offender as iconic of otherness.

The final section explores how a series of discourses organised respondent talk about the management of sexual media in the hospital. Exercising control of pornography could be spoken about as a clinical issue in the context of a therapeutic regime, or the need to maintain order in a rule-dominated institution. But, it was only in relation to the sexual offender that sanctions were discussed without ambiguity. In a world sanitised of adult sexual materials, ideas about pornography and danger merged in talk of the deviant imagination, with the paedophile offender at the centre of policing strategies.

Situating pornography within male talk

For male staff and patients, alike, pornography was typically understood as a product designed and manufactured specifically for the purpose of sexual gratification, and generally described in terms of function and outcome. Their accounts constructed pornography as a source of stimulation, with the user defined in terms of sexual frustration, which acted as a vehicle for the release of sexual energy:

> "I think that erm...it's a quick fix for erm sexual frustration" (S1: 616-617).

> "I suppose it's any sort of er literature erm [long pause] images [long pause] that might erm...stimulate arousal in an...in an individual [break] yeah the main function...I mean...I suppose erm...another function could be relief...from sexual sort of er...frustration" (S9: 177-184).

Respondents tended to draw on personal experience as men rather than any theoretical perspective, though patient accounts were often informed by the language of the sex offender treatment programme. Pornography was something they felt confident to talk about without recourse to any external reference points. Nurse respondent [S2], for example, talked about a stimulus to generate pleasure that did not rely upon a recognised definition; rather, it was a subject that could be spoken about 'off the top of his head':

> "Pornography I would...I would say...this is obviously off the top of my head...I wouldn't say it's like a...er...er a definition erm from the *Oxford English Dictionary*...but I'd say pornography is...a stimulus somebody uses for...to gain sexual...er pleasure" (S2: 4-7).

Gender inequality was fundamental to the way pornography was defined. If there was consensus about the function of pornography in terms of arousal and pleasure derived from depictions of sexual acts, relations between viewer and material were rooted in a heterosexual and masculinist ideology. Respondent [P2], who claimed little personal interest in pornography, understood such materials as displays of the naked body. But, it was women who defined the genre through the exposure of their bodies in a way that was described as 'flaunting themselves':

> "Oh [long pause] women with nothing on [break] women flaunting themselves" (P2: 591-606).

Likewise, patient [P6] discriminated between types of sexual imagery by using language that was grounded in male knowledge. Pornography, distinct from tabloid glamour shots, was marked by specific titles, such as *Fiesta*, which could be subsumed within a larger category of 'girly magazine' where typical contents exhibited women's bodies in graphic detail; publications purveying a social and sexual positioning of women that was about exposure, availability and access:

> "I mean to say...there's people order *The Sun* and things like that and you've got page three and all this kind of thing [pause] but I'm talking about graphic detail...legs open...vaginas seen...typical girly magazine type thing...*Fiesta*...all that kind of thing" (P6: 825-828).

Respondent [P7] acknowledged that the subject of pornography generated passionate and polarised discussion, where multiple interpretations could be ascribed regarding function and effect. However, it was maintained that, intellectual or political perspectives aside, sexually explicit media were fundamentally defined by the gratification they produced for the consumer. This was a debate that existed in a polarised world comprised of 'feminist' women and 'misogynistic' men:

> "whatever underlying meanings pornography may have...er whatever feminists may read into pornography...whatever misogynists may read into pornography...I think the underlying and the most basic principle of pornography...is that it's there for your sexual gratification" (P7: 702-706).

Further, the respondent identified pornography as a script for male sexual relations premised on the hurt, or exploitation, of women. It was conjectured that some men who participated, as performers, in the sex industry were afforded the opportunity to 'treat women' in a way that would be unacceptable in the context of their 'normal lives':

> "Now there must be [long pause] and I wouldn't say everybody does it [pause] the male performers in pornography [pause] there must be a high percentage of them who want to treat women like that...and can't in their normal lives" (P7: 1304-1311).

Respondent [S15] tendered a definition of pornography that was framed in a familiar, and taken for granted, language that conveyed male meaning. When applied to videos or books, the concept of 'hard-core' suggested explicit depictions of the 'full sexual act'. Located in a heterosexual discourse, these materials contrasted with filmic representations that suggested sexual activity in the absence of close-up photography or naked bodies. If the respondent was clear about what constituted the pornographic, though, there was less certainty regarding sexually explicit media that was seen to have an informative or educational goal. This uncertainty featured in the accounts of most respondents, and illustrated how pornography was situated within an environment where decisions had to be made about what was appropriate for patient consumption:

> "I've always considered pornography erm like hard core to be er y'know videos or [pause] books [pause] depicting [pause] y'know the full sexual act within...y'know in explicit terms and I'm not talking about like in a film where you'll see a man and a woman...obviously they're in bed together [pause] and y'know they're having sex...where you don't see...you don't see any close-ups of er y'know the woman naked or the man naked or anything...anything that's sort of explicitly y'know showing a couple having sex [pause] I mean I suppose then there'll be erm an argument to counter that might be...if there's er [pause] there's like an informative book about sex where it's y'know you get these sex manuals y'know *How to Make Love...How to Improve Your Sex Life* and all that sort of stuff where y'know they do...they do show these acts [pause] and that y'know there'd be the argument there whether that's considered [laughs] pornography or whether it's not [coughs]" (S15: 700-710).

When this nurse was asked how mediated images which portrayed similar sexual acts could be differentiated, the response was organised in terms of what the viewer might expect to see in hard core materials. This portrayed a particular kind of representation, and a way of looking, that positioned women in relation to male pleasure. Beyond explicit depictions of sex, hard-core pornography purveyed coercive sexual encounters, appearing to be 'little more than rape', where the consent of women was questionable. It was a type of media that objectified women, and presented gratification from a 'man's point of view':

> "I think the hard core...to me some of it depends on erm y'know whether it looks like...whether it looks like the woman is consenting y'know to what is going on erm (.) 'cos y'know you see...you see some stuff like porn stuff where it might [long pause] some y'know...some of it looks like little more than rape to be honest and it all...it's all it all seems to be there just from the man's...y'know from the man's point of view...for the man's pleasure and the women are just there to be...well the woman's just a sex object really and doesn't y'know know that the...that like they wanna be there really (.) it's...they're doin' it...it's just...it's not her gratification it's just the man's" (S15: 717-725).

For nurse [S17] pornography signified the separation of sexual behaviours and sexual relations, and included representations of the sexual act that ranged from the impersonal to the illegal. Not restricted to the exploitation of women, the scope of the male pornographic imagination was extended to embrace men, children and animals. Such materials, it was suggested, diminished the humanity of its consumers in offering a distasteful and hedonistic substitute for meaningful sexual encounters and intimacy:

> "I think where individuals are treated as objects...where there's no...offering of human companionship or what we term love or feelings toward others...it's just mechanical showing of the sex act in order to stimulate [break] erm and any kind of sex act which...whether it be with [pause] men...women...animals [pause] er children etc" (S17: 915-923).

Male nurses routinely endorsed the total restriction of sexual media for patients with a history of sexual offending, but this did not always preclude consideration of what was described as a physical-sexual, need of men. Masturbation was understood by respondent [S5] as a fundamental component of male sexuality, and pornography was credited with a singular function as the stimulus required for solitary sexual pleasure:

> "I still sort of believe even though someone's got a sexual offence they still obviously need y'know...a physical need for y'know...to masturbate or whatever (.) erm because they're still male and they still need to masturbate (.) now whether that be over a magazine or whatever" (S5: 808-812).

For nurse [S14] the issue was again framed by heterosexual interests, and pornographic images were seen, in a male dominated setting, to be a 'fairly natural' substitute for women. Couching this comment as reflecting the confusion between 'healthy use' and 'misuse' of pornography shifted the focus from the material to the consumer, in the same way that nurses talked about normal men and the other. Later in the chapter it will be noted how a distinction between sexual representations, and the 'real thing', assumed prominence in the way nurse respondents articulated a role for pornography in the aetiology of sexual offending:

> "I think to myself...you've got a lot of men without sort of women and...without sexual stimulus in the kind of heterosexual way...wouldn't it be kind of fairly natural for men in those circumstances to want to see...sort of pornographic images [pause] so I think the two things are very confused y'know...what's healthy use of pornography...as opposed to an adverse kind of er...misuse of pornography" (S14: 1348-1353).

Reflecting on the hospital in more 'lenient' times, this nurse remarked that decision-making about patient access to pornography had previously been the responsibility of the psychiatrist, where the criterion was sexual explicitness (erect penis) and biological function (insertion). Depictions of sexual behaviour, rather than sexual-political positioning, became

a recurrent theme in exploring what staff and patients thought was appropriate for a treatment setting:

> "we've gone through kind of erm...a time in the eighties when things were lenient...and early nineties w here doctors would say...erm 'You can't take pornography off patients because it's not pornographic unless there's erm an erect penis er...or there's insertion'" (S14: 1343-1446).

Suggesting it to be 'anything which creates sexual excitement', respondent [P4] shifted the definition of pornography from conventional, and commercial media, to more obscure items framed by sexual *context* as much as sexual *content*. This construction of pornography was indivisible from sexual excitement, and combined representation and interpretation of some*one* or some*thing* with erotic meaning invested by the viewer. Rather than what might be defined as pornographic, the question was reframed around what was actually excluded. If they produced arousal, linked to the sexual interest of an individual, everyday items could be said to constitute pornography. Instrumental understanding was not restricted to masturbation, and experiencing 'sexual excitement' as a by-product of reading was sufficient to convey the descriptor of pornography to an image or object:

> "pornography is anything which...creates sexual excitement [pause] within a person...that is an image [pause] er rather than the...an actual person or an actual object [pause] so erm...a shoe...if somebody has a shoe fetish then er...er a shoe catalogue has got [laughs] to be...pornographic [pause] er if it's used in a way which will...excite...while masturbating [pause] or...or even just reading it...if it gives sexual excitement" (P4: 885-890).

Nurse [S1] also commented on the attribution of sexual qualities to inanimate objects but, though the account appeared remarkably similar, it illustrated the way that language-use constructed profoundly different results based on the social status and positioning of the speakers. As discussed in chapter four, male nurses shared the masculine space of the ward with men that they routinely designated as other. Here, the idea of footwear providing a 'sexual kick' was deployed to distinguish between people one might conceivably know and those, by implication, one could never know:

> "of the people I...I think I 'know'...they wouldn't see erm some of the things these people see as pornography as...as...as giving them a sexual kick (.) erm...I mean I know people in there who...who erm...who get a kick from seeing a shoe...and seeing a fuckin' sock [pause] they're not sexual...that's not sexual or pornography...but it is to those people in there" (S1: 460-465).

Like other men, patient [P7] talked about pornography as a commodity that could be bought, or borrowed, to provide a source of sexual entertainment and excitement. But, it was also invested with social currency, where the anticipation of being 'turned on' was transacted between men. Exchanging pornographic materials, it was suggested, was one way men could

relate, or signal, sexual interests in an impersonal and indirect way. Using pornography for sexual gratification could be seen as a surrogate for sexual relations, or dissatisfaction with a sexual partner. This was described as balancing emotional and physical needs, where pornography offered a vicarious way to regain a sense of potency. Used, in the same way as women, to make men feel better, it provided a sexual manifesto where performance and prowess defined masculinity; and to fail as a sexual athlete was to risk humiliation as a man:

> "I think people buy it...or view it...or pass a video to a mate hoping that they might find the same...or they may get a videotape off a mate and think 'Oh I'm going to watch this...and yes I am getting turned on' And that's what it's about...it's about getting turned on by it [break] you may be dissatisfied in your relationship sexually [pause] your relationship with your wife or your partner may be absolutely brilliant but sexually it may be a flop [break] in terms of...your partner or your wife may not do something that that you want to do [pause] it could be [pause] that you're not exactly [pause] a stud in the bedroom...and you feel inadequate [pause] so to assert your...masculinity in a way...you've used somebody else...doing something that you would want to do" (P7: 710-732).

Pornography was described by respondent [P5] in a way that attested to the normality of sexual media in everyday life, and relationships, outside the hospital; confined within an ideal of heterosexual marriage, and based upon consensual pleasure. The agony-columnist of tabloid journalism became an arbiter of sexual health, where it was unquestioningly accepted that men would use pornography to compensate for, or enhance, sexual relationships:

> "It's normal [pause] married couples [pause] have pornography...you read it in the papers [pause] 'Oh I came home last night and I saw me husband there...with this magazine...I thought good god am I not enough for him? [pause] So I sat down and I spoke to him about this...what is it all about? Blah blah blah blah' [pause] And it's perfectly healthy...every man does it [pause] so says the health doctor...like Doctor Miriam in the er *Daily Mirror*" (P5: 1683-1688).

Similarly, nurse [S5] discussed the use of pornography as a fairly innocuous feature of adult sex lives. Legitimated through its incorporation within 'normal heterosexual' relationships, it could be consumed without detriment. In stark contrast, divorced from any social or emotional context, the collective body of offenders prompted talk about a *different type of being* and a *different type of use*. Sexual crime was seen as a loss of control where, in the absence of appropriate avenues of expression, the stimulation of pornography became dangerous. If normal men supplemented their sexual lives with the addition of pornography, the 'real thing' was only available to the offender through 'maladaptive' means:

> "I mean most normal adults can...can sort of fluctuate can't they between normal heterosexual sex relationship and additional pornographic material...or whatever is used to stimulate erm...these people can't (.) erm...they'll have the pornographic material which obviously stimulates them to a certain degree...and then they can't obtain the real thing...as to say without being maladaptive or committing an offence" (S5: 876-881).

Nurse respondent [S10], commenting on pornography as a product of the sexual entertainment industry, referred to particular acts as a 'game' in a way that suggested spectator sport. The participants were described as 'paid artists' who adopted a role and provided a simulated service for the viewer. There was a threshold, though, where transgression undermined the legitimacy of the industry and redefined the product in terms of disgust and revulsion. Personal morality established the division between what was considered to be appropriate, and that which was dismissed as deviant, in terms of both the material and the user. The graphic representation of sexual intercourse, from basic to less conventional activities and behaviours, was seen as acceptable to the extent that it was enacted without apparent harm. Normal types of pornography simulated normal types of sexual behaviour, while deviant pornography was defined by association with the abnormal. The frequently mentioned concept of deviant or abnormal pornography emerged as an elastic category that served as a repository for any sexualities, or sexual practices, outside a hetero-normative worldview. Illegal behaviours such as bestiality were, unquestioningly, coupled with same-sex activity in a way that conveyed pathology, dysfunction and disease:

> "Pornography is (.) I mean...I don't know what to call it...a group or two people whatever...indulging in sex for purely...for someone else's pleasure...for someone else to watch on...on camera er it's paid artists performing a game for others to gain pleasure from...and that's my idea of porn (.) that's it and some of it's...porn is like [pause] sex acts...some of them...when you look at them it involves...animals...everything else and you think 'My god it's not porn it's just...it's filth' I said basic sex...and group sex is porn (.) that's porn...fine...if they do it it's not harming anyone that...but it's when you see the deviant side of it...and you think 'My god...that's woeful'...that is like involving animals er...anything that's abnor [unfinished] you class as abnormal...whatever individual's views are...I mean to me it's a [unfinished] animals er [pause] basically homosexuals...I mean fine...this is my point of view and it's er [pause] and I think also...I mean is it sado-masochism? Beating each other to pulp...and you think 'My god like'" (S10: 798-818).

Embedded in this account were a series of linguistic manoeuvres that permitted the respondent to identify certain types of pornography and people as deviant, while legitimating its use for another group of consumers. Adopting a defensive posture the respondent reiterated the caveat of 'harm' and 'offending', as factors that would disqualify certain materials or behaviours, within a discussion of sexual and social freedom. A broad definition of pornography that included 'swingers parties' was acceptable because it was watched, or enacted, in the private sphere of the home by people who chose to engage with it for enjoyment. Again, a masculinist construction of sexual relations informed an account where pleasure was spoken about and defined in male terms. Women were commodities, referred to in terms of ownership, for swapping or trading like the hypothetical 'wife' who could be 'thrown in' to 'have sex with strangers':

> "there's several ways of looking at it isn't there? [pause] People go to swingers parties and just throw their wife in...or whatever...and have sex with strangers...it's fairly...classed as pornography and whatever...it's all wrong (.) as long as it doesn't harm anyone...fine...as long as they're not offending or harming anyone...I mean it only offends people if they buy it and watch it (.) don't buy it and watch it (.) I have no problem with porn at all...none whatsoever [pause] as long as it doesn't involve animals but porn...a piece of porn...so what? But the people who buy it are the people who wanna buy it...it's not necessarily...it's on telly so anyone can buy it and watch it...it's not...so let it be...and let it be...let people enjoy it" (S10: 835-844).

This type of distinction was a characteristic feature in the talk of male nurses, where personal opinions were juxtaposed with professional judgements. The assertion that he was not shocked by pornography-use in the context of the domestic sphere allowed respondent [S8] to locate the issue within a moral debate about types of *people* rather that a type of *product*. Here, the idea of an 'attitude' towards pornography was flexible, and dependent on the character of the individual:

> "my own personal view of pornography is that...erm [pause] if...if people want to watch it that's fine y'know as long...if...if that's their...if they want to watch it in their own...in their own home I've got no problem with it at all [pause] y'know I don't...I don't feel like particularly shocked or...or whatever or puritanical about it...it doesn't bother me [pause] but in here you're gonna have a different...a different attitude because you're dealing with people that it...maybe it has contributed to what they've done" (S8: 762-768).

Though respondent [P7] had suggested pornography could be understood as a substitute for sexual relations for men who were lonely or unskilled in developing meaningful relationships, its use also offered an exciting escape from conventional aspects of life. It was contended that tensions between the normal and the deviant could not be sustained, with 'two worlds' becoming inseparable. The pornographic imagination was described in a way that implied dissatisfaction, and dominance, over the limited sexual repertoire of a stable relationship. In the next section, it will be noted how this became a central strand of this man's account of sexual offending:

> "They may be in a stable relationship [pause] they may be sneaking downstairs at night...to have a look at porn on the Internet [pause] y'know what I mean...and then going back to bed...with their wife [break] you can't...you can't have two separate...'Well I think pornography's great...I think what they do in porn films is brilliant and I get really turned on by it' (.) And then go back to having a kind of...a...I don't know...a normal relationship or a normal sexual relationship with someone...it might be the missionary position once a week [pause] I think there has to be a welding together of two...of the two worlds" (P7: 636-648).

Beyond being a stimulus for masturbation, pornography was seen as providing some form of mental gratification, and the respondent distinguished between using pornography to achieve short-term sexual satisfaction, and a search for meaning that operated at a higher level. Pornography, here, conveyed more than erotic imagery, it offered a discursive script about sexual relations that positioned the male viewer in relation to the viewed woman. For this

man, 'mental gratification' derived from materials that depicted gendered inequality, where vulnerable and victimised women transformed pornography into a template for sexual relations:

> "sexual satisfaction is just something that is quick...brief [pause] right? A mental gratification is [pause] I like seeing people in that position [break] I [pause] get off on...seeing people in that position [break] well pornography [pause] by and large is the subordination of women isn't it?" (P7: 231-239).

Not only did pornography offer representations of sexual-power relations between men and women, it was the physical embodiment of those relations, with male pleasure rooted in the subordinate positioning of women. In contrast to celebrating male pleasure, female sexuality was absent from the account, and women were defined in terms of the use that could be made of a passive body:

> "and it's all...always to do with the [pause] from the pornography I've seen...it's always been [pause] for the pleasure of the man...rather than any pleasure for the woman [pause] the woman...the woman always seems to be used in some kind of...just a body capacity" (P7: 257-263).

The respondent described a range of pornographic materials, based on having viewed them, that were described as ranging from the 'very tame' to 'porn depicting rape', 'child pornography' and 'bestiality'. If the content of pornography determined where it would be allocated on this continuum, it was the subordination of women which actually defined the material. Because this included materials that were legally available was seen as offering approval to view women in a way that diminished their social or sexual worth. To use commercial pornography was a matter of individual choice, which implied acceptance of a particular version of sexual relations. This differed markedly from pornography depicting violent sexual behaviours such as rape or child abuse where an extreme form of sexualised materials constructed a specific client group:

> "I've seen all sorts [pause] erm...ranging from the very tame...erm...man and woman to...bestiality (.) child pornography...erm [pause] porn depicting rape...etcetera etcetera [break] there is [a difference]...because with...on the one extreme you've got the subordination of women in pornography...er [pause] that's a legalised form of pornography [break] I think by and large people...in a majority accept that that type of pornography is...going to subordinate women...er [pause] some people may not like it [pause] but they watch it [pause] er others don't like it at all...and never watch it and then you've got the other class of people who actively seek out [pause] pornography" (P7: 268-317).

Described as inhabiting a secretive and subterranean world, this 'other class of people' shared deviant interests, and sexual materials related to personal predilection had to be actively sought out. Such pornography could not be publicly displayed or traded, and

consumption was based upon affiliation, membership and trust. This group of men were seen as having the potential to offend, and the pornography they shared was indicative of sexual identity and sexual intent:

> "I think even at the age of twelve I had a sort of [pause] a predilection for...people younger [long pause] so [long pause] I sought out that material [pause] er [long pause] it wasn't...difficult [pause] you had to be trusted by the other people (.) erm [long pause] yeah...you had to be trusted by the other people [pause] in order to gain access to that material" (P7: 763-774).

It was suggested by respondent [P4] that the paedophile, as a particular type of sexual being, might consume materials featuring children where there had been no sexual intent in the production of the image. If this was distasteful or disturbing, no law had been violated, no child had been harmed, and no offence had been committed. How the use of any image, within the context of a pornographic imagination, translated into sexual offending was less clear. Echoing an addiction model, he noted that preoccupation with a particular type of sexual imagery might lead to a search for more extreme variants. Conversely, misuse of material might provide a cathartic experience for the expression of deviant, or socially inappropriate, sexual interests. Again, the tension between external constraint, and internal predisposition, assumed a central position in discussion about the institutional management of sexual materials:

> "It's what effect it has on a person [pause] ok...you could get somebody [pause] that is a paedophile...that doesn't buy...pornography...any child pornography...made...where children have been abused in order to...to obtain it [pause] he looks at...I don't know erm...catalogues...with er children's clothes and stuff like that in which...by using it for the purpose he's using it for...for stimulation...erm is now...it could be classified as pornographic [pause] but...it hasn't in actual fact...damaged the original children that took part in it...because they were just...they were modelling clothes...right? Now [pause] where it's bad is if it stimulates the person to...want more...and therefore they go out and offend against a child [pause] so...but there could be others equally...which...it gives them all the satisfaction they need in their lives and they never harm a child [long pause] so how do you draw the line? Well y'know it's down to an individual isn't it?" (P4: 918-929).

Respondent [P6] defined pornography and sexual arousal in a way that was inseparable from sexual offending. He talked at length about an obsessive interest in detective magazines, particularly the front-cover artwork, in relation to fantasy constructions that approximated to his pattern of offending. The sexual potency of the images resided in the vulnerability and helplessness of a woman, disabled by physical restraint, and terrified by the anticipation of inevitable violation. The presence of man, the aggressor, outside the frame and barely visible, signalled a suggestion that the woman was going to be assaulted. The infliction of pain, production of fear, and promise of death, were translated into an erotic expression of the ultimate punishment for women:

> "It was the cover...right? It depicted a...a woman bound and gagged...on a bed...and all you saw was a man's hands...you couldn't...y'know a man's hands like that [gestures] so you just got that in the shot...and he's undoing the buttons...and the look of terror on that woman...and she's going to be assaulted...another one depicted a girl in...and they're always scantily clad...they're always in underwear...they're always in scenes of major terror...and the fear that were on their face...erm strangling someone and she's like that...always the underwear" (P6: 885-891).

Pornography, fantasy and gratification: sexual pleasure and sexual offending

This section of the chapter looks at how respondents talked about sexual offending, with particular attention to the ways that pornography featured in their accounts. The patient group were not required to talk about their offending, but often did, while nursing staff spoke from the perspective of having worked with perpetrators of sexual crime. Though the accounts were situated in very different life experiences, the respondents drew upon cultural, and institutional, repertoires that shared the same discursive territory; where pornography and sexual offending could be accommodated within the language of male sexual pleasure. If patient respondents spoke easily, and fluently, about something of which they had direct experience, nursing staff often struggled to formulate responses about complex aspects of human behaviour. On being asked to provide a definition of sexual offending, it was not unusual for the nurse's responses to be brief or tautological. The lack of sophistication with regard to legal and theoretical frameworks was surprising given the jurisdiction of the forensic nursing role:

> "I suppose it's when one person commits an offence of a sexual nature against another...person (.) erm [breaks off]" (S5: 293-294).

> "[long pause] I've never considered a definition (.) but erm...off the top of me head [breaks off]" (S1: 179-180).

> "I don't really...I can't put me fucking finger on it" (S8: 308-309).

It was noted in the previous chapter how nurses used language in a way that, variously, identified with the patients as men while constructing them as other. This form of talk also characterised their accounts of sexual crime and the sexual offender. These men were described as belonging to a collective group which was marked by high levels of deficit and dysfunction. Respondent [S15], for instance, positioned himself as the product of a 'normal background', relative to the 'unstable family environment' of the typical sex offender. The case notes, of detained men were cited as evidence of human difference that located criminality in the early life of the offender:

> "I think it's family backgrounds and y'know with a lot of them erm [pause] most of the time it always seems to be people who just come from a more unstable family environment

> y'know where they're... y'know...they're living with their mother and father erm...normal family...normal upbringing...there's always...there's always some other problems (.) you never sort of just look at anyone's case notes do you and...and say 'Oh well he looks fairly normal he had a fairly normal background' like...y'know I consider mine and most of me friends as a normal background (.) none of them ever seem to be that way there's always been problems for some reason when they were a kid...y'know starts off in junior school with some of them" (S15: 436-445).

The idea that sexual offenders were, themselves, the victims of abuse featured large in the nursing accounts. Respondent [S5], for example, included this as an ingredient of chaotic upbringings which would impact on the later life of those who were set apart from 'normal people'; constructing a composite of socially inept and isolative individuals unskilled to function in the adult world:

> "they come from a very disordered background erm...abuse within the home erm...socially inept (.) have never...have never been able to interact properly erm from a very young age (.) isolative...erm problems with school...problems in...early adult erm...haven't matured... haven't reached the normal milestones that we all...that normal people would...would be expected to reach without any problem" (S5: 311-316).

When they spoke about offending, detained men also structured their talk in a chronological way that made a connection between personal suffering and the victimisation of others. For patients [P6 & P3] women played a key part in the reconstructed past, as recipients of domestic violence or the enforcers of a strict moral code that precluded emotional engagement with the opposite sex. Learning to be a man was premised on the absence of affection, and rigid gender stereotyping that punished frailty or vulnerability. Though [P3] talked about his early environment as dysfunctional, situating this in the context of affluence dissociated him from social or material disadvantage:

> "I think some of it could be down to the family [pause] I was an only child...and from a very very early age...I witnessed me father giving me mother very very severe beatings [pause] erm I was an only child...brought up with me grandparents and they were strict Victorian...methods that they lived by [pause] I had no brothers or sisters so I didn't live up with a female...I didn't get to appreciate feeling comfortable with a female [pause] er totally [long pause] inadequate as far as interaction and relationships with females" (P6: 217-224).

> "I was...badly...badly battered by my father for any bloody reason...didn't matter...so was me mother (.) so I saw gross violence to me mother...right the way to the age of fifteen [pause] I had gross violence towards me...I was asthmatic which didn't help...father saw me as a pansy because I wasn't a man...in his eyes...he was an ex Australian stockman...he was a man's man [pause] and [pause] I grew up in er...an environment that was very...very dysfunctional although it was a wealthy environment" (P3: 79-85).

The language-use of respondent [S6] suggests how nursing staff could reproduce the voice of the patient in a way that diminished the value of their words, and the authenticity of their being. The idea of sexual offending being somehow associated with childhood trauma was parodied as a transparent excuse for 'getting revenge on the world'. Further, the casual

comments about a 'hatred of women', where to 'punch 'em' was a 'quite obvious aspect' of sexual violence, illustrated how the gendered talk of the institution asserted a collective maleness while distinguishing between individual men:

> "I mean with...with some it's quite obvious that there's a sort of [pause] erm [pause] hatred of women...punch 'em...sort of [pause] erm aspect to it [pause] particularly with the more violent types of offence (.) there's usually something to do with [pause] 'Me mother used to beat me as a child and it's my way of getting revenge on the world' or 'Women have treated me like this' or [pause] erm [pause] a feeling of inadequacy [pause] where they've got to assert them [unfinished] 'I've got to be a man sort of...beat this woman up'" (S6: 577-583).

When patient respondents talked about their initial exposure to pornographic materials, this often took place within institutions for the care or containment of young people. Respondent [P9] commented on the volume of pornography in the prison system, and suggested this was only one area of concern within a network of social care and secure services. He recalled a lifetime spent in an assortment of institutional settings where pornography was always circulating, and indicted a system that had neglected its duty to provide a safe environment for a troubled child who would become a wayward young man. The account connoted a sense of abandonment, and of being the victim; not of what he had done, but of what others acting in loco parentis had failed to do. Institutional life in youth justice and prison establishments was discussed in relation to his changing pattern of offending, from minor infractions and delinquency to violent sexual attacks. Without attributing blame to external factors, the respondent reflected on the insidious and cumulative influence that pornography might contribute to the careers of sex criminals like himself:

> "I've been in custody in...in children's homes where it was abusive...right up to er prison...a life sentence...and erm I've been away in institutions all my life [pause] and pornography's always been available in all of those institutions [pause] but in some ways as well...if they say the parent is responsible for the child...then at some stage the state must be responsible for the people that it takes into its custody [pause] and I think erm...as I say y'know that you become a product of the state in some ways [pause] I don't know how many people like me (.) and whether you could find out...from approved schools all the way up to life sentences or prison sentence...who then become guilty of murder or horrendous sexual offences (.) because [long pause] when all this pornography is available to you...er the staff don't say 'Get that off the walls'" (P9: 604-618).

The respondent sketched out his prolonged exposure to sexually explicit materials as a juvenile, where learning about sex was removed from any familial or social context, and gratification lacked emotion. Pornography was both commodity and currency, to be exchanged, traded and displayed. It was suggested that saturation of sexist imagery could be a detrimental experience for men generally, but particularly problematic in closed-off custodial settings. Here, pornography became an educative, and entertaining, surrogate for interaction or intimacy. Sex described as solitary and soulless, graphic and one-dimensional,

represented aggressive heterosexuality in a world where women were largely absent. Without a challenge to stereotypical images and ideological messages, women were robbed of respect, and denied any reality other than a composite of fetishised body parts:

> "You could have full blown sex going on in the picture...and the more y'know...lads buy pictures off each other...they put them on their walls and of course they masturbate to all these pictures...all these acts and all that (.) and erm if you're in prison or you're in institutions throughout your life then...with these pictures always available and very few females around anyway to fantasise on...people use pornography to fantasise on [pause] you lose [pause] not lose respect...'cos maybe it wasn't there in the first place for...for females [pause] you tend to start looking at them...girls just become tits...fanny and arse because that's what you see all...every day...that's what you masturbate on every night and so in the end y'know they just [pause] you dehumanise er the female [pause] so pornography's damaging...it's destructive (.) especially in the...in the prison system" (P9: 629-634).

Though he claimed to have little interest in the subject, respondent [P8] talked about the availability of sexual magazines in the 'cider houses' that he had frequented:

> "I mean...if I went...I used to go to er...a cider house [long pause] and if them magazines was about I would see 'em" (P8: 539-540).

Unfamiliar terminology required a prompt by the researcher to clarify the meaning of 'cider house', which was described as an informal drinking venue. Pornography and alcohol consumption emerged as sub-cultural components of male working class life:

> "Cider [makes a drinking gesture] just a house...a normal council house where we used to drink [pause] and things like that was about [pause] but it wasn't high on my list" (P8: 544-546).

Likewise, respondent [P7] suggested that his consumption of sexual materials could be understood as part of a gradual and progressive interest that started in early youth. Bonding, created through the secretive screening of forbidden adult images, was described as an exciting and enjoyable experience, but also one that invited an intensely intimate and unique introduction to sexual knowledge. Describing these materials as 'normal' and 'healthy', articulated the idea that a distinction could be made between two types of pornography, demarcating the normal (man) from the deviant (offender). Risk resided in a particular type of pornography and a particular type of person:

> "It was a gradual thing [pause] er...I think the first film I ever watched was when I was about twelve [pause] and we were round me mates house...we were skipping school and we were all in me mates house and [pause] he went upstairs and came back with this tape and he said 'Look...this is what me dad watches' (.) And he stuck it on...erm [pause] we all watched it...er I think there was about...ten or eleven of us there that watched it...I mean I can't speak for all the others in the room but I got turned on by it [pause] and I thought...mmh...I like this...I wonder where I can get some more of this from? [break] As far as I can remember it was...what you'd call normal stuff...er [pause] one woman with two men (.) er...a man and a

> woman...er [pause] a couple of women [pause] y'know just what you'd term normal healthy adult material (.) er [pause] but I...from my point of view I...got turned on by it but it was never enough for me" (P7: 744-759).

Initiation into the world of pornography was described as a rite of passage in the ceremonial process of adolescence. Speaking to the researcher, as another man, the respondent shared what was perceived to be a ritual part of gaining membership to the boys club. The colloquial descriptor of 'mucky magazine' made a connection with something that was seen to be distasteful, dirty and secretive. Pornography was something that had interested and excited the respondent as a youth, offering entrée to a forbidden knowledge. Consumption, though, was without saturation point, and progressed into more extreme and deviant types of material. Here, stimulation was described as a 'fix' that served to increase desire for something new or different:

> "we've all been there at school where you pass mucky magazines around...er [pause] and after a while you tend to think...that's a bit tame [break] I think people do progress [pause] er [pause] I think after a while [pause] if you say...I don't know you've spent a while looking at top shelf magazines...you may have found one under your dad's bed or something...and you may have found some in his shed...and then you go to school and swap 'em with someone else...after a while you become immune to that image...and you think phww [exhales loudly] this is doing nothing for me [pause] and you want to look at something more [long pause] er I don't know...what's the word? [long pause] After a while it becomes less gratifying for you to look at that image" (P7: 589-609).

Thus far, the respondent had talked about the pragmatic and symbolic dimensions of pornography as initiation into the secret life of men; where magazines, hidden by his father, provided the raw material for a burgeoning sexuality in terms of ideas, arousal and gratification. Talking about po rnography in relation to sexual offending, the discussion shifted toward the presentation of women as devoid of human or emotional attributes. Referring to an (imagined) woman as 'that person', was less about a particular individual, than ownership of an iconic, and idealised, (male) representation of female sex. Relating this to sexual offending suggested a process, where the fusion of images and ideas legitimated a way of thinking about women which acted as a script; a move from saying 'I want that', to 'I want to do that to someone else'. Pornography might be accessed and consumed in private, but was discussed as informing and shaping attitudes that manifested in the real world:

> "I mean if you see an image...that is sexually satisfying or gratifying to you...er [long pause] you may then start to think in your own mind 'Well...I want that' [pause] You may not actually want that person in...the picture [break] but I do think that people [long pause] I mean from my own point of view...of my sexual offending...I certainly blurred the lines of reality [pause] in terms of...I'd see quite extreme images on VHS tapes...to...then thinking right...I want to do that to someone else [pause] so it blurs the lines of reality...I did...and I think a lot of people [pause] do that when they view pornography [break] I mean now when I look at it I wasn't learning the right things (.) right? But at the time [pause] I certainly had

> the beliefs (.) one...that all women want this (.) two...that that's how men should behave [pause] and three...if it's on the videotape why can't I do it" (P7: 621-668).

Parallel to explaining the use of pornography, gratification emerged as a fundamental construct in defining sexual crime. A distinction was made between understanding offending primarily as a 'sexual thing', and the secondary gain of 'being powerful', 'macho', and 'controlling'. Across a range of sexually abusive behaviours, the idea of 'sexual satisfaction' and 'sexual thrill' featured as they had in talk about pornography. Legal classifications, and offence categories, were subsumed within a universal understanding of the perpetrator as an individual in search of something pleasurable and exciting. Enjoyment of offending, it was posited, developed through the interaction of immediate and deferred gratification. Over time, with repetition, offence patterns were established, where anticipation and reflection translated the mental life of the offender into reality:

> "if somebody's committed a sexual offence the main reason they've committed that is because it's a sexual thing [pause] being powerful or being...macho or in...controlling is a secondary issue...the main reason that they choose to do it is because they want...sex off another person [break] no matter what offence [pause] it is classed under...sexual offences...whether that be flashing...whether that be rape...indecent assault...etcetera etcetera [pause] right...I think the main reason that people do it is because they get some sort of sexual satisfaction from it...some sexual thrill (.) I mean the case of someone flashing [pause] it's not an immediate physical...satisfaction but it's a mental one [pause] I'm flashing at this person...I'm invading that other person's world...with what I want them to see...and later on I'm going to...masturbate about that" (P7: 884-905).

Here, the excitement and pleasure associated with sexual offending was deeply rooted in the sexual-makeup of the individual offender. After having spent sixteen years in the hospital, and undergoing an assortment of therapeutic interventions, he claimed the compulsion to offend remained undiminished. The impact of time and treatment needed to take into account the meaning that offending occupied in the life of the perpetrator. The attachment to offending was sufficiently strong for the respondent to be dismissive in his comments about patients who claimed to have distanced themselves from a desire to re-offend. The memory of offending was described as a refuge or retreat, and abandonment of this represented an unimaginable sacrifice. Any feeling of guilt or remorse that another human being suffered for pleasure to be experienced was poor compensation, and there was no pretence of forgetting a part of life described as though it were an adventure. The respondent found it hard to imagine he was alone in feeling this way, and those who purported to have escaped the excitement of offending were compared to religious converts. The mental element of sexual offending was spoken about as a 'personal private viewing centre' where fantasy and offence could be re-played and re-lived:

> "it [the desire to offend] stays for years [pause] and in some times...I mean it's...and I can't speak for anyone else...but for myself it hasn't gone away [pause] it hasn't (.) and I don't care how long people do in these places...you might get the odd one or two who have...a flash of light and then renounce everything that they've ever done...right...and feel extremely sorry about it and etcetera etcetera [pause] but I think that if you're doing something that is so powerful and so compelling that you [pause] wait in a dark corner or something...for someone [pause] and you attack that person [pause] and you force someone to do something...er [pause] that image...of what you've done...will stay with you for all time because it's so thrilling at the time [pause] your own personal private...viewing centre that no one can get access to...apart from you" (P7: 956-976).

With reference to his own offending, the respondent identified pornography as an obsession, with the potency to denude external social influences and normalise abusive sexual behaviours. The concept of 'relationship' appeared to be more about the user and his sexual materials, than the user and other people. Pornography defined the domestic sphere, like a surrogate family, that one exited to enter the social world. Sexual interest was divorced from any interpersonal contact, and the aggressive themes of pornography were ascribed to the imagined sexuality of strangers, as much as the intent of the offender. Women who were known to the respondent, with whom he had a degree of regular contact, were defined only in terms of sexual capacity and the potential to satisfy his needs. Though he indicated an awareness of cues that signal the prelude to intimacy, such as physical attraction, contemplating reciprocal relations was unimaginable:

> "And I was obsessed with it...er I had a vast collection...er [long pause] and after a while I started to think right [pause] that's what normal relationships are [break] away from the pornography when I was in normal social settings I used to think...I bet she wants a good one...things like that y'know [pause] I may not have even spoken to the person [break] I may have been working with someone...and a girl in the office...or a woman in the office may have been attractive and I'll think umh I've known that person for a while...I'm not...I'm attracted to her...but I'm not attracted to her on the level of her potential [pause] a normal friendship...relationship type thing...I'm attracted to her because of her potential [pause] of what she might be able to provide for me" (P7: 659-692).

It was the twin ideas of an obsessive and highly selective use of pornography that figured large in the account of respondent [P6] describing his interest, discussed previously, in crime-fiction magazines. Immediately after purchasing these products, the contents would be disposed of, and only the 'glossy cover' was retained as an addition to his immense collection of stereotyped images:

> "me main source at that time was...the American crime detective magazines...er *True Detective*...*Real Life Detective*...*Detective*...because the glossy cover depicted...I mean to say at one time I'd something like...one thousand four hundred in me room...and me father found them all in a suitcase [break] I would get the magazine swap them for other books or magazines that I could find...or buy 'em off him outright (.) I just used to get to the bus station tear the cover off...tear the magazine up...chuck the magazine in the bin...and it was the cover that did it for me...it was the cover" (P6: 868-896).

Sexual arousal as a product of eroticised representations of women's suffering, rather than sexually explicit content, was described as an expression of fantasies enacted in offences characterised by the infliction of humiliation, fear and pain. This account, hinting at the language of SOTP, was resonant with the commonly expressed idea of addiction to pornography reaching saturation point and escalating into offending behaviours. Describing how specific images heightened arousal, the respondent talked about satiation, distinct from stimulation, as akin to a transcendental experience. Euphoric intoxication, it was suggested, strained the fragile boundary between fantasy and reality, where temporary satisfaction competed with the excitement of being the imagined perpetrator. The account resonated with a tension between fantasy as 'real', and 'females' as the 'real thing'. The assertion that there was a link between specific types of *sexual media* and *sexual offending* belied a more complex set of constructions than the idea that imagery caused the behaviour:

> "Many a time I've undressed completely naked and I've got these covers out [pause] and I've spread about fifteen...twenty or whatever [pause] the ones...the most turn on for me...on the floor in the home [long pause] and the fantasy...was so real that I was actually in the picture...I was that person...that offender [pause] and a couple of times I masturbated and ejaculated but [pause] to some degree that pulled me back from actually doing the real thing [break] it pulled me back from actually doing the real thing...but [pause] it wasn't the excitement...it wasn't as exciting as the real thing...it wasn't y'know [pause] and the more and more and more it preyed on me mind [pause] was gradually...the catalyst that was taking me towards...ie actually offending against females [pause] and in many of me offences...committed...it's similar to...scenes that I've seen either on television or magazines or whatever...or them detective magazines (.) so there certainly is...certainly a link" (P6: 916-932).

Considering the role of fantasy in offending, respondent [P9] talked at length about an enduring attraction to young girls, attributed to an experience in youth. This recollection was reminiscent of the therapeutic quest to identify significant life events that might contribute to an 'offence cycle', and deployment of the phrase 'trigger' hinted at previous rehearsal of the issue. The experience of witnessing a younger sister having sex with an older boy was juxtaposed with the collective behaviour of peers to culturally validate his ideas about male behaviour, and narrow the gap between the normal and the deviant:

> "And erm...I always found them [young girls] sexually attractive and...we'd hang around pubs...er older lads...and they'd go past and everybody'd wolf whistle or (.) so y'know I thought 'Oh well they think the same as me' [break] erm [pause and sighs deeply] well when I was younger...er I caught me younger sister having full...full sex w ith erm an older boy...she was only about twelve or thirteen [pause] and erm I think I fantasised on that...since I was young...and I think that had been a trigger somewhere...I'd always kept it with me" (P9: 499-513).

Fantasy was described as an essential ingredient of sexual crime, and the respondent indicated how a rehearsal for offending was enacted in marital sex, with his wife unwittingly

acting as surrogate victim. Unlike marital rape, where partner violence is physical and visible, fantasy converted consensual sex into a prelude for coercive sex:

> "I'd always fancied erm...fantasised over younger girls...pubescent girls...y'know just entered puberty [break] well when we were having sex...when I was having sex with my wife I'd sometimes pretend it was erm...a younger girl [pause] so y'know I would...I would fantasise like that...so I was always fantasising [pause] before the actual act I think everybody...every sex offender fantasises...over [pause] y'know he...whether he's fantasising over rape or whether he's fantasising over younger girls...erm just erm just touching up or whatever [pause] I think...before the act...comes the fantasy" (P9: 494-555).

As noted previously, this man talked about the prevalence of pornography in the institutions that had been his home for many years, and sex was one component of a chaotic life spoken about through the medium of powerful negative emotions such as 'anger' and 'bitterness':

> "So y'know that's just one of the ingredients or the recipes of my chaos...was I...along with everything else...the anger the bitterness and the loss of control...was I grew up in institutions which had women all over boards and loads of magazines...and I erm [long pause] y'know they just became an object...a sexual object...women...females...and that was it" (P9: 735-741).

When talking about sexual offending, discussion about pornography shifted from the objectification of women, generally, to more specific types of imagery that reflected his sexual preference for young girls. Noting that magazines like *Barely Sixteen* were widely available, as 'top shelf' sexual entertainment for men, located male interest in younger women as a larger cultural concern:

> "I sexualised [pause] I made the...the er the young girls in my mind er like a sexual object...that they would...not only would enjoy it...that they do enjoy it because my younger sister...I caught her at it...so they're sexually aware at a certain age...and y'know you tell yourself all these lies...distort all of it y'know...for your own [pause] for your own making...'cos you wanna er offend and erm to offend you've gotta first...justify it [pause] so you distort everything" (P9: 522-527).

> "I think you do...y'know you do Dave you have preferences and erm...when I got out I had lots of them *Barely Sixteen* as well [break] yeah y'know they're top shelf magazines available in every sweetshop" (P9: 760-761).

Many of these ideas were interwoven in the way male nurses talked about sexual offending, accounts which were usually informed by case-histories of men detained in the hospital. While their language typically functioned to make a clear distinction between themselves and the patient population, this distance was bridged by a shared male discourse. Fantasy was central to the account of respondent [S1] who talked about pornography in terms of the 'kick' or 'buzz' it produced. But the interpretation of an image, as sexually exciting, was relative to the viewer:

> "I think a pornographic image is...is in the eye of the beholder really...erm [pause] and what's pornographic to you...may not be pornographic to me (.) I think it's about the kick...the buzz that you get from it" (S1: 707-709).

Pornography, in relation to offending, was described as a message rather than a discrete body of literature; one that represented the dissolution of communal values and promoted a pervasive ideology of acquisition and gendered inequality. Sexual offending was about 'taking' something that belonged to another, and pornography gave permission for these infractions. Though it might reduce sexual frustration, it was an outlet without saturation point. Pornography-users, introduced in terms of predisposition, engaged in a constant search for different types of material to incorporate within, and extend, their imaginary sexual domain:

> "particularly if you've got a predisposition...'Hey society thinks this is ok...to see it in this way' They don't see women anymore as...as people...they see them as meat...they see them as...as literally meat you can go and buy...and if you can't buy it you just rob it...you take it [break] I think that erm...it's a quick fix for erm sexual frustration...perhaps [intake of breath] erm it's...fuels fantasy erm [deep intake of breath] it erm certainly extends fantasy...definitely extends fantasy [break] I think fuelling for me is the idea that the fantasy's already there...but the erm...the images erm [pause] literally add fuel to it...they build up the intensity of that fantasy...that's what I'm getting at [deep intake of breath] erm extending the fantasy would be the idea that there are new images that you never even thought of in the first place" (S1: 594-626).

His identification of the sexual offender as different resided not in personality type or sexual ideation, where selfish behaviour and fantasy represented universal human traits, but in a lack of restraint. The idea of a shared predatory fantasy was unquestioned, and only became problematic for a group of men who had transgressed a set of social sanctions which delimited what any man 'might, or might not do':

> "Self-centred [pause] not exclusively but there's a...there's a self-centredness about them [pause] a self-centredness [pause] I mean there's a self-centredness about us all (.) I think that everybody...I think everybody erm fantasises [pause] but there's something that stops us moving from that fantasy...to take (.) I think we're probably [pause] the idea of being erm...sanctioned [pause] and...and shamed because of what you...what you might or might not do" (S1: 202-207).

Similarly, respondent [S5] constructed the sexual offender in terms of deficits that explained both the need to use pornography and a greater vulnerability to the effects of arousal. Such individuals consumed sexual materials above and beyond what would be considered acceptable for most men. Solitary sex, it was posited, would surrender to a combination of stimulation and disinhibition that blurred the boundaries between image and reality, picture and person. Ultimately, offending would become a possibility, rather clumsily proffered as a 'hurdle to be jumped'. Positioning himself as a 'married man', the respondent asserted his

heterosexual relations with a 'real woman', which precluded the need for artificial stimulation:

> "I suppose in reality there may be a relationship...going back again to the...to the pers [unfinished] to the individual who's got deficits erm...who may then use pornographic material to obtain satisfaction...y'know through masturbating or whatever...and then just jump that hurdle of 'Well what would it be like...to have a real woman?' Rather than y'know 'Ok I'm fed up with this now it's not...it's stimulating me but not enough' Erm [pause] but he'd have had that anyway wouldn't he? He'd have had the pornography anyway...most adults have y'know (.) I do think it's a person with deficits that constantly uses pornographic material...I mean I'm an adult...I'm a married man and I must have looked at say...between the ages of thirteen twelve to...married life...a pornographic magazine twice basically erm...so there must be some kind of link that y'know...what I'm trying to say is...there must be a reason I suppose for him to need the pornographic material" (S5: 851-865).

The simplistic links between pornography and offending suggested above, though, was less evident in his hypothetical conjecturing about rape. In addition to explaining sexual crime as the product of intellectual impairment, another typology caricatured an individual who asserted 'control and power' through a decision to rape someone; an assemblage of ideas and concepts, outwith any organisational framework, offered little understanding of theoretical attempts to explain sexual crime. The account did, though, reveal a discourse that differentiated between sexual offenders by suggesting that some acts of rape were explicable in a way that justified the behaviour and invited sympathy for the perpetrator. It was posited that the actions of a young man who 'ends up' raping a 'girl, circumstantially', which seemed to infer diminished responsibility and choice, could be unfairly categorised as an offence in legal terms:

> "there's obviously factors why a certain offence is committed...whether that be through deficits...intellectually...social interaction erm [pause] with regards rape...and then there's the opposite to that...the sort of control and the power element of a mature person who's fifty...who decides to go and rape someone [pause] but someone who's seventeen...and decides to rape a girl...circumstantially he ends up in that...y'know that strange sort of erm situation where he ends up raping the person...didn't particularly want to rape the person...but did y'know for different reasons...an offence is an offence isn't it?" (S5: 1046-1053).

Talking about actual, rather than imagined, offences patient [S3] attempted to separate sexual from violent components of his killing a teenage girl. Identification with the higher-status of violent crime, as something enjoyable, reduced the offence to an unfortunate by-product of angry protest, and failed to delineate between rape and sex:

> "So where sex is...I'm not really er concerned about rape because it's not my bag...never was...violence was my bag [pause] because of the state of mind I was in (.) so my...act...oh and the other thing was [pause] in killing my victim...apart from penetrative sex...it was me making a statement 'I'm not fuckin' mad'" (P3: 1944-1947).

Distancing himself from individuals with a primary interest in rape permitted this man to discriminate between types of offenders and types of sexual offences. A moral codification of sex-crimes related to the futility of rehabilitation with certain individuals, and clearly demarcated the decent and deviant offender. Riven with internal contradiction, the account ultimately allowed for a distinction between the average and abnormal rape/rapist. The serial rapist was described as repugnant, set apart by the number and severity of offences, with victims diminished as part of an invisible collective. In contrast to men who were seen as beyond redemption, other offences could be understood as the product of context and circumstance; the *average rapist* and the *average rape*. Differentiating between offenders normalised acts of sexual aggression against women:

> "I'm not talking about a gross rapist like er...somebody that does twenty rapes and...mutilates them...something like that...fuck that! (.) What you do with them I don't...pull the plug on 'em I think...probably lock 'em up...I'm talking about most people who what I call rape a woman...in the average circumstances...right? [pause] They're redeemable in my book" (P3: 2143-2148).

Sexual offending might equate with rape, but the sexual offender was seen as the product of a classificatory process. The respondent presented a dichotomy between rape that suggested planning and that which was described as being, almost, accidental. In parallel with this distinction, victim and perpetrator roles were sketched out in a way that coincided with the widely reported evidence of rape-mythology in offender thinking. The first category offered a version of textbook 'stranger rape', as predatory, opportunistic and premeditated; a brutal offence perpetrated against an unknown victim. In contrast to violent sexual attack, the respondent introduced another type of sexual crime, as qualitatively different, and with which he could identify. As a young man, he had engaged in abusive behaviours that were constructed as youthful misdemeanour. Offending behaviour, compared to date rape, only became a sexual crime in retrospect. Unlike the victim of stranger attacks, women were seen to have placed themselves in high-risk situations by frequenting places that marked 'girls' out as sexually available, where rape became a case of mistaken identity. Presenting his offences as socially-situated and circumstantial, rather than premeditated or biologically driven, enabled the respondent to differentiate between himself and offenders unable to exercise control; sick individuals compelled by irresistible sexual urges. As with his talking about a female nurse, discussed above, erectile response and self-restraint were central to understanding offence potential:

> "there's a definition in my book of sexual offences [pause] there's the rapist who stands on a corner...looks at a bird coming and thinks oh I'll put one up her on Wednesday...she comes past here regular so he waits for her and rapes her...violently [break] there's the other one which I did in nineteen sixty when me and me mate went out pub...crawling...picked her

> up...when these days it's called date rape [pause] ok we...I was out of order...I pushed it...yeah...I was a bad apple there's no argument...but then I didn't see it that way...it was...oh she fucks...good (.) in other words it was a pub where the girls did...as opposed to the pub where the girls didn't...now...that's not underestimating it or saying it's not rape [pause] or a sexual offence...it is a sexual offence...but what I'm saying is it's not premeditated...and it's not done because you've got a hard on for women" (P3: 1750-1764).

Nurse respondent [S10] mobilised a similar set of discourses to discriminate between men who had raped adult women, and those whose offences were against children. As noted in the previous chapter these men had a pariah status in the hospital, which would frame them as a specific target in the nurses policing of sexual imagery. Using a hackneyed rape myth about certain women who 'asked for it' permitted the respondent to construct child sexual abuse as a crime where the victim was beyond any culpability. This was an offence that was planned and controlled exclusively by the perpetrator:

> "if you...if you talk to someone and they go 'Ah she asked for it...short skirt on...she was pissed...she was all over me...she said no but she got it' [pause] now against children...they've gotta plan it (.) it's not the children's...it's not the child's act...it's their act and their control" (S10: 1161-1164).

The possibility that some women might be complicit in sexual offending, if only because she 'knew' her attacker, meant that the offender could deny or defend his actions. Only extreme violence, such as 'beating the victim to death', placed the allegation of rape beyond question. In stark contrast, the innocence of children meant that the convicted paedophile could be afforded no opportunity to justify his behaviour:

> "I think with adults...a rape on females...and this (.) unless y'know...they don't beat them to death 'She was a woman...she knew she him' [pause] they can justify (.) but you can't [pause] justify that with a child" (S10: 1173-1175).

Cumulatively, this talk enabled the respondent to move from identification with the offender by justifying sexual crime in particular circumstances, to suggest that some offences were 'far worse'. This manifested in an almost casual, and dismissive, discussion of the rape survivor who, as an adult woman might be expected to have the resources to 'get over' the trauma:

> "it is far worse [offences against children] because they control it (.) I mean they get to challenge that (.) it's the same in adult rape and all y'know but [pause] as a child [pause] I mean I would have thought [pause] some adults can accept rape and others can't (.) I think the majority of children find it very hard to have been abused and to then to live a normal life [pause] but as a woman [pause] maybe 'cos they're adults they can say 'Yeah I can get over this'" (S10: 1181-1186).

The motivation for sexual crime, for respondent [S6] was indivisible from male sexuality, where arousal was understood as a by-product of adrenalin inducing [543] high-risk sports

that characterised hyper-masculinity. The sexual behaviour of men, in general, was described as the uncontrollable outcome of competition, circulating chemicals and testosterone; of high octane activities that fuelled masculine needs. Here, rape could be talked about as a result of feeling 'horny', and might not qualify as a sexual offence:

> "I mean...I don't go rock climbing...motor racing...I don't go rock climbing in order to make myself feel horny [pause] it's a by-product [pause] I'm sure Michael Schumacher doesn't jump in his formula one car [pause] to get himself an erection [pause] it's a by-product (.) so [pause] is it still a sexual offence if the guy's gone out [pause] because he gets a high off burglary [pause] then feels horny and commits a rape afterwards? [pause] I'm not sure whether that's still a sexually motivated offence...is it?" (S6: 556-562).

This issue of motivation figured prominently in the way the respondent talked about pornography and offending. Like other respondents, he located pornography alongside fantasy in the sexual lives of 'normal men'. Sexual activity, spoken about in terms of 'passion' and 'loving', was what distinguished these users of sexual media from the rapist. The content of fantasy, here, was less important than the ability to exercise restraint based on personal morality:

> "there are [pause] I think thousands of normal men who watch pornographic material [pause] who don't go out and rape people [pause] there are people who have [pause] mild sexual fantasies [pause] probably while they're making mad passionate...gentle...very loving [pause] whatever with their wife [pause] erm but they don't have to (word unclear) them y'know (.) that's why I think the thing about the motivation [pause] is the important factor (.) y'know rather than [pause] erm [pause] 'It's alright in my head...if I think about it (.) I know that it's not right if I do it'" (S6: 576-592).

Any detrimental effects that might be associated with pornography were seen as a consequence of the user, rather than the material. Again, the distinction between normal and deviant sexuality permeated the account, this time expressed through the concept of 'desire'. Pornography became a resource to stimulate the viewer, where pre-existing intent shaped the outcome of the experience; for 'married couples' this related to a 'mood for normal sex', while similar materials could enhance the 'mood to offend'. Thus, what was referred to as a 'bloody bizarre porno film' had different meanings in relation to the circumstances in which it was watched. For some it might hold aphrodisiac properties, for others it could furnish a script to offend:

> "I think offenders use pornography to put themselves in the mood to offend (.) i.e. to stimulate themselves to go out and get [unfinished] I don't think that it's [unfinished] I know it's a bit chicken and egg but I think the desire comes before the pornography...not the other way around [pause] the same as [pause] a normal man [pause] will use pornography to put himself in a sexual mood [pause] and even married couples will use pornography [pause] watch it together to get in the mood [pause] for normal sex [pause] it might be a bloody bizarre porno film [pause] and they may not do all the things they see [pause] but it's

> y'know...the desire's there [pause] or the inclination's there [pause] and it's to sort of heighten the desire to...fulfil the inclination isn't it?" (S6: 615-625).

Pornography in the hospital: care, control and censorship

When they talked about the management of sexual media on the wards, respondents usually made an oblique reference to the PDS policy that equated to a blanket ban. Seldom though did they demonstrate a clear understanding of the actual content of the document itself, or how it might contribute to care and treatment of the patient population. Rather, guidelines were seen as another strand of the corporate culture, discussed in chapter four, that was associated with the larger Trust. As such it was symbolic of a distant and disinterested bureaucratic body, from which each set of participants felt marginalised. For nursing staff, pornography assumed import in relation to the sexual offender, and the dominant discourse centred on maintaining institutional order through the application of rules:

> "I've often thought that it's a bit silly [pause] not allowing it [commercial pornography] when it is freely available [pause] but I can understand too that [pause] there has [pause] the hospital has to maintain an element of control [pause] in the words of the hospital management...in order to reduce as much as possible any risks" (S17: 950-954).

> "I fully believe there had to be a blanket decision...even to *Penthouse* and everything else (.) it had to be blanket because there was abuse going on with it and so therefore you had to stop it...and sometimes yes...it's like anyone else...we have to live with it...rules and regulations and yes...it had to...the rules had to be for...for everyone...they couldn't just be for one or two" (S10: 910-915).

If nursing staff were often confused about the identification or management of unsuitable clinical material, it was posited by a team leader [S1] that the patient population would be uninformed, which diminished the value of shared guidelines. This respondent suggested that hospital procedures were poorly communicated to people most affected by them, and that there would be variable definitions of pornography between professional and patient. Detained men were identified as long-term products of institutional care and abuse, echoing the status of other, and assumed to have a 'different take on the world':

> "No they [the patient] wouldn't [be aware of the policy] no the erm [pause] no...no they wouldn't...which is a problem (.) they're not even...not even erm...given any education as far as pornography...to my knowledge [break] I think that their definition of pornography would be completely different to mine but...maybe it would (.) most of them have been in institutional care since they were kids...probably abused themselves...lived in...lived in special hospitals and prisons (.) they're bound to have a different take on the world" (S1: 844-853).

The talk about a pornography policy in this account, devoid of any sense of ownership, was located in excessive documentation which presented the hospital as a rigidly structured environment. Only a few policies, based on frequency of use, could be cited in detail, and

guidelines relating to pornography figured as a low priority in the everyday business of the ward:

> "Do you know how many policies there are in here Dave? Thousands (.) you cannot...it would be a physical impossibility to know all of those policies inside out (.) you could go to them...that's what they do...that's what we do...we use them as references [pause] that's all we can do...except for the ones we use [pause] erm...I don't know...three or four times a day...and I'll know them inside out [pause] do I know the pornography policy inside out? No I don't" (S1: 794-801).

In this context the respondent, and nurse [S16], talked about a pornography policy as reactive, rather than creative, and responding to increased government scrutiny of secure services. Risk-management was cynically interpreted as *risk to the management*, with guidelines providing an insurance against clinical decisions with adverse consequences. For these respondents, effectiveness and evidence had less import than the self-preservation and self-interest of senior personnel:

> "if the government say you've got to have a pornography policy...they jump and get a pornography policy in place...and it touches on some...on some of the aspects of what's important (.) it could be seclusion...it could be anything...it touches on the aspects that the government want it to cover...there isn't very much in here that touches on the evidence...that's got real substance...is gonna do very much (.) people panicking about their own jobs and making sure they're ok (.) if they're ok that policy will do...it's as simple as that really erm [pause] as long as they're ok...in their role and they'll get to their pension...they don't really give a fuck" (S1: 829-839).

> "there's a comfort zone...there's a comfort zone for shall we say the hierarchy [pause] I don't know what to call them...they make these decisions (.) there's a comfort zone...erm risk is that if they don't get it [pornography] they won't do it...do y'know what I mean? And 'We're covered' y'know [pause] 'We said they can't have it...now if they do something without it that's y'know their problem" (S16: 839-844).

Distinct from an understanding of pornography in relation to the management of certain individuals, other nurses [S10 & S8] reframed the argument in terms of institutional management. Pornography, here, was considered alongside other illicit items such as alcohol, drugs or weapons that constituted 'black-market' currency in custodial settings. These accounts paralleled claims of an emerging prison culture within the hospital, and attempts to prevent sub-cultural competition. From video-tapes of bestial sex, to commercial titles, restriction and regulations ensured that there was little opportunity for an internal barter system to develop:

> "pornography it's [pause] you...you gotta be able to monitor it...and you can't monitor it (.) I mean it's like...I mean...but I've found tapes here that patients have...with animals on [pause] this is on the black market here...within here say" (S10: 943-946).

> "There's a physical limit to what they can have erm [long pause] I think we had one patient who was allowed to...erm *Penthouse* or [pause] once...once a month or whatever and that

was like...strongly supervised...that...that could only stay in his room...because people used to barter with it all the time...and swap them...whatever" (S8: 704-707).

Patient respondents also located talk about pornography in a larger commentary about organisational changes that were described in terms of increased control and regulation, but situated their accounts in the experience of life on the wards; where there was uncertainty about whether pornography was an issue for the clinical team or the security department. The implementation of measures to restrict pornographic material was described as having sanitised the environment of almost all materials pertaining to the sexual, which equated to pictures of women. The vernacular terminology of 'mild porn' [P9] and 'pussy books' [P3] hinted at a product, and content, deemed too mundane to attract the censorial attention of the nursing staff:

"Never seen any of it here...I've never seen any pornography whilst I've been here...no mild porn...I've never seen anything of the kind" (P9: 768-769).

"Yeah now there's nothing...you can't even have pussy books" (P3: 2344).

For respondent [P2] the issue of access to commercial pornography was described as one of numerous restrictions imposed in recent times. He claimed that during his twenty five year detention in the secure hospital system levels of security had increased significantly, and attributed the control of pornography to be an aspect of this change:

"Well you can't have it [pornography] you're not allowed to have it [break] security says you can't have it" (P2: 615-619).

Having distanced himself from pornography as a personal concern, support for limiting patient access to sexual media was premised on the idea that pornography, beyond immediate gratification, had the potential to influence susceptible individuals in a detrimental way. The sexual offender, as a distinct type of person, was seen to derive particular pleasure from consuming this sort of material. As in the nurse accounts, there was an implicit suggestion that the sexual offender was set apart from other men, where past behaviour could be taken as an indicator of future risk. If the consequences of sexual stimulation, and arousal, were beyond the control of the individual, it became necessary to enact external sanctions. Risk, in this account, was an innate quality of the offender, and pornography represented an impetus to offend:

"You used to be able to have it...you could buy it [pause] but you can't buy it no more now...because if some of the patients are in here for...for raping young girls and that and the pornography sort of...probably sets them off [break] they [sexual offenders] like looking at that" (P2: 632-642).

Speaking as a gay man, patient [P4] remarked on hospital practices that neglected, and discriminated against, the sexuality of men who have sex with men [MSM]. Rape was narrowly defined as a crime with male perpetrators and female victims; more than a *sexual offence*, it was understood as a *heterosexual offence*. Although informed he could apply for mainstream gay literature, the respondent had chosen to decline. His rationale for this decision was based on the complexity of the application process, the implications of requesting same-sex materials, and an association between such literature and pornography. Publications like *Gay News* might focus on sexuality, but the readership represented a community of people united by minority sexual identity, and collective struggle against discrimination. In contrast, sexual gratification was presented as the only function of commercial sex magazines aimed at a heterosexual male audience, overtly purveying female nudity:

> "people who are here for rape [pause] raping women [pause] right? [pause] I think that's what they're looking at [pause] 'cos this could be a trigger [pause] what they did in the first place...raping this young woman [long pause] erm...I've not actually raped anybody in my life [pause] so...to my mind...this would not apply...so they're tarnishing me [pause] with the heterosexuals [who] have actually raped [pause] and if you're a heterosexual...er the *Mayfair* magazine...women in the nude...oh he'd be there ten to the dozen like y'know [pause] god knows what his fantasies are going to be like (.) er...is this going to start him up for when he gets out? Again? [pause] I think that's what they...they look at (.) and so we're all tarnished with the same brush" (P5: 1658-1675).

The policy on sexually explicit materials was interpreted to include a wide range of commercially available media that might not ordinarily be considered pornographic, but were deemed inappropriate in the context of treatment for offender-patients; in particular, the difficulty of discerning between 'sexual' and 'violent' content. An illustration of the dilemma of imposing controls was illustrated by respondent [P9], who had ordered a number of DVD movies. When these arrived at the hospital they were withheld by the security department because of the violent, and sexually violent, content. As the films had previously been broadcast on television, and most patients had the opportunity to watch them, the decision to prevent a specific individual from viewing them was described as puzzling and discriminatory. For the respondent, violence was a staple ingredient of media entertainment that could be rated on a spectrum from drama to slapstick, where depictions of sexual violence permeated popular culture. Commenting that other men were allowed to watch films described as 'psychopathic' and 'sadistic', that could just as easily relate to their offences, reinforced the way nursing practice used sexual offending to symbolise dangerousness. If staff had little difficulty in recognising the violence of sexual crime, it was suggested they showed less awareness of how physical violence could be sexualised:

> "they [security] said in one of them there's an explicit rape scene [*Once upon a time in America*] and the other two the erm the amount of violence in erm *Natural Born Killers* and erm *Reservoir Dogs* is...give reason for concern [break] but what I've seen on here er psychopathic er...right psychopathic films y'know er...sadistic er films [pause] maybe not sexual...but sadistic [pause] and these are lads who are...they're in for murders or killings [pause] I'm not...although I did commit horrific er violent er sexual acts...I didn't go over to the fact that I sadistically er tortured...or used any sort...I didn't even hit...y'know I didn't even hit them...and I didn't get off on that [break] they [nurses] tend to erm [pause] think it's alright to...for [laughs] I don't know why killers and people who've taken life...they can have these sadistic violent films...but there's always words of concern and caution over giving them to sexual offenders" (P9: 882-908).

Similarly, respondent [P3] questioned the ability of professional staff to accurately predict risk, and made an association between violent video-games and potential to reoffend. In chapter four, it was noted how this man had described nurses as being oblivious to cues indicating an obsessive interest in violence, and this extended to ward-based management of sexual materials. Nurse respondent [S1: 654] had expressed concern about the influence of computer generated imagery, where the fictional character of *Lara Croft* assumed iconic status as an amalgam of sex and violence. In a similar way, this patient saw risk as subjective interpretation and remarked on the, excessive, level of enjoyment that a fellow patient derived from play-station games with a violent content. Compared to the dreary existence of daily life on the wards, technology might offer escape into a more exciting virtual space, but could also signal deception and danger:

> "The other one down here...killed [pause] a member of his family...sexually [pause] will tell me that he's no longer violent...but he plays the most violent games he can pick on the computer which are all shoot 'em up games [pause] I mean I have a PS1...I have a couple of shoot 'em ups...I have a couple of drivers...a couple of *Lara Croft* [pause] er...the usual cross section...and I hardly ever play 'em anyway [pause] this guy lives on the computer...sniping...killing...stabbing...hacking ...whatever...loves it and gets a real...you know he's getting a buzz" (P3: 1964-1971).

Exceptions to the ban on pornographic magazines were described by nurses as rare events. When access had been approved it was presented as the outcome of decision-making by the care team, based upon what was deemed clinically inappropriate in the context of the offending history of particular men. Respondents [S6 & S2] noted how, for sexual offenders, the policy of implementing a blanket-ban was moderated by the assertion of individualised care planning:

> "there are...a couple of patients who are allowed magazines...erm [pause] I mean part of the stipulation of that is it's gotta be approved by the PCTM [pause] erm [pause] the two people where I'm aware of where it's been approved aren't sex offenders [pause] so I think that's...a part of the policy...or certainly something that's considered" (S6: 861-865).

> "It's an individualised care (.) obviously somebody with erm a sexual offending history er who wanted to order erm say *Mayfair* or...or some...y'know pornographic magazines...erm

> that would come to the care team and we'd obviously discuss that and by and large we'd say that that's clinically inappropriate for that individual" (S2: 88-92).

Considering whether, as some nurses suggested, legally available pornography might have therapeutic value if incorporated into assessment and treatment, led respondent [S17] to reiterate his perception of 'control' being the fundamental function of the organisation. Illustrating this commentary, the issue of sexual media was placed alongside other aspects of the patient's lives where choice was replaced by scrutiny, screening, and surveillance. If things such as clothing, music, and communication were regulated and monitored, the possibility of accessing heterosexual pornography threatened the institutional order:

> "You'd never be able to persuade the patient care team though...or the [hospital] authorities in my view...not because it's erm...because of what we're saying in terms of the clinical thing but in that [pause] if you...if you introduce something like that it's another thing that's difficult to control [break] and it's easier to control if you don't have those things...and one of the things that [name of hospital] is clearly about is control [break] you can only have x number of videos...you can only have x number of cassette tapes...you can only have x number of pullovers or whatever it might be...and er you...you know...you can't write to him or her or whoever...and they're the telephone numbers you're to have (.) and if you start to introduce something like erm heterosexual pornography as part of a treatment programme you've lost that element of control" (S17: 1019-1036).

There was a parallel between the way that some nurses talked about the philosophy of care being dictated by patients perceived as presenting greater levels of risk, and allowing pornography on the wards. Respondent [S8], though ambivalent about non-sexual offenders accessing commercial pornography, described individualised decision making as impractical within a highly-structured environment. The account resonated, as discussed earlier, with the idea that masturbation as male need was not a problem, unless the identity of the individual concerned could be exclusively defined in terms of sexual offending:

> "and if they want to watch...like soft porn or something like that and they've not committed any sexual offences and it's for their own personal use so they can...masturbate...and...and satisfy themselves I've got...I don't see a problem with that [pause] but we can't like make...like individual policies for people...for each person" (S8: 796-800).

These accounts introduced a central dilemma in the institutional management of pornography that, in variant ways, was interwoven throughout the findings of the study. Where pornography represented a malleable artefact of the male imagination, it was both an adjunct to healthy sexuality and an indicator of deviant sexual interest; so that any meaningful interpretation of imagery in relation to risk was sacrificed to a crude duality between normal and abnormal men. From this perspective there was little justification for withholding sexual materials from patients with non-sexual categories of offence, and pornography became a neutral category with the potential to be used or abused. For

respondent [S5] the ideological messages of pornography were of less concern than the audience and, while supporting censorship for sexual offenders, the possibility of negative behavioural effects was rejected:

> "if you've got arsonists and [pause] robbers...thieves..y'know...anything that's not rela [unfinished] any offence that is not related to...of a sexual nature...that patient can apply to have pornographic magazines...and material to use in a masturbatory...reasons (.) erm and my view of it is that they will be allowed to have it because they haven't got that sexual offending behaviour...history y'know...erm [pause] and I can see the rationale's for that (.) erm but I...I don't believe looking in magazines made that patient offend anyway" (S5: 819-825).

No longer a recognisable commercial product, pornography became a product of the deviant sexual imagination, manufactured through the corruption of day to day imagery. On the wards of the PDS, mundane and innocuous items were reclassified in terms of the perceived relationship between an image and the offending history of the viewer. Commonly cited examples [S1], intimated as forms of virtual abuse, focused on the potential for children's clothing catalogues and television programmes to be converted into erotica. Respondent [S10], likewise, talked about representations of the schoolgirl, in a series of classic comedy films, as comparable to 'porno' or a 'blue movie'. These extracts of data illustrate a discursive shift that was palpable in all the nursing staff interviews when they began to talk about their role in dealing with pornography:

> "the *Argos* catalogue becomes...becomes erm a...a problem for us because while it isn't offensive erm...in legal terms...it is very definitely them getting off on the *Argos* catalogue...children's programmes on the TV are a problem because they're getting off on those kids (.) now if those kids...those kids aren't...aren't aware of them getting off on them but it's still an image...of a real kid and you don't know what that's fuelling" (S1: 237-242).

> "[in St Trinian's films] running round with pig-tails...women...short skirts...flashing their knickers...flashing their bra (.) my God to a...to a paedophile it's gotta be heaven for them hasn't it? It's gotta be a blue movie...it's gotta be porno for them" (S10: 1136-1138).

Unusually perhaps, respondent [P7] who had talked about sexually offending against young girls endorsed the removal of pictures of 'kids' from the ward environment. Making reference to other people, to support his account, he drew attention to supplements that were included in the Sunday newspapers. Issues of topical interest such as fashion, eating disorder, or teenage pregnancy assumed an additional dimension when it was implied that pictures were taken from the magazine to be used as a source of sexual stimulation:

> "Sometimes they may have a feature on kids clothing...er [pause] they might be doing an issue on...on teen pregnancies [pause] teen anorexics or whatever (.) er [pause] and I'm not saying the images are sexually explicit...but [long pause] I have seen on occasions when people have taken these pictures out...of magazines and sidled off down their rooms with them" (P7: 831-838).

In contrast, respondent [P6] talked about nurses adopting an uncritical approach in searching out, and removing, images of children, where any cultural or intellectual distinction between art, erotica, and pornography had been eroded; with images in the hospital appraised only in terms of their possible effects on the viewer. The description of staff cutting out newspaper articles evidenced the almost visceral assumption that *particular pictures* could result in *particular behaviours*, and that these would largely relate to the paedophile offender:

> "Pictures of children and other aspects have been cut out of various magazines (.) erm there was a lady did an exhibition not long back...a photographic artist...of female...male and female children...I don't know if you recall it? Yeah...well a lot of the Sunday magazines covered that [art exhibition] in depth (.) well you was getting the newspaper orders and the Sunday magazines and they was coming down but you was going like that [indicates difficulty to read] and there was squares cut out of the magazines...somebody had...had sat up there...just sat there and just gone systematically through the magazines" (P6: 808-818).

It might be that, for some patients, pictures of children could be invested with erotic meaning, but stark censorship represented a crude attempt to sanitise the environment, remove sexual cues, and exert *external control* over what patients were allowed to look at, as if this equated with an *internal control* of what they were thinking.

Summary

The chapter has explored how male nursing staff, and patients, shared a discourse about pornography which manifestly exposed the gendered dichotomy discussed previously. In the context of a forensic healthcare setting, concern about an unhealthy male alliance becomes more worrying than evidence of institutionalised sexism. The discussion focused on a commonality in the way that women were spoken about by detained sexual offenders and male nurses, where a departure in their views only occurred at the extreme end of sexually violent offending behaviour. The male accounts clearly demonstrate how being a woman, in this environment, is to be 'other'.

Pornography was something that the male respondents knew about as men, and their discourse was located in ideas, and ideologies, about male sexual pleasure. Attempts to define pornography were contextual, in that while masturbation was seen as a normative feature of male sexuality, with pornography providing a stimulus, the talk was located in a high-security hospital for the treatment of men deemed to present a sexual risk. Nurses occupied a key role in deciding about, and policing, what might be considered as appropriate materials for the patient group to consume. This extends the idea discussed in the previous chapter about a commonality in male discourse, but one that needed to discriminate between the deviant (patient) and the normal man (nurse). The definition of any item, or media, as

pornographic, or clinically inappropriate, focused as much on the user/viewer as the material itself. A range of materials and media were constructed as pornographic on the basis of how they might be used, and manufactured, by the deviant imagination.

In the same way that language defined the ward as male space, pornography defined women in terms of male pleasure and communicated a hetero-normative construction of sexual relations. Talk about pornography was interwoven with the way that men talked about sex and sexual offending, where gratification derived from the subordinate positioning of women. If pornography was a feature of men's lives, risk was spoken about as residing in certain individuals as much as certain materials. This permitted male nurses to make a distinction between normal and deviant sexuality, positioning the dangerous sexual offender as other. However, where the accounts of these nurses fluctuated, as a way of demarcating some moral distance, it was in relation to serious and criminal behaviours. Collectively, women were constructed in terms of *sexual being* and *sexual blame*; common stereotypes identified women as victims of, either, their innate weakness or overpowering natures.

To this point, female nurses have been discussed as invisible, and insignificant, figures within an institutional culture shaped by male values and defined by male language. The next chapter moves the analysis forward by exploring the accounts of those women who chose to work in the field of secure mental health nursing.

CHAPTER 6

Women as 'other': Discourses of discrimination and distance

Introduction

The previous chapter explored dominant discourses which textured the institutional culture of the hospital. They defined how the hospital was talked about, and how security and care were constructed as part of the nursing role. While there was variability within individual accounts, and between those of patients and male staff, this was, largely, the language of men. In contrast, this chapter identifies specific aspects of gendered discourse that were exclusive to the five women respondents. It is noted that male respondents talked about the institution, but the female nurses talked about their experiences of the institution. The broad content of the interviews suggested that more than fifteen years after the publication of the highly critical Blom-Cooper Report (Blom-Cooper et al 1992) an oppressive and densely macho culture remained. The analytic focus here, though, is also concerned with how women used language to position themselves in relation to a designation of otherness as they were spoken about by men. Beyond a discussion of discrimination, sex-role stereotyping had larger ramifications in terms of the discursive construction of nursing, therapy and risk.

The chapter is divided into three, interlinked, sections which explore how women, as outsiders in a predominantly masculine culture, struggled to establish a sense of professional identity. The first part focuses on the way female nurses deployed a risk discourse, which constructed the ward as a place of danger. The second section explores how the women's talk attempted to make sense of nursing within an environment that offered an impoverished version of caring and minimal patient contact. Each of the respondents spoke about the 'macho' style of nursing on the Personality Disorder Service, defined in terms of policing dangerousness and maintaining order. In this context, of male *invulnerability* and women's *invisibility*, the female nurses attempted to retain a nursing persona through talk about care and compassion.

It is recognised that opportunities for women to develop a sense of self were extremely limited, and their accounts were permeated with compromise and contradiction. In particular, female staff shared the tendency to switch their language according to context. Indeed, the final section of the chapter extends these ideas by exploring how collusion with a dominant discourse portrayed the sexual offender as distinctly different and dangerous. By

invoking the concept of fantasy as a central component of sexual offending, the dual otherness of female nurses, and sexually violent men, merged in the production of a discursive distance that excluded them from any dealings with the sexual domain, and diminished their professional agency.

Situating gender in a masculine culture

The female nurses who participated in the study were similar to their male counterparts, and undertook similar roles in a common working environment. The women respondents differed, markedly, from the male nurses in relation to the way that gender and discrimination was prioritised in their accounts. Talking about organisational life, each of the respondents made reference to career inequity, a sexual division of labour and feminised domesticity. The content of their discussions suggested that the historic legacy of patriarchal power and privilege remained as an enduring characteristic of the hospital. This sense of being an outsider, in a masculine culture, became an organising feature in the way that language was used to negotiate professional identity in relation to male colleagues and male patients. Like the other women, respondent [S4] tendered a description of the daily routine of life on the wards that indicated the way language reflected and reinforced a collective masculine identity. Other female participants would, also, make frequent reference to 'football' as a way of signalling male territory and male bonding:

> "so we deal with a lot of patient's requests on a day to day basis (.) erm...and talk to the patients that are still on the ward erm...just about general stuff not...er y'know normal stuff about the football or what they're watching on the telly at that moment...or what they're reading in the newspaper...just have a discussion with them" (S4: 478-482).

The experience of the female nurse, positioned as a woman, could be described in terms of feeling different; a visible and pervasive diminution of being, where the terms 'old boy' and 'little girl' were juxtaposed to connote gender disparity:

> "you do see it all the time...it's very erm [pause] it's very old boy networkish [pause] erm as a woman in here sometimes you can feel that you're the...little girl...you can see quite a lot of that" (S7: 1188-1190).

Collective accounts, that constructed a sense of otherness, situated the respondents within a discursive repertoire that focused on the exclusion, and injustice, faced by women who elected to work in a high-secure care setting. When they talked about the degree of difference experienced by female nurses, the women drew attention to the way inscribed biological properties variously constructed them as physically inferior decorative objects, or valued assets, on the ward. In a classic no-win situation this meant that they either elicited

danger, or provided distraction in reducing the tensions of a closed-off male world. To suggest that the presence of women on a ward exerted a calming influence, unrelated to any skill or expertise, diminished their professional contribution and categorised specific types of work as the province of women. The demeaning language used to describe certain tasks as 'girly jobs', akin to the euphemistic classification of pornography as 'girly magazines', was presented as deprecatory and disempowering:

> "we're seen very much as a decorative [pause] thing and...we're here to smooth the waters (.) 'cos...men mightn't act out as much if women are there (.) our role is very much erm... played down...it's a man's world here erm...promotion prospects are very poor because we're not seen to be...in charge enough...to have enough...power...physical...or whatever erm...patients see us very much as a token role as well (.) erm...and there are jobs that are seen to be girly jobs" (S11: 1122-1128).

Sexually divided labour was talked about as an implicit part of life on the wards, where women were defined primarily in terms of gender, rather than their professional status. One female nursing assistant [S12: 617] spoke about the expectation, incumbent on gender rather than grade, that she make hot drinks for the men on her shift and carry these from the kitchen to the male domain of the office. Likewise, respondent [S11] recounted the challenge involved in confronting entrenched and discriminatory ways of working when she replaced a long-serving female staff nurse, whose age and sex combined to construct a maternal figure. The scenario was sketched out in a way that parodied the idea of the ward as a family, where the role of the woman was to keep the 'boys happy'. Within an oppressive organisational structure this ritual was reinterpreted as a site of resistance, where assertive women posed a threat to male power and privilege:

> "there was a lady on this group who was [pause] of maturing years and...and her role was to make the tea...and that was it (.) and she'd been told by the team leader...who then became the ward manager...that that was her only role...to make sure the boys were happy and that the tea was made [pause] that was what she did (.) anyway I came...and they say I emancipated her...because I said 'You make one cup of tea...and if they have six cups everybody makes a cup' (.) Erm...and I hope that will change" (S11: 1144-1150).

Described as 'doing all the donkeywork' [S12: 593], women talked about the expectation that they, alone, should work in the kitchen area at mealtimes, serving patient food, washing crockery, counting cutlery and generally tidying up. In contrast to the accounts of men that routinely defined the ward as a male space, the kitchen was singled out by female respondents as a territory set apart by the gendered allocation of domestic labour:

> "they're sexist like that...there is that [pause] erm [pause] I do try to...sometimes when it gets on me nerves (.) they don't...they just won't wash dishes [pause] or they'll...they have to dish the food out...I need somebody to help me dish the food out and if there's any men

around I guarantee you (.) yeah...I guarantee you that it's me and [another woman] [pause] in the kitchen" (S12: 597-601).

If the accounts of the female nurses expressed outrage at discriminatory practice, they also revealed how women continued to work in an oppressive culture. The consistency in their rejection of a secondary status was interwoven with a discursive strand that reconfigured talk about sexual schisms by defining the environment in terms of risk. Respondent [S12], for instance, accommodated the sexism of male staff by locating it within a larger institutional discourse about the dangerousness of the patient population. If male staff had talked about a confrontational nursing style, women identified more with relational safety based on rapport and interpersonal engagement. Later in this chapter the construction of nursing, as a product of gender, will be discussed as a further linguistic device that women could deploy to position themselves within the organisation. While the men had commented that female nurses in the hospital were unlikely to be the targets of violence, unless sexually motivated, women invoked physical harm as an ever-present possibility. Fear became a constituent of everyday life on the wards, where the respect of potentially aggressive men was described as something that had to be hard-earned:

"you have to work hard to build a relationship to protect yourself...in a way [pause] you have to work really hard to get the patient to respect you...without breaking your boundaries...so that it can work (.) 'cos you just [long pause] they could really hurt you...physically they could...for example if a patient didn't...was going to take exception to me they could give me a right good pasting and find every opportunity to do it (.) and it would be awful...I would be traumatised by it...and I wouldn't like it to happen...but it could [pause] so there's a lot of fear element to working here...there's always that...chance" (S12: 439-446).

Emphasising risk permitted the role of the female nurse to be reconfigured in an environment that could be described as, both, 'horrible' and 'very supportive'. The organisation of the account adhered to the 'fine line' that was explicated as one way female nurses could survive in the hospital, and illustrated the complex positioning women had to perform in relation to men and male staff. Where physicality was a prized attribute, and protection from harm was granted through male patronage, the discourse shifted from male staff to the team or shift. It now became possible to talk about the men with whom one worked as generally supportive, with problems of chauvinism accorded to just 'some of them'. Being accepted on the ward might entail an investment in the protective function of male nurses, but it diminished outsider status by identification with a collective body. This delineation between individual men, and the team to which they belonged [S7], paralleled patient accounts that made a distinction between individual nurses as good, and the shift as bad:

> "Well it can be horrible...it can be horrible if erm [long pause] it's horrible...it's...it can be horrible (.) but you [long pause] er you use your [long pause] your skills...your everyday skills to get through that...and the male staff are very supportive [pause] they're very very supportive of you and erm [pause] some of them...yeah (.) some aren't though...yeah there's a...there's a fine line...I'm very lucky on my shift...I have a very supportive team erm...they give me the freedom to [pause] they don't...they don't make me feel like I can't make a decision...or I can't er interact...y'know they don't make me feel inadequate...they allow me to do what I do without criticising me...or [pause] whatever...but they're all very protective" (S12: 552-561).

> "I like the shift system where you're working with your own shift day in day out...so you've got the same people all the time...and if you've got a good shift that works really really well (.) but if you've got a bad shift obviously that can be dreadful erm...and you've got your team leaders to go to...you've got your ward manager...as long as it's very safe and secure you're ok" (S7: 1211-1215).

Further extracts of data from the respondent account reveal how tensions, in articulating the role of the female nurse, could be reconciled by shifting the focus of the talk from 'men', to men with a 'personality disorder'. The 'safety' and 'security' afforded by working with male staff might offer some compensation for the demands of the job, but this was set alongside the exclusion incumbent on gender. We are reminded of the informal relations between the male staff and the patient group, where their talk textured the ward environment, and membership of the community was framed by things such as football in which men had a shared interest. The respondent then engaged in a linguistic manoeuvre, which would be a recognisable element in the women's accounts, by redefining the concept of nursing in relation to unique challenges and a specific client group. The patient population became other, a collective force, identified only by diagnostic descriptor, who posed a cumulative, and unrelenting, threat to the physical and mental well-being of those with whom they had contact. Security, here, had a dual interpretation, where comfort and familiarity, through prolonged exposure to this type of patient, had personal and professional costs:

> "on one hand I like working with all men [pause] I do [pause] because they do protect me [pause] generally you feel very protected and very safe with the men on the ward er so I do...in some ways I like it...and in some ways I don't [pause] that y'know...you're not involved with all the boys things and football and things like that so it can be difficult (.) I just don't think you should spend [pause] I don't think anyone should spend more than say five years in one area [pause] because I think you become too comfy and you do...you lose your skills from other areas [pause] it's a very hard environment to work in...it's very stressful it's...you can go home and your mind's swimming erm...but you can become like this hardened person 'cos it is difficult to deal with personality disorders day in day out...eventually they do have a damaging effect on the staff" (S7: 1196-1206).

Respondent [S12], likewise, articulated an ambivalent account that moved between stating a preference for working with a majority of men, and a strong criticism of the way that women were routinely excluded from the team. It was claimed that male nurses 'manipulated' events to create overtime for themselves, but would allow the ward to run on a reduced staff

roster rather than recruit a female nurse. Notwithstanding the accuracy of this complaint, the language-use is instructive at a series of levels; it is men who are seen as being in control and making decisions, while women are peripheral and expendable. Further, repeated use of the term 'manipulate' as a means of describing the men's actions, invested them with what nursing staff asserted was a hallmark quality of the personality disordered patient:

> "Right [long pause] right (.) I have [pause] strong views both ways [pause] I personally prefer there to be more men...than women [pause] on the shift...I wouldn't like it to be all women [pause] but I do take exception when they manipulate that...and the men manipulate that [pause] to get their overtime (.) or they manipulate that situation...for example if we're down...we...we run on six...minimum of six (.) ok...now if there's two women on the shift...they won't recruit another woman to make that six...the person [pause] what they'll do is...they'll run on five [pause] rather than recruit a female [pause] to make up the six...well you tell me? [pause] That's what I take exception to" (S12: 527-535).

In a coalescence of these discursive themes, nursing on the wards was described in moribund language. The option of making a 'change' by leaving, which sounded like an escape plan, suggested the extent to which life within the confines of the ward was experienced as overwhelmingly oppressive. If this sense of desperation is reminiscent of the men's accounts, it was told from the perspective of someone who had been set apart from the other inhabitants of an insular world. The longevity which framed relations between male staff and patients, and provided for some mutual understanding, was viewed from the outside. These two groups of men, inseparable within the account, were talked about as people who could be defined in terms of 'cynicism' and 'stagnation'. The only palpable skill that was mentioned, and which might relate to either nursing or security was 'observation'; a textual image of an assortment of men, locked away together, watching each other over many years. The claim, that being a nurse had been 'forgotten', provides a platform for the next section, which explores attempts by female respondents to position themselves by reclaiming a concept of caring:

> "You gain a lot of skills in one area...sort of observation and erm [pause] you do gain...you gain a lot of skills...but I feel like I've de-skilled in a lot of other areas and I need to change [pause] I think people can become stagnant [pause] people who've been here for twenty five years [pause] become dead cynical (.) I think this place is really [pause] a cynical place and people...people become as despondent as the patients [pause] it can happen [pause] people become very hardened as well [pause] towards...towards patients and sometimes you can see some attitudes towards patients and you think 'Oh god...but you're a nurse'...People forget that because it's very blurred here between nursing and security" (S7: 1167-1179).

Negotiating nursing in a secure setting

In the women's accounts, nursing was contextually defined according to the individual being cared for and the setting of the care process. Their talk shifted between accounts of nursing

within the hospital and external experience with different client groups. Respondent [S4] was one of the staff who had been redeployed from the disbanded Women's Service, and used this employment change to make a distinction between the detained men she currently worked with and female patients encountered in her previous job. The account was located in the dominant discourse of high-security, where being called a 'screw' invited comparison with the role of a prison officer. If this was an acknowledged occurrence on the ward, it could be dismissed as resulting from episodic anger rather than a permanent marker in relations between the two groups. Tensions and conflict were understood as an inevitable product of detention, but there was uncertain optimism that one could still be seen as a nurse. In particular, it was men with whom one had regular contact, described in terms of ownership, that positive relationships could be envisaged:

> "it's mostly when they're angry and things like that and...which you can understand you know (.) but I don't think they truly believe that we are screws...I don't think patients do think that (.) erm I don't think my patients view me like that...I think they see me as a nurse" (S4: 435-438).

Earlier in the interview, the concept of working with detained men had been constructed as markedly different from looking after female patients. In the respondent's talk about either group, though, it was difficult to disentangle a discrete idea of nursing from a familiar institutional discourse focused on security and containment. A role described in terms of 'complete change' made little comment on individual patient need, aside from responding to problems where harmful behaviours could be directed toward the self or others. Reminiscent of male nurse accounts, success on the ward equated to the distance that could be maintained between staff and patients. 'Hands on' nursing was less about the application of practical skills, and more to do with physical intervention as crisis management; an approach to the job that was defined by others, and self-imposed. Female patients assumed an otherness by virtue of their being perceived in terms of a higher level of risk, relative to which the male patients were spoken about in terms of 'independence' and 'trust':

> "My role's changed completely because we were very sort of hands on...on the...on the women's wards er...they're more dependent on staff for things (.) things were are a lot more high security because they needed to be...because there's a lot of self harm and things like that (.) whereas this ward I don't know...I can't erm...I can only speak for this ward...er [name of ward] it's [pause] a lot more (.) less...it's less structured because it doesn't need to be 'cos the patients don't need that maximum level of security anymore...they can be independent...they can be [pause] trusted...if that's the word...with certain things and so it...we do a lot [pause] we [pause] don't have to deal with so much (.) I don't have to do so much for the patients anymore as I did with the females...they had a lot of females on like two to one staff [observations] 'cos they were attacking...self harming things like that (.) we don't get that at all on here" (S4: 79-90).

If practice, as discussed above, did not require the nurse to 'deal with so much' the way the hospital was talked about provided an opportunity to preclude patients from being considered as service users. This way of addressing a person belonged in other places, and related to other people. The respondent located specific terminology in specific contexts. Her nursing role in secure care could be spoken about as though it was apart from her original nurse training and qualification. The label of 'learning disability' defined who she really was, and how she thought about care, but entering the forensic field had required her to adopt a different language:

> "I'm a learning disability nurse really and I've done me conversion [RMN] now...and we always referred to them as service users or clients...but mainly service users...and then I...I came back...well I came back to [name of hospital] and they referred to erm...them as patients...and referred to the patients as patients and that (.) so I've sort of adopted that...whereas I wasn't used to using that sort of language" (S4: 260-265).

Language worked to construct a characteristic otherness that operated in the hospital and, further, disqualified the disordered offender from inclusion in a larger community of mental health consumers. An emphasis on involuntary status and maximum security, rooted in coercive mental health legislation and the forensic system, transfigured the service into a warehouse where keeping patients appeared secondary to actually caring for them. This particular version of the organisation emerged as a linguistic strategy that enabled respondents to retain a professional nursing identity while acknowledging limited nursing involvement. Focusing on the nature of patient admissions negated recognition of their having choice, while reference to other groups of service users outside the hospital delegitimised their needs:

> "we're basically keeping them in a maximum security y'know...hospital (.) so it's not a service that they use [pause] it's not like erm in the community where I worked...they were service users (.) they used facilities in the community...so therefore they were service users...we provided a service for them to enable them to live...the best y'know...the maximum possibilities that they were able to in...in the community (.) but it's hard to provide that for the patients here because of the...the setting (.) it being a secure setting it's very difficult to provide a ser [unfinished] that sort of service for them (.) we try...I try personally...my best to do this...quality...and standard of their life they can have in this setting" (S4: 271-279).

> "I think when people have a choice to opt into...treatment (.) erm if you're working in a generic unit...or your needle and syringe exchange...anything like that...places that I've worked...erm regional addiction units...I think they're service users...they're clients...because they've opted into it [pause] these [men in the hospital] are a group of people who it's been deemed...need treatment" (S11:89-93).

The account of respondent [S7] demonstrated further the way that female nurses tried to reconcile a nursing identity within the unique culture of a hospital defined in terms of containment. The indirect attribution of negative characteristics to the larger workforce, and

the patient population, provided a means of delineating between 'real nursing' and patients who were 'not deserving' of care. The language that underpinned this distinction was framed by a pejorative commentary that was claimed to be the reported speech of others. In stark contrast, the respondent introduced her previous experience of working with elderly mentally ill (EMI) women as a way of demonstrating emotional investment in the act of caring. The clients were idealised as 'little old ladies', and care was talked about as being 'touchy feely'. The discourse, here, connoted nursing as fundamentally rooted in compassion, where there were few barriers between the professional and personal life of the carer; one could, for instance, take home worries and concerns about the people for whom you had a genuine interest in helping. The difference between caring for the vulnerable elderly, and men in the study site, could be configured as 'massive'. Here, it was less an abandonment of the core conditions of nursing, as a sacrifice to survive in an environment where practice required one to become 'hardened'. Talk about a collective denigration of offender-patients within the hospital, and the alleged contempt of friends outside, depicted a sense of being devalued and relatively powerless:

> "I think erm you can often lose sort of your compassion and your...your sort of [pause] real nursing...I call real nursing erm [long pause] to do with having real sort of caring and compassion ...they've...there's a lot of staff here that [pause] genuinely don't give two hoots about the patients [pause] really [pause] really hard...bitter 'they're all dirty pervs' type attitude...don't care anyway [pause] there are some people that are very good...but there are...and I think that's to do with the culture [pause] erm [pause] and I have found myself hardening up [pause] yes I came from EMI to here...that's a massive difference...EMI was very touchy feely...little old ladies [pause] erm real...real sort of caring for them...I used to go home and be really really upset because y'know they couldn't get free continuing care beds and things like that (.) I don't do that here [pause] 'cos people do see our patients as [pause] not deserving anyway...don't they? People see these patients as...well 'They've done all that anyway...they're only rapists...murdering [pause] whatever' (.) I mean my friends definitely see what I do like that...'I don't know how you look after them...they ought to be shot...dirty...I don't know how you don't spit at em?' [laughs] That's the attitude of people outside towards what I do" (S7: 1255-1274).

Blending these discursive strands together, respondent [S11] defended the concept of nursing, in a forensic service, in an account that emphasised competing constructions of 'caring' between two clinical directorates that comprised the secure hospital. A broad concept of 'treatment' was presented as the central component of a nursing role, to which other job requirements were secondary. To 'see yourself' in a particular way was important in communicating a nursing identity to the patient group. Talk about the embracing otherness of personality disorder was combined with claims of gendered discrimination that linked a specific style of nursing practice to the diagnostic classification of the patient population. Suggesting the Mental Illness Directorate had more women in positions of seniority permitted the respondent to draw upon longstanding professional stereotypes and assert the dominance of machoism in the construction of nursing on the PDS:

> "I think you have to be very clear about what your role is (.) erm...and [pause] I think you have to see yourself as a nurse...and the treatment is the main...issue (.) all the other things [pause] are part and parcel of the job...but they're not the main part of the job (.) erm...so you have to make sure that [pause] patients see you very much as the role of the nurse" (S11: 71-75).

> "you look at Mental Illness (.) there's more women in charge down there...because it's more of the caring nurturing role with mental illness (.) but here...it's all about machoism isn't it? So women can't be in charge" (S11: 1174-1177).

Associating the essence of nursing with caring qualities, that were described as cultural attributes of women, developed an account where tradition was compromised by the significantly greater number of male patients and nurses. Invoking the iconic figure of Florence Nightingale personified nursing as a female vocation, where men who entered the profession could be understood as other. If the title of nurse could be owned by women, it was seen to be an embarrassing and unwanted label for men. Rejecting a feminised status could be more easily achieved when the patient group were extricated from conventional understandings of nursing need as a product of illness, as with men subsumed by a diagnostic master-status of personality disorder. Nursing, when related to men and masculinity, was spoken about in terms of policing dangerousness and maintaining control. Described as 'back-up', the job of men was seen as secondary to caring; a physical presence and a visible sanction for those who threatened to upset the stability of the ward:

> "Well it's a...it's...traditionally isn't it? (.) You look at Florence Nightingale...a woman (.) you look at...it's a woman's [sighs] perceived role isn't it? To nurture...to care (.) erm...although we have a lot of men in nursing they want to...they don't refer to themselves as nurses do they? A lot of them...they don't refer to themselves as nurses [pause] and I think (.) in the PD Unit it's about them being sort of there as the back-up y'know they're...they're there to...to sort the problem out and to keep everything just ship-shape but within nursing...within Mental Illness because they've all got a mental illness [pause] it is more about the caring role" (S11: 1274-1281).

> "we have patients that are avoiding personal hygiene...but we don't do the same [pause] because it's not really [pause] seen as (.) there's nothing...that you can say...that he's displaying [pause] psychotic symptoms (.) he needs all of your input at this particular moment...it's not seen as the caring [pause] role this (.) this is more...your talking...your making sure that nothing happens (.) everybody stays safe (.) it's a very hard concept for some people to see this as nursing" (S11: 1296-1306).

This comment about nurses on the PDS being reluctant to engage with relatively basic care needs such as personal hygiene illustrated a discursive device that enabled women respondents to present a more positive sense of self in an environment that denuded their professional credibility. In this, they drew attention to the vulnerability of men and made a claim on the physical components of care.

Respondent [S11], a team leader, offered two instances where men on the ward had undermined and subverted her clinical competence and overall authority. At the commencement of each shift the senior person on the ward was required to identify an individual who, in the event of an incident elsewhere in the Directorate, would be dispatched to provide support. As lead nurse for the team, the respondent had identified another female colleague to respond to any emergencies. However, in response to an alarm call from another ward, a male staff nurse abdicated his assigned role and made a decision to replace the designated nurse. The respondent described this act as compromising her authority and judgement. The reported response of the male nurse was interpreted as a criticism of his maleness rather than his unprofessional behaviour. The account highlighted a rigid task allocation where specific duties, such as carrying the radio, were fixed for the duration of a shift. Further, the language-use constructed a male terrain in which men knew how to 'scrap on the ward', and peer shame could be more powerful than the implications of ignoring the instructions of a female manager:

> "the other week something happened (.) erm...the male member of staff on the radio [pause] a disturbance come over (.) his job was to notify me...let me know if there was a disturbance...for me to send a member of staff (.) I identified her when I came on...on shift...who wouldn't have anything...that person would go to a disturbance...I didn't identify a man (.) the male staff took the radio off and threw it to the female that should have gone...because he didn't believe that she should go [break] and when he came back I said 'What was all that about?' [pause] And 'Why did you think you had to go?' It was a macho thing...and he was affronted that I'd said this (.) but it was...erm [pause] sometimes they're genuinely concerned...er...but it's how would they say to their mates a woman had got injured...in a scrap on the ward" (S11: 1128-1142).

The respondent also talked about subterranean strategies that operated outside of the managerial structure of the team. It was suggested that these were used, by men, to manipulate and control gender at ward level. One example was a male nursing assistant who had been instructed by the ward manager, described as 'one of the lads', to take on a covert role in protecting female staff, one of whom [S11] was his manager. If men wanted to ensure that the environment was safe, this was achieved through a form of conspiratorial control rooted in masculine bonding that cut across clinical grades and professional responsibilities. The respondent offered two broad, competing, interpretations of collusive communication as 'nice' and 'inappropriate'. The intent of the male staff could be understood as reflecting a genuine concern for the well being of a female colleague, but this was experienced as undermining confidence and corroding self-worth:

> "but I remember [laughs] there was me and another female qualified on...and one of the lads said to one of the male nursing assistants...tomorrow there's only [name of respondent] and [name of female nurse] on (.) when they go in the clinic to do the pills make sure you go in there with them...so that they're safe (.) so I'm doing the pills and this male member of staff

> comes in and stands there and...I said 'Yeah...what do you want?' And he said 'Nothing' (.) I said 'What do you want?' And he said 'Nothing' and I said 'Hang on' So I shut the door over and I said 'What're you doing in here?' He said [name of ward manager] gave strict instructions I had to make sure that I had to come in here to make sure you were safe' (.) And that's the sort of thing (.) that was nice...but it was inappropriate...and who was it to make feel better? Not me...it didn't make me feel safe...it made me feel that...I couldn't cope if anything happened to me (.) so...they'd come over the top...they'd put all these things in...for their male pride" (S11: 1151-1167).

These anecdotes echo the discourses discussed in the previous chapter where women were typically described in terms of vulnerability and risk in relation to caring for predatory males. If female nurses were defined in terms of weakness and a dangerous sexuality, it had been an unspoken assumption that men were somehow impermeable to physical threat or emotional abuse; a world of invisible women and invulnerable men. In contrast to the male accounts, female respondents spoke about the costs of an organisational culture that ignored, or denied, the sexual component of masculinity to the detriment of male staff. In this way, respondent [S11] adopted a change of discursive direction in relating further episodes that challenged taken for granted assumptions around gender.

The first of these related to the anticipated admission of a patient onto the ward where she worked. Because this man was noted for his potential to sexually and emotionally abuse staff, regardless of their biological sex, the respondent had familiarised herself with documented reports. Prior to the arrival of the patient, a nurse therapist was invited to talk to all the women who worked on the ward as a risk-reduction strategy. It was stressed that only female staff were identified as a potential victim group who required counselling about the need for vigilance. In the dominant discourse of the wards, the individual assigned a counselling role was described as an outside expert who 'came down' to visit. Throughout this reported interaction the women were depicted as a group apart from the rest of the staff. Concern focused exclusively upon the need to maintain their safety, as innately vulnerable, rather than consideration of the implications for the larger clinical team. The question of who would advise the male staff of the risks that they faced, or of measures that could be taken to support them, was repeatedly raised by the respondent. There was, though, no recognition from the clinical manager that this represented a valid inquiry. What was perceived as a patronising approach, based upon stereotyped assumptions about women, was tolerable to the respondent only to the extent that men be included in the briefing. The ideological thinking and language of the manager constructed the dangerousness of the patient, as a sex offender, only in relation to a history of assaults against women. The classification of sexual offence was so strongly gendered that it could not be conceptualised outside of a crime committed by men, against women; the inevitability of the victim role was compared to the passivity expected of female staff. Men, in contrast, were seen as

tough, self-reliant and capable of taking care of themselves; the suggestion that some intervention might be required, for male staff, was interpreted as an emasculating affront. In opposition to male discursive constructions, the respondent suggested that risk did not have to be about physical confrontation. Instead, it was presented as a sophisticated form of psychological exploitation that was similar to the therapeutic language of grooming to describe the activities of many sexual offenders:

> "I remember a man...a patient coming...now if you'd read his notes...he'd caused a lot of problems...he'd offended against [pause] women...sexually and he'd caused a lot of problems for women [pause] but he'd caused [pause] more problems for men [pause] since he'd been in here [pause] but you had to have read his history...and I'd read his history...because I knew he was coming [pause] anyway I always remember the...the clinical manager at the time [pause] got this erm [pause] nurse therapist...came down to the ward and said 'So and so's coming to the ward' and had organised for this nurse therapist to come to talk to all the women [pause] and I sat there and...and I knew that hardly anybody had read his history and I said 'Ok...so they're coming to see us...who's coming to see the men?' [pause] So he said 'What do you mean?' And I said 'Well this patient poses more risk...there's three men have actually left nursing through [pause] the impact he's had on them erm...than women [pau se] he's got men involved in sexual...inappropriate sexual relationships with him' So I said 'Who's coming to see the men?'...'Ooh no the men don't need it...they're all y'know...strong confident...men' And I said 'But he's subtle...he's subtle in his techniques so why's he going to get into my head and not get into theirs? Why can't we acknowledge that we're all at risk?' And...ahh it was dismissed out of hand y'know...for me to actually suggest that these men [pause] might need [pause] the same assistance as women" (S11: 1362-1384).

Two further incidents, related by the same respondent introduced talk of gendered discrimination into nursing staff perceptions of risk. The first of these related to the inappropriate touching, of a male nurse, by a patient who it was claimed had a history of offences against adult males and young men. The patient allegedly pulled the male nurse onto his lap, where the reaction of his colleagues, described as shocked outrage, became a focus of the account. The youthful appearance of the younger nurse, which approximated to the patient's victim group, meant that he could be invested with qualities usually accorded to women. The re-telling of the story highlighted how this sort of uninvited physical contact between men violated rigid gender rules in the hospital, where a patriarchal culture prescribed sex-specific responses. Asking the researcher to imagine how these men would have responded if the nurse had been a woman, permitted the respondent to differentiate between male anger toward a humiliating spectacle, and risk defined in terms of sexuality or sexual assault:

> "well there was a thing recently there was a...a man in here...a patient who's offended against [pause] erm [pause] male boys and then adult men [pause] and he pulled a member of staff onto his knee [sighs] and said 'Sit down here' (.) And it was a male member of staff [pause] god they were all horrified...they were horrified...that this had happened [pause] and erm [pause] but nobody acknowledged [pause] the risk that he posed to this lad 'cos he...he

> looks very young...he looks like er...like a teenager...erm and he...honestly (.) but if that had happened to a woman can you imagine what would have happened then?" (S11: 1391-1398).

The second scenario was related in a way that signalled an organisational callousness which could be traumatic and damaging regardless of gender. A middle aged male nursing assistant had been instructed to observe a therapy session between a clinician and a recidivist child offender. His role was non-participatory, and the only expectation was that he should intercede in the event of an adverse incident. Given the nature of the offences being discussed, debriefing and supervision would be a component of the therapist's role, but no comparable support mechanism had been put into place for the unqualified nurse. It was claimed that he had become visibly upset by the experience, and that other men on the group had ridiculed his distress. In contrast, the respondent was seen as sufficiently approachable to enable the man to verbalise his inability to cope. If the account positioned women as an emotional resource on the wards, in relation to gender, it framed the respondent's identity in terms of compassion and caring:

> "he came to me on the handover and he said '[name of respondent]' he said [pause] 'I can't cope with what I've just heard' He said er 'I feel traumatised' (.) But knowing this man's offence...and I knew from him saying...that there was something amiss...anyway people were laughing at him [pause] and it was this 'Oh don't be stupid don't be stupid'" (S11: 1421-1425).

The demeanour and disclosure of the nursing assistant permitted the respondent to acknowledge that 'something was amiss', and curtail the institutional routine to allow the matter to be addressed by the simple act of inviting him to talk, and of listening to his anxieties:

> "Anyway I tried to get the handover over as quick as...out of the way...as I could (.) me and this lad went for a chat and I said 'What's the matter?'" (S11: 1429-1431).

The account functioned, in a number of ways, to construct a critique of the institution by inverting dominant ways of talking about nursing and treatment. The respondent's adjectival use of 'horrendous' was double edged in that it described both sexual offending and male nurses disregard for the emotional sensitivity of another human being. In a hospital that laid claim to a therapeutic discourse, the consequences of exposing a basic grade member of staff to explicit details of sexual crime was portrayed as exploitative and detrimental. Indeed, the incident was related as if the therapeutic agency had perpetuated the classic features of an abusive relationship; vulnerability and powerlessness, doing as instructed without choice, and not being believed. The intense distress of the nursing assistant was juxtaposed with the lack of empathy from other members of the nursing team as compounding the emotional

pain. The respondent recreated through language another variant of the tradition of toughness, where only physical harm was validated, and the infliction of any kind of injury or insult had to be taken as an occupational hazard:

> "he said 'I just feel sick to me stomach and I just...I just don't know what to do with it' (.) And what he'd heard was horrific [pause] to hear that...and to have...to have supervision...and to have all the safeguards was bad enough but to just be asked to go into a session and to...for that...to hear (.) and he hadn't heard any of the other treatment...he hadn't heard anything else...and he didn't have (.) and I know...I'm not meaning to malign him because he's a nursing assistant...but he didn't have the skills to deal with what he'd heard (.) and it was horrendous (.) erm...it was the sort of thing that made me feel...ooh gosh y'know...repulsed at that time because he couldn't visualise what this man had said he wanted to do y'know...it was horrendous... and he said 'I don't know what to do with it [name of respondent]' he said 'I just feel really bad' [pause] But it was the way [pause] it was minimised by everybody (.) erm...so much so that you could see he was having difficulty talking about it" (S11: 14-1432-1444).

The suggestion that the nursing assistant was expected to resume his normal tasks, after the departure of the therapist, continued the metaphor of an abuse narrative. Remaining in close proximity with the offender-patient, whose disclosures he had heard, meant this man was alone with an awareness of things that would be unknown to qualified nurses. The issue of therapeutic engagement with offending behaviours will be returned to in the final section of the chapter, where attention is given to the way that female nurses were expected to deliberately disassociate themselves from men with a history of sexual offending:

> "but that person then left the ward...and they were going to go for supervision about what they'd heard (.) erm...and this lad was just left with nothing y'know...and it was a case of just take up his duties...and was looking at this patient who he'd just heard say all that...who wouldn't say those things to us (.) erm...because he wouldn't be encouraged to be exploring those thoughts...because it wouldn't be appropriate [pause] and to listen to all that...and then just go back to his business (.) erm...and I just thought it was disgusting to be honest (.) erm...that he was left with nothing" (S11: 1485-1492).

Like a number of the male nurses, respondent [S7] identified staff sickness as a sizeable problem for the PDS, though, gender was presented as a specific component of workplace stress. The use, value and effectiveness of clinical supervision for ward-based nurses were questioned in the context of an overtly masculine culture. It was suggested that where such support systems were available, uptake was restricted by an implied weakness. While positioning herself as part of a collective nursing 'image', defined as 'macho', the respondent delineated between men and women in relation to acknowledging and talking about problems. The language used, such as 'big strong boys' and 'us girls', identified gender as much as sexual difference in the extent to which staff felt able to communicate things that bothered them. Any emotional need to participate in supervision was presented as incompatible with the attributes ascribed to men. Further, the cost to men, in terms of their

psychological health, was seen as greater. If women could find strength in identifying with their shared experiences, men could be punished for transgressing the gendered rules; to 'lose face' and 'look wimpy' connoted a humiliating loss of identity and purpose:

> "we do have supervision as well [pause] I don't think it's as utilised as it could be...or should be but I think part of that's to do with our macho image and 'Well we don't need to talk about it 'cos we're big strong boys and we're not bothered' (.) I think some people are bothered [pause] but couldn't say for fear of looking wimpy [pause] but it's easier for us girls to do...women to do here [pause] to admit that things are getting to them...whereas [pause] a lot of the men here would be seen to lose face if they said 'It's doing my head in' [pause] High sickness rate isn't it? Massive sick...there's reasons for it" (S7: 1211-1225).

Physical health care needs featured as a discursive strand that ran through the accounts of the female nurses. This might be an expected feature of nursing talk in a healthcare setting, but concerns such as this were notably absent from the interviews with male staff who participated in the study. Respondent [S7] talked about taking on a health promotion role on the ward, and spoke about the patient group in terms of their physical health. While this was distinct from an institutional discourse of need in terms of patient offending, which usually located nursing in terms of custodial management, poor health was discussed as an environment product. Talking about a 'locked up lifestyle', embraced men of all ages and attributed a range of chronic health problems to the same kind of dysfunctional lifestyle that was commonly used to explain anti-social behaviour:

> "a lad's just come over and he's got really high blood pressure for a lad of his age...twenty one...and he's really quite high...and that was picked up on admission just on the general physical admission [pause] also people tend to be out of shape y'know they don't go to the gym...they don't eat very healthy...they've never really had education in that way erm...so part of the educational programme would be healthy eating five a day [pause] if you're overweight seeing erm...seeing the dietician...having a weight management programme...if they want to get themselves into shape [pause] most people come over...they smoke so we talk about smoking erm...obviously prison's rife with hepatitis B and C...massive drug problems...so there's some people could already come over with drug and alcohol issues [pause] Hep B and C screening we would offer...as well as counselling erm [pause] older generation...there's a lot of diabetes...high blood pressure...heart problems because people have lived a very sedentary locked up life style...they don't [pause] they don't come over in the best of health generally...the same as our long stay patients here...very unhealthy population erm...and then there's government health drives as well...things like testicular cancer...we'd go through things like that erm...teach people how to self examine and we've got video's and things" (S7: 289-305).

Drawing on a different dimension of physical health, respondent [S11] talked at length about poor hygiene standards as a cause for concern, and an area that warranted the attention of nursing staff. The extract of data, below, is one segment of a larger account that situated patient disregard for personal care within debate about therapeutic work. It was suggested that body odour, which generally made the ward an unpleasant place to live, was particularly problematic in the context of smaller treatment groups. Though, hinted at here, the

respondent would further posit that failing to shower or change bedding could be indicative of deliberate strategies to sabotage, or avoid, treatment. Discursive manoeuvring, positioned nursing in relation to the other members of the care team who, it was maintained, gave low priority to such matters. It also grounded the concerns of nursing practice firmly in the environment of the ward, as the place where nursing staff and patients lived together. Constructing a nursing identity that retained the larger institutional discourse of the ward as a family home also divorced environmental health from a gendered allocation of duties; this was the business of *nurses*, not just *female nurses*. Overall, nursing emerged as a practical activity, distinct from the intellectual labour of 'doing treatment', that needed to be recognised as the foundation of more sophisticated interventions:

> "Oh personal hygiene's dreadful (.) erm...that's a major conflict erm...because your basic thing is to...to stay clean...to have a clean environment and we get a lot of patients when they're coming up to doing treatments...and they don't want to engage (.) you see that their behaviours in relation to their personal hygiene...deteriorate and that becomes erm...a bit of a battlefield erm...which the rest of the team...in amongst...disciplines input very low priority on personal hygiene (.) but that can have massive impact on a ward [pause] erm [pause] if you're sitting in a room with somebody that smells...that can be really offensive if they're walking on the ward and the patients...other patients complain about the odour...from them...or that the odour that's in the corridors...coming from a bedroom...that can have a massive impact to the point where other people won't mix with that patient (.) so then you've got socialisation problems...so I've been drawing up care plans to say 'Yeah you will shower...you will have to change your bedding' And that's been...two patients within my group at the moment I'm having conflict with erm...and as I say it...it's not acknowledged as being a major problem...but it is a major problem erm...for them...and for the people living around" (S11: 569-588).

Revisiting risk as a function of 'otherness'

The final section of this chapter explores how discursive themes, centred on gender, worked to position female nurses in relation to a construct of the sexual offender as other. The idea of a relationship between sexual thoughts and sexual behaviour permeated the nursing discourse, but it was interesting that the women respondents, typically, colluded with a dominant discourse about risk which reinforced dominant institutional ideologies and eroded their professional role. Nurses, generally, had scant involvement with formal therapeutic approaches to sex offender treatment, and this manifested in an extreme form of avoidance for the female staff. Such professional distancing has import for a professional debate about the management of pornography in secure mental healthcare, where risk was embodied in talk about, and representations of, women. It has been noted previously that dangerousness and risk were narrowly constructed in terms of the *nature* of female nurses, but masculinity was expressed in talk about physicality rather than sexuality. Respondent [S13], though, proffered an account that challenged the dominant construction of women as the exclusive object of male desire within the institution. Rather bravely, perhaps, she contended that men

were as likely to be the focus of patient's sexual attentions, or fantasies, as women who worked in the hospital. In a loosely psychodynamic narrative, male nurses were depicted as representing the sort of idealised lives that detained men might entertain for themselves. Male nurses could be seen as symbolising success, physical attraction, and power; qualities well suited to the masculine culture, that could generate powerful emotions ranging from love to hate. The rigid structure of the hospital was seen as precluding any opportunity for patients to express, or articulate, emotional or sexual aspects of their being; where sexual motivation became an underlying component of aggressive behaviours. In a world where physical touch carried negative connotations, violence became an alternative means to gain close physical contact, and one more readily accommodated within the ideological structure of the institution. It was noted in the last chapter how sexual ideation, by patients, that related to female nurses, could be considered highly *inappropriate*, or rewarded as an *appropriate* therapeutic disclosure with import in risk management. The conjoining of women's professional and sexual identities explained and, to an extent, normalised this type of sexualised interest or attention. Talking about male staff in a comparable way, though, was seen as something that could not be done within a rigidly masculinist environment. It will be noted, later, how the respondent deployed these sexual constructions to illustrate problems of a dominant heterosexist discourse in the delivery of the sex offender treatment programme:

> "To be honest I've said it loads of times...some of these men...some of the male patients are just...have fantasies...because...about male staff...because they see either the staff they love or hate...depending on what they represent to them...successful men...who are able to attract women...who aren't them...and they want to be them...so all that envy...er and they want to either denigrate them or they want to idolise them...and they might generate a fight to get touched by them (.) y'know what I mean 'cos that...that's legitimised in this organisation [pause] erm [pause] or they might...or they might do something else...y'know to get that attention but erm...there's as much...fantasy about those male relationships...but it's just ok to talk about female ones (.) you often tell...say patients...they'll say they've got sexual fantasies about women...but it's just because they're frightened of what the men might do to them...but the women aren't going to be able to do it physically...in the same way [pause] it's more acceptable" (S13: 1403-1418).

As with male nurses, it was fantasy, more than any other concept, which defined the sexual offender in the women's accounts. This respondent, likewise, talked about fantasy as a core component of the sexual being of the offender, realised through enactment at the actual moment of offending. The data extract below is interesting because it draws together a number of discursive themes that constructed the sexual offender as other. The account of respondent [S13] was notable, though, in ways that differentiated the speaker from other female participants. The difficulty of disclosing fantasy to peers and professionals, as part of treatment, was recognised; both in terms of sharing intensely personal information about the self, and the implications of taking on the institutional identity of sex offender. Reminiscent

of some male nurse accounts, there was recognition that deviant fantasy might not be the exclusive property of those detained, and an acknowledgement that the sexual lives of the patient population extended beyond the imaginary:

> "But at...in...in the moment [of offending] they're thinking about it...they're fantasising (.) it forms part of their sexual...being...it's part of who they are...for many erm...and of course one of the questions is...they're being asked to do...is potentially change a sexual interest...and how they could do that? Erm they're also erm...being asked to erm [pause] dis [unfinished] expose themselves in that they're being asked to discuss the most intimate and private thinking...that many people would struggle to do...without being deviant...if you know what I mean (.) maybe we're all deviant and we just don't say it out loud [pause] erm maybe we all have those fantasies but we don't say them out loud er...and to do that under camera conditions in a very tight environment...where people are going to be talking about it...where other people are going to hear...other patients are going to hear...it's a very difficult thing to ask people to do [pause] and I guess patients may not be able to articulate that...but they'd certainly understand it...and there are consequences for them being...labelled as a sex offender 'cos it's still pejorative er...as a nonce and so on [pause] and maybe the other things we don't think about is how people's sex...sex lives are lived out whilst they're in the institution which...y'know...are lived out (.) people are still sexual beings in that sense" (S13: 437-457).

Respondent [S13] was different to the other female nurses in that, prior to being promoted to clinical manager, she had significant involvement in developing and delivering the SOT programme. Sexual offending as an issue for treatment was discussed alongside other medical and psycho-social needs of a detained population; the man with a history of sexual offending, in this account, was spoken of as someone other than just a 'sex-offender'. The suggestion that nursing staff could participate in normalising talk with patients hinted at an abnormal environment, but opened up space for an optimistic interpretation of the nursing role. In the last chapter it was noted how male nurses claimed that the time they spent, in close proximity, with patients contributed to their being in a strong position to realistically estimate risk; in short, this equated to the idea of knowing *them* by watching *them*. Here, though, the respondent claimed this potential contact time on the wards offered an opportunity for mental health nurses to engage in a 'normal human way'. If the ward permitted little space for privacy or emotional expression, intimacy and relationships could be the focus of nurse-patient interactions. This philosophy clearly challenged a dominant discourse that focused on dangerousness, and identified a need for more inclusive relations. Sex, from this perspective, could be talked about in terms of desire rather than deviance, and promoting *sexual health* rather than policing *sexual threat*:

> "being able to discuss someone's sex life (.) erm and dealing with how they're going to cope...I think they should be as mental health workers...be able to erm talk about relationships and intimacy...er as...in quite a normal human way (.) I think that would be pretty important really and I think that is very...very uncomfortable...for a lot of people erm [pause] because...they've got to...people are living here for long periods of time (.) they've got to have...be able to...sexual dysfunction amongst this group is really high...they've got real medical needs in terms of their sexual dysfunction...that needs y'know...to be

> normalised...to have a conversation...that it's ok to talk about (.) that it's not deviant per se sex...even patient on patient (.) erm [pause] desire for each other...isn't...isn't er deviance it's actually alright [laughs nervously] but y'know it's that the sort of thing that...that I think nurses on wards...who are there...day in day out...hour in hour out...it should be about that really" (S13: 1343-1355).

There was little in the accounts of the other nurses, male or female, to suggest that this humanistic approach represented a part of their clinical practice on the wards. The above comments related to a possible generic nursing role in high security care, as distinct from nurses participating in any sort of therapeutic role related to offence-specific behaviours. When asked to comment on the likelihood of female nurses electing to undertake this type of work, the commentary became more circumspect, and generated a response that was framed by talk of difficulty and danger. The predicted reluctance to engage with offence specific matters echoed an institutional discourse that constructed nursing as organisationally alienated and professionally threatened. The support and knowledge of others that was seen as imperative, contrasted with the imagery of nurses as working in isolation:

> "I think it would be...there'd be a lot of reluctance on people to do it (.) I think it's seen as...as a no-no...as too dangerous...too difficult...you don't know what you're getting into and if people do that without the support of other people...and the knowledge of other people...it's seen as their problem...they're getting too closely involved" (S13: 1359-1363).

Talking about the institutional pressure on women to distance themselves from any sexual component of offending, the respondent shifted her discourse from specific intervention skills to the masculine culture and gendered construct of nursing. The female nurse was described as the casualty of a patriarchal polarity which meant they could be seen as, both, helpless and hazardous, in need of protection or inviting risk. Implicit in this account was the informal strategy of interpreting risk that featured in talk about life on the wards, where female sexuality, in relation to patient behaviour, became the subject of surveillance and regulation. The danger that resided in the presence of women on the wards, could be enhanced further if they had more than routine contact with the sexual offender population. To actively elect to work with these men risked being interpreted as a sexual rather than professional interest:

> "I think it's just...a type of patriarchy really in terms of men being able to protect the...er vulnerable woman and actually I...I can tell you half the men you see...loads of men I know would not be able to do that sort of work...and plenty of women who could (.) but it's a structural understanding that...these women need looking after and it's a dangerous territory for them to go down...but it's a very powerful message that women get...that they need help [pause] erm and its dange [unfinished] y'know there's something dangerous going on here...or it means that erm...there's something more to this relationship than meets the eye" (S13: 1374-1382).

Compared to their accounts of nursing on the PDS, there was a noticeable shift in the way that female nurses talked about the sexual offender as a specific group of men within the patient population of the directorate. In stark contrast to a critical commentary about the negative impact of masculinity on nursing care, in general terms, talk about the sexual offender invited a repositioning that invested in gender difference. Respondent [S7] problematised the idea of the sexual offender as a discrete and clearly defined group of men who could be, easily, classified by legal status. Rather, the label related to the motivation that underpinned criminal acts; 'murder' and 'violence', for example could be subsumed within a broader understanding of sexualised aggression. If this account moved beyond a construction of the sexual offender as other, based exclusively on index offence, it also worked to extricate nurses from involvement in sexual elements of offending. Recommending that this was best undertaken by the Psychology Department suggested the issue to be about expertise rather than gender. It will be noted, though, how it represented part of a larger nursing discourse where talk about risk was inextricably linked to talk about women:

> "so there are people that are like that that have not got a sort of Schedule One offender [pause] label...are not in for sexual offences...not their index offence but then afterwards it's come to light that in fact they have committed sexual offences...there are people like that erm [pause] and even if they haven't got sort of [pause] offences there's still a lot of patients here that have got [long pause] sexual [pause] elements to the crime...even though they're not overtly sexual...maybe some murders or things like that or violence that...there's sexual elements that need looking into by the Psychology Department...rather than us really as nursing staff" (S7: 452-460).

Focusing on the language of the female nurses is of value in illustrating the way that they were able to talk about working with sexual *offending* while placing a distance between themselves and the sexual *offender*; not as men on the ward, but as men with sexual stories to tell. For respondent [S4], being the internal care co-ordinator [ICC] for a patient with a history of sexual offences against women translated into talk about offence work. If there was no formal discrimination around gender and offence type in allocating a clinical caseload, informal strategies emerged as the account developed. Given that the patient attended a treatment group, delivered in another location by another set of people, might require understanding his offences, but did not necessitate actually speaking with him. Such details could be gleaned from SOTP facilitator feedback and other recorded information:

> "I do [deal with sexual offending] because one of my patients is on the SOTP at the moment so I'm quite aware of his offences and...which I...I read up on...on anyway (.) but it's very at the forefront at the moment y'know...because of what he's experiencing through the SOTP...and how it effects him" (S4: 192-195).

Suggesting that it would be inappropriate for her to address sexual offending behaviour in detail, the respondent mobilised the concept of fantasy to construct any interaction that trespassed outside a clearly defined boundary as risk laden. In chapter seven it will be noted how the same kinds of restrictions were applied in relation to the way that materials were deemed to be pornographic. Though the emphasis, here, was on words rather than images, the sexual offender became a skilled predator who could derive deviant gratification from even the most innocuous references to *sex*, which always implied *women*. It was characteristic for nurses to validate suspicions about risk with a confession from the individual concerned. The distance between nurse and patient was presented [S4] as a mutual agreement premised on the man admitting to using talk as a vehicle of sexual arousal. This theme ran through the account of respondent [S11], where gender, stated as a 'fact', precluded female nurses from discussing sexual offending with patients for whom they had responsibility. Meeting other care needs of this population was legitimated for women only to the extent that they were framed by an awareness of potential danger. Aside from other people being better qualified for the task, it was talk about gender that clearly positioned the female speaker in relation to these men; this kind of talk it was asserted was inherently dangerous, with damaging consequences for either party:

> "Well I don't actually address any of his sexual offending behaviour in detail...because in the past there's been difficulties with female staff...that he was...and he'll admit this himself...that he was basically using it...to get off on [break] talking to female staff about what he'd done and that was triggering fantasies for him (.) so we've come to an agreement...boundary wise that he's allowed to mention it...basics...not in detail...no detail [pause] erm I focus more on his thoughts and feelings at that time...or on how he thinks and feels about it now [pause] that's why I er...the emotional (.) whereas for him (.) we don't go into any sort of sexual details at all" (S4: 204-25).

> "I think given the fact that I'm a female...erm [pause] I don't really...when I meet with my [pause] erm...patients my role...I don't feel...I think it would be inappropriate for me to discuss their sexual offending...so I don't erm...there are a lot of people...that are better qualified...erm to do that with them so...I look at the other aspects of their care (.) you have to recognise that they have sexually offended...and you've always got to be aware of that...but I don't think it would do them any...help...to sit and discuss that...and it certainly wouldn't do me erm...any good...erm...to sit and discuss their offending behaviour...in relation to sexual offending (.) usually we find it's not just sexual offending...that there's other...offending behaviours that's gone with it that we...would explore (.) but I don't think it would be beneficial for them to sit with a woman and discuss their sexual offending and I wouldn't encourage it" (S11: 133-144).

In the discussion so far it has been noted how female staff, while struggling to assert a positive sense of identity, and resist the otherness ascribed by gender, drew upon a masculinist discourse about women when talking about the sexual offender. This leads to a consideration of the way that the construct of fantasy, as ephemeral and inestimable, mediated an account of risk that was embodied in two groups of individuals who shared outsider status; the sexual offender and the female nurse. Respondent [S7], again, accorded

fantasy a central place in her account of working with sexually violent men. A colloquial reference to the patients as able to 'get off on telling' female staff about their offences repeated the idea of vicarious sexual pleasure derived from subverting the nurse-patient relationship; a narrative gratification where talk could recreate and re-enact abuse. However, this was located within a broader understanding of multiple functions, and interpretations, which constructed fantasy within the institution. Discourse about fantasy became inseparable from the meaning and motivation that could be ascribed to the individual. It might be spoken about as a form of sexual terrorism, or signal the acute distress of a 'disturbed' individual; a threatening gesture of male power, or an honest, and courageous disclosure with therapeutic value. But, despite shifting perceptions, it was women who, were repositioned in relation to the way that the mental life of the patient was talked about:

> "we have got quite a few patients that will tell you everything [pause] sometimes they'll tell you everything because they get off on telling you everything especially if you're a woman like me (.) it's er [pause] there's those problems that come around and then there are some people that are really quite honest and will tell you everything...and are really quite disturbed by the some of the vivid fantasies that they have and then there are some people that I'm sure have violent sexual fantasies every day and would never breathe a word to you...they'd never tell you anything [pause] erm triggers...sort of go off in our minds when patients are coming to you and saying 'I'm having fantasies about other members of staff' That's quite a difficult issue...it's difficult for the staff concerned [pause] because they're quite fearful as well and I think...I think the patient...it takes a lot of guts to come and say 'I'm [pause] I'm having this fantasy about such and such' And then it's difficult for them to sort of engage with that member of staff in the future [long pause] but there's some I think that like it [pause] and will tell you to try and frighten somebody as well...to try and use it as a power thing" (S7: 964-978).

Whether discussion related to formal attempts to express risk, or informal strategies enacted on the ward, women featured prominently in a shared institutional discourse. Respondent [S4], for instance talked about writing an annual risk review that included reference to a self-rating system for fantasy. The patient was required to score himself, on a continual basis, in terms of 'thought's' that were taken as an indication that he might reoffend. Risk was described as a latent, yet ever present, threat that could be translated into a numeric value. Across a range of bandings there were equivalent courses of action that ranged from 'no problem' to a 'need to talk about it', or 'time out'. If, though, a score of above seven was reported, the severity of the situation required that all female nurses be alerted that they could become the focus of a sexual attack. One could question the accuracy, or even worth, of such crude measures, without being critical of any attempt to ensure the safety of people in the workplace. What, however, is of interest in the account is that speaking about women took away their voice; they were described as passive objects who could become victim to a deviant imagination. Though mentioned only once, in the data extract below, it was male staff alone who were assigned an active role in the account. The respondent could record

events, other women could maintain vigilance, but only men who worked on the ward could talk to the patient who generated collective concerns:

> "you write something personally...how you view it...so I'd said about him rating himself and things like that...and using them and being quite appropriate in these...these scales and things like that er...although erm...hard to deal with it when it's at certain levels y'know (.) zero to four it's manageable...no problems...er five to seven erm he may need to talk about it...but it's to be done with the male staff y'know...it's things like that he might need time out...in er...in er a room on his own to try and y'know lie down...get the thoughts...rid of the thoughts or whatever...and then if it's over seven to ten then...erm basically we make sure all female staff are aware that he may re-offend at this time which can be anything from erm stalking...he can stalk female members of staff...right up to...well he never has attacked...in a sexual way a female staff that I'm aware of...but he may...the risk is there y'know if he's if he's in that sort of seven to ten...so obviously you'd write stuff like that in...in the risk assessment" (S4: 790-803).

Rather than representing a response to elevated levels of hostility, as described above, the abdication of sexual talk to male staff was a routine event that permeated female nurse accounts. The women talked about supporting the SOT programme by encouraging attendance for the groups, helping patients with homework, and listening to them if they exhibited emotional distress. It was accepted, though, that this kind of involvement could be sharply delineated from talk about sex, and agreed the latter ought to be communicated between men:

> "but if he's got anything sexual to discuss he goes to male staff not me...agreed (.) and all the male staff on the...the ward are aware of that...staff nurses...so today it would be [name of male staff] he'd speak to" (S4: 233-236).

Interactions between female nursing staff, and patients with a history of sexual offending were taken as a fundamental part of the risk assessment process. Unlike male staff, sex and sexuality epitomised the essential dynamic in the female nurse-patient relationship. Beyond the actual speech content, all aspects of communication such as context and frequency might be interpreted in relation to sexual deviance and dangerousness; too much attention being paid to women staff could be as damaging as too little. If the culture of the hospital wards represented a microcosm of patriarchal ideology and gendered discrimination, it was interesting that the chauvinism of patients was spoken about in relation to their offence history rather than their maleness. In the extract of text below, the issue of women being expected to undertake domestic duties was revisited. Previously, the routine practice of allocating female nurses to work in the kitchen had been located in the culture of the ward, but it became a specific strategy of risk assessment when articulated by a patient who was only referred to in terms of his being a 'rapist':

> "[To assess risk] on quite a superficial level erm we'd look at interactions with female members of staff erm [pause] we'd look at...are they different when being interviewed by a woman...we'd look at...is it [pause] would patients go to a woman rather than a man to ask for something...or do they avoid women and go to the men all the time erm [pause] often it becomes apparent when being challenged by women [pause] over something or other...or they're not adhering to some rule...sometimes they respond better to a woman asking...or sometimes they respond terribly to a woman asking because 'How dare you...you cheeky...you're asking me?' We've got a patient on here at the moment who...rapist who always goes to a woman if he's asking for his razor...if he's asking for something to eat...if he's asking for anything...but always...always go to a woman and [pause] so much so that when I didn't do the dinners one day...asked me 'Why didn't you do the dinners?' And I said 'Well because I was busy doing this' And he said 'Well you should...'cos you're the woman' Because I'm...y'know implying that becau [unfinished] women should be in the kitchen...it gives a lot away about people's [pause] perceptions" (S7: 373-388).

As discussed in relation to the assessment of risk, the patients lived under constant surveillance for attitudinal and behavioural signs of their underlying deviance; where living in a patriarchal system informally condemned their behaviours. If the way that the inmate population related to women staff was taken as indicative of negative or stereotypical thinking in general, individual actions were de-contextualised from the institutional culture of the hospital. Thus respondent [S7] talked about interviewing a patient who had recently been admitted onto the ward. Behaviour that might easily have been exhibited by male nursing staff was seen as worthy of record in the clinical notes. Problems identified in terms of 'acting up' and 'showing of in front of the girls' were situated in individual actions as distinct from the masculine culture of the hospital:

> "we've got a new admission who...on interview with women will behave very differently than on interview with men (.) with women a bit [pause] a bit sort of acting up...a bit erm...erm showing off in front of the girls [pause] compared to how he'd be in front of men...so we have noticed that [pause] and will say things to other patients to sort of look bigger...macho in front of female staff...so that's noticed and that's noted down" (S7: 400-408).

Earlier, it was noted how respondent [S13] had suggested masculine, heterosexual, speech which dominated communication in the hospital, could severely constrain patient talk about fantasy. In closing the chapter it is worth returning to her account again, as indicative of an alternative discursive strand within the talk of female nurses; ideas which, also, stood outside the dominant talk of their male colleagues. Here, talk about treatment, risk and gender was situated in the context of the hospital as an insular and isolated institution. The concept of the SOTP was reconfigured in terms of gauging risk, rather than rehabilitation or behavioural change, in an artificial environment. The expectation that offenders would transact aspects of their sexual deviance in group settings was considered unrealistic to the extent that potential victim status had immediate currency within the hospital. The issue of 'male on male sexual violence' was used to illustrate how discussing past offences in a therapeutic setting, as a way of reducing future recidivism, could have traumatic and

threatening consequences in the present. This was one of the few occasions when a nurse respondent spoke about patients, as a group, who might be fe arful of assault. Risk to children was seen as purely hypothetical in the secure setting, and women who worked on the wards were described as having 'different power', though this was not elaborated upon. Conversely, though, possible harms facing a group of detained men were unacknowledged in the discursive repertoire of risk that framed nursing talk:

> "Well for me that's why the sex offender programme's as it is (.) I...I see them particularly about...rather than treatment...is...is about risk because...because of the detail that you try to get to with someone...and that [pause] I'll not say you get to it at all because I...I think you can't always...erm...because you can't get to those really sort of core issues about...particularly...and about sexual deviance erm in groups because it's just far too threatening to do...you certainly...you certainly can't get to male on male sexual violence because you've potentially got a victim group in the room with you [pause] and I think that's a very traumatic...y'know [pause] you've got adult men in the room who are potentially...who are potential victims if someone...if someone in the room says 'I rape men' [pause] you've got a room full of men he could rape...y'know what I mean...if someone said...'I rape children'...there's no children there [pause] you're talking about...it's a concept really at that point (.) the women are staff...who've got different power" (S13: 520-543).

Summary

The previous two chapters explored the way that the discourses of male nurses and detained patients worked to construct a dominant masculine culture that positioned female nursing staff as other. In this chapter, the focus of attention shifts toward the accounts of those women who worked on the wards and spent extended periods of time in an insular and oppressive environment. The talk of the female nurses was different in that it was situated in the experience of the outsider, and revealed the extent to which they had accepted a marginalised view of themselves. In broad terms, the language explored here is more ordinary, and is about the relations between two groups of people who shared little common understanding. The voices of the women tell the story of what it is like to inhabit a social world that is defined by somebody else, as the casualties or victims of a system in which they had little recognition and less control.

The talk of these women revealed how their role on the wards was constructed by gendered stereotyping rather than professional status. One is arrested by the overwhelming sense of their being trapped, and isolated, by a role that offered limited opportunities for development or promotion. Given their smaller number in the nursing workforce, and token representation within the shift system, the female nurses lacked even the informal support mechanisms, or camaraderie, enjoyed by their male colleagues. As with the men, their pattern of working was task focused and tedious, but the gendering of labour meant that they performed much

of the mundane and domestic duties. The accounts suggested that working, or surviving, in an oppressive environment involved reconciling the sexism of male colleagues with the potential threat of a dangerous patient population, where each group of men became an indivisible entity defined in terms of pathological qualities.

The accounts of the women also differed, significantly, in that they were invested with an overarching emphasis on care and concern, though this was always constrained by a dominant discourse about risk and danger. The respondents gave examples of providing support to, both, vulnerable patients and those male staff who experienced the damaging effects of a callous culture. Though, however, the women aspired to a more therapeutic use of self within the hospital, this was impeded by an institutionally accepted maxim that they needed male permission and relied upon male protection. In contrast to the masculine culture of physicality and confrontation, the women's accounts were permeated by a discourse about relationships and interpersonal engagement.

The practice of nursing was spoken about as an idealised concept, and in the context of high-secure care these fundamental principles of caring were described in a way that connoted loss. The core conditions of the profession, it was suggested, could too easily be suspended for offender-patients typically deemed to be undeserving of compassion. Thus, the women sought to construct a sense of identity in relation to other places they had worked, or of client groups with more clearly defined healthcare needs. Defining themselves as nurses in a forensic setting was usually achieved by accepting responsibility for basic care and health promotion.

The next chapter looks at how female nurses, who were defined in terms of *sexuality* and *risk*, spoke about sexual media, and materials, that would become emblematic of *sexual risk* within the institution. If they embraced the role of a general nurse in relation to meeting physical health needs of the patient population, it will be noted next how a sexual division of labour in the therapeutic process further divorced female staff from the concept of forensic mental health nursing.

CHAPTER 7

Women and pornography: Discourses of exploitation and exclusion

Introduction

All the women who participated in the study contributed unique insights into the experience of working in an exclusively male environment, and of caring for men detained because of their sexually violent crimes. As in chapter six, the accounts of female nurses articulated the experience of surviving in a culture of exaggerated masculinity. There was, though, a distinct difference between the accounts of female nurses and the men who participated, whether staff or patients. This reflected the outsider status of women on the wards and their limited exposure to pornography, which was understood and spoken about as something other. If the men who took part in the study drew upon their knowledge of pornography in relation to being male, the women spoke about it in terms of the hospital and the detained men.

This chapter begins by exploring how the women positioned themselves in relation to talk about pornography which was largely understood as a discourse about male sexuality. Their accounts were often framed by trepidation and uncertainty, which reflected insecurity about discussing something of which they had little personal experience. In contrast to the male participants, their exposure to pornography was a product of working in a densely masculine culture, where sexually explicit media could be strategically mobilised in the enactment of harassment or abuse by patients. The second section of this chapter looks at how female nurses talked about sexual offending and the role that was accorded to pornography in explaining such crimes. The accounts, again, differed markedly by drawing on gendered reflections that routinised male violence in heterosexual relations and structural divisions. Typically, these unfolded as a story, where the challenge of working with detained men paralleled the sexism of male colleagues.

The concept of fantasy assumed a prominent place in the women's theorising about sexual offending, and pornography was talked about in terms of purveying a distorted version of sexual relations. On the wards, though, concern focused on the user of sexual media as much as the content, and represented a *dangerous commodity* in the context of *dangerous men*; where the sexual offender was seen as being particularly susceptible to the influence of such imagery. When they talked about the management of pornography in the hospital, the language of female nurses more closely resembled that of male staff. In this they shared a

common linguistic resource that was informed by organisational and directorate policy and care team guidance. The final section of this chapter focuses on the way that discussion shifted from the prohibition of materials deemed unsuitable for the sexual offender to the policing of images that defined the sexual deviant. The figure of the paedophile emerged as emblematic of a dangerous sexuality that challenged faith in the treatment ethic. Distancing themselves from the relational aspects of sex and sexual crime that characterised their accounts, the women talked about nursing practice by identifying with a custodial discourse that located the other in terms of rules rather than rights.

Situating pornography in the personal experience of female nurses

Most of the men, as noted previously, tendered an initial definition of pornography that, almost unquestioningly, related to some form of material designed to produce sexual excitement or arousal in the user, where the latter was assumed to be male. The women, though, while making reference to similar media, were less clear in identifying an intended audience. Typically, when invited to talk about pornography, the responses were not spontaneous, and sought reassurance, suggesting that the subject matter was something unfamiliar, or embarrassing, which needed to be given careful thought. Respondent [S4], for instance, primarily described pornography in terms of specific media, rather than the actual content:

> "I think it's er...magazines...films erm...I think that's mainly...really how...how I see it...films and magazines" (S4: 533-534).

Prompted to consider what qualified films or magazines to be designated as pornographic, the respondent made reference to something sexual and graphic in the form of a question rather than a statement. This might include a permutation of males or females, but these were conjoined by a stress on 'relationships':

> "About er...sexual...relationships betwee [unfinished] er...which can be male and male...female and female or males and females (.) usually quite graphic aren't they? They're usually...very graphic" (S4: 538-540).

A further question from the researcher, to clarify what was meant by 'very graphic', elicited an opinion about material that was sexually explicit but which lacked an understandable format; if it carried a message, it did not adhere to a recognised style or structure described as a 'story':

> "Very sexually explicit er...no story line and [breaks off]" (S4: 544).

This interaction is instructive in considering how the female nurses positioned themselves in relation to the subject of pornography. The discussion was hesitant, with appeals for reassurance, and made recourse to an idea of sexual relations that connoted some meaning or mutuality. Respondent [S7] also framed her response to pornography in the form of a question. Though the term was interpreted as sufficiently broad to elude a precise definition, reference was made to similar media and couched in terms of pictures that depicted either women or men. Any sense of the nature of these images, or the inclination of the viewer, was inferred rather than directly stated:

> "Can be anything can't it? In...in general terms it's the...magazines...the whole video industry...pictures of women...of men...depending on your inclination [pause] erm [long pause]" (S7: 757-759).

When asked to elaborate on the likely users of pornography, the respondent introduced a discursive theme, which would run through the women's accounts, by making a distinction between 'ordinary people' and the deviant. It will be noted later, how a discourse about the motivation for using sexual materials, of various types, would assume an important function in constructing the sexual offender as other, and justify the imposition of rigid restrictions on what these men would be allowed to consume. The account began by normalising the use of pornography and speaking of it as a culturally legitimate component of human sexuality that embraced 'almost everybody'. Here, the language-use emphasised pleasure that could be shared, by either sex, in the context of partnership or friendship. It might be instructional, as with sex guides, entertaining popular fiction, or an alternative shopping trip that women could enjoy together. Some products were euphemistically spoken of as 'under the counter', hinting at a dubious provenance, but the larger message was organised around 'fun', in stark opposition to the idea of 'harming anyone':

> "Most people I think on a very basic level...almost everybody [pause] looks at pornography in one way or the other even if it's just page three...looking at it with your mates 'She's nice' Women...women as well...women would look at calendars of nice men with nice pec's erm Ann Summers party's...going in sex shops with your friends...so that's on a basic [pause] ordinary [pause] the people that [pause] you would say...it's not harming anyone it's for fun...people in their own home with their partners maybe buy the under the counter video's...books...sex guides...you can get sort of sex guides can't you? That really some people wouldn't see as pornography...but some people would...it...even going down to sort of erm bodice ripper novels...they can be seen as pornography [pause] erm [pause] can't think of the names of the people...Jackie Collins! People like Jackie Collins things like that...that's sort of pornography for the masses isn't it?" (S7: 763-778).

In contrast to understanding the experience of 'ordinary people' who might see, or use, pornography at a 'basic level', the respondent extended the idea of a continuum to include more extreme and illegal materials. It will be noted, later, how this same terminology was

applied to the concept of sexual offending. This was a market that could be linked to specific activities and individuals, and delineated between social and anti-social aspects of human sexuality. Talk about 'child links on the web', for instance, corresponded to 'paedophile networks' that operated 'underground'. Women who worked in the sex trade, described as 'prostitutes', inhabited a shadowy world that was set apart from everyday existence. If the concept of pornography spanned these distinct domains, the users were clearly defined as different species of being:

> "But then at the other end of the continuum there's erm [pause] child...links on the web [pause] there's erm snuff video's...things that's illegal...there's illegal pornography then there's the...the sex trade...prostitutes...S&M [pause] things like that [pause] so we're going from like an underground...like...like paedophile networks underground to everyday...Jackie Collins on the shelf" (S7: 782-785).

Respondent [S12] described pornography within the context of new technologies of cyber-communication, where the erotic marketplace, and audience, became less clearly defined. In contrast to traditional modes of production and distribution in the sex industry, the Internet was talked about as a major provider of mediated sexual representations. Talking about electronic avenues and global access shifted the focus of the discussion to the private sphere of the home. It was accepted that men and women, alike, might choose to consume some form of sexual entertainment, but pornography was spoken about as being, both, *pervasive* and *invasive*. Encountering pornography sites, it was suggested, did not require skill in searching, or even the inclination to surf the web for sexual materials. Rather, pornography was discovered unintentionally, and described as a constant threat to on-line service users. The respondent talked about having a firewall installed as a form of protection from being bombarded by advertisements for unwanted sex sites and services. This language connoted a sexual threat, experienced by women, which extended beyond the professional role of the forensic nurse. Again, though, the account was wrapped up in the mystery of male sexuality, where the only reference to women was the performance of a 'lesbian thing' as an invitation to the voyeur. For the respondent this signified an unknown territory that hinted at the way men could 'have sex with themselves':

> "I think [pause] men and women these days [might use pornography] my God I mean I'm on the Internet...isn't everyone? And they flash up don't they...these things...I've got a little firewall now...before that...it was like 'Oh my God' and y'know the little pictures at the top er 'Nikki says hi there...watch me with me lesbian thing' Y'know it's women as well as...men [pause] but men mainly erm use it to [pause] erm [pause] I don't know...to have sex with [pause] themselves I suppose...or to [pause] I don't know I've never asked anyone" (S12: 665-671).

Similarly, respondent [S13] drew attention to the sexualisation of cyberspace, where the damaging effects of pornography were not narrowly defined in terms of gender. Social harm

as a product of access to unregulated sexual materials was not restricted to the effects of viewing it. Rather, the pornography industry was spoken about as an oppressive and exploitative system where arguments about the freedom of choice to participate were couched in the language of false consciousness. It was suggested that the pornography business did more than harness emerging technologies by actually contributing to the development of the means of mass production and distribution:

> "So even if you get women who...who want to say y'know 'This is the work I choose to do and I want to get paid for it' I think they've just...they've just bought into that system really...a bit like you can...you know you can buy into systems...it doesn't matter what your gender is [pause] erm (.) and I think it's damaging for...for people who produce it...never mind the people who consume it [pause] I'm not saying though that you can always [pause] I think it is so prevalent...and of course we wouldn't have an Internet were it not for pornography (.) you'd always...it's amazing and always has been [pause] at erm...creating its own means of distribution" (S13: 944-951).

The account of respondent [S11] illustrated how women's talk about pornography was contextually situated in relation to male sexuality, and constructed the men, staff or patient, as a group apart. Rather than furnish an abstract definition of pornography, the response was organised around a series of interactions that had recently taken place between her and the men on the ward. This focused on a patient who had been given care team approval to receive sex magazines aimed at a male readership. Her comments, again framed by a question, were qualified with reference to 'soft porn' as a category of publication, accompanied by the acknowledgement that this was unfamiliar territory; to define pornography required 'knowledge' of things that were alien to a woman. Pornography was portrayed as a masculine discourse, where *speaking* about it required *knowing* about it, and this was located in the experience of men.

Her description of a magazine that had arrived on the ward in terms of personal shock, *as a woman*, generated self doubt about her professional judgement *as a female nurse*. The anecdote constructed pornography as a visual discourse that spoke to men, and directed a male gaze at the bodies of women. The speech emphasis on the graphic display of female body parts, captured the realisation of how pornography created a way that men could look at women as uni-dimensional and fragmented sexual objects. Unused to viewing women in this masculine way, the respondent was compelled to verify and validate this material, as appropriate for patient use, by consulting male colleagues; as 'lads' they became experts on 'lad's mags'. In contrast, the men were spoken about as being confident in their understanding of sexually explicit entertainment. It took only a casual glance for them to classify the magazine as suitable for the patient to receive. With no requirement that they should outline how sexual material could be so easily categorised, the decision of the male

nurses was unquestioningly accepted. These interactions created a gendered dynamic in the nursing team that conflated sex, status and professional roles, and recreated a discourse about sexual offenders that was discussed in chapter six. If female nurses had abdicated any involvement with the sexual domain of the men they looked after, the term pornography designated one way of affirming that distance. The respondent might have been the team leader but, as a woman who found the material personally offensive, she was disinclined to give it to the patient and delegated this job to male nurses on the shift:

> "there's a patient on here who's been...approved to have erm...I think it's called soft porn? But I suppose it depends what sort of [pause] a knowledge you have of these things (.) so this magazine came the other day and erm...I opened it and I looked and I was quite mortified to be honest...but that's me being judgmental isn't it? Erm [pause] because it was...it was very graphic of...women's [pause] bodily parts...and I said to a couple of the lads that were in the office with me 'Ooh god look at this' I said 'Tell me if that's...ok?' So they had a look and they said 'Oh yeah that's soft porn' And erm...so...well I felt incredibly embarrassed about giving this...to this patient so I said to one of them [laughs] 'Would you tell him when I'm not around that it's in the office...and he can get it off one of you" (S11: 767-780).

The idea of pornography, to this point, had been defined in terms of male knowing, and the sexualised exposure of women's bodies that was experienced as intimidatory, but the respondent introduced a further issue specific to the hospital setting and patient population. Her reticence to issue materials, felt to be offensive, to the patient conflicted with the fact that the man was not a sexual offender. Pornography, it was implied, only became an issue for professional attention in the context of men with recorded histories of sexually abusive crime, rather than a larger consideration of representations that could contribute to the, more general, subordination of women. To take for granted a socially validated and appropriate role for pornography, though, was to accept uncritically the world in which it belonged, and for women this was rooted in an imaginary domain of which they had no direct experience, and no comparable language.

Thus, when the respondent began to reflect upon, and challenge, these assumptions with 'honesty', her account was introduced as being 'controversial'. To consider that there might be some inherent part of an individual, though men were not mentioned specifically, that needed the kind of representations typified by pornography, conflicted with her personal feelings. In suggesting that pornography could be understood differently and challenged in terms of 'your own life' experience, the respondent was attempting to define a product, and a fantasy, as interlinked aspects of a masculine construction of sexuality. Contextualised within the institutional setting of the hospital, this debate about pornography and male needs became a site of tension, or compromise, between the professional ethic of nursing and personal or political perspectives. The approval of the care team, for a young patient to

receive pornography, assumed centrality in the reasoning of the respondent. The use of pornography in a secure psychiatric hospital, where the nurse had an advocacy role, assumed a different connotation from the consumption of similar materials in society. Here, the need of the patient was related to the expression of his sexual being in an abnormal environment, and whatever infractions he had committed were not seen as sufficient to warrant the level of restrictions placed on sexual materials. 'Need' could be expressed in terms of the patient's youth, sexuality, long term incarceration and commonality with other men outside the hospital. But, still, this was portrayed as a male need in a man's world, and beyond the biological function of stimulation, arousal and ejaculation, pornography remained an enigma. The message of the magazine, as a way of seeing women, became symbolic of the nurse-patient relationship. Pornography subverted this and introduced, or made visible, another set of power relations that undermined the confidence of the respondent in a way that was experienced as disempowering; if the patient had to ask the nurse for the magazine, the nature of the material introduced a sexual dimension that disturbed the safety of a professional relationship:

> "He hasn't offended against women at all...and he came in and he said 'Can I have me magazine?' A nd I said 'No...you'll have to ask one of the men after' [laughs loudly] Because I felt uncomfortable...but that wasn't really appropriate...because that was about me feeling uncomfortable...erm [pause] I felt uncomfortable handing that over to him...only because [pause] he's a young man...and I'm...me being a woman (.) and I just...and then I started questioning...why he'd actually come to me...and then I started questioning myself (.) was it...appropriate for me to say no? 'Cos he's been cleared by the team...y'know...so you start questioning things and [pause] I understand that pornography...there is a need [pause] erm...for pornography in all walks of life [pause] if I'm being honest I don't know if there is a need because I suppose it's [pause] you see this is quite controversial isn't it? If I say there's a need...then I would say that everybody would be using it wouldn't they? And I don't believe that everybody does...because if you look at your own...life erm [long pause] so I don't believe there is a need...I don't know (.) you see with him he hasn't offended against women....and he's a young man and he's got...needs [pause] and if that helps him to cope with being in an institution for a long period of time and his...his behaviours are appropriate then that I think is an appropriate need for him...isn't it? Because he's a young man...erm [pause] and a lot of people use it now...and that's...is that a need? For them? To be able to get a fulfilment? I don't really know because [pause] unless you actually have lots of dealings with it then...I don't think I could answer that appropriately...because I haven't had lots of dealings" (S11: 787-815).

Female nurse accounts also differed markedly from those of the men by incorporating reflective, personal, experiences to frame the discussion in terms of gender and profession. Pornography was talked about as a component of the patriarchal ideology that denuded and devalued their nursing role and sexual identity. One example of this related to the display of pornographic imagery, which had been stopped on the PDS. It was remarked, though, that pornographic magazines could formerly be purchased from the Patient Shop:

> "the days are gone where you could buy *Fiesta* and...and all that through the shop (.) that...that's gone...but I mean you could" (S13: 772-774).

Not untypically, pictures from these publications would be removed and used to decorate the walls of patient bedrooms. Whereas collective understanding of the pin-up as a routine feature of male environments permeated the men's talk, women described this by drawing attention to the traumatic impact such imagery had on them. Regular nursing tasks, such as searching, meant that one could be confronted with a permanent barrage of sexually explicit photographs as part of everyday work on the wards:

> "and display it [pornography] on their walls...so that when you went in to search their rooms...it was this...it was there in your face and it...it was disgusting" (S11: 861-862).

Though the exhibition of pornography in this way was prohibited on the wards of the PDS, respondent [S4] suggested it was still permitted in other parts of the hospital; an uncertainty that reinforced the insularity of life on the wards, and the lack of consistent policy across the hospital campus. This was described as an almost inexplicable occurrence, and located in a different place and time. If the nurse was without a 'clue' as to how such practices could be sanctioned, it was ultimately explained as the responsibility of the care team [PCTM]. This indicated a tension that resonated throughout the women's accounts, where personal beliefs often contradicted the decisions of those who were described as being more powerful within the organisation:

> "I've seen pictures of women on men's wards...not on this ward...but I have seen them...yes er...well about a year ago [pause] posters and pictures [pause] I don't know...I've not got a clue...I didn't work on that ward...at the time I was a student doing my RMN conversion [pause] I'm guessing he must have had approval from the PCTM 'cos everything has to be approved now through a PCTM" (S4: 971-979).

The men who participated in the study had talked, with varying degrees of confidence, about pornography using a male discourse that invested certain materials with an erotic quality. This might refer to commercial or manufactured materials, but the relationship between user and image was always predicated on ideas about arousal or pleasure. In contrast, the talk of female nurses, couched in uncertainty, emphasised feeling, rather than *knowing*, and typically located this in the hospital setting. Respondent [S11] spoke about a number of encounters that, to an outsider, could be easily recognised as sexual harassment or abuse. Within the hospital though, these episodes were accommodated in the accounts as unpleasant aspects of work in an all male environment. The narrative unfolded in a hesitant and faltering manner that hinted at the sensitivity of the topic and the embarrassment of sharing it with another. One of the incidents related to a room-search that had been

undertaken in a side-room, which was introduced with a statement that the patient concerned had asked the respondent to 'perform a sexual act on him':

> "I had several...several erm...experiences (.) one I went into a patient's bedroom (.) now this man erm...had asked me to do...perform a sexual act on him [pause] and [pause]" (S11: 873-875).

This reference to inappropriate patient behaviour, situated in the ordinariness of an interview, was the sort of experience, and disclosure, which contributed to a gendered way of talking about pornography in the hospital, and set the account apart from any of the interactions with male nurses. When asked to clarify the circumstances whereby a patient had been able to initiate a direct sexual request, the respondent reaffirmed the incident, with a clear 'yes', and closed further discussion by commenting that the episode had been 'recorded'; while suggesting that the incident had been organisationally managed, the implication and impact of the abusive encounter framed the account in terms of shock. Her ensuing talk about being confronted by overt sexual imagery, in the presence of the man who had previously made offensive sexual suggestions, employed language that connoted assault. Instead of the usual collection of images torn from glossy magazines, the respondent recognised the subjects in the photographs as women who had visited the patient in hospital. Describing these inappropriate pictures, there was a noticeable use of humour to mask the obvious embarrassment of the nurse, and the explicit anatomical detail of the photographs was hidden in a euphemistic reference to women 'exposing their tonsils':

> "Yes (.) and I'd gone into his room...he'd had a room search and this has all been recorded ...like the fact that he'd asked me to do this and (.) anyway I'd gone in erm...with a senior member of staff to do a room search...and there was...inappropriate pictures of...they weren't out of magazines...these were women that had been allowed to visit him...here [pause] yeah...and they were exposing their tonsils...and erm [sighs and laughs]" (S11: 879-887).

Though little different in form from commercial publications, the domestic production of sexually explicit imagery was a reminder that, through the lens of the pornographic gaze, all women became sexually available to all men. The talk of the respondent focused on having to manage a situation where her professional persona was compromised by sexual re-positioning. The photographs conveyed a powerful message about a particular version of female sexuality. That these women had exposed themselves to the camera, as the eye of the patient, asserted his expectation that women be subordinate performers:

> "and I was absolutely shocked by it all and...and erm I tried not to make a big issue out of it because I didn't want the patient to feel that he'd shocked me (.) but I found it really offensive...and I felt that the staff I was with should have acknowledged the...the impact it had...would have on me (.) erm...and he was quite dismissive of it all as if it was...it was ok [pause] but he was an untreated sex offender...and I couldn't understand why we'd condone

> anybody having pictures erm...around his room...and if he did have them...to be on show [pause] erm [pause] and I've...I had great difficulty with that [pause] I had great difficulty with that" (S11: 891-901).

The failure of the male nurse to recognise her distress compounded the overwhelming sense of powerlessness, and illustrated the distinctly gendered nature of the shock. In the male space of the side-room, and male culture of the ward, the experience of women was unacknowledged or dismissed. In sharp relief, the sexual offender emerged as a figure of particular menace. Though it was hard to 'condone anybody' being allowed to have sexually explicit pictures, the threat of pornography was amplified in relation to men with a history of sexual offending; particularly where the label of 'untreated' identified the individuals as being outside any therapeutic instruction on self-restraint.

A further example [S11] illustrated how patients could strategically use pornography to embarrass and humiliate female nurses. The iconic dangerousness of the sexual offender was introduced into the account in a way that constructed the respondent as a potential victim. It was claimed that this patient had approached the female nurse with a specific type of imagery, referred to as 'reader's wives', which is a standard feature in many commercial pornography publications. These pictures allegedly submitted by subscribers, claim to present amateur subjects, usually a wife, girlfriend or neighbour undressed and unmasked. The description of how these images were deployed, with accompanying gestures, conveyed how pornography could sexualise interactions with a less than subtle message of male power. The deliberate comparison that the patient made between the nurse, and the image, communicated a threatening sexual intent, and showed how pornography could be used in ways other than a simple stimulus for arousal. The overall effect of this experience, spoken about in terms of 'intimidation' and 'vulnerability', was a unique component of the female nurse accounts of pornography. Indeed, this unpleasant sexually exploitative behaviour, not marked by outward signals of aggression, was very different from the focus on sexual and physical violence that characterised male talk about the risk facing women who worked at the hospital. Though all the staff interviewees made frequent reference to formal, or informal, risk assessment strategies, informed by skilled nursing observation, covert and coercive harassment appeared to be a completely neglected problem for female nurses:

> "I remember another patient...and...getting a copy of...it was a magazine...it had pictures of readers wives in (.) and he actually walked down the corridor...and I didn't realise what he was looking at and...it just made me feel awful (.) he came down...and he was going...like this [sexual gesture] as he came up the corridor...and as he got nearer to me he said 'Aww...I think this is you isn't it?' And he gave me this picture of this woman who'd exposed every bit of herself...and erm I just thought it was totally inappropriate...he was an untreated sex offender and was making reference to me...in relation to this picture erm [pause] so they were very uncomfortable experiences that left me feeling...quite vulnerable...erm [pause] and

quite...threatened (.) erm...intimidated [pause] intimidated...erm [pause] and I don't believe that's what we're here for" (S11: 905-915).

This talk about the experience of harassment within the organisation became an important device in the way that female nurses organised their accounts of sexual offending, which is explored in the next section of the chapter.

Pornography and sexual offending: dangerous pictures and dangerous men

Talking about sexual offending, respondent [S13] shifted the discussion away from a narrow and prescriptive focus on legal classifications, to include a range of offensive or abusive acts. If some male staff had made reference to the idea that sexual offending could be located on a continuum of unwanted behaviours, the accounts were abstract and impersonal. In contrast, this nurse was more specific in detailing what might be perceived as sexually offensive, if not defined as a 'sex offence per se'. Though these behaviours could be differentiated in terms of 'seriousness', the motivation underpinning them was spoken about as a property of men, while the potential victim group could be tacitly acknowledged as women. Rather than talking about sexual offending as something that could happen to another person, the respondent identified not with a concept, but with experiences, whether real or imagined.

Beyond physical assault, denigratory and threatening language held the possibility of sexual threat; directly invasive as in verbal abuse, or indirectly through abusive phone calls. A number of the male staff had talked, uncritically, about having worked on construction sites where sexual imagery textured the male environment. Here, though, the respondent utilised this masculine context to construct sexual harassment as a uniquely gendered form of sexual terrorism. The respondent invoked the real fear of inverse power relations between 'men in groups' and 'a single woman', where curtailment of what men might choose to do was the threat of their being disciplined; sanction rather than choice constructing, and constraining, intimidatory male behaviour. Situating this range of unwanted forms of sexual attention and abuse in a discussion about gendered inequality, acted as a vehicle to introduce sexually sadistic killing as the ultimate expression of male sexual hatred:

"I see it [sexual offending] as not...and it's not always reflected in the law...so for instance I think erm verbal abuse erm that's...that's sexually denigrating might...abusive phone calls isn't necessarily a sex offence per se but it's got a sexual motivation to it which is denigrating through...through sex really erm...for everything...and there's a continuum...there's a continuum of seriousness (.) harassment is...y'know sexual harassment...walking down y'know...builders don't do it as much anymore...but I mean it's acknowledged that they will get disciplined if they're heard and stuff [pause] that's one way of curtailing people...what they would choose to do in...certainly men in groups as

> well...when a single woman's walking by erm...but there's lots of forms of that...lots of erm [pause] up to sexually sadistic killing really which could be said to be the ultimate...but in between that there's a huge range of activity" (S13: 988-999).

When this nurse spoke about the sexual offender in relation to the patient population on the PDS, where specific men were identified as perpetrators, it was the routinised violence that characterised women's lives which was prioritised in the account. *Sexual murder* represented an extreme variant of the *sexual violence* that defined relations between men and women. Talking about these behaviours in terms of 'stalking nursing homes', 'nicking underwear' and 'flashing', shifted the discussion from horror to mundanity and, colloquially, situated these acts in women's lives. In contrast to the accounts of male nurses which were dominated by a singular interpretation of rape, the sex offence was resituated within women's talk about the prevalence of domestic violence and spousal abuse where offending could be spoken about in terms of a relationship:

> "a lot of the perpetrators...patients here have erm...have got a lot of experience along some of that continuum...even if it's...it's stalking nursing homes [laughs] which ...y'know...nicking er underwear and so on [pause] flashing (.) I mean it's a highly addictive behaviour erm...and really quite common...relatively...where the sexually erm sadistic killings aren't...they are rare erm (.) but of course domestic violence really...how common is that? And...I guess if...I guess permission to have sex wouldn't be necessarily part of the make-up of that relationship (.) I would imagine there's plenty of sexual violence going on...coercion and so on...and that's...how prevalent is that? There are some men here who've killed their partners and wives...but it's not necessarily classed as a sex offence...but I see it as that" (S13: 999-1009).

The idea of a continuum, and progressive escalation of sexual offending over time, was also a prominent theme in the talk of respondent [S7]. Here, the move towards ever more serious offences, to maintain a level of sexual gratification, was an external manifestation of the fantasy life of the offender. Though pornography was not mentioned, specifically, each of the crimes mentioned were couched in terms of the way that these men looked at women. From non-physical and small-scale voyeurism, this female nurse sketched out a criminal career that led, ultimately, to rape and sexual killing:

> "I think that's the continuum (.) I think that [pause] people start to test and test and test (.) I think sex offenders generally don't walk out one day and go from nothing to big violent sexual fantasy...acting out (.) erm most of...most of them will start on a small scale...maybe stalking someone...maybe looking at things on the Internet and gradually move up and up and up (.) so when things are not gratifying enough...it's not gratifying enough to er rob knickers off a washing line or look at a woman through the window...the next stage is to grab the woman...the next stage is to grab the woman and assault the woman...the next stage is rape and the next stage may be rape and kill" (S7: 928-936).

Incrementally, the hypothetical offenders in the account moved further away from their male peers and closer to the deviant identity bestowed on the sexual offender inmates of high-

secure psychiatry. When prompted to clarify the idea that an individual would gradually test out the limits of what might be possible in terms of offending, the respondent made a clear, if succinct, delineation between physical and sexual violence. The former, it was suggested, could be seen as a spontaneous episode, whereas the latter was more likely to be the product of accumulated experience:

> "Especially the sexual offending [pause] violence is different...violence can go from nothing to bang wham killed (.) I think sexual offending tends to be that...creeping down the path" (S7: 944-946).

Respondent [S13] located an explanation of sexual violence in social inequity that transcended gender relations. Structural divisions around age, sex, and sexuality were seen as constitutive of power differentials that manufactured a sense of otherness and alienation. This appreciation of the role of cultural factors, functioned as an alternative to the dominant, reductionist, discourse that sought answers in individual deviance or defect. If the speaker drew attention to socially constructed inequalities, it was interesting that language-use, emphasising 'we', identified her within that process. The account offered an understanding of sexual violence that moved outside of a commonly held assumption that this equated to heterosexual violence. Indeed, as was noted earlier, same sex relations, which were referred to by male staff as homosexual, indicated deviance rather than difference:

> "I think that...the culture we live in erm...explains male violence really through [pause] through erm the structures that we erm...that we develop...where we create power...erm differentials between different groups (.) er be that young...children and adults and er...or men and women or even erm... gay and straight and so on...er a lot of people think y'know this sense of other and sense of alienation...people react to that and do all sorts of things" (S13: 260-262).

Emotional damage contributed to the genesis of sexual crime in the account of respondent [S11] where the offender lacked qualities such as 'love' and 'respect', which were presented as attributes of intimate engagement. What this nurse referred to as an 'erratic upbringing' had been commented on by some male nurses, where social disadvantage was seen as a shared experience in the lives of the patient population. The men, though, expressed this differently by emphasising the brutality of life in care or custody, rather than the lack of opportunity to learn about caring or loving relations; a stress on negative traits they had acquired, in contrast to positive traits they had been unable to achieve. A discourse about power and injustice was an aspect of the language that female nurses used to describe their experience of life in the hospital, and nursing detained offenders was talked about in a comparable way to their relations with male staff:

> "I think their emotions are all over the place and they don't understand the concept of [pause] of love and respect (.) erm...and...and I don't know if it's proven but most of the people that you look at that have offended in that way erm...their upbringing has been totally erm...erratic (.) erm and I don't think there's been any clear guidance on developing relationships of a...of a caring nurturing...loving way erm...I don't think...I think a lot of it's to do with...power (.) most of the men that I nurse here...that have got...have offended against women...see...women in power as somebody that needs to be erm...they can't interact with women in power" (S11: 314-322).

Sexual offending became synonymous with an attempt to control others and assert a sense of superiority, in the absence of legitimate avenues and opportunities for advancement; burglary instead of work, for instance, could provide immediate gain and secondary sexual gratification. Rape in this account was understood as a product of spoiled lives. Criminality, whether sexual or non-sexual, was seen as part of a 'natural progression', where material motivation and emotional immaturity compounded to explain a deviant career as much as a deviant person:

> "to me sexual offending is...it's wrapped up with wanting to be...in charge and maybe not being able to...through the right ways y'know...through maybe...work or whatever...and wanting instant [pause] 'cos it's usually connected with like burglary and other things erm...there's not many that set out to just...go and rape (.) if you look...it's...they've done other things that's led up to it (.) so I think it's a natural progression for them...because they've not learned...they've not matured and they've not developed erm...appropriate ways to deal with relationships" (S11: 338-344).

Respondent [S4] offered a variant of this argument in talking about sexual offending, but drew upon a more familiar institutional discourse that attributed abusive behaviour in adulthood to the experience of having been abused as a child. As with many of the nurses who used this explanation, it was presented, uncritically, as a personal point of view. Stated as part of a belief system, that was unfounded in terms of evidence, meant that the respondent was able to occupy a position that defied any internal, rational, interrogation:

> "I suppose I can only answer from my point of view er...abuse (.) themselves...they've been abused by family members or people outside the family erm [pause] and found that very difficult as a child and therefore become an abuser themselves (.) and I don't know how that happens or why er somebody who's been abused would turn into an abuser" (S4: 309-313).

When prompted to consider why the abused might, somehow, become the abuser, the respondent used the idea of 'power' to make sense of something that was, repeatedly, seen as 'hard to understand'. A rather simplistic interpretation talked about offending as a form of retaliation, to compensate for the cumulative damage of prolonged emotional or physical harm. The motivation to overpower another person became symptomatic of underlying psychological distress and vulnerability. It will be noted, later, how investment in this model

of sexual offending, albeit crude and uninformed, would translate into an investment of faith in therapeutic interventions:

> "that's what's difficult to grasp...it's difficult to understand that (.) I suppose they might be trying to gain some sort of...somebody who had power over them when they were abused...so they might y'know...be trying to gain some power over somebody else (.) I suppose that's one way of looking at it...it's hard to understand" (S4: 322-326).

If female respondents shared a way of talking about male *sexual offenders* that projected an attempt to empathise with the dysfunctional social lives of these men, the discourse shifted markedly in relation to the way that they spoke about the *sexual offences* they had committed. The language used to describe the offender population varied between individual respondents, but the organisation of their accounts worked to construct an exemplar of dangerous others; no longer hypothetical theorising about causation, the discourse was situated in the experience of everyday encounters. The nature of the criminal acts they had perpetrated, it was suggested, set these men apart from 'sex offenders per se'. This latter group, who were associated with 'general sex offences', provided a benchmark to measure the seriousness and severity of those committed by men detained in the hospital. The forensic population were demarcated by predatory serial offending and, uncharacteristically, excessive levels of violence and sadism. Combining these criminological traits with a victim profile that was also viewed as untypical, because it spanned multiple groups and age ranges, produced a *sexual deviant* who was quite distinct from a *sexual offender*:

> "They are an interesting group and they are different erm from...from er sex offenders per se (.) erm they're usually erm...got multiple offences (.) that's not necessarily erm different but certainly they've been caught for a lot of offences where...knowing the conviction rates for general...sex offences is really low erm...and the population we have generally...erm...do get caught or at least...obviously they're here so they have been (.) erm the extent of the violence...the extent of the stranger violence is...is markedly different to some other erm...other offenders...er the...the multiple...victim groups...multiple age range er the indiscriminate nature of the violence...the...the use of violence before during and after offences (.) erm the level of sadism I would say was different...or the level of sexual deviancy would be marked" (S13: 115-125).

Moving beyond these conceptual markers of deviance, respondent [S12] located her account of sexual offending firmly in the environment of the ward, rather than the directorate or hospital. Previously, this female nurse had proffered a compassionate, almost sympathetic, approach to the men in her care, and the discussion focused on what were described as the behavioural manifestations of personality disorder. While acknowledging that there were real challenges to establish some kind of relational engagement, and that skill was required to minimise aggression, this was balanced by recognition of the torment incumbent on diagnosis and detention. Whatever 'inner demons' they struggled with, these men could still

be described in 'positive' terms; as people who tried to 'listen', could be 'appreciative', or show 'warmth'. And the role of the nurse was responsive, and reciprocal, to circumstances and situations:

> "A positive thing about them is that sometimes they do listen to you...when they're going through a stressful situation and [pause] they...you can see them trying to take on board what you're saying...and they try to respect you [pause] at times...not all the time (.) so I would maybe say 'What about this...what about that?' And as much as their inner demons are telling them to do something else...y'know try to keep them focused...'Why don't you try this...why don't you try that?'...'If you do this and that...you'll see a different outcome...don't do what you always do...the same cycle or pattern...negativity' And if you see that they do try...and then afterwards as well...if it has all gone wrong and they've resorted to violence or aggression...or verbally been aggressive...whatever erm they will come to you afterwards and say y'know 'Thanks for that'...If I've took them a cup of tea or whatever...so they...they've got some warmth there and...and some appreciation for what you do...if you get them something from the canteen 'cos they've...missed their shop...or if you've saved them their lunch because they're in an appointment...they do appreciate it" (S12: 130-144).

As noted earlier, the ward represented a physical and emotional space that nursing staff shared with the detained men in their care, and the language of this respondent illustrated how proximity and familiarity framed accounts of the patient as offender; individuals who were known chiefly in terms of macabre or shocking behaviours. It is, again, interesting that the type of talk changed discursive direction when subject, and speaker, shifted from the generic to the personal in the context of sexual offending. In terms of itemising offences, it was the sexual elements that were emphasised. The choice of language, though, resembled what Foucault (1978) called a 'pathology of the monstrous', where the offences violated social relations that were inscribed with an almost sacred status. These acts included the killing of a parent and the rape of a mother, which inverted any conventional understanding of the familial domain. Children, as symbolic of vulnerability and innocence, or the infirm and dependent, represented the targets of men who acted without conscience or remorse. If respondent [S13] had drawn attention to sadism as a defining feature of the sex offender in high-security care, the detail, here was explicit; a vocabulary of 'hurt', 'torture' and 'violent nasty horrible things'. This combination of distressing detail, abrogation of responsibility, and attribution of blame to others, functioned, ultimately, to explain the removal of this group of men from society, and justify their long-term incarceration in a secure hospital; in short, it unequivocally informed the listener 'why they're here':

> "well the sort of things that they've done...erm [pause] killed a parent because the parent was abusive to the family members...or to them...they've killed them...screw drivers in the heads when they're asleep on the couch drunk [pause] erm they have molest [unfinished] sexually molested young children [pause] erm and blaming others for doing so...it was...it was everybody else's fault because they're either 'a' it's happened to them or 'b' they were exposed to that child...and so y'know it's the adult's fault for putting him up in that situation...rationalising it [pause] they have...raped their own mother [pause] disabled

> mother...in hospitals...it was in a hospital [pause] they have [pause] erm raped numerous women [pause] I'm going through the patients now...raped numerous women and been caught...and they go 'Ok' [laughs] erm having...obviously sex offender therapy as well (.) erm what else? Gosh let me go through the list [pause] have abused young boys...and tortured them...in parks and secluded areas...and done...er sexually...sexual things to them with...tree branches and things like that...and whip them and hurt them...damaged them [pause] erm [pause] took hostages to get their demands met because they couldn't...I think it was they couldn't have a trip out...so they took a [member of staff] hostage in a room [pause] extreme...violent...nasty...horrible things...to other [unfinished] another person...and that's why they're here" (S12: 224-241).

It was noted earlier in the chapter how pornography, for respondent [S4], was defined through the absence of a recognisable 'story line'. In contrast, one of the collective characteristics of the women's accounts was the presentation of salient issues through an unfolding and autobiographical narrative. This formatting of talk has been discussed above in relation to the uniquely gendered way that female nurses experienced pornography in the hospital. Respondent [S12] adopted a similar style of speaking when attempting to discriminate between what she perceived as two discrete types of rapist, where pornography would be introduced into the latter part of the account as a signifier of sexual violence. The first typology was organised around a fictional character described as an 'opportunist man' and recreated the stranger-rapist of textbook taxonomy. The victim, alone in a public place, becomes a target for the hatred and anger of an unknown assailant and is subjected to a violent sexual attack:

> "the opportunist man...who may be walking down the road...and he may be really angry and frustrated and er you don't know what's gone on in his day...throughout daily life...and he might just hate women and see a woman walking home...and he might think right...and use his sexual act as a form of aggression and give her a bash on the head...and have sex with her because he hates women" (S12: 326-330).

It is interesting that the account was premised on an assumed misogyny where the sexual act, defined in exclusively male terms, could be used to punish women. Asked to elaborate this unqualified gender hatred, the scenario was embellished to justify male revenge in a way that invited an interpretation of victim-blaming. The underlying anger of the male aggressor was located in the domestic sphere, at a relational level, and extended outwards to embrace all women. While the character of the 'wife' is described as 'strong', the man is indicted as 'inadequate' for a series of personal, familial and sexual failures, and another more 'vulnerable' woman becomes the casualty of his resentment:

> "for example he could have...er his wife could have told him how inadequate he is and how shite he is and er...she could have been mentally torturing him for a number of months about his...inadequacies...whether it be in his job his family life...or his sexual act...er ...sexual...relationship with his wife...or just...in general putting him down and...he might be right...really not able to cope with that [pause] and so he...he goes and acts out this because he wants to punish the wife but she's like strong isn't she? 'I hate you...you're crap'

> So he...he might go off and get a vulnerable woman and take it out on a vulnerable woman in a park...not necessarily a park...in the street" (S12: 335-346).

It was noted in chapter six how female nurses talked about their experiences of institutionalised sexism, and the stress of working in an all-male environment. It is worthy of note that this respondent would use almost identical language to outline a strategy for coping with the discriminatory attitudes and actions of the male staff. Presented as a form of inverse sexism, the retort of the respondent revisited the idea of marital conflict as the source of unacceptable male behaviour outside the home. The woman in the account is, again, invoked as a tormentor, and the respondent situated herself as the victim of undeserved treatment; where there is an underlying expectation that 'being a woman' is about being made to 'feel horrible'. Not unsurprisingly, perhaps, the use of coterminous accounts to situate women in a network of unequal gender relations was a unique feature of the way that female nurses talked about sex, sexual discrimination, and sexual violence:

> "You get that attitude [from male staff] you do get that...and I tend to ignore it or er...I'll have a little snipe back [pause] and say y'know 'What's your issues...have you not had...' Y'know I tend to be a bit sexist back when they're being sexist like that...say er...y'know 'Have you had an argument with your wife...is that why you've come in here to take it out on me...'cos you can't take it out on her' [pause] Because that's what...what...I just make them feel as horrible as they try to make me feel...being a woman" (S12: 565-571).

The second type of rapist discussed by the respondent was described as the kind of man who would 'plan and plot and scheme', and conjoined talk about sex, fantasy, and offending. Though the account was introduced as being judgemental rather than factual, the narrative was peppered with crude distillations of pseudo-therapeutic speak commonly used by nursing staff on the wards. Delivered, again, in the form of a story, the account was riven with discursive strands that juxtaposed social dysfunction, hyper-sexuality, addiction and emotional blindness. Sketching out a simplistic caricature of the classic 'psychopath' enabled the respondent to talk about sexual offending as sex outwith any social or relational context. The recklessly impulsive rapist was portrayed as a 'misfit' who existed on the margins of society and sought constant gratification in sexual acts, and encounters, that were devoid of intimacy. Pornography was included in talk about impersonal and commodified sex, as a surrogate for meaningful sexual relations, where women had little value outside of their 'sexual form'. The concept of fantasy, which occupied a central position in the accounts of female nurses, was identified as the mediating factor between representations of sex/sexual violence and the commission of sexual crime. In tandem with the, movie like, plot-line that was being discussed, the scenario concluded with a story of control and power, where one person (the woman) is forced to submit to the sexual demands of another (the man):

> "that I feel is somebody who is more erm...I'm only making judgements really...I haven't got any factual basis for this...right (.) and he's erm...maybe watching a lot of pornographic material...he's very sexually...highly sexed y'know...he likes a lot of sex...with women (.) some of them just like sex and pornography and er...maybe go to prostitutes and erm...thinks little of women...thinks of them only in a sexual form...and then he...'cos he may be a little bit of a loner and can't form relationships with people in general...not a warm person so he may then [pause] he'll be one that I should imagine would plot and scheme to rape a woman (.) he will watch the pornography...he'll build himself up...he'll start fantasising about...watching horror films even...y'know films about rape and that...he might start fantasising that he's that person and wonder if he could do that...and he'll start to live it himself and er thinks he's better than everyone else and so he might go round...I don't know...do this on a Wednesday and sees the woman who delivers the free magazine...so 'She's gonna...on a Thursday she's gonna get it...when she's going back to her house I'm gonna hide in the bushes...that's what they did in the film and...I'm going to make her do that sexual act what they did on that film that I watched' And all of that...and I think he would plot and plan...and would be quite calculating...cold...usually...socially...a misfit really for want of a better word" (S12: 361-379).

This segment of data serves well to introduce the way that pornography became a strand in the female nursing discourse about sexual offending. Fantasy assumed a pivotal position in explaining how imagery might influence behaviour. Like many of the male staff, female nurses suggested the sexual offender was more susceptible to the negative impact of such materials, and used this to furnish a rationale for restricting access. But, while men might have been able to theorise a relationship between certain types of pornography and abusive behaviour, the women's accounts prioritised 'hurt' and 'violence' and explicated a difference between 'love' and 'sex'. Talking about the custodial function of the hospital, and length of stay for the patients, respondent [S12] framed a debate which resonated in the accounts of all the female nurses. These were men who had been removed from society and the opportunity for 'normal sexual relationships', and were now living in an environment that had been essentially sanitised of sexual material. Though not directly mentioned, directorate policy haunted the account and placed the nurse in a position where personal opinion might not concur with the expectations of the clinical team; where the privations of censorship could be seen as overly harsh in an already sexually segregated environment:

> "and they find that they go through the system and they can't get out...and...by whatever reason they find themselves here for...for a number of years [pause] but that was the initial thing [pause] then [long pause] well y'know (.) I don't know...I don't know whether I agree with it but...I think that they would request...sexual material to...because they're not having normal exposure to sexual relationships so they may very well want pornographic magazines and things like that to enjoy some sort of sex...like with themselves" (S12: 692-699).

Considering whether there might be a case for permitting some patients to use pornography in this way, though, was contingent on the individual, and a distinct difference emerged between *detention* and *deviance*. The idea of using sexual imagery to replace 'normal' sexual relations for men who were routinely spoken about in terms of abnormality became hard to reconcile. Pornography in the accounts of female nurses was understood as a

corruption of romantic, or reciprocal, sexual relations. It symbolised the eroticisation of suffering, where sex and violence, pain and pleasure, represented interwoven components of male arousal. For the respondent, the management of materials that could be classified in this way became problematic only in relation to the sexual offender. The suggestion that pornography might enhance the 'sexual feelings' of a distinct group of men implied that this would have negative consequences:

> "I think it would definitely exaggerate erm sexual feelings...and...and these images that you see...they're not exactly...er loving relationships are they? They're usually quite erm violent...the ones I've seen anyway...through...throughout my life (.) they're usually of women being...hurt...or some with men being injured in some way and...they're aggressive and it's not really about...they're not really loving relationships are they? [pause] And so it's...portraying a violent...act (.) and then it can misin [unfinished] that could make you misinterpret what sex was about" (S12: 704-711).

Talking about a possible relationship between pornography and sexual offending, the comments of respondent [S11] illustrated, further, how gendered understandings of sexuality produced divergent accounts from male and female nurses. Men's talk about conventional pornography, and coercive sex, was constructed around a shared set of ideas where explicit or extreme imagery could be easily accommodated. They knew pornography and understood the fantasies it purveyed, so what were referred to as 'hard' or 'soft-core' representations could be seen as the poles on a continuum of male (hetero) sexuality. In contrast, the discourse of this respondent placed pornographic media outside of 'real life'. It was seen as manufacturing an inaccurate portrayal of people, and distorting or denying the reality of sexual relations. Returning to the idea of a story, pornography offered a singular script that prioritised sex over 'real relationships' which were based on knowing, understanding and valuing others. If some participants conceded that graphic sexual depictions might provide an outlet for sexual frustration, the larger goal of preparing patients for life outside the hospital was compromised by inappropriate sexual stimulation:

> "I think it's all to do with portrayal isn't it? You can watch a film that doesn't actually show people engaging in sex...but it's the build up that makes you think 'God that was a really sexy scene' Do we need graphic pictures? Erm [pause] where people are [pause] are exposing every bit of themselves without any sort of justification...so I don't think it's appropriate (.) erm [pause and sighs] it's got one aim hasn't it? It's got one aim erm...to be sexually stimulating erm [pause] so I think if we're trying to prepare people to go out and to have...real relationships...that doesn't really happen in relationships does it? It's about getting to know people...understanding them...valuing them...and then all of those other things come...as part and parcel...but they don't come on their own [pause] so I...I don't see erm...that it is right to portray people like that...because that...in real life isn't how people are" (S11: 929-940).

However, it was in relation to the sexual offender that the subject of pornography was most clearly linked to prohibition, and where different sets of discourses around treatment,

therapy and risk were mobilised to talk about the management of sexual media. It was noted previously how respondent [S11] voiced concerns about a patient being allowed to order pornography, where the dilemma hinged on the absence of recorded sexual crime in the patients history. When this nurse was asked how she would have managed the situation if the man had been a sexual offender, the response was direct and unequivocal. While there was doubt that this sort of decision could ever be sanctioned by the team, the nurse was adamant that she would not concur with their recommendation. It is interesting that this radical shift was premised on the *user of the material* rather than the *nature of the material.* While the talk about pornography as an emotionless objectification of women was reiterated, it was only in the context of detained sexual offenders that restriction was vigorously defended:

> "I wouldn't have allowed him to have it...and I wouldn't believe that the team should have allow him to have it so I would...of withheld it (.) I would not give anybody who'd sexually offended against women... men...children...anybody erm...material of that nature (.) and I don't believe that they should have material of that nature because I think we would be...we're then making [pause] the people in those magazines which are usually women erm...we're treating them as sex objects without feeling...aren't we? These pictures are very [pause] er open and should we be encouraging people to see [pause] erm...another individual as a sex object? Erm...I don't believe we should (.) so I don't believe anybody that's sexually offended erm...should be given material of that nature" (S11: 828-837).

Similarly, respondent [S12] developed this idea that men with a history of sexual offending would be more 'susceptible' to any negative effects in relation to the consumption of pornography. Sexual crime might be seen as residing in the 'inadequacies' of the individual but an assumption that exposure to certain materials could result in 'acting out' offending behaviours provided a rationale for the imposition of sanctions. Just as the female nurses had talked about pornography in general as something outside of their experience, discussion of sexual media within the hospital was framed by aspects of male sexuality about which there was little understanding. While restricting access could be justified by defining pornography in the context of the sexual offender, as other, this made it problematic to consider what 'everyday people' might derive from the use of such materials:

> "I don't [long pause] I don't think that patients who have sexually offended should be [pause] they're susceptible aren't they? They...they've already demonstrated that...by their inadequacies and the fact that they've acted out on sexual acts...should not be...have...exposed to pornographic material...but then again I don't think people have an...er...everyday people...should really be looking at pornographic material [pause] it's a...it's hard isn't it because I don't under [unfinished] I don't have an understanding of what they get from that" (S12: 654-660).

A variation of this discourse was used by respondent [S7] who attempted to link pornography to sexual offending, while normalising its use by 'ordinary people'. It was

noted earlier how this nurse had located sexual offending on a continuum that differentiated the normal from the deviant, and the extract of data below illustrates how this understanding was translated into talk about pornography, which could be described as 'good' when it was incorporated within 'loving relationships' as part of a shared experience for 'couples'. Alongside this contribution to celebrating the emotional and physical possibilities of human sexuality, though, was the threat of 'distortion':

> "pornography is pornography (.) pornography is not...people think it's a dirty word but it's not really [pause] pornography [pause] for ordinary people is...is ordinary is...it can be normal...in fact can be good [pause] for couples maybe having trouble or [pause] loving couple...normal relationship...there's nothing wrong with watching a porn film on a Friday night together getting some ideas and trying it out (.) it can enhance relationships...there's nothing wrong with men admiring the female form...there's nothing wrong with women admiring the male form [pause] it...it's when things become distorted" (S7: 818-828).

Asked to clarify what was meant by the term 'distortion' which connoted therapeutic language, as in cognitive distortion, the respondent talked about pornography presenting an objectified version of sex and sexual behaviour, which had as much to do with the user as the material. The account was made up of diverse and contradictory themes. Pornography might satisfy a 'basic human need to have sex', but some individuals were inherently prone to interpret this message in a way that was described as the 'wrong impression'. This applied, particularly, to the patient population, where the familiar descriptor of 'our guys' denoted the hospital as a repository of dangerous men. Here, the concept of 'pleasure' was devoid of reciprocity, and women were the object of predatory hedonism:

> "Objectifying men and women...things like that erm because once...once the person becomes an object [pause] flesh and blood...not a person then [pause] especially for our guys in here...it's easy to commit the crime then...'cos they're objects they're not people anymore...they're not like you and me [pause] they're there to be [pause] 'They're there for my personal pleasure' [pause] Well I suppose it's the things like the poses that people do [pause] in [pause] porn magazines [pause] things like that (.) it encourages people to look at big boobs...nice bum everything on show [pause] erm [pause] which...which could give people the wrong impression [pause] that [pause] that's all that they're there for [pause] 'Women are...are there for me...mine to look at [pause] to touch [pause] and to have sex with'...'cos it's a basic human need [pause] to have sex...sex drive is [pause] there in most people" (S7: 836-851).

Pornography was something that women thought about in relation to their work within the hospital as source of potential risk about which one needed to be 'aware'. It could be talked about as a *dangerous commodity* because it was associated with *dangerous men*. At the same time, these materials were, occasionally, deemed to be appropriate for other men on the ward. The latter patients were usually divided into two types, described as 'non-sexual offenders' and, less often, 'treated sex offenders'. In terms of implementing hospital

guidelines on inappropriate material this meant that any sexual media could be sanctioned, or censored, depending on the circumstances of its use:

> "I think you view it [pornography] more so in here...y'know what I mean...you think about it more in...in here (.) you're more aware of it when you're...when you're working in [name of hospital] because you're working with sexual...offenders...and it's important to be aware of it because some people...have been agreed that they can have access to pornography...ie magazines erm that...by the PCTM...it's all been approved...properly and you've got to be...ensure that...that stays with that person and doesn't go to anybody who...should not have access to it" (S4: 552-565).

Given that female nurses had minimal contact with sexual offenders, and their understanding of pornography differed markedly from male colleagues, the next section explores how the concept of fantasy assumed a pivotal place in their accounts of pornography related risk; where discourse about dangerousness shifted from the sexual threat of the rapist to the deviant sexuality of the paedophile. It will b e suggested that this reflected the limited choices, and outsider status, of the female nurses who participated in the study.

Pornography and nursing practice: dangerous men and dangerous sexualities

When they talked about the management of sexual media on the wards, there was a noticeable change in the discursive direction of female nurse accounts. This, in part, reflected the dominant focus of post-Fallon policy on the Personality Disorder Service, but could also be understood as a way of identifying with more powerful, if contradictory, ideologies about treatment and incarceration which permeated the institutional language. Respondent [S4], for instance, proffered an account that contrasted her own sentiments with a prediction of how other female staff might respond to the issue of patient access to pornography. The remarks came at the close of the interview, when the nurse was asked if there were any other issues that might be addressed in relation to the study. The response, again, illustrated the confusion that surrounded the issue of sexual media on the wards, and the tension between clinical and custodial approaches. The suggestion that access to pornography could be 'managed', if 'appropriate', supposed that it was allowed for certain patients. In contrast, the comment that staff needed to be 'vigilant' and 'on their toes' endorsed a censorial strategy of searching to support the oft quoted blanket ban on sexual materials. The account, more generally, precluded any discussion about the gendered nature of the materials in relation to the users:

> "as a female I don't feel threatened by it...threatened by [pause] patients having access to pornography...if it's appropriate (.) and I don't feel threatened by anything else...I think we are...do manage it well and we are very vigilant [pause] so that makes you more comfortable when you know that everyone around you's very vigilant...and very y'know...on their toes

> sort of thing and you know what you're looking for...and you learn...and you learn quickly" (S4: 1100-1105).

The respondent differentiated herself from other female nurses who, it was anticipated, would be 'uncomfortable' with patients being allowed to access pornography, and support the imposition of a total ban. The language, here, worked to identify the respondent with care team decisions, rather than the presumed opposition of other women:

> "though I think when you interview some females they're going to be very uncomfortable with it...about patients having access to pornography (.) I am not uncomfortable with it at all...I think if it's appropriate...it's been agreed by the care team I think then...great...have access to it [break] I think you will find that some women don't like it though...don't like any of them having access to it...and would put probably a blanket ban on it" (S4: 1036-1050).

Elaborating on this point, the respondent drew upon a larger institutional discourse, discussed above, that delineated between non-sexual offenders for whom access had been agreed, and sexual offenders who might illicitly obtain such materials through deception. The idea of an internal trade or swapping of magazines and pictures, between patients, was reminiscent of the way that male staff had likened pornography to drugs or alcohol as forms of contraband. The risk of a sexually explicit image falling into the 'wrong hands' was premised on the inability to exercise complete control over the lives of the detained men. In unobserved moments, it was posited that furtive exchanges could be made between men who were categorised as either clinically deserving or undeserving:

> "'Cos I suppose that they're scared that it might get into the wrong hands [pause] 'cos y'know it possibly...there could be a chance that they could...when that chap takes it down to his room [pause] they're not allowed in each other's rooms but they're allowed to knock on each other's doors [pause] they're allowed to open a door to another patient and talk to them at the door (.) but how do...you're not stood right by them (.) they can be quick...they can be clever erm you may have [pause] he may be able to sneak the magazine out...he may even be able to sneak just a picture [pause] that'd be very easy to do wouldn't it? A very small [pause] but sexually explicit picture...so that is a worry [pause] that there could still be that going on...because you can't control it one hundred percent can you?" (S4: 1054-1063).

Respondent [S7] thought it unlikely, when asked, that any of the male patients would be granted care team permission to order commercial pornography. Offering an example of one occasion where this had happened, the decision was presented as a defence of individualised care. Though the publication would not ordinarily be designated as pornographic, a condition of access appeared to hinge on his not being a sexual offender. However, this hint of looking at a request in specific, and personal, terms was enveloped within a stronger and generic form of talk about patients as the inmates of a 'special hospital' that diminished any sense of choice or agency. The language clearly denoted a collective identity and status, framed by prescriptive custodial rules. Later in the chapter it will be noted how the women

nurses embraced this construct of otherness in a way that placed the detained offender beyond a discussion of 'human rights':

> "probably not (.) if they asked for it...if they said 'Look I want this magazine to come in' Erm it would go to the care team and it would be a care team decision...and I know it has happened in the past where some patients have erm or...a patient that we used to have he used to get *FHM* regularly which [pause] generally we wouldn't let patients have...but this man was not a sex offender and he had it [pause] so you see...things happen individually don't they? There are some things that we wouldn't allow full stop because at the end of the day we are a special hospital...we have been slated for porn in Fallon erm so obviously you couldn't be allowing y'know...I don't know *Red Hot Dutch* to be [pause] screened in the library...or even on an individual basis" (S7: 1109-1118).

While recognising the limitations of surveillance, talk about searching was a feature of the women's accounts. These might be routinely undertaken by nursing staff, as described by respondent [S4], but also included attempts to involve the patients in regulating their behaviours; where those men who were seen to self-manage their use of sexual materials, in accordance with care team guidance, and communicate this to staff, earned the epithet of 'very good':

> "we do room searches on a regular basis...things like that erm...the ones that have had it [pornography] approved keep it in a locked erm...locker...sort of thing and make the staff aware...they're very good actually...they make us aware that they're accessing it [pause] and then they...they return it" (S4: 570-573).

Respondent [S7] extended the idea of self-monitoring behaviour, which might be considered as risk-inducing, to men who had committed sexual offences and would be ineligible to apply for access to pornography. The development of 'skills' to avoid particular types of stimulus was directed toward patients whose primary sexual orientation was toward children, where television programmes aimed at younger audiences were deemed to be 'inappropriate' viewing. The two extracts of data below begin with an acknowledgement that nursing staff were unable to deal with the volume of everyday media that might be constructed in terms of erotic interest, and indicate the attempts to 'screen' the content of video-recordings for evidence of misuse:

> "No [pause] we would hope they'd do it themselves [pause] we would hope that we'd give people the skills not [pause] not to sit there watching Blue Peter erm [pause] it...it's really difficult though isn't it? People [pause] people need to be given the skills to police themselves really" (S7: 1065-1068).

> "video's are routinely screened just to see what they have recorded [pause] once every few months y'know you might have a video tape taken off you to [pause] be screened to see what's on it...and if it's inappropriate content that someone's recorded...if we [pause] y'know notice that they're recording things that [pause]" (S7: 1076-1080).

When asked to define what was meant by the term 'inappropriate', the response was organised around sexual signifiers rather than sexual content, in the context of a specific category of offender:

> "It depends on the patients...if we know that our patient is a predatory paedophile and has got erm tapes of [pause] children on Blue Peter in gym knickers...we're going to find that inappropriate" (S7: 1087-1090).

This distinction between types of offenders, and types of materials, conflating the pornographic with the inappropriate, underpinned discursive moves between optimistic and pessimistic accounts of treatment, and shifted attention from *dangerous men* to *dangerous sexualities*. Respondent [S4] talked at length about a patient, referred to in terms of ownership, who she considered to be extremely susceptible to the negative impact of pornography. Because of a history of sexual offending, this man was not allowed access to sexual literature, but nonetheless talk about pornography was central to the idea of his being treatable. The censorship of materials that would be legally available outside the hospital was justified in terms of an abstract notion of 'inappropriate sexual fantasy', which was described as ever present but fluctuating in intensity. As noted previously, it was maintained that self-rating permitted the man to score sexual ideation, in terms of risk, and express this as a numeric value. It was asserted, but not explained, that pornography could act as a regressive 'trigger' in activating a latent threat:

> "Because sometimes it's [pornography] inappropriate with their sexual fantasies (.) I'm speaking again mainly from my patient...one of my patients point of view (.) he has inappropriate sexual fantasies and has had these in the past and I think...to some extent or another still has them so if he accessed pornography it would trigger...it would start these fantasies up to...they're at an acceptable level now (.) he knows they're inappropriate [pause] they're at an acceptable level now...they're two out of ten (.) he rates himself...he's very good...he's very aware...very insightful" (S4: 579-585).

At the time of the interview the patient was not using the 'log' because the score had fallen below what was considered to be a threshold for clinical concerns. The account is interesting in that it was based on a simplistic assumption that 'thoughts' could be divided into those that were of a sexual nature and those that were not. There was no attempt to engage with the complexity, or context, of fantasy; it either existed or did not exist. Further, since female nurses did not engage with patients about anything that related to sex, it was male staff that assumed the responsibility to listen to the sexual stories of the patients; as with decisions about what might constitute acceptable types of pornography, men became the arbiters of appropriate fantasy:

> "he doesn't log it anymore because it's not an issue at this current moment (.) he mainly logs it if it becomes an issue (.) he's having thoughts now but they're not sexual in nature...but if they were sexual...nature he will rate himself...and it's usually...once it's five and above out of ten...that he'll rate himself [pause] and he'll make the staff aware...he will talk to a male member of staff about what the...it was because obviously there's boundary issues...he wouldn't be able to discuss that sort of detail with me" (S4: 589-595).

In an effort to explore how sexual thoughts were theorised in relation to pornography and sexual offending, the respondent was asked to comment on the sort of thinking that could produce an elevated level of risk. The response defined sexual fantasy in relation to past offences, and was focused on specific women described as 'victims':

> "Er...to his victims [pause] yeah he's a...a sexual offender so the...the sexual fantasies would relate to his victims" (S4: 633-634).

Although described as one component of a rehabilitative regime, the exercise of monitoring fantasy appeared to have little future focus in the respondent account. When invited to comment on whether this man's fantasy might extend to 'other women', speculation shifted from *previous* sexual violence to the *present*. In the ward environment, the female nurse became representative of all females:

> "They could do possibly (.) I know he's had infatuations with female members of staff in the past so...probably yes the fantasies could be to other females (.) and the other...only females he sees are members of staff...aren't they? So that would be the nursing staff that the fantasies could be about" (S4: 638-641).

It was noted in the previous chapter how respondent [S13] identified the difficulties facing sexual offenders in dealing with fantasy, therapeutically, within an environment that permitted no space for the expression of emotion or intimacy. This theme also informed her account of patient access to pornography on the wards, where clinical engagement between professional and patient was seen to be premised on 'deviance' rather than 'healthy sex'. Decision-making about pornography, described as a clinical issue, offered scope for interpretation and a more creative appraisal of sexual representations. Certain types of material, such as sex videos, could be seen as beneficial in terms of promoting more positive sexual/gender relations, while imagery portraying inequality and objectification was counter-productive to this goal:

> "[The hospital policy] is about guidance for care teams but it's really considered a clinical issue and there are...and in terms of understanding...there are differences across the hospital (.) and I guess there's differences to erm whether it's healthy for a normal sex life...they have to masturbate to something erm...but I think in terms of how...how it's understood in PD is around objectification and that power differential (.) erm...I've got no problem with healthy sex videos at all...where you see er videos of people who are mutually engaging in sex...and people watching that (.) I've got no problem with that at all but the ones that objectify by just showing body bits erm...or showing overpowering...or showing or

> violence or erm denigration erm and so on...really is not...is not erm healthy sex (.) so we should be promoting healthy sex including...because it's really difficult to get people to talk about healthy sex [laughs] erm we'll talk about deviancy I guess...somewhat...but to try and get them...talk to people about their own...'What what's a healthy sex life...how do you...?' And if you can't develop intimacy for whatever reason...and some people can't erm how do you sort of get satisfaction without having to go and...y'know without the envy and the...and the anger that can develop from lack of intimacy" (S13: 737-753).

When questioned about pornography as a discrete topic within the SOTP groups, it was interesting that the respondent talk shifted from masturbation as part of a 'normal sex life' to masturbation as a component of sexual offending. Discussing pornography in the context of treatment closed down a critical commentary about sexuality within the *institution*, and relocated the issue as an *individual* problem. if this nurse attempted to articulate a more sophisticated argument about the relationship between cognitions and behaviours, fantasy remained an elusive property of male sexuality. It could include 'dreams', 'thoughts' or imagined 'pictures', but how these operated in the context of offending remained obscure. Fantasy, it was suggested, could precede a sexually violent act or develop as a product of abusive behaviours, but in either case there was no indication of the part played by sexual representations:

> "There's not really enough [SOTP work] on fantasy [pause] erm...because we...we ask people about fantasies and erm it's actually very hard to think of erm...some people talk about dreams...some people talk about thoughts erm...and some people [pause] erm say that they don't have pictures in their head when they're masturbating (.) but actually the fantasies aren't...the...fantasies aren't necessarily when someone's masturbating...they're just about the thoughts that they would like to do to somebody that may be sexually arousing...or it may not...at that time [pause] because there are some offenders you see who...who don't get erections when they're offending...it's only later...after the act" (S13: 962-973).

Indeed, the rationale for restricting access to pornography, legally available to individuals over eighteen years of age outside the hospital, was constructed in terms of 'power differentials' rather than specific types of offending. Men who were detained for non-sexual crimes could be subjected to exactly the same curtailments in the interests of 'promoting healthy relationships'. Allowing non-sex offenders to consume commercial pornography might not be 'a new argument', but was justified outside of any causal link between imagery and offending. Theorising about 'porn' as a cultural marker in the reinforcement of structural division became an issue of equal rights rather than social wrongs, and outside the heterosexual market embraced materials produced for the 'gay' community. This respect for vulnerable and sexual minority groups differed markedly from the homophobic discourse of some male nurses, but in the context of her earlier comments, the respondent offered a less than compelling strategy for challenging the institutionalised discrimination of a hospital culture:

> "Except we're promoting healthy relationships and like you might say that for all people...that porn... can...y'know...I'm not saying there's a causal link...I don't think you can say that but you could theorise that there's a link between...y'know the power differentials in our society...isn't helped at least by...depicting certain groups that might seem weaker in some way...or certainly subjugated in some way [pause] I understand the argument...I mean it's not a new argument...it's been around a long time (.) but again it does come back to that issue about porn per se being erm one of the erm...markers in our culture that er reinforces these erm divisions (.) erm and at some level reinforces thinking about erm...erm 'It's ok erm to subjugate people in this way' I think it's true of gay porn as well where you've got y'know...vulnerable groups represented" (S13: 850-868).

In a similar way, respondents [S7 & S4] gave precedence to power as an explanatory factor in sexual offending when they were asked to consider how the use of pornography might relate to criminal behaviour. Again, their responses were presented in terms of violent offences characterised by the infliction of hurt rather than vaginal penetration [S7], that might not ordinarily be described as a 'sexual thing' [S4]. Talking about one man who had 'never had sex' [S7], the offence was described in relation to the women he had assaulted, where the 'prostitute' signalled an ideological distinction between the victims of sexual crime. This rigidly dichotomised thinking, which constructed women as 'angels or sluts' was reminiscent of offender accounts that constructed deserving and undeserving victims. Each of these nurses talked about desire as part of 'adult sexuality', but credited pornography, as a singular stimulus, with the potential to corrupt or distort sexual relations by conjoining fantasy and power. For respondent [S4], treatment could transform the way that men viewed women. It was asserted that patients who had been transferred to the ward where she worked, as a result of attending SOTP, no longer objectified females:

> "There's power...quite often sexual offending isn't to do with sex at all...there are some people that are sexual offenders that have never act [unfinished] never had sex [pause] we've got one that's never had sex but is a sexual offender because his offence's against prostitutes...but they're violent sort of S&M things going on...as opposed to...which is more about his feelings towards women and [pause] 'angels or sluts' there's no in between erm [pause] but his crimes are very sexual linked...but were violent" (S7: 486-492).

> "I think it's because it reminds them of that time...like I said previously that they had power over somebody...and that power...it may not be...always be a sexual thing I think...you see it may be...it may be 'cos I think...y'know most adults have sexual desires and fantasies (.) I don't...y'know...they do...so I don't think there's anything wrong with that (.) what I think...when it becomes distorted is...when it links to this...power...that they had and that's why it differs from any ordinary adult sexual fantasy...because it links back to their offence which links to their...having power over somebody...treating somebody like an object...mainly women of course (.) and I've...I've heard them say that... y'know...that in the past they...not now 'cos that's not like y'know...that's why they're on this ward...they don't view...but in the past they've viewed women as objects for their own use [pause] and the women have not had thoughts or feelings really...or they've not been interested in what that woman thought" (S4: 664-691).

Pornography, though, could easily remind them of the past, reactivate inappropriate fantasies and reverse therapeutic progress:

> "Because if it's [pornography] an issue for them...if it's gonna erm [pause] result in inappropriate sexual fantasies...reverting back to how they were in the past...seeing women as objects...to gratify themselves and the power [pause] not to say sexual...as I say" (S4: 899-902).

The ways that pornography was spoken about played a key role in constructing a distinction between the normal and the deviant, driven by corresponding types of fantasy, which informed nursing practice with regard to sexual media. When talking about the need to impose restrictions on sexual literature, the focus moved away from concerns about commercial pornography, associated with rape toward a range of diverse, and relatively mundane, materials that symbolised a sexual interest in children. This was a characteristic feature in the discourses of all the female nurses who participated in the study, that differentiated between *prohibitions* and *policing*, a discussion of which will conclude this chapter. Earlier, it was noted how women talked with difficulty about something that was associated with male sexuality, but located pornography in relation to their experience as female nurses working in a patriarchal culture. Similarly, the sexual offender was spoken of in terms of the personal threat they posed to women, which was distinctly different to the accounts of the male nurses, and loosely informed an idea that some types of sexual publications ought to be censored. However, discussing their role on the wards the focus shifted to paedophile offenders as the embodiment of dangerousness, and the difficulty of policing deviant sexuality. Respondents [S4 & S11], for example, spoke about the almost impossible expectation that the ward environment be purged of materials that could have erotic currency for men with a sexual interest in children. It was noted previously that VHS recordings made by patients were routinely screened and, again, televised imagery featured as a way of attempting to monitor sexual thoughts and behaviours:

> "as I've said children [pause] if they have sexual fantasies about children that is very difficult to control...you switch on a telly now...I bet one of the adverts is going to be a *Pampers* advert...things like that (.) all the video's get checked here...along with the rooms and things 'cos we look for things like that [pause] say...that a patient may have taped a lot of adverts [pause] like with children...and then another advert with children and...or maybe he tapes children's programmes...that've got children in them" (S4:1070-1076).

> "the programmes...that they're recording children's programmes...that's an indicator isn't it? Of how...what they're thinking about [pause] we couldn't [pause] we couldn't scan everything...and remove all these pictures because no matter how hard you try there's...they're always going to be around [pause] erm [pause] so...we've got to just assess their responses haven't we? As I say...like taping children's programmes...erm [pause] hoarding up magazines like...I dislike the catalogues where it shows the children in...in their underwear because [pause] they're the pages that go missing erm [pause] so we have to acknowledge that they...do (.) y'know the little girls in their briefs and whatever y'know...that they are the pages they're gonna be focusing at (.) but if they go missing...and we don't know where they've gone we can't judge...we're...we're unable to know which patient it is...isn't it? And...what's he doing with them?" (S11: 965-981).

For respondent [S7], 'pictures of scantily clad ladies' might be forbidden in a 'structured' environment, but did not warrant classification as 'porn'. Conversely, mail-order clothing catalogues that featured images of children, that could act as a masturbatory aid for a specific group of men, occupied the time and attention of nursing staff who would systematically 'take out' certain pictures. Given that such items were incongruent within the hospital meant that their removal did not constitute a breach of human rights:

> "Erm generally we wouldn't have...I know that some patients somewhere in the hospital have had permission by their care team to have porn magazines or at...at the lower end things like FHM...things like that...there are pictures of scantily clad ladies in but I wouldn't class as a porn magazine (.) erm our patients we're structured living...are here for a reason (.) none of our patients can have anything like that erm...because there's quite a high incidence of paedophiles on our ward when erm...just the *Kays* catalogue or the *Argos* catalogue come in...a member of staff would go through that and take out all the pictures of children because people would use them as aids erm...masturbating etc (.) erm also there's no need for them to have pictures of children [pause] they're not going to order out of that magazine...things for children so they don't need it (.) so we're not sort of [long pause] stopping their human rights" (S7: 861-872).

Given the respondent had framed the issue in terms of human rights prompted the researcher to ask whether refusing access to legally available pornography might not be interpreted in a similar way. The uncompromising response, and subsequent comments, relocated the discussion within an institutional discourse that dehumanised the patient population, and emphasised rules over rights. To be 'living in a special hospital' marked the individual out as significantly different from other human beings. Identified in terms of criminality or mental illness, which needed 'treating', these men could no longer be considered as 'ordinary people':

> "Well yes...but they are over eighteen...but unfortunately they're not over eighteen and living outside...they're living in a special hospital for a reason (.) they are [pause] here because of crimes and because [pause] they are mentally ill and need treating [pause] they're not ordinary people [breaks off]" (S7:881-884).

> "because you are who you are...a patient in a special hospital and unfortunately you haven't got access to everything...just the same as there's a blanket rule on alcohol...we couldn't say 'Well I know alcohol's allowed out there but you're in a special hospital...I know you're not on medication but that's the rule...that's the rule'" (S7:1118-1125).

In contrast to the *sexual* offe nder, the dangerousness of the paedophile resided in the *sexuality* of the individual offender, as illustrated in the account of respondent [S11] where such men were attributed a chameleon-like quality. If the primary attraction was towards children, the absence of a victim group did not preclude their remaining dangerous while detained. Ordinarily it might be assumed that this group of men would present a lesser threat to female nurses, but here it was suggested that enforced privation only encouraged an

adaptation of sexual interest. Allegedly based on personal experience, it was reported that within the hospital adult women had become the focus of their 'inappropriate affections':

> "you find that they may have...offended against children [pause] but when they're in here that changes...because there aren't the children anymore so they then...I'm just thinking of a couple of people that I've been looking after...they then change...because that group is no longer accessible (.) they then I think...just because that group isn't there they then turn their affections to adult women...y'know their...inappropriate affections...erm I can think of quite a few patients that have done that...that have offended against children but then...are inappropriate with women [pause] because that group isn't there anymore" (S11:350-355).

The supposed malleability of their 'sexual urges' constructed these men as unknown and unknowable predators, that seriously challenged optimism in a treatment philosophy. Given their constant search for 'gratification', to compensate for lost opportunities to offend, underscored the importance of vigilance about potential stimuli such as 'reading materials' or 'seeing children':

> "I think it's an indicator of how dangerous they are and how much work has to be done (.) because if you can shift from one group like that...erm... it's because that...they can't get any gratification can they? That...that group is no longer accessible and through reading materials or...seeing children or whatever...so there has to be some focus for their sexual [pause] erm [pause] their sexual urges" (S11: 366-370).

Respondent [S7] used similar language to elaborate on the dangerousness of the paedophile. Drawing on what was claimed to be 'research' informed a taxonomic calculation of risk based on the diversity of individual predilection. Beyond the actual content, the account functioned to make a distinction between the rapist and the paedophile whose offences transcended age, gender and sexuality; where men who were seen to 'prefer' young males were defined in terms of escalating levels of danger over time. More interestingly, perhaps, the talk about dangerousness was firmly situated within a discourse of detention that resonated with the custodial history of the special hospital. Comments about the merits of secure psychiatry, in relation to the prison system, were not organised around therapeutic opportunity. Rather, mental health legislation represented a mechanism for permanently removing certain people from the social body, where treatment and therapy were dismissed as impotent in effecting change:

> "some prefer babies some prefer...some prefer teenagers...and each group have got sort of different...different problems attached [pause] erm research suggests doesn't it? That erm [pause] paedophiles that prey on young girls tail off as they get older...they tail off (.) the same as rapists tail off towards women...they peak...twenties thirties and tail off (.) whereas paedophiles that offend against boys just grow and grow and grow and grow and grow and never become any less dangerous due to age...very underground...very difficult [pause] which is why I like special hospitals because at least we can keep hold of ours [pause] the prisons...they have to let people go" (S7: 996-1012).

> "I also recognise that most of them shouldn't ever get out of here [pause] because we can treat and treat and treat and [pause] therapy therapy therapy as much as you like...but the end result will be...I still think they'll be dangerous to people [pause] or to themselves [pause] or both [long pause]" (S7: 1307-1319).

Summary

This chapter has developed further the ideas discussed previously by placing the gendered dichotomy of the PDS, and inequities experienced by female nurses, under the magnifying glass of analytic scrutiny. The focus on women's accounts of pornography and sexual offending reveals stark differences between their understandings of the world and those of the men with whom they spent considerable amounts of time, whether these be patients or colleagues. Most notably, the centring of a critical lens on sexual media, and sexual ideology, within the secure site made manifest the disparities of cultural and professional power that designated the female nurse as 'other'.

For the female respondents, talk about pornography was contextually situated in their experience of working in an exclusively male dominated institution characterised by a dominant masculinist culture. Pornography was something that these nurses were exposed to as a part of their practice, but any real understanding of such materials resided outside of their experience as women. In this sense, their discourses about sexual media and sexual offending were reflective of gender division rather than a collective professional knowledge base for clinical practice. It was the complete lack of a shared way of talking about pornography that most characterised the accounts of women as distinct from the men who participated in the study. Situating their narratives in the male space of the ward meant that female nurses deferred to the expertise of male colleagues in attempting to make sense of commercial pornographic publications that arrived on the wards, or appraise their suitability for patient consumption.

Because of this discursive hiatus, the women tended to talk about pornography in a way that was notably different to the linguistic organisation of male accounts. They struggled to offer a conceptual or abstract definition of something that was alien to them. Instead, the subject was approached, often with embarrassment or reticence, by a focus on the self which drew upon personal anecdote. Discussions about pornography were located in the experience of their lives as women, and the topic became symbolic of wider debates about gendered exploitation, abuse and harm. Though men talked easily about the objectification of women in literature that was deemed to be a form of male entertainment, the women offered a more visceral interpretation of seeing other females exposed and reduced into fetishised body

parts. This gendered awareness compounded their accounts of working in a hospital characterised by sexual inequality and sexual threat, where pornography could be accommodated in talk about male sexuality and male sexual violence.

Where male respondents talked about pornography, without hesitation, as a component of sexuality, this was another point of variance in the accounts of the female nurses. If they failed to understand the need for pornographic stimulation, this was related to what were described as enigmatic qualities of the way that men engaged in, and enjoyed, sexual behaviour. Pornography represented solitary sex, and masturbation, in contrast to mutual and reciprocal pleasure as a product of loving relationships. The women infused their talk about sex with ideas about having fun, where the hurt and harm that permeated male accounts was an unwanted and invasive aspect of their lives outside the hospital. The presence of pornography, like sexual harassment or domestic violence, represented a corruption of idealised human relationships.

In conclusion, focusing on the way that female nurses spoke about pornography had great import in illuminating how a concept of woman as 'other' was constructed and mobilised within a treatment setting for sexually violent men. The final chapter of the thesis presents a critical synthesis of the study findings, which draws attention to the conflict between the notion of sex offender treatment and the values of an institutional culture that were inimical to the goals of therapeutic intervention.

SECTION III

CHAPTER 8

Discussion

Introduction

This chapter presents the findings of the study in the context of a discourse analytic focus on the constructive nature, and textual variations, of language in a high-security hospital. The chapter explores how mental health nurses, and sexual offenders with a diagnosis of personality disorder, talked about pornography, sexual offending and the institution in which they lived or worked. Attention is given to the theoretical value of the research design in enabling an exploration of the function of language in constructing particular versions of the hospital, and of the social actors who participated. It is noted that there was variability between the ways that men, whether patient or nurse, constructed their accounts in relation to female nurse respondents, where discourse was situated in gendered experience and knowledge. It is noted how respondents used language to position themselves, and the way that this changed according to the contextual location of the talk. Of particular relevance to mental health nursing, is a discussion of a fluid construct of 'otherness' which was constantly negotiated in respondent accounts. The chapter is divided into three parts. The first explores five dominant discursive repertoires that situated language use in the unique cultural formation, and dynamics, of a forensic hospital. The second part draws these discursive repertoires together under three over-arching constructs which organise a discussion about the 'legitimacy' of the hospital. Finally, the third part looks at implications for practice.

The first of the discursive repertoires identifies the centrality of the hospital ward as a physical, and symbolic, space in framing respondent talk. It constructed the ward as an alienated masculine territory characterised by a sexual division of labour that marginalised female nurses. The second focuses on the gendered construction of secure care in relation to detained men with a history of sexual offending. It is suggested physicality defined male nursing staff, while sexuality defined their female colleagues. The third dominant discourse looks at respondent talk about pornography, suggesting that language use embodied gendered knowledge and experience, mediated by institutionalised sexism. The fourth discourse informed respondent talk about pornography and sexual offending in the context of ideological distancing and dangerousness. Sexual pleasure and sexual offending, in the men's accounts, coalesced in a shared discourse of male sexuality. In the context of sharing space and time with the sexual offender, male nurse talk distinguished between 'normal' and

'deviant' men, while female nurses adopted a discourse that positioned them in relation to 'dangerous' men. The fifth discursive strand was evidenced in nursing staff accounts of dealing with pornography, and 'clinically inappropriate' materials, as a part of professional practice. Talk about policing and searching, for images or items that signified risk, fused with a discourse about dangerous sexualities and focused, almost exclusively, on the erotic imagination of the paedophile offender.

Drawing the dominant discursive repertoires together, into a coherent argument, permits a broader discussion of the study findings in terms of a 'crisis of legitimacy' for mental health nursing, organised by three over-arching constructs. These are: systemic isolation and an insular culture; gendered labour and male power in a masculine culture; and, anti-therapeutic discourse in a treatment setting. The findings that have been presented throughout the thesis are synthesised, and incorporated within a reflective account of nursing in high-security provision. It is suggested that, despite reorganisation and progressive policy directives, nursing in the hospital had failed to the escape historic failures of the heavily condemned special hospital system. An overpowering custodial culture, institutionalised sexism, the othering of the patient population, combined with a diminution of the ethical foundation of nursing practice, would indicate that this is not an appropriate environment for therapeutic work with sexual offenders. Though the enterprise of nursing, in the hospital, is defined as morally bankrupt the chapter concludes with some implications for practice. The extent to which these could in any way challenge an entrenched and resistant culture, however, is not presented with any degree of optimism.

The ward as a construct that framed nurse-patient talk

The ward emerged as a central construct in the way respondents formulated their accounts, and represented more than a geo-physical location within the hospital. This was the place where patients and staff spent the greater part of their time in any given day. For the detained men it approximated to home within the institution, and for nursing staff it was the work environment. It is important to note that, unlike other healthcare settings, the opportunity to briefly exit this environment was minimal, and all movement within the hospital compound was regulated by rigid institutional routines. In this sense, the spatial and temporal dimensions of the ward demarcated interactional possibilities. Given the nature of their detention, under mental health legislation, disordered offenders often spent extended periods of time in high-secure provision, which further impacted on the relational dynamics of the ward. This section of the chapter explores how the staff and patients used language to

position themselves in relation to each other and the institution, where talk reflected a unique sub-cultural component of the hospital.

Life on the wards was patterned by the rhythmic repetition of the hospital regime, where an inflexible timetable permitted little variation in the ordering and organisation of the day. Staff and patient accounts offered identical descriptions of task-focused management that centred on specific times for medication, meals, and the movement of patients on, or off, the ward. However, when they talked about relations, rather than routines, gendered discourse signalled a difference between the accounts of men, whether staff or patient, and those of female nurses who worked on the wards. One aspect of the language-use of men could, dependent on context, signal masculine identification or contribute to the construction of otherness.

The accounts of male respondents shared a characteristic sense of alienation and invisibility that positioned them as occupying a marginal status at the lowest level of the organisational hierarchy. The ward was constructed as a remote and isolated component within an autocratic organisation that was subjected to the imposition of external controls and regulations. A discursive strand within the accounts of the male nurses identified the senior management as remote and disinterested figures, described as 'outsiders', who enacted policy directives from 'above'. Here, male discourse was permeated by talk of 'security', which referred to, both, a discrete directorate within the hospital, and a dominant ideological approach that was seen as informing the way that the organisation functioned. Certain procedures, defined in terms of security, were described as invasive and impractical by those who had to implement them, and the men whose lives they most directly impacted on. Male nurses, and patients, each expressed concerns about the intrusion of security personnel into the ward-based care team, and their involvement in clinical decision making. Later, it will be noted how these tensions assumed import in discussions about pornography and the management of sexual media on the wards; where there was real uncertainty about whether controlling patient access to sexual materials was rooted in a therapeutic, or custodial, philosophy.

The female nurses who participated in the study also talked about being, or feeling, invisible on the wards. Their accounts were unique in prioritising talk about gendered discrimination as an institutional issue that was played out in their micro-level interactions between male staff and the patient population. In the highly structured and routinised labour of the ward, women suggested that specific duties were allocated in terms of gender. It was reported that domestic tasks, such as serving food and tidying up, were exclusively seen as women's work

and colloquially referred to as 'girly jobs'. Sexually divided labour was taken for granted as an implicit part of life on the wards, where there was an expectation that they should make the environment a comfortable place for their male colleagues, colloquially spoken about as 'keeping the boys happy'. Their experience of life in a predominantly male environment was spoken about in terms of powerlessness and injustice, and described as overwhelmingly oppressive. It was suggested that if they acted in an assertive manner, female nurses posed a threat to the male power and privilege that constructed the wards. Presenting themselves as outsiders in a densely masculine culture, would become a feature of the way that female nurses used language to negotiate a professional identity in relation to male peers and patients.

If the ward was spoken about as the factory floor of the institution, where the manual work of the hospital was undertaken, this territory was further stratified by a 'shift system' which figured large in the accounts of all respondents. Nursing staff talked about *their* shift in terms of belonging to a team, the membership of which was associated with a group identity. Further, talk of the shift, as an 'early', 'late' or 'night' was used to demarcate a span of time, and temporal marker, in the unvarying cycle of the organisational machinery. The way that reference to the shift system was deployed in accounts represented an important strategy that enabled respondents to position themselves in a complex web of interpersonal relations and conflicts. In female nurse accounts, for example, this was a significant construct in the way they attempted to reconcile a marginalised status on the ward. Rather than associate their exclusion with 'male staff', discourse centred on 'the shift'. This permitted them to talk in positive terms about the support of a collective male body, while indicting individual nurses as chauvinistic and discriminatory in their attitudes. The manner in which women talked about their relations with male staff connoted an endless balancing act, where being accepted in the team depended on investing in the protective function of male nurses. An inverse of this device was often used by patients who would value individual nursing staff, while being highly critical of the shift to which they belonged. These accounts of informal, and fluid, relationships, mediated by gender and otherness, will be returned to in the context of exploring how ideas about risk were constructed in the matrix of the ward.

With varying degrees of candour, talk about the formal and informal relations of life on the ward emerged as a discursive feature in the accounts of male nurses. Developing from the suggestion that the ward was estranged within the hospital hierarchy was the idea that it could be seen as a separate community, or less commonly a 'family'. Here the male patients, and male staff, were united in their shared sense of abandonment. They owned the physical space of the ward, and professionals who visited during the day were spoken about as

'visitors' and designated as outsiders. This allegoric explanation also included the idea that men who lived and worked on the ward engaged in a constant drama, where they would perform different versions of the self according to the audience. It was further suggested that a point in time, referred to as 'after five o-clock', signalled a transformation in the relational character of the ward. When the 'visitors' had departed, life on the ward was described as a group of 'lad's' who would talk about shared interests such as sport, sex and women. Transcending institutional roles and statuses, the men were constructed as a cohesive group that found a common bond in their maleness. In this way, male nurses would recount conversations they had engaged in, with patients, which overtly sexualised female nursing staff. However, it was commented that territorial divisions inside the hospital, such as the 'staff room', or outside the hospital, such as the 'pub', contextualised a different type of talk for male nurses. This was described as a pejorative set of discourses, based in humour and derision, which devalued the humanity of the patient.

If female nurses, who were fewer in number, talked about the ward as a 'man's world', it was from the perspective of being made to feel different. Male staff were described as controlling, and manipulating, the environment to suit their needs. This was the same language that the female nurses employed to construct a pathological identity for patients who were diagnosed as having a personality disorder. Like male nurses, the women expressed frustration about what was perceived as an impoverished professional status, but the speakers positioned themselves as being set apart from the other inhabitants of the ward. Similarly, male staff and patients were spoken about as an undifferentiated set of 'people', defined in the context of the ward as casualties of cynicism and inertia.

It was at the level of the ward that pornography represented an issue that had to be managed in accordance with hospital guidelines on 'inappropriate materials'. Whether this was talked about as a delegated responsibility of the care team, or as an aspect of maintaining a secure environment, it was predominantly nurses who took the lead in policing sexual media. At this point it is worth considering the male space within which decisions were made, and the way that talk about pornography contributed to the masculine texturing of the ward. Many of the detained men articulated annoyance about the prohibition of pin-up pictures which they had previously been allowed to display on their bedroom walls, citing this as a normative practice in male environments; something it was assumed that men understood, even if it proved difficult to explain the popularity of such images. This discourse about pornography as a, taken for granted, medium of communication between men was also evident in the talk of male nurses. Again, the hospital ward was compared with the working class culture of the factory, where the behaviour of manual workers was taken as symbolic of physicality and

masculinity. Patients conjectured that use of pictures, taken from pornographic magazines, had multiple interpretations. In a single-sex environment, with a macho culture, there was a need to present an aggressive heterosexual identity, avoid the risk of being feminised, and delineate ownership of physical space. Significantly, male accounts of pornography, in the context of the ward, omitted any reference to the female nurses who worked there; where women, in their exposure, became invisible.

Within this masculine space, female nurses were subsumed within a shared male discourse that constructed for them a limited identity defined in terms of sexuality and risk. Following the closure of the women's service directorate, and redeployment of many female nurses in the personality disorder service, male nurses described the hospital as being 'swamped' by women; pejorative language that positioned them as unwanted and unwelcome additions to the ward. Male respondents suggested the hospital was not a suitable working environment for women and ascribed feminine characteristics to female nurses. These were talked about as innate qualities which could offer a counter-balance to the excesses of undiluted masculinity. The contradiction of defining female nurses as *sexual beings*, rather than *professional beings*, meant that they could be seen as inviting risk or, conversely, as biologically programmed to defuse volatile situations. Here, male staff and patients talked about the need for women to be aware of their sexuality, where external regulation might be needed to ensure that they dress and act in an 'appropriate' manner, which was relative to the sexuality of the respondents. It will be discussed later, how this same language informed a, more general, nursing discourse about the types of images or representations that would be considered appropriate for patient consumption.

The gendered construction of secure care

When they were asked to talk about the role of a forensic mental health nurse, respondents typically described their job as an amalgam of 'security' and 'treatment'. As discussed above, the custodial components were, both, visible and predictable. Nursing staff, for example, carried keys and undertook a series of security procedures at specific points in the day; aside from counting them at regular intervals, patients leaving and returning to the ward would be subjected to a rub-down search. The technology of containment, and surveillance, was evident in the physical structure of the plant; high-mast lighting, infra-red cameras, and alarm systems were strategically placed throughout the campus. This section of the chapter explores how nursing on the PDS was defined in terms of masculinity and physicality. It identifies the way that female nurses were talked about as the embodiment of risk, and looks

at strategies employed by those women to negotiate a professional identity in the face of a diminished role and marginal status.

One shared discourse within the men's accounts centred on concerns about an emerging prison culture within the hospital. This reflected the enhanced security restrictions, discussed earlier, and what was described as a significant increase in the number of men being admitted from the prison system. This was a discourse that the respondents used to construct accounts of nursing in a secure setting, and to situate themselves in relation to other men on the ward. For male nurses, talk about a prison culture provided a rationale for the imposition of rules, which were recognised as compromising interpersonal relations with patients, while locating the job of nursing in a tough, and macho, world. There was a noticeable difference in language-use between longer term patients, who had usually been admitted via the courts on a section of the Mental Health Act (1983), and those men who had come into the hospital from the prison system. The former, typically made reference to an increase in the number of violent incidents, attacks on staff, the bullying of more vulnerable patients, and internal dealing that had necessitated the rigorous application of security measures. The language of incarceration was borrowed to describe visiting arrangements, where talk about contact with friends and family was mediated by the stark imagery of the penitentiary. Life on the wards was, again, framed in terms of an aggressive and predatory world, where organisational changes had detrimental effects for those living on the wards. Two patient respondents who had spent many years in prison, prior to entering the hospital, furnished a different discursive construction of relations on the ward. While suggesting that the security in the hospital was comparable to penal institutions, if not more stringent, they rejected the otherness associated with mental disorder by identifying themselves as 'prison transfers'; a status that was described in terms of a different way of talking, and the shared experience of doing 'hard time'. Talk about pornography permeated the men's accounts of institutional life. In addition to the idea of marking out male territory, sexual materials were spoken about as part of an underground market; for patients it represented currency, and for staff it was spoken about as contraband.

Unlike the discourse of security, talk about caring was less clearly articulated by nursing staff, and respondents variously spoke about 'nursing', 'treatment' and 'therapy' as undifferentiated concepts. Gender, again, became an important factor in the way that the nursing role was constructed through language, with discursive dimensions that embraced sex, sexuality, and the management of the sexual self. Male nurses spoke infrequently about caring as an activity, and rarely elaborated on the constituent parts of a caring relationship. Indeed, like the detained men, they talked about 'passing the time' in an environment where

very little happened. Therapy was spoken about as an off-ward activity, in the same way that attending a range of vocational placements was referred to as 'going to work'. Groups of patients would be collected, at an arranged time, and escorted to a centralised rehabilitation centre. The few patients who remained on the ward sat around in the day area, idly watching television, slowly turning the pages of a newspaper, or busying themselves with 'ward work' such as vacuuming the carpet or cleaning the kitchen area. The male nurses would play an occasional game of snooker with the men, but more often stayed in the office and performed clerical or administrative work such as liaising with other disciplines involved in the delivery of different types of treatment; individuals who were, otherwise, described as outsiders.

Talk about 'risk' ran through the accounts of nursing staff and patients, acting as a conduit between the discourses of therapeutic engagement and custodial containment. Like care, though, risk was presented in broad and abstract terms that had little anchorage in the clinical business of forensic mental health. When the men, patient or staff, talked about risk it was located in the social milieu, and interactional encounters, of the ward. Each of these groups of men had spent the greater part of their lives within the institution, and the longevity of this contact generated the idea of risk assessment through 'knowing' the other. A recurrent theme in the discourse of male staff maintained that nursing the personality disordered offender required an intimate understanding of their individual traits and idiosyncrasies. This involved learning to 'think' or 'act' like the patient, developing an intuitive ability to interpret cues and out-smart them. One male nurse, interestingly, went further and claimed that his skill in working with this client group was based on having 'lived like them'; where, describing his life before professional training he talked about having inhabited the subterranean world of petty criminality. In this sense, male nurses purported to know the men they looked after, and locked up, as a *type of person*, rather than a *type of patient*.

In this context, male nurses often described the exercise of risk assessment as based on 'gut instinct'. If formal rating tools were recognised, they were dismissed as the property of expert disciplines, such as clinical psychology, that were described as owning a different type of knowledge and speaking a different type of language. It was suggested that these intuitive hunches, expressed in lay language, constructed risk as a product of proximity in the confines of the ward environment. Here, patient behaviours were subject to continual scrutiny, where slight variations in their daily rituals could signal cause for concern, producing increased levels of observation. If these interpretations, or suspicions, were recorded in the ward report they would become a topic of discussion for the care team, so

that informal conjecturing could have formal consequences. Not untypically, it was patient interactions with female staff that signalled particular attention.

Female nurses occupied a dominant position in male discourses about risk, particularly in the context of an environment housing a large number of sexual offenders. It will be noted later, for instance, how women that worked on the wards, like pornography, became emblematic of male sexual fantasy, and the potential for male sexual offending. In the same way that male staff talked about watching the patients, they also watched the female staff. In part this reflected a masculinised role premised on ensuring the safety of female colleagues who were described as vulnerable, and in need of protection. But, because risk resided in the sexual being of women, their presence on the wards provided a resource for assessing risk in others. Just as male staff claimed to manage patient behaviour by *being like them*, they talked about sexual risk as *seeing like them*. It was significant that, while, male staff and patients talked about women as provoking sexual interest, the shared way of looking at female nurses was easily accommodated within the patriarchal culture of the wards. Similarly, male nurses related conversations with patients, where the physical attributes, and sexual possibilities, of female staff formed the basis of their discussions.

Male nurses talked about physical assault as a potential hazard of working on the wards of a secure hospital. In contrast, they described the risk to female nurses in sexual terms, and interpreted a part of their role to be about chaperoning and protecting the women. These themes featured in the accounts of female nurses, but language-use revealed a complex process of positioning that reconciled the threat of the patient population with the sexism of male colleagues; where physical violence was seen to be a greater risk than sexual violence. The female nurse accounts revealed a tension between working in a forensic setting, and an idealised version of nursing, that illustrated their relative powerlessness to affect change in the organisation. Like the male nurses, they contextually defined their role in relation to the patient group and the care setting. They talked about minimal patient contact, aside from intervening in crisis situations, and adopted a risk discourse to emphasise the dangerousness of the men they looked after; where daily life on the wards could be described in terms of 'fear'. Sacrificing the core conditions of nursing practice was one way that female nurses talked about fitting into a dominant culture of masculinity, where the profession was portrayed as a patriarchal construction.

The female respondents talked about nursing in the hospital as being devoid of compassion, or any meaningful engagement, that required learning a 'new language' and adopting a context specific form of interaction. But, their acceptance of a denuded role was

accompanied by a competing discourse that claimed ownership of the profession, more generally, where caring was associated, specifically, with women. The greater number of men who worked in the hospital, and the types of crimes committed by men on the PDS, were described as inverting a traditional understanding of nursing, which was embodied in strong female figures like 'Florence Nightingale'. It was not unusual for these nurses to talk about previous jobs, in different service settings, as a means of retaining a nursing identity that was defined by caring. Here, they would talk about individuals they had looked after, such as the elderly, in terms of emotional investment. Language-use constructed this sort of 'client' as distinctly different from the recipients of forensic provision; vulnerable people, deserving of the time and attention of nurses, were starkly contrasted with men compulsorily admitted on account of their offending behaviours. Female nurses made a, further, discursive distinction between men in the hospital who were diagnosed as having a 'personality disorder', and those who could be talked about as 'mentally ill'. The latter were defined in terms of legitimate sickness and genuine need that invited care, while 'PD' was a pejorative descriptor that constructed an unpopular and undeserving group of men. This typology permitted the female nurses to disengage from talk about working with the 'offender', and focus instead on the physical health needs of detained 'men'; basic issues such as promoting personal hygiene and healthy eating. If female respondents critically interrogated the impact of masculinity on nursing, and nursing care, another strand of their discourse merged with that of the male nurses to reposition the sexual offender in terms of 'otherness'.

Whereas male nurse accounts connoted a confrontational style of dealing with problem behaviours, women talked more about relational strategies to ensure their safety. They might not be able to 'know' patients in the same way that the men claimed, but they could attempt to engender the respect and trust of the inmate population. The accounts of male nurses, though, indicated how in relation to the sexual offender, this sort of approach could be interpreted as risk-laden and collusive behaviour that re-situated risk in female staff. Gender, and sexual risk, became an organising feature in the way that therapeutic work with sexual offenders was spoken about by respondents. The nurses who participated in the study had little direct involvement in the delivery of offence-focused treatment groups such as the sex offender treatment programme [SOTP]. As with formalised risk assessment, male nurses, typically, distanced themselves from the SOT programme by claiming it to be the province of trained experts who worked outside of the ward, where their presence would be unwelcome. If reluctance to be involved was couched in terms of institutional elitism, it was also described as a choice that could be made. Female nurses though, were actively discouraged from taking part in offence-focused therapy, and prevented from engaging with sexual aspects of offending behaviour in patients for whom they had a clinical responsibility.

A focus on male discourses that constructed the sexual domain illustrates, again, how female nurses were disqualified from practice on the basis of gender rather than professional ability; where female sexuality, and male fantasy, combined to designate their otherness. This dominant discourse echoed in the accounts of the female nurses, and was deployed when they talked about the sexual offender.

It was when they talked about sex offender treatment, where fantasy was a central strand of the discourse, that nurse respondents would usually introduce the subject of pornography as a concern for their practice on the wards. All the nurse respondents claimed that promoting offender therapy, and monitoring patient attendance, was an important part of their work. However, the discourse of male nurses, and patients, in terms of the value of this treatment, differed significantly from that of the women; the former shared a cynical interpretation, while the latter tended to invest optimism in the ideal of a rehabilitative function. Male accounts revisited the idea of formal and informal relations that shaped events on the ward, where being seen to do 'therapy' was more important than the actual outcome. Each set of men talked about a ritualised engagement in terms of game-playing or putting on a performance, which could not be understood outside of a system where the offender-patient was hostage to psychiatric power. Here, the fluidity of male nurse discourse enabled them to express a degree of sympathy for the dilemma of the 'captive client', or indict the patient for manipulating the system to present themselves in a more favourable way. Patient respondents frequently spoke about risk in relation to their detention under mental health legislation. Because transfer, to lower a security service, hinged on a professional estimation of their being less dangerous, meant they were acutely aware of the centrality of the concept of risk in forensic mental health; so that accepting therapy became one of the few opportunities to signal change or progress. In common with male staff, the patients invested little faith in the value of actuarial measures or psychometric testing. They each talked about the hospital as an artificial environment, so far removed from the real world that it was impossible to assess future risk to society. Like male nurses, patient respondents embedded an understanding of risk in the tough world of men; where *knowing* risk was a part of *knowing* violence.

A theme in the female nurse accounts drew attention to the pathologising discourse of the institution, where sex was spoken about in relation to sexual deviance rather than sexual health. It was suggested that, within treatment groups, the patient was expected to disclose personal aspects of the self, while the hospital afforded no opportunity for the expression of intimacy outside a hetero-normative hegemony. In this context, it was proposed that talk about fantasy precluded any consideration of same-sex interest, and reinforced the dominant

idea that only women could be viewed in a sexual way. In this context, it was contended that an exclusive focus on the sexuality of female nurses, ignored the sexual component of masculinity. Within the women's accounts was the idea that male nurses could, equally, become the focus of patient fantasy, as idealised figures that represented masculine traits of power and success. The normalisation of women being constructed as sexual beings in the hospital was seen as enhancing the potential risks they faced, and incorporating this within therapeutic speak. Male nurses, in contrast, were assumed to be immune from any form of sexual or emotional abuse. The women, though deployed a discourse that challenged the construct of male invulnerability, by citing examples of male colleagues being harassed by patients or punished by peers for expressing emotion. Though the concept of clinical supervision featured in the accounts of female nurses, as a forum for discussing work related stresses, it was commonly reported that men seldom made use of the facility; where the hint of vulnerability could severely compromise the requisite macho persona. In keeping with this gendered construct of nursing, male nurses made reference to 'supervision' as a euphemism for informal gatherings, in the pub, after work.

Before moving on to explore how gendered discourse informed talk about pornography, in the context of caring for personality disordered sexual offenders, it is worth considering the few glimpses that male nurses offered of the *sexual-self* in relation to the *sexual offender.* There was acknowledgement, albeit limited, that patient and nurse, as men, might share similar sexual fantasies, and that these could trespass into the domain of the 'deviant', so that it was the offending of one group that was emphasised to set them apart, and mark them out, as a different type of being; constructing otherness and inviting strategies of exclusion. In this context, male nurses talked about taking part in the SOT therapy sessions as a frightening prospect, and expressed fears that the fragile boundary between the 'good guys' and the 'bad guys' might dissolve. Staff who chose to engage in therapy, and experience first-hand the thoughts and feelings of the sexual offender, were spoken about in terms of risk-taking and described as very different to 'normal men'.

Pornography and gendered talk: men's knowing and women's experience

The way that pornography was spoken about by respondents cannot be understood outside of the context within which that talk was organised. The discourses, discussed above, that constructed the hospital ward, and staff-patient relations, in terms of a rigidly gendered and masculine culture were instrumental in defining what was meant by pornography, and how sexual media could be related to sexual offending. Though access to pornography was severely restricted within the hospital, the men who participated in the study had

encountered, bought, and used a range of materials that would constitute the pornographic, at some point in their lives. This section of the chapter explores how pornography was something that male respondents knew about as *men*, and that female nurses experienced as *women*.

Though their interest in, or exposure to, pornography varied, the male interviewees shared a collective, and gendered, understanding of such materials in terms of content and function. In discussion they drew upon a common discourse that represented the shared language of being a man; where their accounts could be likened to men talking about sex. When they defined pornography, the male respondents had no recourse to external reference points. As Dworkin (1981) noted, pornography has the power to 'name', and the discourse of male respondents named arousal, pleasure, and orgasm through the textual and visual depiction of sexual acts. Most of the men defined pornography as an image, usually films or photographs, with a singular purpose. They talked about a range of commercial media, but all these materials were seen as being designed to act as a stimulus for male masturbation. If this referred to a solitary activity, it also defined sexual and social relations between men and women. Generic terms like 'nudity' and 'intercourse' were associated with a way of looking *at* women's bodies, and a way of doing things *to* women's bodies. The men talked about pornography inside the hospital, their accounts were framed by knowledge of pornography outside the hospital; it was a personal part of their lives that had meaning beyond any professional debate regarding access within the institution. Pornography was, variously, spoken about as a form of entertainment, an aphrodisiac within relationships, or a sexual substitute for what was typically referred to as 'the real thing'. Legally available, mainstream, pornography was an easily identifiable and normative feature of sexual life. If sex was natural, and healthy, the use of pornography, likewise, could be understood as promoting satisfaction and fulfilment. Comparisons with the advertising industry suggested that commercial pornography offered a product for male consumption and, in this sense, the male staff were often sympathetic to the sexual needs of a patient population who were detained for long periods of time.

The responses of female nurses, when invited to talk about pornography, were markedly different in, both, the content and the delivery of the accounts. They spoke with hesitancy and deliberation, in a way that suggested the topic was unfamiliar and a cause for embarrassment. In contrast, male respondents were more spontaneous, and equipped with a language that framed pornography according to male rules and codes. For example, women talked in general terms about 'films' or 'magazines', that were loosely equated to 'sex', but lacked any details regarding the specific content that might define them as pornographic.

Men, however, could readily categorise different types of pornographic materials within a larger genre of sexual media, such as 'hard' or 'soft core' that derived from their awareness of what each would offer a male audience. More specifically, male respondents were familiar with popular titles, such as *Mayfair*, *Fiesta*, or *Penthouse*, and colloquial slang, like 'pussy books', that communicated a taken for granted world. Female nurses had no comparable vocabulary to talk about pornography, and had difficulty conceptualising sex that was divorced from human relations or intimacy. In the talk of these nurses, pornography was placed outside of 'real life' as something that distorted, and denied, sexual relationships by prioritising a physical act over an emotional experience. A discursive theme in their accounts, for instance, identified pornography as purveying 'sex' without a 'storyline', and it was interesting they often used a narrative device in organising their thoughts about why men would use pornography.

Whereas the male staff and patients located pornography in the context of their lives, the women tended to define it in the context of the hospital. Female nurses spoke about pornography in terms of working in an exclusively male environment, and in relation to the mysterious sexuality of men from whom they were set apart. More broadly, pornography was described as pervasive and invasive; permeating contemporary culture and cyberspace in a way that required defensive action to prevent it from entering the domestic setting. Depicting pornography as a threat was a dominant theme in female nurse accounts of pornography inside the hospital, and one which revealed the, uniquely, gendered nature of their experiences. The sense of pornography, as an abusive and intimidatory sexualisation of women, contributed to the way it was defined by female nursing staff. Examples were offered of the way that pornography had been used by patients to harass and humiliate women who worked on the wards; undermining professional status by repositioning the nurse in terms of a particular version of female sexuality. In response to distressing experiences, such as this, female accounts incorporated a reflective component that enabled them to express shock or trauma. Female nurses talked about feeling vulnerable, in an environment that diminished the worth of women, but it was reported that their experiences were unacknowledged by male colleagues. Though insensitive to the feelings of the women with whom they worked, it was male nurses who would be consulted for guidance regarding the acceptability of materials for patient consumption; as men, their gendered knowledge invested them with a level of expertise.

The subordinate sexual positioning of women, in contrast, was embedded in men's accounts of pornography. From the 'page three pin-up' to commercial sex magazines, graphic sexual depiction of women was described a commonplace feature of male, working class, life. Both

the patients and male staff talked about the proliferation of sexualised images of women in working, or custodial, environments defined by masculinity. This pornographic texturing of male space, as a form of male communication, featured prominently in patient talk about institutional life. Though, male staff and patients shared an identical language to describe the use, and function of pornography, the latter group of men made a distinction between 'short' and 'longer term' gratification, which would feature in their attempts to explain sexual offending. It was suggested that pornography provided a template for sexual relations that was based on, and legitimated, the presentation of women as inferior beings. Later, it will be noted how early exposure, and institutional careers where pornography had been prevalent, combined in staff and patient accounts of the offender as using sexual materials in a distinctly different way to 'normal' men.

Pornography and sexual offending: constructing the 'normal' and the 'deviant'

This section of the chapter looks at how respondents talked about pornography in relation to sexual offending. Though their life experiences were very different, the accounts of male staff and patients, again, shared a discursive territory where pornography and offending could be accommodated in the language that described male sexual pleasure. Attention, so far, has been focused on sexual materials, aimed at a male market, which would be legally available to adult consumers. Though these feature in the following discussion, another set of discourses are explored, that shifted the debate from sexuality to sexual deviance. Here, talk about representations of the sexual domain were replaced by a focus on manufactured imagery that constructed a *dangerous individual*, characterised by a *deviant imagination.* When they talked about pornography, in the context of sexual offending, the idea of otherness permeated nursing staff accounts. For female nurses this was a component of the discourse of dangerousness, discussed above, by which they positioned themselves in relation to sexual offenders. Male nurses, though, needed to find a way of distancing themselves from the patient body, where pornography was a shared feature of their lives as men.

A discourse of addiction ran through patient talk about pornography, where the discovery of sexual materials in early life, such as magazines or videos, had prompted a search for more exciting imagery and initiated an escalating interest. This was often accompanied by stories of unhappy childhoods, where home life was characterised by domestic violence, physical and emotional abuse, and rigid gender stereotyping; factors which it was claimed had profoundly disturbed their emotional growth. A number of the patient participants had spent much of their lives in institutional settings, from care homes and youth treatment centres to

high-security prisons. In these environments, pornography was described as an endemic aspect of the culture, and represented an important part of the way that sex was talked, and learned, about. Echoing the therapeutic speak of the SOT programme, these men talked about 'objectification', and the 'dehumanisation of women' as a prelude to the sexual offences they had committed; where the absence of knowing women in the context of human relations had robbed them of humanity and respect. When they discussed patients who resided 'on the ward', nursing staff would constantly refer to the volume of case-notes and files that attested to their transition through an assortment of state agencies. Here, though, there was a gendered difference between female and male nurses. The former, identified the early lives of the detained men in terms of emotional damage that prevented them from learning about, or experiencing, loving relationships. However, when talking about sexual offending, female nurses surrendered an empathic position about *damaged lives* for talk about *dangerous men.* Male nurses also referred to the likely impact of traumatic experiences in the formative years of the sexual offender, but emphasised the brutalising effects of growing up in care or custody. If this lent some credibility to their accounts, as a form of theorising, the same ideas could be re-presented as a strategy for diminishing the value of patient accounts; placing the blame on others, usually women, was presented as a hackneyed attempt at self-justification for criminal acts.

There was a noticeable difference in the way that male and female respondents talked about sexual offending. Patient respondents were not asked to describe their own offences, but most did this in constructing accounts that reverberated with a visceral quality. The male nurses lacked any theoretical framework in which to locate their ideas, but shared a discourse, with offenders, that discriminated between victim types and, in some circumstances, served to legitimate sexual offending. In the same way that patients would talk about the 'average rape' and the 'average rapist', normalising acts of sexual aggression toward women, examples of 'rape mythology' ran through the male nurse accounts. Patient respondents talked about having respect for, and enjoying close relations, with women who worked on the wards. This, though, was accompanied by comments about the ease with which they could be sexually assaulted in the hospital, where the terminology of 'sex' and 'rape' were used interchangeably. Indeed, one discursive strand suggested that female nurses were well placed to attest to the low level of risk presented by patients, based on the fact that they had not been raped in an environment that afforded many opportunities for this to happen.

Female nurse's talk about sexual offending, as with pornography, was experientially located. Whereas male nurses talked about 'rape' as a euphemistic descriptor for all sexual crime,

female nurse accounts moved beyond a narrow focus on legal classification to embrace a wider range of offensive or abusive behaviours, and situated these in the reality of women's lives; personal rather than conceptual accounts which focused on the routinised violence that defined relations between men and women. Sexual-murder was frequently described as the end-point of misogyny, but male violence toward women was just as easily accommodated in the domestic setting of the home. Likewise, female nurses shared a narrative about male behaviours, which did not involve interpersonal violence, but could be described as intrusive and threatening; These included unwanted phone calls, the theft of underwear, and sexual harassment in the street. In adopting a story-telling format to talk about sexual offending, female nurses wove an autobiographical thread into their discourse, which contrasted with the attempts of male staff to conjecture in abstract and impersonal language.

When female nurses talked about the use of pornography, though, it was framed in terms of a clear distinction between 'ordinary people' and 'deviant men'. This shifting language-use paralleled the deployment of a discourse of dangerousness to describe sexual offenders on the wards. Though pornography was overwhelmingly spoken of as belonging in the world of men, there was a theme in the female nurse accounts that, as a recreational resource, it might have some utility in making sex more exciting. But this was couched, firmly, in the context of 'fun' and 'friendship'. Conversely, when they articulated what might be the negative effects associated with using pornography, these nurses talked about the corruption of romantic ideals and reciprocal relations; where men's enactment of 'hurt' and 'violence' was starkly contrasted with women's ideas about 'love' and 'sex'. This discourse identified the sexual offender as the inhabitant of an underground marketplace, defined by sexual deviance, which purveyed anti-social, and illegal, materials. Another distinctive feature of female nurse's talk about the detrimental effects of pornography was evident in their broader understanding of social harm. Beyond the effects that it might have on an individual viewer, pornography was located within an oppressive system, where structural divisions such as age and sexuality sat alongside gender as the target of exploitation and social injustice. With clear links to the ward, as a microcosm of discriminatory attitudes, this included same-sex relations, which would feature in male nursing accounts as comparable, in social harm, to bestiality.

Male nurse accounts also made a distinction between men who consumed pornography, but their accounts lacked the authenticity of emotional engagement that had characterised those of the female nurses. Talk about fantasy occupied a central place in the comments of male nurses about a possible relationship between pornography and sexual violence. Fantasy was something that they readily acknowledged as a 'normal' component of sexual life, but in the

context of sexual offenders this became a characteristic marker of 'dysfunction'; where the offender's use of pornography defined a particular type of person rather than a particular type of material. Male respondents, generally, normalised pornography-use within relationships, constructed in a masculine and heterosexist discourse, as a way of enhancing sexual pleasure by asserting potency, or compensating for feelings of inadequacy. For male nurses, 'normal pornography' was a stimulus that would produce 'normal sexual behaviour'. Respondents, for instance, frequently suggested that 'couples' could benefit from watching films with an explicit sexual content, though the 'wife' typically played a passive role in the process. It was interesting that materials which were defined in terms of a 'deviant' or 'bizarre' content were included in the male nurse's talk about a recreational use of pornography. Sexual media and activities were talked about as a form of home entertainment where women, talked about in terms of 'ownership', could be 'swapped' like commodities. If such products were consumed in the privacy of the home, with consenting adults, the possibility of there being detrimental effects was beyond consideration. Though it was seldom clearly defined, talk about 'harm', was used exclusively to demarcate the sexual offender as other; a status that had more to do with personal morality than professional judgement.

Reminiscent of the idea that male staff needed to assume the characteristics of the personality disordered patient, to work effectively with them, was the claim that self-serving behaviour was a fundamentally human trait. In the same way that fantasy was seen as a component of male sexuality, the potential for predatory behaviour resided in competitive masculinity. What differentiated the 'normal man' from the 'deviant', in male nurse accounts, was that the former had the internal control to exercise restraint. Thus, if a patient needed to use pornography, it could be interpreted an indication of his being 'deficient' in some way, but making an association between fantasy and offending was taken as proof of this. 'Normal' men were seen as being able to negotiate their pornography use within a social and relational network, while the sexual offender was constructed as a socially unskilled outsider, unable to discriminate between the imagined and the real. Within the accounts of male nurses, then, the explaining the motivation to sexually offend was inseparable from an understanding of male sexuality and aggressive masculinity; where exercising control, or acting with conscience, was what differentiated the two groups of men.

Patient talk about pornography and sexual violence resembled that of the male staff, but it was rooted in, and informed by, the experience of offending. Focusing on the language of the offender illustrates a shared male discourse, but also reveals how these men positioned

their crimes in relation to particular types of sexual imagery. While few nurse respondents had any experience of sex offender treatment, six of the nine patients who participated in the study had some level of involvement with the SOT programme. As mentioned earlier, it was not unusual for patient accounts to be peppered with therapeutic discourse in a way that Jensen (1998), undertaking similar interviews in the United States, referred to as ideological filtering. The language they had employed to describe men's using pornography was revisited to explain sexual offending in terms of excitement and thrill seeking. Patient respondents identified specific types of imagery that was defined in terms of 'predilection', and associated with a *type of victim*, such as young girls, or a *type of offending*, such as the sadistic infliction of pain for sexual pleasure. Patients talked about, obsessively, collecting sexual images or films in terms of an unrelenting search for satisfaction that had no saturation point. Within the complex circumstances that framed their lives, pornography was spoken about as blurring the boundaries between a solitary relationship with an imagined set of ideas, and social relations more generally; where fantasy, talked about as 'real', shaped attitudes and behaviours toward women, referred to as 'the real thing'. Men who described their sexual identity in terms of a specific interest in prepubescent girls, made reference to child pornography as an illegal source of sexual stimulation, which required membership of a subterranean community. But, in identifying commercial titles, such as *Barely Sixteen*, they attempted to culturally validate the sexualisation of younger women and narrow the gap between themselves and 'normal' men who did not go on to offend. A discourse about discrete forms of sexual media as contributing to sexual offending paralleled patient talk about pornography use, where arousal and excitement was understood in terms of, both, immediate and deferred gratification. In a similar way, the act of offending could be described as primarily sexual, with a secondary gain that was related to the sense of power in exercising control over another person.

To conclude this section, attention is given to a dominant theme in the respondent discourse which focused on the manufacture of 'pornography' from mundane materials that might be available on the hospital ward. The idea that images with non-sexual intent could be transformed into erotic constructions, that mirrored sexual fantasy, featured in the accounts of all respondents, but worked differently to position the speaker, or to construct the other. Male and female nurse discourses merged in the suggestion that a whole series of images, or objects, could be sexualised as a product of deviant imagination, where particular concern focused on the 'paedophile' as an icon of dangerousness. It will be noted, in the concluding section of the chapter, how this institutional interpretation of what constituted pornography translated into a rigorous policing of everyday items that included newspapers, travel brochures and clothing catalogues.

Talk about pornography on the ward: differentiating the 'normal' and the 'deviant'

This part of the chapter is focused, largely, on the discourse of nursing staff, because it explores how the management of pornography and sexual materials on the wards was described as an important part of nursing practice. Gendered talk about sex and sexual offending, discussed above, informed the way nurses talked, in general, about allowing patients to access sexual materials, but there was a distinct coalescence of their discourse in relation to any imagery that signalled the erotic imagination of the child offender.

Each ward policy manual contained a copy of the 'guidelines' relating to patient access to 'pornography' and 'clinically unsuitable materials' (AHA 2001), though it was significant that patient or staff respondents did not anchor their accounts in relation to the content of this document. Though reference was frequently made to a 'policy', these were oblique comments that attempted to invest the collective actions of nurses with an official sanction, rather than explain how decisions were made in individual cases. At the time of the study, the wards of the PDS had been, essentially, purged of commercial pornography magazines. The rationale for this level of censorship, though, was a source of contention in nursing staff accounts, where there was uncertainty about whether it represented a 'blanket ban', or was the result of care team discussion. The interchangeable terminology of 'pornography' and 'clinically inappropriate material' in the nurses talk obfuscated any systematic approach to managing sexual media on the wards. Similarly, there was confusion in the patient accounts about access to pornography being a 'clinical' issue or another component of the expanded function of the Security Directorate. The lack of clarity in patient accounts, and the ambivalence of nurse's talk about what was described as an important issue, was resonant with the institutional estrangement that introduced this chapter.

One strand in the discourse of male nurses attributed the introduction of guidelines, referred to as the 'pornography policy', as an excessive response to the Fallon Inquiry Report (Fallon et al 1999) where there was no shared ownership. This talk symbolised antagonistic relations with what was perceived to be a remote and disinterested set of managers, whose motivation was located in self-preservation; an insurance against any negative publicity about the hospital in the future, where those who worked on the wards would be seen as culpable for failing to carry out the instructions of those from 'above'. Another strong theme within the accounts of male nurses focused on their role in maintaining order on the wards, within an institution that was fundamentally understood in terms of social control. This discursive strand was synchronous with talk, discussed previously, of a prison culture developing within the hospital. Pornography, here, was spoken about as representing a form of

contraband that could become part of an inmate controlled market, dealing in a range of illicit products and substances, that threatened the stability of the institution.

Patient respondents had internalised a dominant understanding of pornography as problematic only in relation to the detained sexual offender. Indeed, this was the contextual framework that informed nursing talk about pornography in the hospital, where there was an assumption that this group of men were uniquely susceptible to the influence of imagery, and that this related directly to their previous offences and future risk. Decisions about access to sexual materials were always discussed, by nurses, as an issue that had import for men who had committed sexual offences; while individuals with other types of offence history were disqualified from the discussion. Masculinist talk, that constructed rape as a heterosexual offence, shaped the way nurses policed sexual imagery on the wards. Though it related to only one patient respondent, a discourse emerged around discrimination against sexual minorities. It was suggested that the exclusive interest of staff in imagery that they associated with the aetiology of sexual offending, took no account of materials that reflected different aspects of human sexuality. In this domain there was a divergence in the discourses of male and female nurses.

Identifying pornography with male sexuality permitted male nurses to make a distinction between the 'healthy' and 'unhealthy' use of such materials by men who were forced to spend many years in a custodial setting; where the sex offender as 'other' could also be understood as a man with 'normal' male needs. As in male accounts of sex and offending, pornography was talked about as a substitute for 'real women' in an environment characterised by sexual deprivation. Female nurses, though, who understood pornography in the context of their work in the hospital, defined it as a dangerous commodity through an association with dangerous men; with pornography representing the 'fantasy' of men's inequitable and exploitative treatment of women. Conceding that non-sexual offenders had an opportunity to apply for care team approval to receive pornography, female nurse accounts were largely resistant to the idea of sex offenders being entitled to the same set of rights. A less articulated theme, within the corpus of female discourse, suggested the language of pathology and deviance to be so embedded in institutional talk that sexual media, regardless of intent, would be constructed negatively.

Commercial materials represented one strand of nursing staff discourse about pornography, where access could be controlled by a standard procedure for ordering goods from outside the hospital. On the wards, though, the concept of pornography became an elastic category which subsumed any images that nurses could relate to deviant fantasy as an indicator of

potential risk in some individuals. In terms of practice, male and female nurses talked a rigorous strategy of searching and censure, where it was uncritically assumed that particular pictures could produce particular behaviours. Numerous examples were offered of pictures, books and magazines that had been confiscated, the majority of which related to pictures of children. Patients talked about picking up the newspapers to discover that certain stories, or features, had been cut out with scissors to prevent them being seen by the patients on the ward. An irony of this crude policing, though, was evident in both staff and patient accounts, which generated a shared sense of frustration. Most patients on the PDS owned a television and video recorder, with unrestricted access to terrestrial channels. This meant that programmes could be watched when broadcast or copied for later viewing. Aside from routine checks of video-cassettes, there was barely any control over what the patients chose to watch in the privacy of their bedrooms. Particular concerns were expressed by nurses about the alleged popularity of television shows aimed at, and featuring, children such as *Blue Peter* or *Grange Hill*. Similar caution, it was stated, had to be given to a series of filmic representations that had only a tangential association with children; the *St Trinian's* comedy series, for instance, was included because adult women dressed as 'schoolgirls' could be reconstructed as a masturbatory stimulus for paedophiles. The possibility of this being the case is inarguable, but it highlights the insurmountable problem of attempting to police the sexual domain where the boundaries were infinite.

Forensic mental health nursing: A crisis of legitimacy

The introduction to this thesis was framed by a series of personal observations, rooted in professional experience, which grounded the research question in clinical practice within a high-security hospital. It is fitting that the conclusion of the report should incorporate a reflective component to locate the findings of the study in a discussion about the development, or otherwise, of forensic nursing since that time. Collecting data meant returning to a place that I had left almost fifteen years earlier. As discussed previously, the process of gaining access had been a protracted and, oftentimes, painful process. In some ways this was unsurprising. Along with a number of other individuals, from different disciplinary backgrounds, the decision to take up a position in higher education reflected a growing tension between an emergent academic culture and the hostility of hospital management to any kind of internal critique of service provision (see Mason 2007).

At a superficial level, at least, the hospital to which I returned was marketed in a very different language. Senior personnel, who acted as institutional gatekeepers, were keen to stress the immense changes that had been initiated since my departure. The claims that 'This

is a therapeutic regime now', and 'You won't recognise the place', were dispensed with collective uniformity. In contrast, early exposure to staff and patients who would represent the respondent groups did not instil the same sort of unquestioning optimism. Before the interviews had commenced there was a strong sense that life inside the secure compound had not been radically transformed in the manner to which service managers wanted, or wished. Collecting keys in the Central Control Complex, and visiting wards on the PDS, involved meeting with a number of nurses with whom I had previously worked. Many were unaware that I had left, and questioned me about where I was currently based. Some assumed that I had taken refuge on permanent night duty, others presumed I had opted for an easier life in the Staff Education Centre which, numerous name changes later, was still referred to as 'the school'. On one ward, where patient interviews had been arranged I was asked by a nurse, who remembered me of old, to help out because one of the team had reported in sick. If this sort of event would entail a careful management of the ethical boundaries of doing research, the request had a much more prescient impact. I felt like a traveller in time, of someone trapped in a memory, where past and present blurred, and realities shifted.

It is this context that frames the remainder of the discussion which integrates the dominant discursive repertoires, introduced above, into a coherent set of constructs. In the pessimistic tradition of Goffman (1961) and Martin (1984) attention is directed at the way a large institution, manifestly dedicated to a rehabilitative or therapeutic function, failed to protect the needs of a vulnerable inmate population. Given the tragic history of scandals in mental health care, generally, and high secure hospitals in particular, it is disappointing that the findings of this study should replicate former critiques of institutional provision for those diagnosed as mentally ill. Thus, a recurrent theme in this thesis has been staff talk about maintaining order, and the routine rituals of mundane labour as a part of everyday working life. Reference to multidisciplinary practice was contradicted by a pervasive psychiatric ideology, where therapeutic goals were poorly defined and the diagnostic label of 'personality disorder' became a pejorative and dehumanising label.

Another finding, which echoed previous analyses of failing services, resided in the numerous comments about a hierarchical structure and remote management which connoted an alienated nursing workforce within an insular and isolated community. Such issues have long troubled mental health nurse educators, where the 'theory-practice gap', a disjuncture between theoretical knowledge and clinical skills, has been overshadowed by a professional failure to address critiques of provision and initiate radical reforms (Hopton 1996). The latter author, for example, remarked (227): "This absence of praxis may be demonstrated

with reference to the occurrence of serious human rights abuses within British psychiatric hospitals...long after the training of registered mental nurses had supposedly been influenced by Russell Barton's (1959) treatise *Institutional Neurosis*...and by nurses' continuing inability to provide the kind of counselling and psychotherapy interventions demanded by service users despite the emphasis put on such skills in the *Syllabus of Training* 1982". In relation to the findings of the current study, it might be suggested that ongoing debate about a 'theory-practice gap', (Gallagher 2004) and the education of mental health nurses (Jones & Lowe 2003) could be greatly enhanced through an exploration of discursive practice.

Systemic isolation and an insular culture

The study findings invite a discussion about how effective mental health nursing can be conceptualised, let alone implemented, in settings that are characterised by systemic isolation. Much of the early, critical, work on the English special hospital system (Harding 1985, Cohen 1981, Gostin 1977) drew attention to their geographical isolation from mainstream health service delivery, where the containment of patients was matched by on-site, self-contained, living accommodation for staff. Integration into Mental Health Trusts, as a part of the NHS, represented an attempt to combat the historic marginalisation of these institutions and reduce the symbolic distance it placed between the 'normal' and the 'deviant'. Blom-Cooper et al (1992) indicted the culture of Ashworth Hospital, yet this was left analytically unrefined in the Inquiry Report (Richman & Mercer 2000). Nonetheless, metaphoric language of 'purification' permeated a series of culture change strategies aimed at inverting a system charged with corruption. Richman and Mercer (2000: 636) remarked: "Salvation is to be achieved by the trinity of new culture of allowing patients full dignity, being therapy-orientated and having purposeful leadership as guardians of the new order. Other unrefined absolutes of 'justice', 'truth', 'culture', 'therapy' and 'leadership' also became new mantras for Ashworth". Typically, 'culture' (which interestingly was a term that did not feature large in any of the research interviews) was talked about as an undifferentiated and homogenous system of ideas which were expressed through prejudicial attitudes and practices. Invariably, solutions were sought by importing expert practitioners from outside and imposing changes from above.

In contrast, this study began at the bottom of the organisation, which was how staff and patient respondents talked about the wards, and their respective statuses within the organisation. Similarly, Chandley (2007), documenting a study in the same institution has reported the way in which nursing staff and patients describe themselves as 'stigmatised', a 'single lower class of citizen', who are not included on the organisational flow-chart of the hospital. He comments: "One nurse stated that while he was waiting for a signature in an

office block there were a number of office staff looking out the window at nurses going off duty. To the amusement of office colleagues one said 'there go the arse wipers', reinforcing that lowly social status of the ward nurse" (Chandley 2007: 139).

The research findings from this study enable an understanding of the way that everyday talk reproduced and perpetuated a set of relationships that were rooted in difference and otherness. The way that the ward was talked about, for instance, did not correspond with more conventional descriptions of a care setting. Rather than a living space for the detained men, or work setting for the nursing staff, it was a space where the ideological tensions of forensic psychiatry were enacted on a daily basis; societal fears of madness, political uncertainty about sentencing, and professional ambiguity about caring for men defined in terms of dangerousness rather than need (Moon 2000). Each of these types of discourse informed nursing staff accounts of the people they looked after (or locked up) and the hospital (or prison) in which they worked. In any textbook on mental health nursing, or healthcare communication, the basic unit of interaction is described in terms of 'the nurse-patient relationship' or 'therapeutic use of self' (e.g. Barker 2009), yet these were revealed as redundant concepts. There was, for example, no shared language to define the identity of an individual. Variously, the detained men were referred to as 'service users' or 'clients' invoking the discourses of managerial directives or therapeutic-speak. More, often, they were spoken of as 'patients', though 'prisoner' was usually identified as a more honest descriptor. It was the latter, which the offender-patients deployed to describe themselves in a way that connoted 'captive clients' and coercive treatments (Pilgrim 1988a). The sacrifice of individual identity, to institutional identification (such as 'sex offender' or 'psychopath') permitted no meaningful engagement with the fundamental principles of mental health practice that emphasise emotional growth and positive regard. The language of empowerment and collaboration peppered the discourse of nursing staff, but these terms were hollow sound-bites that had no resonance in a world were relations were defined by the assertion, not the sharing, of power.

In relation to nursing practice, concerns that arise from this piece of work include (a) the extent to which nurses are prepared to engage with individuals diagnosed as having a personality disorder; (b) the professional support, and opportunities for development, that are available to nursing staff; and (c) how each of these issues is compounded by the isolation of ward-based nurses from senior clinical and managerial grades of staff. It can be argued that the poor quality of nursing practice in this hospital is the casualty of a historic legacy compounded by contemporary inertia. Despite incorporation into the healthcare system, nursing staff that participated in the study were cut off from progressive

developments outside the hospital, and remote from good practice initiatives within. Therapeutic activity such as the sex offender treatment programme (SOTP), it was typically reported, was undertaken by other professional groups in another part of the Personality Disorder Service. Indeed, it is hard to reconcile the ideal of rehabilitation with the descriptions that were tendered of everyday life on the wards. Both sets of respondents talked about 'passing time' and likened the environment to a penitentiary, where each day consisted of a repetitive patterning of routines without any measure of progress or change.

The offence histories of the detained men who agreed to take part in the study would attest to their posing a considerable degree of risk to the social body, albeit the inordinately long periods of incarceration which they shared. The need for secure facilities to contain, and manage, certain individuals is an unfortunate part of the human condition (Morse 2004, Martens 2000, Arboleda-Florez 1990), but the manner in which this is undertaken is worthy of debate. The potential dangerousness of the inmate population was mirrored in a massive investment in surveillance technology, but the physical apparatus of confinement needs to be understood apart from the discourse of security which permeated the clinical talk of the hospital. Previous work on the role of the forensic nurse has focused on the concept of 'therapeutic custody', as an amalgam of conflicting responsibilities. (Burrow 1998). Over time, optimistic interpretations of the job have suggested that this balance can be reconciled by rigorous staff selection and recruitment combined with professional integrity (Dale 2001)

In this study, however, there was an overwhelming sense that security as a discursive practice had completely eclipsed any rehabilitative enterprise. In the accounts of nursing staff and patients it was, often, difficult to discern how the word 'security' was being deployed, permitting variations in the analytic interpretation of data. It might relate, for instance to a discrete department or body of staff, or, alternatively, to a larger shift in the ideological core that informed the management of the institution. Both sets of respondents spoke frequently about 'security liaison' as a way of illustrating concerns regarding the expansion, and infiltration of 'security' as, both, Directorate and discourse. This referred to a newly created grade of staff, mostly recruited from the nursing workforce, with the responsibility to represent the interests of security at the level of care team meetings on the wards. For nurses and inmates, alike, this development was symbolic of an intrusion into the discourse of the multi-disciplinary team that subverted clinical decision-making and compromised staff-patient relations. Again, though, there was variability in the way that nursing discourse functioned. For those more therapeutically inclined it placed an additional barrier between themselves and the detained population, while for others it legitimated withdrawal from a caring role.

Reference has already been made to the mechanistic routine of institutional life, and the clockwork-like repetition of tasks, but it needs to be noted how this was accompanied by the way that nursing staff would talk about themselves as a factotum, subservient to a larger machine. Arguably, their descriptions of nursing as being akin to working on the 'factory floor' have to be contextualised in the geographic and economic construction of the local workforce. The hospital is situated close to Kirkby, a 'new town' that was purposefully developed in the 1950s/60s to accommodate 'overspill' from the nearby City of Liverpool. During the last three decades the area has been ravaged by the results of global recession, and of Liverpool's decline as an industrial centre and major seaport. When driving through the town one is confronted by derelict factories and deserted buildings that speak loudly of deprivation and hardship. While preparing for the interviews, a number of staff told me that they deliberately chose a more circuitous route to work to avoid having to witness the 'depressing' ugliness of the scenery on a daily basis. Since the hospital opened in the mid 1970s it has been one of the largest employers in the area, and professional training has afforded many local people an alternative to low wages or unemployment. Maghull, a more affluent suburb, has become home to many of the hospital staff and is colloquially referred to as 'special hospital town'. In short, the history of the local community has been characterised by displacement, decline and disadvantage. In close proximity to an exclusively white population, and post-industrial landscape, it is perhaps unsurprising that in the 1980s far-right racist parties like the National Front should exploit the opportunity to recruit members from within the special hospital (McKeown & Mercer 2010, Blom-Cooper et al 1992). These observations are outside of the data, but nonetheless they enhance an understanding of the staff discourses, in particular male nurses, and the centrality of gender in defining the hospital culture.

Gendered labour and male power in a masculine culture

If working at the hospital afforded nursing staff a good degree of financial security, belonging to a particular shift gave them a sense of solidarity. The largely male nursing team included female staff, but the collective identity was a masculine one that rendered the women invisible. An all pervasive sexist discourse characterised the talk of men on the wards, and this included both the nursing staff and the patient participants. Ironically, in a treatment setting for sexual offenders, chauvinist ideas provided a shared discursive territory that enabled these two groups, oftentimes defined by hostile relations, to communicate as men. Again, it was a subterranean discourse that permeated staff-patient interactions on the ward, which signalled their distance from other members of the care team; individuals designated as 'visitors' or 'outsiders'. Once the psychiatrists, psychologists and other therapeutic agents had exited the environment, prescribed institutional roles could be

abandoned. The data from men who worked, and lived, on the wards permitted entree to an otherwise unknown social world; one very different from that described in scholarly articles or conference presentations that purvey the latest evidence of therapeutic advances in secure care. Indeed, one is assaulted by the disjuncture between the narrative accounts of respondents and the academic/professional discourse of the scientific community.

One of the most significant issues to emerge from the study findings, and a concern for the nursing profession, echoing Morrison (1990), relates to the impact of an exaggerated version of masculinity on the way that nursing itself was defined in the high-security hospital. The implications, here are twofold: (a) as will be discussed below, the propagation of a discriminatory value system inimical to the goals of sex offender treatment, and (b) the exclusion of female nursing staff from the core business of the service. When male staff talked about their female colleagues, it was situated within a discourse of risk, where women were constructed as the powerless victims of, either, their own sexuality or the sexual aggression of predatory inmates. To this extent, their professional lives were impoverished, and the limited number of duties they were allocated reinforced a rigid division of labour that was based exclusively on gender. Promotion to more senior positions, for the women respondents, was reported as unlikely in a male dominated institution, but whether this would contribute to more equitable sex-specific relations is questionable. Those female respondents who had managed to gain a small degree of managerial status, for instance, talked about a struggle to resist the overwhelming culture of masculinity and physicality that was prized on the wards. In an environment defined, and owned, by men it was female staff who became outsiders needing to be protected and chaperoned. It is interesting that no consideration was given to the damaging effects of the environment upon those female nurses who elected to practice in a secure mental health setting. A completely wasted resource, they were talked about as looking after the comfort needs of male staff in a dutiful and maternal way, while acting as the mirror of masculinity; constructing women as dependent and deferential beings, the men exerted a potent sense of power and control that redefined the concept of nursing in male language.

The construction of the female nurse as other, communicated by a gendered institutional ideology that found expression in the talk of patients, placed women outside of any therapeutic engagement with the detained sexual offender. This will be discussed further, below, in an exploration of anti-therapeutic discourses that operated within the hospital. Here, though, it is worth noting how nursing research, using a discourse analytic design, has drawn upon post-structural feminist theory to understand the nurse-patient relationship and the discursive constitution of nursing work (Crowe 2000). Here, the central concern is with

medical and managerial discourses that render invisible traditional constructions of nursing as 'women's work'. Earlier, Witz (1992) had signalled, for nurses, the value of this type of intellectual approach in exploring how power relations are sexualised within large bureaucratic structures. It is remarked: "The concept of discourse seems to me to provide a bridge between hitherto different, and conflicting, explanations of gender divisions in the workplace, between those which used the concept of 'ideology' and others which have adopted a more materialist focus on patriarchal practices. At points in my analysis, I do refer to 'discursive strategies', and now think these are more important than I used to" (Witz 1992: 7).

The type of work, discussed above, has focused on health care contexts where sexist talk and practice are enacted in a negative construct of nursing as a feminised profession, rather than a negative construction of women as a component of nursing. There is little comparable inquiry into the experiences of women who undertake a nursing role in an environment where they are significantly outnumbered, devalued and professionally dismissed; and where talk about sexual violence, abuse, and exploitation are embedded in the discourse of the treatment setting.

Anti-therapeutic discourse in a treatment setting

Drawing on discussion of systemic isolation and gender inequities, attention has to be given to the therapeutic value of the service where this research took place. In particular, it raises concerns about the extent to which offender focused initiatives, like the sex offender treatment programme (SOTP), can be in any way effective in the institutional culture outlined in this thesis. The findings relate to one forensic institution, and it would be injudicious to imagine that they could be extended to embrace other high-security hospitals or smaller regional units. There is a growing recognition in health policy of the need to offer more inclusive services for individuals with a diagnosis of personality disorder, most notably publication of *Personality Disorder: No Longer a Diagnosis of Exclusion* (NIMHE & DoH 2003). Progressive attempts by academic mental health nurses, and educators, to reclaim the humanity of personality disorder have invested in constructionist theory. Wright and colleagues (2007: 237) explore how practitioner and public discourses have a negative impact on therapeutic relations with this client group. Discussing an original multi-professional programme, for individuals who work with personality disordered clients, they suggest that training and education need to be seen as 'deconstructive acts' which challenge constructions of difference. It is noted: "The central importance of discourse that depicts this client group as essentially and fundamentally different, or 'other', is focused upon to suggest that it is important to critically engage with these notions, so that progress can be made in

improving affairs in line with the policy aspiration that services are no longer exclusionary" (Wright et al 2007: 237). Interestingly, the hospital where this study took place contributes to the course, and seconds staff to attend, but there was little in the data that evidenced the 'self-reflection' and 'self-awareness' that are central components of the learning process.

In nursing talk, the terms 'therapy', 'treatment', 'rehabilitation' and 'caring' blurred together as undefined, and undifferentiated, categories deployed to suggest a clinical role that extended beyond custodial duties. If this hinted at an ill-defined professional persona for nursing, it represented part of a larger semantic conflation about interventive work with medicalised offenders (Pilgrim 2007). Unlike 'security', though, these were a set of discourses that lacked a discrete practice component, and each of the categories collapsed into talk about 'interaction' as the defining feature of the nurse-patient relationship. Seldom, though, were staff-patient exchanges defined in terms of any kind of outcome, except at the most basic level of communication. Thus, nurses spoke about sorting out problems, issues that had more to do with maintaining the smooth running of the ward than in addressing human needs. Involvement, or engagement, with the detained men, as personality disordered offenders, was spoken of as *something*, done *somewhere* else, by *someone* other than themselves. For large chunks of time, during the working day, there were very few patients actually on the wards. The majority of men were collectively escorted, en masse, to centralised workshops or services; counted in and out, and searched, by members of the nursing team. The patients who were left behind, like the nursing staff, filled their time according to the limited options that were afforded in a sterile and unstimulating environment. They sat fixed before the wall mounted television, flicked through the daily newspapers, stared out of the windows or, just as likely, into space. This was a place where nothing seemed to happen, and nothing seemed to change.

Despite the centrality of risk as a political discourse shaping high-security provision (Woods & Lasuik 2008, DoH 2007, DoH & HO 2000), from treatment planning to decision-making about the transfer or discharge of individual men, at the level of the ward it emerged as an unscientific, and unspecified, construct. In the talk of nurses it translated into 'knowing' the men on the basis of prolonged exposure in a confined space; where longevity, and lack of movement, characterised each set of respondents. Risk, as an abstract concept, related to the offence histories of the men, coupled with their behaviour while in hospital, and the predictive value of this information for the *present*. In a 'temporal vacuum' (Chandley 2007, Richman & Mason 1992), nurses only ever talked vaguely about the *future* of the men in their keeping. Managing risk was spoken of as staying safe and surviving from one shift to another, one day to the next. Standardised risk instruments or actuarial measures, like

therapy groups, were discussed by nurses as the property of other professional groups. Thus, disciplines, such as clinical psychology, were defined in terms of expert knowledge and an enhanced institutional status, and credited with being able to utilise 'research' to inform their interventions. In contrast to professional calls for evidence-based practice (Montgomery et al 2009, Woods & Richards 2003), the nurse respondents talked about themselves as poor relatives, reliant on 'life-skills', whose traditional role and territory was under threat. Again, it was the geo-physical confines of the ward that prescribed what nurses knew, and set the limits on what they might achieve.

The accounts of staff and patient participants suggested that, although meaningful contact was impoverished, they spent inordinate amounts of time watching each other. And, the field-note observations of the researcher recorded the, almost, limitless opportunity for them to engage in this panoptic pastime. Each of the respective respondent groups would recite, in minute detail, the whereabouts, and activities, of the other at exact points during the day. For nurses, the smallest deviations from the usual routine, of a particular patient, became indicative of impending danger; sitting in a different chair on the ward, or chatting with a different group of men, for example, signalled the need for increased vigilance. This practice, described as a routine occurrence, was reminiscent of deviance amplification (Cohen 1992), where single behaviours could trigger a series of responses that contributed to the manufacture of deviant identities. Staff described a successful span of duty as one where nothing much happened, and a bored and disinterested apathy pervaded the lives of those who worked or lived on the wards.

It was ironic that female nurses talked with some degree of optimism about sex offender treatment, but were actively discouraged from being involved in the therapeutic process. When male nurses spoke about the inmate population, and female staff, sex and sexuality represented a dangerous combination. Talk about 'sex' was a clearly delineated male territory, whether it related to a nurse and patient reviewing progress, or a group of 'lads' swapping prurient stories for entertainment. And, dissecting these different forms of discourse, 'fantasy' figured prominently in defining male desire and the male sexual self (see Williams et al 2009). The men, together, indulged in more cavalier, and antagonistic, talk about sex offender therapy as an instrumental exercise, which each group referred to in terms of 'game-playing'; attending the SOT programme equated with demonstrating a commitment to change, though neither side invested any faith in the therapeutic enterprise.

Though the management of pornography in a secure service for sexual offenders was the initial focus of the research question, sexual media itself became one of a series of analytic

issues that emerged from the data. Talk about pornography was only one of a series of interwoven discourses that textured the overtly masculine, and oppressive, culture of the institution. Pornography was something that the men, whether nurse or patient, knew about through experience. They had learned from it as an adolescent rite of passage, watched it for pleasure, and displayed it publically to mark out male territory (see Kimmel 1990). For a number of the patient participants, in particular, pornography represented a totemic feature, and powerful currency, within the institutional environments in which they had spent much of their lives. Pornography was a discourse of male pleasure, where only the more extreme sexual behaviours differentiated the two sets of respondents. If male nurses were able to theoretically locate pornography in a debate about the exploitation or harming of women, there was no recognition of the way that institutional power relations similarly demeaned and diminished the value, and professional identity, of the women with whom they worked. In contrast, female nurses lacked the language to talk about pornography. It was not something that had any meaning in their lives outside of the hospital and, as with other forms of sexual talk, they deferred to the expertise of men. As with other aspects of their institutional lives, the female nurse's experience of commercial sex products, on the hospital ward, was articulated in talk about embarrassment, harassment, and the callous attitudes of male colleagues that compounded their sense of invisibility.

In conclusion, the findings of this study raise serious concerns about the quality of nursing practice within the hospital where the research took place. It is regrettable that this should be the case for an institution that had witnessed investment to support change following two high level inquiry reports (Blom-Cooper et al 1992, Fallon et al 1999) that condemned high-security care and prompted debate about the future of the former special hospital system (Coid, 2000). The discourses of staff and patient participants echo the past failings of mental health practice in general, and nursing in particular, directing attention to a morally bankrupt profession. Peternelj-Taylor (2005, 2004) identifies engagement with the 'other' as an ethical principle of forensic, and correctional, nursing practice, where practitioner views about justice and punishment influence engagement with the patient, and establish a foundation for that branch of the nursing profession. It is noted: "For it is in the moments that when we pause to reflect upon our purpose that we are presented with the greatest opportunity to grow and to learn, for engaging the Other is about the heart and soul of every forensic nurse" (Peternelj-Taylor 2005). Similarly, Rose (2005) explores the meaning of 'relational autonomy' in regard to the mentally disordered offender, where the patient is compulsorily detained and mandated to treatment. Drawing on feminist theorising, it is posited that a person's 'being' and 'identity' is embedded in social relationships and structures such as gender, ethnicity, age, and class. In this sense, he observes: "The

oppressive socialisation encountered by nurses, the majority of whom are women, and the oppressive social relationships that linger in male-dominated health care facilities jeopardise patient autonomy" (Rose 2005: 25).

These larger, and global, debates about forensic nursing are equally important to mental health nursing in general. Sadly, here, literature attests to stigmatisation of the mentally ill (Ross & Goldner 2009), unpopularity of the personality disordered client (Bowers 2002), impersonal services and tokenistic involvement with the user-movement (Beresford 2000). The findings of the present study are interesting in that they focus attention on institutional practice where isolation, and insularity, highlights problems in an extreme form. Equally regrettable is the realisation that policy and professional directives to combat the exclusion and discrimination of individuals diagnosed with a mental disorder should have fared so poorly. *The National Service Framework for Mental Health: Modern Standards and Service Models* (DoH 1999), *Chief Nursing Officer's Review of Mental Health Nursing* (DoH 2006), *Nursing: Toward 2015, Alternative Scenarios for Healthcare, Nursing and Nurse Education in the UK* (Longley et al 2007), have, for over a decade, promoted anti-discriminatory and anti-oppressive working.

In this context, the findings reported in the thesis, are more fitted to a description of the nineteenth century asylum. Closing this section, it is worth noting the comments of Hopton and Glenister (1996) in evaluating *Working in Partnership* (DoH 1994) a review of mental health nursing that was published close to twenty years ago. The document embraced language of positive change, such as championing user-involvement in planning and implementing services, while tacitly accepting the legitimacy of the nursing profession. In stark contrast, it is suggested that the report reflected the 'arrogance and conservatism of the occupational culture of mental health nursing', and falsely portrayed a profession which faced a 'crisis of legitimacy'. The authors note: "[The report] does not address key issues such as institutionalised racism, sexism and other forms of discrimination and myths about the presumed 'dangerousness' of mentally distressed individuals in any depth. Instead there has been only an acknowledgement that such problems exist, without any acknowledgement of nurses' role in perpetuating them or any recommendations as to how they might develop more enlightened practice...becoming a celebration of imagined achievements, rather than a blue print for a revolutionised service for the future" (Hopton and Glenister 1996: 118). These sentiments have been expressed since and, on the basis of the findings presented in the thesis, they need to be voiced again. In a final reflection, no better words could be borrowed to describe the personal, and professional, experience of undertaking this study

than those outlined above. Forensic mental health nursing, in this high-security hospital, is confronted by a crisis of legitimacy.

Implications for practice

This study has identified a series of context-specific issues that relate to the recent history of the hospital where data was collected, but the findings might have wider relevance for the management of pornography in other types of secure mental health service. Concerns were raised about the place of pornography in forensic units (Duff 1995), as a professional issue for nursing, long before the report of the Fallon Inquiry (Fallon et al 1999) transformed it into a national problem in high-secure provision. It is difficult to conjecture how generalisable the findings would be to similar settings and services, and this may be worthy of further research. Most importantly, the results of the study emphasise that there are no simple solutions to complex problems. Decision-making about sexual offenders accessing sexual materials rely on specific definitions and agreed criterion, while pornography, in a broad sense, evades easy classification. Approaching the topic from a discursive perspective, shifts attention from pornography as a discrete commodity, and permits an understanding of the way mediated images texture the treatment environment.

Though the focus of the research question was unique, the study contributes new knowledge to a growing body of critical social research conducted in the English high-security hospital system. Previous discourse analytic inquiry (Stowell-Smith & McKeown 1999), for example, explored race as a central construct in diagnosing psychopathy through textual analysis of psychiatric reports. More recently, an ethnographic study by Chandley (2007) investigated social conceptions of temporality, or how time is measured and understood by those who live and work together on the wards. Observing that external critics of the former special hospital system frequently cite Goffman (1961) to understand these institutions as relics of the asylum era, he offers an alternative view of social relations between the inhabitants of the secure hospital: "I notice relations between patients and ward-based staff as more gracious and respectful and there is commonly more rapport than has been described by Goffman or beyond. This is the social situation today. In fact, as those called 'patients' and those called 'staff' live together over decades, their view of the world amalgamates into a single culture. The latter has its own stock of shared knowledge, beliefs and norms" (Chandley 2007: 139). This interesting assertion is echoed in the findings of the current study, and the data extracts included in his work closely resemble the accounts of the respondents discussed in this thesis. But, if there is a high degree of similarity, there is a distinct difference. In the study by Chandley, the nursing staff are written about as an

undifferentiated body, so that the gendered aspects of the ward culture were unrecognised. Other work that adopts a social constructionist approach (Warner 1996, Warner & Wilkins 2004) has drawn attention to the 'invisibility' of women as patients, in 'invisible hospitals' concealed within a 'general male story', but the female staff who work in high security hospitals remain unseen and unheard. The current study goes some way toward redressing their silence.

Finally, the study has some important implications for the way that nursing is understood in high-security care. Forensic mental health nursing has emerged, in the last two decades, as a recognised area of specialist practice, not just in the United Kingdom, but globally. It is supported by a growing body of knowledge, represented by textbooks, academic journals, and international organisations. In this context, the results of the study offer an impoverished view of the profession as it was talked about in one secure hospital. Given the current organisation of mental health services, there is an imperative to define nursing practice in secure settings according to nationally agreed standards and targets. It is also important that individual nurses adhere to the statutory standards outlined in *The Code* (NMC 2008) that governs their professional conduct, performance and ethics; where the first requirement is to treat the client as an individual and to respect their dignity. Considering changes to the pre-registration preparation of nurses, in anticipation of future healthcare demand, mental health nursing is described as driving a 'recovery' model through collaborative working (Longley et al 2007). Similarly, *The Chief Nursing Officer's Review of Mental Health Nursing* (DoH 2006) locates mental health nursing, across a range of settings, within the broader modernisation agenda of the National Health Service. Here, the core values of the profession are identified in terms of promoting social inclusion, delivering evidence-based psychological therapies, and a reduction of time spent on administrative tasks. The gap between these ideals, and the reported findings, are immediately clear. In conclusion, it is possible to identify a series of professional, and clinical, issues that warrant further attention, and action:

- High-secure provision is now integrated within the National Health Service, but staff and patient respondents, alike, retained the language of the 'special hospital'. There is a need to consider how this isolationist mentality can be challenged. This is not a new problem, and there have been numerous calls for the closure of large-scale institutions in favour of smaller regional units (Fallon et al 1999, Blom-Cooper el 1992, NHS Hospital Advisory Service 1988). It would appear that previous attempts at 'culture change' (Rae 1993) have been insufficient to erode a masculinist culture that invests in physical containment rather than therapeutic engagement.

- The dominant culture outlined in this study is inimical to the ideals, and goals, of therapeutic work with sexual offenders. The values of the type of sex offender treatment programme referred to in this study, typically, understand sexual offending as an abusive 'behaviour' rather than a 'sickness' (e.g. Mann 2004), where therapeutic aims are about changing the way offenders construct their victims through thought and language. In stark contrast, talk, rooted in the culture of the hospital, reinforced rigid, stereotypical, assumptions about sex and gender. The involvement of female nursing staff in the core business of forensic mental health nursing might contribute to the promotion of a more positive attitude to women who work within secure care settings.

- Nursing within the hospital was spoken about as being isolated and alienated within the larger managerial structure of the organisation, forging its professional identity at the level of the ward. There appeared to be little dialogue with other professional disciplines that were involved in orchestrating the process of rehabilitation. Other members of the care team were described as 'outsiders' who, it was claimed, visited the ward infrequently, and with whom there was no sense of professional identification. Though nursing staff might choose not to be actively involved in facilitating SOTP groups, there needs to be much closer collaborative working.

- Based on the accounts of staff who participated in the study there is a clear need for some form of continuing professional development [CPD] in the context of their work with a challenging client group. Currently, there is no required post-basic qualification to work in forensic mental health nursing, and it is questionable that pre-registration training for the registered mental nurse [RMN] is appropriate preparation for the role. The unsophisticated language that was used to talk about sexual offending, and offender treatment, would suggest the need to develop a robust theoretical and clinical evidence base for practice. While it was surprising that few of the nurse respondents were familiar with the contents of the hospital guidelines on pornography, it was disappointing none of them made reference to the professional *Code* (NMC 2008).

There is little satisfaction in reporting the findings of a study which reflect poorly on the nursing profession, but the research has great import in considering the future development of a much troubled system. This piece of research does not lend itself easily to the language of evidence-based practice. It did not begin with an easily defined problem, and it did not

conclude with a neatly packaged solution. Through the accounts of nursing staff, and detained patients, the concept of pornography emerged as a way of talking about injustice, discrimination and exploitation. Any debate about the danger of sexual images, by those who view them, has to take place alongside a discussion about the damage of secure hospitals, for those who live and work within them.

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APPENDIX I

Gaining access to the Research Site

The nature of the study, and proposed informants, constituted both sensitive topic and vulnerable population (Lee 1993), but the pragmatic issue of gaining entrée to the field demonstrated the political dynamics of researching in a secure hospital. A former colleague recently captured the sense of despair, and spirit of resistance, facing those who confronted formal and informal power structures in a defensive institution: "We felt the sabotage of management strategies that attempted, some successfully others less so, to undermine the research process, to tamper with ethics committee members, to sterilise certain research programmes and publications and to issue threats of disciplinary action, litigation or termination of employment" (Mason 2007: 33). The experience of undertaking this study did little to restore any confidence that insularity and inertia of psychiatric power in high-security settings had been eroded by the transition to NHS Trust status.

The research proposal was originally submitted, to the Research Governance Committee, in February 2002. A response from the Medical Director, made it clear that they were unable to approve the application. It was stated that the inclusion criteria, could not be met because of an embargo on the admission of personality disordered patients. Furthermore, revision of the proposal (widening the inclusion criteria) would 'only create another reason for not approving the project', given 'concerns about over-researching this group of patients'. No information was offered regarding the nature, or design, of four ongoing research projects, and the application was not referred to the Local Research Ethics Committee [LREC]. With some amendments, the proposal was resubmitted to coincide with the appointment of a new Director of Research.

The second submission fared more favourably, and the Medical Director wrote to confirm that the Committee had approved the project, subject to ethical approval by the North Sefton Research Ethics Committee. The researcher was invited to attend an LREC meeting in March 2003 to address concerns. Discussion was productive, with the Chair delegating lead responsibility to a representative from Ashworth Hospital Authority. Following recommendations from the Committee, relating to research 'interfering with treatment', and management of 'patient disclosure'/'confidentiality', a risk reporting protocol was incorporated into staff and patient information sheets. The Data Protection Officers for the hospital and university were informed. The researcher was required to undertake a one-week induction programme at Ashworth, given key clearance, issued with an honorary contract and car-park pass, and granted permission to take a tape-recorder/microphone into the secure compound. At this point, two pilot interviews were undertaken, with members of staff, in the Education Centre.

The next period of data collection did not commence until late in 2005. Correspondence between the researcher and an assortment of agents from the hospital, indicate divergent explanations for this two-year gap. The length of time in processing the research request meant that final approval to commence interviewing coincided with teaching commitments of the researcher, and precluded time being taken out of the semester. Disregarding a series of institutional impediments, this delay would (at a later date) be used by the R&D Manager at the hospital to construct the researcher as blameworthy, dismissing complaints about lack of co-operation from clinical staff. With agreement to proceed given at LREC and Ashworth Governance Committee levels, objections were then raised within the Personality Disorder Service. The researcher was informed that, in failing to submit the research protocol to the PDS Governance Committee, organisational procedures had not been followed and he would be prevented from entering the hospital. The Hospital Governance Committee was reluctant to intervene, commenting that the project had received full approval. With deference, multiple copies of the proposal document were dispatched to the Chair of the PDS Governance Committee. On two occasions, the proposal was tabled as an agenda item, but not discussed.

At this point, the majority of exchanges were taking place over the telephone. Notes were kept to record mixed-messages from a series of people (including the Director of the PDS) who staked a claim in the additional approval process. At a meeting on the 12th May 2005 the proposal was reviewed by the PDS Committee, and an extension granted. In terms of patient recruitment, further problems arose when the PDS Director again questioned the service level status of the project and raised concerns about the patient population being over-researched. Agreement had been sought for the researcher to attend one of the Ward Manager's weekly meetings, as a courtesy, to outline the (fully-approved) project and explain procedures for recruiting participants. The reception was hostile and interrogative, with little understanding of research or the ethical principles of informed consent and confidentiality. One manager was reluctant to allow staff to take part, expecting to be allowed to listen to interview recordings 'in case they say things I don't agree with'. After leaving this meeting, the researcher was informed by a Senior Clinical Manager that he could find no evidence of institutional support for the study. At the same time, the 'authority to retain prohibited items' form (allowing a tape-recorder into the secure site) needed updating by the Director of Security. Only persistent requests, made through the Research Department, secured this request, with a loss of valuable time. Tensions between the Trust, hospital, and the Research Governance Committee, were evident in an e-mail (27/5/05) sent by a manager in the Research Department to the Director of Security:

> "It appears that this may be a matter which would benefit from some close liaison between your department and the research structures within Mersey Care as, for example, in other circumstances, for example if it occurred to a research assistant specifically tasked to collect particular data, a delay of a month would be the equivalent loss of £2000 to the researcher's employing authority, and a major slip

in a project timetable which funders would not accept with good grace. This would, in turn, affect the likely success of any future funding applications, having a knock-on effect in terms of the reputations of both researchers and of Mersey Care in general"

An apologetic response, from the R&D Manager, offered assurance that these concerns would be addressed at the Research Governance Committee, and the Trust's Strategic and Finance R&D Committee. Having been informed that appropriate participants would be approached through the patient care teams, no communication was received from any of the medical staff on the PDS, and telephone calls/letters went without reply. The deadline for data collection lapsed and, in correspondence with a PDS Governance representative (01/08/2005), the researcher felt compelled to comment:

"Beyond the issues of my own project I think that this experience has wider implications, and generates a set of concerns, for any external research attempting to negotiate access to a detained population through the agency of a powerful professional group. Time constraints may provide an opportunity to close the project down, but from my perspective which is about the integrity of inquiry the study remains an open – if unanswered – one".

The reply from the R&D Manager (16/08/05), following discussion at the Mersey Care NHS Trust Research Governance Committee meeting on the 11th August 2005 was predictable. Difficulties were acknowledged, but most related to the re searcher in terms of a delayed start, l ack of a visible presence, and the failure to retain the interest of staff. In short, it was noted:

"Your suggestion that the problems that you had in recruiting participants had wider implications for other external research projects was treated very seriously by the committee. While it was accepted that it is sometimes difficult to engage busy clinicians in supporting research, the committee disagreed with you that there was an inherent problem for external research in the organisation or within this specific professional group".

In terms of resolution, a serendipitous meeting, at a conference in Canada, introduced the researcher to a newly appointed Consultant Nurse for Ashworth PDS. Acting as a supportive intermediary, this individual saved the project by gaining the support of Responsible Medical Officers to identify potential respondents from their clinical caseload. Sadly, a few months later, this spirited professional made the decision to leave the hospital.

APPENDIX II

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RMO Consent Form

(For research to be undertaken with patients in Ashworth Hospital)

Name of applicant: David Mercer

Title of project: A discourse analysis of narrative accounts of pornography in relation to the nursing management of personality disordered sexual offenders in forensic care

Part 1a To be signed and dated by the Responsible Medical Officer.
Part 1b To be signed and dated by the Responsible Medical Officer.
Part 1 To be held on the researcher's file.

Part 1 – Section A

I ..... Responsible Medical Officer to ..... hereby give my approval for the above-named patient to be invited to participate in the research project.

I have received a written explanation of the study.

Signed / Date .....

Part 1 – Section B

I ..... Responsible Medical Officer to ..... am satisfied that the patient is capable of giving consent to his involvement in the proposed research project.

Signed / Date .....

Version 3: May 2003

APPENDIX III

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Taking Part in Research

Patient Information Sheet

Title of Study: 'A discourse analysis of narrative accounts of pornography in relation to the nursing management of personality disordered sexual offenders in forensic care'

You are being invited to take part in a research study. Before you decide it is important to understand why the research is being done and what it will involve. Take time to read the following information carefully. Discuss it with others if you wish. Please ask if anything is unclear, or if you would like more information. Take time to decide whether you wish to take part. Thank you for reading this.

1. The purpose of the study

The study is about exploring the different ways that patients and nursing staff talk about pornography in forensic settings. Previous research has attempted to find a relationship between pornography and sexual offending by measuring sexual arousal toward specific images. This study is very different. It uses a 'narrative approach' and is concerned with language and meanings - how people 'talk' about a subject in their own words. Using 'discourse analysis' the researcher identifies patterns or themes within the accounts. The study is designed to help understand how patients and nurses in forensic settings talk about pornography, and how those individuals see pornography related to sexual crimes

2. Why you have been chosen

The research will involve 20 patients with a diagnosis of personality disorder, where a sexual offence was the reason for admission, and 20 nurses with experience of working with this client group.

3. Consenting to take part

It is up to you to decide whether or not to take part. If you decide to participate you will be asked to sign a consent form, and will be given a signed copy of the consent form to keep. If you decide to take part you can withdraw at any time without giving a reason. A decision to withdraw, or a decision not to take part, will not affect your care. As part of the procedure for research at Ashworth Hospital Authority, your Responsible Medical Officer will be informed of the project and required to give consent for you to participate.

4. What the study will involve

Each participant will be required to take part in two interviews, with the researcher, one week apart. The interviews will last between one and one and one half hours. The first interview is to introduce the topic and begin a general discussion; the second will focus on themes from the first interview. During interview you can talk in general terms. Though it would be helpful, you do not have to discuss details of any specific offence. You will not be asked any questions about offences. The researcher will not have access to any case-material or official/medical records that relate to you. Interviews will be recorded on audio-tape. Strict guidelines and procedures will ensure that your identity, and anything that you say, remains confidential (see section below).

5. The benefits of taking part
As with any research project your participation will add to the production of new knowledge. The study is not related to your treatment and will not pertain to you as an individual. It is hoped that the results will contribute to forensic nursing care.

6. Maintaining confidentiality
If you consent to take part the information you give will be kept strictly confidential. However, it is important to note that there are 'limits to confidentiality'. If you disclose information to the researcher that directly or indirectly suggests a risk of harm to others (see attached criteria) the Patient care Team will be informed. This is a condition of ethical approval to undertake the study and is outlined in the attached Reporting Protocol.

Any information that leaves the hospital will have your name and address removed so that you cannot be recognised from it. In line with the requirements of data protection:

- All materials will be stored in a secure cabinet at the University of Liverpool with access restricted to the researcher.
- All interview tapes and transcriptions will be coded with a number so that you cannot be identified.
- Transcription of the audio-taped interviews will only be undertaken by the researcher
- All computer files will be password protected.
- Audio-tapes will be transcribed, wiped and destroyed within six weeks of the interview.

To guarantee clear boundaries between the research and your care in the hospital any nurses who have direct involvement in your treatment are excluded from the study.

7. The results of the study
When the project is completed it will be written up as a PhD thesis. The findings will also form the basis for scholarly articles and conference presentations. It is important to note that you will not be identified, or identifiable, in any report, publication or presentation derived from the findings of this study.

8. Review of this study
For approval to undertake this study the research proposal, and all appropriate documentation, was submitted to North Sefton Local Research Ethics Committee (LREC)

9. Contact for further information
If you require more information please ask your Ward Manager to contact the researcher at the following address:

Dave Mercer
The Department of Nursing
The University of Liverpool
The Whelan Building
Quadrangle
Brownlow Hill
Liverpool L69 3GB

Tel: 0151 794 5902

E-mail: dmercer@liverpool.ac.uk

Version 3: May 2003

APPENDIX IV

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Consent Form (Patient)

Title of project: 'A discourse analysis of narrative accounts of pornography in relation to the nursing management of personality disordered sexual offenders in forensic care'

Name of researcher: David Mercer

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐
3. I agree to take part in the above research study. ☐

Name of patient _____ Date _____ Signature _____

Researcher _____ Date _____ Signature _____

1 copy to be retained by the patient

1 copy to be retained by the researcher

1 copy to be filed in the hospital notes

Version 3: May 2003

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Consent Form (Staff)

Title of project: 'A discourse analysis of narrative accounts of pornography in relation to the nursing management of personality disordered sexual offenders in forensic care'

Name of researcher: David Mercer

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐
3. I agree to take part in the above research study. ☐

Name of participant _____ Date _____ Signature _____

Researcher _____ Date _____ Signature _____

1 copy to be retained by the participant

1 copy to be retained by the researcher

Version 3: May 2003

APPENDIX V

Transcription notation

(.)	Short pause
...	Speaker in-breath
[pause]	Pause of five seconds or more
[long pause]	Pause of more than one minute
Under	Indicates speaker emphasis (raised voice)
Under	Indicates speaker emphasis (loud voice)
Under	Indicates lowered speech (soft voice)
Under	Indicates lowered speech (whispering)
[word]	Non-verbal communication (e.g. sighing, laughter, gesturing)
[unfinished]	Word left uncompleted as a part of speech
'Word'	Speech attributed to another person, or spoken in another context
?	Where a question is asked directly, or inferred by a rising inflection