RESISTING CONFINED IDENTITIES: WOMEN'S STRATEGIES OF COPING IN PRISON

by

Jennifer M. Kilty
M.A., University of Ottawa, 2003
B.A. (Hon), University of Windsor, 2001

DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

In the
School of Criminology

© Jennifer M. Kilty (2008)

SIMON FRASER UNIVERSITY

Spring 2008

All rights reserved. This work may not be
reproduced in whole or in part, by photocopy
or other means, without permission of the author.

Approval

Name:	**Jennifer M. Kilty**
Degree:	**Doctorate**
Title of Thesis:	**Resisting Confined Identities: Women's Strategies of Coping in Prison**

Examining Committee

Chair: **Joan Brockman LL.M.**
Professor – School of Criminology
Simon Fraser University

Senior Supervisor: **Dorothy E. Chunn Ph.D.**
Professor – Department of Sociology & Anthropology
Simon Fraser University

Supervisor: **Robert Menzies Ph.D.**
Professor – Department of Sociology & Anthropology
Simon Fraser University

Supervisor: **Margaret A. Jackson Ph.D.**
Professor – School of Criminology
Simon Fraser University

Internal Examiner: **Marina Morrow Ph.D.**
Assistant Professor – Faculty of Health Sciences
Simon Fraser University

External Examiner: **Susan C. Boyd Ph.D.**
Associate Professor – Studies in Policy and Practice
University of Victoria

Date Defended/Approved: Friday February 29th, 2008

SIMON FRASER UNIVERSITY
LIBRARY

Declaration of Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to Simon Fraser University to keep or make a digital copy for use in its circulating collection (currently available to the public at the "Institutional Repository" link of the SFU Library website <www.lib.sfu.ca> at: <http://ir.lib.sfu.ca/handle/1892/112>) and, without changing the content, to translate the thesis/project or extended essays, if technically possible, to any medium or format for the purpose of preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author's written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

While licensing SFU to permit the above uses, the author retains copyright in the thesis, project or extended essays, including the right to change the work for subsequent purposes, including editing and publishing the work in whole or in part, and licensing other parties, as the author may desire.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Simon Fraser University Library
Burnaby, BC, Canada

Revised: Fall 2007

SIMON FRASER UNIVERSITY
THINKING OF THE WORLD

STATEMENT OF ETHICS APPROVAL

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

(a) Human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

(b) Advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

(c) as a co-investigator, in a research project approved in advance,

or

(d) as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Bennett Library
Simon Fraser University
Burnaby, BC, Canada

Abstract

This study analyzes the self-injurious behaviours that women in prison adopt as coping strategies, the 'psy'/medical practices and policies that govern such behaviours, and constructions of prisoner identity. Correctional officials and feminists have been aware of self-injurious behaviour among women prisoners since the 1970s, but little Canadian research on the topic has been conducted to date. By centring self-harming behaviours and examining the experiences of both federally and provincially sentenced women, this dissertation contributes to feminist and criminological knowledge.

Findings are based on twenty-six in-depth interviews with ex-prisoners and social workers who work with at risk and criminalised women. An integrated theoretical framework that links citizenship and identity literatures with feminist critiques of 'pathologisation' is used to track the relationships between several dichotomies, including constructions of fixed/fluid identity and choice/disease models of addiction. Adopting a feminist lens allowed me to centre the voices of my participants while conducting a critical discourse analysis of their narratives.

This research produced two important findings among others. First, criminalised women have a broader conception of self-injurious behaviour than do most researchers and correctional authorities. Participants discussed not only cutting, but also disordered eating, and substance use (illicit and licit) as forms of self-harm they invoked to express their emotions and cope with life stress. Second, classical and positivist languages co-

exist in prisoner as well as correctional discourse. For example, some women used positivist descriptions of their addictions to generate distance between constructions of selfhood that reflect negative components of their identities. The women's use of classical and positivist discourses often reflected their feelings of empowerment and their ability to resist carceral control strategies or, alternatively, a sense of powerlessness to their addiction, their imprisonment, and even their roles as mothers.

Policy responses to self-harming behaviours were relegated to threats for or immediate removal to segregation. While the women viewed segregation as punishment for harming themselves, correctional authorities reconstructed self-harming behaviours as threats to institutional security. This study also highlights the incongruity between correctional officials' responses to licit versus illicit substance use and the problematic over-prescription and medicalisation of women in prison.

Keywords: medicalisation; self-injury; disordered eating; substance use; identity; biological/psychiatric citizenship

Subject terms: women; prisoners; mental health, social aspects

Dedication

This dissertation is dedicated to those 26 women who agreed to sit down and share their life stories with me, all in the name of research. As I listened to their narratives I was struck most by the strength these women exuded, by their desire to overcome their pasts, and most importantly by their resiliency. This research was possible only because of their bravery, honesty, and sincerity. Moreover, I found that it was their desire to put their stories 'out there' – with the selfless hope that revealing their experiences to me and explaining their own personal accounts of imprisonment would help to make some kind of difference for other women who become criminalised across Canada.

Acknowledgements

I would like to extend my thanks to the Social Science and Humanities Research Council of Canada and to Simon Fraser University for their financial support. In addition, I would like to thank several people, without whose support I could not have completed this dissertation. To my father Brian – thank you for your unwavering support. I must say, that I am privileged to be your daughter. To my sister Amy, the consummate teacher, who is somehow always able to make you see how to just buckle down and get the work done because that is what you have to do. To Lorraine, for your sympathetic ear and reason when I am feeling defeated. To all of my friends in Ottawa, Vancouver, Waterloo, and Port Colborne – thank you for continuing to support me, for making me laugh, for baking me treats to support my dangerous sugar addiction, and for listening to my endless diatribes of how difficult it is to complete a dissertation. I love you all.

Extra special thanks go out to the following people, who gave of their own time to help me edit my terrible comma splices and other writing faux pas – Matthieu, Daniela, Sheri, and Rebecca. The four of you have been especially supportive of me, and I cannot think of better friends to have. Your friendship, advice, and willingness to listen have been instrumental in my ability to complete this degree. On a more personal level, I want to thank and dedicate this work to Matthieu. I love you more every day and your support has meant more to me than I can express here. I first truly witnessed the extent of your ability to be selfless on the day I was accepted to SFU, and without hesitation, you told

me to go. You have never made me feel guilty for leaving, and have always ensured that I knew that no matter where I was you would be right there with me. Thank you for always being willing to help me; whether it is to format, edit, listen, launder my 'uniform', or to get me out of the house. You have been there – every day. I love you.

Thank you to both Sylvie Frigon and Colleen Anne Dell who have supported and encouraged me throughout this degree. I have been fortunate enough to work with and learn from your caring advice and friendship. Thank you for the years of support you have given me. Thank you to both Marina Morrow and Susan C. Boyd for your time and willingness to be external examiners for my doctoral defence. Your insight and careful examination of my work will undoubtedly serve only to strengthen this dissertation.

Last, but certainly not least – to Bob Menzies, Margaret Jackson, and most importantly, Dorothy Chunn. It was because of your work that I was originally attracted to SFU. However, it was after a phone conversation with Dorothy (that lasted nearly 45 minutes) during my Ph.D. application process, that I knew SFU was the place for me. Any professor who would make that kind of time for a prospective student they had never met was someone I wanted to work with. I have never seen professors give as much or work as hard as the three of you do for their students. Over the past four and a half years you have been my teachers, mentors, supervisors, comprehensive exam reviewers, referees, and at times – counsellors. Working with you has inspired me, and has shown me how I want to be as a teacher and as a supervisor. Your influence has made me a more critical thinker, a much improved writer (although I cannot seem to get rid of those comma splices Bob), and a more compassionate researcher. The only words I can think to say are thank you, thank you, thank you – for everything.

Table of Contents

Approval ii
Abstract iii
Dedication v
Acknowledgements vi
Table of Contents viii
List of Figures xi
Glossary of Terms xii
Introduction 1
On Criminalised Women and Identity 1
The Research Aims 2
Chapter Organisation 5
Chapter 1 Understanding Self-harming Behaviours as Strategies of Coping: Self-injury, Disordered Eating and Substance Use 10
Self-Injury 11
Psy-Approaches 11
Correctional Approaches 13
Feminist Approaches 16
Disordered Eating 19
Medical Positivism and Psy Diagnoses of Disordered Eating 20
Feminist Discursive Readings of Disordered Eating 25
Substance Use 28
Coping with Past Sexual Trauma and Imprisonment 29
Choice or Disease: The Substance Using Self 33
Chapter Summary 38
Chapter 2 Theoretical Framework Part I - Regulating Criminalised Women: Carceral Governance in Neoliberal Times 41
Technologies of Discipline: Of Syndromes, Pathologies, Mad Women and Bad Biology 42
Technologies of the Self: Empowerment and Responsibilisation 49
Theorising the Relatedness of Dichotomies 54
The Public/Private Divide 55
Free Will and Determinism 57
Compliance or Resistance, or Compliance as Resistance? 60

Chapter 3 Theoretical Framework Part II - Negotiating Identity and Constructing Citizenships Within the Carceral Context **64**
Making Up Selves: Identity Negotiation in the Carceral Context 64
Fixed or Fluid, or Fixed and Fluid Identity 66
Constituting the Self in Neoliberal Times: Technologies of the Self 73
The Meaning of Citizenship in the Prison Context 85
Biological Citizenship 89
Psychiatric Citizenship 94
Conclusion 98

Chapter 4 Ways, Means, and Methods: Constructing an Integrated Methodology **101**
Part 1: Epistemological Issues and Methodological Concerns 102
Critical Feminist Lens 102
The Ethnographic and Grounded Theory Approach to Interviewing 105
The Ethical Positioning of the Self and the Participant 109
Maintaining Sensitivity Through Emotionality And the Active Engagement of Difference 111
The Critical Social Theorist Approach to Discourse Analysis 115
The Impact of Feminism on Critical Social Studies of Discourse Analysis 122
Part 2: Ethical Issues and Creating a Feminist Informed Research Design 126
Research Design 126
Ethics and Access 128
Fieldwork and Conceptual Baggage 129
Research Process: Locating Participants, Confidentiality, Building Rapport, Coding, and Analysis 132
The Strengths and Limitations of this Research 140
Chapter Summary 143

Chapter 5 "Drowning in a Sea of Me" **145**
A Biographical Profile 146
Self-injurious and Disordered Eating Behaviour as Coping Strategies 148
Self-injurious and Disordered Eating Behaviour as Self-punishment 157
Self-injurious and Disordered Eating Behaviour as Symptoms of Madness 162
Self-injurious and Disordered Eating Behaviour as Attention Seeking and Manipulation 167
Strip Searching and Segregation as Triggers to Self-harming Behaviours 171
Chapter Summary 179

Chapter 6 Sojourning Through an Addictive Identity **181**
A Strange Marriage of Coping Strategies: Addiction and Imprisonment 182
Motherhood as Praxis: Relying on One's Identity as a Mother to Resist Addiction 194
Duelling Identities: The 'Addicted' Versus the 'True' Self 204
Constructing Addiction: Disease or Choice? 214
Chapter Summary 227

Chapter 7 The Practice of 'Psy' and Prescription Medication in Women's Prisons 230
Medicalisation: Over-prescription as a Technology of Control 233
Seroquel and the New Prison Order 242
On (Mis)Informed Consent and Lack of Access to Psy-care in the Correctional Context 248
Of Turf Wars and Territoriality: Butting Heads and Competing Expert Discourses 257
Chapter Summary 272

Chapter 8 Politicking Self-harm – Cutting, Emaciating, and Using: Coping Strategies and the 'Hole' 275
Setting the Stage 277
Policies and Procedures: Correctional Responses to Self-injury, Disordered Eating, and Substance Use. 280
The Federal Mission Statement and Provincial Mandate 280
Feminising Masculine Women: Operating Correctional Responses to Disordered Eating Practices 282
Abstaining and Sedating: Responding to Illicit Versus Licit Substance Use in the Carceral Context 286
Prevention, Management, and Response to Suicide and Self-Injuries (CD 843) 288
Offender Intake Assessment (OIA) 296
The Unintended Consequences of Current Policies 300
Who and What is Left Out? A Women-centred Policy 305
Chapter Summary 308

Chapter 9 Concluding Remarks and Ideas for Future Research 311
Situating This and Other Research on Criminalised Women 311
Important Contributions of this Research 314
Research Implications for Correctional Policy and Practice 316
Theoretical Findings and Contributions 319
Pathways for Future Research 323

Appendix A: Interview Schedule for Former Prisoners 326

Appendix B: Interview Schedule for Staff 331

Appendix C: Information Sheet for Participants (Former Prisoners) 336

Appendix D: Information Sheet for Participants (Staff) 337

Appendix E: Informed Consent Form 338

References 340

List of Figures

FIGURE 1: Chain of Policy and Procedural Directives Enacted After A Self-injurious Incident 300

Glossary of Terms

CAEFS – Canadian Association of Elizabeth Fry Societies

CHRC – Canadian Human Rights Commission on Federally Sentenced Women

CSC – Correctional Services of Canada

DSM-IV – Diagnostic and Statistical Manual of Mental Disorders

Efry – Elizabeth Fry Society (local chapter)

FSW – Federally Sentenced Woman

OMCCS – Ontario Ministry of Corrections and Community Safety

P4W – Kingston Prison for Women (closed in 2000)

PSW – Provincially Sentenced Woman

TFFSW – Task Force on Federally Sentenced Women

Introduction

Dana (FSW): I just want to be me. I just want to be able to stay clean, get a job, and be with my kids and grandkids. So I'm taking the steps to be able to do that, you know? I've done all the programs and I still see counsellors. But I don't want to be seen as a criminal, you know? Like, that's not who I am. It's what I did, but it's not who I am.

On Criminalised Women and Identity

Historically, those who draft laws, set correctional policies and conduct social science research have generally not considered criminalised women. When they have, it has been as a kind of afterthought to criminological or social science research. Criminalised women have also usually been constructed as dangerous and "more terrible than any man" (Lombroso 1895:150). To construct women's criminality as a manifestation of the deceptive or manipulative essence of women's nature ignores the social conditions and multiple forms of oppression commonly experienced by criminalised women. This approach to theorising women's criminality has led to the entrenchment in law and correctional policies of the belief that this population is in fact different and dangerous because its members transgress the traditional, patriarchal, norms of femininity and womanhood. Because criminalised women continue to be constructed as inherently different and dangerous, they are often subjected to correctional programming that is structured around beliefs about women's place in society, e.g. that real women are by nature mothers, selfless and nurturing (Boyd 1999; Dell, Fillmore & Kilty forthcoming; Hannah-Moffat 2001; Hayman 2006).

As a feminist criminologist, I am deeply concerned by the issues that hold women back and that contribute to their criminalisation. Owing much to the surge in critical and feminist research in criminology of the late 1980s and the 1990s, I have been able to privilege the voices of women who have historically been marginalised and silenced by a range of powerful institutional discourses and practices. Through my research, I have attempted to dissect how institutional discourses and practices fabricate, in an essentialist way, how criminalised woman are viewed. To reduce a person to their crime reflects an attempt to construct a type of criminal, man or woman, whose identity is inexorably intertwined with their criminality. This approach ignores that individuals have multi-faceted identities that cannot be reduced to a specific act. This dissertation tries to unravel some of the traditional and masculinist constructions of women's criminalised identities by investigating how the women construct themselves and negotiate their own identities even as the process of criminalisation affects them.

The Research Aims

Carrie (Efry): The biggest public misunderstanding? I think it's a combination. I think probably the biggest thing would be thinking that these women are completely different. A completely different breed of women altogether. Society has this perspective that if you're a woman and you've been in a jail, then maybe you're not a real woman because real women don't do this, and real women don't do that, and real women certainly don't go to jail.

Marlene Moore was the first woman in Canadian history to be declared a dangerous offender, although she had not committed a serious violent crime. Moore had been in and out of jails and prisons since the age of thirteen, mostly for petty offences and assaults. During the time she spent at the Grandview Training School for Girls in Kitchener Ontario, Moore, like so many of the other young girls there, began to self-

injure[1]. There is no evidence to suggest that Moore self-injured prior to her stay in the training school (Kershaw and Lasovich 1991:40). Biographers Anne Kershaw and Mary Lasovich (1991) suggested that Marlene Moore used self-injury as a coping mechanism and as a way to express her frustration, anger, fear, and sadness at the brutality she had experienced both inside prison and within her own family[2]. In a sentence completion test written for a psychologist in 1985, Moore wrote:

> My friends don't know I am afraid of *living outside of jails*; Some day I will die by my own hand; The worse thing I ever did *was to live*; If I were in charge *I'd change the correctional system* (Kershaw and Lasovich 1991:iv).

On December 3rd 1988, Marlene Moore's body was found hanging in the hospital wing of the Kingston Prison for Women. Moore's case led to an inquiry that publicly shone a light for the first time on the issue of self-injury committed by women prisoners. Despite the attention that Moore's death and the subsequent inquiry brought to this issue, a great deal of debate remains surrounding how to define, categorise, and explain self-injurious behaviour. Authors from different disciplines suggest that self-injury can be explained as a coping or survival strategy, a strategy of resistance, a manipulative behaviour, attention seeking behaviour, a reaction to trauma or abuse, or a psychiatric response or symptom of a greater mental pathology.

This research began as an attempt to learn specifically about the act of self-injury – why criminalised women seem to be more prone to it, and the purposes this particular form of self-harming behaviour serve. The focus, however, gradually shifted. I soon

---

[1] Since Moore's time at Grandview, several women have come forward to report multiple rapes, as well as psychological and physical abuse by the staff at this institution (Faith 1993).

[2] Moore revealed to friends and prison psychologists that several of her brothers had repeatedly raped her, and that a stranger had raped her again at the age of nineteen.

learned that my participants felt that it was equally important to discuss the practices of disordered eating and substance use. Methodologically, this project draws from the grounded theoretical approach outlined by Strauss and Corbin (1990). As such, rather than trying to fit the women's discourses into a pre-existing theoretical framework and to avoid predetermining their responses, I asked them open ended questions about the strategies that enabled them to cope. As a result, all three of these practices (self-injury, disordered eating, and substance use) were identified and described as self-harm more broadly, and as coping strategies in a more practical sense.

I also contextualized the work as having been envisioned, crafted, executed, analysed and written from a critical and feminist position in order to privilege the voices, standpoints, discourses, narratives, stories, and opinions presented by my participants – who, as previously mentioned, represent a population that has been historically silenced in law, policy, theory and in social science research.

It is important to first demonstrate how the women on whose narratives this research is based are relatively 'typical' in terms of the average criminalised woman in Canada in order to confront the negative constructions of criminalised women that are so widespread throughout criminological research. While they are not a representative sample, my interviewees do reflect some of the broader demographic characteristics of criminalised women in Canada. For example, the crimes for which my participants were imprisoned were quite varied, and ranged from theft or fraud, to a host of drug offences, to first-degree murder. Some of the women had cycled in and out of local jails or detention centres so much that a few days or even weeks in prison had become normal and was viewed as a part of their routine. Others were first time offenders whose crime

was atypical considering their customary behaviour and/or lifestyle. Most of my participants were sentenced provincially as opposed to federally, and very few had been incarcerated for violent crimes.

This research explores the perceptions and experiences of women who have been imprisoned and how traditional constructions of criminalised women impact correctional policy and ultimately the lives of criminalised women[3]. To these ends, this project set several overarching research goals:

- To put the interviewed women's voices at the core of this research and to analyse the women's narratives through a feminist lens that incorporates analyses of race/ethnicity, class, and gender.
- To learn how women cope[4] with imprisonment.
- To learn how imprisonment impacts the identities of criminalised women.
- To determine whether there are differences in the experiences described by women at the federal and provincial levels of imprisonment.
- To uncover how correctional authorities respond to the self-harming behaviour of women in prison.

Chapter Organisation

The remainder of this dissertation consists of nine chapters. Chapter One reviews the existing literature on the three self-harming behaviours that I have examined in detail in this study; self-injury, disordered eating, and substance use. Given the extensive literature related to all three of these topic areas, I limited my review to the discussions of

[3] I suggest that broadly speaking, criminalised women are marginalised because of their gender, race, class, and sexual orientation/identity and their criminalised status.

[4] A more detailed examination of the term 'coping' and what is meant by coping strategies is outlined in Chapter Three.

these three behaviours as coping strategies since this was how my participants constructed them.

Chapters Two and Three combine to provide an integrated theoretical framework that helps us understand the current political climate operating within the carceral context, and how this climate actually impacts policies and ultimately the treatment of women while they are housed within Canadian provincial and federal prisons. Generating an integrated theoretical framework allowed me to draw from several theoretical perspectives to more accurately explain my data and findings. Situating Chapter Three within what I have called the feminist "pathologisation literature" – feminist literature that focuses on the deconstruction and reconstruction of the diagnosis and treatment of women within the realm of psy[5] – provides a point of entry into this integrated theory.

After examining the pathologisation literature, I undertake a brief overview of the key elements of governmentality theory, which offers an understanding of the current political and correctional landscape in which the discourses and narratives of my participants are located, created, negotiated, confined, and constrained. I also offer a feminist critique of governmentality, and a brief examination of three dichotomies that are pertinent to my work: the public / private divide; free will (agency) / determinism (structure); and compliance / resistance.

---

[5] I use 'psy' as an umbrella term to encompass the range of disciplines that investigate the mind, human behaviour, and mental capacities and/or mental 'illness'. To be clear, I want to acknowledge that these disciplines are not homogeneous; for example psychiatry is considered a medical discipline that studies diseases of the mind whereas psychology may adopt different approaches (social, cognitive, clinical, forensic etc.) to studying human conduct. However these disciplines commonly accept mental illness as a reality and as having roots (albeit to different degrees) in bio-genetic causes, and often fail to address the impact of personal socio-cultural histories on individual behaviour.

In Chapter Three, I examine how identity is constructed, how it develops, and how it is negotiated and maintained. Given that my participants constructed their self-harming behaviours as active components and expressions of their identities, it was necessary to engage in an analysis of identity formation. Drawing heavily on the work of Kenneth Gergen, I situate this discussion around the conceptualisations of two forms of identity constructs: fixed and fluid. I argue that identity can actually be both fixed and fluid and that this continuum creates the space for the possibility of resistance. I then address how certain technologies of the self operate as part of the institutional discourses that affect criminalised women, and how they negotiate their identities to survive in the carceral environment.

I conclude Chapter Three with a discussion of citizenship which, while not a new concept, is one that I suggest is as pertinent as ever and deserves to be renewed. I introduce the idea that self-harming behaviours can foster identities that form the basis of potential citizenship statuses through which criminalised women may be able to make rights claims.

In Chapter Four, I provide an overview and discussion of the different methods that have been incorporated and blended to help foster an integrated methodology. Key concepts related to discourse analysis, grounded theory, ethnographic or in depth interviews, and feminist approaches[6] to conducting research are all examined. Chapter Four also addresses research design; ethical considerations and clearance, access to participants, confidentiality, anonymity, as well as a detailed examination of the transcription and coding procedures.

[6] Feminist approaches to research that emphasize the importance of generating a space for women to be heard as a unique and heterogeneous population has been an essential part of the methodology.

Chapter Five is the first of four data analysis chapters. Here I discuss self-injury and disordered eating together because participants described them in a similar way, as coping strategies and attempts to gain control. I examine how the women explain these behaviours and how correctional authorities respond to women who self-injure or who suffer from an eating disorder.

Chapter Six focuses on illicit substance use. It was clear throughout all 26 interviews that addiction defined some of the most difficult issues faced by criminalised women. Substance use was overwhelmingly constructed as a way of coping with chaos and stress by 'numbing', making the women 'unable to feel'. While these are not new claims, my participants' discussions of addiction as a distinct and separate component of identity, and my dialogue about the construction of addiction as either a disease or a choice, warrant renewed research.

Chapter Seven explores the ever-expanding role and power of psy discourses and practices within the carceral context, including the role of prescription medications in both provincial and federal institutions.

In Chapter Eight. I present a critical feminist analysis of the federal and provincial policies and operating responses invoked for the three forms of self-harming behaviour discussed in this dissertation. I begin by arguing that women's needs are reconstructed by correctional authorities and in correctional discourses and practices as institutional risk factors. Despite the claimed federal correctional commitment to a woman-centred and gender responsive approach to corrections for federally sentenced women, segregation remains the operating response to self-harming behaviours.

In the concluding chapter, I attempt to bring together the overarching themes and main conclusions that emerged from this research. Discussions of its major strengths, and limitations, findings, and theoretical contributions are highlighted, in an effort to delineate potential avenues for future research.

I now turn my attention to a review of the existing literature regarding the three forms of self-harm discussed by the participants of this research project. Understanding how authors before me have explained self-injury, disordered eating, and substance use will help set the stage for the ensuing analysis.

Chapter 1
Understanding Self-harming Behaviours as Strategies of Coping: Self-injury, Disordered Eating and Substance Use

Broadly speaking, the term *self-harm* includes more than behaviours that are directly and physically injurious to the body. For example, self-harm includes eating disorders, engaging in dangerous sexual activities, self-injury, as well as alcohol and drug use (Fillmore & Dell 2000). My examination of the existing literature on self-harming behaviour is limited to self-injury, disordered eating, and substance use since these three topic areas are so broad and multi-faceted. Mirroring how my participants discussed these three forms of self-harm, my review of the existing literature canvasses work that specifically examines self-injury, disordered eating and substance use as potential coping strategies.

Reflecting a truly grounded theoretical approach to conducting research, this literature review is structured around the key issues that emerged from the participants' narratives. That by no means all of my findings are present in the existing literature points out both the gaps in the literature and the contributions of this work. I begin by presenting and commenting on the literature and main debates surrounding self-injury, giving particular attention to research that emphasises self-injurious behaviour committed by women in prison.

Self-Injury

Three different perspectives on self-injury emerged from the literature review: (1) psy understandings of self-injury; (2) correctional understandings of self-injury; and (3) feminist understandings of self-injury.

Psy-Approaches

Self-injury, like female criminality, is frequently explained by both medical doctors and psychiatrists as a psychiatric problem that surfaces because of some women's inability to adequately deal with the changes that occur during adolescence, pregnancy, and menopause. For example, Favazza locates some of the causation of self-injury in faulty female biology:

> The female genitalia, for example, are partially internal; menstruation cannot be controlled; changes in body contours at puberty may be dramatic; during pregnancy the fetus is experienced as the 'other within'; the lactating breast belongs both to the child and to the mother. Thus, there are elements of ambiguity, paradox, and discontinuity in females' experiences of their bodies (Favazza 1996: 293).

Favazza's explanation suggests that, while rare, self-injury occurs when women perceive their bodies as unknown, unknowable, and as not their own. This approach assumes that men are better able than women to accept and understand their bodily changes[7]. Normal female bodily changes are constructed as deviant, unnatural, and incomprehensible, and the cause of self-destructive madness. From this perspective, self-injury is irrational. Ironically, constructing it as such removes agency while suggesting that the behaviour is manipulative. Several authors (e.g. Ross and McKay 1976; Favazza 1989, 1996) have also argued that self-injury is used by women prisoners as a stimulus, a

[7] Self-injury is presented as a female problem; a construction that is reinforced by the fact that far fewer men than women engage in self-injurious behaviour.

way to feel alive because they so often feel 'dead' or 'empty' while imprisoned. Controlling pain, by cutting, could serve to calm the rage that many women frequently feel while in prison.

Women are targeted by psy-labelling more than are men (Chesler 1972; Ussher 1991) partly because of the general practitioner's inability to account for the problem somatically, and partly because women (including prisoners) self-injure more often than men. Women prisoners are frequently diagnosed as having an untreatable personality disorder (Dobash, Dobash et al. 1986; Carlen 1990; Liebling 1992; Liebling 1995; Becker 1996; Carlen 1998), which reinforces the view that self-injury is a symptom of the madness associated with criminalised women. By suggesting that self-injury is the result of a mental malady, psychiatric diagnoses fail to acknowledge the social and environmental impact of imprisonment (Ussher 1991; Pollack & Kendall 2005; Maidment 2006).

According to the *Diagnostic and Statistical Manual of Mental Disorders 4th Edition*, self-injury is a symptom of other "mental illnesses", such as borderline personality disorder (American Psychiatric Association 2000). In fact, a large proportion of the psy literature attempts to make substantive links between self-injury and other mental disorders and/or recurrent symptomology. For example, psy literature continues to present correlative evidence between self-injury and childhood abuse and trauma, both physical and sexual (Jones 1986; Heney 1990; Miller 1994; Connors 1996; Peters & Range 1996; Heney & Kristiansen 1997; Fillmore and Dell 2000; Dahme & Nutzinger 2002; Turell & Armsworth 2003). Some authors have even claimed that self-injury is a form of trauma re-enactment (Miller 1994), suggesting that the women feel empty and

depersonalized because of abuse experiences and therefore feel the need to punish themselves. While the conceptualization of self-injury as a form of self-punishment does occur in some of the feminist literature, feminist explanations do not rely on the link to past trauma since some women who self-injure have not experienced such trauma[8]. Authors writing from a psy perspective rarely provide any interpretation or attempt at theorising about these atypical cases. This lack of engagement is one of the great downfalls of psy literatures more broadly (Chesler 1972; Ussher 1991; Pollack 2006).

Miller's (1994) suggestion that many women who have been diagnosed with 'borderline personality disorder' should be relabelled as having 'trauma re-enactment syndrome' is a way to present old wine in new bottles and does not offer new understandings of self-injury. Worse still, Miller's interpretation of self-injurious behaviour as the symptom of a "new" psy diagnosis contributes to silencing the women's discourses by suggesting that women want to relive past trauma. This claim is dangerous, as it sustains the historical construction of women suffering from a madness.

Correctional Approaches

Correctional responses to self-injurious behaviour have historically been punitive, unsupportive, and impractical, exemplified by the policy-driven response to continue the use of administrative segregation for women who self-injure. Segregating women because they have self-injured demonstrates the Correctional Service of Canada's (CSC) myopic focus on the security of the institution, which ignores the needs and safety of individual women prisoners (Heney 1990; Kilty 2006). Despite the fact that women prisoners perceive the use of segregation as a punishment, CSC continues to enforce

[8] Feminist explanations favour more holistic and reflexive analyses of why women harm themselves.

isolation in segregation units as the official response to self-injury which, in fact, increases their self-injurious behaviour (Ross & McKay 1979; Heney 1990; Liebling 1994; Heney & Kristiansen 1997; Carlen 1998).

Canadian authors Ross and McKay (1979) found that an inordinate number of girls at the Grandview Training School in Kitchener, Ontario engaged in self-injurious behaviour. They describe the atmosphere in that institution as oppressive and harsh, with discipline being the paramount concern, second only to custody:

> Speaking was forbidden, crying was punished. Self-mutilators had been counselled, punished, lectured, cajoled, reprimanded, educated, and isolated to no avail. The staff had made them hide their scars by wearing extra clothing. They had punished them for carving by reducing the limited number of privileges which they had, or by disallowing visitors, or by assigning extra work, or by delaying their release from the institution. If there is any substance to the reports communicated to us, at one point in the institution's history a standard response to carving was the application of salt directly to the wound with a toothbrush (Ross & McKay 1979:2-3).

Fillmore and Dell (2000) claim that understanding self-injury as a manipulative act ignores how the women themselves explain it and that this discrepancy is highly problematic. Women's voices are silenced by the managerial discourses used to survey, monitor and control their behaviour, in the name of custody, security, and discipline. Women's discourses are dissected and re-constructed according to the needs of 'others'; doctors, psychiatrists, lawyers, social workers and correctional officials. If the current use of the neo-liberal language of the psy-disciplines in correctional discourse is an indicator, little will be done to understand the behaviour, let alone prevent it (Carlen 1998).

Much like it has done with feminist language generally, correctional literature that addresses self-injury has adapted much of the psy-literature to serve its specific ends; a

continued focus on custody, security, control, and punishment. Correctional literature constructs self-injury as an attention-seeking and manipulative behaviour (Ross and McKay 1976; Cookson 1977; Liebling 1994; Miller 1994; Favazza 1996; Maden 1997; Frigon 1999; Hyman 1999; Fillmore and Dell 2000; Hannah-Moffat 2001), which reconstructs women prisoners as threats to institutional security, making it all the more likely that women who self-injure will be punished rather than 'treated', counselled, or simply listened to. Ultimately, the way CSC defines self-injurious behaviour both originates from and reflexively legitimates their punitive response to it.

Understanding self-injury as a manipulative behaviour is rooted in psy efforts to differentiate it from suicide. In other words, self-injurious behaviour is attention seeking if it is not a suicide attempt. This approach does acknowledge women's agency since manipulation indicates forethought, planning, and choice, but only insofar as it is used against others (e.g. prison guards). Fillmore and Dell (2000:53) revealed that some of the staff they interviewed saw self-injury as 'acting out' behaviour, which minimized the women's "genuine need for caring attention and nurturing". The idea that the women are attempting to manipulate the system, whether to obtain a phone call, counselling, a visit or some other privilege, constructs criminalised women as deceitful, jealous, and calculating. Worse still, understanding self-injury as a tool for manipulation fails to acknowledge that self-harming behaviours serve a coping function for the individual (Ross & McKay 1979; Jones 1986; Heney 1990; Connor 1996; Heney & Kristiansen 1997; Fillmore & Dell 2000).

The reconstruction of self-injury as manipulation demonstrates the correctional fixation on security and risk factors, and its failure to address women's needs. Because

CSC relies so heavily on psychiatric and risk assessments, the construction of mental health and illness as both a need and a risk factor has increased (Blanchette 1997). In fact, feminist criminologists have argued that the needs of women prisoners have been co-opted and redefined as risks so that CSC is able to maintain its oppressive and authoritarian penal government (Hannah-Moffat 1991 1995 1999 2000a 2000b 2001; Hannah-Moffat and Shaw 2000 2001; Kilty 2006). By constructing self-injury primarily as a risk factor, correctional authorities ignore the obvious needs of those in crisis. Women who self-injure are immediately placed in segregation for monitoring purposes and as a consequence will have no access to the programming that CSC claims they need most. Indeed, Heney (1990) found that the women wanted to talk with someone following a self-injurious incident, a counsellor or a friend, and that being isolated in segregation only made matters worse.

Despite the literature that suggests that self-injury in prison causes a ripple effect or potential epidemics of the behaviour (Ross & McKay 1979; Heney 1990), and despite the fact that women prisoners have consistently revealed to researchers that they feel the use of segregation for self-injury is a form of punishment, CSC's practice of segregating women remains unchanged (Heney 1990; Fillmore & Dell 2000; Kilty 2006). Despite CSC claims to have adopted a more 'woman-centred' approach to corrections, they have in fact maintained their focus on security and punishment, to the detriment of women prisoner's needs.

Feminist Approaches

For years, feminists have championed the idea that women prisoners are very rarely a threat to the institution's staff or its security (They are more likely to be a threat

to themselves). Researchers writing from a feminist perspective have emphasised the need to engage with women as subjects to learn about their subjectivity, identity and personhood. The need to listen to the voices of women, particularly marginalised women, is frequently mentioned in the feminist literature. Turning the psy model on its head, criminalised women are presented as the experts while the researcher is an outsider who learns from the women's expertise. Much of feminist literature regards self-injury as a coping strategy, often but not necessarily rooted in abuse or trauma, and as a potential resistant practice given the powerful and controlling nature of the carceral context (TTFSW 1990; Faith 1993; Miller 1994; Hyman 1999; Fillmore and Dell 2000).

Fillmore and Dell (2000:44) found that all but one of the 47 women they interviewed had experienced either sexual or physical violence as an adult, while 92% had experienced childhood violence. While a single-cause explanation of self-injury is obviously incomplete, it is important to recognize the histories of abuse that so many criminalised women share. Feminist explanations of the link between self-injury and past trauma differ greatly from those of psy experts. As feminist therapist Hyman (1999) claims, self-injury is a way of expressing emotion without using words. This is important for women in prison, who are frequently discouraged from, and even punished for, expressing their anger or frustration (Ross & McKay 1979; Heney 1990; Faith 1993; Fillmore & Dell 2000).

Prison leads to feelings of deprivation, which have been called the "pains of imprisonment" (Sykes 1958) or 'prisonisation' effects (Giallombardo 1966; Jensen & Jones 1976; Lindquist 1980; Dobash et al. 1986; Jones 1986; Carlen 1990; Liebling 1992 1994 1995; Carlen 1998; Stevens 1998). Without positive outlets for their feelings of

anger, fear, sadness, and frustration, some criminalised women have turned to self-injury as a way to cope with these feelings. Fillmore and Dell (2000) found that self-injury offers a variety of coping and survival functions, including: (1) a cry for attention/nurturing; (2) self-punishment/ self-blame; (3) dealing with isolation/loneliness; (4) distracting/deflecting emotional pain; (5) response to an abusive partner; (6) release/ cleansing of emotional pain; (7) opportunity to feel/ bring back to reality; (8) expression/message of painful life experiences; and (9) control/power over the self.

Generally, women are much more likely than are men to be pathologised and thus to come into the criminal justice system with mental health labels and histories. They are also more likely to injure themselves whereas men tend to injure others. Because of these factors, feminists critique existing explanations of women's criminality and 'mental illness' in order to combat the construction of women as pathological, irrational, and illogical (Smart 1976; Schur 1984; Ussher 1991; Stoppard 1992; Russell 1995; Smart 1998; Snider 2003). Referring to doctors and psychiatrists, Smart observes that,

> They omit any discussion of who is in a position not only to define mental illness but to enforce that definition, and also whether these diagnoses are influenced by the double standard of mental health which applies to women and men... [s]ince the doctor's diagnosis and prescribed remedy take place within a social situation in which hegemonic stereotypical conceptualizations of women are entirely pervasive and in which doctors (of either sex) will perceive their female patients differently from their male patients (Smart 1976: 155-156).

The syndromization of self-injury removes women's agency and re-constructs them as little more than infantilised adults who are pathological, not only because they are criminalised but also because they are mad.

Carlen has stated that, "as the twentieth century draws to a close, every part of a woman prisoner's existence is laid out for physical, medical, psychiatric, legal and social work analysis" (1998: 42). Having a team of 'experts' map out a prisoner's very existence is consistent with the increasingly neo-liberal doctrines of surveillance and self-responsibilisation. In the case of criminalised women, these doctrines have operated through a correctional discourse of empowerment.

Self-injury may be understood not only as a coping technique, but also as an act of resistance to institutional power (Fillmore & Dell 2000). Heney (1990) found that 51% of the prisoners she interviewed stated that the pettiness and inconsistency of prison rules stripped them of all control (Heney 1990[9]). In this context, self-injury may then be seen as a form of resistance to the prison environment and staff that disregard and misunderstand their needs.

In an environment that ensures compliance through punishment and the withholding of privilege, a false concept of choice is presented; prisoners are blamed and penalised for making the 'wrong' choices (Kendall 1994a; 1994b; 2000). Self-injury is re-constructed as a choice by correctional officials; a bad choice is a threat to the security of the institution and thus merits punishment in the form of segregation.

Disordered Eating[10]

Although there is considerable literature on disordered eating behaviour, very little of it addresses such behaviour within the carceral context. Of the several different

[9] This finding is available at: http://www.csc-scc.gc.ca/text/prgrm/fsw/selfinjuries/selfe04_e.shtml#32.

[10] Given the fact that the majority of the existing psy and feminist literature examines anorexia rather than bulimia nervosa, this review will also focus on anorexia. I will, wherever possible, make reference to bulimia and disordered eating more broadly.

kinds of disordered eating behaviour, I focus primarily on the two most common types; anorexia and bulimia nervosa. Given the amount of literature about disordered eating in general, it was also necessary to limit this review to feminist literature that treats disordered eating as a potential coping strategy. I present a reflexive reading of the existing literature to emphasise the experiential realities of those who suffer from anorexia and/or bulimia nervosa. This approach addresses the gap left by psy discourse, which strives to make connections between disordered eating and identifying features, symptomology, and other potential co-morbid syndromes. In order to contextualise feminist discursive readings of disordered eating, I start by examining psy understandings and the medical positivism associated with the diagnoses of anorexia and bulimia nervosa.

Medical Positivism and Psy Diagnoses of Disordered Eating

Literature from the psy-disciplines tends to explain self-harming strategies only as symptoms of mental illness. It also tends to give a superficial explanation of eating disorders, linking them to an inordinate preoccupation with thinness, body-image, and/or self-esteem that is often linked to media constructions of beauty and the importance of thinness (Hay 1996; David & Johnson 1998; Steiger et al. 1999; Denisoff & Endler 2000; Striegel-Moore & Cachelin 2001; Bekker & Boselie 2002; Mond et al. 2004; Serpell et al. 2004; Moradi et al. 2005; Tylka & Subich 2004; Van Boven & Espelage 2006). When psy-explanations of disordered eating and self-injurious behaviour do attempt to examine these practices as coping strategies, they ignore how the behaviours are, in some cases, useful and positive (Frank 1991; Pitts & Waller 1992; Waller 1992; Striegel-Moore et al. 1993; Leal et al. 1995; Connors 1996; Peters & Range 1996; Deep et al. 1997; Heney &

Kristiansen 1997; Blaase & Elklit 2001; Bardone et al. 2003; Turell & Armsworth 2003).[11]

More problematically, both eating disorders and self-injury have emerged within the context of a medical-discourse that has gendered, individualised, and pathologised these behaviours and ultimately failed to acknowledge the social and contextual world within which they are born (Malson 1995; Wilson 2004; Rich 2006). One common thread that runs throughout the literature on disordered eating is the premise that the sufferer will also have a low self-esteem, typically correlated with higher than average levels of depression, which itself causes the behaviour (Bardone et al. 2003; Mond et al. 2004). Women's lack of self-liking and/or self-confidence is also linked to feminine gender role stress (sometimes associated with media constructions of the importance and beauty of thinness) (Moradi et al. 2005). Bekker et al. (2002) have claimed that highly feminine women are more susceptible to suffering from an eating disorder because of the cultural pressure to be thin. Similarly, Piran and Cormier (2005) argue that self-silencing, anger suppression, and self-objectification are part of a set of socially constructed restraints that are internalised by women and thus affect their emotional and physical well-being.

Some psy constructions of eating-disordered women suggest that disordered eating is a coping strategy, but one that is "depressogenic", "maladaptive", "psychopathological", "avoidance-focused" and/or "emotion-focused" (Steiger et al. 1999; Denisoff & Endler 2000; Bekker et al. 2002; Bardone et al. 2003; Van Boven & Espelage 2006). When applied to criminalised women, this construction not only

[11] Moreover, the majority of research in this area has used college and university students, who are generally quite distinct from women who have been in prison, as their sample populations.

perpetuates the construction of women as psychologically maladjusted and/or lacking, but also ignores the invariable impact of social and environmental contexts on an individual's disordered eating behaviours. Alternatively, some critical scholars (Godderis 2006a 2006b; Smith 2002) have examined the symbolic meaning of food and its use in exercising resistance, subjecthood, and agency in prison. These authors claim that, in prison, food is a tool used to exert penal power and discipline and that it is used strategically by correctional authorities to transform individuals into inmates. Conversely, prisoners may also use food as a medium for exerting a sense of self.

Stress is frequently identified with the onset of disordered eating (Denisoff & Endler 2000; Moradi et al. 2005), although there is very little work available that actually attempts to discuss, theorise, and/or explain this relationship. Given the heightened stress caused by imprisonment, it is not surprising that some women in prison develop eating disorders as a strategy of coping. The link between disordered eating and stress management is supported by Frank's (1991) argument that women who suffer from an eating disorder experience higher levels of guilt and shame, which affect their perception of eating and food. Frank (1991) claims that the ritual of purging, along with excessive rumination about food, eating and weight, are similar in nature to obsessive-compulsive disorder and suggests that further research should be conducted to discover any connection or correlation between the two. Here again, the psy focus on seeking new symptoms and connections to other constructed psychopathologies undermines the beneficial impact that self-harming strategies of coping can have for the individual, and the logic behind using them. Resistant undertones are very important to consider when studying minorities and criminalised populations, but the psy focus relegates the

behaviours to a psychopathology; it is the behaviour of a crazy and maladjusted woman, not a resistant one.

Not only is disordered eating presented as being a maladaptive coping strategy used to combat life stress, it is constructed as a hypersensitive response to social interaction (Steiger et al. 1999). While social self-consciousness is important to consider, explaining disordered eating by a preoccupation with social appearance oversimplifies the behaviours, reducing them to the status of individualised pathologies. For example, Striegel-Moore et al. (1993:297) state:

> Bulimic [and anorexic] women appear preoccupied not only with their physical presentation but also with their social self – how others perceive them in general. A central symptom of eating disorders is preoccupation with appearance – a constant concern with how the physical self is viewed by others. Beneath this manifest symptom seems to lie a pervasive concern with how others view the self in general.

From this vantage point, sufferers of anorexia or bulimia create a social façade or a 'false self', which leaves them feeling like frauds both for their projection of a false self and for their false weight control method (Bruch 1985; Jones 1985; Streigel-Moore 1993; Stein & Cortey 2007).

The claim that eating disorder sufferers have not developed a secure sense of self emphasises women's failure to develop a fluid identity. Instead, disordered eating women's identities are constructed as static, fixed on negative self-schemas that cause them to manage this negative self-perception through weight control (Stein & Cortey 2007). Disordered eating is still seen as a coping strategy, but one that emerges as a result of the individual's failure in terms of their identity development and ultimately their individual psychology. The most problematic aspect of these psy accounts of

disordered eating is that they rely so heavily on individualised, bio-medical or quasi-medical explanations of anorexia and bulimia nervosa as distinct clinical entities (Malson 1997:223).

Part of this biomedical orientation has been devoted to identifying the symptoms of disordered eating so that doctors, psychiatrists, schoolteachers, and the parents of young and teenage girls can recognise the 'signs' of an eating disorder. Early identification is desirable so that experts can intervene before the behaviour reaches a danger point. The recognition of the individual's potential history of sexual abuse or trauma seems particularly important for identifying signs and symptoms of future disordered eating behaviour. Especially pertinent for criminalised women, the link to sexual abuse is commonly expressed as one of many co-morbid symptoms of disordered eating, including substance use, borderline personality disorder, obsessive-compulsive disorder, depression, and anxiety (Pitts & Waller 1993; Waller 1993; Connors 1996; Peters & Range 1996; Heney & Kristiansen 1997; Deep et al. 1999; Turell & Armsworth 2003).[12] Psychoanalytic and psychiatric explanations of these links rely more on the construction of disordered eating and self-injurious behaviour as forms of trauma re-enactment, which illustrates the over-reliance on the creation of new 'syndromes' to classify certain kinds of behaviours (Miller 1994). Ostensibly, arguing that an individual is expressing self-punishment due to self-loathing caused by sexual trauma is logical, and while it is important to examine the critical and experiential histories of the populations we study, merely acknowledging that many anorectic and bulimic women have experienced sexual trauma does little to help us understand the connection. Indeed, few

[12] These same links to past sexual abuse and trauma are made for self-injurious behaviour. (Heney 1990; Connors 1996; Heney & Kristiansen 1997; Turell & Armsworth 2003).

authors who have found statistical significance in the connection between sexual abuse and disordered eating have gone on to explain this link.

We must not be seduced by simple cause and effect explanations and keep in mind that sexual trauma is not a necessary or sufficient condition of disordered eating since many women who have experienced sexual abuse do not develop eating disorders.

Feminist Discursive Readings of Disordered Eating

Due to the fact that disordered eating has been, in a sense, discovered, identified, and explained through the lens of a medical model, understandings of disordered eating as an expression of self have been marginalised in discussion about treatment. (Bordo 1993; Malson 1995; Malson 1997a; Malson 1997b; Malson & Ussher 1997; Malson 1999; Malson & Swann 1999; Goodin 2003; Wilson 2003; Rich 2006). In Benveniste, Lecouteur and Hepworth's 1999 research study, anorectics discussed the aetiology of anorexia nervosa as being structured through two key discourses – sociocultural and individual. The authors write:

> First, the location of the problem indicates that changes to cultural representations of women may decrease the incidence of anorexia nervosa. Second, the sociocultural discourse avoids victim blaming which implicates the individual woman in the onset of the perceived pathology of anorexia nervosa. In contrast to the sociocultural discourse, the discourse of the individual constructs the cause of anorexia nervosa in terms of factors internal to the individual, such as personality (Benveniste, Lecouteur & Hepworth 1999:62-63).

The impact of socio-cultural demands for thinness, and thus the influence of hegemonic constructions of femininity and masculinity, constructs women as "pathologically susceptible to media images" (Probyn 1987:203). From this position, women who suffer from disordered eating are failing to self-govern according to the

accepted notions of femininity and womanhood prescribed by a patriarchal society. The adoption of a critical and feminist lens requires shifting our focus from these explanations to concentrate rather on a critical and gendered understanding of disordered eating.

Unfortunately, the majority of feminist literature has focused almost exclusively on anorexia nervosa, effectively ignoring bulimia nervosa. One reason for this exclusion is that the physical effects of anorexia are much more obvious – emaciated figures, frail, and skeletal – while bulimic women can hide their illnesses because they show fewer outward signs of the disease. For example, Burns (2004:282) writes that, "unlike the body produced by anorexia … the 'end product' of bingeing/purging is a visibly normal body, which escapes public scrutiny." I agree with Burns' conclusions that bulimia is "embedded on the derogated side of the eating disorder binary" (2004:283) because of "the public fascination with the figure of the anorexic [which] amounts to a fetishization" (Bray 1996:413). Gendered constructions of women's bodies are structured on a body image that is modelled on deficiency (Bray 1999); to be without, to be small, to be dependent on others. The anorectic and/or bulimic woman has not only accepted these gendered notions of femininity, she has also embedded them within her identity politics and practices of self-hood, exhibited by a form of extreme control and self-mastery. She has gone too far; she is seen as having become pathological about the very practices and notions she is supposed to embrace.

The anorexic and/or bulimic body is a fluid construct, always already developing, forming, and emerging. Problematically, psy diagnoses of anorexia [or bulimia] create a medical discursive identity whereby any other understanding of the anorectic's identity is

marginalised (Bray 1999:424). From there, we can see how biomedical and psy knowledges become authoritative (Bray 1999; Bell 2006). Bell (2006:293, 300) writes:

> My identification of the anorexic "prisoner" is threefold: She is struggling with her own (culturally constituted) desire to overcome the prison of her unruly female body; her pathologization for these efforts draws her into the "prison" of medical panopticism; and, once "re/formed" from her pathological state, she will return to the more subtle, though no less ever-present, panoptic regime of normative femininity.
>
> The anorexic patient/prisoner has failed to appropriately control her body. Taking up the sociocultural theme of control over the body, this medical discourse first penalizes the anorexic woman for adhering too well to the desire for bodily control and then demands her re/formed adherence to this same impetus.

While Bell suggests that the anorexic patient/prisoner is constructed by biomedical reasoning to have failed to appropriately control her body, Burns (2004) takes this analysis further by suggesting that anorexia represents both total control and total denial, while bulimia represents a complete absence of control. Burns' work highlights how anorexia and bulimia are actually constructed in biomedical and socio-cultural literature as a dichotomy, where anorexia is more valued because of the self-control it reflects and the resultant culturally accepted thin body it produces. Bulimia is seen as repulsive due to its association with a loss of control and indulgency, and as "revolting in its final scenario (the vomit spattered toilet, the streaming eyes, the stench)" (Burns 2004:269).

The dichotomous construction of anorexia and bulimia is also evident in some of the psy literature that associates anorexia with personality characteristics and behaviours such as perfectionism and self-control, and bulimia with rebellion and drug use (Burns

2004). In the following passage, anorexia is held up as the "epitome of control" (Burns 2004:277):

> Women with anorexia have something extra that just pushes them there, which distinguishes them from the weakness or indulgence embodied by bulimic women. According to a hierarchical and dichotomous construction of indulging one's appetite as 'the body out of control' and not eating as 'the body in control', bulimia and anorexia are represented as failure and success.

By explaining the relationship between the two eating disorders, Burns clarifies the common connection between anorexia and bulimia and the ineffectiveness of constructing them as opposing or mutually exclusive categories. Bordo's (1993) analysis of disordered eating suggests that anorexia embodies an abnormal capacity for self-denial, while bulimia is reflective of "western culture's "schizophrenic" relationship with food – where women are encouraged to indulge and are simultaneously chastised for their consumption" (Burns 2004:285).

Substance Use

It is beyond the scope of this literature review to provide a comprehensive examination of the field of substance use and addiction studies. As with self-injury and disordered eating behaviours, much of the substance use literature identifies connections between substance use as a way of coping with earlier trauma and particularly, experiences of sexual trauma. Sexual assault is commonly constructed as a most heinous and traumatising crime and as the criminal activity that causes the most pain and suffering for its victims. As such, there have been frequent attempts to understand its impact and how individuals cope with having been victimised in this way.

Without minimising the coping role substance use serves for individuals who have experienced sexual abuse, we must recognise that there is very little literature on self-harming behaviours as they relate to coping with other stressors, such as imprisonment. Drug use is only one of many diverse responses to imprisonment, and has been shown to be both positive (as a source of joy and as a useful method of coping through self-medication) and negative (as a source of chaos and destruction in one's life) (Alexander 1990 as cited in Boyd 1994:163). While not all drug use is negative or related to coping, since my participants described their substance use as a technique used to help them cope with their life's stresses, I have reviewed the literature that examines substance use as a way to cope with past sexual abuse, and as a method of coping with imprisonment[13]. In addition, because it evolved as a key finding of this research, I also review the literature that discusses the reconstruction of a non-addict identity as an important precondition to overcoming addiction and attempting to shed the stigma of criminalisation.

Coping with Past Sexual Trauma and Imprisonment

Much of the literature that examines substance use as a form of coping originates from the psy disciplines and draws on constructions of and debates between emotion-

[13] It should be noted that while the women acknowledged their drug use as a source of fun, enjoyment and resistance both in and outside of prison they universally agreed and primarily spoke about how over time their drug use became negative and a source of chaos and destruction in their lives. Given the fact that I interviewed street level substance users as opposed to a more heterogeneous population of users this finding is not surprising. Moreover, because my participants focused on their substance use as a negative addiction there is an underlying assumption of harm associated with how substance use is presented in this dissertation. This may reflect mainstream and correctional discourses of addiction and treatment. Finally, it should be noted that not all drug use is negative, nor is it necessarily harmful; however, following the grounded theory methodological approach I have focused primarily on those instances of negative addiction as they are expressed by my participants. For more critical examinations of drug use and treatment see: Boyd 2004; Reinarman 2005; Reinarman & Levine 1997; Valverde 1998; Wagner 1997).

focused coping, otherwise known as avoidance coping (finding ways to regulate the emotional consequences of stress), and problem-focused coping (finding practical and effective behavioural responses to help cope and deal with the source of stress). Coping strategies are conscious and purposeful attempts to reduce stress and are often differentiated as being either adaptive or maladaptive, the latter generally seen to be ineffective overall (Pimlott et al. 2005). The psy literature repeatedly refers to substance use as an avoidant style of coping, which is also described as 'maladaptive'(Weaver et al. 1999; Bonin et al. 2000; Simons et al. 2003; Littleton & Breitfopf 2006). Although finding less physically harmful ways of coping is of course preferable, labelling substance use, or self-injury and disordered eating, as "maladaptive" dismisses its beneficial consequences, for example helping calm the individual who is either upset or experiencing stress (Pimlott et al. 2005). These are the same effects recognised for prescription psychiatric medications, which are aggressively promoted as safe and effective. More problematically, beneficial aspects of self-harming behaviours are often overshadowed by the negative side effects and/or consequences of these behaviours. For example, a circular relationship exists between substance use and prostitution by women. Women who engage in sex work often do so in order to support their drug habit, but their continued involvement in sex work is also linked to their increasing drug use (Young et al. 2000).

Observers who have described substance use as a form of 'avoidance coping' for women who had experienced sexual, emotional and/or physical abuse have stated that, "it is the response to a traumatic event, rather than the presence or absence of a specific traumatic event, that is tied to alcohol [or other substances] to self-medicate" (Simpson,

2003:261-262). As a result of either childhood or adult sexual abuse or assault, victims often become more reliant on avoidance coping strategies, including substance use as a way to self-medicate (Cope 2003; Littleton & Breitkopf 2006). Self-medication as a coping strategy is often indicative of self-blaming for the sexual trauma experienced by the individual (Littleton & Breitkopf 2006). Supportive friendships and social networks help to provide a kind of buffer for the victim of sexual abuse; victims of sexual abuse who did not have a wide and supportive social network have relied rather on substance use as an avoidance coping strategy (Simpson 2003; Littleton & Breitkopf 2006). While there is virtually no literature on the subject, it may be that criminalised women, who already experience stigma as a result of their criminalisation, have fewer social support networks and may be more likely to turn to substance use as a way to cope and/or avoid emotional distress.

Given the link between past sexual trauma and substance use and the fact that criminalised women have higher than average rates of sexual abuse histories, it is not surprising that they also have higher levels of substance use. However, what we must remember is that all women who have been sexually abused do not engage in self-harming behaviour. Pimlott et al. (2005:172) claim that "the extreme power differentials that exist in prison require coping that sustains survival – perhaps sacrificing short-term action, which may result in more harm, for long term safety." The authors suggest that women prisoners with histories of sexual assault may not be able to invoke 'problem-focused' coping strategies while they are incarcerated because the carceral context is such a highly controlled environment. Such an environment dissuades individual self-control, self-expression, and self-empowerment. For example, criminalised women's drug use is

often thought of as peripheral or an adjunct to men's; women substance users are often constructed in correctional and psy discourse as having transgressed socially accepted norms and standards of feminine behaviour and womanhood (Malloch 1999:352). Unlike men, women commonly report using illicit drugs in order to lose weight and to "fulfill the normative feminine criteria of 'looking good'" (Malloch 1999:355). This finding illustrates a uniquely woman-centred understanding of substance use as a way to cope, and as a method used to attain a specific kind of appearance or outward identity that may be directly linked to personal feelings of self-worth or confidence.

Filipas and Ullman (2006) found that women who had reported having experienced childhood and adult sexual abuse were more likely to suffer from post-traumatic stress disorder, and as a result of this were also more likely to use drugs and/or alcohol to cope. Many women have reported that they turned to their doctors for prescription medication to help them cope with the stress, anxiety or depression caused by having been victimised by sexual assault (Sturza & Campbell 2005). The authors denounced this as the medicalisation of sexual abuse; doctors either prescribed medication too quickly and/or upon request, without having full knowledge of the sexual abuse, or they systematically turned to prescription medication when women disclosed their experiences of sexual trauma. The women who disclosed their experiences of sexual abuse to their doctors reported feeling hurt and upset because they felt that their doctors did not encourage them to discuss their feelings, did not refer them to counselling services and only offered to medicate them. Medicating these women actually reinforced their feelings that something was wrong with them, and encouraged the internalisation of their negative feelings and self-blame for the sexual abuse (Malloch 1999; Sturza &

Campbell 2005). Given the historical documentation of the over-prescription of psychiatric medication to women, especially criminalised women (Chesler 1972; Ussher 1991), this medicalisation of sexual assault victims is saddening but not surprising.

Choice or Disease[14]: The Substance Using Self

Substance use in prison is common despite frequent searches and the illegality of possession. Nina Cope (2003) concluded that illegal drug use in prison is used strategically as a way to cope with the slow passage of time. However, Cope writes that "total autonomy with regard to passing time is probably rarely achieved, although the extent of external control over time will vary considerably (2003:159)." Despite disciplinary technologies that operate to secure control and manage the lives and time of prisoners, there is still a great deal of unstructured time during which individual prisoners must occupy themselves (Brown 1998; Medicott 1999; Cope 2003). Giddens (1984) suggested that routines and structured time provide ontological security. Free or unstructured time in prison may cause prisoners to feel insecure as they are forced to come to terms with their new identities as prisoners. Substance use can be a way for prisoners to cope with imprisonment (by suspending time) and their newly emerging prisoner identities (Cope 2003). Substance use can thus be understood not merely as a way of coping, but also as a strategy to escape, forget or suspend time, as well as to confront and/or deal with personal life stressors.

[14] It should be noted that the dichotomous framing of substance use as either a disease or a choice actually confines the analysis to traditional paradigms – and excludes the possibility for a different and more nuanced approach. However, my participants consistently referred to this binary and it is therefore important to present the literature that addresses these two streams of thought. A more critical analysis of using dichotomous thought as a way to frame issues will be presented in the concluding chapter of this dissertation.

On the other hand, substance use has also been found to increase stress due to the creation of a substance-using identity. To identify oneself as either a substance user or the more stigmatised 'addict', is to accept this label as a component of one's individual identity. Brenda Geiger and Michael Fischer (2005) claim that prisoners often reconstruct their identities to reject the substance user (or addict) identity to protect their understandings of self by embracing a more positive and socially acceptable construction of person or self-hood. The authors suggest that to:

> ... [a]ppeal to human strengths and virtues, such as skill, loyalty, and honesty, was another potent strategy to reject the deviant labels by challenging the boundaries between conventional and delinquent worlds. By calling themselves honest thieves, and/or reliable drug dealers, offenders stressed self-confidence and personal worth in both worlds. Appeal to human strengths and virtues that transcended both conventional and street norms allowed for the outright denial of deviant labels and/or for an identity split into a good and a bad self (Geiger & Fischer 2005:203).

In order to construct a favourable identity or self-concept, criminalised women frequently reject stigmatising labels (Geiger & Fischer 2005). It often becomes important for criminalised women to reconstruct substance use as something that was done occasionally and only during a short period of time in their lives. Distancing one's personal self-concept from the substance using self (bad self) is an important component in the recreation of the sober or clean self (good self).

For criminalised women, a frequently cited way of rejecting deviant or stigmatised labels and self-concepts is to re-emphasise and re-focus on their identities and roles as mothers (Geiger & Fischer 2005). As the authors note, it is paradoxical for criminalised women to try to adopt the role of motherhood as their master status:

> Motherhood is for female offenders the only realm within which they could gain or show a sense of competence. Separation from children destined female offenders to become anomic, without a centre or future direction. Paradoxically, for female offenders adherence to the master status of motherhood compromised gaining any positive sense of self. The only way they were expected to gain a sense of worth and personal strength in both the conventional and street world was to fulfill the essential duties of motherhood successfully. These normative contexts constrained female offenders to attribute to self rather than to others the blame for neglecting their maternal duties (2005:206).

This paradoxical relationship between understandings of one's substance using self and one's identity as a mother is important. While re-emphasising one's status as a mother may help the individual to overcome her negative self-concept, because of the potential for feelings of failure, it may actually at the same time reinforce the negative self-concept the person is trying to manage. Women in prison have not only transgressed the normative standards of acceptable femininity as the result of their criminality and substance use, but also because of their failure at being 'good', selfless, and nurturing mothers.

Susan C. Boyd (1999) describes in detail how women's illicit drug use is used to discredit their status as 'good' mothers. The literature presents substance users as having the potential to change their identities by socially reconstructing their understanding of their substance use and addiction; the initial discovery that substance use hinders their abilities to mother their children and that being clean and sober will allow them to be good mothers. In fact, Baker (2000) suggests that, in order to break the paradox of using motherhood as a strategy to gain personal strength and a positive self-concept, individuals must "transform their identities to those of 'ordinary' people. This can be done by reverting to an old identity (true self), extending an identity present during addiction, or creating a new, emergent identity" (Baker 2000:864).

McIntosh and McKeganey (2000) support this notion by indicating that constructing a non-addict identity is integral to the recovery from addiction and that this construction usually takes place while the individual is in treatment, seeking recovery. In fact, these authors claim that the context within which the individual attempts to reconstruct their self-concept and identity impacts how and in what ways the individual manages to alter their new self-constructed identity (McIntosh & McKeganey 2000; Plumridge & Chetwynd 1999). Baker (2000) suggests that women often make identity transformations based on the beliefs expressed in the programs they are attending. Rather than denying the construction of substance-using women as inadequate mothers, current gender-sensitive treatment programs frequently place a great deal of importance on providing substance using women with better parenting skills (Baker 2000; Plumridge & Chetwynd 1999). For example, when recreating a non-addict identity in a gender-sensitive treatment centre that focuses on parenting skills training, women may begin to emphasise their motherhood status as a key defining feature of their identity, distinctly separate and mutually exclusive from their substance using identity. Similarly, prisoners have been found to espouse the rhetoric of the correctional programming they are required to take while incarcerated (Bonnycastle 2004).

Assembling a new non-using identity often requires that women adopt a sense of emotional well-being and happiness about being clean and sober. Baker (2000:872) writes that:

> Identifying oneself as a good mother was an important part of the shared identity of the women in gender-sensitive treatment. The discovery of their poor mothering practices while using, the importance of their children to them in general and in treatment, and their children's physical and emotional needs each contributed to a discourse about parenting that became an essential component of the new identities these women crafted

> during treatment. Most women I interviewed and observed during treatment became aware that substance abuse negatively affected their parenting practices. A second discovery these women made related to their parenting was that their children were important to them and to their treatment.

Ultimately, women substance users who are also mothers have to find new ways of coping if they are to be emotionally happy about their new status as clean and sober non-users. Many authors have found that in order for women to be able to accomplish this identity shift, they must 'discover' that their children deserve a different and better lifestyle and a mother who is available emotionally and physically and who will prioritise their needs over using (Baker 2000; Boyd 1999; McIntosh & McKeganey 2000).

The literature reviewed has presented substance use and addiction as something that the individual controls. Adopting a non-using or sober identity as a strategy to help reinforce a clean lifestyle refers to the construction of substance use as a choice, made by the user. Surprisingly, while there is much debate about whether addiction is a choice, or a disease, few authors have tried to explain this as a dichotomy, as two sides of the same coin. There is little agreement about which model can best explain individual substance use or one's potential for recovery. Is it as simple as saying that choice refers to behaviours and actions, while disease is an uncontrollable biological, chemical, and ultimately corporeal and bodily experience? Is this merely revisiting the nature versus nurture debate?

The disease model is accepted both in popular outpatient and continued care support groups such as Alcohol and Narcotics Anonymous as well as in the biomedical sphere of research that seeks to identify prescription medications that are useful in 'treating' or helping the individual avoid substance use. Experiential narrative accounts

of substance users reveal mixed reliance on the choice and disease models of substance use. Former addicts describe both their lack of power over their drug use and their ability to become sober after hitting 'their bottom' and realising that survival required change (Miller & Carroll 2006).

Chapter Summary

This chapter has reviewed literature in three ever-expanding topic areas – self-injury, disordered eating, and substance use – which, in turn, fall under the broader label of self-harming behaviour. I attempted to present some of the main issues and key debates found in the literature on each of the three topic areas. It was especially important to note the differences in language and theoretical understanding regarding self-injury, as these differences generate distinctly different treatments or responses, especially in the carceral context. There is surprisingly little literature that addresses self-injurious behaviour; the most predominant approach comes from the psy disciplines where self-injury is constructed as attention-seeking and manipulative behaviour or as a symptom of some greater mental pathology. Correctional responses to self-injury reflect psy discourse modified to suit a punitive and neo-liberal framework and are reified by the practice of segregating women who engage in self-injurious behaviour. Feminist literature, on the other hand, suggests that self-injury is a way of coping with stress associated with imprisonment, where women prisoners have few avenues for coping and self-expression available to them.

Disordered eating (anorexia and bulimia nervosa) is commonly identified in the psy literature as a maladaptive form of coping. Much of this literature points to the fact that many women who suffer from anorexia or bulimia have histories of sexual abuse but

surprisingly little is presented to explain this connection. Feminist literature, which does acknowledge the link between disordered eating and sexual abuse, suggests that this form of self-harm is better explained as a strategy of coping and an attempt to gain control one's life and body. This explanation is particularly relevant when studying criminalised women, who, when living in a neo-liberal carceral environment, are exposed to moral and managerial technologies of discipline aimed at re-constructing their behaviour and that leave few opportunities for individual self-expression. In this light, disordered eating like self-injury, can be understood not only as a way to cope with stress but also as a means of expression. They are therefore expressions of identity.

Finally, I examined the literature on substance use which, like both self-injury and disordered eating, is linked to past histories of sexual abuse. Substance use is commonly presented as a maladaptive form of coping that is generally referred to as avoidance or emotion-focused. Few authors discuss the pleasurable, adaptive, or beneficial effects of substance use. While there is a clear divide between the choice and disease models of substance use, very few authors have attempted to theorise this dichotomy, which leaves a glaring gap in the writings on substance use. The literature that does address the importance of identity negotiation and stigma management demonstrates a reliance on the choice model. The user is constructed as having the ability to make the healthy changes and decisions required to become a non-user (described as a process of identity and self-concept reconstruction). To help generate a clean or non-using identity, women often re-emphasise their roles and statuses as mothers, which seems to provide both a motivation for change as well as credibility for their newly emerging identity.

In the next chapter I outline the first part of my theoretical framework. More specifically, I focus on feminist examinations of governance, power and psy-care as they pertain to criminalised women.

Chapter 2
Theoretical Framework Part I - Regulating Criminalised Women: Carceral Governance in Neoliberal Times

The theoretical framework that I have generated is in fact an integrated one since no single theory had the capacity to explain all of the issues that emerged during this study. I have assembled my own 'theoretical toolbox' full of the most pertinent vocabularies and conceptual tools that I used in this dissertation. To begin with, it was essential to embrace a critical and feminist perspective. In fact, feminism is the critical lens through which this research has been envisioned, conducted, analysed and ultimately crafted. I begin by examining feminist literature that critiques positivist constructions of madness in women. Given that it aims to re-centre women as rational actors in order to deconstruct the portrayal of criminalised women as suffering from some kind of syndrome, feminist literature is the most appropriate theoretical starting point for this dissertation. Therefore I begin this chapter by examining those technologies of discipline that operate via psy and medical discourses and that are used to explain the behaviour of criminalised women. Following this discussion I examine those technologies of the self (empowerment and responsibilisation) that are endorsed by correctional discourses, and how they may come to impact women's constructions of self. In closing this chapter I outline three familiar dichotomies and theorise how they are related rather than existing as mutually exclusive categories.

Technologies of Discipline: Of Syndromes, Pathologies, Mad Women and Bad Biology

Theorising women's bodies as malfunctioning, evil, dangerous, lacking, or as 'always already' trying to be more masculine constructs women as inherently 'mad, bad, or sad' (Smart 1995; Frigon 2000). Explanations of women's madness tend to compare women against a male normative standard, resulting in the pathologisation of women (Smart 1995; Astbury 1996; Suyemoto 2002). Mental illness has historically been constructed as a problem of female difference. "It became an easy matter to prove that it existed and that women departed in a pathological way from the ideal of a male norm; in other words, women were deviant by definition" (Astbury 1996:3-4). Consequently, women are more likely than are men to seek psychiatric counsel to cope with their (supposedly) problematic and overdramatic emotionality (Chesler 1972). Increased reliance on psy intervention is not indicative of more mental illness among women but rather that women are socialized to seek help while men are not (Chesler 1972). Women are encouraged to self-medicate, self-loathe, and self-deconstruct because they are fallible, imperfect and un-pretty. Women are never 'enough' and are constructed by the medical, psy, and criminological literature as beings always striving to complete themselves, to find what they are 'lacking'. The continual presence of women as psy-patients suggests that women attempt to manage rather than cure their ills. Is this the neoliberal construct of self-responsibilisation, or does this mean that 'psy-care' is both an ironic construct and an erroneous belief?

Nineteenth century psychiatric care focused on moralising 'asylum patients', and was often done through religiously inspired torture. Those labelled mad were infantilised, deemed unreasonable and unable to accurately assess their own needs

(Russell 1995; Smart 1995). This treatment foreshadowed how women prisoners would be treated in the centuries to follow. In both cases doctors became father figures that re-moralised, re-educated, and re-constructed women in the likeness of a responsibilised subject. Foucault (1965) has suggested that the 'moral treatment' of the mad included: Ignoring the voice of the individual (because of their craziness) no matter how elegant their discourse, forced self-reflection (so they would realize that they were in fact crazy), and constant surveillance and judgement (1965). Foucault writes:

> Reason's victory over unreason was once assured only by material force, and in a sort of real combat. Now the combat was always decided beforehand, unreason's defeat inscribed in advance in the concrete situation where madman and the man of reason meet. The absence of constraint in the nineteenth-century asylum is not unreason liberated but madness long since mastered (1973:252).

If madness is long since mastered, and with the exception of closed forensic settings women are more often subjected to psychiatry's gaze, psy-care must be seen as another method used to regulate women.

Women are held to a higher moral standard than are men because of stereotypical expectations of womanhood. Women are not supposed to reveal their passions, wants, or anger, and when they do, they are syndromised as mad (Ussher 1991; Smart 1995; Maracek 2002). In reference to hysteria Foucault writes:

> The notion of hysterization of women, which involved a thorough medicalization of their bodies and their sex, was carried out in the name of the responsibility they owed to the health of their children, the solidity of the family institution, and the safeguarding of society (1979:146-7).

This syndromising effect of hysteria[15] and more recently borderline personality disorder and mood disorders fails to take into account the socio-political context within which women's emotionality and criminality are born (Smart 1995; Suyemoto 2002).

Not only are women more likely than are men to come into contact with the psy-disciplines, but as Russell writes,

> From the perspective of biological psychiatry, nearly all women are disordered. Even if we take into account only depression and premenstrual syndrome, it is difficult to imagine many women falling outside this net. It is no surprise, then, that criminal women are viewed as psychiatrically disordered (1995:96).

Russell demonstrates how the law does not allow for a female criminal subject because criminalised women are deemed irrational and/or mad.

Medicine and psychiatry have been instrumental in shaping women's identity and personality, mainly because of the perceived legitimacy these expert disciplines hold (Rose 1990, 1996).

> The long ascendancy of the belief that women's psyches created their own distress, unmediated by the conditions of their lives or what happened to them, has formed an almost insuperable obstacle against which women have had to struggle in attempting to have their perceptions and experiences taken into account in clinical practice and in the explanatory models that inform psychiatric practice (Astbury 1996:23-34).

This dynamic is most compelling within the prison setting, where women are encouraged and arguably coerced to engage with and embrace psy-diagnoses and psychopharmacological treatment (Penfold & Walker 1983; Ussher 1991; Russell 1995; Smart 1995; Penfold 2001). The growing range of diagnostic categories and the ever-

[15] The word hysteria is derived from the Latin term 'hystera', which means uterus. Women's irrationality is embedded in biologically deterministic discourse that renders the female body disabled and malfunctioning.

expanding selection of drugs, in general and more specifically in the prison context, demonstrate the impact of psy-based treatment/interference based on theorising women's 'own good' (Smart 1995; Astbury 1996).

Psychiatry's unshakable dedication to scientificity and objectivity (and as a result the equitable application of treatment and diagnostic criteria to men and women) suggests that the discipline possesses incontrovertible truths regarding human behaviour and emotion (Penfold & Walker 1983; Farber 1990; Leifer 1990). With the discursive shift from 'madness' to 'mental illness', the new experts find their power not in the definition itself, but in the power to identify, name, label and define (Penfold & Walker 1983:21). This power to define the rational and irrational or sane and insane behaviour has given the men who have historically theorised women's mental illness "the power to prescribe and proscribe the nature and the role of women in society" (Penfold & Walker 1983:28). For generations, these knowledges remained unchallenged because women's knowledges were subjugated. Psychiatry has therefore proposed explanations that categorise and diagnose based on social norms that have been produced within a hierarchical and patriarchal society.

The medical model is based on divisions between normality and abnormality, usually associated with gender. Penfold and Walker suggest an alternative starting point:

> ...that proposes that human growth, development and consciousness are shaped and given definite form by the experience of living in a particular location within the social structure. This is a view that allows for the consideration of different experiences of domination and subordination, power and powerlessness, not as a matter of personal fault, misfortune or choice, but as the outcome of living out the structuring of social relations in a group or society where power and resources are not equitably distributed (1983:39).

Therefore, definitions and diagnoses are not infallible truths; they are commonly agreed upon assumptions made by designated experts. Sane behaviour is identified according to a code within the medical model, through which psy experts attempt to differentiate appropriate and inappropriate behaviour (Leifer 1990). Definitions of (ab)normality come from the social and moral consciousness of those with the power to define, typically, white upper-middle class men. The discourses that label women as mad are regulatory practices that seek to maintain women's historic construction as irrational (Ussher 1991).

Certain images continue to influence our view of women; the witch, the bitch, the mother, the Madonna, the whore, the man-hater, the lesbian, the blonde bombshell Barbie-doll, or the femme fatale. Penfold and Walker (1983) suggest that these myth-constructions are representative of men's ambivalence toward women and I argue that these images are also indicative of men's fear of women and of their capabilities. As part of our consciousness, those images are a part of life's (hierarchical) structure and regulate meaning within society. Women's power is imagined only in relation to men's power. Archetypal images and Cartesian dualisms have created binaries of thought that construct women as the (inferior) antithesis of men, so much so that women came to embody deviancy (Penfold & Walker 1983; Ussher 1991; Kilty 2003). When considering the impact of dichotomous thought, women are divided further into constructions of the good and bad woman (Kilty 2003). Women criminals are constructed as all that is negative and irrational about womanhood; they are mad and bad and therefore dangerous.

Rather than viewing the increase in prescription drug therapy to control psychiatrised and criminalised women (Pollack 2006) as a signal to change the way

institutions govern their populations, it has been used tautologically to validate the increase. As the thinking goes, there is an increase in deviant, mentally ill and criminal populations, which calls for an increase in the use of drug treatment. At the same time, the increase in drug treatment is used to indicate growth of the population of deviants in society. The symptoms are vague and indistinct so that too many people are now able to self-diagnose and medicate, creating a 'culture of symptomology' exemplified by the dramatic increase in drug advertisements on television and in magazines (Healy 2003).

Constant happiness is the goal, as though sadness and its role in identity formation is not permitted. It becomes unacceptable to grieve, mourn, feel loss, feel lost, or feel unmotivated. Better that we remain constant since any fluctuation in a woman's mood will be constructed as abnormal and hysterical. "To discuss madness in terms of illness is to mystify and falsely legitimate a moral judgement" (Ussher 1991:132).

The increase in the use of diagnoses of mood and personality disorders for women (Russell 1995; Farber 1990; Leifer 1990) is particularly troubling because of Ussher's suggestion that madness acts as an indicator that positions women as Other[16] (1991:11; Farber 1990; Leifer 1990). Psy discourses are used to both assign and deny women agency. Criminalised women are constructed as evil, dangerous, and even more terrible than criminalised men.[17] The dominance of psy discourse is "based on the belief in a physical aetiology for madness, which serves political ends. It allows psychiatrists to maintain the continuity between physical and mental illness and to deny the role of social, economic or political factors in madness" (Ussher 1991:133). By attempting to

---

[16] The term 'Other' is derived from Simone de Beauvoir's classic 1959 text, *The Second Sex.*

[17] As indicated earlier, this idea with respect to criminalised women first appeared in Lombroso and Ferraro's 1895 text, *The Female Offender.*

maintain a connection to a physical aetiology of madness, psy discourses operating within the medical model shift the focus onto the innate deficiency of the woman rather than addressing the fact that the problem may reside elsewhere, within society.

With respect to the construction of madness as irrationality in women, Ussher contends that:

> ...madness is the absence of reason or rationality is seen as an explicit assumption of the positivistic argument, for the model which sees madness in terms of 'cause' and 'effect' implies the person is not a rational agent, he or she having been *made* to behave in a particular way. It is implicit within the positivistic discourse that the mad person has no control (Ussher 1991:146).

If the absence of reason separates madness from badness, what then do we make of women prisoners who engage in self-harming behaviour? If they are not mad but are bad because they are prisoners, then how do we define self-injury, disordered eating or substance use? Correctional authorities cannot accept self-harm as a symptom of madness because this would disqualify the use of imprisonment and segregation. Madness would be beyond the individual's control and would have to be treated differently from punishable behaviours. Self-harm is therefore constructed as the inability to self-responsibilise, self-govern or manage; it is written off as attention seeking behaviour used by manipulative 'bad women'. According to both of these approaches, the problem remains within the woman and is used to reinforce the hierarchy of therapy within the prison (Farber 1990; Leifer 1990).

Ultimately, we must remedy the over-classification of normal, but diverse, reactions that women may have in a society that oppresses them. It is important to listen to a plurality of women's voices in order to understand how the structure of

pathologisation functions to systemically discriminate against women (Jhappan 1996; Suyemoto 2002). We should acknowledge that:

> If behaviour were always described with the causal-deterministic model, choice and responsibility would become meaningless terms. No one could be held accountable for his or her actions and the drama of our lives would lose significance. This problem is not sufficiently discussed, in my opinion, because open dialogue on this issue would undermine the medical identity of psychiatrists and would call into question the morality of using the medical model as an ideology to justify social control (Leifer 1990:255).

Women prisoners are thus doubly or triply marginalised – as women, as mentally ill, and as criminals. Pathologising criminalised women will only worsen their correctional treatment by dismissing their claims as irrational, all the while 'medicating away' their very real and normal responses to imprisonment.

Technologies of the Self: Empowerment and Responsibilisation

With the ascendancy of neoliberalism in the late 20th century came a modification of the dependency argument. The goal became the empowerment of the individual (Cruikshank 1994). Empowerment focuses on individual agency since individuals are responsible for managing themselves, particularly their health. Neoliberalism diffuses state power exemplified in welfarism and demands that citizens become empowered and self-governing (Cruikshank 1994; Garland 1985, 1990, 2001; Hannah-Moffat 1999, 2001). This shift marginalises specific populations such as the mentally ill, children, the poor, racialized minorities and prisoners who do not have the means to become 'empowered.' Criminalised persons are no longer in need of care, treatment, or rehabilitation because they are constructed as 'beyond repair' (Melossi 2000).

Neoliberalism reconstructs criminals as dangerous because they have failed to empower themselves (Pratt 1997). Here, 'empowerment' is a term that has been co-opted from feminist literature, and similar to the terms 'rights' and 'social justice', is treated very differently by neoliberals (Hannah-Moffat 1999, 2000, 2001). The discourse of empowerment has been lost in translation, so to speak, because of its displacement from radical feminist roots. Hannah-Moffat writes,

> More recently, the concept of empowering individuals (whether they be the poor, workers, patients, immigrants, students, citizens, or prisoners) has become popular in various political and policy circles. The widespread use of this term in everyday language has gradually depoliticized or deradicalized the language of empowerment, so that nowadays both advocates and policymakers easily resort to it (2001:168).

Barbara Cruikshank outlines four features of the political relations that construct the notion of empowerment (1994). Empowerment is a rationality of government based on a new knowledge and a form of expertise regarding the population being empowered. It is essential for those who seek to empower to understand and 'know' the population that they are supposed to enable (Cruikshank 1994). For women prisoners, this process entails a self-description or a revealing of personal information, which is used by the prison officials and psy-experts to empower criminalised women through correctional and psy programming. Practically speaking, prisons must 'know' the population of prisoners, their physical health status, mental health status, status of their legal issues, family relations, visitors, friends, habits, education level, addictions, history of abuse, etc. In this sense, the prison must have experts on hand to offer strategies and technologies of empowerment in the forms of a correctional plan, health care plan, mental health care

plan, educational/vocational plan etc[18]. At the same time, prisoners must become empowered to engage in these programs. If they choose not to, the length of their sentence may be extended because they have not become responsibilised since they will have failed to prove themselves capable of self-government.

These relations of power also involve a "voluntary and coercive exercise of power upon the subjectivity of those to be empowered" (Cruikshank 1994:35). This is an unaccountable exercise of power where subjectification and constraint are obfuscated through what neoliberal doctrine has termed a 'voluntary exercise of power'. Clearly, divisions of power and structure are present in this strategy. Can it be said that these subjects are truly empowered and act voluntarily or is coercion a factor influencing their participation? Correctional literature seeks to empower women prisoners, pushing them to become self-governing and responsibilised agents of their own welfare (Blanchette 2002; Verbrugge & Blanchette 2002), and yet, the women are expected to become self-governing only through accepted methods and programs offered by the prison.

Prisoners are now responsible for their own reformation according to the prescribed notions of correctional discourse. Hannah-Moffat writes that, "one of the preconditions for a new form of governing appears to be the ability to reconstruct subjectivity – in this case the female criminal subject" (2001:166). The subjectivity of women prisoners is now at stake (or ironically, at risk). Attempts to control the mind, soul and ultimately the subjectivity of criminalised women are now key programming initiatives within correctionalism. This subjectivity is universalized, essentialist, and

[18] The increase in professionalization (and the use of paraprofessionals) mirrors the expansion of the prison industrial complex. For a more detailed explanation of the increasing reliance on professional expertise, see Stanley Cohen's 1985 work, *Visions of Social Control.*

denies differences between women – particularly Aboriginal and non-Aboriginal women (Morin 1999). In fact, Aboriginal women report feeling as though they are treated with less respect and dignity than other prisoners (Morin 1999).

Feminist criminologists have questioned the capacity of prison officials to empower women prisoners. As previously noted, there are inherent power imbalances between these parties and to suggest that prisoners can be empowered by a system and people that maintain their oppression and imprisonment is suspicious at best. For example, Hannah-Moffat writes:

> Prisons are organized to limit individual expressions of autonomy, control, and choice. They are sites of repression; behind their walls we find an undeniable imbalance in the relations of power between the 'keepers' and the 'kept'. Rarely are the 'keepers' able or willing to relinquish their power to facilitate empowerment. While incarcerated, women prisoners have little influence, collective or otherwise, over the conditions of their lives. In the end, the techniques typically associated with empowerment are in the control of the prevailing organization (2001:170).

As a result of the document *Creating Choices*[19], CSC claims to have incorporated a 'women-centred' model of penal governance (Blanchette 2002; Verbrugge & Blanchette 2002). However, using the terminology of empowerment simply 'feminises' the discourse of the practices operating in the new prisons (Hannah-Moffat 1999, 2000, 2001). Erecting new buildings does not change the penal regimes operating within the walls of the new prisons.

The correctionalist focus on empowerment suggests that all women prisoners lack self-esteem and self-worth, and that they do not know themselves or have incomplete or

[19] *Creating Choices* (1990) is the federal policy document for corrections for women in Canada that was written through a collaborative effort by feminists, correctional officials and former women prisoners. This report has since been criticised for its failure to address maximum security level women.

inadequate identities. In this context, the prison's *raison d'être* is to supply a new subjectivity, a new identity, and one that is empowered, self-responsibilised and reformed according to correctional ideals. Correctionalist literature suggests that women with low self-esteem are disempowered, and may engage in self-destructive practices as a result (Wichmann et al. 2002). This explanation fails to acknowledge the possibility that these may be self-reflexive strategies and possible acts of resistance.

Women prisoners who self-harm may be moved to administrative segregation which incurs an automatic increase of their security classification. Far from being empowering, this response is in fact disciplinary. Morin concluded that prison officials constructed self-injury as attention seeking behaviour and did not take this behaviour seriously (1999). Using segregation as a response to self-harm illustrates a clear attempt to punish the unruly prisoner and can increase the severity of the behaviour (Morin 1999; Carlen 2001; Hannah-Moffat & Shaw 2001). Rather than empowering women, this response reveals a system that seeks to reformulate women prisoners into idealised notions of what 'good' women should be. Similarly, women prisoners are frequently prescribed medications to address their 'mental illnesses', disempowerment and low self-esteem. Again, women who choose not to take the prescribed medication run the risk of being charged with institutional misconduct for being 'difficult to manage' (Hannah-Moffat & Shaw 2001).

In this repressive context. women prisoners are not allowed any real way to vent their anger, sadness, or frustration at the system or, for that matter, anything else. In the end, being charged for swearing or yelling is a common occurrence that can lead to an increase in sentence length or to the denial of programming (Morin 1999). Programming

is the key method used by CSC to empower and treat the women, but even that is problematic since Morin found that CSC uses authority based programming, where the women's access to programs was withheld as punishment and in order to get the women to conform and obey (1999). Doomed to fail, CSC seeks to empower criminalised women but routinely withhold programming, the only means of becoming responsible that is deemed acceptable by the institutional experts. Describing the new discourse of choice and responsibility, Hannah-Moffat cites Simon (1994) and writes:

> A recent phenomenon of modern forms of government is a shift in emphasis away from 'choice and responsibility for choice' toward 'creating the conditions for responsible choice' whereby making choices is as much a process of government as a practice of freedom. Given Simon's understanding of choice as a process of government, the provision of 'meaningful and responsible choices' in new, women-centred prisons takes on a new meaning. In the prison context, empowerment becomes a technology of self-governance that requires the woman to take responsibility for her actions in order to satisfy not her own objectives but rather those of the authorities (2001:173).

In other words, while the discourse of correctionalist literature suggests that the new focus is on women's empowerment, the women are empowered only in so far as they make choices that are outlined by correctional authorities. The empowerment strategy ultimately extends the power of the state as women are subjugated to conform to a predetermined set of beliefs, programs, language, and psy-care. Notwithstanding all these obstacles, if the women fail to become empowered and responsibilised, disciplinary tactics may be enforced such as increased periods of segregation and imprisonment.

Theorising the Relatedness of Dichotomies

Dichotomous thought essentialises concepts as mutually exclusive rather than theorising about how they are inherently related. In this section I demonstrate how the

two sides of three dichotomies do not operate independently of one another, but rather exist in mutual relation. We cannot explain the public without the private, free will without determinism, and there can be no such thing as compliance without understanding the possibility for resistance. Drawing upon the wide-ranging theoretical framework presented so far, I continue to illustrate the overall contradictory relationship between classical (responsibilisation) and positivist (pathologisation) approaches to explaining and regulating criminalised women. I demonstrate how these two approaches are not mutually exclusive but actually operated simultaneously during the late 20th century in concert with the ascendancy of neoliberalism and within the carceral context.

The Public/Private Divide

Much of the literature suggests that there is a division between the state and non-state, or between the public and private domains in society. But to the contrary, we have witnessed a blurring of the boundaries between the public and private, because neoliberalism is signified by a rise in privatisation. Rose and Miller suggest that,

> The political vocabulary structured by oppositions between the state and civil society, public and private, government and market, coercion and consent, sovereignty and autonomy and the like, does not adequately characterize the diverse ways in which rule is exercised in advanced liberal democracies. Political power is exercised today through a profusion of shifting alliances between diverse authorities in projects to govern a multitude of facets of economic activity, social life and individual conduct. Power is not so much a matter of imposing constraints upon citizens as of 'making up' citizens capable of bearing a kind of regulated freedom. Personal autonomy is not the antithesis of political power, but a key condition of its exercise because most individuals are not merely the subjects of power but play a part in its operations (1992:174).

With this oscillation between what have traditionally been viewed as opposing binaries, Rose and Miller demonstrate that the two are now working in conjunction with

each other. In this sense, the 'state' becomes a mythical construction of social philosophers, ascribing to it either the status of the nightmarish 'Big Brother' or a necessary functionality of the social, as in welfarism.

Under neoliberalism, knowledge of the population gained through statistics, calculation, surveillance and constant evaluation has created an increase in what Cohen (1985) calls professionalization, which expands the carceral net and control into the community. Each new professional has specific tasks and expertise (Cohen 1985; Rose & Miller 1992; Rose 1996). Thus, governance occurs through networking between state and non-state institutions (Rose & Miller 1992:176). Government operates via techniques of calculation known in the private sphere, where the two are linked through the power of knowledge. Rose and Miller write:

> Inscription itself can be a form of action at a distance. Installing a calculative technology in the enterprise, in the hospital, in the school or the family enjoins those within these locales to work out 'where they are', calibrate themselves in relation to 'where they should be' and devise ways of getting from one state to the other... By such mechanisms, authorities can act upon, and enrol those distinct from them in space and time in the pursuit of social, political or economic objectives without encroaching on their 'freedom' or 'autonomy' – indeed often precisely by offering to maximize it by turning blind habit into calculated freedom to choose (1992:187).

As the boundaries between the public and private blur, free citizens are expected to be 'responsibilised' to make the right decisions or choices. However, it must be recognised that certain citizenship statuses are contested due to, for example, criminalisation or psychiatrisation. Unlike in the United States, Canadian citizens are not disenfranchised because of a criminal record. Nevertheless, such citizenship and identity

statuses[20] do impact the treatment that criminalised populations receive when inside prison.

Self-regulatory practices are only constructed as rational and responsibilised when citizens align themselves with choices outlined as correct by the new experts. This is government or action at a distance (Garland 2001; Hannah-Moffat 2000, 2001). We have shifted to a form of 'active citizenship', in order to combat what has been constructed as welfare dependency (Rose & Miller 1992; Dean 1999). While this shift in governance indicates a decline of the welfare state, I do not think that there has truly been a "death of the social". Each westernized state differs in its actual practices, however. For example, it is unclear whether any real ascension or decline of welfarism has ever occurred in the United States (Siltanen 2002). In Canada, while the social is not dead, it is in flux – a transitory period that will lead to its demise if our neoliberal governance continues to privatise. When governance is entrepreneurial it is no longer social. As Curtis has said, "political power is beyond the state" (1995:576).

Free Will[21] and Determinism[22]

> Choose life. Choose a job. Choose a career. Choose a family. Choose a big television. Choose washing machines, cars, compact disc players and electrical tin openers. Choose good health, low cholesterol, and dental insurance. Choose fixed interest mortgage repayments. Choose a starter home. Choose your friends. Choose leisurewear and matching fabrics. Choose DIY and wondering who you are on a Sunday morning. Choose sitting on that couch watching mind-numbing, spirit-crushing game shows, stuffing junk food into your mouth. Choose your future. Choose life (Welsh 1996:1).

[20] I will be discussing citizenship statuses in greater detail in Part II of my theoretical framework.

[21] Conceptualising free will suggests notions of agency and choice that are inherent in classical thought.

[22] Conceptualising determinism suggests notions of structure and biology (disease/pathology) that are inherent in positivist thought.

The concept of choice is a foundational principle in current neoliberal discourses. Institutional discourses greatly impact how individuals understand and experience the social and thus exert their own agency. It is toward this concept of choice – and the freedom to choose – that we now turn our attention.

Being careful not to confuse 'agency' with 'freedom', we must acknowledge the entrenchment of power in and around us, and we should begin by considering how citizens develop or earn the freedom to choose. How is freedom constituted? Whose freedom is it? How can active citizenship be active when even the micro-forces of governance are deterministic in the vision of choices offered? What are the right choices? Who determines what the 'right' choices are? Are choices made voluntarily or coercively? And perhaps most importantly, how do race/ethnicity, class, and gender impact the ability to secure and then to exercise freedom? A case in point, we cannot assume that a prisoner freely chooses to engage in correctional programming without considering the very real constraint that is exercised when 'choosing'.

Rose and Miller virtually ignore any sociology of the state, and in so doing, they imply through omission that the state no longer wields power. Their argument suggests that all citizens are free and have the required individual agency that is necessary to make decisions for themselves. This argument therefore de-contextualises the fact that structural inequalities exist with respect to socio-economic status, gender, or race. Curtis writes,

> Still, no argument is offered for treating the exercise of power exclusively as a rational political science, nor is any justification made for the decision to ignore the 'irrational' in politics. Violence, lying, scheming, manipulation, and struggle, conflict and resistance among identifiable groups or classes, are simply treated as matters of no interest to political

> sociology. Having refused the realist concern with large-scale relations of exploitation and domination, having refused to accord any utility to a concept of ideology, politics becomes a cooperative, consensual process, where well-intentioned authorities seek to rule according to well-articulated ethical considerations (1995:577).

Curtis' point is important, as it demonstrates two of the major shortcomings of theorising dichotomies as mutually exclusive categories. First, we must recognise that while sociological theories of the state may have in the past been constructed too negatively or cynically by suggesting that the state is all-powerful, theories of governmentality seem not to acknowledge how the power of the state can still operate in a neoliberal society. Second, authors too frequently adopt uncritically the neoliberal construction of the rational actor, which suggests that we are all citizens operating with equal status or power.

Citizens cannot be equally responsibilised or free; without the same access to resources, power/knowledge, or socio-economic status, certain groups are destined (determined) to behave in the ways that the experts deem appropriate or most beneficial. It is in this nuance of 'what the experts deem appropriate' that we are able to see how deterministic the political rationality of neoliberalism really is. While neo-liberalism is touted as freeing and enterprising, the fact that there are more choices does not mean that we all have access to these 'available' options or choices.

The conditions that confine our lives impact our ability to make choices; therefore, exercising agency/making choices is not synonymous with freedom. Not every citizen can therefore exercise agency as it is promoted by neoliberal discourse. For example, a battered woman cannot truly exercise individual agency and the freedom to choose while being terrorized. If she kills her abuser, will she be regarded as an active

citizen exercising free agency, or will she be a constructed as an inherently dangerous woman? Garland writes,

> Freedom (unlike agency) is necessarily a matter of degree – it is the configured range of unconstrained choice in which agency can operate. The truth is that the exercise of governmental power, and particularly neoliberal techniques of government, rely upon, and stimulate *agency* while simultaneously reconfiguring (rather than removing) the *constraints*, upon the freedom of choice of the agent (1997:197).

The neoliberal juxtaposition of agency and freedom has constructed a tautological argument that states that you are free to choose and exercise agency, but that your choices are limited to a range of goals determined for you by a range of experts: free but determined, agency only through structure. In relation to the first dichotomy, the state may have dispersed its power among new professionals, but in doing so it has subtly extended and ultimately increased its range of powers.

Compliance or Resistance, or Compliance as Resistance?

Inherent in Foucault's analysis of power/knowledge is the concept of resistance. If power is relational then there exists the power to resist. This may be true, but one's power to resist is ultimately impacted by one's social positionality. While much of the governmentality literature fails to empirically account for resistance, several feminist authors have attempted to use this theory in a real and practical way (Bosworth 1999, 2001; Carlen 2001; Frigon 2000). For example, Carlen suggests that:

> Admittedly, analyses of governmentality may well discursively align the conditions which made possible the present without also indicating the disjunctive moments at which the present could have been otherwise. But, insofar as they omit to specify the points at which the prevailing power relations and their conventional practices were under threat or open to challenge, they also omit to identify new configurations of resistance to penal oppression (2001:460).

Having the power to make decisions can be liberating, depending on the context and the extent of the constraint on one's available choices (Garland 1997:197). While the responsibilised or free subject is encouraged to make decisions, their choices are limited, which is truer still in a prison setting. Ultimately, choice is illusory since the subject or citizen is only free to be compliant.

Carlen's critical analysis of the suicide policy at Cornton Vale (a Scottish prison for women) demonstrates how theorizing governmentality has led to a "near-erasure of the quality of the life of the governed" (2001:467). This finding is particularly important when discussing resistance since assessing resistance becomes impossible if the possibility for resistance is abstracted from our analyses. Carlen's analysis suggests that we need to listen to the voices of 'speaking subjects' to understand how penal regimes or other technologies of the self – for example, discourses emphasising self-responsibilisation and empowerment – are in fact demanding compliance rather than granting the freedom to choose or resist (2001:468; Foucault 1978:14).

Bosworth and Carrabine observe that "prison life is characterised by ongoing negotiations of power" (2001:501). Bosworth argues that resistance rests on identity and identity formation (1999, 2001). If resistance rests on identity that is based on some sense of an individual subjectivity, then we need to analyse how it is that subjectivity and identity are formed.[23] Some self-awareness may therefore be essential to allow for the space for resistant practices. Without it, compliance may become the only method of expression. Bosworth and Carrabine write,

[23] Understanding how identity is formed is the central focus of Part II of the theoretical framework.

> For us, the importance of resistance is that it makes explicit the connections between everyday actions and broader inequalities. Nevertheless we identify three limitations in conventional characterizations of resistance. First it is understood as a privileged quality in the human spirit. Second, is the assumption that those who do not challenge authority accept the legitimacy of the institution. Third is the equation of resistance with rudimentary political action (2001:501).

The authors' claim that traditional understandings of resistance that suggest all individuals possess the ability to practice resistance speak to a type of hardwired human essence. This kind of claim is reminiscent of positivist assumptions of innate biological and psychological essences. Similarly, to insinuate that those who do not resist are choosing to accept the legitimacy of the institution denies the very real possibility that compliance itself may be a form of active resistance. In fact, for criminalised women, resistance is often expressed by subtle actions and self-expression. Resistance is an expression of power and should not be diminished by the size or grandeur of the action; resistance may therefore be invisible to an audience, because of its personal and subjective nature (Bosworth 1999; Bosworth & Carrabine 2001).

Resistance can be symbolic in form and may thus go undetected by others. In this light we can see how the concepts and practices of compliance and resistance should not be dissociated, and that they are dialectically related, not opposed. Their hybridity suggests interdependence. Compliance may in fact come to either represent or camouflage what may be resistant practices embraced by marginalised groups such as criminalised women. Agency is therefore a key component of one's ability to engage in a self-expression of power through resistance.

In the next chapter, I draw upon these discussions of the relatedness between these binaries, in order to push this theoretical framework down an important, albeit

different and unique path. Understanding how concepts such as agency/structure, compliance/resistance, and free will/determinism actually operate inside a prison will lead to an examination of identity formation. Bosworth and Carrabine's work provides a fertile ground on which to create our own theoretical space. While there has been much evaluation of identity construction in the postmodern context, notably in the writings of social psychologist Kenneth Gergen (1989, 1991), the terrain surrounding identity politics has become muddied in other works. In fact, few criminological authors other than Bosworth and Carrabine have attempted to discuss the importance of identity politics in an empirical way.

While many scholars acknowledge Erving Goffman's (1963) seminal work on stigma and Stanley Cohen's (1985) work on master status as they impact one's construction of self, little has been done to examine the importance of identity as a tool for potential resistance or as a strategy or technique of coping with the impact of the carceral environment. In the next chapter I attempt to do just this by examining how criminalised women negotiate their identities in the carceral context via a discussion of the fixed and/or fluid nature of identity development. My goal is to generate a discussion of how criminalised women make up or constitute their 'selves'[24] in relation to the impact of the technologies of discipline, i.e. medicalisation and pathologisation, and the technologies of the self, i.e. responsibilisation, empowerment, the rebuilding of self-esteem, and self-care, that operate upon them in the carceral context.

[24] Note the plural form as an indication of a multiplicity of individual personae.

Chapter 3
Theoretical Framework Part II - Negotiating Identity and Constructing Citizenships Within the Carceral Context

Making Up Selves: Identity Negotiation in the Carceral Context

Understandings of how we make sense of who we are have shifted over time, influenced by the theoretical positions of the era. In this chapter, I borrow concepts from the literature that examines both identity processes and identity politics which contribute to the integration of my own theoretical framework.

There are two main streams of thought regarding identity, which are often presented as a dichotomy. First, identity has been described as innate, biologically and/or psychologically hardwired into each of us which makes it an essence that is simply maintained.[25] Thinking of identity in this way constructs it as rigid and unchanging. Individuals may perceive identity as a relatively fixed construct to maintain their construction and perception of self over time, thus giving them a sense of power over who they are and how others will perceive them. The second stream of thought centres on the construction of identity as a process; something that we negotiate and something that continues to evolve and develop in conjunction with the experiences we have throughout our life.[26]

[25] This stream of thought is most commonly associated with modernism (Gergen 1991).

[26] Conceptualising identity as a process – as something that is fluid, malleable or as always already developing – emerged in the postmodern context (Gergen 1991; Giddens 1991).

Building on the theoretical framework started in the previous chapter, I examine the dichotomy of constituting identity as fixed or fluid and argue for an understanding that recognizes identity as both fixed and fluid. Key to this discussion is how life-changing experiences such as imprisonment and self-harming behaviours can impact, alter, change, solidify, entrench, and potentially reformulate an individual's identity and their construction of selfhood. How do criminalised women make up their 'selves'? Do they discuss identity as fluid or fixed? If so, in what situational contexts and with respect to which issues? Does identity reflect an individual's sense of power or powerlessness? Do criminalised women resist through the expression of their identities/selves, as Bosworth and Carrabine postulated (2001)? Can identity be disrupted and then returned to – indicating a certain kind of rigidity or stability – or are our identities always already in flux? Should identity be conceptualised as a singular entity that operates in a similar fashion across different contexts, situations, or people? Or alternatively, should we understand identity in a plural sense, where we all have multiple selves that emerge according to our surroundings?

Following a discussion of the binary of fixed and fluid constructions of identity, I examine technologies of the self that operate most frequently in the carceral context, used by correctional officials in an attempt to exercise power in the prison.[27] I also discuss the ways by which criminalised women constitute their 'selves' while they are impacted by those technologies of the self.

[27] While I am not able to provide a detailed examination of the institutional discourses of prison authorities and experts and how they impact the women's identities, this is an extremely important avenue for future research that to date has remained relatively untouched.

Fixed or Fluid, or Fixed and Fluid Identity

Kenneth Gergen's (1991) seminal work on 'the dilemmas of identity in contemporary life' is one of the most relevant pieces of literature to have examined identity processes. While others have attempted to theorise identity, Gergen's work is reflective of both the social and the psychological, which makes it especially relevant for my theoretical framework. I focus on Gergen's work to examine how technologies of the self affect the ways criminalised women formulate their selves and may use their identities as strategies of coping with stress and strain associated with imprisonment.

According to Gergen, we are surrounded by technologies of social saturation via media awareness and globalisation expressly related to the construction of selves in the postmodern era. Technologies of social saturation expose us to an increasing range of possibilities, new people, new forms of relationship, opportunities, job potentials, knowledges, religions, politics and cultures (Gergen 1991:69). The impact of these experiences is the populating of the self, which can be described as a reflection "of the infusion of partial identities through social saturation" that leads to a "multiphrenic condition" with respect to our understandings of identity (Gergen 1991:49).

Ultimately, Gergen offers a genealogy of the cultural assumptions and beliefs regarding identity as it has been constructed in three consecutive eras: romanticism, modernism, and postmodernism. This approach fails to identify any overlap between the eras and posits each era as based on only one construction of identity. Gergen suggests that during both romanticism and modernism, identity was seen as a unique essence of each individual – a component of self that was relatively fixed and stable over time. Similarly, Grossberg (1996:89) claims that this model of identity "takes the form of

offering one fully constituted, separate and distinct identity in place of another". However, as a result of the populating of the self, social saturation pushes individuals to become amalgamations of characters selected from those to which they have been exposed. This suggests that identity is actually quite fluid and malleable. For example, Gergen (1991:71) writes:

> As social saturation proceeds we become pastiches, imitative assemblages of each other. In memory we carry other's patterns of being with us. If the conditions are favourable, we can place these patterns into action. Each of us becomes the other, a representative, or a replacement. To put it more broadly, as the century has progressed selves have become increasingly populated with the character of others. We are not one, or a few, but like Walt Whitman, we "contain multitudes." We appear to each other as single identities, unified, of whole cloth. However, with social saturation, each of us comes to harbour a vast population of hidden potentials – to be a blues singer, a gypsy, an aristocrat, a criminal. All the selves lie latent, and under the right conditions may spring to life.

This exposure to new and potential ways of being creates a multiphrenic condition[28], implying that the individual now has a multiplicity of selves or rather a multiplicity of opportunities to express different selves.

The argument could be made that identity was once fixed and is now fluid. However, it is more useful to suggest that elements of one's identity (or elements of one's projected identity – as we must recognise that a postmodern identity is in some capacity a social construction) still remain quite fixed and rigid today. While Gergen agrees with this observation, his work does not emphasise it nearly enough. Despite the growing repertoire of knowledge, experience, information, emotional responses, and relations

[28] Gergen is quick to point out that "multiphrenic condition" is an explanatory term and does not denote any form of mental illness.

from which to choose to express ourselves, we wish to convey ideal forms of a self or identity.

In this light, identity is contextual, situational, and affected by the social. Gergen writes (1991:138):

> And as political events, news-reporting, and other realities are found increasingly to reflect the passions and prejudices of their makers, the replacement of real by constructed selves becomes increasingly plausible. If words cease to carry truth, then authorities also lose their command. All attempts to declare the nature of selves – their intentions, aspirations, and capabilities – become suspect. No transcendent voice remains to fix the reality of selves. As rational coherence is increasingly questioned, so does the traditional view of identity as fixed by cross-time continuity lose its appeal. When anything goes, so does personality as a discriminant category. In the end consciousness of construction turns reflexive. The very consciousness of self-construction must inevitably be viewed as a construction, and this sense as well... with no ultimate grounding in the one indivisible self.

Drawing heavily upon social constructivism, here the author pushes us to see identity as continuously developing, forever being negotiated, as always already in flux, emerging and re-emerging and as in a process of constant mutation. Gergen, like many others (Bauman 1996; Grossberg 1996; Hall 1996), links this view of identity to our increasing involvement in social relationships.

However, Gergen also cautions that we must "first bid adieu to the concrete entity of the self, and then to trace the reconstruction of self as relationship" (1991:140). This suggests that identity is no longer a fixed construct and that it is now a fluid and relational one. The author is emphasising his claim that the boundaries that have historically been used to outline identity (its nature, context, or development) have been blurred, muddied and merged beyond distinction.

I disagree with this proposition, and suggest that the opposite is true. The blurring of these boundaries has led to an increase in tolerance and acceptance for individual differences. Social saturation has in fact given us more power than ever to determine how we want to portray our selves. To be clear, and to avoid any confusion with romanticism, I do not propose that varied forms of prejudice, hate, discrimination, bigotry, racism or sexism no longer exist. Simply, when differences in self-expression are no longer shocking, an increase in potential individuality – and at the very least tolerance for difference – becomes possible.

At the same time, Gergen claims that objectivity has been replaced by perspectivism:

> The concept of "individual persons" could not be a simple reflection of what there is, but a communal creation – derived from discourse, objectified within relationships, and serving to rationalize certain institutions while prohibiting others. Within this simmering stew, one begins to savor a newly emerging taste. As the ingredients coalesce, and the self vanishes with the rising vapors, one now detects a new reality – the reality of relationship (Gergen 1991:140).

Identity is a relational entity and is context and audience dependent. If we accept, as Gergen does, that identity is now a communal creation that lends power to the institutions that foster it, then we can begin to understand how the carceral context comes to impact prisoners' senses of self. Social saturation continually increases our ability to engage in self-comparison against the standards that define what it means to be a good or bad person, a good or bad mother, a drug addict, a sober individual, a psy patient or even a criminal. For example, prisoners have been found to adopt and re-create themselves according to the psy and correctional discourses espoused in institutional programming (Bonnycastle 2004). What Gergen fails to acknowledge is that if identity is relational, as

is power, then we have power to accept and/or reject (resist) different constructions, expressions and presentations of our selves.

It is important not to lapse into an acceptance of the 'reality' of choice – and the rhetoric of choice in neoliberal discourse. If we accept Foucault's claim that knowledge is power and power is relational, and we are also willing to accept Gergen's claim that identity is relational, then we can see that individuals do have some power in the construction and expression of their selves. For example, while some participants in my research had adopted correctional and psy discourses (see also Bonnycastle 2004), others completely rejected them. At the same time, we should be careful not to minimise the power of institutional discourse in formulating the identities of prisoners. Resistance can be an important part of an individual's self-conception and self-expression – and nowhere is the need for resistance more evident than in the carceral setting (Bosworth 1999).

While it is important, Gergen focuses too much on the impact of media consumption on our awareness and construction of self. Gergen claims that we are almost machinelike and that any "claims to sincerity evaporate" because "each move of the body, is orchestrated for social effect" (1991:149). Clearly drawing on Goffman's depiction of a dramaturgic culture[29], Gergen argues that to be a dramaturgic agent and to play a role, the expression of self requires that there be a comparable real or true self to contrast with the acted role. But Gergen then rejects this possibility because to have a real or true self is to see identity as having a fixed component (which he argues is a modernist construction).

[29] Goffman first discussed his concept of a dramaturgic culture in his 1959 book *Presentations of Self in Everyday Life.*

How then can we explain the common claims individuals make about returning to their true selves? Individuals who come out of depressions – like many of those who quit using drugs or alcohol – frequently describe that they are returning to their real personas that had been muddled as a result of their depression and/or substance use (Baker 2000; McIntosh & McKeganey 2000; Plumridge & Chetwynd 1999). We cannot dismiss these discourses or write off those who suggest that they have a true concept of self as mistaken or ignorant of the relational component of identity. As with the dichotomies we have examined thus far, we need to move past a mutually exclusive explanation of identity construction as being either fixed or fluid, and toward one that allows for an understanding of identity as being both fixed and fluid.

Identity is surely plural, but to claim that we are nothing more than social chameleons trivialises our potential for individuality. Of course it is true that we act in certain ways in certain contexts; it would be strange to start yelling and jeering while attending an opera, or to stare blankly at someone who says hello to you. We must still question how and when such expressions lose their sincerity to become simulations rather than 'true' expressions. I agree with the critique of postmodern analyses that reducing everything to social construction paints a very shallow picture of humanity (Roseneau 1992). We have indeed shifted from viewing identity as a singular and embedded entity toward a fragmentation of selves that are context dependent. The fragmentation and fluidity of identity allows us to be adaptable, allowing, for instance, criminalised women to adjust and cope with their imprisonment.

It is our desire to project a sense of self as being true or real that matters. If a particular construction of self is who we believe we are and it is by this self that we live

our lives, then this construction is true in the life of that individual. For example, several of my participants claimed that they used their identities as mothers to help them overcome their addictions. The idealised notions of what it is to be a good mother (being drug free, clean, and sober) could be the result of socially constructed norms and mores. However, this relational construction has the potential to shift our conceptions of who we are and thus who we are not – or more importantly, who we are and who we *want to be*. There is an obvious danger of buying into or consuming such an idealised and morally constructed vision of motherhood. It can, in some cases make it more difficult for some women to come to terms with their drug use. Nevertheless, to adopt a fixed notion of one's selfhood does have the potential to work as a coping strategy by allowing us to transform understandings of who we are and to alter the ways in which we live. Ultimately, allowing for a fixed notion of selfhood amidst the fragmentation of identity generates space for real resistance.

More specifically, Gergen writes:

> No single act of deviance is "telling" of one's personality, because there is no personality to be told about. In the postmodern world such events are no longer indicators of "flawed character," but of unfortunate quirks, momentary slips in judgement, or complex situations (1991:185).

While Gergen suggests that deviancy is not an inherent character flaw, prisoners continue to be subjected to institutional discourses that attempt to label, define, categorise, rehabilitate, reform, retrain and recreate them through prison programming, psy therapy, and prescription medication. Although part of our identities is fluid, fragmented and relational, correctional discourse and policies view the identities of criminalised women as damaged and in need of repair. Ultimately, correctional discourse

does not address the criminal identities of prisoners as transitory but rather as something the individual must actively reform and choose not to associate with. For criminalised women, allowing for a fixed notion of self generates the space for them to reject and resist a criminalised identity (Bosworth 1999). In the next section I broaden this initial discussion of how we make up our selves and identities by examining how different technologies of the self operate in the context of the prison. The goal is to examine how criminalised women constitute their selves, or make up their identities in prison during neoliberal times.

Constituting the Self in Neoliberal Times: Technologies of the Self

Whereas Gergen's work reduces identity to a less than tangible social construction, Bauman nuances our understanding of the fragmentation of identity, stating that we journey to "make the world solid by making it pliable, so that identity could be *built at will*, but built *systematically*, floor by floor and brick by brick" (emphasis added) (1996:23). While identity can, in a sense, be seen as disposable because of our ability to adapt situationally, by changing projections of our selves according to who we are with or where we are, no component of our identity is necessarily fixed over time. Although Bauman accepts Gergen's proposition that identity is fragmentary, discontinuous and fluid, subjected to social saturation and the populating of the self, he allows that we can pick and choose elementary elements from which we can create an assemblage of self. Identity is relational and we build it temporally and spatially. We have the ability to hold on to elements of ourselves as long as we feel they reflect who we are and what we believe. By exercising these choices, we are able to escape the fleeting and seemingly endless constructions of identity outlined by Gergen.

Stuart Hall's work (1996) offers us a useful bridge between Gergen's work and the governmentality literature that examines the technologies of the self inspired by Foucault's work. Hall uses the concept of identity to refer to what he calls:

> A meeting point, the point of suture, between on the one hand the discourses and practices which attempt to 'interpellate', speak to us or hail us into place as the social subjects of particular discourses, and on the other hand, the processes which produce subjectivities, which construct us as subjects which can be 'spoken'. Identities are thus points of temporary attachment to the subject positions which discursive practices construct for us (1996:6).

Hall's conceptualisation of identity as a kind of suture is both intriguing and functional. It provides the space required to begin examining the link between identity as a construction (Gergen's work) and the different kinds of socio-historically located institutional discourses that impact and constrain that construction (Foucault's conceptualisation of the technologies of the self). Bauman's (1996:22) work supports Hall's by examining the impact of culture on identity-building, and the idea that having a 'destination' or goal with respect to what he calls 'life's pilgrimage' allows us the opportunity to "make a whole out of the fragmentary" in order to generate a kind of "continuity to the episodic".

Understanding that identity building is a process is particularly important when studying marginalised, and in our case criminalised, women to analyse their experiences of imprisonment and the potential space in which they are able to exercise some form of resistance. We must use our discussion of identity and examine not only how concepts of the self are formulated generally, but also when they are confined by institutional discourses and powers. When examining identity as resistance, Bosworth and Carrabine suggest that:

> Taking identity as a site of the negotiation of power requires a smaller-scale approach to questions of inequality, and, perhaps most significantly, places the voices and experiences of individuals at the centre of analysis. Such an approach allows the incorporation of a range of human actions and emotions into the discussion of power. It reveals the relationship between socio-economic and cultural characteristics and the capacity for agency. In other words, it shifts an exploration of power from a purely instrumental capacity to 'get things done' to the much more subtle and complex circumstances involved in expressive gestures that try to 'get things said' (Bosworth & Carrabine 2001:511).

This excerpt is critically important, as it highlights both the theoretical avenue I take as well as the methodological importance of incorporating the participants' standpoints. Not only should we avoid romanticising resistance, we must also be cautious when looking for acts of resistance; as Grossberg asserts, we should "give up notions of resistance that assume a subject is standing entirely outside of and against a well established structure of power" (1996:88). According to Rose, because we live our lives in constant movement across time, space, and in relation to certain others and because we are not a unitary homogenous group, "it is no longer surprising that human beings often find themselves resisting the forms of personhood that they are enjoined to adopt" (1996:140).

Rose (1996:130) suggests that our notions of identity and selfhood have assumed the forms that they have "because [they] have been the object of a whole variety of more or less rationalized schemes, which have sought to shape our ways of understanding and enacting our existence as human beings in the name of certain objectives". It is toward these rationalized schemes that we now turn our attention. To understand identity negotiation we must begin to theorise how different technologies of the self and techniques of discipline operate via institutional discourses and practices. Rose (1996:132) writes:

> Technology, here, refers to any assembly structured by a practical rationality governed by a more or less conscious goal. Human technologies are hybrid assemblages of knowledges, instruments, persons, systems of judgement, buildings and spaces, underpinned at the programmatic level by certain presuppositions about, and objectives for, human beings.

Rose advises us to examine these technologies of the self in the context of neoliberalism. Our earlier discussions of the three dichotomies (public/private, free will/determinism, and compliance/resistance) help to do just that.

Technologies of the self take on the form of those kinds of:

> … techniques for the conduct of one's relation with oneself, for example requiring one to relate to oneself epistemologically (know yourself), despotically (master yourself) or in other ways (care for yourself). They are embodied in particular technical practices (confession, diary writing, group discussion, the twelve-steps of Alcoholics Anonymous). And they are always practised under the actual or imagined authority of some system of truth and of some authoritative individual, whether these be theological and priestly psychological and therapeutic or disciplinary and tutelary (Rose 1996:135).

Prisoners are increasingly expected to use all three of these techniques – they are expected to know themselves and the reasons for their criminality, which should allow for self-mastery over their criminal impulses; and they are expected to care for themselves by becoming healthy, clean/sober (with the exception of prescription medications), 'good' mothers, and financially secure (independent from any form of welfare or social assistance). Corrections for women often operate primarily via the language, discourses and practices of psy in their efforts to influence prisoners' self-identities.

Rose effectively demonstrates the influence of psy in the construction of selfhood (1996a, 1996b), claiming that, unlike other disciplines that remain elitist, psy has been

willing to lend its knowledge and 'give itself away'. Psy discourses are indeed pervasive in everyday life, to the point that it is virtually impossible for us to experience life without referring to psy language and/or discourse. The result of this trend has been an extension of psy into other domains; many institutional discourses now speak the language of psy. Nowhere is this transference of psy into other domains more evident than in corrections.

Drawing on the work of Gilles Deleuze, Rose suggests that our identity is more than just fragmentary, but that it is situated in a series of folds (1996c). To speak of folding or cleavages of identity or selfhood may be a useful concept to us. As we engage in different experiential and material realities we may come to adopt the ideologies, messages, discourses, languages and practices of the institutional discourses that attempt to act upon us. The concept of folding allows us to view identity as something that is truly fluid, moving, shifting and adapting. Conceptualising identity as a series of cleavages or folds allows for the acceptance of some forms of individual autonomy or agency for which Gergen's work did not provide space. This space for agency allows the reintroduction of subjectivity in our analyses of identity.

Despite having some form of agency within the folds of our selfhood or identity, we are still subject to institutional discourses and technologies of the self. In corrections, these (gendered) technologies often focus on those personal weaknesses characterised as typical of criminalised women and the practices of psy, that have become authoritative in corrections, and that are presented as being able to correct what is considered unacceptable. For criminalised women the key technologies of the self are strategies of

empowerment and self-esteem building, both of which are carried out through reference to self-care[30].

Cruikshank's work on self-esteem and Hannah-Moffat's extensive work on the notion of empowerment in Canadian corrections for women have been a useful framework from which to begin. Both strategies promise to deliver a technology of subjectivity that will help eradicate criminality in women by waging a revolution on the self and the way the individual woman self-governs (Cruikshank 1996). The correctional attempts at reformulating the identities of criminalised women go beyond re-building their self-esteem or trying to empower them. Prisoners are expected to know themselves and to practice self-care. In the corrections context, some of these practices include confession (to psy experts, therapists, and social workers), journaling (which is a kind of self-confession), as well as engagement in correctional programming (for substance use, relationships, parenting skills, job skills, and even cultural awareness).

Within correctional discourses of self-care, a woman must be clean, sober, financially secure, and a 'good' mother. This construction of normality represents a paradox for criminalised women who are attempting to re-enter the community as crime-free individuals. There is precious little space or time for them to get on their feet – or to self-care – before they are expected to re-enter the role of 'super-mom'. The imperative to be a certain way can often set women up for failure. For example, if they take too long (whatever that may be) to overcome their addictions, they are failing to self-care. If they are unable to find work and are financially dependent on the state, they are taking

---

[30] Self-care is a vague term that is used to encompass a range of technologies geared toward self-betterment. In practice, self-care is a disciplinary technique that operates to achieve the neoliberal goal of self-responsibilisation.

advantage and are failing to self-care. If they cannot afford their own apartment or housing, because they cannot find decently paid work, and cannot afford to take their children back into their custody, they are also failing to self-care.

The neoliberal shift toward self-care espouses the notion that you are 'in it alone'. Self-care is thus rooted in the discourse of choice since the prudent individual will be able to remodel their identity by psychologising their own discourses, thoughts, actions and behaviours. Criminalised women are now encouraged to consume the language, discourses, practices, and beliefs that allow for the reconstruction of identity and enable them to reformulate their selves as prudent, responsibilised and crime-free. Consuming the ideology of self-care means buying into the concept of lifestyle choice.

With respect to consumption and the concept of lifestyle choice Rose writes (1996a:162):

> Consumers are constituted as actors seeking to maximize their 'quality of life' by assembling a 'life-style' through acts of choice in a world of goods. Each commodity is imbued with a 'personal' meaning, a glow cast back upon those who purchase it, illuminating the kind of person they are, or want to become.

The institutional discourses of corrections provide an outline of the kind of identity they wish criminalised women to consume, adopt and exude. The programming that corrections requires criminalised women to take, both inside prison and upon their release into the community, is imbued with notions of 'self-help' that were made popular during the 1970s and 1980s.

Self-care, constructed as being an individual responsibility, is actually an extension of the institutional power of corrections. The discourse of self-care, which is

rooted in psy language and discourse, masks correctional attempts at fostering self-discipline, self-mastery and self-responsibilisation by adopting the more positive-sounding language of self-betterment.

In order to self-care we must draw on different elements of our selfhood or identity. We must adopt and/or create a 'proper' work(er) identity, an acceptable motherhood identity (one that is undoubtedly permeated by patriarchal constructions of the ideal mother) (Boyd 1999, 2001), as well as the clean and sober self who realises and now resists the pitfalls and dangers of addiction and who rejects that aspect of their former self (Baker 2000). Self-care is thus not only rooted in the language of psy, it is rooted in the discourse of identity maintenance, construction, and negotiation. Criminalised women can now 'fold' inward aspects of self that are displeasing or threatening to their ability to self-care, because only through self-care can they re-generate a post-criminalised identity. The criminalised identity does not evaporate, but through self-care it can be pushed inward into a fold or cleavage that allows for the newly negotiated self (that is mastered, disciplined, and responsibilised) to be on display to others.

To illustrate, let us turn our attention to disordered eating, a form of self-harm discussed by many of the participants in this study. Maree Burns (2004) claims that women often 'become' their diagnosis, reflecting an identity transformation where the 'true self' is lost to the anorectic or bulimic self. Psy's iatrogenic influence here is key – and demonstrative of its desire to present identity as something that is fixed rather than fluid. To be an anorectic or bulimic is thus different from suffering from anorexia or

bulimia; the latter signifies the continued negotiation of self and identity and the former signifies a more fixed and thus rigid understanding of identity.

From this frame of reference, disordered eating allows us to understand what Peters (1995) has called the "pleasant aspects of asceticism" such as self-control, determination, uniqueness, independence, and efficiency. Starvation and purging are spectacles (Gooldin 2003), embedded in the ongoing process of perfecting a work in progress (Malson 1999). Dialectically speaking, these spectacles are also acts and expressions of identity, personhood, womanhood, and independent self-hood. Notwithstanding claims of individuality, agency, or self expression, and given the predominance of psy with respect to identifying and treating disordered eating, however, it is not surprising that the legal and human rights of anorectic and bulimic patients have been disregarded within the complex realms of medical and legal positivism.

Using medico-legal discourse to supersede women's control over their bodies reflects current neoliberal doctrines of empowerment used by correctionalism to promote self-governance by women prisoners. Interestingly, there is no real acknowledgement within correctional literature of disordered eating as it is experienced by women in prison nor is there an 'official response' to the behaviour. Is this behaviour acceptable in the carceral context as a form of self-punishment and as a way to experience hegemonic femininity? Akin to the self-governance expected from prisoners, Nicole Moulding (2005) suggests that by surrendering control to hospital staff, eating disorder patients are reconstructed as rational and self-controlled because of their 'decision' when in fact they are entering a curative regime that is coercive and disciplinary. Moulding (2005:798) writes:

> The emphasis on rational, voluntary choice also represents a slippage between theory and practice because these same practitioners defined anorexic psychopathology as a lack of autonomy and rational self-control. The anorexic individual is therefore called upon to make a free and rational choice upon using the capacities she is theorised not to possess.

Therefore, with these medico-legal and correctional prescriptions on the autonomy of women, women lose control over their own bodies, even though control may be precisely the goal of disordered eating or self-injurious behaviour. If women do not 'choose correctly' to enter treatment, or participate in prison programming etc. they are forced to do so because they are clinically constructed as not having the mental capacity to make the correct decision regarding their own health[31].

We must remember that body management practices and norms vary cross-culturally. With this fact in mind, Malson and Ussher (1997) have indicated that there is a paradoxical relationship between anorexia and identity. To assume that all disordered eating practices are pathological denies the variety of body management practices and, more broadly, the variety of women's coping strategies. For example, to read the anorexic body as an indicator of the desire to "fade away" also implies the avoidance of the disciplinary gaze – whether a parent's, psy expert's, social worker's, prison guard's, or abusive partner's (Malson 1995, 1997a,b, 1999; Malson & Swann 1999; Malson & Ussher 1997). Furthermore, this reading implies that the individual is attempting to destroy her observable self, but is making herself more visible through each pound lost (Malson & Ussher 1997).

> This construction of the thin or anorexic woman as elusive converges with the construction, discussed above, of anorexia as fading away or

[31] For example, Keywood (2000) reveals that in England, the anorexic person can be forced into treatment because they are viewed as unable to make reasonable decisions concerning their own health.

> disappearing, as an evasion of identity. Yet, the same elusive female figure is constructed here as an identity in itself. It is, at once, an identity and an escape from identity (Malson & Ussher 1997:54).

We must still question whether disordered eating practices are in fact manifestations of what Malson (1999) has called "identity-put-under-erasure" since these specific and harmful body management practices have emerged from the discursively situated and gendered cultural ideologies that surround idealised femininity.

To truly understand disordered eating, we must extend our explanation beyond linking it to a desire to master and exhibit hegemonic femininity, for, like identity, femininity is not fixed over time and space. While a body may be 'put under erasure', identity is not susceptible to the same pressures. Attempts at fading away are a structured part of the expression of the anorectic's identity. Malson claims that the anorexic identity is an "absent presence", "an identity that signifies its own absence" (1999:147). The case is not fundamentally different for a bulimic identity although it is common for the individual to be of normal weight. The goal of weight loss and management remains the same. The goal of purging, which works as a coping strategy, is also the same; only one's outward corporeality differs. Attempts by anorectic and bulimic persons at self-expression, whether toward one's corporeality or one's social and broader life situation (for example, criminalisation), through techniques of body management arrive at similar ends – coping and self-punishment.

Disordered eating practices thus become components and expressions of identities (Malson 1999), and at times (but not permanently, unless they are embodied to the point of death) 'the' identity and expressed self. Therefore, anorectic and bulimic identities can give purpose to a person who is feeling shame and guilt. Moulding (2005) suggests

that concealment practices used by many people with an eating disorder are symbolic sites that demonstrate how the individual is trying to assert self-determination and their own identity. Disordered eating practices can thus foster a sense of empowerment and are ways to manage one's feelings – simultaneously representing self-governance and self-punishment (Moulding 2005).

Going back to Hall's work (1996) we can see how identity is the point of suture that fosters notions of change or adaptation, which in corrections occurs through the discourse of self-care. These examinations of identity set the stage for a discussion of citizenship; a notion that offers a space for dialogue focused on the possibility for positive change for criminalised women. Many feminists, including Smart (1989), have argued that feminists can no longer use rights discourse to bring about change. Rooted in the talk about rights that emerged during the 1970s, theorising citizenship directs this rights talk toward a more contemporary discussion that is reflective of a globalised discourse. Again, identity is a point of suture; different identity statuses provide the starting point for the construction of a kind of citizenship that should allow for certain rights and privileges that are currently being denied or ignored within the correctional system.

In the next section, I outline two kinds of citizenship; biological and psychiatric, that are based on constructions of, and have repercussions for, individual and group identities. While I draw primarily on the work of Novas, Rose, Orsini, and Petryna for

my discussion of biological citizenship, little existing work discusses the possibility of a kind of psychiatric citizenship[32].

The Meaning of Citizenship in the Prison Context

Self-responsibilised neoliberal citizens are expected to be active rather than passive, independent rather than dependent, prudent rather than reckless, and organised rather than spontaneous. Those on the margins and those who challenge these notions of citizenship – prisoners for example – risk not being considered as citizens. White and Hunt (2000:107) claim that citizenship is based on constructions of identity and that these two constructs operate in a strained relationship: "once identity is viewed as a project always open to contestation, liable to fragmentation or to the Balkanization of identity politics, then it always exists in tension with claims of citizenship that rest on some dimension that is shared by differentially situated identities".

Traditional understandings of the notion of citizenship are undergoing a theoretical transformation. First of all, citizenship, like identity, is not completely fixed and should not be theoretically relegated to discussions about nationality. Second, citizenship is inherently related to identity. Third, notions of citizenship require discussions of power and rights, which can and should extend beyond the walls of the prison. Citizenship, in the current neoliberal political rationality, is active and participatory but also fragmentary – like the identity upon which it is formed.

The idea of citizenship implies that individuals have certain rights but also a corresponding set of obligations in relation to the government that offers them the status

[32] With the notable exceptions of Arrigo 2002 and Rhodes 2004.

of citizen (Marshall 1950; White & Hunt 2000; Hindness 2002). Because citizenship is a fundamental component of national and state control "many individuals who belong to that state will be citizens while others, who might also belong to the state in some sense, will not" (Hindness 2002:128). In some nations, such as the United States, individuals with certain kinds of criminal records are disenfranchised permanently. Most problematic is that prisoners do not have access to the kinds of physical and mental health care that they would if they were not incarcerated. Citizenship functions as one component of contemporary attempts at population management through the allocation and denial of rights, privileges, and even services. Given the fact that we are governed partially through the reactions of others and through social saturation (Gergen 1991; Hindness 2002) we are able to begin to theorise citizenship as flowing from or as being built upon our identity statuses. Being governed through freedom, choice, technologies of the self, and the population of the self provides the footing for a theorisation of citizenship as flowing from different identity statuses.

Melanie White and Alan Hunt (2000:94) contend that citizenship "is a technology of government because it is what constitutes individual membership in a political community". They suggest that the care of the self is a viable practice that influences how individuals are perceived by others, either as competent members in their political community and ultimately as citizens, or not. White and Hunt write about the concept of truth telling as a strategy used to engage in citizenship (2000:95):

> To be a free citizen obliges us not only to tell the truth, but [it] also requires us to engage in practices that reveal certain truths about ourselves. Truth-telling is crucial to citizenship because it is what enables one to produce specific truths about oneself. It is distinct from other discursive practices such as expressing hopes, wishes and desires to the extent that the practice of truth telling is what makes one a subject of government.

If truth telling is crucial to the construction of citizenship, how do we actually determine truth? When a prisoner expresses their fears and feelings about the over prescription of medication that occurs in prison do we listen to this narrative as a truth? Whose discourses are accepted as being potentially truthful or trustworthy? In this light I suggest that criminalised women may be denied the rights associated with certain kinds of citizenship given that they are chronically disallowed a voice. If we are to accept, as White and Hunt suggest, that citizenship is "rooted in the domain of an expanded conception of government" (2000: 96), then we are able to understand how certain citizenship statuses are denied to criminalised women.

Barbara Cruikshank suggests that self-esteem is a technology of citizenship as well as of self-government because it calls us to take charge of ourselves so that others do not have to (1996:234). In this light, citizenship reflects a kind of social responsibility. However, the pendulum of responsibility is constantly moving depending on the social issue at hand. The health and well being of its citizens is at times the state's responsibility, for example ensuring cancer treatment regardless of a citizen's ability to pay.[33] Other times (Cruikshank discusses self-esteem), it is the individual who is responsible. Where does the citizen who has failed to self-govern appropriately and has engaged in what is regarded as reckless, imprudent, or dangerous behaviour (e.g. disordered eating, self-injury or substance use) fall? Should we deny citizenship rights that concern health to individuals who engage in self-harming behaviours while they are being disciplined by the correctional system?

[33] I am theorising here within the confines of the political rationalities and the political economy found specifically in the Canadian context. For example, in contrast to Canadians, citizens in the United States have to secure and pay for their own cancer treatment.

White and Hunt present citizenship as a mechanism of government that moves between technologies of power and technologies of the self. They write:

> "Given the extent to which we think that citizenship involves an ethical relation with the self, it is important to recognize the productive potential of government. The ethical practices of citizenship, in other words, are what ultimately renders one a competent member of a political community" (2000:98).

The ethics and aesthetics of the self constitute an ongoing process whereby the individual is continually acting upon the self in an attempt to master it. Self-mastery requires that the individual both know and be able to care for the self. Within neoliberal discourse, self-harm reflects individual difficulties in caring for the self. Because of the regulation of available choices, governments cannot ensure that all citizens are able to get what they want or need (White & Hunt 2000). Unfortunately, all choices are not available to all citizens.

Under neoliberalism, the art of governance, and so citizenship, is based on what we consume, the types of lifestyles we choose and the kinds of identities that we create and express. Ultimately, citizens' decisions that are deemed inappropriate according to the neoliberal standards of acceptable behaviour should not be grounds to deny the fundamental rights accorded to us as biological and/or psychiatric citizens.

The following two sections examine these two newly emerging forms of citizenship – biological and psychiatric – which I use to discuss the rights that prisoners have with respect to their health and mental health.

Biological Citizenship

Adriana Petryna (2002) coined the term 'biological citizenship' in her work on the aftermath of the Chernobyl disaster in the Ukraine. Petryna describes biological citizenship as:

> ... a massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it. The damaged biology of a population has become the grounds for social membership and the basis for staking citizenship claims (2002:5-6).

Subsequently, Nikolas Rose and Carlos Novas took this original conception of biological citizenship and adapted it:

> ... to encompass all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species. Biological citizenship can thus embody a demand for particular protections, for the enactment or cessation of particular policies or actions, or, as in this case, access to special resources (2004:2-3).

By citizenship projects Rose and Novas (2004) are referring to the strategies through which governments and/or authorities think about and make up certain individuals as potential citizens, and the ways in which these authorities act upon citizens and encourage self-government.

Political scientist Michael Orsini claims that paying attention to the notion of biological citizenship "opens a space to think about the emergence of illness as a new political cleavage, as an identity through which citizens frame their demands on the state and civil society. This identity is linked to how we relate to our biological bodies" (2006:5). Similarly, neoliberal citizenship projects can be viewed as rooted in the goal of identity management (Muller 2004). Orsini's work examines the narratives of Hepatitis

C sufferers, and illustrates how a risk discourse is used to downplay individual health concerns in order to reemphasise the individual's responsibility for their own health and welfare (2006:8). For example, Orsini found that when Hepatitis C was contracted through injection drug use, emphasis on the recklessness of drug use reinforced the notion that the victim was at fault.

A chronic illness can create a kind of biographical disruption (Bury 1982 as cited in Orsini 2006), but it can also act for some as a motivator to develop a comprehensive plan about how to make positive life changes[34] (Orsini 2006). Similarly, Orisini found that some individuals have more than one biological identity and/or illness to address, and that one illness may at times take precedence over the other. A biological identity may be constructed around a Hepatitis C (or other chronic illness) diagnosis or, as I suggest, it may be built around a shared kind of biological identity such as identities that are found amongst those suffering from self-harming behaviours.

While I believe that Orsini is right to politicize illness narratives, this approach is, like Petryna's, too narrowly focused. While some suggest that the concept of citizenship is rapidly becoming "too elastic" (Powell 2002), I argue that being overly restrictive provides a foothold for exclusionary politics that may prevent those who are marginalised from realising biological citizenship claims. Certainly, basing claims for biological citizenship on illness narratives begs the question of what kinds of illnesses will be accepted as foundations for making such claims. The conceptualisation of biological citizenship offered by Rose and Novas allows for a broader scope that has greater potential than did Petryna's original one. We must not limit our analyses of biological

[34] This is not meant to imply that there are appropriate and expected ways of self-governance.

citizenship to cases that evoke massive state responsibility due to, as in Petryna's example, chemical or nuclear disasters. I use Rose and Novas' work to begin discussing the implications of self-harming behaviours that are carried out by women prisoners, and to examine the potential for making biological citizenship claims regarding better treatment for substance use, and the danger of using administrative segregation as the official response to women who engage in self-injurious behaviour.

A goal of neoliberal governance is to downplay the responsibility of the state by focusing on the responsibilities of each individual citizen as a social agent. This responsibility for the self includes a corporeal responsibility.[35] It is important to consider what happens to the citizenship statuses of individuals who fail to act responsibly with respect to their corporeality and/or health – for example, by engaging in illicit substance use or self harm. As discussed in the literature review, a division exists about how illicit substance use is constructed. The disease model of substance use suggests that like other physical illnesses, all of which may invoke an illness narrative and an illness identity that the sufferer may come to adopt, substance use should also be viewed as a chronic illness or physical disease. This model leaves no question that a substance use illness narrative and bio-identity should be the footing on which to build a kind of biological citizenship.

Novas and Rose (2004:5) suggest that biological citizenship operates in a kind of political economy of hope, so that "biology is no longer blind destiny, or even foreseen but implacable fate. It is knowable, mutable, improvable, eminently manipulable" (see also Rose, 2007). Given that biological citizenship is both individualising and

[35] Rose and Novas (2004) and Rose (2007) suggest that the neoliberal responsibility for the self also includes a genetic responsibility, but as this point does not further the current discussion it will not be explored here.

collectivising, it has come to be a part of government and can thus be viewed as a kind of technology of the self. However, biological citizenship is unique because it has the potential to turn the notion of self-government on its head due to its inherent ability to connect the individual to similar others. This provides the space for a rallying point from which to seek social change.

With respect to the collectivising aspect of biological citizenship, Rose and Novas claim that:

> The forms of citizenship entailed here often involve quite specialised scientific and medical knowledge of ones' condition: we might term this 'informational bio-citizenship.' They involve the usual forms of activism such as campaigning for better treatment, ending stigma, gaining access to services and the like: we might term this 'rights bio-citizenship.' But they also involve new ways of making citizenship by incorporation into communities linked electronically by email lists and websites: we might term this 'digital bio-citizenship' (Rose & Novas 2004:6).

When we look at our example of substance use, we see that if fulfils all three of these collectivising criteria. In fact, the report published by the government of Canada on the stigma associated with substance use and mental illness (Kirby 2007) illustrates both the informational and rights bio-citizenship discussed by these authors.

Some of the most predominant substance use treatments continue to be based on the twelve-step approach originally outlined by Alcoholics Anonymous (and later adopted by Narcotics Anonymous, Gamblers Anonymous and many other similar groups). Proponents of this program claim that addictions are diseases, which suggests that the individual is powerless over their drug and that they must fight addiction every day in order to maintain a clean and sober lifestyle. A disjuncture exists between this view and the corrections approaches to substance use. In the carceral context – despite

their reliance on AA and NA groups – substance use is reconstructed as a poor choice. Because of the illegality of substance use, women who use are reprimanded with new institutional charges that commonly result in longer sentences and disciplinary segregation for having contraband.

In Canada, there are three stages of substance use programming at the federal level, while at the provincial level there is only limited access to AA and NA groups that come to volunteer in the prison. Upon release, the women are encouraged to continue with AA and NA groups in the community, however, some centres require that women be clean for a certain number of days before entering, while others refuse to allow women to bring their children. If we understand addiction as a disease then this should allow space for substance users to regroup and demand an increase in services as a right of their biological citizenship. However, corrections' reconstruction of substance use as a poor choice by the individual represents an attempt to deny the potential for substance users to collectivise, and is certainly an endeavour to thwart any potentiality for criminalised women to make citizenship claims based on their biological identity.

Acknowledging the use of the disease model is particularly pertinent given the rhetoric of corrections that tries to blame and fails to offer help to substance users. Citizenship claims require a 'remaking' of these citizens and a reshaping of how authorities view them, as classification has the potential to both unify and divide (by delimiting the boundaries of different kinds of treatment) (Rose & Novas 2004).

However, tensions arise because a fundamental component of biological citizenship is to become active; the 'good' biological citizen lives by calculation and choice. If diagnosed with cancer, quit smoking, start eating better, exercise etc. The

tension is created by the fact that the 'disease' of substance use is reformulated as a 'bad decision', often compounded by more 'bad decisions'. Rose and Novas suggest that "the enactment of such responsible behaviours has become routine and expected, built in to public health measures, producing new types of problematic persons – those who refuse to identify themselves with this responsible community of biological citizens" (2004:22). Substance users are one of these groups of problematic persons who are denied citizenship claims by the neoliberal health care system that requires activism on the part of the individual. Substance use does not make the cut for biological citizenship claims – mostly because the individual is constructed as inflicting the harm on themselves.

Next, I build on this notion of biological citizenship by pushing this new envelope to include a kind of psychiatric citizenship. There is some overlap between these two concepts, but it is more reflective of the nature of the issues plaguing criminalised women to discuss them under the umbrella of a psy-identity and the potential for psychiatric citizenship.

Psychiatric Citizenship

The question surrounding 'psychiatric citizenship' is: How can we offer citizenship rights to those deemed to lack the required mental capacities for making (the right) choices? There is a clear link between biological and psychiatric constructions of illness, identity, and citizenship – most importantly because the psy identities discussed here can have serious health consequences.

Like biological citizenship, psychiatric citizenship also embodies demands for protection, for the enactment or cessation of particular policies or actions, and access to

special resources. In other words, criminalisation should not disqualify individuals from receiving care, treatment, or resources that are available to the wider public.

Concretely, self-injury and disordered eating are two potential psychiatric citizenship projects. Given that disordered eating is listed in the DSM, it seems clear that it is accepted as a psychiatric illness by the governing authorities (psy experts), and thus has the grounding from which to construct a psy-identity. Self-injury is less clear-cut, as it is only listed as a symptom of other psychiatric illnesses such as borderline personality disorder. As technologies of the self that are also constitutive of identity, the individual embraces disordered eating and self-injury as practices of self-reflection and as strategies of aesthetic or ethical self-improvement and self-punishment.

To make the link between (self-harming) identity and citizenship, we must revisit what citizenship entails. Rose and Novas (2004:27) write:

> Biological citizens ... are encouraged to read and to understand their condition in particular, and their biological existence in general in the languages and rhetorics of contemporary bioscience and biomedicine. Citizenship takes on new biological colourations and hope becomes bound up with scientific truth.

Sufferers of what are seen as acceptable or legitimate biological conditions are expected to educate themselves about their condition; the same cannot be said for those suffering from 'psychiatric illnesses'. Particularly in the carceral context, individuals who suffer from a psychiatric illness are denied access to knowledge regarding diagnoses of their own illness (Rhodes 2004). In the carceral setting, self-injury and disordered eating lose their status as identities on which citizenship claims can be made *because* of their status as psychiatric illnesses (or symptoms of).

In the carceral context, psy treatment consists of medicalisation and periodic confessions to a psy expert. Criminalised women often embrace psy through illness labels that are rarely fully or adequately explained to them, and accept prescription medications about which they have little information. Concealing or denying information about an individual's psy identity makes it difficult for individuals to collectivise under a psy identity or to form psychiatric citizenship. Similarly, it is difficult for individuals to become political with respect to illnesses that carry such stigma (Kirby 2007).

Islin (2004) suggests that we have moved past Foucault's conceptualisation of biopolitics toward 'neuropolitics' that are based on the "neurotic citizen" (Islin: 2004) who governs herself reactively through responses to personal anxiety, uncertainty or unease (2004:223).

Islin's notion, which is reminiscent of risk theory (Castel 1992), that the anxieties of the neurotic – and I argue the psy – subject are to be managed rather than eliminated is critical:

> Governing through neurosis means that the neurotic subject is incited to make two adjustments in its conduct to render itself a citizen. While on the one hand the neurotic citizen is incited to make social and cultural investments to eliminate various dangers by calibrating its conduct on the basis of its anxieties and insecurities rather than rationalities, it is also invited to consider itself as part of a neurological species and understand itself as an affect structure ... the neurotic subject is one whose anxieties and insecurities are objects of government not in order to *cure* or *eliminate* such states but to *manage* them. (Islin 2004:223)

Whereas the biological body has the potential to free itself from some diagnoses or to become symptom free through the adjustment of conduct and the proper treatment, psychiatric illnesses are constructed as chronic and ever-present even when managed. Islin (2004:226) points out that "the transformation from neurotic subjecthood to

citizenship involves responding to calls to adjust conduct via calculating habits but soothing, appeasing, tranquillizing, and, above all, managing anxieties and insecurities." Living in a *Prozac Nation* (Wurtzel 1994), this management of the anxiety of the neurotic citizen and the symptoms of the psychiatric citizen is of course predicated upon pharmaceutical intervention. The fact that every single one of my participants was prescribed some form of medication is more than just an indicator of medicalisation as a prison practice – it is indicative of a desire to sedate and quell any potential for rallying under the umbrella of their psy-identities in order to make citizenship claims.

> If the body was trained and disciplined in the nineteenth century and cared for in the twentieth, in the twenty-first century it has become the site of a strange experiment where it aims for an illusory perfection by various forms of intervention … so the problematizations of anorexia and bulimia are caught up in a cycle of three overlapping phases: a condition brought upon achieving a perfect body and hence creating the neurotic subject in the first place; a neurotic problematization of this condition in search of solutions, almost a neurotic response to neurosis, hence creating new neurotic subjects (those who are in charge of anorexic and bulimic subjects); and neuropoliticization and neuromedicalization as responses to the problems thus defined, which transforms the neurotic subject into the neurotic citizen. (Islin 2004:227-228)

Diagnosing and prescribing medication to sedate a population is not treatment, nor is it addressing the rights of an already marginalised population who may be in need of and have the rights to (access) different services.

The neurotic citizen cannot make the claims, demands, and requests for adequate access to services, knowledge, information, and social support that can be made by psychiatric citizens. It is not about entitlement for the psychiatric citizen, but of rights to services that would help them with their illness. In the carceral context, criminalised women are denied services and potential treatment options which might be available in

the community.[36] Moreover, self-injurious behaviour is reconstructed in neoliberal terms as manipulative and attention seeking behaviour.[37]

Ultimately, there are three avenues available for the betterment of the health of criminalised women in their capacity as psychiatric citizens: (1) re-evaluate the power of psy as it is practiced in corrections, with the hopes of reducing reliance on such diagnoses and prescriptions; (2) improve access to the kinds of services and treatments desired by criminalised women (which would require improved access to information and education regarding each individual's mental health so that they are able to be involved in the decision making process – which by and large would be a step toward a woman-centred model); and (3) provide care in and through the community rather than through correctional authorities.

Conclusion

There is an historical trend within criminological and correctional literature to construct criminalised women as dangerous, evil, mad, bad or sad. Women (and criminalised women more specifically) have a long history of involvement with psy-care, where their minds and bodies have been constructed as pathological and malfunctioning (Ussher 1991). As a result, women have been encouraged to seek cures for their inherent 'lacks' via myriad treatments ranging from the current focus on medications to electro-convulsive therapy and even surgery (including lobotomy, hysterectomy, and sterilization) (Kershaw & Lasovich 1991; Menzies 2002).

---

[36] It should also be noted that treatment options for mental health care are widely privatised and are too expensive for many people to access.

[37] The impact and consequences of using administrative segregation as a response to self-harming behaviours is addressed in detail in Chapter Eight of this dissertation.

We need to recognise the negative consequences of trying to use the criminal justice system as an instrument of reform since its primary role is social control of threatening populations (Snider, 1994) and challenge the veil of institutional secrecy that still cloaks life in prisons.

To date, few criminologists have examined identity processes or politics in any empirical way. Critical scholars need to turn to the concept of identity as a reflexive strategy and as a method of coping and resisting in order to legitimise the voices and agency of criminalised women. As Bosworth (1999) demonstrated, women will be able to preserve some agency even in a system that seeks to reform and responsibilise, if prisoners are able to maintain some semblance of identity. I have suggested not only that we have fixed components to our identities, but also that one's identity as a whole is always already changing, re-emerging, developing, and being negotiated. The malleability of identity allows us to be adaptable to different situations – including the carceral context.

Given that criminalised women exist in a world that labels them, a constitutive piece of their identities may certainly be built around their identification with the labels they receive from the correctional system. Medically speaking, psy diagnoses may actually proffer a residual space for criminalised women to unite under their bio and/or psy identities in order to create biological and/or psychiatric citizenship claims for better access to services and treatment – both within the carceral context and in the community. To make such claims does require a certain degree of activism, and given that prisons are inherently divisive and individualising, becoming unified can be quite difficult. A positive example to follow is the groundbreaking resistance engaged in by Irish political

prisoners (Corcoran 2006). To reconstruct oneself as a biological or psychiatric citizen may open up the space for a new kind of dialogue centred around prisoners' rights issues that are all too often ignored.

In the next chapter, I explore the methods used to conduct this research. Specifically, I outline how I generated an integrated methodology that draws on elements of feminism, grounded theory, in depth or ethnographic interviewing, and critical discourse analysis. The research design and issues of ethics, access, confidentiality and anonymity are all addressed.

Chapter 4
Ways, Means, and Methods: Constructing an Integrated Methodology

> They have welcomed us into their spaces to 'exploit' our capacity – our class and professional positions and networks – and our willingness to write and to testify to those aspects of community life that the media ignore, that stereotypes deny, that mainstream culture rarely gets to see. And yet we seek not to romanticize resilience – for these spaces represent severe critique as well as warm comfort. (Fine et al., 2000:123)

> The problem is not one of changing people's 'consciousness' or what's in their heads; but the political, economic, institutional regime of the production of truth. (Foucault, 1977:14 as cited in Lather, 1991:100)

> Use your heart and your brains when you talk to people, Jennifer. (Brian Kilty, a lifetime of personal communication).

This chapter consists of two overarching sections. The first section examines the methods (ethnographic interviewing and critical discourse analysis) and the methodological approach (critical feminist lens) adopted to complete this research. The second section provides a discussion of the research design, details of the methodological journey, data sources, sample, data collection procedures, ethics, confidentiality, anonymity, informed consent, conceptual baggage, as well as the strengths and potential limitations of this research project.

Part 1: Epistemological Issues and Methodological Concerns

Critical Feminist Lens

In her classic 1986 text, *The Science Question in Feminism*, Sandra Harding suggests that we should not think about a distinct feminist method, but that we need to filter method through a feminist lens[38] (1986, 1987). The goal of feminist research is to discover the material and experiential realities of people rather than universal or generalisable knowledges. So while research methods are the tools used to obtain these partial and situated knowledges, feminist standpoint epistemology[39] demands that our methods begin with questions that are rooted in women's lived realities (Hesse-Biber et al. 2004:15). Smith contends that epistemology must start from women's experiences, and must stress women's personal understanding thereof (1987:107). Ultimately, the goal is to examine the relations of ruling[40] and the experiences of both the dominant and the subjugated (Smith, 1987, 1990a, 1990b).

Feminism challenges the traditional 'scientific'[41] and ahistorical approach to professionalism, which demands that we abstract experience and subjectivity (Addelson 1991; Fonow & Cook 1991; Grbich 1991; Mies 1991). Traditional androcentric research requires that the researcher remain removed, objective and invisible in the research process; a male normative standard is invoked, where femaleness and subjectivity are

---

[38] Stanley and Wise (1983:55) contend that there is no singular feminism, but that three key features underlie most feminist research: women are oppressed, the personal is the political, and there is a feminist consciousness. While these three features may be universal in a general sense, I would argue they also are individuated by each researcher/participant relationship.

[39] 'Feminist Standpoint Theory/Epistemology' has a rich history and development; however, it is beyond the scope of this dissertation to examine the complexity of standpoint theory. For a more detailed examination of the history of standpoint theory, see Naples 2003. I should also point out that I am using a more multi-contextual standpoint theoretical approach to methodology and interviewing.

[40] This notion of "relations of ruling" was conceptualized by Smith (1990a, 1990b).

[41] For a more detailed examination of this literature see Addelson 1991, Harding 1986, Mies 1991.

equated with less valid and/or biased research (Addelson 1991; Fonow & Cook 1991; Grbich 1991; Mies 1991). Feminist researchers have challenged this assumption and require that we acknowledge ourselves within the process. Moreover, they suggest that not doing so is unethical and biased (Addelson 1991; Fonow & Cook 1991; Grbich 1991; Mies 1991). Grbich writes:

> Male knowledge as objectivity not only places women as unknowledgeable, it excludes the different representations about power constituted within women's lives... The focus becomes one of retrieving women's experiences of authority in both senses of being subjected by the traditions of objectivity and rationality and being the subjects of authority, that is, being knowledgeable about relations of power (1991:75).

Through a feminist approach to research methods, women have become knowledgeable and knowable on their own terms and in their own voices (Fonow & Cook 1991). Feminist research has therefore attempted to give authority and 'power' back to subjectivity. More generally, feminism has created a space for action-oriented research, or research as empowerment (McCormack 1987; Ristock & Pennell 1996; Naples 2003). This approach to research results in more than knowledge production; the goal is research as praxis and social awareness, emancipation and/or consciousness-raising (Acker et al. 1991). Lather writes,

> I use empowerment to mean analyzing ideas about the causes of powerlessness, recognizing systemic oppressive forces, and acting both individually and collectively to change the conditions of our lives... Empowerment is a process one undertakes for oneself; it is not something done 'to' or 'for' someone (1991:4).

Ultimately, one cannot assume that empowerment will be the outcome of the interview experience, nor can a researcher resolve to make it happen. The concept of empowerment emerged from feminism as praxis as women started to become empowered

by telling their stories in their own voices and from their own standpoints (Stanley & Wise 1983, 1991; Ristock & Pennell 1996). However, mainstream bureaucracy has since reduced the concept to mean little more than self-assertion (Ristock & Pennell 1996:3). In fact, empowerment is now a claimed goal of federal corrections for women in Canada (TFFSW 1990; Morin 1999; Hannah-Moffat 2000; Kilty 2006). As a critical feminist researcher it is essential to be aware that empowerment ultimately comes from within, and that one's role as a researcher may or may not assist a woman down that path.

Standpoint epistemology has been criticized for constructing a universal and essentialist standpoint of women, requiring that we shift toward a more fragmented and identity-driven standpoint approach (Hartsock 1987; Millman & Kanter 1987; Hannen 1987; Harding 1986, 1987; Naples 2003). This approach requires that we see women and researchers as having a multiplicity of identities and a unique subjectivity that come to interact within the interview process (Bloom 2002). According to Harding, rather than threatening it, subjectivity increases both objectivity and reflexivity by creating a dialectic between the two (1986, 1987). Feminism has demanded that we recognize that our own conceptual baggage, status, positionality, and histories impact how we do research (Kirby & McKenna 1989; Stanley & Wise 1983, 1991; Williams 1990; Acker et al. 1991; Fonow & Cook 1991; Mies 1991; Reinharz 1992; Ristock & Pennell 1996; Naples 2003). Situating the self in field notes is a way for the researcher to reflect on her impact and role within the interviews (Williams 1990). Knowledge from this vantage point is constructed rather than given, and truth is always relative and context dependent (Hannen 1987:45; Williams 1990:256). Constant reflexivity changes how questions are asked and formulated. However, "the feminist researcher must not ignore the power that

is inherent in her own assumption of ability to grant voice to the 'othered'" (Acker et al. 1991; Naples 2003; Hesse-Biber & Leckenby 2004:215).

The Ethnographic and Grounded Theory Approach to Interviewing

Research methods literature is vast, nuanced and fragmented, and is continuously being developed and changed by the research we actually 'do'. The researcher has become a *bricoleur*[42], because of the blurred genres of methods and the ability to borrow across disciplines (Denzin & Lincoln 2000:3). Rather than triangulating methods, the post-modern researcher uses the crystallization process whereby the writer tells the tale from many different standpoints (Denzin & Lincoln 2000:5).

> Crystals grow, change, alter, but are not amorphous. Crystals are prisms that reflect externalities *and* refract within themselves, creating different colors, patterns, arrays, casting off in different directions. What we see depends upon our angle of repose. Not triangulation, crystallization (Richardson 1997:92 as cited in Lincoln & Guba 2000:181).

Adopting this bricoleur approach to research methods, I have borrowed concepts and approaches from a variety of methods, integrating them into my own methodological toolbox. For example, I have used 'ethnographic interviewing' as the method to gather data.

Metaphorically describing the ethnographic interview, Erving Goffman discussed how we live in, and experience, a 'dramaturgical culture'; life is a stage, whereby social actors engage in social interaction and experience (Prus 1996; Denzin 2001). Denzin writes,

[42] The term 'bricoleur' was conceptualised by Claude Levi-Strauss in his 1962 book [published in English in 1966] *The Savage Mind.* Chicago: University of Chicago Press.

> We inhabit a performance-based, dramaturgical culture. The dividing line between performer and audience blurs, and culture itself becomes a dramatic performance. Performance ethnography enters a gendered culture with nearly invisible boundaries separating everyday theatrical performances from formal theatre, dance, music, MTV, video, and film (2001:13).

Interviews are social interactions, but they are also performances by both the interviewer and the interviewee. The 'real' persona of either party can never be truly known in this process, as they are engaging in an interaction where certain elements of their personhood are made known and others are kept hidden.

Reinharz suggests that, "ethnography is a multi-method research involving observation, participation, archival analysis and interviewing" (1992:46). However, traditional ethnography is androcentric and in a sense positivistic because it involved the interpretation of a culture by the 'objective' researcher (Harding 1987; Tedlock 2000). No researcher can be truly objective and it is essential to the validity and ethicality of the study to acknowledge and investigate how one's own subjectivity affects the interpretation of a culture, and ultimately the creation of knowledge. In this sense, ethnography is constructionist/constructivist as we interpret and define a reality that is not our own. It is therefore necessary to foster a co-constructed reality with a sense of intersubjectivity, where the participants actively engage in the interview and analysis process (Caplan 1993; Reinharz 1992; Karim 1993; Coffey 1999). Prus writes,

> Like the mind more generally, people's images of the self are predicated on interaction with others and involve people "taking the role" (adopting the viewpoint of the other). As with mind, interaction (made possible through language) is essential if people are to develop a sense of self (1996:54).

In this sense, our 'selves' are co-constructed via interaction and what Goffman calls 'impression management' (Prus 1996:79). Here the interviewer and interviewee engage in an ongoing social relationship and dialogical production of knowledge. Identity work is thus contingent on our ability to be self-reflexive (Prus 1996:152). Our self-identity is thus ever emerging and always already developing. Culture and cultural identity cannot be assessed as stagnant or readily observable, but rather they constitute a process involving identity, representation, interaction and reflexivity.

I conducted semi-structured interviews to provide interviewees with the ability to discuss their experiences of imprisonment; therefore, I forfeited the role of 'expert' in order to project the approach of participant as expert (Flick 1998; Fontana & Frey 2000). By semi-structured, I mean only that self-harm and identity were addressed as topic issues. In this way, questions remained open for participants to answer as they saw fit. The questions were descriptive and acted almost like "friendly conversations" (Flick 1998:93; Warren 2002). As noted by Wincup, "semi-structured interviews allow women to introduce issues they would like to discuss and therefore help interviewers gain insight into the most important aspects of the women's lives" (2001:23). "Thus, the interviewer can and must decide during the interview when and in which sequence to ask which questions… and if and when to inquire in greater detail" (Flick 1998:94). This method of interviewing requires a high degree of sensitivity to the research situation and the dialogical exchange. The goal is to obtain unobstructed narratives regarding life in prison, self-injurious experiences and identity.

Borrowing from grounded theory, to the effect that participants are encouraged to construct their own narratives, allows for the creation of a meaningful theoretical position

from within the cultural milieu of the data. Drawing theory from the dialogical exchange is more representative of the participants' lived experiences (Fontana & Frey 2000). This aspect of the grounded theory approach is also conceptually complementary to the postmodern trend in interviewing that requires abandoning any overarching theoretical beliefs or 'truths' (Fontana 2002). In fact, Flick states that, "by linking narratives and question-answer sequences this method realizes the triangulation [or more accurately, crystallization] of different approaches as the basis of data collection" (1998:111).

Warren suggests that, "the interview, like the ethnography, is about the self as well as the other" (2002:97). The ethnographic interview should therefore be reflexive for both the researcher and the participant, where spoken discourse is co-created and mediated by the interaction between the two. This type of interview requires in-depth discussions as well as reciprocity and mutual self-disclosure (Edwards 1993; Johnson 2002). Because very personal and perhaps traumatizing topics were being discussed, the use of in-depth interviews was essential as was the ability to empathize and self-disclose. Through self-disclosure, I was able to gain participant trust and build rapport. In fact, many women seemed to feel more comfortable with an exchange of information rather than a one-sided interrogation.

Grounded theory asks the researcher to engage in active interviewing (Holstein & Gubrium 2002, 2004). The active interviewer seeks to converse with interviewees and is part of the co-construction or meaning-making process. Meaning is therefore socially situated and the interviewer has a contingent impact on the interviewee's construction of the experience. While detractors of grounded theory contend that it glosses over meanings with narrative stories (Charmaz 2000:521), this criticism neglects the fact that

the theoretical position that is generated is reflective of an interactive and dialectic process between interviewer and interviewee. The theory is not simply a re-presentation of the participant's story; it is a reflexive account of an intersubjective experience where both parties create knowledge. This approach does not limit entrance into the other's world; rather it actively engages with the construction of that world. Grounded theory offers a self-reflexive and perpetually comparative approach that purposefully seeks out deviant cases, which in turn provides strength to the validity of the study (Glaser & Strauss 1967; Charmaz 2000).

The Ethical Positioning of the Self and the Participant

Interviewing as an interactive process is an occasion for identity work by both the researcher and participant. However, the 'self' is often constructed as having a dual identity as respondent and researcher (Edwards 1993; Coffey 1999). I inevitably practiced some level of self-censorship in my self-disclosure and adapted my approach and level of disclosure to each participant, as I am sure they did with me. Coffey suggests:

> The positionality of the self is the starting point for such accounts. The narratives of the self parallel, and to some extent consume, the narratives of the field. The selves that are constructed and written are complex and relational. They are not research instruments, or props. Rather they are gendered, racialized, sexualized, embodied and emotional (1999:125-126).

Selves are also historicized, in that our actions and perceptions are founded in historically situated contexts; it is the job of the interviewer to attempt to understand the in situ positioning of both themselves and the participant. The self should therefore be present and emergent within the dialogical process and text.

Ethnographic interviewing is a process of interaction and negotiation[43] between the two parties. Rapport is thus critical and is intensified when researching a sensitive topic (Tewksbury & Gagne 1996). Although we may attempt to adapt or script ourselves (including style of dress, demeanour, and interview style) to each participant, we may never know how he or she truly perceives us (de Laine 2000; Tewksbury & Gagne 1996:73). Further, there is much discussion about what has been called the insider/outsider debate (Tewksbury & Gagne 1996). I would argue that having a shared status (such as race, class or gender) does not guarantee trust and rapport, although in some instances it may help (Edwards 1993). Trust and rapport are often more difficult to establish among groups that may be justifiably suspicious of authorities or 'experts' (Berk & Adams 1996). In my case, it may be a hurdle to overcome that I am an outsider, never having been imprisoned. In fact, several of the women asked me if I had ever been in prison, as in the following exchange:

Phoebe: Have you ever been in prison?

Jen: No.

Phoebe: Oh, it just seems that you sort of get it, you know. So I thought you'd done some time or something.

Despite the social distance that existed between the women and myself, I was clearly able to connect with them to build rapport. I achieved this connection by being sensitive to their stories, and by presenting myself as someone who wants to see change in the system rather than someone who was interviewing them out of morbid curiosity (Berk & Adams 1996:61; de Laine 2000). Taking this kind of advocacy stance requires the researcher to try to 'give back' or engage in research as praxis (Harvey 1990). In

[43] This concept of the negotiation of the self comes from the symbolic interactionist approach to research. This approach contends that the self develops over the course of one's entire lifetime (de Laine, 2000).

order to do this I joined the Board of Directors at a local Elizabeth Fry Society (Efry), so that I am able on some level to effect change for criminalised women.

It was important not to appear shaken by what I heard or saw; loss of composure could diminish rapport that was building (Berk & Adams 1996). Listening without judgement is key when dealing with criminalised populations given that you may be exposed to actions and behaviours that run counter to your own value system. If you are shocked or show disapproval, you may 'lose face' and credibility with that group. This concept of 'losing face' highlights the fact that each culture has its their own context-specific scripts, and for example I would not be privy to 'prison scripts' before engaging with my participants. Therefore, it was important to act naturally and at ease, as this is one of the simplest ways to encourage a dialectic relationship (de Laine 2000:41-43). Obviously, because the prison script is implicit rather than explicit, I had to be highly sensitive to the culture as well as to how the women engaged with me. Ultimately, I took my cues from them. To clarify, I did not 'act' or present a false sense of self; I did however, aim to come across as judgement free so that participants would not feel as though I was looking down on them.

Maintaining Sensitivity Through Emotionality And the Active Engagement of Difference

In order to maintain sensitivity to the positionality of your participants, it is essential to acknowledge how their knowledges are gendered, racialised, class-based, sexualized and historicized. Theoretically and methodologically feminism has opened the door to this research strategy. I would like to focus on two important approaches to

maintaining sensitivity: first, the use of studying emotions (emotionality) in research; and second, the 'active engagement of difference'.

Studying emotions is a relatively new phenomenon. Gilbert defines emotions as:

> ... varied, complex, unintentional, intentional, socially constructed, something to be actively engaged in, and interwoven with one's value system... They are more than physiological sensations, but are often experienced in this way. They guide our interpretations of what we experience and are shaped by our life experience (2001:10).

This excerpt is important as it highlights the fact that our emotions guide our interpretations of our experiences. The symbolic interactionist approach to emotions suggests that, "expressions of emotions and gestures are not inherently meaningful but rather reflect the social contexts in which people find themselves" (Prus 1996:174). While Prus' observation is partly accurate, it ignores the fact that emotions are inherently meaningful as they reflect our sense of self and identity, and can thus influence and guide social interactions. They can be both individualistic and reflective of one's awareness of the other.

It is important to understand how certain groups are constructed as being 'emotional', where emotionality is seen as negative. People are categorized not only on the basis of their 'statuses' but by the ways they express their emotions (Prus 1996). These emotional labels are often reflected in psychiatric diagnoses and correctional labels and discourses, where women are constructed as 'emotional' and therefore as irrational. Emotions are expressions of identity where identity is continously developing, and thus shifting with new experiences and interactions. Race, class, gender, and sexuality, and the emotions that flow from them, are components of one's identity. Gilbert suggests that, "researchers are expected to be emotionally affected by the research process"

(2001:4). If the ultimate goal of research is to enter the world of the participant and to see life and experience through their eyes, then research is ultimately emotional as well as intellectual (Gilbert 2001:4). Ethnographic interviewing offers a sensitive approach to studying culture and the life experiences of the participants[44] (Fetterman 1998). Tapping into emotions is the precursor and requirement for active reflection (by both parties) (Morgan et al. 2001; Wincup 2001).

As a feminist interviewer, I advocate a non-exploitative approach to research that is based on "informality, equality, reciprocity, empathy, rapport, and subjectivity", requiring that we proactively discuss differences of positionality with our participants. Striving for equality requires a high level of sensitivity to differences in statuses (Stanley & Wise 1983, 1990, 1991); however, the relationship is inherently unbalanced because the researcher has the final word with respect to what is written and published. Wincup contends that a "shared sisterhood [is] not predestined" (2001:26; see also Webb 1990). To overcome this potential division, Fine (2000) suggests that researchers must 'work the hyphen', recognising the struggle for connection despite social differences, whether she is similar to (as she can never be the same as) or different from her participants.

> What emerges, in considering actual practices of 'working the hyphen', are the limitations of reflexive practice, which has been seen as a powerful methodological device for attending to, and making explicit, power relations and social and subjective locations within qualitative research (Gunaratnam 2002:91).

[44] At the same time, I do not want to romanticize the study of emotions. It is not necessarily a therapeutic or empowering exercise although there is a great deal of literature that examines the interviewer-interviewee relationship as a possibly therapeutic one (see Kirby & McKenna 1989; Oleson 2000; Stanley & Wise 1983). I cannot critique this argument in detail here, but this may be a very slippery slope if we begin to treat or see ourselves as therapist-like. I would feel much more comfortable offering debriefing sessions with each participant and offering them contacts for counselling if they so desired them. While some participants may find the interaction to be therapeutic in a sense (because they are openly discussing sensitive and emotional topics) I do not want to enter into the research process with the assumption that this may be the result.

Because no research is free from bias or conceptual baggage, more self-reflexivity may not be enough to foster the needed sensitivity to positionality. Gunaratnam suggests that an 'active engagement of difference' (and thus the intersectionality[45] of that difference) will help generate a reciprocal interviewer-interviewee relationship:

> Lived experiences of 'race' and ethnicity (with other social differences) may create 'spaces', or possibilities, for people (in relation to this discussion we can think in terms of researchers/interviewers and research participants) from minoritized groups to use our own constructions of 'experience' to develop insights into the connections between social location, power and difference (Gunaratnam 2003:96).

By actively engaging with difference (and emotionality) the researcher and participant are able to foster a co-construction of race, class, gender, and sexuality, which helps foster empathy, trust and rapport. In the end, interpreting difference is an emotional process that brings full circle my approach to maintaining sensitivity to difference. That is to say, persons who enter the research relationship from a marginalised social position hold a unique, and arguably, a clearer perspective of both the dominating and dominated groups. Actively engaging in 'difference talk', therefore, allows for the emergence of a more critically intelligible position (Harding 1986, 1987; Collins 1991, 2000).

An active engagement with difference forces us to question the authority of those who have historically defined the position and identity of marginalised persons (Cannon et al. 1991; Collins 1991, 2000; Dunbar et al. 2002; Weber 2004). Maintaining sensitivity to positionality demands that we allow for self-definition (Collins 2000;

[45] Collins' 'black feminist thought' and other racialized feminist researchers called for feminism to acknowledge that the early feminist and standpoint theories ignored the fact that racialized women experienced the intersection of race, class, gender, and sexuality as a complex form of oppression, which she calls 'the matrix of domination' (2000).

Dunbar et al. 2002). It is the job of the researcher to create a safe environment for dialogue through active engagement and mutual self-disclosure. The goal of my research is to shift marginality[46] to the centre of research (hooks 1981), to make visible the invisible, and to include omission/exclusion, or what Collins calls 'outsider within status' (1991, 2000). Race, class, gender and sexuality are formed, constructed, and emerge as part of the 'micro-politics of people's lives' (Hesse-Biber & Yaiser 2004:114; see also Dunbar et al. 2002; Weber 2004). Actively engaging in difference offers a strategy for understanding oppression at the macro, mecro, and micro levels of interaction.

The Critical Social Theorist Approach to Discourse Analysis

Narrative scripts allow us to construct different selves, so that we can display different parts of our identity in different situations (Coates 1990:301). Discourse, then, is a means of constructing and 'doing' identity. Discourse analysis[47] emerged from sociological and psychological linguistic approaches to studying language and communication. It has been used to examine how language holds power and is gendered, racialized and class-based. Key to this research is the impact of institutional talk or discourse, which elicits an asymmetry in access to knowledge and discourses. Heritage writes:

> At the same time as professionals and institutional representatives are often cautious about making claims, they also deploy distinctive, functionally specialized, and superior knowledge bases that can impart a

[46] Marginality here refers to the conceptualisation of "research from the margins", which is taken from Kirby and McKenna (1989).

[47] Cameron (2001) goes so far as to distinguish between discourse analysis in anthropology, ethnography of speaking, philosophy, pragmatics, sociology (conversation analysis), linguistics, and critical discourse analysis. I feel that while each strand may have distinctive features, and while I am primarily engaging in critical discourse analysis, I will ultimately draw on elements from each. I believe that discourse analysis is a multi-disciplinary site and approach to research methods, and is therefore much richer as a result.

> specific expert authority to claims made within the relevant knowledge domain. .... In institutional interaction then, knowledge may not be enough; one must also be *entitled* to the knowledge, and have come to it in an appropriate way (2004:239-240).

Institutional talk focuses on the asymmetrical relationships often found in spoken discourse that confine and constrain the talk within interaction. Critical discourse analysis is therefore concerned with the socio-political issues that create and confine discourse (Harvey 1990; Lather 1991; Cameron 2001).

Critical discourse analysis evolved out of the Foucauldian construction of discourse(s) (Gubrium & Holstein 2000; Titscher et al. 2000; Jager 2001; Wodak 2001; Cameron 2002;). Cameron writes:

> Recall Foucault's definition, quoted above: although he calls discourses 'practices', he goes on to say that they 'form the objects of which they *speak'*. The link between practice and speaking (or more generally, language-use) lies in Foucault's concept of 'power/knowledge'. In the modern age, Foucault points out, a great deal of power and social control is exercised not by brute physical force or even by economic coercion, but by the activities of 'experts' who are licensed to define, describe and classify things and people. Definition, description and classification are practices, but they are essentially practices carried out using language. Words can be powerful: the institutional authority to categorize people is frequently inseparable from the authority to do things to them (2002:16).

The notion of a speech act refers then to the fact that language and discourse are used to pragmatically 'do' something. This approach to discourse analysis differs from the sociolinguistic and conversation analysis approaches by allowing meaning to be inferred from larger social structures, rather than solely from the talk itself. The goal here is not only to observe talk within interaction, but also to gain detailed knowledge of the participants' identities and experiences (Gubrium & Holstein 2000; Silverman 2001; Cameron 2002). Gender, race, class and sexuality are always relevant, whereas in

conversation analysis they are only relevant if the speaker makes them so in the talk. Despite Foucault's failure to address gender, race, and class in any substantive way, he did advocate a more in-depth understanding of not only talk/speech and language but also the social forces that create and confine it. Critical discourse analysis is therefore concerned with the 'hidden agenda' of discourse (Cameron 2002:123; see also Gubrium & Holstein 2000; Jager 2001; Wodak 2001).

'Reality' within critical discourse analysis is a social construction whereby each individual has multiple realities and identities. The job of the researcher is to uncover how these realities and identities are used and engaged with in different settings and contexts. There are multiple sides to each story and differing perspectives presented together create a more complete picture of the discourse as a practice in demonstrating identity. In this sense, critical discourse analysts are also interested in constituting how certain images and discourses come to be naturalized (Jager 2001; Wodak 2001; Cameron 2002); this approach is in keeping with the Foucauldian focus on the hidden agenda of discourse and the role of expert classification. Cameron writes:

> In analysing the ideological significance of a text attention needs to be given not only to its surface linguistic features but also to what is not said, but is indirectly hinted at or presupposed as obvious. On 'sensitive' subjects like immigration or sexual violence, speakers may actively avoid stating contentious propositions 'on the record', relying on the ability of a competent addressee to infer those propositions (2002:128).

Meaning then comes not only from what the speaker says explicitly but also from what is implied and from what the researcher is able to uncover from other sources. Critically studying discourse allows us to examine how the individual and the social environment develop over time. Wodak suggests that being "critical is to be understood

as having distance to the data, embedding the data in the social, taking a political stance explicitly, and a focus on self-reflection" (2001:9). Language and discourse are two of the most important and commonly used ways to express identity and who you are, or are not (Cameron 2002:161). I was particularly interested in uncovering how the women talk about, construct, and define themselves; do they use institutional or program scripts, or do they resist these narratives?

Data work for critical discourse analysis can be seen as an ongoing process of simultaneous data collection and analysis (Glaser & Strauss 1967; Titscher et al. 2000; Meyer 2001). The researcher must engage in analysis throughout the process of data collection as a way to focus the study via theoretical sampling, so that there is a constant movement back and forth between theory and data[48] (constant comparative method) (Glaser & Strauss 1967; Meyer 2001; Strauss & Corbin 1998; Titscher et al. 2000).

As previously mentioned, discourses grow, shift, change and take on meaning that is often quite different from the original intent. Jager writes:

> ... in discourses reality is not simply reflected, but ... discourses live a 'life of their own' in relation to reality, although they impact and shape and even enable societal reality... This also means that discourses determine reality, always of course via intervening active subjects in their societal contexts as (co-)producers and (co-)agents of discourses and changes to reality. These active subjects conduct discursive and non-discursive practices. They can do this because as subjects 'knitted into' the discourses they have knowledge at their disposal (2001:36).

[48] I used open, axial and selective coding in order to help locate my themes and sub-themes from the data. For a more complete investigation of coding see Strauss and Corbin, 1990. I also addressed the distinction between the grounded theory of Glaser (1967), and of Strauss and Corbin (1990), respectively. This present work lies in between the two, drawing on elements of each. For example, I used Strauss and Corbin's open questioning approach to interviewing, and I agree that a literature review before the interviews are conducted is helpful. However, it is still essential to return to the literature review over the course of the research, engaging in a constant comparative method here as well as within the analysis/theory development process.

Jager's words are key, as they highlight the concept of *accessible* knowledges and discourses – namely, who has access and who is *entitled* to specific knowledges and discourses. Do the women have access to the knowledges and discourses of those who kept them confined? Are they entitled to read their personal 'case', 'client' or 'patient' files, or is access constructed as being detrimental to their rehabilitation?

In addition, it was important to investigate whether the women engage with or resist correctional discourse. In other words, how do they construct themselves as prisoners and/or as social agents? Similarly, how do the women experience and engage with the construction of their self-injurious behaviour as attention seeking, as evidence of mental illness, or as a threat to the safety and security of the institution?

If discourses hold power because they hold knowledge, then entitlement to power/knowledge should make us question the entitlement of discourse. In prison, individual consciousness is clearly confined within institutional consciousness, which attempts to silence or stamp out individuality. As discourse changes, the object of the discourse also changes, thus potentially altering individual identity (Jager 2001:43). Personal identity is thus always already in flux, as it is altered by shifting discourses that withhold and disseminate knowledge, because personal consciousness is the link between discourse and reality (Jager 2001:45).

Deconstruction requires that we reverse the position of hierarchical discourses, where the subjugated discourses and knowledges get placed at the centre of the inquiry (Lather 1991). To deconstruct and re-construct a text (spoken and written discourses) is to turn the text back in on itself, to see what has been muted, silenced, or complicated (Lather 1991:83-84). Harvey (1990) suggests that the reconstruction process is not

simply about putting things back together again, but of reconceptualizing them. As a critical discourse analyst, it is imperative to create the space for subjugated persons to create discourses and knowledges for and about themselves, and in their own voices. The goal here is to offer room for resistance and to generate a space for a unified subject-hood that is made up of a fragmented consciousness. Ultimately, we need to think of deconstruction and reconstruction[49] as a socio-political action, where "social relations mediate the construction of knowledge" and where we must ask who is speaking at all times (Harvey 1990; Lather 1991:91; Titscher et al. 2000). To use critical de- and reconstruction as a methodological tool, one must be aware of how she is involved in the construction and possible subjugation of knowledges and discourses.

According to Titscher et al., "discourse analysis means ... the analysis of relationships between concrete language use and the wider social and cultural structures" (2000:149). However, while discourse analysis sheds light on socio-cultural and socio-political structures, "culture is not directly observable" [50] (Alasuutari 1995:94; Baker 2002). The dialogical exchange is not representative of the 'true' culture, and must be recognized as being socially constructed and situated. Deconstruction and reconstruction are therefore laden with subjective and ideological influences.[51]

[49] For a more detailed examination of the process of de- and reconstruction, see Harvey 1990.

[50] In that culture is not directly observable, internal validity can be assessed by participant agreement with the analyses (Merriam 2002). And as aforementioned, when my participants disagreed with my analyses of their realities, I returned to my analyses to rework them; apart from this, I attempted to present the two perspectives within the written report. This form of collaboration is often referred to as conducting *member checks* (Merriam 2002).

[51] While my research draws on Foucauldian notions of discourse theory and analysis and he did not use the concept of ideology in his work, I do not think they are mutually exclusive categories that cannot work together. To support this notion I draw on Purvis and Hunt's (1993) article "Discourse, Ideology, discourse, ideology, discourse, ideology..." in which they propose a theory of ideology that supplements discourse theory rather than opposing it.

In this sense, the deconstruction and reconstruction of discourse is similar to the analysis of narrative accounts, in that "the truths of narrative accounts lie not in their faithful representations of a past world, but in the shifting connections they forge among past, present, and future" (Riessman 2002:705). Harvey writes:

> With each new conceptual level the area of enquiry is empirically and conceptually deconstructed. This process is ongoing, the new conceptualizations are used to reconstruct an alternative perspective. Thus, slowly, the ideology embedded in prevailing conceptualizations is undermined. The core abstraction is related to the social totality to see if it reveals further the nature of the workings of the totality. Empirical data is used to elaborate the relationship and suggest further deconstructive stages. The nature and manifestations of ideology are continually revealed. The new and radically different conceptualization of the social processes and structural relations emerges. For critical methodologists then, science as the basis for the understanding of the social world, is not the construction of causal laws, but of a deeper understanding which goes beyond surface appearance and relates the parts to the whole. As such it differs too, from phenomenological approaches in relating this essentialist analysis to the social totality. This process is one of deconstruction and reconstruction (1990:31).

When we deconstruct and reconstruct discourse, we are not, of course, re-creating cultural reality or 'truth', but are instead co-constructing a narrative of fragments of 'truths' in the lives of the participants. Both the researcher and the participants are performing within the interview, and the de/reconstruction of the discourse is the creation of new text, discourse and knowledge surrounding the experiences discussed in the dialogical exchange. It is at this point that we see what Foucault described as the shifting nature of discourse, where the goal is to study experience and meaning, which consists of multiple truths (Riessman 2002). Ultimately, it is important to recognize that "the power relations that emerge in interviews are embedded in the data they produce" (Briggs 2002:912). This is why it is imperative that we re-centre the participant as a subject and co-creator of discourse, rather than as an object to be studied at a distance. Briggs (2002)

contends that this aspect of discourse analysis requires the researcher to relinquish some control over the reconstruction process to the participant.

The Impact of Feminism on Critical Social Studies of Discourse Analysis

Dorothy Smith uses the term institutional ethnography, meaning "the empirical investigation of linkages among local settings of everyday life, organization, and translocal processes of administration and governance", to describe her work on creating a space for the sociology for women (DeVault & McCoy 2002:751). Stressing the importance of investigating the institutional processes that shape the experiences being studied, Smith is particularly interested:

> ... in how people in an institutional setting describe their work using the language of the institution. This is especially the case with people who have been taught a professional discourse as part of their training or people whose work requires them to provide regular accounts of institutional processes. The challenge for the institutional ethnographer is to recognize when the informant is using institutional language. Not to do so is to risk conducting interviews that contain little usable data beyond the expression of institutional ideology in action, because institutional language conceals the very practices IE aims to discover and describe (DeVault & McCoy 2002:767-768).

Smith's approach goes beyond giving a voice to participants and to those marginalised or oppressed persons being studied. It seeks to understand how institutional discourse is used in the oppression of the individual, not only by the institution as a social control structure, but by the individual as well. For, according to Smith, we are all involved in the relations of our own ruling.

Smith suggests that for discourse to be recounted as factual, the experience or information must be shown objectively so that it is clear to anyone that it is so (1990b:27). For example, in her evaluation of a woman (K) who was labelled mentally

ill, Smith found that the people who directly observed and described K's[52] behaviour as abnormal presented K's construction as being 'mentally ill' as a fact. However, this construction is outside of K's control, as K is described as not being part of the labelling process. That which is constructed as normal is separated from that which is constructed as abnormal, where the hierarchy maintains the abnormal person as being an unworthy source of information. The patient, prisoner, or in Smith's case K, is silenced in the labelling process, and the discourse surrounding her 'mental illness' is constructed for her by others. This process reveals a sense of entitlement and even an authorisation process, where the woman's site of experience is regarded as invalid (Smith (1990b:32) calls this the cutting out operation). Who is entitled to discourse construction and who is left out is important in a system or structure (like the prison) where a pervasive, subjugating hierarchy is used to silence certain persons.

Discourses are therefore active. They organise and define the order of things. Active scripts have the power to "constitute a discrete order of social relations characterised by the detachment of discourse from the locally situated speaker and her particular biography" (Smith 1990b:123). These scripts constitute 'institutions within the prison', by which I mean the multiple agencies and sites of discourse: psy-care and treatment discourse, medical care and medicinal discourse, correctional and rehabilitative discourse, and correctional historiography (the correctional biography of the prisoner). Each one of these sites has the ability not only to create its own discourses but also to silence the woman herself who is not entitled to her own discourse within such a total

[52] It is not essential to give detail with respect to Smith's account of constructing mental illness, but it should be noted that her example (of K as mentally ill) provides an excellent analysis and guide for how to deconstruct and reconstruct institutional language and discourse in order to provide a different and critical perspective and situated standpoint (Smith 1990b).

institution.[53] In this way, the actions of individuals can become appropriated by the organisation within which they work. Scripts are therefore "part of the social courses of action in which they become active" (Smith 1990b: 221). Identity is then something we do, produce, engage with and re-create; but it is also created by discourses that confine it to text.

With this, Smith redirects the focus of analysis back onto the body:

> Entering the governing mode of our kind of society lifts actors out of the immediate, local, and particular place in which we are in the body. What becomes present to us in the governing mode is a means of passing beyond the local into the conceptual order. This mode of governing creates, at least potentially, a bifurcation of consciousness. It establishes two modes of knowing and experiencing and doing, one located in the body and in the space it occupies and moves in, the latter passing beyond it. Sociology is written in and aims at the latter mode of action (1990a:17).

Smith advances a feminist critique of sociology and conceives women's bifurcated consciousness to be blended, allowing experience and identity a place within sociology. Knowing from within demands that sociologists start by making their own embodied experiences the basis of their knowledges and discourses (Smith 1990a:22). Simply put, Smith stipulates that "an alternative sociology, from the standpoint of women, makes the everyday world problematic" (Smith 1990a:27).

It was essential for this study for me to realise the site of the women's experiences as embodied subjects. Embodied activities include harmful behaviour such as self-injury, addiction, and eating disorders, not simply body language and bodily interaction in the interview. Heath suggests that visual and material aspects of interaction are becoming

[53] The term 'total institution' was conceptualized by Erving Goffman with respect to his work on asylums. Goffman, E. (1961) Asylums. New York NY: Anchor Books.

more important to the understanding of social engagement (2004:266). Visual data also include the social environment and the setting context, as these can have a direct impact on social interaction. Heath writes, "the sequential and interactional organisation of the conduct remains a critical resource for the analysis of how participants themselves orient to each other's action, make sense of each other's contributions, and produce their own conduct" (2004:271).

The body itself can be seen as a site for interaction research. My own research concerning self-harm is clearly centred on behaviour involving the body. For example, while it was not appropriate to ask to view the women's actual scars, they were quite visible on the arms of some of my participants. I did encounter one woman, Phoebe, who wanted to tell her narrative by explaining what her scars meant to her. Phoebe's explanation of each cut and scar told parts of her life story, similar to how Coffey suggests that:

> The body is negotiated in everyday life, serving as an agent of cultural reproduction and as a site of cultural representation... The body has been recast as a site of discourse and action; as a form of representation; as intimately linked to biography and the crafting of the self (1999:59).

The body as a site of discourse and cultural representation is clearly representative of a Foucauldian inspired analysis. Body-work is symbolic, physical, observational, organised, managed and governed (both by the self and by externalized discourses). A key part of my research is the need to engage in a theoretical analysis of prison discourse as a site that attempts to manage, control, govern, 'empower', rehabilitate, treat, cure, watch and mandate the bodies of its prisoners.

Thus far, I have outlined the methods used to conduct this research. Beginning with in-depth interviews and situating my approach in grounded theory, I conducted a feminist and critical discourse analysis of the data. Doing so allowed me to look at the individual as a site of multiple identities (both discursive and bodily). I treated discourse not merely as representative but as a technique to construct meaning (Sunderland & Litosseliti 2002:6). From this vantage point, spoken discourse is only a slice of the participant's identity. It cannot possibly be an accurate exemplification of the individual's entire identity because discourse and thus identity are always already forming and re-forming.

Part 2: Ethical Issues and Creating a Feminist Informed Research Design

Research Design

This research project underwent several changes from its initial conception. Upon entering the doctoral program, I had my heart set on interviewing federally sentenced women about their experiences of self-injury, specifically self-cutting. Despite the initial best efforts of my supervisor to advise me that this might be a very difficult task to undertake due to the sensitivity of the topic, ethics reviews, and the difficulty so many other feminist researchers were having in trying to gain access to the federal prisons across this country, I ploughed on for two years with this same goal in mind. In the end, I was unable to secure access to either federal or provincial prisons in order to interview women in prison. Therefore I began locating women who had served prison time but who were now living in the community.

This research is exploratory in nature and seeks to understand the impact of imprisonment on women's strategies of coping. Several research questions helped to guide the research process.

- What coping strategies do women prisoners (federally and provincially sentenced) identify as being helpful to them while living in the carceral context?
- Are the coping strategies identified as useful in prison the same strategies used when living in the community, or are they exclusive to the carceral context?
- Do women prisoners identify self-injury and other forms of self-harm (eating disorders and/or substance use) as strategies of coping?
- What functions (if any) do self-harming behaviours serve women prisoners?
- What steps do institutional staff members take when a woman is in crisis?
- How does the use of segregation for self-harming behaviours impact women prisoners?
- Are the identities of women prisoners altered by their imprisonment? If so, how?
- Are there differences between the discourses of federally and provincially sentenced women with respect to the key issues studied?
- How do race, class, gender, and sexuality impact women's experiences of imprisonment and of self-harming behaviour?

Once I had identified these key research questions I began to define the central concepts of the study. For example, I conceptualised coping strategies as any behaviour or practice that enables the individual to face and deal with personal responsibilities and stress. Self-injury[54] is defined as the deliberate cutting, burning, or scratching of the body. Similarly, the term 'disordered eating behaviour' includes both anorexia and bulimia nervosa. I separated discussions of addiction or substance use from those of self-

[54] I decided not to use the term self-mutilation because it stems from the psychiatric and psychological literatures, which construct the behaviour as irrational and as symptomatic of mental illness. Because I understand self-injury as a harmful method of coping, I chose to reflect my understanding by using a different term, one not associated with psy-disciplines.

injury and disordered eating because despite being identified as another form of self-harm, participants described substance use as performing a different function (namely escaping emotional pain or stress rather than attempting to feel pain) than self-injury and disordered eating.

Ethics and Access

My research journey began to shift as I applied for ethical clearance to conduct my interviews. At this point the scope of this project broadened to include provincially sentenced women, and then later to include both provincially and federally sentenced women who had been released and were now living in the community. I fleshed out my topic and self-injury now was incorporated in questions about women's coping strategies and methods or techniques of survival more generally as they pertained to the impact of imprisonment on identity development, maintenance and negotiation. I did so because of the sensitive nature of the topic of self-injury, as well as the likelihood that I would not be granted ethical clearance if I were to ask questions directly about self-injury. Ultimately, I reformulated the interview questions[55] to be broader and more encompassing: for example, rather than asking, *Is self-injury a helpful way for you to cope with stress or sadness? What does self-injury do for you?* Or even, *why do you self-injure?* I would ask, *Could you describe some of the ways you would cope with stress or sadness?* This reformulation actually increased the validity of this study because the women had the opportunity to indicate that they themselves viewed various forms of self-harm (self-injury, eating disorders, addiction) as strategies of coping, without my first identifying them as such. In the end, I conducted 26 in-depth interviews, 22 with women who had

[55] See Appendix A and Appendix B for copies of my interview guides.

served time in either a federal or provincial prison but who were now living in the community and four with Efry social workers who work with criminalised women.

Fieldwork and Conceptual Baggage

Fieldwork always starts from where we are (Lofland & Lofland 1995; Palys 2003). We do not come to a setting without an identity, constructed and shaped by complex social processes. We bring to a setting disciplinary knowledge and theoretical frameworks. We also bring a self, which is, among other things, gendered, sexual, occupational, generational, and located in time and space. This approach does not imply an uncritical celebration of the self. It does imply a self-conscious and self-critical approach to fieldwork (Coffey 1999:158).

My initial focus on self-injury emerged as the result of personal experience, a friend with whom I lived while completing my undergraduate degree engaged in self-injury. While I saw her cut and scar her own body I felt ashamed by my ignorance and inability to provide her with any real support. I began to research the topic and found very little literature. The literature that did exist came predominantly from the psy-disciplines and seemed to construct self-injury as a symptom of a greater mental pathology, but these explanations were lacking with respect to my friend.

Then, I read the book *Rock-a-bye Baby*, the story of the life of Marlene Moore written by Mary Lasovich and Anne Kershaw (1991). Moore had done time both provincially and federally, and was a chronic self-injurer who eventually died by her own hand in the Kingston Prison for Women (P4W). After reading this book, I learned that self-injury was a serious problem in P4W but that there had been no research on self-

injury committed by women prisoners since Jan Heney's 1990 report, which was published by CSC. Given the subsequent changes in federal corrections for women in Canada (including the closure of P4W and the creation of five regional facilities and a Healing Lodge for Aboriginal women), Heney's research was dated, and the absence of subsequent research on the subject represents a glaring gap in the literature. Therefore, this research project is noteworthy, as it addresses a topic that has been ignored in both feminist and correctional literatures.

Ethically, it is important for a researcher to consider: (1) creating a safe environment for mutual self-disclosure; (2) representing voice/standpoint; and (3) recognising personal 'conceptual baggage' (both intellectual and emotional). In order to be ethically responsible towards my participants, I had to engage in a self-reflexive analysis of my own conceptual baggage and standpoint before starting the interview process. Conceptual baggage allows you to identify "whether any pre-established goals, assumptions or responsibilities may be overly influencing how your research is developing" (Kirby & McKenna 1989:51).

Critical social researchers Kirby and McKenna note the importance of revisiting conceptual baggage throughout the research process[56] (1989). First and foremost is my feminist position; I accept as 'true' that women occupy a marginalised position in society and that on a macro level institutional and social structures help to maintain a power imbalance between men and women via patriarchy, misogyny, and gendered, class-based and racialized practices (de Laine 2000). I am also very sceptical of the psy-disciplines because of my negative personal experiences with them where I felt silenced, mis-

[56] Kirby and McKenna refer to this revisiting of your conceptual baggage as layering (1989).

labelled and 'mis-diagnosed'. I was forcibly confined to a hospital at the age of sixteen and I entered voluntarily again at the age of nineteen. Because I was acutely suffering from anorexia and bulimia, my father forcibly confined me to the hospital in order to save my life. There was no specialised facility for acute eating disorders, which led hospital officials to confine me to the addictions wing of the mental ward of the local town hospital. Because I still refused to eat, the hospital staff tied me down and I was force-fed. My clinical diagnoses (of which I was only informed of years later) included: depression, obsessive-compulsive disorder, hysteria, narcissism and borderline personality disorder.

Precious little therapeutic treatment was offered and the stays in hospital never provided any 'cures'. Due to my initial negative experience with hospital confinement, one may question why I voluntarily checked myself into treatment for a second time. I did so because my bulimia had become so severe that I had started both vomiting blood and passing out. Ultimately, I felt as though I had reached my 'bottom' and that I could not save myself. For me, my second attempt at confined treatment was the only intervention I saw as being available to me at the time, but in the end, getting well rested on my own shoulders. It has taken years to cope with my eating disorders, and I still struggle with them today. This period of my life has negatively influenced my perception of psy-care, institutional confinement and 'treatment' and has caused me to be extremely critical of 'therapeutic' psy-discourse. It has also made me intensely aware of the importance of acknowledging the discourses of the patients (or in my study, ex-prisoners) as it is they whom I believe are silenced through institutional discourse. While I do not

feel that I need to engage in a 'confessional tale'[57] beyond what I have revealed here, it is important to acknowledge such traumatic experiences because they influence what we do as researchers – from the very choice of what we research to how we analyze data and present findings.

Research Process: Locating Participants, Confidentiality, Building Rapport, Coding, and Analysis

Due to the above-mentioned inability to secure access to women in either federal or provincial prison, I conducted 26 in-depth ethnographic interviews with women who had been incarcerated, but who now live in the community (22 with women ex-prisoners and 4 with professionals who work with and provide services to the women). The interviews took place between May and September of 2006, and they ranged in length from one hour to nearly four hours (the average interview lasting two hours and thirty-eight minutes). I interviewed eight women who had done time federally (all of whom had also done time provincially), 14 women who had only done time provincially, and four social workers who work with criminalised women in the community and as they are discharged from local jails and/or prisons. Nine of the former prisoners identified themselves as Native or Aboriginal and the remainder identified themselves as white.

In order to locate the women, several local Efry's in Ontario were contacted. After I generated a rapport with two local Efry's,[58] the staff members assisted by distributing information sheets to women who used their services, and the women were

---

[57] This notion of a confessional tale is from Van Maanen (1988).

[58] I have not identified the locations of the Elizabeth Fry Societies that I dealt with, in order to help protect both the women's and the agencies' identities. There are so few women in corrections in Canada, particularly at the federal level, that identifying the locales would make it relatively easy to identify some of the women.

able to contact me directly to arrange a meeting. Attempts to establish contact with two National Parole and Provincial Probation and Parole Offices were also made; however, after much effort and no returned phone calls, I desisted. Once a few interviews had been completed, the word started to spread and more women in the community, some of whom did not even use Efry's services, actually contacted me through Efry looking to be interviewed. This snowball effect offered a positive sign of how my initial participants felt about the experience of being interviewed. Each participant was given twenty dollars for her time, and either a ride home or bus tickets were offered to help compensate for travel.

Each initial meeting began with an explanation, where I indicated that I was using the interviews to write my dissertation. I gave an information sheet[59] to each woman, which stated the objectives of the research and provided both my contact information and that of Simon Fraser University. In order to reduce any harm to my participants (Snyder 2002; Stratton 2002; Van den Hoonard 2002), I reviewed the informed consent form[60] carefully with each participant to ensure that she understood how the interview material was going to be used in future. Each participant signed an informed consent form (that I photocopied for them), and most of the women were extremely cautious and careful to discuss their confidentiality. To help involve my participants in the protection of their own confidentiality, each woman was encouraged to select her own pseudonym, which allows them to easily identify themselves in any written work. All participants were informed that the taped recordings were going to be saved to a laptop computer, to which

[59] See Appendix C to view copies of the information sheets (for both the women and the professionals whom I interviewed).

[60] See Appendix D to view copies of the informed consent forms.

only the researcher had access, and that the recordings would be destroyed as soon as the interviews were transcribed (the transcription process and the destruction of the recordings were completed at the end of the fall semester of 2006).

In order to provide a safe environment in which participants could feel comfortable about disclosing information, I was open about my personal experiences, although at times it was difficult to negotiate if, when, and how much I should disclose. At the start of every interview, each participant was informed that she had the right to ask personal questions as well as questions about the research, and was encouraged to do so at any time throughout the interview. Some women were not interested in questioning me; others quickly took on the interviewer role and were keen to discuss my experiences of self-harm (anorexia and bulimia) and my time in hospital. Here is an excerpt from my interview with Emma where this dialogue proved helpful in building rapport.

Jen: I understand, I was in a hospital myself for having an eating disorder. For a long time I had an eating disorder. Like almost 15 years.

Emma: Really? Wow. It's so hard eh?

Jen: Yeah it is. They hospitalized me when I dropped to about 78 pounds.

Emma: When I first went to get help, my lowest was down to 85. Skinny, skinny, but I still had my big chest. The chest wouldn't leave me. I bet on you, like on me, you could see all your rib cages? Yeah yeah. Can you imagine me with this chest and being that skinny, looking back it's disgusting. I burned all of the pictures.

Jen: There's no pictures of me either. That's funny – I wouldn't allow pictures either.

It was clear that the women who were interested in discussing my experiences felt more comfortable discussing their own self-harm once they knew that I "got it,"

"wouldn't judge them," or "think they were crazy." As aforementioned, several women asked if I had done time in prison or jail, and seemed genuinely surprised that I had not, because I was able to discuss their experiences with them from a sympathetic position. In fact, some of the women were surprised that anyone would be interested in studying women in prison if they had not done time themselves, suggesting they felt "looked down upon," "ignored" and "forgotten about" by the general public.

I conducted the majority of the interviews in Efry residential houses; some of the women who were staying at Efry wanted to hold the interview sessions in their own rooms, others preferred to do them in a spare room or office, and a minority of the women opted for more public venues and asked that we sit in the living room or kitchen so we could have a coffee and 'chat'. The Efry's were extremely accommodating and supportive of the research, and allowed me the use of their spaces. However, Elizabeth Fry Society policy dictates that any woman who was not using Efry services was not permitted in the house, which meant that the interviews with these five women had to be conducted off their premises. For them, arrangements were made to meet either in their homes, or in public venues such as coffee shops. In each case, possible alternative venues were discussed beforehand and each woman was asked where she would feel the most comfortable meeting. In addition to securing a safe environment to conduct the interviews, I spent a great deal of time in the houses socializing and getting to know the women. We would have coffee and chat, and one woman tried to teach me to knit (I say 'tried' because I am not very good at it). By spending some extra time in the houses, I was able to make my presence somewhat 'normal' which helped the women become more comfortable speaking to me during their interviews.

The process of data gathering via interviewing was completed when the point of theoretical saturation was reached (Glaser & Strauss 1967; Strauss & Corbin 1998; Charmaz 2000, 2002).[61] Theoretical saturation occurred when similar scripts from the women were being heard; saturation not only validated their narratives but also provided me with an endpoint for the interview. To help document the research process and journey, I kept a research journal; writing an entry following each of the 26 interviews. Keeping a research journal assisted in helping to document the course and setting of each interview, my emotions throughout the engagement, how the participants interacted with and responded to me, as well as the participants' mannerisms and/or body language. The following is a sample from my first entry:

> Julie was the first woman I interviewed. She is a petite Native woman, but does not feel that she has ever experienced racism because of this. Julie was quiet spoken. Upon a different meeting, while I was at the house interviewing another woman, Julie indicated that she likes to dye her hair because it makes her feel more feminine and pretty.
>
> Julie comes across as a very private woman. She did not want to do the interview in an empty bedroom, where I conducted the majority of the interviews, but in her own bedroom, where she felt she had more privacy and control. It was clear that she felt comfortable in her room – it was very neat and tidy; everything put away orderly and in its place. She had her stereo on her dresser, with all of her CD's lined up. I noticed one (the best of *No Doubt*) that was lying flat and not lined up, as though this was the one in the CD player. I commented that I had that CD myself, and she was keen to discuss how good it was, and that her boyfriend had given it to her.
>
> During the interview, Julie sat on her bed, and I in a plastic chair facing her. She wore jeans and a cotton v-neck shirt. Julie indicated that she had done time both in provincial and federal prisons and that she was well known by some more infamous prisoners. Her face lit up, impressed that I knew of both of these

[61] While there is much literature surrounding the *coding* of grounded theoretical data, I have borrowed from the grounded theory approach – meaning I am generating my theoretical framework from the data themselves. I completed four independent rounds of coding, each time moving back and forth between my theoretical framework and the data. Also important to note is that I kept a journal throughout the research process, and wrote memos throughout during the interview interactions.

> women. Her face then calmed and she actually bowed her head as she spoke of M. Moore and how Moore committed suicide.
>
> Julie seemed pleased with federal corrections – mostly because she had spent a lot of time in provincial corrections, where conditions are so much worse. Julie was keen to be interviewed, but was a bit quiet and even nervous at the beginning. She warmed up to me with time, and stated that she really wanted to help me. She asked me if I had ever been in prison, and was surprised when I said no. She was surprised that someone who had not done time would be interested in helping prisoners.
>
> When I went into my bag to get the envelope with the twenty dollars she said, 'Oh, yeah!! I forgot about that!' I found this interesting, and demonstrative of the fact that she wanted to be heard and to help me, more than she was involved for the remuneration.

I found that keeping a journal provided me with a more concrete and active method of remembering the interview. When I began coding, I was able to go back and read my entries to re-familiarise myself with that particular meeting. Conducting the interviews was actually the first step in my analytic process, as I would jot down ideas about themes as they emerged following each interview. I did not take notes during the interviews because I wanted to give my participants my full attention. However, journaling after each interview provided the opportunity to make note of themes that I began to see at this early stage in the research process.

Due to time constraints, once the interviews were completed (September 2006), I hired two research assistants to help with transcription, paying them 120 dollars for each of the seven interviews they transcribed. In order to feel secure about the transcription ability of the research assistants, I held a short 'transcription workshop', during which issues of confidentiality and accuracy were discussed. In addition, both research assistants received a sample of a previously transcribed interview as a concrete guideline for the transcription style required. I gave each research assistant a CD of the interviews

to be transcribed, which was returned and destroyed. Upon receipt of the transcribed interviews from my research assistants, I listened to the audio recording of each interview while simultaneously reading the transcript. This stage of the process served as a reliability check and allowed me to fill in gaps where the dialogue was difficult for the research assistant to hear. I was also able to make notes of any lengthy pauses, hesitancies, or noticeable tonal shifts in the participants' responses. It was much easier for me to make such notes, given that I was the person who had conducted the interviews. Transcription of the 26 interviews was undertaken between September and December of 2006. On average it took four hours to transcribe every one hour of audio recording, meaning the transcription process lasted over 273 hours and produced nearly 2000 pages of single spaced raw data.

Transcription, the second step in the analytic process, allowed me to begin identifying in a more concrete way the key themes that were running through the interviews. Transcription also provided an opportunity to re-familiarise myself with each interview and each participant. Each interview was transcribed into Microsoft Word, then resaved in an RTF file that was imported into QSR NVivo qualitative data analysis software that allows the researcher to code and/organise qualitative data thematically in an electronic format. I coded each interview thoroughly in a first round attempt at organising the data according to both general and specific themes that emerged while reading the data. Once each interview had been initially coded, I embarked upon a second round of coding in order to review how the data had been sorted. At this point each theme (called a node) was reviewed and where necessary the data were re-coded, re-organised and shifted to more appropriate nodes. During this second round of coding,

some themes were eliminated altogether, others were collapsed into broader themes, and new themes emerged. Following the completion of this second round of coding, all of the node coding reports were independently generated, saved to my hard drive, and finally printed and bound in four three-inch binders as a hard copy. After the second round of coding there were 131 node-coding reports in total, all reflecting different themes and sub-themes running throughout the data.

A third round of coding involved reading the printed copies of all of the data as they appeared in the node coding reports. This was done to identify the most powerful quotes, which were underlined in red, as well as which node coding reports would be most helpful in discussing the major findings that were generated from the interviews. Once I had available an exhaustive list detailing which node coding reports reflected what major findings, I separated out the node coding reports I viewed as most useful to my analysis and placed them in four new binders, each reflecting one of the four data chapters in this dissertation. I then re-read the node coding reports for a fourth time to solidify the sub-themes for each data chapter. Finally, I colour coded the themes for ease of identification. To do this, I placed different coloured tabs (in the form of post-it notes) beside each of the quotes. In the end, the four independent rounds of thematic coding that I conducted allowed me to move back and forth between the data, theme generation, and theory construction in a holistic and grounded theoretical approach to data analysis. The process of coding the data took the better part of four months, and occurred between January and April 2007.

The Strengths and Limitations of this Research

There are a few important limitations to this research that must be acknowledged. The largest impediment to uncovering in-depth material is the fact that, because of financial and time constraints, I was restricted to a one-shot interview as opposed to multiple interviews with each participant (Charmaz 2002). To some extent, this limitation can constrain the establishment of rapport and trust as well as emerging theory construction. Charmaz writes,

> In addition to picking up and pursuing themes in interviews, grounded theorists look for ideas by studying data and then returning to the field to gather focused data to answer analytic questions and to fill conceptual gaps. Thus the combination of flexibility and control inherent in in-depth interviewing techniques fits grounded theory strategies for increasing the analytic incisiveness of the resultant analysis (2002:676).

As aforementioned, I offset this limitation by spending extended periods of time in the Efry residential houses and with some of the participants. I also attempted to involve my participants in the analysis process by offering copies of the transcribed interviews for their input; however, only four women wanted copies.

Another important limitation to this study is that access to women in federal and provincial prisons was denied. While women living in the community may offer the benefit of being able to reflect back on their experiences, it would have been advantageous if I had had the opportunity to compare and contrast the respective discourses and narratives of women currently inside federal and provincial prisons, with those of women who have since been released. A third limitation exists as a result of how participants for this study were located. I found the majority of women interviewed through two local Ontario Efry's. Women who associate with such an organisation may

be more likely than their counterparts to comply with correctional demands (including living at an Efry residential house) and therefore may be potentially supportive or even embracing of correctional discourse. This is not to say that these women do not or have not resisted correctional discourse. It was, however, something to consider as I analyzed their scripts.

Nevertheless, this research project has a great number of strengths and is therefore important for several reasons. I have attempted to demystify the historical constructions of criminalised women as mad, bad, and/or sad by deconstructing and reconstructing the stories of 22 women who have been involved in the criminal justice system in some way. Stripping away dated patriarchal, sexist, racist, and homophobic constructions of criminalised women will hopefully help tear down some of the existing barriers that this marginalised group of women currently experience. For example, deconstructing notions around motherhood and substance use, and the stigma associated with madness, self-harming behaviours, and substance use allows us to foster a more compassioned and 'real' understanding of the socio-cultural life histories of women in prison. This research will serve to contextualise the experiential and material realities of criminalised women, and to present a starting point from which change may materialise.

Moreover, very little existing literature examines disordered eating and self-injury among incarcerated populations, which is a gap this research helps to fill. Similarly, while some Canadian feminist academics have conducted research on the impact of segregation on women (Martel 2000, 2006), on law as a gendering practice (Comack 2000, 2004, 2006), on the risk/need dichotomy that exists within current neo-liberal penal governing strategies (Hannah-Moffat 1995, 1997, 1999, 2000, 2001, 2004, 2006), and on

the bodies of women prisoners (Frigon 1995, 1996, 1999), few have examined the construction, maintenance, and negotiation of identity as it is impacted by the carceral context. In addition, very little research currently examines identity as a potential foundation for coping.

This research helps to fill this gap by examining how criminalised women use different aspects of their identities and a variety of self-harming behaviours to cope with the stressors associated with imprisonment. My work examines what identity is and how it is used, by focusing on coping as an expression of identity and as a technique of the self as it is situated in and constituted by the carceral context. From this viewpoint we can begin to understand how self-harming behaviour, if it is reflective of identity, also reflects women's potential for resisting institutional discourses and practices through the self-expression of their emotionality and identity. What is of particular interest is the discussion of identity development and my argument that there are different potential citizenship statuses based on these varying components of identity. I have tried to build a theoretical framework that allows for the creation of new possible ways forward that have the potential to really change the conditions of imprisonment experienced by women in Canada.

In conclusion, examining the experiences of both federally and provincially sentenced women is a rarity within criminological research in Canada. The majority of work focuses on federal prisoners because of the lengthier periods of time they are imprisoned; however, this focus on federally sentenced women neglects an even larger population of women who often cycle in and out of provincial jails and the provincial prison for women in Milton Ontario (Vanier Centre for Women). Focusing solely on

federally sentenced prisoners neglects what are often times more severe living conditions, lack of 'treatment', and fewer opportunities. Excluding provincially sentenced prisoners only increases their marginalisation and neglects the impact that shorter terms of imprisonment may have on an individual.

Chapter Summary

The construction and execution of this research project have been tedious and frustrating while at the same time being a positive and truly rewarding experience. From the shifting nature of my research design through to the learning curve of applying for ethics, conducting this research has provided me with invaluable insight into the inner workings of a large-scale research project. Adopting a critical feminist lens through which this entire project has been envisioned and carried out, I argue that the following chapters reflect a truly feminist and women-centred approach to interviewing and conducting critical discourse analysis. Similarly, conducting interviews provided me with the opportunity to really listen to the women's stories about their own lives, which ultimately aided in my desire to situate my understanding within the context of their experiences. Actively engaging in difference also allowed a more collaborative understanding of the impact that gender, race, class and sexuality had on the lives and experiential realities of my participants. My methodological approach allowed participants to employ the empowering process of self-definition and explanation. Placing my participants' voices at the centre of inquiry and analysis precluded my own voice and interpretation from drowning out the women's narratives.

In the next chapter I begin to present the findings of this research. I examine the interconnectedness of two forms of self-harm (self-injurious and disordered eating behaviours) that were identified as being useful coping strategies.

Chapter 5
"Drowning in a Sea of Me"[62]

Chapters Five through Eight present the voices and discourses of the women who so openly and courageously shared their stories with me. This chapter addresses several research topics namely: the functions of self-harm (i.e. as potential coping strategies); the impact of segregation on women who self-harm; and any differences in these areas due to factors such as level of imprisonment, race, class, or sexuality. In what follows I examine how my participants discussed both self-injurious and disordered eating (anorexia and bulimia nervosa) behaviours. Self-injury and disordered eating are discussed together because my participants described both of these behaviours more broadly as self-harm. While participants also depicted addiction as self-harm, it was presented as performing different functions than do self-injury and disordered eating. Addiction represented a complete lack of control over one's body, while self-injury and disordered eating represented an attempt at securing ultimate control over the body. I examine the concept of control in both this chapter and the next through a discussion of power, and I examine addiction as a key component of the women's identity management and negotiation separately in Chapter Six.

This chapter is divided into six sections. The first is a biographical outline of my sample. The remaining sections reflect the five main themes that emerged from my research: self-injurious and disordered eating behaviours as (1) strategies of coping; (2)

[62] The title of this chapter, *Drowning in a Sea of Me,* is a direct quote taken from my interviews with Joan.

self-punishment; (3) symptoms of madness; (4) attention seeking and manipulation; and (5) triggered by and/or responses to strip-searching and segregation. It is important to note that these categories are not mutually exclusive – and that there is some overlap between them.

A Biographical Profile

In total, I interviewed 26 participants: 22 women who had been imprisoned – 8 (36%) in federal and 14 (64%) in provincial prisons – and 4 professional women who work with and provide services to women who have been in conflict with the law and now reside in the community. My sample of participants parallels the overrepresentation of Aboriginal or First Nations peoples seen in the broader prisoner populations at both the federal and provincial levels. Of the former federal prisoners, 3 (37.5%) were First Nations or Aboriginal and 5 (62.5%) were white. Of the women who had only served provincial time, 6 (43%) were First Nations or Aboriginal and 8 (57%) were white. All eight women who had served federal prison time had also served provincial prison time. All four professional participants were white, and one was an immigrant from Eastern Europe. The 26 women interviewed had a diversity of life experiences to share and they reflected the same kind of diversity with respect to their biographical information.

Of the 22 former prisoners, levels of education were diverse. Four (18%) of the women had an elementary school level education; 5 (23%) had done some high school but had dropped out before completing; 8 (36%) had completed high school or had earned a General Education Degree (GED); 1 (4.5%) was currently attending college with plans of going to university in the future; 1 (4.5%) had taken some college level

courses but had not completed the requirements for a degree; and 3 (14%) had completed college degrees and had professional careers.

With respect to the participants who were former prisoners, 14 (64%) were mothers. Of these mothers, half had lost primary or total custody of one or more of their children either to social services or to a family member. The other half had adult children and had not lost custody of their children as a result of their criminalisation, addiction or imprisonment. In addition, 15 (68%) of the women had endured some form of physical and emotional abuse at the hands of a partner, but only one remained in an abusive relationship.

All 22 of the former women prisoners had been prescribed psychiatric or psychotropic medications while in prison. Eighteen women (82%) continued to take some form of prescribed medication upon release. While several of the women discussed their 'need' for these prescription drugs, none identified themselves as being addicted to them.[63] Some participants identified themselves as having addictions to more than one substance. In total, 17 (77%) of the women noted that they suffered from problematic use of some form of illicit drug; 8 (36%) were First Nations or Aboriginal and 9 (41%) were white. Similarly, 45 percent of the women (10) admitted to having problems with alcohol[64]; 7 (32%) were First Nations or Aboriginal and 3 (14%) were white.

In total, exactly half (11) of the women I interviewed had engaged in self-injury – 7 (32%) of whom were First Nations or Aboriginal and 4 (18%) were white. With respect to disordered eating, 9 (41%) of the women had suffered from either anorexia or

[63] I discuss psy-care and prescription medication use in greater detail in Chapter Eight.

[64] I examine addiction as a component of the women's identity and as a strategy of coping in Chapter Seven.

bulimia nervosa; 5 (23%) were First Nations or Aboriginal and 4 (18%) were white. However, it should be noted that there was some overlap where 6 (27%) of the women both self-injured and had an eating disorder. Overall, five themes emerged from how self-injurious and disordered eating behaviours are described and understood by the women. It should be noted that these five themes are complementary and often overlap in women's discourses. I will now discuss each of these five themes in turn.

Self-injurious and Disordered Eating Behaviour as Coping Strategies

Brooke: I used to cut when I was inside. I don't do it so much anymore. But it was just a way of coping with whatever was going on in my life, and the fact that I was back in prison, and this last time was my first time in the pen, so it was serious.

Of the 22 former prisoners interviewed, 13 (59%) had engaged in self-injurious and/or disordered eating behaviour. Of this group 8 (51.5%) first began to engage in self-harming behaviours while in prison. The predominant discourse from both the former prisoners and the professional participants was that self-injurious and eating disordered behaviours were strategies of coping used to deal with the stress and strain of imprisonment. An individual has so little control over her own life in the carceral environment that self-harm can become a technique of the self and a mechanism for self-expression.

To date, self-injury has not been included as a diagnosis in the DSM IV,[65] whereas both anorexia and bulimia nervosa are included as 'mental illnesses', not symptoms of another pathology. Unlike the small body of literature on self-injury

[65] DSM IV is the abbreviated term used for the *Diagnostic and Statistical Manual 4th Edition* (2000) Arlington VA: APA. This book is the tool used by psychiatrists to diagnose and prescribe medication to treat mental illness and psychopathologies.

reviewed in Chapter Two, there is an extant literature that examines eating disordered behaviour from a variety of theoretical and methodological approaches. Here I focus on the work that describes self-injurious and disordered behaviours as strategies of coping with stress and strain.

One woman, Cate, pled guilty to federal charges in order to avoid the local provincial detention centre, and served over two years in Grand Valley Institution. For Cate, cutting was a way to cope with the pain, stress, and anger she felt at being imprisoned (Heney 1990; Fillmore & Dell 2000). When I asked her what sort of coping skills she used when in prison, her response was immediate; while she acknowledges that she also used self-injury as a way of coping outside of prison, Cate emphasises that cutting was a particularly useful tool in the carceral context.

Jen: When you were inside, how would you cope with different things?

Cate: Coping skills? I slit myself a lot like, especially in jail.

Jen: How come?

Cate: I don't know any other way to cope.

Jen: You don't want to lean on anyone…

Cate: No, I never do.

Jen: You want to be completely independent?

Cate: I am. And that's the way it is and always has been.

Self-injurious and eating disordered behaviours are extremely private (Fillmore & Dell 2000; Heney & Kristiansen 1997; Miller 1994) and several of the women emphasised that their self-harming behaviours were something they found difficult to speak about and something they did not want others to know about. I would argue, from personal experience, that there is a great deal of shame associated with self-harming

behaviours, thus making it quite difficult to discuss them with other people (Fillmore & Dell 2000; Heney 1990). The fact that they were so willing to discuss this facet of their prison experiences with me is a testament to how much the women wanted their voices to be heard.

Likewise, Tammy, an Efry manager of community service and programs, discussed how she understood eating disorders more broadly:

> So to bring it back to the eating disorder, I find often times we look at eating disorders about this need to be thin. And that's part of it, but really, it's about control. And the one area we have full control over is what we consume or don't consume. And that's why I say if I was going to use an analogy, I'd compare cutting to an eating disorder where it's very much about individuals who are lacking control in one area or another, even in terms of unfair personal loss.

Highlighting the importance of control is essential to our understanding of self-harm in the carceral context. As Tammy so clearly states, "the one area we have full control over is what we consume or don't consume". Despite the control exerted by correctional authorities, the women have the ability to resist and to demonstrate agency and subjecthood through what they do and do not consume (Malson & Swann, 1999; Keywood 2000; Smith 2002; Gooldin 2003; see also Godderis[66] 2006a, 2006b). My research shows that self-harm can be a coping strategy aimed at securing some level of control, but it can also be used as a resistant practice. Furthermore, the two are not mutually exclusive; self-harm can serve both purposes for the same person.

While rare in the Canadian female correctional landscape, hunger strikes are commonly used by both male and female political prisoners in Ireland (Corcoran 2006). Political prisoners are often better organized and share a common goal or ideology and

[66] Godderis' (2006a, 2006b) work illustrates the same findings with respect to men prisoners.

are therefore able to form a collectivity in prison, something women in Canadian prisons find more difficult. Prisoner organizations like the Native Sisterhood do exist but these organizations have not established themselves around a concept of citizenship that is rooted in a collective identity, and which could help the women press for certain rights or privileges. Analogous to Mathiesen's (1965) concept of individual censoriousness, women in Canadian prisons are too often isolated, and left 'to do their own time'. Unfortunately, this lack of collective citizenship has required women to use their individual identities to express their emotions and who they are. While self-harming behaviours may be acts of resistance for certain women, this is not always the case. Even as many women stated that their use of self-harming behaviours peaked while in prison, many continued to engage in self-harming behaviours in the community, which indicates another dynamic at work. It is also significant that some of the women engaged in self-harming behaviours before they went to prison, which demonstrates that cutting is not just a response to the institutional context.

Several women spoke about self-harming behaviour as a method of coping with and displacing emotional pain (Miller 1994; Hyman 1999; Fillmore & Dell 2000). A few women discussed their eating disorders and self-injurious behaviour as coping mechanisms used to divert their attention away from things they felt unable to deal with head on. Joan's narrative illustrates well how self-injurious behaviour was commonly used by some of the women as a way to cope with their feelings of low self-worth.

Joan (PSW): But I didn't feel I was of any value. And that would make me angry, like you pack that stuff down and after a while, you know, you do for everybody else and your needs are not getting met. You get angry and eventually it comes out sideways. When I was in last time, I just grabbed a comb and ripped my arms and face apart. I was just in such terrible emotional pain.

Jen: So you see self-harming behaviour as a coping mechanism?

Joan: Yeah. Not wanting to see. It's easier to focus on the cut on my arm than it is to focus on my fucking life is shit, I'm in jail again, I've lost everything; I have nothing. It's easier to do that when you're thinking, well, I have nothing anyway. Because we've got so much… if I'm not dealing with things and I just, yeah, it's almost like an obsessive thing, you know, like if I, and it's just how mine comes out, because I'm not dealing with things that are bothering me, I'm not talking about them. So cutting kind of releases the pressure. Makes me focus on that.

Jen: So you feel the slashing is a way to…

Joan: Escape, yeah, the emotional pain. I'd rather have the physical pain than the emotional. Yeah. And I know that from myself too. Like I've broken limbs on my body, and have pins and plates and I can handle that better than I can handle the emotional stuff. Yeah talking about my children and what happened and where my disease (addiction) took me and taken away from me. And you know, it was easier to, easier to deal and re-focus on broken limbs and… than it was to deal with anything emotional.

Joan described at length how she self-injured as a way to displace and cope with emotional pain. Several women suggested that self-injury was an emotional release from stress. Mary's discourse corroborates the claims made by Joan:

Mary: But I know, before I went to prison and that, I used to do the same thing with a razor blade, like, cut, cut, cut. And for me, it was like, better than a medication. 'Cause when you cut, all that stuff it just seemed like that would go away. I could actually sleep and everything 'cause of everything that was bothering me.

Jen: It made you feel like an emotional release, to cut?

Mary: Right, and so, then I started doing it again inside because it was like, I was spinning.

Mary's statement that cutting was "better than a medication" because it completely distracted her from everything that was causing her stress is extremely powerful. The fact that some women see self-cutting as a positive and helpful strategy of coping with emotional stress shows the dearth of available alternative strategies that are

offered or accessible to women in prison (Dobash et al. 1986; Faith 1993; Corcoran 2006; Kilty 2006). I suggest that while self-injury can be a way to cope with stress, it remains a way of coping at a distance.[67] Because the women explain it as a way of displacing emotional pain with physical pain to distract themselves from focusing on emotionally difficult issues, self-injury, while effective, actually prolongs the duration of distressing emotional issues and prevents the women from addressing them in a less harmful way.

In her narrative, Julie presented a somewhat different explanation of the useful aspects of self-harming behaviour. While Julie did not cut herself, she suggested that cutting was a coping strategy, albeit an unhealthy one, used by some women to internalize their emotions of anger and frustration to insulate others from these emotions. This observation relates to Smart's earlier work that examined how women prisoners often turn their emotions inward, rather than outward onto others (Smart 1978).

Jen: Did you see some women dealing with things in an unhealthy way?

Julie: Uhm-mm. Cutting themselves. I understand that they do it just to get out the anger and frustration. You know, instead of hurting anyone else, they are hurting themselves.

While self-injury was frequently portrayed as a coping mechanism of last resort – when the women had few or no other alternatives– the women were more inclined to speak about their eating disorders as a way of life. It was a part of their daily routine, and of their identities. Both self-injury and disordered eating were described as being coping mechanisms although self-injury was not generally used daily in the same way as disordered eating was. This finding parallels other feminist works on the importance of

[67] The phrase 'coping at a distance' is a play on words, referencing David Garland's discussion of government at a distance in his 2001 book *The Culture of Control.*

anorexia as a key defining feature of self-hood (Bordo 1990, 1992; Bray 1996; Malson 1995, 1997, 1998, 1999; Malson & Swann 1999; Malson & Ussher 1996a, 1996b, 1997; Keywood 2000; Gooldin 2003; Burns 2004; Wilson 2004; Bell 2006; Rich 2006).

The overlap between identifying self-harm as a coping strategy and as a method of self- punishment is clear. In the carceral context, self-harming behaviour is a coping strategy, an expression of emotions, and ultimately an expression of identity. The women use self-harm as a way to deal with the emotional pain often associated with imprisonment. Hating or loathing oneself requires some method of expression; self-harm therefore serves two very real functions: coping and self-punishment.

My interview with Emma, a woman who has done time in several provincial prisons in both Ontario and Quebec, lasted nearly four hours. She was uncommonly eloquent in her speech and in her ability to reflect back on her experiences with insight. Emma had been "taken in" by a motorcycle gang at the age of thirteen, and was soon expected to dance and prostitute for them.[68] This environment quickly led to the development of her eating disorder.

Although it helped her earn more money as a dancer, Emma found the pressure to have a perfect "Barbie body" extremely stressful.

> I did very well as a dancer. I had the Barbie body, and that's why I had that attitude of Barbie bodies, because for so long I had to strive to have that body, and for the longest time when I gained any weight I just couldn't deal with it. Even though I was still thin. Because I would look in the mirror and go 'hippopotamus'!

[68] Emma's disordered eating was linked to her work in the sex trade which supported her drug habit; in fact, Emma was unknowingly injected with heroin on her first night of dancing and claims that she quickly became addicted.

Emma's explanation of her eating disorder corresponds to some feminist accounts of eating disorders and body image. Women who have a distorted body image, despite being thin, view themselves as being overweight (Hay 1996; David & Johnson 1998; Steiger et al. 1999; Denisoff & Endler 2000; Striegel-Moore & Cachelin 2001; Bekker & Boselie 2002; Mond et al. 2004; Serpell et al. 2004; Tylka & Subich 2004; Moradi et al. 2005; Van Boven & Espelage 2006).

For Emma, bulimia became her method of choice for coping with her body image as well as her stressful life situation (Bordo 1990, 1992; Malson 1995, 1997, 1998, 1999; Malson & Swann 1999; Malson & Ussher 1996a, 1996b, 1997; Bray 1996; Lloyd 1997; Keywood 2000; Gooldin 2003; Burns 2004; Wison 2004; Moulding 2005; Bell 2006; Rich 2006).

Emma: I was bulimic. For years and years.

Jen: So bulimia was a coping strategy for you.

Emma: Absolutely. Some women don't eat – I couldn't do that. I would eat and gorge and then get sick. It is really important to dancers to be thin – because you have to make enough money to keep the guys [in the gang] happy, and enough to be able to stay high.

The biker gang for whom Emma worked often degraded her in terms of her self-worth, in an attempt to keep her subordinated and working for them without resistance. I suggest that Emma's bulimia was a manifestation of the pressure she felt to exist in this world where she had little power over her own body, let alone over her finances or work. Therefore, having a distorted body image, while common among those suffering from an eating disorder, is only one of many reasons why women develop disordered eating habits or self-injurious behaviour in the carceral context.

Jen: Did you find that a lot of women had eating disorders inside?

Emma: Oh god yeah. Lots of women didn't eat, which is understandable seeing how awful the food is. Others do the opposite. Eat to the extreme and then they feel sick and they throw up. It's either or. But I've gained a lot of weight and I am really uncomfortable with my body right now. I'm afraid I am going to slip and start throwing up again.

More importantly, self-harm demonstrates attempts at securing control over some part of your life, when all other areas are determined for you without your knowledge, input, or consent.

Joan, a woman who has done several bouts of time in provincial prison, also expressed this feeling several times during her interviews, describing how even when she received positive attention from others about her "ripped" appearance, she never viewed herself as such. Low self-esteem is a very common emotion felt by many women who self-injure or who suffer from anorexia and/or bulimia. Some of the feminist psychology literatures have linked low self-esteem to the impact of socio-cultural ideations of femininity and womanhood on disordered eating (Malson 1995; Wilson 2004). For example, Malson (1995:88) writes that, "the anorexic body, like other bodies, is … 'always already' caught up in systems of meaning, eating, symbolic representations, and power relations".

Like Emma and Joan, Laura, a woman who had spent the last few years cycling in and out of a local detention centre, described how cutting was related to her negative body image and the low self-worth that flowed from same. Focused on thinness and body image, Laura describes using crack to lose weight.

Laura: I was a cutter. Yeah, for a few years.

Jen: What did that do for you?

Laura: Uh, just not liking myself, not liking the way I looked, and the drugs didn't help. I'd be so lonely. I used and cut by myself. There were times where I'd use and then I'd quit for a while and get, try to get my life back together again. And then well, you're eating properly and if I'm working out, I'm feeling better about myself and I'd stop doing that, abusing my body. It's the 'Jenny Crack diet'. It's the best diet around, believe me. Yeah. I've had an eating disorder my whole life, but it got worse after my second child. Yeah, I went right up to two hundred pounds and I have such low self-esteem. I don't like anything I see when I look in the mirror. If I see a touch of fat, a part of my body I don't like, it depresses me so bad that I'm crying and yet if I'm not taking crack or anything to lose the weight I can't stop myself from eating. And then that depresses me even more and makes me run to get the crack. Then I always end up back in jail and I can't eat when I'm in there. The food is so bad and full of fat and I hate myself for being there that I can't bring myself to eat.

Laura's narrative is particularly interesting as she highlights the cyclical nature of her self-harming behaviour, drug use, and imprisonment. When she was not prostituting or using drugs, Laura was able to exercise and eat without dangerous restrictions. Ultimately, Laura described both her eating disorder and self-injurious behaviour as flowing from her personal self-loathing, which she links to her addiction and criminalisation.

Self-injurious and Disordered Eating Behaviour as Self-punishment

There is a connection between self-injurious and eating disordered behaviour as a form of self-punishment and as a coping strategy. Self-harm can be a form of self-punishment, which flows from the women's desire to cope with their shame, guilt, and anxiety over the stresses in their lives, particularly those which come from being imprisoned (Fillmore & Dell 2000; Groves 2004). At the same time, there is an equally important distinction between understanding self-harm as coping and as self-punishment. Engaging in self-injurious and disordered eating behaviour to cope was constructed by

the women as being empowering because it was something they had control over when they otherwise felt out of control, whereas using these behaviours as self-punishment is actually disempowering and punitive. Understanding self-injurious and disordered eating behaviours as forms of self-punishment is linked to two main feelings: (1) shame and guilt about one's criminal acts and subsequent criminalisation; which can often lead to (2) feelings of worthlessness.

Joan spoke extensively about her self-injury and bulimia as self-punishment strategies, which helped validate her feelings of shame and worthlessness.

> I scratch. That when I'm stressed or I'm burying things instead of being assertive and expressing like you know, when this happened, that this is the way I felt, can you please try and... Instead of coming out and being assertive and saying my needs, I hang on to stuff and I scratch my skin open. And then well, it would start piling up and then I'd get anxious and I'd get like, 'I don't want to feel like this, why are people treating me like this'? Instead of saying something, I hold on to it and then I start scratching. It's in jail and even more when I'm dealing with the community and stuff. It's almost like body, body memory, that. I was here one day and something was going on and I felt, I felt like old tapes were going off in my head. And like I have to watch that, like, I've been giving messages to myself for so long that are wrong, you know? That I'm not good enough, I'm not this, and I'm not that.

This narrative supports my claim that self-injury is a coping strategy, a way for Joan reinforce her beliefs that she was 'not worth it' (Groves 2004).

In a similar fashion, Phoebe described how she actually began to cut herself as punishment, reinforcing the negative treatment and emotional abuse she experienced from her abusive partner. For Phoebe, who cut both inside and outside of prison, cutting was a strategic attempt to humanise herself in the eyes of her partner in an attempt get him to stop harming her. Over time, she began to turn her emotions inward; cutting became a technique used to cope with and ultimately displace her feelings of sadness,

stress, and pain and a way to cope with a life situation that included addiction, homelessness, partner abuse, and sex trade work (Smart 1976).

> It's pain displacement. Instead of feeling pain inside, like hating myself, I would do that to myself and it made me feel better. I would be able to go back out on the street and sell myself and make some money, you know. I just felt so badly about myself and my life, and every time I got in a fight with my boyfriend I took it out on myself and I cut myself. I have scars on my arms and I just look at them and anytime I feel a craving or an urge, you know, something, you know, I could use, I look at my arms and I'll just think of the negative things, the misery of it all and I was in a very miserable state.

Phoebe's discourse links the coping and self-punishing components of self-harming behaviours. Phoebe paid a figurative penance by cutting herself before she could continue to prostitute and use crack, activities that shamed her. It is clear from her discourse that Phoebe loathed her addiction and her involvement in the sex-trade. Her feelings of disgrace and sadness were expressed through cutting.

Not only was cutting a form of coping and self-punishment for Phoebe; she also described her scars as symbolic reminders of a time she does not want to return to. During my time with her, Phoebe offered to roll up her sleeves to talk candidly about her scars and what they meant to her. It was extremely emotional and moving to listen to this woman identify scar after scar and the associated situations and describe what the scars mean to her. Phoebe stated that her scars act as a reminder of a time during which she hated her addiction and the fact that she was engaging in sex-trade work in order to support her drug habit. For Phoebe, her scars acted as a graphic diary of her journey through the hell of addiction, shame, sex-work, criminalisation, partner abuse, and ultimately drug treatment and motherhood.

Phoebe's scars reminded her of a life, characterized by her criminalisation, to which she did not want to return. Similarly, many of the women self-injured to punish themselves (Frank 1991) as a result of the guilt, shame, and anxiety they associated with their criminalisation. For example, Shannon, a woman in her mid-forties who had never before been imprisoned, was so ashamed of her criminalisation that she punished herself by repeatedly cutting her own skin. At the extreme, Shannon expressed how her crime made her suicidal.

> I drank and drove and nearly killed two people, you know, so, I was beside myself. I didn't want to live because of that. I had hurt somebody. But I couldn't kill myself. I just sat there with the razor to slit my wrist but I couldn't do it, which made me feel even worse. And that's when I started to cut myself.

Mortification at her crime sent her into a downward spiral, to the point where she was cutting herself because she felt she deserved that kind of pain and punishment.

Julie, a woman who had done time federally but who did not cut herself, described a friend she had lost to suicide and self-injury in prison.

Julie: Because the friends that I've had and that, it's just horror stories. You know, I've had friends die in there and shit.

Jen: You've had friends die in P4W.

Julie: Yeah, Marlene Moore.

Jen: You knew Marlene Moore?

Julie: Oh yeah, very well. The last time I seen her, she said, 'Julie, if they send me away again, I'm not coming back. And she didn't come back.

Jen: That must have been really hard for you. I know she had a long history of cutting herself.

Julie: God, tell me about it! I shared a cell with her! One night, she broke a razor and we were in our cell, and she started slashing. I mean

> we were locked in already, and I was on top of my bunk and below me she just started slashing. So finally the guards came by and gave her towels. And all the towels are white, and then they were all solid red.

Julie's understanding of self-injury comes from her experiences with friends and former prisoners who engaged in self-injury. Julie observes that self-injury is a response to going to prison and the accompanying shame. She made clear that women prisoners who self-injure desperately need somewhere more therapeutic , indicating that prison, and worse still segregation, were harmful to women engaging in this behaviour. In fact, from Julie's perspective, the prison experience and environment only exacerbated self-harming and destructive behaviour.

Building on this notion of self-punishment, self-harming behaviours can be read as attempts to construct a specific identity, one that serves a specific purpose for the individual. For example, Mary, a former lifer who had spent over fifteen years in P4W for murdering her abusive husband, discussed developing both anorexia and bulimia while she was incarcerated.

Mary: And I mean, when I went to jail, by the time I got to jail, from a hundred and something, I went up to 192 pounds within a year, so I was way overweight. So then this other girl and I and a lot of people said here is what they used to do for the weekends and stuff like that. So that's why I went to the gym every chance I got. We played badminton all the time. When the weight room was there, I went to that. Kept busy, busy every like, every day.

Jen: Was that a way for you to cope with being in prison?

Mary: Not coping with being in prison. It was, I didn't want to be that person I was when I got arrested or before I got arrested. And so I had to change my image all the way around. And that was losing weight, doing my hair a different colour, doing a lot of things that wasn't, started to do the things that I always wanted to do as I was growing up. And not being forced to do things I didn't want to do. So, yeah, I had to change it and I had to change it fast. I just

> couldn't deal with what I'd done, my crime. The guilt, and shame. I mean, some of my kids no longer have a father, and his kids with me and his first wife – they won't talk to me anymore.

Mary's narrative is particularly interesting, as it reflects her guilt for having killed her husband and her subsequent desire to "not be that person I was when I was arrested". Mary discussed at length the guilt she felt for her crime. She describes her eating disorder as being directly linked to the guilt she felt for having murdered her abusive husband, and for her subsequent criminalisation and imprisonment.

In addition, Mary's dramatic weight loss was part of her strategy to reclaim an identity she had lost because of her abusive husband. Mary was attempting to recreate a new self, distinctly separate from the self that existed during the part of her life during which she had absolutely no control. For nearly twenty years her husband had controlled every aspect of her life – socially, sexually, and financially. Mary's eating disorder and self-injurious behaviours were extreme attempts at exerting power over her own self – something she had not been able to do for the entirety of her adult life.

Self-injurious and Disordered Eating Behaviour as Symptoms of Madness

Explaining self-harming behaviour as a symptom of madness is promoted by both the psy-disciplines and the existing correctional discourse (Connors 1996; Dahme & Butzinger 2002; Fillmore & Dell 2000; Heney 1990; Heney & Kristiansen 1997; Jones 1986; Miller 1994; Peters & Range 1996; Turell & Armsworth 2003). While some of my participants depicted self-harming behaviours as indicators of some form of madness or 'mental illness', this was a relatively minor theme. Interestingly, the theme of self-injury as an indicator of some form of madness surfaced predominantly from the discourses of

those women who did not cut themselves. I also found that several of the women, while engaging in the same or similar behaviours, would attempt to differentiate themselves from other women who were either self-cutting or suffered from an eating disorder. By this I mean that the women would claim that their reasons for self-harming were different, or that they were in some way more in control of their self-harming behaviours than were other women.

Kellie, a former federal prisoner, presented self-injury as a failed suicide attempt (Heney 1990; Liebling 1994). Kellie had not engaged in self-injury but had adopted the correctional discourse proposed within the carceral context.

Kellie: Oh yeah, a lot of bulimics. A lot of bulimics. And a lot of cutters.

Jen: You saw that a lot when you were inside?

Kellie: Oh yeah, too much. You would see these women with scars like this (indicates going across her arm), like twenty or thirty scars. It's like, oh my god, what are you doing to yourself? Like if you want to die, just do it, don't play around with it.

The official federal correctional response to self-injury is to place the woman on suicide watch in segregation.[69] Kellie later described a woman with whom she shared a house in Grand Valley Institution as being mentally ill – self-injury being the indicator of her madness:

> We had one girl that we called the chicken scratcher. She didn't take care of herself; she couldn't have loved herself because she was just gross. Like she was big like me, but she stank, she didn't shower, her hair was greasy all the time. At first we all thought she did it for attention. But she was psychotic, I swear. You know how you can open a BIC razor, or whatever, and she would run it over herself to get tiny cuts, little tiny cuts. Or she'd threaten to do it. So you'd get the women that do the peer support team and peer support can go to any house at any time. If

[69] The use of segregation and the increased harm it has been found to cause will be discussed in a later section of this chapter as well as in Chapter Eight.

someone's in trouble they could go. It took two hours before she'd give up the blades and then the guards came to take her to seg.

Kellie's shock and disgust that a woman could not only fail to take care of herself hygienically but could also cut herself is demonstrative of how self-injurious behaviour is often viewed. Self-injury frequently evokes feelings of incomprehension, confusion, fear and even disgust in those of us who have not experienced this behaviour (Brickman 2004; Groves 2004; Hodgson 2004; Adler & Adler 2007). Given the complexity of this behaviour and the strong emotions it stirs up, it is not surprising that some of the women have come to accept the psy-explanations of self-injury as a symptom of madness.

Although Kellie viewed self-injury as an indicator of madness, she became outraged at having been treated as mentally ill and suicidal by the correctional authorities. In this instance, Kellie was describing an incident during which a male guard entered the washroom while she was showering:

Jen: And all the showers are open?

Kellie: Yeah, they got a swing door but that's it. Anyway, I was standing there waiting for her [guard] to tell me to get dressed again and the male guard just came in and was standing there, staring. Like what the fuck are you doing? Get the fuck out! You know, like, what the fuck? Who the fuck are you? You can't just stand there staring at me, what the fuck? Get the fuck out! That's why they put me on suicide watch in GVI because I was so upset and crying and shit.

Both Kellie and the women she had known who self injured were treated in the same way by the institution. No distinction is made by the correctional authorities; their reaction was the same. It struck me that Kellie was unable to empathise with the other women in distress she had known who were sent to segregation. It is likely that because

self-injury is such a shocking behaviour that whoever witnesses it from the outside may not grasp the internal logic that motivates someone to cut.

Nelly, who was not a cutter herself, was actively using crack when I interviewed her and had been serving short periods of time in and out of provincial jails in both Ontario and Quebec. Nelly formulated how she understood the behaviour in order for it to make sense to her. In so doing, she reconstructed self-injury as a symptom of madness.

Jen: Did you see a lot of women cutting themselves inside?

Nelly: Yes I did. They're suicidal, they're sick in the head. They got a serious problem. I saw that a lot, yes, and those women are fucked in the head. You'd have to be to cut your own skin open.

This perspective allowed Nelly to reduce self-injury to an act of desperation by a "sick" woman. I find it ironic that, despite their own personal struggles with such drugs as heroin and crack injection, some of the women who had never suffered from an eating disorder or had never engaged in self-inflicted cutting could construct these behaviours as being beyond the realm of normal comprehension.

Even for women who self-injured, it was difficult to acknowledge a connection to other cutters or anorectics/bulimics. Although the behaviours were obviously similar, some women differentiated their own motivations from those of other women who have self-injured. For example, Mary who has suffered from both anorexia and bulimia and who engaged in self-inflicted cutting, discusses her self-harming behaviour in functional terms as a tool she used to punish herself for her crimes, as well as to alter her identity and to separate herself from the person she was when she had been arrested. In contrast, she describes other women who self-injure simply as being mentally ill.

> When I worked in laundry, I had to go and take the stuff down to segregation for the girls, and that wasn't a pretty sight. So, some of them just sat there and rocked back and forth staring at the wall in their baby-doll dresses. I mean, some of these girls just never came back to reality when they cut.

Mary fails to acknowledge that segregation often leads to an increase in the frequency or severity of self-injurious behaviour, despite her own experiences of having been segregated for self-harming behaviours (and continuing to cut while in segregation). Mary's attempt at illustrating individualism can again be contrasted with the collectivism demonstrated by political prisoners. Mary's desire to separate her identity from that of other criminalised women is also indicative of why we have seen so little collective activism and potential for citizenship claims that could be based on a collective identity between the prisoners who self-injure.

Part of this desire to differentiate oneself from other criminalised women may represent an attempt to resist the prisoner identity, or to resist the stigma associated with mental illness. At the same time, it demonstrates the women's desire to exhibit their own agency but within the confines of what is deemed acceptable and responsible prisoner behaviour. This process illustrates the women's efforts at demonstrating their individualism by differentiating their self-harming behaviours from others', which become, in effect, attempts to be good, self-regulating, neoliberal subjects. Mary did not want to be viewed as having a 'mental illness'. In order to differentiate her actions from the other women's, she emphasised the control she felt over her behaviours – and her ability to understand the harm she was inflicting upon herself and her ability to overcome and stop her eating disorders and self-injury. Her ability to perceive her behaviours as unhealthy responses allowed Mary to construct herself as an active social agent and as a

rational person. The 'other' women who were cutting themselves and who did not realize the dangers involved or who were simply unable to stop cutting were therefore acting irrationally presumably because of some form of mental illness.

Self-injurious and Disordered Eating Behaviour as Attention Seeking and Manipulation

As discussed in Chapter Two, a great deal of the psy-literature constructs self-injury as a symptom of a larger and more serious mental pathology, which suggests that the behaviour is beyond the woman's complete control. At the same time, the psy literature constructs self-harm as an attention seeking and/or manipulative behaviour indicating agency and thus responsibility. Such accounts were very rarely apparent in my interviews. The popularity of this explanation in the corrections discourse is completely at odds with its absence in the minds of the women who self-injured in prison. These two components of the psy-discipline's understanding of self-harming behaviours demonstrate not simply a division, but also a contradiction that begs the question: How can these women be controlled by an incapacitating pathology and also have enough agency to control their behaviours to manipulate others, especially those in positions of power?

Only two of my participants described, very briefly, self-injurious behaviour as an attempt to manipulate. Both women's discourses were quite atypical of my participants overall. Cassie, who had never suffered from an eating disorder or self-injured explained that her understanding of self-injurious behaviour was based on the views of a guard with whom she had a relationship. It becomes evident that this lack of experiential knowledge, whether for the women whom I interviewed or for the psy disciplines, fosters

explanations of self-injurious behaviours that are seductively uncomplicated but nonetheless incomplete. Not surprisingly, my research offers little support for psy understandings or explanations of self-injury by women prisoners.

Cassie: I would think that a suicide watch,[70] I mean you hear the guards talk eh? Coming out of segregation. I would think that a suicide watch is a woman's way to, an easy way out of a murder charge.

Jen: That's what the guards would say?

Cassie: Yeah.

Jen: What do you think of that?

Cassie: I thought, well depending on the source obviously. But there was a female guard there in particular, who was, well I wouldn't call her nice, but she was really nice to me. I wasn't a troublemaker – I didn't get into shit. And I heard her say, that it's sometimes their way of escaping or trying to escape a murder charge or trial. You know, 'I'm insane, I'm trying to hurt myself, I don't know what I'm doing.' And she said that you can look at them and know that that's a crock of shit. And I was thinking, [if this guard] is saying that, then the chances are it's true because she's not, in the time I was there, she's never come across as being the type of person to just cause shit for somebody. She's there to help.

The notion that cutting could be an attempt at "getting out of a murder charge" reveals an underlying belief that women who self-injure may be doing so in order to slyly manipulate their situation for their own benefit. According to Cassie, the guard was not callous or indifferent. Her views on self injury and eating disorders were not exceptional in the sense that they coincided with what she had heard other guards say about segregation. These facts are of course not surprising in a corporate culture as strong as Corrections', where conformity is the norm. In contrast, as has been presented earlier in this chapter, those participants who have engaged in self-injurious behaviour view and

[70] As all women who self-injure are placed on suicide watch, this status is not necessarily indicative of having made an attempt on your life.

explain it as a strategy of coping and as an issue about securing more control over their own lives and bodies.

While Cassie had adopted the correctional guard's self-harm as manipulation discourse, she did in fact state at a later point in the interview that she did not believe women who self-injure should be placed in segregation. Her narrative suggests that women, who are self-injuring in order to obtain the attention of and manipulate the correctional authorities, may not represent the motives for self-injury for all women.

The interview I conducted with Phoebe was the only other time when self-harming behaviour was mentioned as being an attention seeking behaviour. As I discussed earlier, while self-injury did operate as a coping strategy for Phoebe, she also described it as an attempt to secure the attention of her abusive boyfriend.

> I was a cutter. A lot of it was frustration. It started when I was living with my ex in the crack house. I just felt so frustrated, felt like you know, he believed I was such a bad person. You know, he thought I was stealing from him, that I was doing this and that with all these other men, and it just got to me. There was nothing I could say or do, you know, to convince him otherwise, you know? And I didn't know how to deal with schizophrenia back then, I didn't know what it was about so I really just thought that he believed these things. So, it started making me feel like a really bad person and I tried to get his attention. By getting his attention I thought, maybe, you know, if he saw how upset I was, you know, that he would think these, things, I thought maybe it would change him. So I cut myself. I started cutting myself on my arms, not suicidal, but just you know, at first it was to be dramatic, but after a while I felt every time I got upset, I felt like, if I didn't have my drugs to help me cope, then I thought cutting myself would be better, it felt better, made me feel better.

Rather than manipulating her partner, Phoebe was attempting to communicate to him that she was a real person, with feelings and emotions, who was hurt by his comments and actions. While she describes her cutting as 'attention seeking', it is more akin to a non-verbal attempt of last resort at communication. Given their living

conditions and physical and emotional states,[71] it is not surprising that Phoebe was having a difficult time communicating and expressing herself effectively, or that her partner was unable to respond to her attempts at communicating with him.

In addition, while Phoebe's narrative may suggest that her self-injurious behaviour began as attention seeking, it actually merges into a discourse that describes cutting (as well as addiction and later anorexia and bulimia) as strategies of coping. In her own words, Phoebe stated that cutting was "a pain displacement". She was able to concentrate on the physical pain rather than deal with the emotional and psychic pains and stresses of her life. Ultimately, Phoebe's narrative supports my finding that self-harming behaviours serve as coping mechanisms for women (both in and out of prison), and are used when alternative and potentially less harmful methods are unavailable because of either the confines of the prison or the circumstances of their lives.

In contrast, Julie's discourse directly opposes the construction of self-injurious behaviour as being an attention seeking or manipulative act:

Jen: Ok, so you see it as a coping mechanism then. They aren't trying to manipulate anyone?

Julie: No, no, no. Because the only time they have is in their cells, by the time someone sees them doing it... it's hard to see a woman actually doing that. It's private.

For Julie, self-injurious behaviour is a private act, which explains her rejection of the argument that self-injury is a way to manipulate correctional staff members. Her observation is quite accurate and insightful, given that women cut and/or harm themselves in their cells and while they are alone. I did not find evidence to the contrary,

[71] Phoebe's partner was schizophrenic and not taking his medication. They were both addicted to crack, and initially living in a crack house and then on the streets.

nor is it suggested in any of the existing literature that women in prison cut themselves in any other location than the privacy of their own cells. Similar to the effect of those actions taken by political prisoners (Corcoran 2006), to be effective as a method of manipulation self-injurious behaviours would need to be as public as possible. It is difficult to reconcile these findings with the common psy-based belief that women are hurting themselves in a strategic attempt to gain attention and/or manipulate correctional authorities.

Amongst the women interviewed, self-harm was predominantly constructed as a way of coping with stress and sadness, as well as the guilt and shame they felt because of their crimes and criminalisation. The carceral environment in which the women were living often exacerbated their self-harming behaviour. All of the women who had developed eating disorders and/or who self-injured had been strip-searched and then moved to segregation as a result of their self-harming behaviour. Similar to what Joane Martel found with respect to segregation practices (1999, 2000, 2006), time spent alone in 'the hole' intensified the women's self-harm, aggravating their feelings of low self-worth and self-hatred.

Strip Searching and Segregation as Triggers to Self-harming Behaviours

This section presents data supporting the claim that both strip-searching and placement in segregation can trigger or intensify the frequency and severity of self-injurious behaviour (Ross & McKay 1979; Heney 1990; Liebling 1994; Heney & Kristiansen 1997; Carlen 1998; Dell & Fillmore 2000). In practice, segregation occurs in

both federal and Ontario provincial prisons.[72] According to CSC policy, a prisoner will be removed to segregation – more commonly referred to as suicide watch – for surveillance and monitoring as a result of self-injurious behaviour[73] (CSC 2002).

In order to understand how the practice of strip-searching affects the self-harming behaviours of women prisoners, it is important to contextualise its use as a disciplinary technology in the carceral context. Several of my participants noted the regular and routine use of strip-searching. For example, Cassie and Shelley, two provincially sentenced women who served sentences over 16 months in Ontario's Vanier Centre for Women, both 'earned' their way up to the working range of the prison. Earning this status allowed them to work in what is known as 'cook/chill' – the kitchen where food is prepared for the women housed in Vanier Centre and the adjoining provincial prison for men. However, to work in cook/chill meant that they were searched before leaving and upon returning home from work.

Similarly, Mary, a lifer at the old Kingston Prison for Women, described similar experiences of the overuse of strip-searching, both in P4W and in the local jails she had spent time in. Mary also linked being strip-searched to her own self-cutting.

> Well in the prison system, in provincial, it was a regular everyday thing. Every day you had to like, get everything done, you had your breakfast, everything done and when they say, okay – stand across from your things and they would do their search in the room. And then one at a time, the

[72] Unlike the rest of this chapter, the current section focuses on self-injurious behaviour exclusively and does not include a discussion of disordered eating behaviours. Part of the reason for this exclusivity is the failure of corrections to acknowledge eating disorders in their examinations and responses to self-harm. In fact, there is virtually no existing literature in Canada, published either by CSC or by independent researchers, that discusses eating disorders among incarcerated women. While there is a federal policy outlining procedural directives for staff following a self-injurious incident by a prisoner, there is no corresponding policy in the provincial system, nor is there any such policy that addresses eating disorders.

[73] I examine the existing policies and practical responses to self-harming behaviours in greater detail in Chapter Eight.

> males would have to stay out and the female guards would come in and take you in and strip you down. Strip you down everyday. It was just part of the routine. Breakfast, room search, strip-search. You have no control over your own body.

Since the closing of P4W the use of strip-searching has decreased in federal prisons, or is at the very least no longer conducted on a daily basis or when the women go to work. The practice of strip-searching is one of the most degrading and embarrassing incidents a woman prisoner is likely to experience at the hands of the institutions. Given that so many women prisoners have histories of sexual abuse (Faith 1993, 2004; Comack 1996; Frigon 2002), being forced to strip may in fact trigger feelings associated with past trauma. Undoubtedly, being forced to strip in front of strangers is an act of power that has the intended effect of maintaining the hierarchical division between prisoner and prison staff. It represents a lack of citizenship, and thus of power held by prisoners.

Trying to determine the normal versus pathological[74] response to incarceration is not necessarily possible. My research supports the existing literature that reports being strip-searched and placed in segregation following a self-injurious incident increases the severity and frequency of self-injury (Heney 1990; 1992, 1994, 1995; Liebling & Ward 1994; Heney & Kristiansen 1997; Liebling). The fact that segregation is used as the response to self-injurious behaviours reveals the influence of psy-explanations of self-injury as indicative of some form of 'mental illness' and their implementation by the CSC.

For example, after having been observed in the shower by a male guard, Kellie, understandably, became angry and distressed. Adding to her anger was being placed in

---

[74] This phrase 'the normal and the pathological' is a play on words, and is the title of an article written by Emile Durkheim and reprinted in 1938. Durkheim, E. (1938). English translation by S. A. Solovay and J. H. Mueller. *The Rules of Sociological Method.* New York NY: Simon & Schuster Inc.

segregation on suicide watch for three weeks. Kellie categorically described this response as a form of punishment.

Kellie: You don't want to go to the hole. I guess some women would consider it punishment. I considered it punishment when they put me on it when I was in Vanier and in GVI. Like I haven't been suicidal in three years and you're putting me on suicide watch? Like what the fuck is this shit? I'm a realist, I knew I was going to jail and I knew what it was going to be like. I'm not going to hurt myself though; I'm not depressed over it, well maybe a little.

Jen: Being a little depressed in that situation is probably normal though right?

Kellie: Well yeah! You know, you say one word, like I said I was suicidal three years ago and automatically you're suicidal now. It's like fuck off. They think seg is helpful. But you don't want to be alone; you want to be with people who are going to cheer you up. Have people talk to you. A lot of the time when you're in that situation and you're feeling kind of, well not suicidal but depressed like that, you're not wanting to talk to staff.

Her experience in segregation only worsened how she felt about herself – to the point where she identified feeling "defeated", "worn down", "beaten down", and "worthless". Kellie's discourse reflects how the voices of incarcerated women are ignored, despite their screams. Kellie indicated that she was initially outraged, and that she "snapped" on the guards, yelling and begging them not to put her in segregation. No one listened to her. After years of stability, she cut herself while in segregation. It is important to note that Kellie highlighted her desire to be around other women, not be isolated in a segregation cell. Being segregated only made her feel worse emotionally. Her discourse supports earlier feminist works that also underscored claims regarding the harmful impact of segregation on criminalised women (Heney 1990; Liebling 1992, 1994, 1995; Liebling & Ward 1994; Heney & Kristiansen 1997; Dell, Kilty & Fillmore forthcoming). Despite continued warnings, from both feminists and the women in my

research, that segregation can actually increase the frequency and severity of self-injurious behaviour among criminalised women, Canadian correctional policies and practices have not changed.

In both federal and provincial prisons, part of the segregation process entails strip-searching the prisoner and giving her nothing to wear except for what is commonly referred to as a 'baby-doll dress' (Arbour 1996; Martel 1999, 2000; Dell, Kilty & Fillmore forthcoming). The prisoner is not allowed a normal mattress to sleep on; instead she is given a segregation or suicide watch mattress, which is much thinner and made out of the same flame-retardant and anti-tear material as the baby-doll dress. Of all my participants, Shannon was visibly the most negatively affected by both her time in segregation and her experiences with strip-searching. Shannon described in horrific detail and at great length the effects of being strip-searched.

> I just started bawling. She goes "what the fuck is your problem? She goes, what's the meltdown for Shannon?" I said "but you…" and then I was cut off again and then I had to go and strip. She made me bend down like 5 times. To touch my toes and cough. And she's going "Do it again" "Do it again". And finally, I just took my ass cheeks, and I was so mad and crying and said "is this what you want, you know?" Her and another guard just started laughing. Like humiliating right? I couldn't stop crying, like hysterical. So they put me in seg. I cut that night.

The control exerted by prison authorities, with respect not only to the administrative dimensions of imprisonment but also to every aspect of the women's existence during their incarceration, creates an environment in which prisoners have few avenues for self-expression, emotionality, or identity negotiation and development. In this context, self-harming behaviours take on a new kind of meaning. In an environment

where the women are not permitted to yell, scream, and often even to exercise,[75] self-injury and disordered eating can become the only outlets for expression. Shannon's statement that "when you allow yourself to actually think about what they are doing to you, it can't be normal. Making someone strip isn't normal", is eye opening. The correctional authorities continue to construct the women's self-harming behaviour as a pathological response to the conditions of their imprisonment. However, cutting is a reasonable response to the pathological environment in which women experiencing emotional distress are stripped and isolated in a cell, only to be watched voyeuristically on a closed-circuit television.

Several women described their experiences of strip-searching as being abuses of power in a similar way to having been sexually assaulted. Cate, a woman who did time both provincially and federally, was keen to discuss how invasive strip-searching could be, depending on the guard(s) conducting the search. Mary described her experiences of sexual harassment and assault at the hands of one particular correctional officer and how they had incited her to self-injure.

> This one guard, she ended up getting fired [transferred]; she would always feel on us. Like usually they say lift them, but not her. She had to feel everything and you had to strip right down to nothing. It used to make me feel sick. I was anorexic at that time and I used to cut a lot after being stripped.

Mary's account of having been sexually assaulted by a female guard is indicative of the power guards can exert, and the code of silence that exists behind prison walls

[75] Several of the provincially sentenced women described how they were unable to go outside for yard time, despite wanting to get out to stretch their legs, if the weather was not sunny. In addition, there is no gymnasium facility for women in either the Ottawa Carleton Detention Centre or the Vanier Centre for Women. I say there is no facility for women, because there are gyms but only the male prisoners use them. The women I spoke with revealed why women had no access to the gym – namely, because "there weren't enough of us, so everything is for the guys" (Danielle).

(Arbour 1996). I suggest that this code of silence with respect to how prisoners are treated by correctional staff is similar to the code of silence – and ultimately what was found to be an unethical cover-up – by the CSC regarding the 1994 deployment of a male Institutional Emergency Response Team to strip-search and segregate women in the Kingston Prison for Women (Arbour 1996). However, it should be noted that Mary did state that due to the large number of complaints filed against this particular guard, that the guard was eventually "removed" from this prison. While the guard in question was removed from P4W she continued to work for the correctional system, and was simply sent to work in another institution.

In contrast to the humiliating, punitive, and disciplinary searches conducted by correctional staff, I found that the Efry social workers took a very different approach to dealing with situations where women had self-injured. Efry social workers adopt a more woman-centred approach by dealing with *situations* where women had self-injured, rather than with the women themselves. Superficially, this distinction could be nothing more than semantics, but my experience has been that it demonstrates a genuine differentiation between the approaches used by correctional and Efry staffs. The focus by the latter on behaviour allows us to seek the root cause in a social context rather than by simply locating the problem within a mad or manipulative woman.

Three of the four professional Efry staff interviewed had first-hand experience dealing with situations where women living in Efry residential houses had engaged in self-cutting. For example, Carrie stated:

> At the residence, once, I had a woman who was a cutter and I didn't know. I don't think any of us really knew. And she had mental health issues and uhm, she just kind of came into the office and was like 'hey look what I

did'. So it was just like, 'okay'. I think I had maybe been on the job for a month. You know, it was just like, 'what do I do?' and 'how do I...'. I think that you see blood and you see cutting and you're like 'oh my god. Is she hurt?' Your immediate reaction is like, 'Is everything ok?' But then you also want to keep that cool front, because you know that this is something women do. I know that, from learning. You know, from school, that it's not an attempt. It's not a suicide attempt. It's an attempt to relieve something that's going.... It's more used as a method to cope. To relieve something that you're feeling.

Carrie's understanding of self-injury as a way to cope and to relieve emotions is indicative of Efry's woman-centred approach to assisting women who have been in conflict with the law. Likewise, when I asked her about the correctional response of segregating and stripping women who had self-injured, she was appalled and stated that punishing women for harming themselves may only make the situation worse.

Both Carrie and Veronica, a woman who manages one of the Efry residential houses in Ontario, spoke of a harm reduction approach to dealing with situations where women have engaged in self-harming behaviours.

Veronica: We handle it in a way that ensures the woman's safety. So, if she's superficially cutting herself, we'll invite her to talk to us and to tell us what the problem is, why she's doing that, if she's comfortable sharing that with us. And we'll monitor her to make sure she's not cutting herself to the point of physical danger. And that's the only time that we'd step in and intervene, if a woman really needed medical attention, cut herself so deeply that she needs help. It's a harm reduction approach. Some of our clients will say, you know, 'I cut, but it's not as bad as my last cut.' And we'll say, 'that's good. Can you tell me a little bit about why you cut? What's going on with you?' We won't make a big deal out of the cutting itself but more just support the woman and explore the reasons why she's cutting.

Carrie: No, the bottom line for me is that it's your body, it's your body and I'm not here to tell you what you can and what you can't do. And I think that maybe when I first started off in the field, I was like 'you know, people shouldn't do this, they're hurting themselves, we can't let this go on'. Then you kind of realize that while you

wish women would cope in a less harmful way, that it is coping, and people do these things.

Both Carrie and Veronica's narratives avoid any description of self-injury as madness, portraying it rather as a normal behaviour considering the abnormal life circumstances of the women. Their discourse is important because while they do not endorse cutting and hope that they will eventually find a less harmful method of coping, these Efry workers indicate that it is the woman's body to with what she likes. These social workers avoid labelling, individualising, or pathologising self-injurious behaviour. Their discourses are completely different from what occurs behind prison walls, where self-injury evokes fear and disgust.

The differing emotive responses from Efry and CSC fuel the vastly differing practical responses: one evokes sympathy, the other punishes. Unfortunately, once a specific behaviour has been used successfully as a strategy for coping and for diverting attention away from a stressful experience, an individual is more likely to continue engaging in this behaviour, regardless of whether or not she is going to be punished for it while in prison. Refusing to generalise regarding the reasons why women engage in self-harm reflects Efry's desire to allow for a subjective socio-cultural and environmental understanding of the woman's behaviour and life circumstances.

Chapter Summary

Self-injury and disordered eating perform different functions for the women interviewed in this study. This finding indicates a heterogeneity across women who are engaging in similar behaviours. Interestingly, there were no differences in discourse regarding self-injury or disordered eating when examining them according to race,

ethnicity, sexuality, class, or level of imprisonment. The one important difference was that some of those women who had not self-injured were more likely to adopt correctional or psy explanations of this behaviour – as being manipulative or indicative of some form of madness. Most participants constructed eating disorders and self-injury as coping strategies and methods of self-punishment. Self-harming behaviours are also methods for self-expression, and are thus components of individual identity.

But women prisoners in Canada unfortunately lack a collective prisoner identity that could unite them and create a kind of citizenship status through which they could resist and make requests. This lack of collectivity is fostered by correctional attempts at segregating women, and practiced through programming, confinement, security features and designations, segregation, and strip-searching.

In the next chapter I discuss addiction, which was constructed as a mechanism for the women to lose themselves and to lose control; while self-injury and disordered eating were constructed in the opposite way – as mechanisms to secure complete control over their bodies. In addition, addiction was very clearly identified as a component of either a fixed or fluid identity.

Chapter 6
Sojourning Through an Addictive Identity

Donna (PSW): You have to be strong, you have to be positive, you have to go with the flow because once you're in the inside, right, you have to, your prison life in the inside is a lot different than the outside, so me when I got in there I just put the outside life away.

This chapter addresses several key research questions – namely how imprisonment and addiction impact how criminalised women negotiate identity as a result of these experiences, and how substance use reflects an active attempt at coping with life's stressors. I examine the role illicit drugs and alcohol[76] play in the construction, maintenance and negotiation of identity for women in prison.

In all, four key themes emerged from my interviews: (1) both addiction and imprisonment are used as coping strategies; (2) the women's statuses and identities as mothers were key to their ability to be able to cope with or overcome addiction; (3) addiction is a distinct component of one's identity, but is not indicative of the individual's 'true self'; and (4) addiction is constructed at once as a disease and a fixed part of one's identity (reflective of a biological identity and citizenship), and as a choice that represents a failure to self-responsibilise.

[76] I am using the term illicit drugs to refer to psychoactive substances that are not legally available. The term does not include prescription drugs and medications, which I discuss in Chapter Seven. Throughout this chapter I will be using the term drugs to refer to both illicit drugs and alcohol.

A Strange Marriage of Coping Strategies: Addiction and Imprisonment

Carrie (Efry): I think we 'other' them a lot. You know, the 'other people'. Those people. Well I've met a lot of those people, and a lot of those people could be me in a bad situation.

This section outlines a connection between addiction and imprisonment that has not yet been addressed in the existing literature. The construction of addiction as a coping strategy is well documented (Comack 1996, 2004; Weaver et al. 1999; Bonin et al. 2000; Cope 2003; Simpson 2003; Simons et al. 2003; Pimlott et al. 2005; Sturza & Campbell 2005; Filipas & Ullman 2006; Littleton & Breitfopf 2006). Similarly, some research identifies the revolving door phenomenon of imprisonment involving different system agents, such as the repeated arrest of people during the cold winter months to prevent them from freezing to death on the streets (Comack 1996, 2004), or as a kind of 'time out' from life on the streets (Barron 2007). However, very little literature examines imprisonment as a practical coping strategy for drug using or homeless women (Morin et al. 2005). Several participants in this study did suggest that addiction was a coping strategy; however, they also described their shorter stays in provincial prison or local jails as ways for them to detox after drug binges, or to gain shelter if they needed to get off the streets. This construction of imprisonment illustrates that women have few resources available and are making use of the one resource to which they always have access. It also suggests a link between addiction (which is constructed as a coping strategy) and imprisonment (which is constructed as a way of coping with the negative outcomes of a life burdened with addiction). This is a rocky marriage, however, given that many of the women claimed that the pains of imprisonment intensified their experiences of stress associated with the conditions of their outside lives. I will start by presenting evidence to

support the claim that addiction is a general coping strategy for many criminalised women.

My participants suggested that addiction, like the practices of disordered eating and self-injury, is a form of coping. Despite this similarity, participants explained the impact of drug and alcohol use, in comparison to these other two methods of coping, differently. Participants claimed that disordered eating and self-injurious behaviour were methods of attempting to secure a form of control over one's own body. Disordered eating is an attempt to secure power over what you consume or do not consume and over how your body appears, and self-injury is an attempt to gain control over how your body is marked and how you experience pain. Discussions of addiction differed in that my participants experienced addiction as a loss of control over their bodies and, for some, their minds (meaning here the intrusive thoughts about how to acquire one's next hit). Addiction took away the women's control, and is a controlling force that they have to fight. The women suggested that using drugs and alcohol was a less personal act than either disordered eating or self-injurious behaviour – and at times it was depicted as a strategic attempt at altering individual self-perception in order to be able to be a social person existing in a social world or environment. Many women described addiction as a strategic attempt at 'numbing', 'freezing', 'forgetting', and 'disassociating' – all of which are conceptualisations of ways of coping. These conceptualisations distinguish the functions of substance use from those of self-injury – which they presented as a way to focus on self-inflicted and specifically placed pain.

Alternatively, my participants constructed addiction as a way not to feel, rather than to displace feeling to a different kind of sensory-emotive experience (Weaver et al.

1999; Bonin et al. 2000; Cope 2003; Simpson 2003; Simons et al. 2003; Pimlott et al. 2005; Sturza & Campbell 2005; Filipas & Ullman 2006; Littleton & Breitfopf 2006). For example, Joan stated:

> It was chaos but it was better than feeling pain and sadness because I never knew how to sit with that. To be sad and say it's okay to be sad. Emotionally, I never learned proper coping skills or soothing methods to calm myself. And then my coping skill was self-medicating with drugs or alcohol. I've had so much chaos, the life my disease kind of took me on was chaotic. There was always mayhem around. And then getting in jail causes more anxiety too because you don't have your self-medicating stuff. You don't have it and then it's like reality, okay now I gotta cope with all this, all these feelings. My addiction took me to a place where it didn't matter what it was. It just numbed. Whatever was there, I'd use so I didn't have to feel.

This quote exemplifies how using drugs is a way to cope with stressors experienced both in and outside of prison. Moreover, this narrative points to the notion that imprisonment actually heightens the experience of those stressors that the individual may be feeling on the outside. In addition, Joan illustrates the two very distinct sides of drug use – the positive (including the joy and self-medicating effects one experiences from use), and the negative (where drug use results in destructive types of behaviour) (Alexander as cited in Boyd 2004:163). Joan's script is also important because it demonstrates how my participants distinguished between the effect of their addictions and that of their self-injurious or disordered eating behaviours as being coping strategies. In contrast to the latter, addiction was explained as a way *not* to feel and ultimately to avoid dealing with or confronting their emotionality and life circumstances.

Likewise, Phoebe claimed that her drug use was a way not to have to deal with different things in her life:

> Back then I was using, I just wouldn't, I refused to look at my life. Going to jail meant a change, cause I knew I would be thinking about going clean. And that was a scary prospect cause I didn't want it. I didn't want to face reality. Getting clean meant dealing with all of the things that you run away from when you're high.

Phoebe demonstrates how jail time can encourage some women to rethink their lives and their substance use, and how it is also an intense experience that can actually push an individual in the opposite direction, toward resisting quitting drugs. For instance, Brooke indicated that after she had done a lengthy stretch of time in the Ontario provincial prison for women (Vanier Centre) she "stopped caring about everything." For her, enduring imprisonment exacerbated her desire to use drugs. Brooke stated that she "felt so bad and worthless that it just didn't matter, so I would just use and use and use more and more every time I got out. Until I ended up getting federal time." Brooke's identities as a drug user and as a prisoner were fused and she struggled to free herself from these labels. From this script we can see how imprisonment can work either as a 'wake-up call' or to exacerbate substance use.

Many women discussed their emotions as something that they could distance themselves from or that they could segregate from their active thought processes. For these women using drugs or alcohol was the easiest and most effective way not only to cope with uncomfortable, difficult, stressful and fearful emotions, but also to aid in compartmentalising them. Donna's script elicits this argument well.

> It's because you can't cope at that time. Well for me, it was I couldn't cope with those feelings at that time [when she was actively using]. I wasn't ready to deal with them. I put them in a box, put them up there and use so they'd stay there.

This separation of selves and emotions, conscious and unconscious, through the use of drugs or alcohol is a deliberate attempt at coping through avoidance (Pimlott et al.

2005). Being in a drug or alcohol induced state drew Donna's mind off her emotional pain (Cope 2003; Simpson 2003; Littleton & Brietkopf 2006). Again, this finding is in stark contrast to how some of the women described disordered eating and self-injurious behaviour as ways to focus on, control, and ultimately experience both emotional and physical pain. For Donna, and several other participants, it was when they felt that they could not stop using that they realised they were in fact 'out of control' with respect to their substance use. This dichotomy of being in or out of control is key to understanding the difference between how and why the women engage in substance use versus disordered eating and self-injurious behaviour. However, from this vantage point the enlistment of disordered eating or self-injurious behaviour to secure control over one's body, body markings, and appearance is not completely dissimilar to the dynamics of substance use, which represents an attempt to secure control over one's emotionality.

Consistent with much of the existing literature (Comack 1996, 2004; Weaver et al. 1999; Bonin et al. 2000; Cope 2003; Simpson 2003; Simons et al. 2003; Pimlott et al. 2005; Sturza & Campbell 2005;Filipas & Ullman 2006; Littleton & Breitfopf 2006), for some using drugs and alcohol was a way to cope with having experienced a serious incident of sexual assault. For example, Joan talked at length about drinking and using drugs as a way of 'numbing' and 'forgetting' the sexual assault she had experienced.

> Drugs and alcohol were my only friends that could take away any hurt or pain because I'd been through abuse as a child and I was gang raped and I used that. And even doctors have told me that I probably used drugs and alcohol and it kept me alive for a long time. So I think my addiction was kind of to cover up the pain. I internalized it into my own shame and blaming myself, because sex had become very distorted. It became, part of me was thinking it was dirty, but when I used, I didn't care. So that made me feel like if I used I was normal. You know what I mean, that like, why is everybody else okay with it but I'm not?

Joan spoke to me for over three hours, and she consistently brought our conversation back to her feelings about her drug and alcohol use. Though she was not a sex worker, using drugs and alcohol was, for Joan, a way to feel normal when engaging in sex, an act that carried with it memories of past traumas. In fact, her claim that sex was dirty, but that when she was high it did not bother her and that it made her feel 'normal', illustrates the practical benefits of using alcohol and drugs. However, Joan's desire to 'be normal' is also problematic, given that it represents her failure to acknowledge the impact of having been gang raped. Joan seems to want to feel 'normal', to be able to engage in sex without trauma, but her self-blame and self-loathing would not allow her to do this if she was not high. Having internalised these feelings, Joan was engaging in a form of self-punishment that also served as a coping strategy. Addiction in this light is a useful tool, engaged in when an individual is unable to face certain emotional contexts, situations, and interactions.

Similar to Joan's drug use as a way to cope with her feelings of shame and fear with respect to sexual intercourse, Laura shifted from drinking to smoking crack after learning she had contracted Hepatitis C.

> I was an alcoholic for thirty-seven years. So then six years ago, I found out I have Hep C so I quit drinking, and went from drinking to crack. Because at the time I was drinking I was a functioning alcoholic. I had a regular job my whole life, so I worked all day then I drank at night and I got up and went to work every day. But then when I found out I had Hep C I quit drinking. I had started blacking out too, and peeing my bed. So I said now is the time to quit drinking. It wasn't doing very good for me.

This narrative suggests that Laura used drugs as a way to cope with her diagnosis of Hepatitis C and the health and/or biological identity that comes with such a diagnosis. Laura admitted to being "devastated" upon learning she was positive for Hepatitis C.

Similar to what Michael Orsini (2006) found, this new biological identity did not forge in her a sense of biological citizenship in that she did not begin to lobby for her own health and health rights. In fact, this biological and health identity actually fostered in Laura a sense of lowered self-worth and shame, which only aided in elevating her substance use from drinking to using crack. Hepatitis C is an extremely stigmatised disease as well as being a sexually transmitted disease. Laura's shift from drinking to smoking crack, in addition to her diagnosis of Hepatitis C, served only to increase her feelings of marginalisation and stigmatisation.

Using drugs was a way for some of the women to escape confronting their emotionality; however, it was also a way to both have and be without emotionality. To live within the world of addiction my participants described a life full of chaos, mayhem, and danger that called on them to be alert and self-protective at all times. Indeed, this 'world' calls on these individuals to construct a self that is emotionally hypersensitive. Yet at the same time, 'being addicted' was their way of avoiding their emotions and life circumstances. Drug and alcohol induced states are temporary ways of coping with stress and strain, but they do not readily address the issues at hand. For my participants substance use actually increased their sensitivity to and experience of their emotions.

Interestingly, for some of my participants, prison operated as a kind of detoxification centre and/or shelter for homeless women with addiction issues. This was especially the case at the local jail and detention centre level where women cycled in and out serving short sentences. Out of the 13 women who acknowledged having used jail as a place to detox, a disproportionate number (6) were First Nations (the other seven women were white). All 13 of these women were poor, and many were homeless and

living on the streets when they opted to use prison as a detox or temporary shelter. This finding reflects the overrepresentation of both First Nations and poor women in prison that has been documented at both levels of imprisonment (Comack 2006), and it thus supports the argument that sexism, racism, and classism are deeply entrenched forces working throughout the criminal justice system (Davis 2003).

Several of the women I interviewed discussed incarceration as being a positive part of their routine because prison provided a shelter and an opportunity to eat and gain weight following a drug binge, which is often associated with a dramatic weight loss. Many of my participants had, quite literally, grown up in some form of detention, making it logical for them to view prison as a kind of sanctuary and way of coping with their marginalised existence on the outside. For example, Stacey depicted time in prison as being a 'time-out' during periods of heavy use.

> I know for me, cause a lot of the times I'm doing what I'm doing because I don't want to think about things. Or I'm doing crime and a lot of the time I would go to jail cause I need to sleep, you know?

The fact that some women would welcome going to prison in order to sleep demonstrates the lack of community services for women suffering from substance use issues, with jails replacing shelters. This 'solution' is certainly inappropriate to say the least.

Indicating the diversity across women and between users and non-users, Danielle, a former provincial prisoner without a history of drug or alcohol use, was an empathetic observer who stated:

> You're not punishing them, you're just, basically detoxing them for a bit, and some of them want to stop. They don't like the lifestyle 'cause there's not a dignity that comes with it. I heard that a lot.

It is interesting that prison was acknowledged as a kind of shelter and an opportunity for detoxing by women with and without drug habits. Despite not using drugs, some participants gained first hand knowledge of 'prison detox' by observing other women come in and 'sleep for days'.

Both Phoebe and Laura, a participant in the new drug courts,[77] claimed that prison is an active detoxification centre. Despite being able to secure drugs while in provincial prison, it is difficult to maintain an addiction because of the frequent cell 'sweeps' that the correctional officers conduct. Short stays in prison or jail are therefore actually constructed as helping some of the women to start "thinking about quitting," "changing their ways", or "getting clean".

Laura: To me, prison isn't prison. It's more of a – well you're being locked up till you're off the drugs. And your mind starts thinking. Yeah, it's like a Detox centre. It's the best Detox they have, because you're refused everything, right? It's hard though, cause you're being cut off like cold turkey and it's hard but you have no choice because you're behind bars.

Phoebe: 'Cause I knew I was going to be in for a while. And I knew I was going to be into the rehab thing. I knew that. Cause when you're in jail, a lot of girls want to go clean. They talk about going clean. Because that's, cause you can't do that when you're out on the street. When you're on the street, when you feel like using, you're using. And it doesn't give you a chance to really think about your life. You don't get a chance to think about rehab. You know, you don't think about your responsibilities. But when you're in jail,

[77] In certain major cities across the country (Vancouver, Toronto, Ottawa, Montreal), courts have created an alternative system for individuals with illicit drug charges. Rather than automatically sending the person to prison, the drug court system allows the individual to enter into treatment programs while continuing to live in the community on a probation order. Drug courts are a relatively new alternative in the Canadian system, and their existence is still a contested issue. Critics argue that the system is not providing a real choice, given that the accused must plead guilty (the 'choice' being either treatment or prison time), and that this kind of mandatory treatment may not have the desired effects of long lasting recovery or abstinence. The drug court system is illustrative of the neoliberal trend in governance as it operates within the criminal justice and correctional systems. For more information on this topic, see: Edwards, M. (2005). *Therapeutic Jurisprudence Revisited: The Experience of Criminal Justice and Treatment in Toronto's Drug Treatment Court.* Unpublished MA Thesis. Burnaby BC: Simon Fraser University.

> when the drugs have gotten out of your system, and you have no choice but to think, and you have no choice but to just sit, that's when you really start seriously thinking about yourself. You're taking a really good look at yourself.

Jane, a young pregnant mother[78] with a long-standing crack addiction recounted how she had a friend who she never saw on the street but who she always "ran into" when in prison. Jane's narrative is particularly important, as it highlights the lack of help, support, or programming offered at the provincial level. Without these kinds of support, suggests Jane, women with addictions issues have little recourse in terms of abandoning their drug use.

> I think that women who have issues with addiction shouldn't be put in jail and then released on conditions all the time. Because then we go back in jail, we do our time, there's no support at all. Then you get out and do the same thing all over again. It's like, I have a friend who, I only see her in jail, I've never seen her on the street. We write letters and everything, but it's so pointless. She'll do six months, she'll get out, she'll be a month or two in the community, getting high and she'll be back in jail again. There's nothing in there for us.

This quote emphasises how imprisonment becomes routine for many women. Sadly, prison has become a space for women to get clean and improve their nutrition for a short while, before heading back out to the streets to use. If prison is the current venue for women to begin thinking about drug treatment and detoxification, our current health care system is clearly lacking in funding and ability to care for persons with substance addictions.

The participants cited three main reasons behind the difficulties they encountered in accessing treatment in the community. First, many drug and alcohol treatment centres only take individuals who have a certain number of days clean – an extremely difficult

[78] Jane was pregnant both at the time of the interview and while she served a few months time in a local jail.

feat for a woman living on the streets in the throes of addiction. Second, the lengthy waiting lists deter some women from going to treatment. Third, some treatment centres refuse to admit criminalised women (representing an inter-agency conflict that serves only to increase the marginalisation of criminalised women).

To expect an individual to 'be clean' before entering a program defeats the purpose of inpatient drug and alcohol treatment. It also displaces responsibility onto the individual seeking help. Under such circumstances, these types of treatment centres are best understood as 'maintenance' centres. Likewise, insufficient funding and lack of access to treatment centres continue to increase the length of waiting lists for those in need of help – a consequence which is amplified for those living in rural areas. Literature on addiction commonly notes that there is often a small window of opportunity available during which people are willing to seek treatment (Boyd 1999, 2004; Fillmore & Dell 2005). These policies may in fact be closing the door on some individuals who will lose the desire, courage, energy or ability to enter treatment. Phoebe's narrative supports this claim, as she states: "When you're on the street, when you feel like using, you're using." It was only when she was in prison – with "the drugs out of her system" that she was able to "think about herself" and ultimately think about treatment and her ability to stop using drugs. Even more problematic is that some treatment centres refuse treatment to criminalised persons; in fact, four of my participants had been refused because they were still 'actively' using, were homeless, and were criminalised. Refusing a population that is so marginalised serves only to reinforce the notion that these women are on their own. This kind of policy effectively discriminates against criminalised women and leaves them with fewer resources than other groups in need of drug and alcohol treatment.

Given that women who have been criminalised are often excluded from treatment programs it is not surprising that some with serious substance use or addiction issues actually view prison as a kind of time out from and way of coping with their drug use. Viewing prison as a 'wake up call' and deterrent is one of the claimed goals of the continued use of imprisonment (Morris 1993; Christie 2000), but this view fails to recognise how women are actually using imprisonment as a means of maintaining their addiction. Getting clean clearly requires more than attending treatment, given the number of times the women said they had gone through treatment programs (including the substance abuse programs offered in federal prisons). To quit using, the individual woman must come to a point in her career as an addict when she truly wants to quit using. I am not suggesting that getting clean is completely up to an individual, or that it is simply a decision (or choice) one must make. It is much more nuanced than that, and it is dependent on obtaining the supports needed to continue the process of recovery outside the treatment centre context.

In any case, some of my participants viewed prison as a 'turning point' or 'hitting rock bottom' (McIntosh & McKeganey 2000), at which point they began to tally the costs of their drug and alcohol use on their health, their lives, and the lives of their loved ones. In this light, imprisonment is a negative outcome associated with drug and alcohol use (not to be confused with a reason for their departure from a drug and/or alcohol using lifestyle) and a strategy used to manage addiction. As such, imprisonment should not be misunderstood as a positive social and personal experience that leads to sobriety. To construct imprisonment in this way would not only be misleading, but would be a complete (re)construction of a negative social and personal experience. To think that

incarceration is responsible for women's desire and ability to quit using betrays a lack of understanding about the impact of one's identity and consciousness, not only in the decision-making process but in the practice of becoming 'clean' and maintaining sobriety.

Motherhood as Praxis: Relying on One's Identity as a Mother to Resist Addiction

As I mentioned earlier, of the 22 former prisoners with whom I spoke, 64 percent (14) were mothers. Of these mothers, 50 percent (7) had lost primary or total custody of one or more of their children to either social services (3) or a family member (4). The other 50 percent (7) of the mothers had adult children and had not lost custody of their children as a result of their criminalisation, addiction or imprisonment. Only 14 percent (2) of the women were still in a relationship with the fathers of their children, while 21 percent (3) had adult children who had contact with their fathers. The rest of the women were single mothers. While motherhood was clearly an essential component of the identities of these fourteen women and was discussed at length when we spoke about addiction, motherhood was not referenced at all when we addressed self-injury or disordered eating.

Many of the women were eager to identify themselves as 'good mothers' in spite of their drug and/or alcohol use. For example, Laura explained that even in the face of her crack addiction, she was always careful to provide financially for her son, which required her to engage in sex trade work.

> Like my youngest one, I was closest to him. Richard, my handicapped son, I go sometimes a month without seeing him [he was in a special care facility], but Billy, I practically see him every day. But what I'd do is, I

> call him first thing, I'd give him a hundred bucks – I kind of paid him to get lost. So that I knew he wouldn't be knocking on my door while I'm in my room doing my drugs all day or all night. So I made sure I had enough money, then oh come get your money, food money, whatever, you know, go do what you want with it and then I wouldn't have to see you until the next time you need money. So I'd get that out of the way all the time, so it's like I was paying him to get rid of him.

Laura's narrative reveals two forces simultaneously working and guiding her actions and impacting her decisions: (1) her desire to use crack; and (2) her desire to nurture, mother and ultimately provide for her adult son. Laura's statement "I was paying him to get rid of him" may sound like harsh words from the mouth of a mother, but in her view she was providing for and protecting her child. Ensuring that her son was financially secure allowed her to continue using drugs, and it prevented her son from witnessing her drug use first hand. Although her son knew she was using, Laura was attempting to keep the two worlds of motherhood and drug use separate.

Interestingly, these women spoke of their identity and role as mothers as a strategic attempt to remind them of what they were losing because of their continued drug use. For example, Jane stated:

> But it's bad because we all have kids. We should be all talking about our kids. But then, it's too hard to talk about it because you know, you start to cry and that's not something you wanna do in jail.

Similar to the existing literature, Jane expressed the notion that good mothers are altruistic, always placing their children before their own needs or desires (Boyd 1999, 2004; Diduck 1998; Greaves et al. 2004; Geiger & Fischer 2005). Jane's narrative illustrates the tension she felt between her ability to mother her child, her decisions to continue smoking crack, and her eventual imprisonment. It is important to note that Jane stresses what she feels she *should* be doing – talking and thinking about her child rather

than doing drugs – but she also notes that self-expressions of emotionality are uncomfortable and potentially inadvisable in the prison context.

Jane noted three reasons for not wanting to express oneself emotionally in prison. First, she did not want to lose control emotionally because she was not in an environment where she would get the support she needed. Second, Jane intimated the importance of maintaining a certain bravado or 'tough girl' image. Crying about one's children would weaken this image and could potentially make you more vulnerable to assault. Finally, Jane did not want to become upset in prison because there was nothing she could do to change her situation while inside.

Several of the women described how thinking about their children in an altruistic way, often expressed as "putting them first", was both a strategic attempt at staying clean and a motivation to initially become clean. For example, Phoebe stated:

> I wouldn't use. No. But right now, I have my daughter to look forward to. You know, she's with, she's in a foster family right now and I have a chance of getting her back, so I don't want to screw that up. I'm going to see her. I almost lost custody, total custody of her. And so this time, when I went back to jail in July, I wasn't much, I had a slim chance of getting her back, so I'm taking that chance now and got cleaned up because of it.

Phoebe discussed at length her feelings about her daughter going into foster care. For her, losing custody was motivation to stop smoking crack and using heroin. Phoebe's daughter acted as a beacon toward which she was striving. For Phoebe, becoming and staying clean and sober rested on her identity as a mother. She relied on this aspect of her self as a way to manage her identity as an addicted person. In this light, addiction, a strong and driving part of her persona, was to be overcome by her identity as a mother (Baker 2000; Geiger & Fischer 2005).

Throughout the interviews I was struck by the women's acceptance of the ideology of conventional motherhood (where 'good' mothers do not take illicit drugs or drink to excess), and by their distinction between 'bad' (illegal) and 'good' (legal) drugs. I found Stacey's story particularly interesting. Similarly to both Phoebe and Laura, Stacey eloquently illustrated the pressure she felt as a result of her continued drug use and what she described as her 'opposing role' as a mother. When I asked Stacey how she came to the point of moving away from drug use, she described her guilt as a driving force:

> I think getting out on parole, fucking up, going back, and you know, and just not wanting it in my life anymore, you know? I'm not like my mother, but I am. I gave, I chose drugs over my own daughter. And I don't want her to grow up and, either I did it, a hit and I died or you know I'm on the streets, somebody killed me, and I already feel bad now because I chose drugs over her. So I don't want her to grow up and I'm still a drug addict. My daughter, she's what keeps me going. Trying to stay clean for her.

Stacey's narrative underscores the fact that she feels tension between understanding drug use as either a 'disease' or a 'choice' (which I contend are not necessarily mutually exclusive categories). It also highlights her acceptance of the neoliberal emphasis on individual responsibility for substance use problems. By using language such as "I chose drugs over my own daughter" Stacey is demonstrating how she experiences herself as a failed mother. Further, Stacey revealed that her own mother had been a drug and alcohol addict and that other family members as well as foster parents had raised her. At one point, Stacey suggested that she had learned this way of mothering from her memories of and relationship with her own mother. This memory of her mother also stood out for her as a way not to mother her child. This marker of what not to be thus served only to increase the guilt she felt for her continued drug use and abandonment

of her child (Stacey left her daughter in the custody and care of her own aunt). Stacey used her role as a mother as encouragement for her to avoid drugs and be a responsible parent.

Idealized notions of womanhood typically include similarly idealized and essentialised notions of motherhood; to be a true, complete and fulfilled woman one must also be a mother – and to be a mother means to be nurturing, selfless, and chaste. From this perspective, to be a mother implies particular ways of mothering and certainly excludes illicit drug use (and possibly excessive alcohol consumption) (Boyd 1999, 2004, 2006; Diduck 1998; Greaves et al. 2004). While several of the women I spoke with suggested that they constructed motherhood in this way of their own volition and understanding, these idealised constructions of motherhood and womanhood are also exacerbated, elicited and encouraged by institutional discourses found within corrections. For example, when discussing programming for drug and alcohol use, every one of my participants noted that the program providers used the women's status as mothers as a tactic to get them to stop using. Prison authorities and correctional workers, reconstructed the 'mother' identity as leverage to encourage women out of their drug use. They enlisted motherhood to foster shame and guilt, neither of which necessarily leads to arresting substance use, and which may in fact push an individual to continue or increase use as a way of coping with that shame. Drawing on their identities as mothers did help push some of the women toward sobriety, at least temporarily. However, when one of my participants relapsed she found herself in a serious depression as the result of what she saw as her continued failure as a mother. Her depression reflects the danger of adopting an ideology of motherhood that dichotomises good from bad mothers.

For example, Sophie continued to bring the interview back onto the topics of motherhood, her children, and her fears of legally losing complete custody of her young son.

> I don't wanna end up going in. I'm fighting for my son right now, and a stupid little slip-up right now is going to screw everything and I'm so scared. I don't want my son to end up being adopted or something. That's my biggest fear. Because I love my boy. I would never hurt him in any way. Like I raised my girls and they're perfect kids. And he doesn't deserve what his mother's doing to him right now. Like I mean, he needs his mom and I'm screwing it up for him. He's my motivation right now. Everything is for him. I don't want to be in jail and my son coming to visit. I don't want that, you know? I wanna be a normal mom. It's not his fault that I'm being a screw-up. But he's paying the price.
>
> It's hard. It's hard to watch your child cry when they have to take him through the door, to go somewhere else. I don't want somebody else raising my boy, that's my baby! So I'm fighting really hard to get him and I'm fighting really hard to stay off the drugs. That's all I have to do. Being a mother makes me feel like a woman. I feel whole, when I'm with my children. I don't feel that way when I'm not with them, you know? It's weird. I feel complete when I'm with my children. And when something like this is going on, I'm, I'm lost.

Sophie was ultimately preoccupied with her young son, fearful of using drugs again and of losing custody. She was keen to emphasize that she was a good mother despite her drug use. She criticised the Children Aid's Society for removing her son from her care, explaining that she had successfully raised her two older children and that it was solely her recent drug use that had led them to question her ability as a mother.

Likewise, Sophie was adamant that her son was being punished for her mistakes, which in her view was unfair given her past successes as a mother. Sophie stressed again and again the fact that "all she had to do was not use drugs" in order to get her son back. Diduck (1998:210-211) suggests that a woman who comes before the law as a mother, and her "subjectivity comes laden with requirements of motherhood: chastity, self-

sacrifice, nurture and care and she also comes bearing a mystical maternal connection to her child. How well she is able to negotiate these factors in the circumstances of her life determines whether she is essentialised as a good or bad mother." Sophie's narrative demonstrates this tension between her belief that she is a good mother (because of her past maternal experiences) and a bad mother (because of her drug use). Sophie's fear of being a bad mother was only aggravated by the correctional discourses that reconstruct mothers who use illicit drugs as unfit.[79]

Most intriguing was Sophie's statement that she does not feel as though she is a complete person without her children. Motherhood was what made her feel like a 'real woman', and having her child removed from her care because of her drug use led to her feeling incomplete, lacking, and a failure as a woman. If one feels complete as the result of being a mother, it is therefore logical to assert that having your children removed because of your drug use and criminalisation would only increase your feelings of inadequacy, self-loathing, guilt and shame. Unfortunately, these feelings provide a fertile ground for a cyclical experience of drug use, where drugs are used to cope with feelings of inadequacy and guilt, but at the same time reinforce support for the removal of the child from the mother (Boyd 1999, 2004; Greaves et al. 2004; Geiger & Fischer 2005).

Very few of the women I interviewed gave up custody of their children willingly to either a family member or child services. In western societies, to give up your child of your own volition is more than stigmatised – it is looked down upon with disgust, confusion, and very little sympathy or understanding, as though it is a violation of

[79] There is clearly a paradox with respect to licit and illicit drug use, by which the former is accepted and is primarily unquestioned, and the latter is demonised. I address this paradox as a question of policy in Chapter Eight.

accepted standards of motherhood and womanhood (Comack 1996, 2004; Diduck 1998; Malloch 1999; Hannah-Moffat 2001; Blanchard 2002). One participant who did give up custody of her young son and daughter was Emma.

> I had two kids at home, I was working two jobs – I was dancing and I was bartending and I was 17. I had the day off, my son had been colicky for a week and a half, I fell asleep on the couch and my daughter climbed up on the stove and got second and third degree burns while I was sleeping. When I woke up she was playing on the floor beside me saying 'mommy we got bobos', and I realized that I couldn't do it. That was the hardest decision I ever had to make in my life – to give her up. I gave her and her brother up to my mom. So my son has just recently come back into my care, a month and a half ago, but I've had some access to them all their lives.

The observations of Veronica, an Efry social worker, support the extensive research in various jurisdictions that indicates that only 'bad' (read criminalised and/or drug using) mothers' go to prison (Comack 1996 & 2004; Diduck 1998; Boyd 1999, 2001, 2004;).

> I think the greatest misunderstanding is not seeing them as mothers, sisters, or daughters. People don't see women prisoners as that. They see them as some 'other being', that you know, is not like anybody we know. Generally in society it's even more horrendous for a woman as opposed to a man to have a criminal record because the woman is, typical stereotype, is supposed to be the good, mothering, nurturing person. So if they lost their kids, well, right then society looks at them as being a monster for losing their children. Even if that woman made a conscious choice to put her family in a safe environment. If they've decided that they can no longer care for their children and they put them in a safe, loving home, society will still frown upon them for giving up their kids.

In this light, women who are mothers and who also have drug and/or alcohol addictions are caught in an untenable position. They *cannot* be 'good mothers' even if they are prudent or responsible enough to give up their children or if their children are removed from them. What this suggests is that women with both children and addiction issues are necessarily understood as bad mothers. From this viewpoint, to be a good

mother is to be free of illicit drugs. This belief is maintained, no matter how responsible you are with your children, no matter how well you care and provide for, nurture, watch over or – for want of a better word – mother your children. Idealized constructions connote that motherhood is in opposition with illicit drug use; the beliefs and values of the two worlds are incompatible. Constructing motherhood in this idealistic way is dangerous because it leaves little room for alternative and perhaps more experientially based understandings of motherhood and addiction (Greaves et al. 2004).

Only one participant in this study negatively constructed the interconnection between an individual's identity as a mother and one's drug use. As with eating disorders and self-injury, the least empathetic woman was the one who was not an addict. It was only with Shelley, a provincially sentenced woman with no history of drug or alcohol use, did I see any differences with respect to this theme. For the first time in this research, differences in the women's discourses emerged along racial and class lines. Shelley who was a white middle class woman completely embraced the ideology of good and bad motherhood, and became visibly upset when discussing drug use by other women prisoners who were mothers.

> What surprised me the most was the women that, ok, I appreciate that you use and it takes over you, but when you have a baby – and you hear the women, 'Oh, my boyfriend is picking me up and he's gonna have a ball, whatever, crack, ready for me when I get in the car.' I mean, it made me sick to my stomach. And they were all, they were all like that. Nobody said, 'Oh, I'm clean now, I've been clean for X number of days and I'm gonna stay clean and I'm gonna have this baby and I'm gonna be healthy.' You didn't hear that.

Similar to what Greaves et al. (2004) found regarding the construction of addicted mothers in the media and in policy, Shelley demonstrated a great deal of judgmentalism with respect to those mothers who used drugs. Judgmentalism reflects the vague

discourse of 'doing things in the best interest of the child', which commonly pits the interests of the child against the interests of the mother (Greaves et al. 2004:23). For Shelley, this attitude stems from her experiences with a cocaine-addicted husband whom she had to support on her single income, and who she reports was not a 'real' father to their children.

My point here is to stress Shelley's experiential reality, as it is distinctly different from the other women I spoke to. In fact, even women who had children but no histories of addiction, and women with histories of addiction but no children demonstrated more empathy for this group of mothers than did Shelley. With respect to this research, while Shelley's discourse methodologically represents only one negative case it is clearly important to make note of it. Shelley's belief in the traditional conceptualisation of motherhood, the nuclear family and the sexual division of labour is idealistic, not necessarily realistic. Her beliefs may reflect her personal experiences with family members who suffered from addiction more than her experiences in prison.

Ultimately, Shelley, the mother of two grown children who only used prescription drugs while in prison, had a specific construction of acceptable motherhood that excluded drug use. Because of her personal experiences, Shelley actively resists empathising with mothers who continue to use drugs. This resistance is due in part to Shelley's desire to distance herself in every way possible from other women prisoners. Shelley was in her mid forties and this was her first time in conflict with the law. She had lived a pro-social life to this point and being incarcerated was a shock to her and her family. Criminalisation had already been cemented in her mind as something foreign that she would never experience. Shelley's frame of reference was quite different from that of my

other participants, many of whom had parents or family members who had been in conflict with the law, and/or grew up in different forms of institutional custody. In fact, Shelley stated several times that she was "not like the other women", and was keen to demonstrate and in her words "prove" this difference to me, correctional officers and authorities as well as to the Efry staff.

Duelling Identities: The 'Addicted' Versus the 'True' Self

Phoebe (PSW): The power of the bag is very, very strong.

Having two distinct selves (addicted and true) emerged as a key theme from the women's narratives. While I had anticipated that the women I interviewed would talk about their past and current issues surrounding addiction, I had not anticipated the extent to which my findings would bear out that assumption. For several of my participants, having the opportunity to discuss their problems with addiction was certainly the issue with which they were most preoccupied. The opening passage to this chapter, taken from my interview with Donna, illustrates what many of the women discussed: namely, having two distinct lives, personas and identities – one reflecting their time on the outside, the other in prison. That an individual must hide away her outside life and self in prison reflects the need to cope with isolation and imprisonment. It is indicative of a separation between selves. It also echoes how the women described the separation between their using and non-using identities. The women described this separation as having 'an addict self' and a 'true self' (Plumridge & Chetwynd 1999; Baker 2000; McIntosh & McKeganey 2000). Distancing their addict identities from their 'true selves' reflects an attempt to foster a master status (Becker 1963) that is free of a deviant label and identity.

The women's resistance to having a master status of 'addict' also illustrates their desire to overcome their addiction, and reveals the use of hope in personal identity management.

As cognitive creatures we all develop, maintain, resist and ultimately negotiate personal understandings of our 'selves' as individual as well as social beings. We have several components of our identities that are often dependent on our sociality and contextual environments. Prisoner, ex-prisoner, criminal, mother, alcoholic, drug addict, victim, HIV positive, AIDS patient, or prostitute, for example, are both individual and social identities that illustrate how we label ourselves and one another in order to associate, understand, reflect upon, experience and express our personhood.

Jessica, a young woman who had been an injection heroin user for five years, but who is now clean and maintaining sobriety with the help of a provincially sanctioned methadone programme, discussed this division between her addict and her true self.

> I was only an addict for five years, so it wasn't a big part of my life. Getting clean was kind of like picking up where I left off. When you're an addict, the addiction is driving you. You're not even making your own choices. The addiction is making the choices for you. Oh yeah, you're a different person when you're using. The addiction is running you. When you get clean, the drug isn't making your choices anymore.

For my participants, adopting the 'addict self' as part of their 'true identity' was admitting that they were capable of doing things they were ashamed of and/or felt guilt for[80]. Therefore, constructing a division between the addict self and one's true self is a

[80] It was beyond the scope of this dissertation to engage with the critical literature surrounding drug treatment (for example, see: Boyd 2004; Reinarman & Levine 1997; Reinarman 2005; Valverde 1998). However, I would like to note that my participants' responses do echo mainstream addiction/treatment discourses, especially those offered in prison, which clearly distinguish between the sober (regulated) and the addicted (out of control) self. I do not agree that there is a clear dichotomy between these two selves, and suggest that they exist simultaneously. Moreover, the women's discourses reflect the belief that drugs are 'always bad'. This construction effectively fails to recognise that prohibition is largely responsible for the crimes associated with drug use, and that it is inequalities of race, class, and gender that help to shape drug use and addiction in negative ways (Boyd 2008: personal communication).

protective measure for some women – one that allows them to save face and to potentially avoid some degree of the shame and stigma they may have felt for their substance use. For example, Joan stated:

> That's not who I was. You know, that's what my disease is. You know, that's who I am when I use. That's my disease, that's not who I am in here [indicates her heart and her mind] you know? I'm not somebody who would have hurt their mother. I'm not somebody who wanted my kids to be taken from CAS and now they're with their father! That's not me, it's not who I *really* am. *Emphasis added.*

Both Jessica's and Joan's narratives illustrate a perceived separation between their addict and true self: Joan claims that when using, the addiction is making your choices. Personifying addiction allows the segregation between the addict and the true self, which helps protect the true self by saving face (Goffman 1963). Jessica's assertion that "you're a different person when you're using" is an attempt at drawing a dividing line between who she was as a drug user and who she is as a non-user. In addition, her claim portrays the addict self as uncontrollable and 'blames the drugs', arguing that heroin was making her choices for her.

In our current neoliberal governmental landscape, Jessica's discourse is re-constructed as non-responsibilised. Her script may be seen as violating the ethic of taking responsibility for one's actions, choices and behaviour. In fact, at the same time, Jessica became responsible by quitting heroin, going back to school, and putting her 'self' (true self) first. In this light, neoliberal constructions of responsibility, prudence, and self-care can be shown to be too limited to properly assess a person's (ir)responsibility, especially when that person has a complex lifestyle that strays from the norm. To suggest that an individual is irresponsible ignores the fact that decision making is not black and white, and that it occurs over time, shifts throughout one's life course,

and is context dependent. In atypical, but very plausible, situations, using drugs may not be irresponsible, and is certainly explicable – as is the long time it takes for some individuals to stop using.

My research resonates with the founding premise of standpoint theory and illustrates that there are important differences among women, as well as between women and authorities[81]. For example, in order to segregate her addict self from her true self, Phoebe found solace in a prison guard who was kind to her.

> Lindsay [prison guard] was part of the reason I felt like I would have wanted to go straight. Just because she seemed to have a lot of, she really thought I was different from the other girls. That I really had hope to get off the streets. She just didn't think I was the norm. Which was true, because a lot of the women have been on the streets for years and years and years. They've been in and out for so many times and for long periods of time. Myself, it was just recent – two years on cocaine and heroin and I was only on crack for five years. You know, I started late on drugs. I'm only thirty-two years old, so.

Similar to earlier findings, Phoebe not only separates her addict self from her true self, she also attempts to be different and to distance herself from other drug using women (Plumridge & Chetwynd 1999; Baker 2000; McIntosh & McKeganey 2000; Geiger & Fischer 2005). Wanting to avoid being seen as a typical drug addict in trouble with the law, or someone who has been in and out of prison for most of her adult life, Phoebe was happy to accept the discourse of a correctional officer who claims to see her in a different light than her fellow prisoners. Allying herself with this external opinion validates her beliefs that she is in fact not the norm. In addition, Phoebe even uses the length of her addiction (seven years) as a factual presentation of how and why she differs from other 'addicts'. Although she was addicted to drugs, she did not possess that 'addict

[81] These differences between the women and authorities are more clearly investigated in the next chapter on psy-care and prescription medications.

identity' that other individuals may acquire. Phoebe is resisting that sense of self in order to reconstruct her persona, identity and personhood in a more favourable light. I sensed that she was doing so during the interview both for my sake, as someone who could potentially be judging her, and for her own peace of mind.

Related to my earlier finding that using their status or identity as a mother helped some of the women in their efforts at recovering from substance use, motherhood was also a key part of some of the women's efforts to separate their addict selves from their true selves. For example, Phoebe claimed that:

> Phoebe the addict was very different. I just look back at the things that I've done to people, what I did to my own baby, you know? She was born with crack in her system. And I look back and that was a lot of guilt and shame associated with those feelings. And I hate those feelings, with drugs. When I was in rehab I dealt with those feelings. I had to learn to forgive myself for doing those things because that was the addict in me, you know? I'm not like that now. That's not the real me.

Not only did Phoebe use her identity as a mother as a way to battle her addiction and gain sobriety, she once again elicits that aspect of herself as a way to resist her status or identity as a drug addict (Plumridge & Chetwynd 1999; Baker 2000; McIntosh & McKeganey 2000; Geiger & Fischer 2005). It was the 'addict self' that caused her daughter to be born with crack in her system. Her true self, the 'real Phoebe,' would not have let that happen. Surely, it must be anguishing emotionally, mentally, and morally to cope with having a child be born with drugs in their system. The separation between the addict and true self is certainly one way of avoiding that shame and guilt.

For the majority of women with whom I spoke, drug and/or alcohol addiction was inextricably linked to their criminality and criminalisation. For these women, shedding their 'addict identities' combined with the desire to shed their labels as 'criminal' or

'prisoner'. Emma stated that she wanted people to 'look past her crimes and addiction' and suggested that 'there was more to her beneath the surface'. Likewise, Dana asserted:

> Addiction changes a person, big time. So I had to learn, some people didn't understand me as well, like I sort of understood that, that there was good in people. That it wasn't them, you know?

In a way my participants personified their addictions as controlling or demon entities, they feared and loathed but also as something they often felt powerless to resist. Consequently, many women described feeling as though their substance use was a distinct and separate part of who they were that did not reflect their values or abilities, for example, regarding motherhood. This argument parallels the earlier point that some of the women felt they were good mothers when not on drugs. The fact that so many of these women repeated the idea that their addiction did not 'make them' as a person, that it was not representative of their true selves and that it was more like a shadowed existence is inspiring. This construction of their drug use suggests that despite the hardships caused by their addiction and criminalisation, these women refused to give up or give in. Being careful not to romanticise this resistance, I suggest that it is their positivity and desire to be seen for who and what they *can* be as well as how they potentially see themselves that drive their insistence on separating these aspects of their person or self-hood. Interestingly, the women seemed to accept that there was a dividing line between illicit and licit drug use, where addiction gets referenced only in relation to the former. The fact that some drug use is criminalised should not be confused with the notion that these women's identities, selves, or souls are not inherently 'criminal' or 'addicted'. From this understanding sympathy and empathy may be born and compassion expressed.

Part of helping women differentiate their addict selves from their true selves, is the ability to make a distinction between common or 'normal' lifestyles and an addict or street lifestyle (Plumridge & Chetwynd 1999; McIntosh &McKeganey 2000). Reconstructing their drug and street lifestyles in a negative light was a mental and emotional device that allowed the women to not only express their antipathy for these lifestyles, but also distance themselves from that part of their lives and thus identities. This was an extremely difficult task for some of the women. Jane spoke explicitly about the tension she felt about both wanting to leave and longing to remain a part of her drug subculture.

> It's so sad, 'cause it's unimportant, the dealers are nobody. They have no education, they have kids running around everywhere, they're lazy slobs and they don't even have homes themselves 'cause they use. It's just because they're managing to sell dope that they're seen as gods. Every day is hard. For example, if a woman comes back home and they're trying to be clean because you can't focus. Like you try to read a book and can't think. It's worse in jail because you can't get away from all the talk. It's everywhere. It's all they talk about. Everybody starts to feel sick from craving the drug and they start talking about it. There's nothing else to talk about, we don't know anything else.

Jane's narrative reveals the difficulty many women felt in walking away from their drug using lifestyle. While they found living in crack houses abhorrent, they also described this life as having a certain glamour that they longed for. Jane's script suggests that she both reviled and revered the dealers, whom she also described as being 'gods' to many of the women.

Marsha's claims echo Jane's; she said that doing drugs, prostituting and living on the streets was the only life she knew, given that she had been doing it since the age of thirteen. Marsha noted that she experienced a sense of excitement and longing for this lifestyle, that 'getting clean' and 'being straight' were boring and she longed for the

exhilaration and thrill of life on the streets. The ability to reconstruct the 'self' as drug free, clean, straight or sober is directly related to one's ability to separate these two 'lifestyles'. Therefore, to resist identification with an addict identity, the true self must be drug free and one's lifestyle must also be disassociated from the drug subculture. In a low and sombre voice Stacey described what her life was like when she was living either in crack houses or on the street.

Stacey: As an adult I didn't really have a home.

Jen: Where did you stay?

Stacey: Wherever, it didn't matter. Didn't care. I slept on the streets. I've slept on a couch that was just sitting outside. Stayed with friends in dirty, dirty houses. The toilets came up like holes through the floor.

Jen: That must have been really hard. Stressful.

Stacey: You don't think about that when you're a drug addict. At the time it doesn't matter cause you're getting high, you're getting your fix. You're getting what you need, right?

Stacey had attempted to get clean several times and had not been successful. Of all of my participants she was the most solemn and grave in how she spoke. She seemed defeated, and worn out by her drug use, lifestyle and history. However, Stacey continually repeated that she "wanted to do good for herself" by getting clean. Regardless of the despair in which she lived while using, Stacey found it difficult to quit using and leave 'the life'. Stacey, like many of the other women, had few supports or ways of financially supporting herself which were not tied to this lifestyle. As aforementioned, it is only when an individual is able to abandon this subculture that she can attempt to shed her identity as an addict.

Strangely, while many participants feared being branded with the stigma of addiction, which they feared would preclude their identification as a good mother or a hard worker, many women still commented on their ability to determine by mere appearance who was and was not 'a criminal' or 'an addict'. The irony here is their simultaneous claim that they did not want to be judged or stigmatised on the basis of their addiction or their criminalisation. Fearing that they would be 'found out' and stigmatised was a key component in the women's attempts at distancing themselves from their identity as an addict. Cate stated:

> You would never know I was a criminal. Like I was a drug user only the last couple of years before I went to jail. You wouldn't know it now to look at me, you would have known it then to look at me. I can pick a criminal out from far away. I hung around with a lot of them when I was using drugs. And I can always tell when people are on, what they're on, what they're up to – a shady character. Things like that.

While Cate claims to be able to know who is using and who is not using, she not only resists being labelled as an addict or as an ex-prisoner by others, but she also rejects the notion that she herself could be found out in this way. In fact, because she was one of only a few federally sentenced women to stay in the Efry halfway house, she felt stigmatised by being labelled "the federal girl". This claimed ability to discern what may seem to be a hidden identity enabled the women to be more prudent in the management of their lives, identities, and choices. By defining who they were by who they were not, the women re-constructed themselves as hyper-aware of both the criminal and drug subcultures, and thus as being hyper-vigilant in their attempts to shed their associations with and identities as drug users and former criminals. Having been part of the subcultures the women expressed a kind of expertise, which they invoked as a status claim in helping them move away from this lifestyle.

Finally, the segregation between one's addict and true self must be examined through an analysis of the individual's struggle for power. As I have discussed earlier, my participants described their drug and alcohol use as being a loss of power, and their attempts to lose, disassociate themselves from, or resist their identities as addicted persons as an act of empowerment. However, Jane stated that, "the most power I ever had was when I was selling drugs." The reasoning for this exclamation came from having enough money "to do whatever I wanted". Living within the lifestyle and culture of drugs and fast money provided for Jane a sense of herself as a powerful woman, something she had not experienced before.

The shift in power came with the onset and experiential reality of Jane's addiction. Initially, selling drugs and being an important person in this subculture (she was a dealer) fostered an empowered identity for Jane. But losing custody of her son due to her own drug addiction initiated her downward spiral, which signalled to her a loss of control and empowerment. Similarly, when Jane first met the father of the then unborn child she was carrying, she was impressed by his fortune and ability to provide for her.

> He had money and a nice condo and he could take care of me. He asked me to move in after three days. And then when I got to really know him, I fell in love with him. And I wanted to quit and then I started slowing down. He's poor now. Has nothing. He lives from crack house to crack house. That's what happens to all of us, in the end. You know, selling drugs, there's no talent in that, there's no school. It's kind of an idiot's way to gain power.

Jane's description of becoming poor, and her observation that living from crack house to crack house was what happened to "all of us, in the end", are highly significant because her script marks a shift and loss of power. This shift, often characterised by tragedy and sadness, nonetheless enabled Jane to reclaim her 'true self'. In an attempt to

manage the stigma she experienced (Goffman 1963), by re-constructing her former partner, the lifestyle she once admired, the easy money and status – and ultimately her understanding of the techniques with which one can become empowered in a negative way, Jane is able to distance her 'true self' in order to reclaim a 'straight' experiential reality and identity.

It is a difficult enough task to reconstruct how you envision yourself, and even more so to portray this reconstruction to others in order for them to see you differently, and to truly believe that you have changed. To carry out this reconstruction, one must abandon stigmatised aspects of one's character, self and/or identity. Given that stigma is entrenched in and around our understandings of what it means to be criminal, woman, alcoholic or addict, shedding the 'addict self' from one's identity is no small feat. As I chronicled above, women often employ a range of techniques in order to facilitate their reconstruction of 'self'. These techniques of the self – or what Rose (1996) calls "techniques of subjectification" – are both practical (choosing to identify with different aspects of one's identity – for example, motherhood) and metaphysical (rejecting and resisting identification with 'other' addicts to the point of defining one's self in opposition to such groups).

Constructing Addiction: Disease or Choice?

Let us begin by defining the term 'disease.' A disease is "a disorder of structure or function in a human, animal, or plant, especially one that produces specific symptoms or that affects a specific part" (Oxford Dictionary 2001: 410). A disease can be a biological or mental impairment that can impact an organism's functioning. Drug and alcohol addiction are commonly referred to as diseases, which impact both one's physical

(biological) and mental capacities. A disease connotes the idea that an individual has little control over or ability to govern the treatment of the disease or its outcome. In our current neoliberal political climate, citizens are expected to manage their health according to approved doctrines of medicinal treatment. For example, if a person has cancer, they may engage in medical intervention in the forms of surgery, radiation, pharmacotherapy, and/or chemotherapy, as well as alternative naturopathic medicines such as homeopathy, nutritional management, and acupuncture. These are seen as responsible behaviours; however, an individual who fails to have surgery or chemotherapy, the traditional western medicinal approaches to treating cancer, and who solely relies on and adopts naturopathic remedies, may be constructed as failing to manage their illness responsibly.

Similarly, Roxanne Mykitiuk (2006a,b) has written about the ways in which women are responsibilised with respect to biological reproduction; for instance, if pregnant women opt out of certain tests used to detect genetic 'defects' and then bear a child who is not 'normal', they get blamed because of their bad 'choices'. Using Mykitiuk's work as a frame of reference, it is clear how, within neoliberalism, discourses on addiction have shifted away from earlier positivist disease explanations toward a (classical) choice model, which lays blame on the individual for failing to manage her own health appropriately. Unfortunately, using a simple dichotomy (disease/choice) essentialises these terms rather than generating space for a more nuanced explanation of their interrelatedness. In this section I examine this disease/choice dichotomy as it relates to illicit drug and alcohol addiction.

In light of the risk of failure associated with treating any given disease, and if drug and alcohol addiction are to be understood as 'diseases' of the body and mind, then

treatment surely cannot be seen as 'foolproof'. Therefore, it is *the failure to attempt* to secure treatment that conceives addicts as being irresponsible in managing their own health identities and health risks. However, it must be recognised that for many reasons – such as living in rural areas, or because they are their children's sole parent – not all individuals can access treatment. Nevertheless, it is the refusal or avoidance of treatment that reconstructs the drug and alcohol addicted person as ungovernable and irresponsible. This reconstruction serves to marginalise criminalised women with substance use issues, requiring intervention and forced or coerced substance use treatment. Yet, recovery from addiction is often associated with a history of attempts at sobriety, thus suggesting that this reconstruction of the drug or alcohol addicted person as irresponsible is misplaced. Unsuccessful attempts are attempts nonetheless, and they demonstrate a continued desire to achieve the goal of sobriety.

The reconstruction of addiction as a failure to self-govern or self-responsibilise is particularly relevant in the case of federally sentenced women, all of whom are required to take the first of three 'substance abuse programs',[82] whether or not they have or have ever had problems with addiction. The fact that women who have no history of drug or alcohol use must enrol in at least the first of three substance abuse programs is indicative of how women prisoners are, by their nature as criminalised women, constructed as being incapable of taking responsibility about their health. The substance abuse programs in federal corrections reflect the cognitive behavioural model that aims at changing the

[82] There are three levels of substance abuse programming in federal prisons for women in Canada. They are titled WOSAP (I, II, III) – Woman Offender Substance Abuse Program. The WOSAP programs, similar to other federal correctional programs, are run via a risk/need assessment, which targets a woman's criminogenic risks for change by addressing her needs – for example, addiction education.

individual's behaviour through learning how to make better choices.[83] The cognitive behavioural model is the hallmark of current federal programming and, with respect to substance use, reflects the belief that addiction is merely a poor and irresponsible choice.

Cate, a federally sentenced woman, examined her health identity as a drug addict through her examination of the power her drug addiction wielded. Despite having taken the WOSAP programming, Cate constructs addiction as being both a physical and mental disease she had to actively battle.

Jen: So power for you is being able to make decisions?

Cate: Positive decisions. You know, having negative and positive and being able to weigh it out and decide what's best for you.

Jen: So having control as well?

Cate: For sure. When I was using I had a different power. A different power, a power of being high. I thought I was more powerful, that I could do anything, like superwoman. Cause I wanna be superwoman. But it was the drugs, they helped me be what it is I feel I am. That's why I liked them so much, I felt really powerful. But I really had no control over my mind or my body, everything was about getting my next fix. It was all about making sure I had my drugs so I didn't go through withdrawal or the bad cravings. I didn't feel like I had a choice, the drugs were making my decisions.

Understanding the interaction of power and powerlessness in terms of addiction aids in our understanding of it as both a disease and a choice. To be able to discuss and believe in drug and alcohol addiction as a form of physical and mental disease allows the individual to save face. By reconstructing addiction as a disease she can maintain some semblance of dignity and personhood. If addiction is a disease, and thus beyond one's

[83] For more information about the WOSAP programs see the CSC website: http://www.csc-scc.gc.ca/text/prgrm/fsw/pro02-2_e.shtml.

control, it is driving one's actions and minimising or potentially eliminating the space for individual choice, agency, and responsibility for being unable to quit using.

This conceptualisation of addiction as a disease is closely linked to my participant's use of their identities as mothers to help them fight their 'illness'. As aforementioned, several of my participants segregated their 'addicted selves' from their 'true selves', by claiming that only their addicted selves would allow their children to be removed from them or be born with drugs in their systems. Using the disease model of addiction removes individual agency and elicits more understanding and potential compassion for the difficulty found in securing treatment and discontinuing use.

For example, Cassie discussed her drug use as an addiction and disease that is part of her identity – a covert aspect of herself that she actively must fight and suppress.

> I used to use to deal with things. But I've been clean for four years. Day by day struggle; it's not an easy thing to overcome but with proper support and proper belief in yourself it is a disease you can win. It's a daily struggle. Absolutely. It's a, I named him Bob – he's a monkey. He sleeps on my back. Most of the time he's dormant, but occasionally he'll shift and wake up and that's when I'm like, 'dooing'! And if he sinks his fangs in I have to tell him to shut up. I like him to stay asleep, it's bad when he's awake!

Cassie's narrative indicates her belief in the disease model of addiction, that she will always have to actively fight her addiction, that it remains within her – dormant – and waiting to try and lure her back.

Consistent with Cassie's narrative, both the AA and NA[84] models (which were commonly-used groups by many of my participants) are based on the belief that addiction

[84] AA and NA are acronyms for Alcoholics Anonymous and Narcotics Anonymous, which are public support groups promoting a self-help model to assist individuals recovering from drug and alcohol addiction. For more information about AA see: http://www.alcoholics-anonymous.org/en_information_aa.cfm. For more information on NA please see: http://www.na.org/.

is a disease, against which the individual is 'powerless'. In fact, to admit this powerlessness to oneself and others is part of the AA and NA process. Both Kellie and Phoebe demonstrated this point:

Kellie: AA and NA they teach you that. Like if you're a crackhead and you come down off a three-day binge and it's the day after and you're feeling like shit – then you're cursing yourself and kicking your ass. But that night, you're right back at it. It's just something you can't control.

Phoebe: I gained my power through rehab. Knowing that I can stay away from it, that I can say no makes me feel powerful. NA and AA teaches you that. You know, the twelve steps where you have to admit that you're powerless, you know, to drugs?

The conceptualisation of individual control and/or power is clearly what is at issue here: to have power and control over, or to be without power and to lack control with respect to addiction. To have control means to have agency, while lacking control suggests powerlessness in terms of decision-making and choice. To have a disease (in this case addiction) suggests a lack of complete control over its outcome: however, not over how it is treated. I argue that it is this lack of control or determination over one's illness or disease that fosters a biological or psy identity (in our case, the 'addicted self'). In turn, it is the emergence of a biological or psy identity that allows for the generation of a kind of biological or psy citizenship, through which sufferers of the said disease have certain recourse in terms of the reclamation of treatment and resources (Rose & Novas 2004; Orsini 2006; Petryna 2006; Rose 2007). However, while many participants constructed their addictions as a disease and as a component of their 'addicted selves', they did not unify or take this biological or psy health identity to entitle them to a form of biological citizenship.

As I discussed in Chapter Three, Rose and Novas claim that "biological citizenship can ... embody a demand for particular protections, for the enactment or cessation of particular policies or actions, or ... access to special resources" (2004:3). This definition can include the illness narratives surrounding addiction. However, Rose and Novas (2004:22) also claim that as a result of the generation of these responsibilised health behaviours we have simultaneously produced new kinds of problematic groups, to which I would add substance users. The neoliberal trend in health care that requires action on the part of the individual serves to further increase the marginalisation of those suffering from 'illnesses' that we refuse to accept as worthy of citizenship claims. Given the neoliberalisation of health care and the inherent discourse of choice and responsibility that is built into it, substance use is likely to be excluded from discussions of biological citizenship.

In all, only one of my participants touched on the construction of a form of biological citizenship. Jessica, a former heroin addict, discussed her ability to stay clean via state-sanctioned methadone maintenance programming.

> Methadone, it keeps you from being sick, so you can get on with your life. You can't go to school if you're worried about being dope sick, you know? You gotta go find pills. You can't go to work. You can't rehabilitate your life. If you have to look for dope every day and you're afraid of being sick and you are sick. So methadone, in a way you do, you go to the clinic each morning so you can get your fix so you can get on with your day and then you can get on with your life. You don't get high from methadone. Methadone just keeps you normal.

Jessica's narrative demonstrates the kind of hold drug addiction can have over the life of an individual user. In her view, methadone maintenance programs help to keep the former opiate or heroin addict "normal" so that they can 'rehabilitate' their lives. However, there was an incongruity in Jessica's discourse; she claimed that "you don't get

high from methadone", while at the same time she stated earlier in our interview that some people take advantage of methadone programming and use it "just to give them another hit". For Jessica, then, her biological identity as a methadone user is dependent on the fact that she is truly 'in recovery'. Inherent in this discourse is an understanding of the importance of a biological identity and construction of a biological citizenship. Because Jessica was in recovery and not using heroin, she was being a responsible methadone recipient; her status further entitled Jessica to a form of biological citizenship with the benefits associated with drug treatment via state sanctioned methadone maintenance and support groups. Conversely, if other methadone recipients were failing to follow the guidelines by continuing to use illicit opiates, they should, according to Jessica's discourse, be removed from the methadone maintenance programming.

One of my most important findings is that positivist and classical ideas co-exist, and that despite neoliberal efforts at stifling the disease model approach to explaining substance use positivist explanations continue to exist. [85] Under neoliberalism, images of 'the addict' and 'the alcoholic' shifted from those suffering from an unfortunate illness to irresponsible self-governing agents and citizens. In neoliberal discourse, addiction becomes a choice made by the individual and is thus within the realm of her control. However, there is a great deal of slippage between positivist and classical explanations. For example, under neoliberalism the disease model that is commonly associated with AA and NA support groups and discourse is unfashionable. These programs, however, are not losing their lustre within current penal regimes, mainly because they are supported by volunteerism rather than government funds. There is therefore a disjuncture

[85] Some experts, however, argue that the disease model of addiction is making a comeback in the field of addictions (Rebecca Jesseman, personal communication).

between correctional discourses of addiction and those community-based programs with which they encourage prisoners to engage. This is of particular importance in the carceral context where large numbers of persons struggle with alcohol and drug addiction. For many women prisoners, it has been their journeys through addiction that have led them to become criminalised.

Substance abuse programming is a central and required component of correctional programming for all federally sentenced women in Canada. And while there is no equivalent or even similar programming at the provincial level, it is important to understand the mixed messages that many provincially sentenced women are receiving concerning their drug and/or alcohol addictions. Provincially sentenced women find themselves exposed to correctional discourses regarding addiction that support its reconstruction as a poor choice, an irresponsible choice, and one that reflects their inability to self-govern or manage their health risks appropriately. At the same time, due to a lack of programming, this group of women is encouraged to join the AA and NA resource groups that are facilitated in the community, which espouse the opposing construction of addiction as a disease.

To claim that drug and alcohol use is a choice constructs the behaviour as a risk knowingly taken by a consciously choosing individual agent and citizen.

Steph: The women have to make the decision to get clean and to stay sober. No one can do it for them, no one can make you get clean. So many of them go to treatment and start using again, and do that over and over. It's because they don't really *want* to stop using [my emphasis].

The Efry social workers, clearly impacted by the cognitive skills model adopted by corrections and the AA groups they encourage the women to attend, commonly

emphasised that addiction, while difficult to overcome, was in the end a choice. I argue that this understanding of addiction is simplistic. Constructing addiction as a choice is problematic because it lays all blame for initial and continued drug or alcohol use onto the will of the individual. This approach fails to acknowledge the socio-cultural and economic positionality of individual women and the impact this may have upon their drug and/or alcohol use. Ironically, understanding addiction as a choice is similar to understanding it as a disease, because both models suggest that inherent in the individual is some sort of pathology. In the disease model, we view the individual as a victim of her own faulty biology; in the choice model we construct the individual as weak minded and weak willed, as incapable of making 'the right' decisions.

Just as several of my participants claimed to be powerless to addiction and empowered by their sobriety, so they did with respect to understanding addiction as a choice. Emma claimed that to gain power over her heroin addiction she needed to make the choice to reclaim that power.

Emma: I got my power back just through the realisation of where I need to work on. What I want. What I don't want in my life anymore. Making the choice. Making the choice to really quit heroin. Choosing not to run to it every time something was hard; choosing to find better ways of coping with all the shit in my life.

Emma claims that she has and always has had the ability to quit using heroin; that this was merely a choice she had to make for herself, by herself. For Emma giving up heroin was symbolic of her reclaiming her life and ultimately her 'self'. Emma's narrative demonstrates the impact of current neoliberal constructions of addiction as failed self-governance and poor decision-making. Emma's conceptualisation of 'choice' leaves unexamined and actually obscures the ways in which licit drugs are not so

stigmatized. This line of reasoning in its binary structure is potentially dangerous to recovering persons because it lays blame on the individual for her failed attempts at recovery, rather than acknowledging the social conditions that contribute to fostering and maintaining addiction.

Cate described how her claim that she committed her crimes because of her drug use was reconstructed by correctional authorities as being her failure to 'take responsibility' for her actions.

> That's the impression they are under; and then in the paperwork it says that they don't feel that I am being truthful about my drug use. They think that I don't really have a drug problem, that I'm using that as a crutch to say that's why I did my crimes and they don't feel that I'm taking responsibility for my crimes. I will take responsibility for the ones I did, not the ones I didn't do. As for my drug problem, look at my record, look at my medical file. You'll see I was very high on drugs. Why would I tell you, admit to you, that I used needles if I didn't?

Despite correctional officials' deliberate rejection of Cate's discourse regarding her drug use, they required she take all three of the federal programs for women and substance use. While Cate suggests that 'they' did not believe the extent of her drug use, I suggest that their rejection was more a matter of failing to accept her drug use as a reason, or potential excuse for her crimes. This quote illustrates the crux of my argument that we are shifting from a disease to a choice model for explaining addiction. The neoliberal discourse influencing Canadian corrections rejects the disease model in order to eliminate the possibility of using addiction as an excuse for criminal behaviour. From this vantage point, there is no *reason* for committing crime (or using drugs); criminality is similarly demonstrative of a (poor) choice.

Of all my participants, only Joan did not dichotomise her explanation of addiction, and actually moved back and forth between constructing addiction as a disease and as a choice. For example, at one point during our interview Joan constructed addiction as a disease that must be actively fought, and where a failure to do so results in a continued loss of power.

> I really thought I was just misunderstood. It's all them, it's not me! If my husband didn't beat me, if this wasn't like this, if this wasn't like that. I wanna be medicated, I wanna be numb. If I don't feel I don't care, and if I don't care, I can survive. No Joan! Bottom line, it's your disease. You're using and it's caused chaos and it's almost like I was a magnet for chaos. That's just my disease telling me that so it can kill me. So I had to go to treatment, that was my choice, I had control over that.

Joan personified her addiction as a disease that was trying to get her to kill herself. For Joan and many other women with whom I spoke, internal struggles raged with respect to their continued drug and alcohol use, their identities as addicts, and feeling powerful enough to overcome this 'disease'. To feel powerless undermines our sense of ourselves as beings in the world, and of our abilities to make decisions regarding our own health and well-being. It is therefore understandable and logical that despite being supplied with discourses that construct addiction as a disease that has a certain incontrovertible power (and is thus somewhat responsible for an individual's actions), some of the women still maintained that they had the power to choose to recover. For example, Joan stated:

> I don't want this anymore. Bottom line I had to make a choice. It's just the nature of addiction, like that's [jail] where it goes. You know? And unfortunately people get lost there. They don't think they have a choice anymore. So actually, jail gave me my chance to make my choice. For which I'm grateful. I'm not grateful I had to go there to get it, but it did open my eyes. Do I wanna keep coming back to these places? Is this what you want out of life? Some can really struggle and some can have the worst time, but it's all choice. Like when I got out of jail I figured I

> was clean five months, my brain's not clouded with drugs or alcohol and I'm not feeling desperate that I have to go use. So, what kind of choice are you going to make? Bottom line, yes, it's my choice. And as soon as I use that word, like I get goose bumps when I say that. As soon as I say that word, I can't deny what I'm going to do. I'm not in the white, like I'm never gonna be an angel, ever. You know, I'm gonna make mistakes, I'm gonna make bad choices. Although, they're gonna be clean choices, you know it's part of being human.

As Joan simultaneously constructed addiction as both a disease and a choice, she did so as a way of demonstrating her feelings of power and powerlessness when it came to her addiction. When Joan felt powerless over her addiction she spoke about it as a disease she had to fight and would have to fight for the duration of her life. However, when she wanted to reveal that she could also be empowered Joan spoke about her addiction as a choice she made and thus had control over. From Joan's discourse, we can see how women may move between these two discourses as a way to manage their own feelings of empowerment and control. During different points in an individual's career as an addicted person she will rely on different reasoning to explain her addiction.

As discussed in an earlier section of this chapter, Shelley, clearly influenced by neoliberal discourse, was my only participant who absolutely refused to construct addiction as a disease. For Shelley, addiction was a choice, and mothers who continued to use were failing to be responsible parents. They should put their children before their own needs, desires, drives, wishes, and ultimately addictions.

> I can't think that addiction is a disease because I think it is so selfish. And even AA and NA teach you to be so selfish. You have to put yourself first, you have to put yourself first. Self-care and self-love – you know, you hear the same thing out of the girls all the time. You know, I can't handle that today, that's you know, that makes me angry. That's fine, if you're alone, and you have no children, that's fine. You wanna put yourself first, that's fine, you have that right. But the minute you have children, it turns. And you can no longer put yourself first.

Shelley's discourse rejects any notion that addiction might be a mental or physical disease. It should be noted, however, that Shelley was a white, middle class woman, and first time prisoner who was keen to prove herself to the correctional authorities. I argue that her socio-cultural upbringing and positioning, her desire to be a 'model prisoner' who was different from 'other' women prisoners, as well as her personal experiences with familial addiction served to shape her understanding of addiction as being the selfish choice of immature individuals. As previously discussed, Shelley believed that the continued use of drugs by a mother is indicative of a failure to parent to the best of one's abilities. For Shelley, drug use and motherhood are two worlds that should never mix. Shelley's script illustrates the current penal discourses regarding addiction that are operating in prisons today. The concepts of 'self-care' and 'self-love' that she espouses are indicative of a discourse aimed at empowering the individual to arrest their drug use, again demonstrating that drug and alcohol use is a choice, and a choice that comes from within and that the individual thus has control over. These discourses are also illustrative of how addiction is strategically individualised and subsequently removed from the parameters of governmental discourses, policies and regimes, as well as our current social infrastructure.

Chapter Summary

In this chapter I examined four themes regarding addiction: (1) addiction and imprisonment are coping strategies; (2) women prisoners often use their identities and statuses as mothers to resist and reconstruct addiction in a negative light; (3) participants claimed their 'addict selves' were not part of their 'true selves'; and (4) addiction is

constructed as both a disease one needs to 'treat' and as a (poor) choice by individual citizens.

Through this discussion I presented evidence that supports the argument that illicit drug and alcohol addiction are strategic attempts at coping, which are effective because of their ability to numb an individual's experiences and emotions. In contrast to the practical use of self-injurious and disordered eating behaviours discussed in the last chapter, addiction serves as a way to lose control, while the former types of self-harm represent attempts at securing control over one's body. Similarly, idealised notions of womanhood and motherhood have emerged from my data, suggesting that to be a good woman, one must be a mother, and to be a good mother one must be drug and alcohol free.

What I found to be the most intriguing aspect of my data was the discussion of the separation of one's true identity or self, from one's identity as an addict. This separation marks the shame felt by women who use drugs and their desires to distance themselves from the negative connotations associated with addiction. Ultimately, this division of selves supports my argument that identity is a symbiosis of a fluid and a fixed construct. For women with drug and/or alcohol addictions identity is something that does shift but is also static in certain circumstances (given that so many of the women described sobriety as being a return to their true selves). We have many aspects of our 'selves' that unite to form our unique personal identities, and we carry certain parts of our 'selves' with us through time, space, and experience, while other parts are either adopted or abandoned along our journeys through life.

Perhaps the most important aspect of the above discussion was the realisation that to be able to construct an 'addict self' and thus an 'addict identity' is the first step in creating a kind of biological citizenship through which addicted persons can collectively unite in order to secure more effective treatment, resources, and support. Part of the current shift from a disease to a choice model of addiction (particularly within correctional and health discourses) is the fact that claims of biological (addict) identity and citizenship are eradicated. If addiction is the result of poor choices by self-governing citizens, then our health care system cannot be held accountable for the decisions made by citizens with agency. This model enables our governing structures to increase correctional mandates for programming, security, restraint and punishment, while diffusing demands for increased social welfare and health care for individuals with addictions.

In the next chapter I examine the reasons proffered for and the impact of the prescription of psychiatric medications for women in prison. Key issues that will be addressed include the construction of a psy-identity, the potentiality for a psychiatric citizenship, and the governing capabilities of correctional psy-care.

Chapter 7
The Practice of 'Psy' and Prescription Medication in Women's Prisons

The primary focus of this chapter is the varied correctional approaches to prescribing and dispensing prescription medications. My interviews revealed both similarities and differences in how 'psy' is practiced across federal prisons, the Ontario provincial prison (Vanier Centre for Women), and local jail or detention centres, suggesting that authorities, like the women, are not uniform in how they view using prescription medications. While psy experts usually consist of psychologists and psychiatrists, I demonstrate how medical doctors are using their own kind of expertise to encroach upon the practice of psy, which is causing tension due to conflicting expert discourses in some of the prisons. In particular, discussions about, and the women's accounts of, the drug *Seroquel*[86] are especially compelling and demonstrative of the new prison order (Garland 2001). Seroquel is merely the current prescription drug of choice, similar to the widespread use of Prozac ten years ago, or the use of Valium since the 1950s. However, due to the nature of Seroquel, its claimed effects, uses, and its potential side effects, I argue that its use is demonstrative of a particular kind of governing strategy operating within the walls of our correctional institutions.[87] This governing strategy is

[86] First introduced onto the market by the pharmaceutical company AstraZeneca in 1997, Seroquel also goes by the clinical name Quetiapine. The manufacturer's website for the prescription drug *Seroquel* can be found at: http://www.seroquel.com/index.aspx. (Accessed on June 18, 2007).

[87] Very little research exists concerning prescription drug abuse by incarcerated populations. I am using the term prescription drug or medication 'use' as opposed to 'abuse' because my participants did so; however, I argue that my participants' accounts construct an image of prescription medication use that often teeters on the edge of dependence.

reminiscent of the historical use of prescription medications on women more broadly, and to an even greater extent on women in the carceral context, that is executed in an attempt to subdue, sedate, and ultimately render docile a captive population of women who are constructed as mad, bad and sad.

Prescription medication, including the unethical testing of new drugs, has always been a large component of the governance of prisoners (Mitford 1974), but pharmaceutical companies have increasingly also targeted the general population (Healy 2003). Today, however, the current primacy of psy-care and the use of medications and psychiatric and/or psychological discourses, in conjunction with neoliberal correctional discourses about the rational subject, serve to reconstruct women prisoners as psychiatric patients, or more accurately as 'clients' of psy-care, unable to exercise agency or even provide informed consent. Despite the predominance of neoliberal governing strategies operating in Canadian corrections, the inability of women prisoners to choose the medications they will or will not take limits their control over their own psy-management. This fact illustrates that while neoliberal governance does have a great impact on correctionalism in Canada, the conceptualisation of the rational subject required to exist within neoliberal discourse is often denied by correctional attempts at governance.

With this inconsistency in mind, I will attempt to reconstruct women prisoners as potential psychiatric subjects who, by holding specific and unique psychiatric identities, also possess the agency and potential to engender and exhibit a kind of *psychiatric citizenship.* Generating a space to discuss the psychiatric subjectivity of women prisoners makes it possible to begin accounting for this subjectivity and identity with the

creation of a kind of citizenship. I will show that despite the emergence of neoliberal governance and its counterpart, neuro-liberalism (Islin 2004), an aspect of women prisoners' subjectivity is constituted and exists inside the walls of an institution that detracts from the very rationality that fosters both the neoliberal (rational) and neuro-liberal (neurotic) subjects. Particularly problematic to the following discussion is the fact that prisoners – like in-patients in psychiatric hospitals – are not able to reject prescription medications while under confinement. The removal of individual agency, as well as the possibility for informed consent and the ability to deny treatment or medications, are part and parcel of the psy-management construction of a psychiatric citizenship that is constituted by one's criminalisation.

Similar to the general trend in the social context of contemporary society the overprescription of medication seems to be endemic in prison as well, illustrating the common focus on procuring a pill to generate a biological fix to the social ills affecting our lives (Healy 2003). Overall, what I found most intriguing were the very apparent similarities and differences in how 'psy' was practiced across the federal, provincial, and local jail and jurisdictional level. In noting these similarities and differences, four overarching themes emerged from my interviews: (1) the systemic over-prescription of medications for women at both the federal and local jail or detention centre levels; (2) the use of the prescription drug Seroquel and its consequences; (3) lack of informed consent and lack of access to psy-care as strategies for diminishing potential resistance to psy practices; and (4) the systemic misuse of prescription medications due to what can only be described as a prescription 'turf war' between medical and psy professionals in the

provincial prison for women in Ontario (Vanier Centre). I will now discuss each of these themes in turn.

Medicalisation: Over-prescription as a Technology of Control

Medicalisation is a process that, in the realm of corrections, operates through the over-prescription of psychiatric medications. Medicalisation in this fashion is most predominant at the local jail or detention centre level where prisoners are so overcrowded that they are often double and triple bunked in their cells. Over-prescription effectively subdues this population of women, who are traditionally characterised as misbehaved or rowdy. Using prescription medications in this way fails to acknowledge the harmful impact that imprisonment itself has on criminalised women. For example, Jane discussed how imprisonment impacts one's emotional well-being.

> Well it makes you crazy in there [prison]. You're not well in your head. Like they send a psychiatrist to see you once you've been there for about two weeks. To see how you're doing, and some people just get depressed or they go crazy and those people get sent to segregation. In seg, they're just on a whole bunch of medication.

Jane's narrative illustrates how prescription medications and the practice of segregation, as technologies of discipline, are tools that are effectively used to render this population docile. In her interview, Jane acknowledged that incarceration in and of itself has a negative impact on the women's emotional well-being.

The reconstruction of sadness and stress resulting from one's imprisonment and criminalisation as being indicative of some form of madness or potential dangerousness provides a fertile ideological ground from which to create illusory images of "crazy" or "rowdy" women prisoners who must be sedated and segregated. For example,

consistently in my interviews, women perceived as being more rowdy, resistant, drug addicted, loud, and questioning of authority were prescribed higher dosages of Seroquel in order to ensure their compliance and docility. Rather than understanding sadness and anxiety as a normal, rational, and reasonable response[88] to being criminalised and imprisoned, psy-experts working within the correctional system reconstruct these 'normal' responses to their current life situation as abnormal. Rather than seeking alternative forms of intervention for the difficulty a prisoner is having coping, medicalising criminalised women has become the de facto policy for how psy is practiced in the correctional system as well as in the community, again illustrating the extension of carceral control strategies beyond prison walls (Cohen 1985).

Carrie, an Efry social worker, articulated this very point.

> This woman had good supports on the outside; good family, a house, had never been in trouble before. You know all of these good things, and so when she got to GVI she is obviously upset. She's bawling her eyes out for the first few weeks she is there and they keep trying to push meds on her. 'Oh here, you need to go on an anti-depressant'. And she's like, 'I'm in jail! That's why I'm depressed. I am going to be here for three and a half years! I am going to be here for three and a half years, like that's why I'm crying.' She had never taken meds in her life, and she didn't want to start in prison. She kept saying, that it had to do with where she was, and that it didn't have anything to do with some kind of imbalance or any of those things. You know, 'I am in jail, that's why I'm crying!'

Within the correctional system there is a reconstruction of any kind of emotional response that deviates from contentedness as indicative of either an inability to cope or some kind of greater mental pathology (Chesler 1972; Ussher 1991; Russell 1995; Suyemoto 2002). To suggest that sadness, anger, or anxiety are inappropriate responses to being imprisoned is to ignore the well-documented impact of imprisonment. This

[88] Several authors have discussed the medicalisation of normal responses to daily life more broadly (Chesler 1972; Conrad & Schneider 1980; Ussher 1991; Russell 1995; Suyemoto 2002; Healy 2003).

practice seeks to effectively separate the prison experience, environment, and context from an individual's emotional well-being and response to being incarcerated.

In this light we can begin to see how in the correctional arena, psy is practiced as an extension of the process of medicalisation. Joan, a provincially sentenced woman, likened the impact of this process on women prisoners to the sedation of mental patients in locked psychiatric hospitals or institutions.

Joan: There's drugs and alcohol problems, okay that's a primary problem. That's the one that's affecting them now, but there's also the underlying mental illnesses. That they have anxiety, depression, bipolar, manic, there's lots. There's so many people on medications for that in jail, you should see the med-line.

Jen: Do you think they prescribe too much?

Joan: Well, some of them really need it. But then some of them that really need it aren't getting the care they need in there, and then there are the ones that take it just to sleep through their whole time. Some of them take Seroquel just to sleep through, or we used to call it bug juice, they used to give them Nozepam and they'd be like walking zombies; that's what they give mental people in mental institutions to keep them sedated. Like they're drooling out of the sides of their mouths.

Joan's narrative reflects her ambivalence regarding the use of psychotropic medications for women in prison. Joan acknowledges her belief in mental illness and in medicalisation as the appropriate method and course of treatment for some, but at the same time is uneasy with the impact of such high dosages on the women. Joan's narrative illustrates how believing that every woman requires some form of medication represents an acceptance of the construction of an unproblematized and inextricable link between criminality and madness (Frigon 1995; Menzies & Chunn 2006; Sim 2005). This link is the result of the fact that the philosophies, ideologies, discourses, languages, and practices of our correctional institutions have notions of psy built into them. It is psy

that has claimed expertise regarding the governance of subjectivity and the mind; and one of the most predominant practices or treatments offered by psy is the medicalisation and psychiatrisation of carceral populations.

In contrast to the inconsistent prescription of psychiatric medications that occurs in Vanier Centre, several of the women discussed the ease with which they were able to attain prescription psychiatric medications in federal prison. For example, Kellie, a former prisoner of the Grand Valley Institution in Kitchener Ontario, stated:

> The psychiatrist that's another matter [she was comparing the psychiatrist in GVI to the one in Vanier Centre], she was great. You tell her what you want, some psych pills and she'll give them to you, no questions no nothing. Oh you want this, you want that, no problem. You know what they do, they medicate people to keep them calm. They had me on three different antidepressants at the same time! The only time you talk to the psychiatrist is to get your medications. You're in there for ten minutes maybe. Oh, I need this, I need that, this isn't working, can we try this. Write, write, write. It's ridiculous.

The fact that prescription medications are dispensed so readily is illustrative of the federal correctional approach to psy intervention – medication over therapy or counselling (Heney 1990; Sim 2005). The over-prescription of medication is reconstructed as a preventative measure taken against a population commonly characterised as being difficult to manage. In this light, psy medications reduce the chances that women prisoners will be resistant to correctional regulations and other forms of correctional intervention, for example the mandatory programming that exists. The goal of subduing this population is the result of centuries' worth of theorising about the dangerousness of criminalised women (Smart 1976; Comack 2006).

Both former prisoners and Efry social workers criticized the use of Seroquel as a sedative; for example, both Danielle (a former prisoner) and Carrie (an Efry social

worker) referred to the potency of Seroquel as a sedative, and suggested that it was overly powerful and unnecessary as a sleep aid. Danielle stated that, "I don't want to be a zombie and I don't want to, like I could sleep all day on that shit." Carrie illustrated the impact Seroquel had on one of the women she was working with at Efry:

> There are a lot of women on medications. One woman was on 550 milligrams of Seroquel a day. For the first few weeks, she was comatose. You know, and this was prescribed by a doctor from the jail. He had said, 'come back in two weeks and we'll see how that goes'. I mean, how can a doctor who doesn't know the person give them grandiose doses of medication and then tell them to come back in two weeks when she hasn't been assessed by a psychiatrist? Like there are so many problems.

Carrie's narrative demonstrates a trend that was evident in many of the women's accounts – that there is little correspondence between prison medical doctors and psychiatrists. In fact, what occurred in more than one instance was dual prescription by both doctors and/or a battle for power between the two, which commonly resulted in the women being placed on one medication, then others shortly thereafter.

The dosages of Seroquel that are being prescribed to women prisoners vary substantially. This fact alone is not abnormal given that varying dosages of any medication are common depending on how the individual reacts to the medication and the claimed seriousness of the diagnosis. However, some women had been prescribed twenty-five milligrams of Seroquel, while others were taking over five hundred milligrams of the same medication. Stacey found that with respect to Seroquel as a prescription medication, the federal prison system adhered to a 'more is better' philosophy.

> The one thing with prison is that they like to heavily medicate people, and I'm a prime example. Yeah, Seroquel, stuff like that. I was on a lot of medications. I was a walking zombie. I could not function. I do not

> remember half of my time. I don't know how I functioned or how I made it from point A to point B. I can't even describe to you how many different medications I was on. When I left prison my parole officer from Guelph was even asking, 'How are you walking? How are you doing this?' I actually went through withdrawals when I came off this stuff.

Given the fact that so many of my participants used the exact same phrase to describe the impact of Seroquel as making them become "walking zombies", one must question whether or not our current system is actually, subconsciously or not, effectively creating prescription drug dependence among women prisoners. Stacey's claim to have experienced withdrawal from prescription drugs is a case in point.

It was overwhelming to hear some of my participants discuss how they *needed* different forms of prescription medication. Whether they had clinical diagnoses or not, many of the women said that they needed their medications to "get by" and that they "couldn't sleep" and "couldn't function" without them. With few other avenues to help them cope in prison and the ease with which they are able to obtain them, many women seem to turn to prescription medications as a way to cope and get through their sentences. The unfortunate outcome for many women incarcerated at any of the three levels of imprisonment is a new form of reliance on prescription psychiatric medications (Russell 1995). This reliance does little to help women reintegrate smoothly back into the community, or to remain 'crime-free'. It does, however, serve to bolster psy claims of expertise regarding the management of prisoner subjectivities and the treatment of behaviour leading to or supporting criminalisation.

Despite some of the women's attempts to explain that they did not want or need psychiatric medication, but rather that they needed only time to adjust and cope with their new surroundings, their self-assertions seem to go unacknowledged by correctional and

psy-experts. Getting criminalised women to take psy medication is thus not merely a feature in the practice of psy, it is a key component in the exertion of psy expertise reflected in corrections' effort to transform women 'criminals' into 'inmates' and then into 'rehabilitated' women. In this light, psy expertise becomes an effective instrument for altering the conduct of criminalised women (Dean 1999; Rose 1998a, 1998b; 1999a, 1999b). However, to assume that women must be medicated in order to cope with imprisonment does not help them in the long run; in fact, it may foster a kind of reliance on psychiatric medications that they may not have otherwise had.

Ultimately, some psy diagnoses reflect more general assumptions about the nature of women (Chesler 1972; Ussher 1991). For example, to be told by psy-experts that they 'need' these medications to get by reinforces the characterisation of women prisoners as weak, passive, emotionally unstable, and unsuitable for other regular or common everyday attempts at coping with stress. This practice similarly reconstructs women prisoners as incapable of determining the courses of their own mental health care. In this light, we can see how psy-experts working within a neoliberal carceral context attempt to reclaim a certain degree of control over the emotionality as well as the management and mental health identities of women prisoners.

Particularly problematic is the fact that women are, in Kellie's words, only in to see the psychiatrist "to get your medications" and that they are there "for ten minutes maybe". Very little intervention or discussion between psy-expert and patient occurs, thus minimizing the potential for any kind of 'therapeutic' involvement. Given that there is only one clinical psychologist on staff at an institution that houses well over one hundred women at any given time, it is obvious that access to therapy and counselling is

limited. Darla stated that upon arrival at GVI, the women are seen by the psychiatrist for "around an hour" to "see what your needs are and whether you're suicidal, or what your problems are, or if you're argumentative, you know, your background." To expect women upon their initial arrival in prison to be ready to discuss their clinical history again ignores the traumatic impact that federal incarceration has on people. This procedure is a component of the risk assessment strategy that is so ingrained in correctional discourse, and confirms my claim that correctionalism's main concern is always the security of the institution; looking to quickly identify argumentative and therefore potentially resistant women illustrates a desire to identify those who will be subject to increased security, medication, and isolation practices (Hannah-Moffat & Shaw 2001). This investigatory procedure is hardly effective as a means of securing the kind of detailed information that should be required before prescribing any type of psychiatric medication.

Julie provided insight about the opposing psy approaches and strategies that exist at the federal level. For example, she stated that once you have cascaded your way down to one of the minimum houses in GVI, you are given a week's worth of your medication and you are entrusted to take it accordingly.

> What they do is they give the girls all their medication for a week. Some of them will give them to other people for stuff, trade them, sell them. Some would use them to get high, or trade them for things. That's one thing I didn't like about it [GVI] was the medical. You know enough is enough. I'm tired of people telling me I have to do this, I have to do that, I have to take this medication. I want that control. Like last week I just lost it. I went off my meds. I was on something for depression. See that was another thing in federal, they'd say you *have* to take these. And I didn't want it. You couldn't refuse it. Or else I would go to seg. Because I was on Zoloft before I came to prison and then I needed it because I was drinking, going through some things, bad relationship, so ok I needed the medication. But when I went in, I was still on it, and I felt that I didn't

> need this. So when they called the house and said for me to go to health care, and I went over and the guard that was in charge asked why I hadn't taken my medication, I said that I don't feel like I need it right now. Then I had to go in to see the shrink, and the shrink said, 'well I feel that you need to be on something,' So I just said ok because I wanted to get out, you know.

The correctional practice of giving the women housed in minimum security a week's worth of their medications at a time may be seen as demonstrative of an actual attempt by correctional officials to entrust a certain degree of control over their own mental health to the women themselves. However, the women are still *required* to take the medication and if they refuse to do so, they run the risk of jeopardising their minimum-security status and even their potential for parole release (Pollack 2006; Pollack & Kendall 2005).

Allowing the women to manage the taking of their own prescription medications is indicative of a push by corrections to get the women to self-govern, but to do so according to their standards of acceptable psy-care – which in the cases of many criminalised women means continuing to take all those medications that are prescribed for them, whether they want to take them or not. As Julie stated, she wanted the control and decision-making power regarding the medications she took, but knowing that failure to comply would result in a longer stay in prison she desisted from her attempts to exercise that control. Resistance may take different forms, and is defined as: (v.) to withstand the action or effect of; refrain from; struggle against; and (n.) the ability not to be affected by something (Oxford Dictionary 2001: 1218). In this light, Julie's compliance in taking her medications can actually be seen as an act of resistance – as she was actively doing everything in her power to secure her release. Julie is following a rational strategy aimed at her ultimate release from prison, and her compliance with

respect to taking prescription medications was a way for her to withstand the punitive actions of the prison and thus not to be affected by those disciplinary technologies that serve to punish and keep her in prison for a longer period of time. This finding illustrates the point I made in Chapter Three – that dichotomies do not effectively operate in opposition to one another, but rather work as two sides of the same coin, and in Julie's case, in an interconnected way, where one (compliance) reflected the other (resistance).

Criminalised women thus lack the real freedom to make informed choices regarding their own psychiatric identities and mental health care. It is ironic that women prisoners are constructed as being manipulative in terms of securing psychiatric medications, but correctional authorities use a woman's parole release to ensure that she continues to take medication. Worse yet, is that these same authorities actually present their strategy as an attempt to help empower women. Coercion is not empowering; it is in fact the exact opposite – it is disempowering. These women have not voluntarily signed themselves into a psychiatric hospital, nor have they given up their right to determine their own mental health welfare; they are incarcerated in a prison against their will.

Seroquel and the New Prison Order

Women have historically been more subject to the discourses and practices of psy than have men, and as a result more women have been prescribed medications, both in the community and in prison (Chesler 1972; Ussher 1991). Little has changed over time in this regard. Today, the most commonly referenced prescription medication discussed by my participants was *Seroquel,* which, according to the manufacturer's website, is useful either as a mono-drug-therapy or as an adjunct to the drugs Lithium or Divalproex

for the treatment of both the acute manic and depressive episodes in bipolar 1 disorder,[89] as well as for schizophrenia. Of particular importance is the manufacturer's recommendation that all patients who are prescribed Seroquel "should be periodically reassessed to determine the need for treatment beyond the acute response." This disclaimer is deliberately vague, and does not specify the length of time meant by the term 'periodically'. Whether reassessment should occur the day after the acute episode ends, or two days, or a week thereafter, remains unclear. Further, because Seroquel is intended to treat acute depressive and manic episodes related to bipolar disorder, and is not advertised as a sedative that can be used long-term, the prolonged use of Seroquel seems inappropriate. In fact, while twenty-one of the 22 former prisoners I interviewed had been prescribed Seroquel, only one was prescribed it for a corresponding psychiatric diagnosis of bipolar disorder.[90] Unfortunately, modern medicine views the 'cause' of every discomfort as biological, and every such discomfort is potentially syndromised and treated with a different kind of prescription medication (Russell 1995; Suyemoto 2002).

Nearly every woman with whom I spoke had been prescribed Seroquel as a sedative to help with the common difficulty of getting to sleep upon initial arrival in prison. For example, Jane stated:

> We're just on a whole bunch of medication. Seroquel is something they use often in there. My cell mate and I would get our Seroquel and then pass out like ten minutes later – you know, be out for like twelve hours.

---

[89] Bipolar disorder (formerly manic-depressive) reflects a psychiatric diagnosis of a person who fluctuates between manic or elevated and depressive episodes. There are two levels and different component features of bipolar disorder. Please refer to the Diagnostic and Statistical Manual 4th Edition (DSM IV) for a more detailed explanation of how one is diagnosed with such an illness.

[90] The only woman who was not prescribed Seroquel had done life in prison at the Kingston Prison for Women. During her time in prison at P4W, Seroquel was not available on the market. It is important to note, however, that she had been prescribed other medications (both Valium and Prozac) while inside, which substantiates my claim that 100% of my sample had been prescribed medications while serving time in prison.

> Just gone. I'd rather be asleep than just sitting there doing nothing. They have nothing for us in there.

At this point, it is important to note that the use of Seroquel as a sedative reflects a trend that traverses all three levels of imprisonment. While Jane served time only in a local jail and detention centre, Dru served nearly two years in Vanier Centre and similarly declared, "yeah, Seroquel is the new med. Ta da! Everybody, here you go! Candy! It's the culture in there." And when asked about the use of prescription medication more generally, Stacey, a federally sentenced woman, stated that, "like Seroquel, stuff like that. They gave me so much of that it's hard to remember things. You're just so out of it." This drug is used universally in the current correctional climate as an effective way of managing the women by sedating them. Unfortunately, the widespread use of this particular drug reflects a failure of corrections to understand that imprisonment is in and of itself a stressful experience that will naturally take some time to adjust to. Correctional and psy authorities have used this discomfort as an opportunity to sedate women prisoners as a population, arguably making them more subdued, less resistant, and more likely to follow correctional orders (Pollack 2006). However, I argue that prescribing an anti-psychotic medication, intended by the manufacturer to be of use for either bipolar disorder or schizophrenia, to sedate prisoners is unethical and is therefore a violation of the women's rights to health care and security.

There are several noted side effects recognised and reported by the manufacturers of Seroquel. The manufacturer's website includes a list of the most common side effects and the percentage of cases during the drug's laboratory trials in which each side effect is found to have occurred: (1) dry mouth (9-44%); (2) sedation (30%); (3) somnolence (18-

28%); (4) dizziness (11-18%); (5) constipation (8-10%); (6) SGPT[91] increase (5%); (7) dyspepsia (5-7%); (8) lethargy (5%); and (9) weight gain (5%) (http://www.seroquel.com/index.aspx). Other more extreme and rare side effects were also noted, including Neuroleptic Malignant Syndrome (NMS), a potentially fatal symptom complex; tardive dyskinesia (TD), a potentially irreversible syndrome of involuntary dyskinetic movements; and hyperglycaemia, which in some extreme cases is associated with ketoacidosis, hyperosmolar coma, or death. Given the lengthy list of potential side effects, prescribing Seroquel as a sedative is a complete misuse of this drug, not to mention the fact that there are potentially less expensive medications that are specifically created as sedatives, which have fewer side effects and are not generated and marketed as anti-psychotic medications (Cohen 1985; Healy 2003; Breggin & Breggin 1994).

At this point it is important to consider those negative side effects of the drug Seroquel that were experienced by my participants. Phoebe stated that without taking this medication she would have active dreams in which she saw herself using crack and which would leave her waking up craving the drug. For Phoebe, Seroquel stopped her dreams of craving the drug, by inducing such a deep sleep that she did not wake for "at least ten hours" and from which she had no recollection of her dreams. On the down side, and due to the intensity with which she slept while on Seroquel, Phoebe also noted that she would sometimes urinate in her bed while she slept.

[91] **SGPT:** Serum glutamic pyruvic transaminase, also called alanine aminotransferase (ALT), is an enzyme that is normally present in liver and heart cells. SGPT is released into blood when the liver or heart is damagEd. The blood SGPT levels are thus elevated with liver damage (for example, from viral hepatitis) or with an insult to the heart (for example, from a heart attack). Some medications can also raise SGPT levels.

Similarly, some of the other women noted that they experienced negative side effects from the Seroquel that was prescribed for them by their psy experts. Several of my participants described the "vivid" and "intense" dreams and nightmares they experienced as a result of taking Seroquel as a sedative. The women often felt that they were unable to wake up from these dreams, which left them feeling anxious, nervous, and poorly rested the following day. Kellie stated that, "it's supposed to help you sleep. But it also gives you bad nightmares" while Cassie claimed that, "it's a form of antidepressant but you take it at night – it knocks the shit right out of you, and you have some pretty vivid dreams." Feeling poorly rested when they woke, both Kellie and Cassie were under the impression that they were being prescribed Seroquel as an antidepressant and as a sedative. Neither woman knew that the drug was actually an anti-psychotic medication. The women are given little or no information about the medications they are required to take.

Given the continued increase in the marketization of the social, we must recognise that doctors are not exempt from influence and participation in the market, specifically the increase in advertising and information on the ever-expanding repertoire of new prescription medications and the 'pushing' of drug samples by pharmaceutical companies. For example, in the film *Selling Sickness,* which is based on his 2003 book *Let Them Eat Prozac,* psychiatrist David Healy reports how pharmaceutical companies target family doctors with medication samples and advertising. Healy's (2003) argument is that doctors prescribe medications too freely without much thought to the potential side effects of these medications. The problem is compounded by the fact that prison physicians are prescribing extremely high dosages of Seroquel to women without

knowing their medical or psychiatric history. Some of the women in local jails and detention centres are serving very short periods of time, and it is often a difficult task to have their medical records transferred to the jail physician or psychiatrist. Because transferring the required medical files is such a time-consuming procedure, women who are serving a few weeks in a local jail are usually prescribed medication by doctors who do not know their medical or psychiatric history. Additionally, given the transient lifestyles of some of these women, they are not likely to have a regular doctor. The randomness of psychiatric medication prescriptions demonstrates two key points: (1) disciplinary technologies that operate within the correctional context support the medicalisation of women prisoners; and (2) a diagnosis of psychiatric disturbance or 'mental illness' is not necessarily required to prescribe anti-psychotic medication in jail.

In the same vein, the prescription of psychiatric medication, specifically Seroquel, is methodically used as a disciplinary technology to manage and regulate the conduct of women in prison by effectively sedating them.

> Veronica (Efry): A lot of them are on what we affectionately term 'bug juice' – sleeping meds. Yeah, Seroquel. Almost all of the women are coming out on Seroquel. They use it to numb women so they don't make noise. So yeah they are generally overmedicated.

Despite the claimed adoption of psychotherapeutic care in the form of counselling for prisoners, what goes on inside the walls of detention centres and prisons is a transformation of psy-ideology from one of care and treatment to one of medicalisation, psychiatrisation, segregation, and punishment. While Rose was speaking about psy in the broader context as opposed to the carceral environment, this finding goes beyond his conclusion that "the exercise of authority, here, becomes a therapeutic matter: the most powerful way of acting upon the actions of others is to change the ways in which they

govern themselves" (1996:64). I agree with Rose that we are, in fact, experiencing shifts in governance through adoption of neoliberal strategies of invoking self-government of conduct in accordance with the philosophy, discourses, language and practices of psy; however, in prison, particularly at the local jail level, a more accurate depiction of current governing strategies still reveals an overt expression of power where the right to refuse medication is virtually non-existent. This expression of power remains relatively unchallenged today. For example, and to make matters worse, criminalised women have limited access to psy-care in the form of counselling and/or therapy, and no opportunity to view their own medical files. It is to this issue of access and informed consent that I now turn.

On (Mis)Informed Consent and Lack of Access to Psy-care in the Correctional Context

Stacey (FSW): I wanted to be released so I took the fucking pills.

One of the most disturbing facts that I uncovered is that women cannot refuse their prescribed medications and to do so results in punishment via segregation, restriction of privileges including yard time, programming, visitation rights and access, and even a potentially longer sentence. For example, Kellie shared an observation that was also made by several other participants, which demonstrates my point well; she stated that criminalised women have a limited ability or right to refuse treatment.

> I had to go back on all of those meds. They had me on, um, three different prescriptions at the same time. I had to go back on them because after I originally went out I was breached. So they said that if I wanted to go out again [to be released on parole] that I had to go back on my meds.

While it is not a new strategy, requiring women to take prescription medications in order to be released on parole once again illustrates the interconnection between psy

discourses and practices and the criminal justice system. It also exemplifies how the extension of psy and correctional control from the carceral context into the community is serving to widen the carceral net (Menzies et al. 1992).

The following discussion raises ethical issues related to consent. In theory, prisoners should be adequately informed about the benefits and potential side effects of the medications they are prescribed so that they are able to make an informed decision about whether or not they want to take the medications. In practice, this procedure is not being followed, particularly at the local level. Very few of my participants had any knowledge regarding the prescription medications they were 'required' to take, and were often confused about the uses of the medications and their potential diagnoses. Similar to earlier findings (Heney 1990; Kendall 2000; Pollack 2006), one of the most predominant complaints by my participants, regardless of their level of incarceration, was the lack of availability and access to psy-care in the form of therapy or counselling. Similarly, across all three levels of imprisonment, there are major concerns regarding the limited resources for health promotion and education. If there is no health promotion or education about psychiatric illness and the specific diagnoses with which the women are labelled, then there is little opportunity for the women to resist or make demands regarding the management of their own psychiatric identities and collective psychiatric citizenship. This process demonstrates a deliberate attempt to mitigate the women's potential for exercising a kind of psychiatric citizenship, where the ability to actively engage in the regulation of their own mental health identity is reconfigured to fall under the realm and power of the psy-experts within the prison.

Several participants discussed their entry and release from prison as being a trying experience with respect to their medical, psychiatric, and mental health. More specifically, a lack of consistency in terms of access to their prescription medication caused anxiety and, due to the high dosages, withdrawal for some of the women. For example, Emma, a woman who accepted her diagnosis and the belief that she needed medications to 'treat' her condition, stated:

> Emma: Oh, no, no, no, long waiting lists. They need more access to psychiatrists, more access to psychologists and the big thing is when you talk to a woman from jail give her medication until she gets to the doctor. Because when you're released you're released cold turkey. I'm bipolar and I don't have a family doctor. I don't have a psychiatrist. The psychiatrist in the jail prescribed me Seroquel. I used to have Lithium and Trazodone but Seroquel is the one I need most right now. Seroquel, it stops the voices. It stops the paranoid delusional states, hearing voices. And it helps me sleep; I can't sleep at all without it. I'm out like a light when I take Seroquel. I fall asleep in one spot and I wake up the next morning and my mind's not racing a thousand miles, going 'ok, how am I going to get high'?

Given her acceptance of her clinical psychiatric diagnoses, Emma stated that she would have been better off at the Royal Ottawa Psychiatric Hospital than serving time in prison. For Emma, and several other participants, Seroquel helped her cope with her time in prison.

It should be noted that the anti-psychiatry movement during the 1960s and 1970s which did result in the de-institutionalisation of some psychiatric patients, unfortunately also led to the increase of the prison population which is now reaching unprecedented numbers around the world (Cohen 1985; Christie 2000; Garland 2001; Burstow 2005; Maidment 2006). With more and more individuals who suffer from mental health issues being scooped into the criminal justice system and imprisoned, fewer individuals receive

the kind of care or treatment they may need.[92] For example, in her interview Emma noted the detrimental impact of the lack of access to and shortage of psychological counselling for women in prison, indicating that with the current waiting lists it can take upwards of three to six weeks to see a psychiatrist who, moreover, predominantly prescribes medication and offers little in the way of talk therapy. Given the short sentences women serve in local jails, detention centres, and even in Vanier Centre, waiting three to six weeks to consult a psychologist is of no use since some women are released after this amount of time, leaving no opportunity for any kind of intervention. At the federal prison level, this waiting time does not pose the same problem because all of the women housed there will serve a minimum of two years at the institution. The fact remains that the first few weeks may be one of the most stressful and emotionally trying times during a woman's imprisonment, which suggests a need for immediate access to a counsellor should the women desire it.

The lack of access to psy-care has shown itself to be an important and disturbing similarity across the three levels of imprisonment. As Julie stated, putting in a request to see a psychiatrist or psychologist is often a fruitless effort, because "they just sit on things". Many of my participants offered similar responses when questioned about how one accesses psy-care. Laura stated that she has put in a request every time she has been in jail but to no avail; despite serving time in jail on and off for the past eight years, she has never seen a psychiatrist. Kellie stated that it sometimes took so long following your initial request to see either a psychiatrist or a psychologist that by the time the request is

[92] This is not to suggest that there was an abundance of treatment in the forms of counselling or therapy offered prior to the decarceration movement – however, there has been a serious decline in the availability of such care given the growth in the prison industrial complex and the correctional obsession with security rather than therapy.

processed, you know longer feel like speaking to them. Some women explained that this shift in desire to see the psy staff was either because they had learned to cope with the issue or because they now had an aversion to seeing these doctors because of the lengthy amount of time they were made to wait. Shannon also noted that her requests to see the psychiatrist went unacknowledged at the Ontario provincial prison for women. Cassie corroborated this lack of access stating, "it's hard to get to see them – sometimes you have to put in like ten requests to get in to see them."

Denial of access may be due to the lack of adequate psy-experts working within the institutions, but it also illustrates the reconstruction of psy-care as a privileged service. In either case, denying access to psy-care has the effect of denying the women control over the management of this aspect of their own health. Problematically, and for two reasons, the criminalisation of therapeutic care has resulted in what could be argued as a violation of the rights of women prisoners as psychiatric citizens. First, it is problematic to simply displace women with 'madness' issues by involving them in the criminal justice system rather than securing care in the community (Maidment 2006). Second, if so many of these women are clinically diagnosed as suffering some kind of psychiatric illness, do they not have the right to adequate support and mental health care? If the prison is not able to provide this service, then it is arguably not the right place for them.

Not only is there a lack of resources for women who wish to seek psy-care, but there is an increased stigma for those who are trying to access these services. Some women are actually taunted and mocked by correctional staff regarding their mental

health status. When serving her time in a local detention centre, Emma described her experience as a woman seeking psychiatric care within the prison institution.

> Emma: I had a male guard come in and say, "Okay, time to go for your mental walk" when he was bringing me to see the psychiatrist. Yeah, then he'd call ahead to the front desk to let us go through the doors, saying, "Psycho lady on the loose, psycho lady on the loose" so they'd open the doors quicker.

The comments made by the correctional staff toward Emma demonstrate how, similar to the historic constructions of women's criminality, women who are seeking psychiatric care inside prison are more likely than men to be reconstructed as being both mad and bad (Frigon 2000). Such constructions of women creates an image of crazy dangerous women who have the dubious distinction of carrying the dual stigma of having been both psychiatrised and criminalised (Lloyd 1995).

While concerns about the availability of and access to psy-care or counselling are heightened because of the short sentences many women serve in jails, detention centres, and provincial prison, the situation is actually similar at the federal level due to the fact that there is only one psychiatrist for each institution. Julie spoke about the psy care available at the Grand Valley Institution for Women in Kitchener, Ontario.

Julie: I find that if they are mentally disturbed that they should not be sent to prison though. The only way they deal with them is by medicating them. They are just walking around like zombies, like they are ok to talk to but they're not all there. I mean they've only got one shrink in the whole place, you know?

Jen: So it was really difficult to get access to see the psychiatrist?

Julie: Oh yeah, yeah. It would take, let me see. It took me three months to get to see them. And putting in a request, that's useless because you don't get the response. And then you're waiting, waiting, waiting. They just sit on things. And they got a file on you, that thick, and you know, where did it all come from? You know? But

> it seems like when you're finally talking to them, they are typing more than what you're saying.

Julie's account underscores not only that counselling services are lacking, but also that the therapy that is available is off-putting and distracting given that the psychiatrist fails to engage with the women and is "typing more than what you're saying". If a counsellor fails to acknowledge a woman as she is speaking, and chooses rather to focus on their notes, it would not only be distracting, but also might impede the woman's desire to continue with the 'treatment' in this form.

Julie's description also illustrates her amazement at the detail and length of her 'file'. While the women have no opportunity to discuss or even review their files with the psychiatrist, Julie stated that her psychiatrist would pull her file folder out whenever they met, and that it was approximately two inches thick. Several of my participants felt apprehensive about the content of their files. To deny a patient access to their file is a common psy and medical practice in general as well as in prisons. The tradition of the psy-expert using private notes and thoughts to determine and monitor an individual's treatment maintains a hierarchy between the doctor and patient. In the carceral context, compared to populations elsewhere, this practice has a more serious and potentially more threatening impact on the lives of women. Throughout one's interaction with the criminal justice system, an individual's 'files', whether they be criminal history, psychiatric information, reported institutional (mis) behaviour, addiction history, and even information on one's family, friends and 'criminal associates', will follow her.

The women's psychiatric files are used to help determine their potential for release, and can impact them in any future dealings with the system including at trial and/or during sentencing. Fearing what could be written or said about them, women must

be cautious regarding what they disclose to a psy-expert (Horii 2000; Kendall 2000). A consequence of this strategy is that women are infantilised by being denied access to their files. For example, Brooke stated:

> It's like they don't want you to get better. How do you get better if they won't even tell you what is wrong with you? All they do is prescribe you some medications and send you on your way. We always felt like we were in the dark about that stuff. And how can you move forward that way? It's like they treat you like a kid that can't handle the diagnosis.

Brooke's narrative illustrates how the strategic denial of access to her own file made her feel as though she was being treated like a child. Like Brooke, having been denied access to their files, several participants reported feeling unsure about their psychiatric identity, which made them feel alone and as though they could not speak to anyone about their mental health. In practice, this strategy clearly serves to individualise prisoners and thus prevents collectivisation. With respect to the women's psy identities, correctional authorities do not want women to be truly self-governing in the sense that psychiatric citizenship requires. Psy and correctional authorities only wish for women to be responsible in managing their psy-identity to the extent that they take the medications prescribed for them and participate in the programs outlined for them in their correctional plan.

The women's awareness of the impact that their 'files' can have in terms of their release was clear, and I suggest this awareness does not bode well for a positive therapeutic relationship. Of course we must question whether it is even truly possible to have therapy inside prison (Balfour 2000; Kendall 2000; Pollack 2000, 2006). Professionals who attempt to offer therapeutic services in prison cannot avoid the fact that their ability to help is constrained by their duties as employees of the correctional

institution. Prisoners cannot be expected to truly trust these professionals when the latter are bound as employees to break confidentiality and report to their superiors regarding information conveyed to them by prisoners. It is also clear that prisoners will be released more quickly if they participate in programming and thus may be involved with therapy for this reason, rather than from a true desire to attend. From this vantage point, I question whether women are truly in a position to form trusting relationships with prison psychiatrists and/or psy-experts (Kendall 2000; Kilty 2006; Pollack 2000, 2006).

Veronica, the manager of an Efry residential house, was concerned with the fact that many women coming out of the federal system must undergo mandatory psychological assessment and counselling as a component of their parole release.

> I think that's one of the problems with the federal programming – that once the women get out, some of them will have a condition to see a psychologist. And it would be mandatory, and it's a Correctional Services of Canada psychologist. So, how helpful that is, is really debatable.

'Treatment' in the community may amount to no more than a visit with a psychiatrist or general practitioner in order to continue taking prescription medications. Therefore, whether in prison or in the community, psy-care for criminalised women is inextricably linked to correctional discourse and practices. Given that non-legal agents, for example psy experts, tend to act like legal agents when working in the criminal justice system (Chunn & Menzies 1990), psy-care in this context *is* a correctional practice.

Brooke: I had to see counsellors and things when I was released, like it's part of my parole. But it's hard, I have to be careful what I say to them you know because they work for the prison and I don't want anything to get misunderstood. You know, like you don't want to tell someone who can send you back that you are afraid of using or something.

Given Brooke's statement, I seriously question how criminalised women can be expected to feel safe to discuss personal issues, emotions, feelings, or experiences such as past abuse or trauma or their addiction issues with someone who is required to report back to the very institutional authorities that have the power to deny or revoke their parole.

Of Turf Wars and Territoriality: Butting Heads and Competing Expert Discourses

Carrie (Efry): They either over-prescribe or they deny certain meds. It seems like a mystery in terms of how the decisions are made, there's no consistency.

Shannon (PSW): In Vanier, they give you nothing. They take everything away. They make you go crazy and then they throw you in seg.

Despite the fact that they both fall under the jurisdiction of the Ontario Ministry of Corrections and Community Safety there seem to be certain distinctions between how local jail or detention centres and the Vanier Centre for Women operate in terms of their provision of psy-care, treatment, and the prescription and dispensing of psychiatric medications. In this section I highlight two seemingly opposing strategies that are operating at the provincial level, over-prescription and the denial of medication, which actually serve to achieve the same end – social control (Sim 2005; Pollack 2006). Moreover, in one institution there is in effect what can only be described as a 'turf war' between the medical doctor (who refuses prescription medications) and the psychiatrist (who over-prescribes medications). The battle between these two experts is resulting in a seesaw effect with respect to the medications prescribed for and taken by the women housed in this institution. While I have already specifically examined the use of the drug Seroquel, here I am referring to prescription medications more broadly.

First, let us consider what is a common experience in local jails and detention centres where women either await trial or serve short sentences. In these local institutions, where overcrowding has reached the point where prisoners are being double or triple bunked (Christie 2000; Garland 2001), there is a widespread trend toward over-medicating criminalised women. For example, Tammy, an Efry social worker stated:

> The institution is quick to dispense medication. All it really takes is an appointment with a doctor and you're prescribed medication. I mean, when I do programming in there and the nurse comes by dispensing meds, I don't think there is ever one woman in the group I'm seeing that wasn't getting medication.

Tammy's script illustrates a very specific picture, one where the two worlds of criminalisation and psychiatrisation are forever intertwined. Women are more likely to have a mental health record prior to criminalisation than are men (Chesler 1972; Ussher 1991; Russell 1995). In fact, some psychiatrised women are criminalised as a result of their psychiatric statuses; this experience is linked to the deinstitutionalisation movement that led to an increase in the number of persons with mental health issues being criminalised rather than placed in psychiatric institutions (Cohen 1985; Christie 2000; Morin et al. 2005). Alternatively, some criminalised women are psychiatrised expressly because of their criminalisation (Pollack 2006).

Psy claims of expertise regarding the subjectivity and mental health of criminalised women date back to the birth of the prison, and to the birth of psy as a discipline that seeks to explain human behaviour, including criminality, and to treat and/or cure those mental illnesses associated with the identified deviant or criminal behaviour (Smart 1976; Rose 1989, 1996;Comack 2006). Given the role of psy in the evolving penal system, it is not surprising that so many women in prison are

simultaneously subjected to some form of psy intervention. However, psy experts did not become an active part of the penal system in Canada until well into the 20th century (Hannah-Moffat 2001; Hayman 2006). During much of the 19th century, women (and children) were housed in the Kingston Penitentiary with male prisoners, although women were confined in a separate area of the prison (Hannah-Moffat 2001; Hayman 2006). The problem is the extent to which this psy-care involves prescription medication, combined with a lack of counselling and the inability of prisoners to refuse take their prescription medications[93].

Given the common problems associated with the over-crowding seen in small jails and detention centres, it is not surprising that excessive amounts of psychiatric medication are being used; it is a seductive, quick solution to a larger problem. Sedation represents an attempt to quieten resistance and 'rowdiness' from women prisoners. For example, Cate spent over a year and a half in her local jail before pleading guilty[94] and being sent to the federal system at the Grand Valley Institution for women in Kitchener, Ontario. With respect to the use of prescription psychiatric medication available to her while serving time in the local jail, Cate stated:

> They put us all on medication. Whatever I wanted. I was addicted to morphine on the streets, and as soon as I went in they put me on morphine! Because I had been prescribed it on the street, but I had been completely abusing it. I was on so many different kinds of meds in there. They told me I was schizophrenic and they had me on a whole bunch of

[93] Practically speaking, prisoners can opt out of taking prescription psychiatric medications, but such a decision has a direct and negative impact on their chances at parole or release. Women who actively choose not to take their prescribed psychiatric medications get reconstructed within correctional discourses as being difficult to manage, and as failing to self-govern and/or manage their mental health according to the psy-expertise proffered by the prison. It should be noted that some of my participants accepted their diagnoses and treatment plans, while others pretended to do so in order to be released, and fewer openly resisted psy intervention.

[94] Cate stated that she pled guilty in order to get out of her local jail because the conditions and treatment she experienced there were so bad.

> things for that. I had never been told that before, I'm not schizophrenic, I was just coming down off of crystal meth and morphine and whatever else I was doing on the street. I don't even know how the psychiatrist diagnosed me because I just saw him for like ten minutes and he told me he was giving me these meds.

For Cate and a few other women, local jail and detention centres function in such a way as to control but also to promote the use of psychiatric medications. Again, despite falling under the same jurisdiction and operating via the same ministry, this approach stands in stark contrast to what is occurring in the Ontario provincial prison, the Vanier Centre for Women.

Many participants who had served time in a provincial prison were accused of merely wanting to be prescribed psychiatric medications when they were finally (often following multiple requests) granted access to the psychiatrist. This construction by correctional authorities and psy-experts of criminalised women as being manipulative is similar to the reconstruction of women who self-injure and/or who suffer from disordered eating as being manipulative (Ross & McKay 1979; Heney 1990). The construction of women as manipulative seems to be a component of correctional understandings of criminalised women. Rather than attempting to understand the root of the issue and the devastating impact of imprisonment on an individual's emotional well-being, women are redefined as individuals who are trying to manipulate their way through their time. This failure to acknowledge the experiential realities of women only re-enforces the historic image of criminalised women as manipulative, crazy, and dangerous.

Such accusations of manipulation also show the disjuncture between the two levels of provincial incarceration (the local jail and/or detention centre versus Vanier Centre). Women prisoners spend their initial time and sentence in local jails or detention

centres while awaiting trial and sentencing. It is not unreasonable for the women to assume that if they were prescribed high dosages of Seroquel (or any other medication for that matter) in their local detention centre, they would receive the same in another provincial institution. In this light, requests for psy-care and medications are hardly manipulative, and are in fact rational requests made by women who are seeking to continue the treatment prescribed by the psy-experts with whom they have had prior contact in prison.

Also troubling was the fact that all of the women who had served time in the provincial system similarly described the inconsistent treatment and the use of psy-care and prescription medications as a method of reward and punishment. Withholding medication exercises authority; it is done to maintain the hierarchy between correctional staff (including psy-experts) and the women. Prior to going to federal prison, Kellie served time in Vanier Centre, where she was taken off the medications she had been prescribed and had been taking for over two years while living in the community.

> They took me off my scripts[95] that I'd been on for two years! They said it was addictive. I said, 'excuse me, I've been on them for two years, you can't fucking do this to me!' And they said, 'Oh well, we'll wean you off and put you on something else.' Bullshit.

Prescribing psychiatric medications in the carceral context at the provincial level seems to be an exercise in power and authority, mitigating the women's ability to govern their own mental health care (Pollack & Kendall 2005; Pollack 2006). This tactic is similar to what Mitford (1974) found with respect to men's prisons. While local detention centres appear to prescribe psychiatric medications quite freely, with or without reference to or receipt of a woman's medical file from her doctor in the community,

[95] Some of my participants used the term 'scripts' as a shortened version of 'prescriptions'.

Vanier Centre appears to completely withhold medication from women despite knowing that they had been taking prescription drugs in the community. This finding suggests three things about the practice of psy as it occurs in the Ontario provincial prison: (1) a lack of collegiality and trust between prison doctors and prison psychiatrists in terms of the diagnoses and prescriptions made; (2) the supremacy given to the expertise of those working within the correctional system, as superseding all other diagnoses made by similar experts working in the community, despite the fact that the latter are more likely to have had a more prolonged contact with and thus more time to assess their patients; and (3) an unhelpful territoriality and a virtual power struggle as both psychiatrists and medical doctors are attempting to supersede the power and prescription patterns of the other.

Interestingly, it was not only psychiatric medication prescriptions that were interfered with in Vanier Centre. Several of the women mentioned that physical health medications their doctors had prescribed for them in the community were withheld from them in Vanier Centre. For example, when we discussed her blood pressure medication, Darla stated:

Darla: Vanier was bad, they took me right off my meds and they took me off my blood pressure medicine. Oh no, they were not nice up there at all. They said my blood pressure was fine, that I didn't need it.

Jen: And you'd been on it for how long?

Darla: Years. I even took a packet plus a prescription with me of my blood pressure medicine so that I could continue taking it, and they refused to give it to me. They just said I didn't need it, they said my blood pressure was normal. I said, 'yeah it's normal, cause I've been on this medication for years. And so every day it kept rising and rising and rising and rising. You could see it in my face, getting red, red, red.

Interfering with a woman's blood pressure medication is not only illogical – it is dangerous. It is also demonstrative of an attempt at securing authority over the women's health identities (Sim 1990). Danielle confirmed Darla's narrative stating that, "medication is fucked up because, pardon my language, because the doctor will medicate the girls differently than on the outside." Danielle was particularly reflective when discussing this issue, suggesting that this was part of the culture of imprisonment.

> Yeah, it's the culture. But the nurses shouldn't be refusing people Tylenol. Nobody is gonna OD on a few tablets of Tylenol. You know, if somebody has a headache or they have their menses and they can't get something to deal with the pain, it's absolutely stupid.

Being restrictive of over-the-counter pain medication like Tylenol is irrational and punitive and indicates the attempt at securing correctional authority over even the most mundane aspects of an individual prisoner's life.

Similarly, Julie claimed that there were major differences between the kinds of health treatment she received in the provincial and federal systems. For example, while Julie was serving a sentence in Vanier Centre, she began experiencing severe abdominal cramping and stomach pain. Despite requesting medical attention more than once for the same problem, she collapsed before she was given a medical examination for her stomach pain, which turned out to be a bowel obstruction requiring surgery. Therefore, operating under the assumption that women are being manipulative in order to secure prescription medications or privileged treatment may end up having devastating and tragic consequences.

Such punitive control over the women's health actually runs counter to the current neoliberal attempts at fostering self-governing prisoners. This control also illustrates that

while neoliberal discourses and practices are clearly operating within correctionalism, claims about wanting to teach prisoners how to self-govern are not wholly grounded in correctional practices and policies. To deny women the right to exercise any authority over their own mental and physical health statuses and/or identities and to construct an environment where they are dependent on correctional authorities for all health decisions are demonstrative of the fact that governance occurs through different methods, strategies, and technologies of governance (Foucault 1977).

Of all of the women I spoke with who had served time in Vanier Centre, Shannon depicted the most extreme violation of her rights to have safe, secure, and humane treatment for her health and emotional well-being. Shannon's prescription medications were changed so many times that her entire period of incarceration was marred by periods of anxiety or alternately, withdrawal. I quote at length from my interview with Shannon since it exemplifies the two opposing psy-approaches taken by correctional and psy authorities at Vanier Centre. As discussed previously, Shannon was a first time offender who was experiencing extreme anxiety about her imprisonment and debilitating guilt surrounding her offence. Upon her initial arrival at Vanier Centre, she was denied access (by the prison medical doctor) to the anti-anxiety medication (Clonazepam) that she had been taking for the year following her drunk driving charge and leading up to her incarceration.

> When I went in I was taking Clonazepam and the doctor took it away from me. He said, 'you don't need that.' Well I thought was going crazy because I couldn't sleep, I couldn't breathe, things were flashing. I guess I was having withdrawal because I had taken them for so long and they just said automatically, 'you don't need them anymore." I kept saying, 'I need to see the psychiatrist. The doctor won't let me see him.' And she [social worker] goes, 'well you know if I make an appointment for you to see him, don't think you're getting any medication off of him.' I said, 'I need

> to talk to somebody, don't you understand that?' I kept saying to her, 'don't you understand? Look at me, don't you understand?'

Listening to Shannon speak about her experiences, nearly two full years after they had occurred, I was struck by the desperation that still sounded in her voice as she told her story. Shannon literally begged to be allowed to see the prison psychiatrist, and was initially denied access until it got the point where she was hysterical and unable to calm down. What is most interesting here is the authority with which the social worker speaks with respect to Shannon's psy-care and potential treatment. While not a psy or medical expert, the social worker is acting as a gatekeeper to this expertise. In this case, the medical doctor and the social worker seemed to be working together and at cross-purposes to the psy-expert. This collusion may be attributable to one of two potential reasons: (1) this particular medical doctor's disdain for psy care; or (2) this medical doctor's heightened awareness of the problems associated with over-prescription of medications in the prison context. The medical doctor too is acting as an arbiter of psy-expertise and is rejecting the findings of those psy-experts who treated Shannon while she was living in the community, to be superseded by his own medical expertise, which resulted in the denial of medication. Denying medication may seem to be a different approach than the over-prescription of medication that is so prevalent in local jails and detention centres, but it serves the same end – social control.

Given the nature of Shannon's crime she was offered admission to a substance use treatment centre as part of her sentence. Shannon described the treatment centre as much more peaceful than life in prison. At the treatment centre, she was re-prescribed those medications that she had been taking while in the community and she continued to take the Seroquel that had been prescribed to her upon arrival in prison. However, upon

her transfer back to prison, Shannon once again experienced withdrawal and denial of her medications.

> When I first got back from treatment my meds were fine; the ones I need had been reinstated at treatment. But my first night back, the nurse comes and says, 'you won't be getting this, and you won't be getting that' and I said, 'I just got put on those meds, I'm okay.' She says, 'well you'll be seeing the doctor tomorrow... whatever.' Then I see the doctor who says, 'you don't need this, you don't need that;' just took me off it and only left me with 1milligram of Clonazepam left. Changed my anti-depressant from the Celexa I was on to this Effexor. Took my 50 milligram's of my water pill away, which is for my blood pressure. Took that away and only gave me half because he doesn't believe in that. Took my Ritalin again and said 'you don't need that dose.' The social worker kept saying that they were mixing me a cocktail at the treatment centre and that the doctor doesn't like it. So the doctor took away my medicine and eventually they sent me to the psychiatrist because I was flipping. I just couldn't cope with things and I was crying and just very anxious, and very depressed and crying all the time, like uncontrollably. So they sent me to see the psychiatrist and he put me back on it and said the doctor shouldn't have taken me off of it. The psychiatrist said, 'obviously you and the doctor have locked horns. I'll give you your medication and if you don't have to go to the doctor for anything, don't. The next day the doctor found out that the psychiatrist had given me my medication and it was gone. I put in a request – request after request after request to see the doctor, and he wouldn't. He wouldn't answer any of my requests. So I had everything taken away, they took me off everything, cold turkey.

Here, Shannon's narrative illustrates the turf war that I have suggested exists between the medical doctor and the psychiatrist. Again there is a social worker making claims about expertise she does not possess. The medical doctor once again is found to reject the diagnoses made by other medical and psy experts in order to stop Shannon from taking prescription medications. Most problematic in this account is the fact that because he found Shannon to be a thorn in his side, and did not want to have to deal with her any longer, the medical doctor simply started ignoring her requests for medical service. This account demonstrates the extent to which such experts attempt to maintain control over the medical and psy health identities of criminalised women. According to

Shannon's story, the psychiatrist in the institution was fully aware of the medical doctor's proneness to refusing medications and also tried to supersede his authority by re-prescribing medications. Most unfortunately, in this instance Shannon's mental and physical well-being were actually secondary to the conflicting discourses between the medical doctor and psychiatrist.

Toward the end of Shannon's sentence, she was still being pushed and pulled back and forth with respect to her medications.

> At one point they tried to say that I was hoarding my medication, and they decided to take me off my Ritalin and then they decided to take me off of my Effexor, my anti-depressant. And I was like, this is wrong! Now, I'm totally afraid of needles, but I said, you can take blood tests, you know, because this is wrong, it's a lie. And I tried to tell the nurse that. She said, 'well you're not getting your medication anymore. If you were giving it away…' I mean, first I was hoarding it, now I was giving it away! I was so off balance and everything. I was so dizzy and I felt like I was going insane and I felt like I was going mental. I couldn't sit still when they took me off my Ritalin. They just said, boom, gone!

After being prescribed and denied medication time and again, Shannon was then accused of hoarding and giving away the medications she fought so hard to have. The psychiatrist continued to re-prescribe medications for Shannon subsequently with the medical doctor removing them from her, to the point where she experienced withdrawal symptoms. Having the prison psychiatrist reinstate her medication following its earlier suspension by the prison medical doctor, as well as having a social worker intervene and simultaneously accuse her of hoarding and giving away her medication paints an image of a confusing and punitive environment for the women who are forced to receive 'care' from these staff members. Despite requests that they run blood tests on her as evidence that she had the correct amount of medications in her system, the outcome was to once again deny her medications. While I would like to be clear that I am not advocating the

use of prescription medications, the kind of inconsistent treatment Shannon experienced was unnecessary and inappropriate. Not only did the social worker involved accuse Shannon of abusing her medication, she also insisted that the psychiatrist should not and would not give her any medication because "that was the way the doctor ran the prison". Shannon's narrative shows that the social worker is working alongside the medical doctor to undermine both the women's attempts at securing and the psychiatrist's attempts at providing prescription medications.

From these excerpts we can see how two seemingly opposing strategies are working toward the same end – that being social control. Both the medical doctor and the psychiatrist are trying to exercise control over criminalised women and are exerting their own power as 'experts' in their fields; the medical doctor through denial of medications and the psychiatrist through over-prescription of medications. I do not want to presume this was a conscious strategy of these two doctors. It is more akin to a kind of territoriality reflecting competing expert discourses and a desire to rule the roost in the 'treatment' of women prisoners.

While the language, discourses, and practices of psy have permeated the everyday, and most certainly the domain of corrections (Rose 1989; 1996), the facility with which different disciplines have adopted psy has actually led to a blurring of the boundaries of authority and expertise in this domain. Similarly, because psy-expertise relies so heavily on its scientificity and the biological roots of mental illnesses, the discourse of my participants illustrates how medical doctors, due mostly to their power and ability to prescribe medications, have been able to break into the realm of psy as a practice without necessarily having a background in that discipline. This new voice in

the psy sciences mirrors the influence of the pharmaceutical companies on family physicians described by Healy (2003). Because of this finding, I argue that the psy 'treatment' Shannon received while incarcerated in provincial prison is demonstrative of how the practices of psy within the carceral context can and do function as technologies of discipline that illustrate a strategic attempt to secure control of the prison and the women housed there. The lack of internal consistency in terms of psy diagnoses and medicalisation represents a failure of the institution to rectify its position on the appropriate course of treatment, which serves only to weaken the potential for psy to help the women exposed to its practices.

In this context, medical and psy authorities effectively operate to strip away human agency, while at the same time demanding of the women that they cope with imprisonment in positive and 'acceptable' ways (i.e. non self-harming ways). From Shannon's narrative we can see how, as in all disciplines, there is much dissension over how to practice psy and 'treat patients'. In total, Shannon received different diagnoses from four separate parties: the medical doctor in the prison, the psychiatrist in the prison, the psychiatrist at the substance abuse treatment centre, and her own psychiatrist and/or doctor in the community. With four different experts came four different ways of 'treating' her. It was not just the inconsistency in terms of 'treatment' that is problematic; it was the lack of respect for and, more importantly, the lack of communication with, the other psy-experts that is cause for concern. Making independent judgements without consulting one another segregates treatment modalities and creates conflicting treatment (Maidment 2006). This battle of expert discourses demonstrates a desire by both medical and psy experts to claim ownership over the

mental health of criminalised women rather than working with others (and the individual woman for that matter) in the women's best interests. In Shannon's case, the failure of the medical doctor and the psychiatrist to put her interests first and the disjuncture between the medical and psy practitioners' respective desires to see treatment done in a particular way, is unprofessional at best and certainly jeopardizes the women's mental and physical health.

The psy-care provided to the criminalised women housed in provincial prison exists and operates in an extreme dichotomy. There appears to be no middle ground; reliance on medications has replaced any kind of talk therapy or counselling, which should at the very least be used in conjunction with the prescribed medications. Shannon paints a picture of psy-care as being black or white – either you take an excess of psychiatric medication or you take none.

Absolutely no attempt was made to help Shannon cope with the shame, guilt, and grief she was experiencing as a result of hitting and almost killing two people while she was driving drunk. That there was no recognition of her requests to speak with the psychiatrist illustrates an attempt by corrections to shake the women's senses of self by interfering in their ability to manage their own mental health identity (Pollack 2006). Denying access to care prevents any realization of psychiatric citizenship, through which the women would be able to collectively unite, make demands, and have their psychiatric rights preserved. Psychiatric rights may include community care (as opposed to imprisonment), addiction treatment, feminist therapy or counselling, and access to counsellors who are not working within and for corrections. While some may argue that this inability to determine their own manner of care has always existed (Hannah-Moffat

2001; Pollack 2006), there is no reason to maintain an unhealthy status quo. Rather than having professionals determine what to do *to* criminalised women, I suggest that a discussion of psychiatric citizenship can open the door for potential future action.

Like their physical health care,[96] prisoners have a right to safe and secure psy treatment. Unfortunately, the inability of psy-experts to agree upon diagnoses and courses of treatment shatters the possibility for criminalised women to exercise their rights through a psychiatric citizenship, because if there is no agreement on diagnoses and courses of treatment, there are no accepted and agreed upon understandings about what would constitute inclusion under the title of psychiatric citizen. Psychiatric citizenship should ensure care that is equivalent to what the women would be able to secure in the community; unfortunately, corrections has extended its gaze into the community (expanding the carceral net) as several participants had parole stipulations that required them to see counsellors in the community who work for and report to corrections.

In the end, Shannon's inability to 'cope effectively' or 'appropriately' with the continued tampering of her medication resulted in severe bouts of stress-induced anxiety and depression, which were coupled with, in her own words, "uncontrollable crying". Correctional authorities responded to her distress by strip-searching and segregating her. Veronica, an Efry social worker, supported Shannon's claims, stating:

> Definitely more attention is given in the federal system than in the provincial system. In the provincial system, most women with mental health issues are just thrown into segregation and that's their way of dealing with women who are going through a mental health crisis.

[96] While it is beyond the scope of this discussion to examine it here, it should be noted that participants described the health care provided in prison as less than standard. Similarly, I suggest that prisoners have a venue for making claims for better health services through the discourse of biological citizenship.

These narratives highlight how women who are experiencing some kind of distress, which is arguably caused or perpetuated by the prison environment, are ultimately punished for it. In terms of correctional responses to women experiencing a crisis, the source of distress is ignored, and it goes unaddressed because the woman's behaviour is reconstructed as being a threat to the security of the institution (Kilty 2006). The outcome is to segregate women in an attempt to subdue and quieten them.[97]

Chapter Summary

In this chapter I examined four themes regarding psy-care and prescription medications for women in prison: (1) there is a continued reliance on psychiatric medications to the point of dangerous over-prescription of psychiatric medications that is done in an attempt to subdue a population traditionally constructed as difficult to manage; (2) there is a current reliance on and misuse of the drug Seroquel, which doctors are prescribing to criminalised women due to its sedative side effects, despite being marketed for treatment in schizophrenia and bipolar disorder; (3) there are concerns at both the provincial and federal levels of incarceration surrounding the limited access to psy-care in the form of counselling, and there is a lack of health promotion and education regarding mental health, individual clinical diagnoses, and the use of psychiatric medications that women are *required* to take; and (4) the psy regime currently operating in the Ontario provincial prison is confusing and ultimately punitive in nature, because the medical and psy authorities there seem more concerned with exercising their expertise and power than they are with the mental and physical health needs of the women.

[97] I discuss the practice of segregation as a correctional response to women in crisis, specifically women who self-injure, in Chapter Nine of this dissertation.

Of particular importance has been the emergence of the potentiality for the construction of a kind of psychiatric citizenship, through which criminalised women may be able to garner support and make requests for better and more readily available services. What complicates the solidification of a psychiatric citizenship is the interconnection and interdependence between correctional and psy discourses and practices. Correctionalism's long-standing connection with and reliance on psy explanations of criminality have shifted the power to treat only to those practices determined by psy-experts, to the exclusion of the women themselves. In this context we can see the relationship between criminalisation and psychiatrisation quite clearly, where being a criminalised woman means being a psychiatrised and medicalised woman.

Despite the neoliberal discursive shift in correctional policies, programming, and standard operating practices, very little is being done to encourage independent thought by women prisoners regarding the negotiation of their own mental health identities and destinies. Criminalised women are not truly expected to be self-governing prisoners with respect to their own mental health identities; rather, correctional and psy experts expect them to swallow without question the diagnoses and pills they prescribe them. While in wider society citizens are expected to research their own health statuses in order to make educated decisions regarding their physical and mental health, in the carceral context, women prisoners do not have the opportunity to become so learned or to make these kinds of educated decisions. More disturbing is the fact that, at the federal level, we are actually generating a reliance on prescription medication with little clinical reasoning or support for these exorbitant prescription practices.

In the next chapter I examine the existing federal correctional policies that outline the use of segregation as a response to self-harming behaviours. These policies support the reconstruction of women's needs as risk factors, and women in crisis as risks to the security of the institution.

Chapter 8
Politicking Self-harm –
Cutting, Emaciating, and Using: Coping Strategies and the 'Hole'

In this chapter I examine the existing policies and subsequent responses operating in both federal and provincial prisons for women in Canada, with respect to the three forms of self-harm discussed by the participants in this study: self-injury, disordered eating, and licit and illicit substance use. However, the bulk of the chapter focuses on policies and responses[98] to self-injury. This is due to the fact that there is no official policy (at either the provincial or federal level) for disordered eating, and given that illicit substance use is illegal both in and outside of prison it is not surprising that there be some form of disciplinary response when a prisoner is found in possession of an illicit substance. Conversely, what is important to our discussion of substance use is the contradictory nature of the responses to and treatment of licit (meaning prescription) versus illicit substance use.

Specific attention is paid to the harmful impact that these policies and operating practices have on criminalised women who self-harm. Throughout this chapter, I explore the concepts of *need* (women's programming, counselling, health, educational, and vocational needs) and *risk* assessment (level of threat to the security of the institution, society, themselves, staff, and other prisoners), as they are fundamental parts of the

[98] It should be noted that there is no official written self-injury policy at the provincial level. However, in practice, the Ontario provincial system uses the same strategy of dealing with women who self-injure – segregation – as does the federal system, and I suggest that this is therefore a 'de facto' policy.

overall management of both federal and provincial corrections for women. By assessing the policies regarding self-injury, the operational responses to disordered eating, and the inconsistent responses with respect to licit and illicit drug use, I argue that self-harming prisoners are either ignored or inappropriately constructed as risks to the institution.

The existing policies and operating responses serve to prioritize the security of the prison rather than to address the needs of female prisoners. For example, current policy mandates that women who self-injure are to be routinely disciplined for their self-injurious behaviour through admittance to administrative segregation. Similarly, correctional officials were found to actively ignore disordered eating behaviour, which may be due to the fact that the public unfortunately views these practices as a common experience for women and – given that few women become emaciated and noticeably ill – as potentially less dangerous than, for example, self-injury (Bordo 1993; Malson 1997).

Finally, the inconsistent responses with respect to licit and illicit substance use by women in prison reflect the (re)construction of some behaviours and practices as dangerous or threatening, while others, although technically the same, are more acceptable. For example, while prescription (licit) substance use is acceptable because the women are being both governable and self-governing, illicit substance use in prison is responded to in two overly harsh and punitive ways – with institutional charges (which can increase the length of a woman's sentence), and with a period of time in segregation. Before presenting the analysis of these policies, I set the stage with a brief discussion of the importance of using theory when drafting policy.

Setting the Stage

Theory allows us to test, create, and explain policy. As Margaret Jackson (personal communication 2004) suggests, policy making is the activity of constructing beliefs (theoretical constructs) in a pragmatic way so that they may be operationalized. Without a strong theoretical explanation, policy is likely to be unsuccessful because the implementer has failed to understand the context within which the policy must exist and operate. With respect to prison policies it would therefore be ineffective and irresponsible not to include the voices and standpoints of prisoners, who are directly impacted by said policies and responses, in their generation and implementation.

Despite the CSC's claims to have adopted the feminist philosophy of *Creating Choices*,[99] it soon became clear that key feminist terms such as 'choice' and 'empowerment' were adapted rather than adopted by the CSC and made to fit into existing penal discourses (Hannah-Moffat 1995, 1999, 2000a, 2001). Throughout this process of redefinition, the needs of federally sentenced women in Canada, including those who self-harm, were seamlessly redefined as risks to the security of the institution.

What is more, given the failure of academics to adequately examine the experiences of provincial prisoners, little has changed during this time with respect to the conditions of provincial imprisonment for women in Canada. Ironically, the federal system, which has been subject to extensive scrutiny by feminists, academics, and prisoners' rights advocates, uses the same problematic method of dealing with the issues

[99] *Creating Choices* (Task Force on Federally Sentenced Women, 1990) is the policy document that outlines how to manage and administer federal corrections for women. It was the fourteenth of fifteen similar inquiries that called for the closure of the only federal prison for women in Canada, the Kingston Prison for Women (P4W). The report argued that because of its geographic dislocation from the rest of Canada, federally sentenced women were often reported as being punished more harshly than their male counterparts.

of self-harm as does the Ontario provincial system – namely, segregation. At the very least, given the originally explicit feminist nature of the document *Creating Choices* we must reconsider what should be the gender responsive nature of federal correctional policies for women.

A feminist perspective is a useful tool to critically assess policy creation because it seeks to understand social realities and contexts of women's lives. Using a politics of difference to inform policy creation transfers the elite decision-making power and representation to those persons who are directly affected by the policy. At the most basic level, therefore, female prisoners should be canvassed regarding how they feel the CSC and the OMCCS should address self-harming behaviours; this involvement may enable the construction and implementation of more effective women-centred policies regarding self-harm committed by women in prison. However, we must recognise that it is not simply a matter of asking what the women 'think'; we must strive to understand how the current policies affect their decisions to self-injure, practice disordered eating, or use substances. For example, if administrative segregation makes these problems worse for the women, then the policies should be revised.

Schram suggests "that the state has a vested interest in ensuring its own legitimacy and therefore cannot actually solve its problems by attacking their systemic causes" (1993:253). Therefore, it is important to examine the discourses of the women whom the policy directly affects, in order to evaluate the possibility that the policy as it functions in practice may actually serve a more sinister and unintended purpose: that it contributes to the frequency and possibly the severity of these self-harming behaviours. The continuance of women's subordination can be seen in the patriarchal overtones that

still permeate the correctional philosophies governing women's prisons at both the federal and provincial levels. For example, failing to recognize the agency of individual prisoners, and creating a correctional plan *by* correctional officials *for* the women effectively infantilises the latter.

At the federal level, the CSC has argued that it has made a financial and philosophical commitment to a program design and delivery strategy that focuses on the needs of federally sentenced women as outlined in *Creating Choices* (Arbour 1996). Yet, the Service has been inconsistent in its application of the recommendations proposed in *Creating Choices*. Although the Service claims to have adopted the five following principles: (1) empowerment, (2) meaningful and responsible choices, (3) respect and dignity, (4) supportive environment, and (5) shared responsibilities, its execution has been flawed. The women are told to make 'meaningful and responsible choices', but if their decisions do not match the correctional agenda that was outlined for them by correctional officials, then their decisions are not considered to be meaningful and/or responsible. For example, correctional caseworkers identify the programs in which the women must participate to be seen as cooperative, responsible, and open to making changes to their lifestyles and behaviour. As such, all women, whether they have a history of substance use or not, must take, at the very least, the first of three substance use programs. The women's cooperation helps them earn parole, whereas being uncooperative or resistant hinders their chances. As Hannah-Moffat (2005:39) has suggested, "correctional interventions are prioritized according to what is pragmatic, rather than what may be meaningful to the offender. Individuals are positioned as

potential recipients of predefined services, rather than as active agents involved in processes of self-identifying needs."

Although there may be certain situations where a prisoner may not want to participate in programming that may in fact be beneficial to her, current risk-based discourses preclude individual agency in favour of creating prisoners who self-govern according to a predetermined correctional plan. By adapting the feminist position of *Creating Choices*, correctional research has over-emphasised women's risks while selectively neglecting to consider whether women's *needs* are being met.

Policies and Procedures: Correctional Responses to Self-injury, Disordered Eating, and Substance Use.

The Federal Mission Statement and Provincial Mandate

The mission statement outlines the main aims of a governing body and is thus the overarching governing policy in place in a given agency or institution. It represents an overview of the agency's position regarding its goals and directives, and it therefore sets the tone for the agency's other policies. All other policies and procedures must therefore flow from and be consistent with the mission or mandate statement of the agency. The CSC's mission statement reads as follows (CSC 2002b):

> The Correctional Service of Canada (CSC), as part of the criminal justice system and respecting the rule of law, contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control.

And the mandate of the Ontario Ministry of Community Safety and Correctional Services reads as follows:

> The Ministry of Community Safety and Correctional Services is committed to ensuring that Ontario's communities are supported and protected by law enforcement and public safety systems that are safe, secure, effective, efficient and accountable.[100]

When they respond to self-injurious behaviour by moving female prisoners to administrative segregation, both federal and provincial correctional institutions are violating their mission and mandate statements. An increase in security level contradicts the very aim of exercising reasonable and humane control. Just as problematically, the Ontario provincial mandate focuses exclusively on community protection and fails to address or even acknowledge the safety of those housed in provincial correctional institutions. This failure to ensure the safety of criminalised women in provincial prison demonstrates an active disregard for their health and well-being, in favour of a focus on protection from a group of women traditionally constructed as misbehaved, rowdy, and dangerous. Focusing on their potential for 'acting out' functions to the detriment of women, who are subsequently disciplined for nothing more than experiencing a crisis and harming only themselves.

Moreover, women who are placed in segregation are commonly evaluated as being severely mentally ill,[101] in crisis, or as having acted out violently toward others within the institution[102] (Hannah-Moffat 2001; Kendall 2000). To similarly categorise, place, identify, and designate the security levels of women who are harming themselves

[100] Sourced at: http://www.mcscs.jus.gov.on.ca/English/about_min/mandate.html.

[101] I have separated the notions of 'mental illness' and being 'in crisis' because I do not want to suggest that self-harming behaviour is necessarily indicative of some kind of mental pathology. It should be noted that the use of segregation for women with mental health issues is also extremely problematic, but it is beyond the scope of this chapter to engage in a discussion of this contentious subject.

[102] Prisoners may be sent to administrative segregation on four grounds: (1) for the safety of a person in the prison; (2) for the prisoner's own safety (i.e., self-injury); (3) for the security of the institution; and (4) if there is an investigation into a possible disciplinary or criminal charge. Disciplinary segregation is used when the prisoner is found guilty of an institutional offence (CCRA 1992: s. 40).

and women who are acting out violently toward others is demonstrative of the re-construction of the different types of self-harm both as potential features of severe mental illness and as threats to prison security. As will be explored in detail below, the practice of segregating women for self-harming behaviour is a violation of both the federal mission statement (it violates their rights to safe and humane treatment) and the provincial mandate (it has no basis in providing community safety). With this point in mind, I now examine the correctional responses to the three forms of self-harm (disordered eating, licit and illicit substance use, and self-injury) that my participants identified as coping strategies.

Feminising Masculine Women: Operating Correctional Responses to Disordered Eating Practices

In the absence of an official policy regarding disordered eating at either the federal or provincial level, bulimic and anorectic practices, similar to how they are treated and viewed in wider society, remain in shadows inside Canadian prisons. Unlike self-injury and illicit substance use, correctional staff turn a blind eye to disordered eating practices. For example, while CSC has conducted some research on self-injury, there is no existing correctional literature on disordered eating and women prisoners. This is not because disordered eating practices do not occur in prison, nor because they occur so infrequently that it is impractical to research them at length. Rather, correctional authorities simply do not view disordered eating practices as threatening, either to the safety of other prisoners or to the security of the institution. This assessment dismisses the common claim that self-injury creates a kind of social contagion effect (Ross & McKay 1979; Favazza 1989; Heney 1990; Heney & Kristiansen 1997). Moreover,

despite the harm that disordered eating practices cause an individual, because correctional researchers have not linked these behaviours to any criminogenic risk factors, eating disorders are treated as beyond the realm of official correctional mandates.

Given that criminalised women have historically been constructed as overtly dangerous and as masculinised women (Smart 1976; Kilty 2003), disordered eating practices, which are predominantly embraced by women attempting to achieve a specific ideation of acceptable and desired womanhood, actually have the effect of feminising this group of women to correctional authorities. If women prisoners are striving to attain these unrealistic (albeit accepted) standards of beauty and femininity, correctional authorities may be reconstructing disordered eating practices as indicative of the self-governing changes made by individual women. Unfortunately, this process serves to normalise anorectic and bulimic practices, and as a result it places the mental and physical health of these woman at risk. Given that 37.5% (9) of my participants engaged in disordered eating practices, this issue deserves more attention than it currently receives from correctional authorities.

My argument that disordered eating practices elicit virtually no attention from correctional staff and policies is exemplified by the fact that only Mary, who served her sentence in the now closed Kingston Prison for Women, reported that corrections responded in any way at all to her failure to eat and to her dramatic weight loss (of nearly one hundred pounds). It is highly problematic that when a woman's eating disorder becomes so dire that correctional officials can no longer ignore the behaviour, their response is the same as it is for self-injury and substance use – namely, segregation. For example, Mary stated:

> And then I started learning, cause I wanted to get rid of the weight and I did all the wrong way. I stopped eating and I started throwing up and everything, so I went down from 192 to 100 pounds and I would eat one spoonful of peanut butter a day, that was my meal, and black coffee. So when they realised what was going on, well, then they threatened me that I'd be put in seg if I didn't stop that. By then I'd done enough damage to my body that I was really sick and this one girl came up one time, she was crying, and she says, 'you look like the people in, you know, those countries where they're nothing but skin and bones'. And I couldn't see that. right.

The fact that the only response offered to anorectic behaviour is to place a woman in segregation is illustrative of the inherently punitive and disciplinary nature of corrections for women. Using segregation for women suffering from an eating disorder has three possible effects: (1) it unnecessarily reconstructs the behaviour as threatening and/or dangerous to the security of the institution; (2) it ignores the physical and mental health needs of a woman suffering from an illness that can have serious negative health consequences; and (3) it illustrates the correctional view that you can punish this kind of behaviour out of an individual rather than offering help.

It should be noted that none of the women with whom I spoke mentioned experiencing or witnessing extreme responses to disordered eating, like those seen in psychiatric and/or medical hospitals where patients who refuse food are force-fed. This may be because few of the women reached a point in their disordered eating where they had lost so much weight as to become emaciated. Few individuals actually do experience this kind of extremity in their disordered eating practices, particularly if they are bulimic. Furthermore, visible emaciation is only one of many obvious signs that an individual is suffering from an eating disorder; and the fact that the women were not force-fed should not be interpreted to mean that correctional authorities were unaware of the existence of the women's disordered eating.

While Mary was threatened with segregation, which petrified her because she felt that she did not deserve punishment since she always attempted to be a model and well-behaved prisoner, no other participants mentioned this response to their eating disorders. In fact, when I asked Emma how correctional officials responded to her bulimia, she stated:

> What did they do? Nothing really. I would eat and throw up in the toilet in my cell. I mean, when I did get in to see the shrink I just got my meds, we never even really talked about the fact that I was bulimic.

Some correctional authorities are essentially ignoring anorectic and bulimic behaviours, and potentially pathologising them as individual bouts of mental ill health that the individual should learn to control as she is reformed and transformed by corrections and correctional programming into a self-governing and responsible prisoner. Similarly Jane stated,

> No they don't watch you. If you don't eat and stuff like that. Like one of the other girls will tell them eventually, "I haven't seen her eat in three weeks." But there's no counselling for that. And they don't watch you if you're eating or not.

To ignore disordered eating – perhaps in the hopes that the women will overcome it on their own – or worse to threaten afflicted women prisoners with segregation contradicts the federal correctional mission statement which claims that a key goal of corrections is a violation of prisoner rights to safe and humane and treatment. In fact, turning a blind eye to disordered eating behaviours directly counters the mission mandate of safe and humane control; ignoring an eating disorder may prolong the behaviour, and segregation may actually increase the frequency and/or severity of this coping behaviour due to the negative impact of segregation on a prisoner's self-esteem.

Conversely, given that the Ontario provincial mandate makes no reference to the humane control of prisoners housed in provincial institutions, ignoring disordered eating practices does not technically violate it. However, the fact that there is no mention of humane control in the mandate illustrates how women's needs are ignored throughout Ontario provincial prisons – from the very mandate down to the operating (non) responses to certain behaviours. Segregation, in this instance, offers no additional value to the province's mandate of securing community safety. Ultimately, given that my participants constructed their disordered eating practices as ways of coping, failing to offer space for women to generate more positive and less harmful ways of coping suggests that correctional authorities accept this form of self-harm by criminalised women.

Abstaining and Sedating: Responding to Illicit Versus Licit Substance Use in the Carceral Context

There is a glaring inconsistency in the correctional responses to women who are found using licit (meaning prescription medication) and illicit substances while in prison. While illicit substances are obviously banned because they are against the law, licit substances are embraced by correctional and psy authorities. In both federal and provincial contexts, if a prisoner is found to have contraband in the form of an illicit substance, the substance will be confiscated and the individual will be given an institutional charge that may result in a lengthier period of imprisonment if they are found guilty. While the charge is being processed and the case investigated, the individual will serve time in an administrative segregation unit, which can only be viewed as a preliminary punishment for the infraction. For example, Dana stated:

> They used to do searches all the time in provincial. They'd just come toss your cell with no warning because there was always drugs in there. They don't search as much in federal. I got caught once with drugs and they put me in a dry cell first and then in seg. It's shit, I mean I'm already being punished and now you're going to put me in seg because I got high, I mean I didn't do anything to anyone else, you know?

Dana's narrative illustrates two different responses that may be invoked after finding a prisoner with an illicit substance. These responses reflect the institutional mandate that prisoners be abstinent and also the fact that some form of punishment will occur if these mandates are violated. Dana's account of going into a dry cell is particularly disturbing. A dry cell is one with no plumbing. It is where correctional authorities place a prisoner if they believe she has ingested some form of contraband. The hope is that when the individual does eventually defecate the correctional authorities will be able to find evidence of the contraband in order to lay charges.

Despite the persistent presence of illicit substances, the practice of dry celling illustrates the seriousness with which illicit substance use is viewed in prison. Much controversy has surrounded the continued use of dry cells; those who contest their use claim that the practice is a violation of prisoner rights to a safe and secure environment and to humane treatment (CHRC 2003). I suggest that given its punitive nature, the use of dry celling is actually a form of punishment rather than an acceptable investigatory technique. What is more, the use of administrative segregation before the individual has been found guilty of possession of contraband is also a violation of her rights.

In contrast, while a zero tolerance policy for illicit substance use exists (implying all prisoners must be abstinent), the over-prescription of psychiatric medications is rampant in both federal and provincial correctional institutions for women. Sedating women with exorbitant amounts of prescription medication is done with the intention of

rendering them more docile, more agreeable, less likely to resist, and more likely to follow institutional orders without question (Chesler 1972; Smart 1976; Ussher 1991; Russell 1995; Kilty 2006). The main issue with licit drugs is that correctional authorities, who supply women with prescription medication, do not find the use of these drugs problematic. The inability to refuse treatment without sanction is also a violation of prisoner rights. Women who do refuse prescription medications are more likely to serve longer periods of their sentences and are thus more likely to be denied parole than are women who accept their prescriptions without question and without resistance (Hannah-Moffat & Shaw 2001).

Prevention, Management, and Response to Suicide and Self-Injuries (CD 843)

The *Prevention, Management, and Response to Suicide and Self Injuries* policy, which is outlined in Commissioner's Directive No. 843 (2002c), is the policy that governs how CSC responds to self-injury. This document defines self-injury as "the deliberate harm of one's body without conscious suicidal intent" (CSC 2002c:2). The CSC differentiated self-injury from suicide or suicidal intent, which they explain is "the intentional self-inflicted injury or action that does not result in death although death was intended" (2002c:1). Nevertheless, regardless of whether prisoners attempt suicide or engage in self-injurious behaviour they will be placed on a suicide watch that calls for their isolation and mental health assessment. There is no self-injury policy at the provincial level, but the operating response remains the same. It is this similarity in the use of segregation for a woman who self-injures that was the cause of concern for many of my participants, who discussed how they did not intend to commit suicide and that they did not want to be treated as though they had.

Moreover, using segregation as the operating response to self-injury is illustrative of the redefinition of women's needs as risk factors. This shift, in turn, is symptomatic of the failure of federal corrections to fully adopt the women-centred principles of *Creating Choices*. Segregation should be deployed as a last resort, and unless the women request it, it should never be used as a response to self-harming behaviours. Despite the fact that several observers (Cookson 1977; Ross & McKay 1979; Carlen 1998) have described self-injury as having a contagion effect, it is not a threat to the security of the institution. I agree that self-injurious behaviour may be detrimental to the morale of other prisoners, but surely using segregation in full knowledge that it increases self-injurious incidents is much more so? Moreover, segregating self-injuring women rejects their view that this response is punitive. For example, regarding the use of segregation for women who have self-injured in provincial prison, Joan asserted:

> I got nothing but time to focus on the negative and the fact that I'm being punished for hurting myself. I mean, what's it to the prison that I slashed you know? How is it an offence against them? So it, yeah, it was, it is self-destructive. To me it's, you know, unless somebody is a threat to others I can't see it being a healthy place for anybody. You know, when you slash you do it alone. And to be alone in seg and you're doing that to yourself, you could die. At least if you're in a group, somebody will see it and say something. You know because I don't ask for help, it's private and embarrassing, you know?

Joan's narrative highlights the negative emotional impact of time in segregation for women who are self-injuring, where being left alone merely exacerbated the negative feelings she was already experiencing and increased her self-destructive behaviour. There was a commonality across the women's narratives, which suggested that they were confused as to why they would be punished for self-injuring. None of the participants

who self-identified as having engaged in self-injury found segregation to be helpful as a means of curbing their self-destructive behaviours.

The failure to listen to women prisoners who claimed segregation has a negative impact on their self-esteem, and more specifically on their self-injurious behaviour, reduces their narratives to an insignificant status and ultimately serves to infantilise criminalised women. This practice contravenes several tenets of *Creating Choices* that were supposedly adopted by the Service, for example: (1) segregation for women who have self-injured is disempowering rather than empowering; (2) segregation as a response to self-injury is a practice that systematically denies women respect and dignity in terms of what they identify as being helpful to them; and (3) this practice fails to provide women with the supportive environment required to help alleviate self-injurious behaviour. Moreover, the fact that the federal system uses the same response as the provincial system, which has not had the same kind of scrutiny by feminist criminologists nor the beneficial experience of the Task Force and the generation of the policy document *Creating Choices,* is indicative of CSC's resistance to real change to their correctional practices and their reliance on more traditional, punitive, risk-based, and non-feminist or non-women-centred approaches to control and intervention.

Kellie, who had served time in segregation in both provincial and federal institutions, stated with respect to her time in GVI:

> They kept saying that I was suicidal, and I'm like, 'I don't think so'! They threw me in seg on suicide watch. Took my clothes, took everything, you motherfuckers. Oh I was mad. All I got was that stupid baby doll gown, you don't get a real mattress or pillow, you don't get fuck all. I mean the gown doesn't even cover you. I just kept cutting in there, I was so upset because I didn't want to go to seg, not because I had cut myself, like I

> wasn't suicidal. If you cut they treat you the same as they do if you try to commit suicide and as if you've been charged with a misconduct.

Kellie's narrative demonstrates how, despite definitional differentiations between the two, self-injury is still regarded as a potential risk factor in suicide rather than as a coping mechanism, as it is identified by the women. None of my participants who had self-injured admitted to having been suicidal nor did they want to be transferred to segregation; in fact, they actively resisted segregation and often pleaded with correctional authorities not to go. Unless women are restrained when in segregation, which would be a complete abuse of power and would only increase a woman's anxiety and emotional distress, there is no real way to ensure that they do not harm themselves while there. Therefore, unless a woman requests to go into segregation this response should never be used for a woman who self-injures.

The current federal policy outlines three principles that supplement the overarching goal of ensuring the safety and intervention of prisoners who engage in self-injurious behaviour. The principles are as follows:

> (1) Protection of life takes precedence over preservation of evidence; (2) Self-injurious or suicidal offenders shall not be subject to disciplinary measures for their self-injurious behaviours; and (3) With the offender's consent, the input of support persons or groups shall be taken into consideration in the treatment plan to respond to the risk of self-injurious or suicidal behaviour (CSC 2002c: 2).

The third principle, which states that the individual must give consent to the generation of a treatment plan, is merely paying lip service to the voices of individual prisoners given that they may serve lengthier periods of time in segregation if they do not abide by their correctional plan. Moreover, given that self-injuring behaviour increases in segregation units, this response violates the first principle which claims that the

preservation of life, which can be interpreted as the health and well-being of the individual, takes precedence over the preservation of evidence (Cookson 1977; Liebling 1994; Carlen 1998; Fillmore & Dell 2000). Finally, segregation infringes upon the second principle, which mandates that a person cannot be subjected to disciplinary measures for said behaviour.

Similar to the use of segregation for disordered eating and substance use, this policy's validity as well as its effectiveness in dealing with self-injurious behaviour is greatly undermined because so many women prisoners are interpreting isolation as a form of punishment. For example, Mary, a former lifer at P4W, discussed the impact of having been segregated for cutting herself.

Jen: Did you feel that was the best thing to do, put you in seg?

Mary: No. It scared me to go to seg because I was the one who always tried to get along with everyone. I didn't misbehave and I wasn't doing anything to get put there. I was only hurting myself. I was just trying to get by, you know, there was no other way for me to get things out. I didn't have any other way of coping with stuff in there. I felt like I was drowning, suffocating.

Following Mary's narrative, I suggest that stripping away the only coping mechanism available to some women does not foster a supportive environment, nor does it help the women to make meaningful and responsible choices. Failing to find alternative and more helpful ways of dealing with women who engage in self-injury, and continuing to use segregation despite the women's pleas that they feel worse and confused as to why they are being punished, actually incites further self-injurious behaviour rather than curb its occurrence.

As reviewed earlier in this dissertation, both the psy and correctional literatures depict self-injury as a symptom of mental ill health and a potential symptom of a more serious psychiatric illness. Unfortunately for women in prison, there are no mental health professionals on call 24 hours a day within the institution, as they are only available during normal business hours (Heney 1990). As a result, women may have to wait up to 48 hours for professional intervention, whether it is in the form of counselling or assessment. When asked about suicide watch Brooke indicated that the conditions of segregation were the same in both levels of imprisonment:

> In seg. You have nothing and you wear a babydoll. You get a seg mattress, which is like sleeping on concrete. You don't have normal blankets either. When you're on suicide watch they have to give you, I forget what they're called but they're made specifically so you can't harm yourself with them, but it's like a sleeping bag that you can't wrap around or tie yourself up with.

Given the lack of counselling intervention and the conditions of segregation, such a strategy hardly ensures the safety of the individual, especially when self-injury occurs more frequently while in segregation or psychological units (Liebling 1994). Segregation cannot foster emotional well-being because the women are interpreting their isolation as punishment.

In this light, self-injury is misunderstood and ultimately reconstructed as a threat to the security of others as well as to the institution. In theory, self-injury is not a variable used in determining security level.[103] However, segregation cells are located in

[103] However, self-injury is a variable under the heading "other considerations" on the Security Re-Classification Scale for Women. It is currently weighted at zero when re-classifying security level because it lacks predictive ability (Hannah-Moffat, personal communication). One must question why self-injury is kept as a variable on the tool used to determine security level if it has no predictive validity. Because of a lack of empirical evidence, I cannot definitively claim that self-injury is a variable used to "override" (which allows the justification of an increase in security), but this possibility must be addressed in future research.

the secure units (which also house maximum-security women) (NIWG 2003); at the provincial level, segregation cells are similarly found in the maximum-security wing of the prison. Minimum and medium security women should not be housed in segregation unless there is a special need to do so (NIWG 2003); self-injury is apparently considered to be one of these exceptional circumstances. Although the change in security level may not be permanent, prisoners experience an increase in security designation because of their placement on suicide watch. Segregation units are the most secure units in the prison, and this increase in security for a woman can be devastating because it does not only alter her physical environment (which can cause unease and anxiety), but it also delays treatment availability and reduces the likelihood of favourable consideration for parole release (Irving and Wichmann 2001).

Because those who self-injure experience an increase in security during their stay on suicide watch, it is important to understand the reasons why a woman may have her security level increased. In Canada, the factors that most frequently lead to an increased security classification for women are as follows: (1) displaying an uncooperative attitude (refusal to participate in institutional activities such as programs or work, disruptive to staff or other inmates); (2) being convicted of serious institutional charges (such as assault); (3) expressing little or no motivation to comply with the correctional plan or programs; (4) possessing or distributing contraband (including illicit substances); and (5) having a history of being unlawfully at large (Irving and Wichmann 2001:iii). This list includes two "static factors": (1) having a history of being unlawfully at large; and (2) having been convicted of a serious institutional charge. As static factors by their nature

do not change, their inclusion predestines and makes it difficult for a woman to effect a change in her risk potential.

In 'corrections speak' risk assessment is correlated with needs assessment, where criminogenic needs (factors that if changed are expected to decrease the prisoner's risk of re-offending) are determined in order to provide treatment, therapeutic intervention, and rehabilitation (Hannah-Moffat 2005:38):

> Variables that are significant but not related to recidivism, yet require intervention, are deemed non-criminogenic needs (i.e. poverty, health) and considered a low priority in terms of intervention, except for 'humane' consideration. An intervenable need is not an individual's self perceived need, but rather it is a characteristic an individual shares with a population that has been shown to be statistically correlated with recidivism.

Ultimately, needs are defined on the basis of their intervenability and their ability to reduce risk (i.e., recidivism) (Bonta et al 1995:38). Therefore, if a prisoner has a need that is not outlined in her general programming requirements (a non-criminogenic need) that need may not be addressed. Self-injury and disordered eating are thus constructed as non-intervenable needs, and they are, in fact, reconstructed as risky behaviours – risky not just to the individual but to the security of the institution as well. Problematically, the CSC simultaneously supports the claim that self-injury is both a criminogenic and a non-criminogenic need. According to the CSC, because self-injury is not significant in predicting risk it should not be used to validate an increase in security. However, as Fortin writes, "there is evidence that self-injurious behaviour is linked to recidivism[104] and to institutional incidents of violence, substance abuse, and disciplinary problems"[105] (2004:6). This confusion indicates not only that women who self-injure are being

[104] See Bonta et al. (1995).

[105] See Wichmann et al. (2002).

punished with segregation, but also that self-injury as a non-criminogenic need is being reconstructed as a criminogenic need and thus as a risk factor.

At the federal level, once a woman self-injures in prison members of the mental health team determine the level of intervention necessary, which may range from one counselling session to segregation for monitoring and safety purposes. To determine the level of necessary intervention, the designated members of the mental health team must complete the sections of the Offender Intake Assessment (OIA) that address "mental health issues." In the next section I examine how the OIA can significantly influence the security classification of women who have self-injured. For example, because it is only the mental health aspects of the OIA that are revisited following a self-injurious incident, women who are high in *need* and who are experiencing a crisis are judged on the basis of that crisis to warrant either a period of time in segregation located in the secure units that house maximum-security women, or a transfer to one of the regional psychiatric treatment centres.

Offender Intake Assessment (OIA)

To determine the level of intervention necessary for an individual who self-injures, the mental health team re-evaluates the mental health section of the OIA for that woman. The OIA is not a policy; it is an actuarial risk assessment tool that was designed to determine at which level of security and in which institution the prisoner should reside upon her initial admission. This tool has several principal components (criminal risk assessment, case needs identification analysis, community intake assessment, initial

assessment, psychological assessments, and a criminal profile),[106] which provide a detailed synopsis of any general concerns, treatment needs and treatment issues, as well as potential for recidivism (Blanchette 1997:1). If officials see a woman as having mental health issues that cannot be directly dealt with by the prison, they may transfer her to one of the regional psychiatric treatment centres. All prisoners transferred to another institution must be re-evaluated within the parameters the OIA. Within the psychological assessments section of the OIA, the criteria for referring an individual to a psychologist for a mental health screening are as follows: (1) situational adjustment problems (anxiety, withdrawal, panic, vulnerability and feelings of inadequacy); (2) mental health (prior psychiatric admission, current psychotropic medication); (3) suicide (prior attempts, current ideation, current plan), and (4) self-*mutilation*[107] (history of self-injury, current threats) (CSC 2003:7).

After a self-injurious incident the mental health team reviews the portions of the OIA that deal with suicide, self-injury, and mental health. The mental health team consists of a "psychologist, nurse, case management officer, a psychiatrist when necessary, and other ad hoc members as needed" (CSC 2002a:1). Psychological personnel provide assessment, therapeutic intervention, crisis intervention, and program development, delivery, and evaluation. Given the power that prison psychiatrists have in terms of diagnosis, treatment and prescribing medications I find it odd and even shocking that, following a self-injurious incident, a psychiatrist is called into a mental health

[106] The Custody Rating Scale is a tool used by parole officers to determine a prisoner's initial security levels. The scale consists of accumulating scores on two key dimensions: institutional adjustment and security risk. The same Custody Rating Scale is used for both male and female prisoners, indicating a failure to differentiate between their risks and needs.

[107] I italicize this term to demonstrate how the Service uses the terms "self-mutilation" and "self-injury" interchangeably.

assessment only "when necessary". If women are segregated, medicated and isolated from their programming, I question when it would *not* be necessary. Equally strange is the fact that this same group of authorities conducts assessments that invariably impact security level, length of stay in isolation, and program delivery/evaluation. This team of experts therefore have authority over mental health care, treatment and intervention, as well as security level designations, which are subsequently dependent on the mental health evaluations.

We have witnessed an increase in the pathologisation of criminalised women as a result of correctional policies and practices (Kendall 2000:91). In practice this means correctional authorities construct women not just as mad or crazy women, but also as dangerous resistant women. The outcome of this reconstruction is an increase in custodial security. Steph, a social worker at an Ontario Efry, demonstrated this point well:

> But I guess from a prison perspective, from their perspective, well because their only concern is safety right? It's always, in prison, it's always about safety, safety, safety. Anything that can be threatening has to be stopped, so they try and stop self-injury by putting the women in segregation, which doesn't really work. I suppose they figure that by locking a woman up with absolutely nothing they can stop her from harming herself in that moment. But what about tomorrow? What about next week? I don't understand why self-injury is seen as a security issue for the prison, nor how they cannot understand that locking them up in the same place other women are punished for institutional misconduct is the wrong route to take.

Steph's narrative poses a very important question. If segregation is used to stop women from self-injuring "in the moment", what is done to stop future acts of self-injury? In this light, segregation is a band-aid solution to a larger problem. However, when examined in the context of the women's narratives we see that this band-aid

solution does little even to curb the self-injurious behaviour "in the moment", let alone to arrest such behaviour in the future.

In correctional discourse self-injury is constructed not just as the crazy behaviour of mad women, but also as a failure to self-govern according to institutional standards of desired conduct. What Hannah-Moffat has called the hybridisation of risk and need (2006) is clearly exemplified by how we explain and respond to self-injury. Self-injury, while explained through psy discourse, is actually managed in the carceral context via disciplinary and punitive regimes rather than through therapeutic interventions. The reconstruction of self-injury as a threat to institutional security demonstrates how women's needs continue to be overlooked and unaddressed.

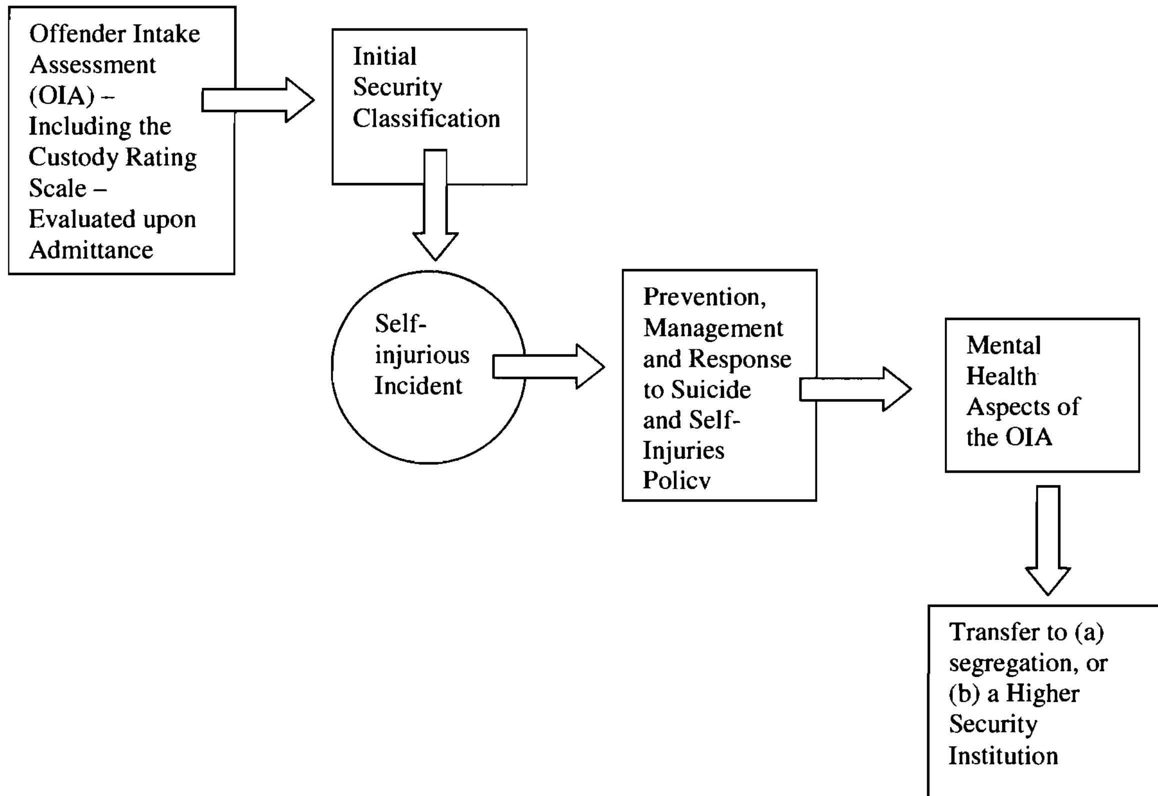

FIGURE 1: Chain of Policy and Procedural Directives Enacted After A Self-injurious Incident

The Unintended Consequences of Current Policies

Paradoxically, although prisoner advocates have indicated the need to focus on programming rather than on security, traditional risk management is thriving. In fact, risk management has become so blended with needs management throughout both levels of corrections that it is difficult to discontinue attention on actuarial risk assessment without curtailing that on women's needs. As areas of need emerge through research and activism, new risks are found to flow from them. Unless addressed, areas of need will

continue to be seen as increasing risk and potential for recidivism.[108] Although P4W is closed, the six regional facilities are in many respects merely smaller versions of the old prison (Faith 2004); the new facilities are still multilevel in security and maintain the practices of administrative segregation for women in crisis.[109]

The continued focus on risk management justifies the practices of strip searching and segregation. At both levels of imprisonment part of the segregation process entails strip-searching the prisoner. As was discussed in Chapter Five, strip searching is not only a common and unfortunately normalised component of daily prison life in provincial prison, it is also a trigger that incites some women to self-injure. Participants discussed the routine use of strip-searching for such things as missing plastic spoons when food trays were returned; this disciplinary technique was devastating for some women and incited them to cut.

Danielle recounted a similar abuse of power. She reported that some correctional officers would hold a flashlight to prisoners' vaginas while making them squat and cough and remove their tampons, in order to be sure that they were not concealing contraband. Asking a woman who is menstruating to remove her tampon during a strip-search is nothing short of degrading and dehumanizing, and is meant to maintain power over and minimise resistance by women prisoners. Similar to the use of segregation, strip

---

[108] For example, Fortin (2004) describes how each area of need (substance abuse, abuse and trauma, mental health, criminal behaviour, employment, and social programs) is related to a risk potential and a program geared to facilitate risk minimization, in the hopes of reducing recidivism. These areas of need fail to address the root causes of much of women's criminalization, for example, sexism, racism, and poverty.

[109] Although this is no longer the case, for a time after the closure of P4W, the regional institutions still housed maximum-security women in maximum-security wings in male prisons, because they viewed these women as being too high in security risk for the new multilevel prisons (Hannah-Moffat 2000a, 2001).

searching women so often (and for such trivial things) is a violation of prisoners' rights to safe, secure, and humane treatment.

After being strip-searched, women who self-injure are moved to a segregation unit, which in the new regional prisons were initially relabelled "enhanced security units," indicating a shift in language rather than practice. Currently these units house maximum-security women in all regional prisons except for the Healing Lodge, which still does not admit them.[110] Reconstructing women as crazy is done in order to justify their removal to segregation. In terms of unintended consequences, as Kathleen Kendall (2000) has observed, a continued reliance on a psy perspective maintains an acceptance of discourses that pathologise women.

Correction's failure to recognize prisoner agency and their refusal to conceptualise self-harming behaviours as coping strategies are increasing the harm done to criminalised women. Rather than providing a more conducive environment, and under the guise of segregating women "for their own safety," risk management discourses continue to allow and ultimately legitimate the use of segregation as a response to self-harm, despite the continued claim made by women prisoners that they view this response as being punitive.

If, as the literature has stated (Cookson 1977; Ross and McKay 1979; Favazza 1989; Heney 1990; Liebling 1994; Crump 1995), women in crisis who are already in a vulnerable mental state are housed alongside others who have been segregated for

---

[110] The denial of maximum-security Aboriginal women from the Healing Lodge is troubling, because of the need for Aboriginal women to heal within their own cultural milieu. A recommendation by the Canadian Human Rights Commission was for the inclusion of maximum-security women in the Healing Lodge, but this recommendation was denied by the CSC because of a lack of support and staffing at the prison.

institutional misconduct, there may be an epidemic ripple effect leading to more self-directed violence or misconduct. This potential outcome violates the mission's goal of reasonable, safe, secure, and humane control because it is not safe to house women in crisis in an environment that leads to an increase in either the frequency or severity of self-harm. What is more, if it is a standard practice to admit self-injurers to the segregation unit, then there is a strong possibility that more than one self-injuring woman will be housed there at any given time. Theoretically this practice could lead to an epidemic of self-injury, particularly if there is a 48-hour wait for psychological intervention.

All of the participants who had been segregated following a self-injurious incident were adamant that their placement in segregation was not going to arrest their self-injurious behaviour. For example, Marsha stated:

> Why would being in seg stop me from cutting? It's so stupid! I felt like shit in my cell, and I felt worse in seg. At least in the house I had some of the women to talk to, a bathtub to go relax in, you know? In seg, I'm just sittin' there, doin' nothin' but thinking about how I'm in jail again, and how I keep fucking up.

Marsha's narrative perfectly illustrates how many criminalised women find it difficult to understand the logic behind segregating them because they have self-injured. All of my participants expressed a need for increased services for women with 'mental health issues' and those specifically for women who engage in self-harm, but none could see any therapeutic or helping potential in the continued use of segregation.

The practice of stripping and segregating women who self-harm generates what are most undoubtedly unintended consequences, the most harmful of these being the increased frequency and/or severity of self-harming incidents. This research confirms

earlier conclusions that segregation inevitably increases feelings of loneliness, abandonment, and despair, which in turn can lead to a heightened risk of further self-harming behaviour (Heney 1990; CHRC 2003; Fillmore & Dell 2000; Martel 2000). For example, Shannon described the ease with which correctional officials use segregation as a response to self-injury and the impact this practice has on the women who are forced into isolation:

> They throw them in seg. That's where you see them go. That's where I went. And it is such a common thing to see; there was a lot of women who did it. I just kept cutting though. I've seen a lot of scars and I've seen a lot of women who have cut themselves. Being in seg just makes you feel worse and I don't get why they put you there.

As Shannon explains here, and as my participants indicated, self-injury was often used as a coping mechanism, but commonly one of last resort. More specifically, my participants suggested that due to the nature of correctional policies and regulations as well as the carceral environment itself, they had been stripped of other more positive or less harmful coping strategies. Therefore, using isolation to monitor self-harming women serves only to reinforce feelings of loneliness that the prison already creates, and it may encourage women to suffer in silence when they experience stress or are "in crisis." If those women who self-harm (whether it be self-injury, disordered eating, or substance use) commit a further act of self-harm as a result of their segregation, their safety, life, and personal security are being forfeited in favour of the security of the institution.

In addition, because correctional policies and responses to self-harming behaviours are gender-neutral, federal and provincial corrections are failing to recognise the substantive differences between criminalised men and women. Given that men prisoners engage in self-injury and disordered eating much less frequently than do

women prisoners, correctional policies inadvertently affect women more than they do the men.[111] Therefore, by transferring women prisoners to segregation, women are not being guaranteed their right to equal protection and equal benefit of the law without discrimination. The unique differences in areas of need between male and female prisoners as well as between different groups of female prisoners must be acknowledged to guarantee substantive equality (CHRC 2003). The specific needs of women who self-harm are not recognised in policy because the voices of female prisoners surrounding these issues are demonstrably absent from correctionalism literature. Therefore, policy reform is imperative for the protection and safety of this particularly marginalised population.

Who and What is Left Out? A Women-centred Policy

Correctionalism's focus on risk and security demonstrates that their main value is expediency, and not necessarily a concern for women's needs. Although feminists participated in the writing of *Creating Choices*, their recommendations regarding the context of penal regimes have not been properly implemented. Hannah-Moffat writes (1995:149):

> Rather than presenting a viable alternative to the problems face by the incarcerated women in the prison setting, feminist discourses, informed by therapeutic ideals are selectively immobilized. The selective integration of some feminist ideas and not others contributes to the production of a feminized social control talk dressed up in therapeutic and feminist language. In some ways, these "woman-centred reforms" only replace the discredited regimes with a less overt but nonetheless oppressive exercise in power.

[111] However, I would argue that segregation is also an inappropriate practice for men engaging in self-harming behaviours.

Correctional policies treat prisoners as threats and as objects of social control, allowing security (i.e., risks) to override women's needs. At the same time, a push for self-governance has grown within this risk-based penal system and women are expected to empower themselves within a specific correctional plan that is set out *for* them, but not *with* them. It is this responsibilising aspect of empowerment that allows it to coexist with punitive penal regimes. The result is an adaptation of feminist language to make it fit within the existing risk discourses of correctional literature, policy, and procedure.

There is a diffusion of power among psy-experts, case management workers, and correctional officials in determining the procedures for dealing with women who self-harm. Risk assessment is left to the prison psychologist whose assessment is used to determine security classification. The fact that (s)he is responsible for determining the prisoner's risk level and security classification, while simultaneously being the person with whom the prisoner is supposed to engage in therapeutic counselling, creates a conflicted role for the psychologist. It may cause frustration and distrust among prisoners if their psychologist is both their therapist and disciplinarian. How can the prisoners be expected to engage in counselling, particularly during a crisis, when the professional whom they are asked to trust with their feelings is the very person who can use this information to place them in segregation or into a higher security level? The intermingling of psy-care and risk-based security determination raises questions as to the effectiveness of the treatment orientation of the prison system. The result is that these policies are caught between treatment and punishment.

Correctional policies have yet to acknowledge the standpoints of women prisoners. Although at the federal level the CSC claims to have adopted the women-

centred principles first documented in *Creating Choices*, there is still a long way to go before there is an appropriate implementation of those principles. In fact, *Creating Choices* is now so dated that we have come to recognise missteps within it – for example, a failure to address how to house and manage women designated as maximum-security.

A feminist policy would discontinue the isolation of women experiencing crisis and would strive to recognise the voices of women in order to secure a more individualised approach to intervention. While the use of a peer support program (originally conceptualised and recommended by Heney in 1990) is a positive step toward involving prisoners in their own counselling, this program is still new, and the CSC should be careful of inadvertently creating a prisoner hierarchy whereby staff may give preferential treatment to prisoners selected for peer support training which, in turn, may cause tension among prisoners. Correctional staff must be careful when selecting peer support team members, to ensure, for example, that Native women have the opportunity to go to a peer who understands their cultural positioning. Women are generally excluded from the policy process, and it is time that their divergent discourses, identities, and standpoints are incorporated if policy is to be effective. The historic exclusion of women from the policy process has "contributed to the social relations which have enforced our silence" (CAAWS 1991:5).

For a women-centred policy to bring real change for women prisoners we require greater consensus among stakeholders when defining and explaining self-harm within women's prisons. *Creating Choices* is only a starting point from which to create correctional policy for female prisoners. Because of the document's failure to address the pressing issue of how to deal with women deemed "difficult to manage" (which would

encompass women in crisis, women in segregation, and maximum-security women), its position is far from complete. While federal corrections has at least attempted to generate a kind of woman-specific philosophy, this has not occurred at the provincial level. Ironically and sadly, the (problematic) response of segregating women for engaging in these three forms of self-harm occurs in both federal and provincial prisons for women. A continual sharing of knowledge and a refining of strategy are needed to create a dynamic process (CAAWS 1991:5). The goal is to work toward changing women's unequal status by listening to their experiences rather than by silencing them.

Chapter Summary

Although there is no doubt that the CSC has made serious attempts to improve the living conditions for federally sentenced women, more remains to be done to combat self-harming behaviour. While we should award CSC credit for offering better programming and educational or vocational training, even the Healing Lodge for First Nations women, which was considered a step forward for allowing Native women to learn and heal within their own cultural milieu, has been criticized for its failure to house maximum-security women (Faith, 2004). In the end, the additional custody and security features added to the Healing Lodge "are characteristic of maximum-security prisons" (Faith 2004:286). Sadly, Despite the fact that *Creating Choices* recommended that CSC needed to reduce its focus on risk and security to adequately address the self-identified needs of criminalised women, we have seen only an increase in the use of actuarial risk assessment tools at both the federal and provincial levels.

In fact, as this policy evaluation demonstrated, women's *need* factors are redefined as institutional *risk* factors. Correctional responses to self-harm support the

idea that self-harming women present an increased security risk, and that they jeopardize the safety of the institution. Rather than understanding these behaviours as coping mechanisms, we continue to discipline women for harming themselves. Self-harm poses no threat to the security of the institution but only to the individual woman. The use of segregation for women who self-harm suggests correctional authorities fear that leaving the prisoner in her own cell may cause an epidemic, inciting other women to harm themselves. However, this position fails to recognize two considerations: (1) that some women may fear or may not want to be transferred to segregation because their self-harming behaviour will increase as a result of the isolation; and (2) that some women may want to be removed from the general population to a more conducive therapeutic environment rather than to segregation, which they view as punishment.

As the Arbour Inquiry recommended over ten years ago, there should be an external agency to investigate the actions and inactions of the Service. I suggest that a similar agency be created at the provincial level. These agencies would constitute a regulatory system for enforcing adherence to effective, sensitive, and forward thinking policies and procedures. A therapeutic environment for women in crisis could exist if the CSC and the Ontario Ministry would acknowledge that the prison environment and the over-emphasis on rules, security, and risk factors play a role in perpetuating self-harming behaviours. I recommend that the CSC and the Ontario Ministry adopt not only a women-centred but also a prisoner-centred policy regarding self-harming behaviours. The inclusion of key feminist stakeholders as well as insight from prisoners could enlighten the more traditional position held by corrections, and the policies would enable a more holistic understanding of self-harm, thus providing a more therapeutic and

effective approach to dealing with it. Because policy cannot be separated from social context, we should acknowledge that, "the potentially differential effects of policies, programs and legislation on women or men can often be masked or obscured. When gender is explicitly considered in policy analysis, these effects are revealed, and previously hidden implications come to light" (Status of Women Canada 1996).

In the next chapter, I draw together the main themes and conclusions that have emerged from this research experience. I also propose next steps and important pathways for future research, activism, and policy reform as they pertain to the issues of self-harm committed by criminalised women.

Chapter 9
Concluding Remarks and Ideas for Future Research

Brooke: I'm just so glad you wanted to talk to me. I mean it's not easy to talk about this stuff, but nobody ever seems to want to listen to anything a bunch of us ex-cons have to say, you know? I hope people listen to what you write, you know, maybe then they will hear us. Maybe then they'll see that lots of things need to be changed.

Situating This and Other Research on Criminalised Women

The opening passage of this chapter is illustrative of a common statement made by the participants of this study. All of my participants exclaimed that they were not only thrilled to be a part of a research project, but that they were appreciative of the opportunity this gave them to tell their stories, and ultimately just to be heard. This passage supports the long-standing feminist argument that criminalised women have historically been either excluded or relegated to a position of secondary importance in social science research. Despite the advances made by feminists over the course of the past few decades in terms of making research on women's issues of primary concern in different social science fields, recent governmental shifts illustrate the maintenance – and in fact even a resurgence – of the unfortunate historical tendency for research, law and policy to marginalise women. For example, as recently as September of 2007, the conservative Canadian federal government drastically cut funding for national women's organisations. This budget cut caused the National Association of Women and the Law

(NAWL)[112] to shut down their office and lay off their entire staff, after thirty-three years of service. As a discipline, criminology is not exempt from the practice of marginalising women in research. But it is not enough just to conduct research on women's issues. One must do so from feminist theoretical and methodological frameworks.

The historical marginalisation of research on women who have been criminalised is linked to the fact that so few women in comparison to men actually are criminalised (Adelberg & Currie 1987; Comack 2006). Because of this fact, women prisoners receive less governmental funding, fewer services, and programming initially constructed for the very different needs of criminalised men. Moreover, conventional constructions of criminalised women as dangerous and irrational have resulted in their being subject to unnecessarily strict forms of punishment and security while housed in Canadian prisons. The needs of criminalised women are frequently reconstructed as risks or as threats to the security of the institution in which they are housed. As discussed in Chapter One, the most extreme example of corrections' focus on security, discipline, and punishment remains the cell extraction, strip-searching, and body cavity searching of eight federally sentenced women by a male Institutional Emergency Response Team at the now closed Kingston Prison for Women in 1994.[113] While CSC has tended to portray this 'incident' as an unfortunate and extraordinary blot upon the history of Canadian corrections, it is by no means unique. As recently as October of 2007, a nineteen-year-old woman housed in the Grand Valley Institution in Kitchener Ontario was found dead due to asphyxiation.

---

[112] Since 1974, the National Association of Women and the Law has advocated for substantive equality for women under the law. Most notably, NAWL fought to have substantive equality guaranteed under section 15 of the Canadian Charter of Rights and Freedoms (http://www.nawl.ca/ accessed September 2007).

[113] For more detail on what has come to be known as "the incident" at the Prison for Women, please refer to Arbour Inquiry (1996), which provides a detailed and critical socio-legal analysis of the events.

Three correctional officers have been charged with criminal negligence causing death for their failure to intervene as the woman tightened a bed sheet around her neck until she died.

The work presented in this dissertation builds on existing feminist literature that highlights women's voices and is concerned with the issues facing women in Canadian prisons (Comack 1996; Comack & Balfour 2004, Martel 2000). By adopting a feminist theoretical and methodological framework I have been able to put the voices of a traditionally marginalised group of women at the core of this entire research project. Re-centring women's voices enabled me to analyse their discourses through a feminist lens that incorporates analyses of race/ethnicity, class, and gender. This project has taken the better part of two and a half years to complete. However, despite the time and stress involved, the long journey has been both inspiring and rewarding.

I conducted a total of 26 interviews with women who had been incarcerated (provincially and federally) but who were now living in the community, as well as with social workers who work with criminalised women in a variety of capacities in the community. It became apparent very early in the interview process that my initial interest in self-injury was too narrow in scope, and that self-injury was only one of three self-harming behaviours identified and adopted by the participants as a strategy of coping. Because there is so little research on self-injury and disordered eating as they affect criminalised populations, I did not foresee the importance and strength of the connection between these behaviours. In addition, the women's constructions of their uses of both licit and illicit drugs provided the basis for discussion regarding the accepted methods of social control adopted by corrections. Overall, one of the most intriguing

findings of this research has been that the three forms of self-harming behaviour identified by the participants of this study (self-injury, disordered eating, and licit and illicit substance use) actually operate in different ways but work to serve the same end – coping.

Important Contributions of this Research

This research is exploratory in nature. The goal was to discover how the experience of imprisonment impacts how women cope. The primary research objectives were to: (1) learn how women cope inside and outside of prison, and uncover whether any differences exist between the experiences described by federally and provincially sentenced women; (2) uncover how correctional officials respond to self-harming behaviours; (3) engage in a theoretical discussion about women's coping strategies; and (4) attempt to offer a space for the women to find more positive (less harmful) methods of coping.

From these objectives a series of research questions emerged,[114] which helped structure this dissertation. I was able to address all of the research questions throughout the tenure of this research. For example, one of the most important findings of this research is that criminalised women do in fact engage in different self-harming behaviours, and that they adopt them as ways of coping with the stress of their lives. Participants identified three different forms of self-harm – self-injury, disordered eating, and licit and illicit substance use. These women used self-harm as coping strategies, but there were differences in what the behaviours offered them. Participants described using self-injury and disordered eating as techniques both to feel pain and to try and secure

[114] My research questions are set out in Chapter Four.

some control over their lives, which they felt were out of control in many different ways. This explanation differed from the women's constructions of their substance use, which they described as a method of avoiding pain and emotional stress by numbing and freezing their emotional selves. Interestingly, while most women acknowledged the over-prescription of psychiatric medications at both levels of imprisonment, few recognised licit substance use as a form of addiction. Instead, they constructed it merely as an aid for them to cope. Many women had not been prescribed medications in the community, but they began to depend on them while inside, and subsequently continued to use them once released.

While some women began self-injuring and/or engaging in disordered eating practices while in prison, others did so before going to prison. It was clear, however, that the use of these self-harming coping strategies was heightened while the women were incarcerated, and that some women continued to engage in self-injury and disordered eating upon their release. It was also evident that those participants who had problems with illicit substances experienced these difficulties prior to imprisonment – in fact, illicit substance use was often the cause of their imprisonment.

There were no differences between the discourses of federally and provincially sentenced women with respect to how they explained the three forms of self-harm, nor with respect to their continued practice of these behaviours upon release from prison. What is more, Aboriginal or First Nations women (41% of sample) and white women (59% of sample) also described these self-harming behaviours in the same ways. This finding suggests that the functions the three forms of self-harm serve for criminalised women are universal. However, there were identifiable differences in how the women

described illicit substance use when examined by class. These variations increased when the person had not engaged in illicit substance use herself, and when the status of motherhood was considered. One participant in particular, who came from a white middle class family, expressed idealised notions of womanhood and motherhood, of the traditional (nuclear) family, and of women's gendered role within that family. For her, substance use was an indicator of a woman's failure at being a good mother. This research was eye opening as it truly illustrated the diversity as well as the similarities across criminalised women, among social workers, and among the correctional authorities with whom the women had contact while inside. Given that none of these groups were homogeneous in how they spoke about the issues being raised, my project is a testament to the importance of placing participants' standpoints at the centre of research.

Research Implications for Correctional Policy and Practice

This research highlights the fact that, despite the claimed women-centred philosophy of federal corrections for women in Canada, the responses to certain kinds of behaviours still parallel those operating in the provincial prison system. Little change at the federal correctional level has actually occurred in practice. As Jan Heney found in 1990, and like their provincial counterparts, federally sentenced women are still being punished via isolation and time in segregation for self-injurious behaviour. The

institutional practice of segregating women who are in crisis poses an increased threat to their health and welfare.[115]

In addition, I found that for criminalised women there is a clear link between being strip-searched and engaging in self-injury. Both of these institutional responses (segregation and strip-searching) forfeit the safety, health and well-being of prisoners based on unfounded claims about the existence of risks to institutional security. The continued (over) reliance on strip-searching women in prison ignores the fact that many criminalised women have histories of abuse and trauma that often include sexual assault (Comack 1996; Faith 1993; Frigon 2002). Strip-searching is a degrading and dehumanising practice that is used far too often in prisons for women in Canada, particularly at the provincial level where some groups of women are stripped daily (all those who have been deemed to be 'model prisoners' and who have made their way onto the work range). Given the argument that strip-searching is a violation of the women's Charter rights to life, liberty and security of the person, this practice should be viewed and used only as a last resort rather than a normalised institutional technology used to engender the social control of criminalised women.

Disordered eating practices (namely anorectic and bulimic practices) on the part of criminalised women receive much less attention in the carceral context than does self-injury. This is due to two reasons. First, it is easier to hide an eating disorder. Second, disordered eating is not considered to be life threatening in the way that self-injury is. The visual scars left by self-injury may make correctional authorities more conscious of

[115] The unintended consequences and potential violation of the Canadian Charter of Rights and Freedoms that the practice of segregation as a response to self-injurious behaviour poses were discussed at length in Chapter Eight.

the potential harm that it may cause; this argument is reflected by the fact that self-injury is responded to in the same way as are suicide attempts.

At the federal level, while cottage style facilities may be viewed as a way forward or as an improvement in the carceral conditions for women, they pose a more disturbing unintended consequence with respect to self-harming behaviours – particularly self-injury and disordered eating. Given that women are housed in their own 'cottages' they have less contact with correctional officials and it is therefore easier to ignore the fact that some women are self-harming. For corrections, turning a blind eye and sidestepping responsibility for offering care or services for a self-injurious, anorectic or bulimic woman in prison has never been so easy.

While illicit substance use is illegal –and it is therefore logical to penalize prisoners found to have contraband in the form of some kind of illicit drug – there is an obvious and troubling paradox in how licit and illicit substances are treated by corrections. The participants in this study identified both prescription and street drug use as coping strategies. The paradox in corrections' response to these two forms of substance use comes from their use of disciplinary segregation and institutional charging of prisoners who are caught with illicit substances, while at the same time encouraging prisoners to take a multitude of different prescription medications – to the extent that many participants reported having "slept through their time". My participants described taking prescription medications as being similar to taking medicine for a physical illness (i.e. antibiotics for influenza), and often spoke of "needing" these medications "to function". In fact, several women who had not taken prescription medications prior to imprisonment found themselves dependent on them upon their release. Moreover, many

women who were addicted to illicit drugs left prison dependent on both licit and illicit drugs.

Correctional authorities use (or threaten to use) segregation as a response to all three forms of self-harm identified and discussed in this study. Policy reform is required so that women who are harming themselves are not punished for it. Moreover, officials should also consider increasing the availability of counselling and other forms of care. Criminalised women should have greater access to services and treatment plans that they view as being potentially helpful to them. Similarly, criminalised women should not be punished for opting out of a certain treatment, for example refusing to take prescribed medications or to enrol in certain correctional programs.

More consistency in correctional responses to licit and illicit substance use is needed. Women found in possession of narcotics should not be segregated and charged with an institutional misconduct. In fact, persons who are criminalised as a result of their substance use should not be sentenced so easily to time in prison, which does little to arrest substance-using behaviour, particularly at the provincial level where there is no programming. Rather, there should be an increase in available drug treatment services for individuals with substance use issues or addictions. Access to services is particularly important given that criminalised persons are often refused entry into drug treatment programs and/or centres.

Theoretical Findings and Contributions

Much contemporary critical criminological research draws heavily on Foucauldian and governmentality inspired theoretical perspectives. However, these

studies often fall short by not grounding their arguments in empirical work. This shortcoming discredits this theoretical framework by opening it up to criticism from both the conservative right and quantitative researchers who are increasingly demanding evidence based conclusions. To combat this limitation, instead of making governmentality my central theoretical framework, I borrowed certain concepts that contextualise the current political and carceral climates that are rooted in neoliberalism.

In addition, I drew on feminist literature that examines how the 'psy' sciences have historically pathologised women. This literature is key to deconstructing psy as a technology of social control, and to understanding its influence on corrections for women. When we consider the neoliberal inclination toward and society's increasing focus on self-responsibilisation in conjunction with the historic and continued practice of pathologising criminalised women, the current correctional strategies and programming discourses begin to make more sense. Women in prison find themselves continually subject to the gazes of medicine, psychology and psychiatry. Yet their mental health statuses are re-inscribed as merely one of many other prospective criminogenic risk factors. Each woman is now expected to govern herself appropriately, responsibly, and prudently according to the standards of acceptable behaviour identified for her by correctional experts.

In order to manage their own risk potentials, and to address their own needs, criminalised women must engage in a series of programs and forms of treatment. Illustrating correction's reliance on neoliberal discourses, the goal of these programs and treatments is to reform the prisoner into becoming a self-governing individual. Correctional attempts at reformation operate through a discourse of self-care, of which

the ultimate goal is to alter an individual's understandings of their own identities. Understanding identity to be a simultaneously fluid and fixed construct offers the individual the space to resist those identity labels that carry stigma and that have the potential to harm our feelings toward and beliefs about our selves and self-worth.

This research challenges the dichotomisation of issues and demonstrates how using simple binaries to frame such important issues essentialises both positions and confines debate to only the two available options. In order to deconstruct this either/or pairing I have discussed the relatedness between several conceptual dichotomies – public/private, agency/structure, compliance/resistance, and fixed/fluid identity. Moreover, this research tracks the historic divide between classical and positivist approaches to criminalised women. Dichotomous thought serves to maintain the status quo by failing to allow for space to analyse these issues in ways that go beyond classical and positivist paradigms. My research demonstrates how the classical/positivist divide is not a divide at all; the two paradigms are not mutually exclusive and are thus related on a continuum. This finding was clearest in the discussions of licit and illicit substance use. The fact that most women dichotomised addiction as either a choice or a disease illustrates this divide and the corresponding practices of responsibilisation/pathologisation used in response to addiction.

The classical school is commonly associated with (neo) liberal thought, and underscores concepts such as choice, responsibilisation, agency and free will; alternatively the positivist school is characterised by concepts such as determinism, pathologisation and disease. Illustrating their relatedness, both approaches also simultaneously emphasise individualism – classical discourse suggesting that the cause of

addiction is our weak will/mind reflected in poor decision-making; positivist discourse suggesting that the cause of addiction is intrinsic to our biology. In terms of identity, my participants constructed their 'addict selves' as distinct and separate from their 'true selves'. This finding demonstrates how identity is simultaneously fluid and fixed and the argument that to post binary constructs in opposition to one another is inappropriate, as they are more related than dichotomous thought generally allows for. The relatedness of classical and positivist explanations was demonstrated in my examination of psy practices. In the carceral context psy (composed of historically positivist approaches) functions through neoliberal discourses that stress choice, responsibility and self-care.

By understanding the relatedness of what appear to be mutually exclusive binary concepts we see how the boundaries between the public and private are now blurred, how compliance can actually be a form of resistance, and how agency is in fact always already constrained by different structural forces. For example, women had little ability to resist taking prescription medications in prison. In fact, most correctional authorities and/or experts encouraged licit substance use, whereas illicit substances were approached in a punitive way. Positing the two as mutually exclusive ignores the fact that they are both forms of substance use and actually serve similar ends for the women – namely, coping. Unfortunately while illicit substance use is punished, the over-medicalisation and prescription of psy medications illustrate how correctional authorities are actually creating drug reliance in some women. Corrections treats illicit substance use as though it is a poor choice, at the same time as it reconstructs prescription drug use as a tool to combat positivist psy-based or medical diagnoses. Ultimately, reliance on classical or positivist approaches to criminalised women is not indicative of singular shifts in penal

discourses and practices. Rather, the two operate at the same time, and often times together in mutually reinforcing ways.

Pathways for Future Research

This dissertation builds on and thus contributes to the fields of critical studies, feminism, women's studies, criminology, sociology, law, policy and legal studies. The research helps fill a gap in criminological literature by examining the positionality and material realities of a marginalised and criminalised population. However, because I relied exclusively on the narratives of former prisoners now living in the community, it would be advantageous to expand the participant population pool by interviewing women who are still in prison. Moreover, an important avenue for future research would be to examine how young women (aged 12-18) and adult men discuss these issues. Are young girls and men who are criminalised also segregated as a response to their self-harming behaviours? Do these groups even construct self-harming behaviours as coping strategies? If not, how do they explain them?

It is important to note that correctional authorities keep no official records of self-injurious and disordered eating behaviours. Therefore we do not know the extent, frequency, or severity of those acts, as they are committed in prison. With no official documentation of these behaviours it is easier to claim either that they do not occur, or that they occur infrequently, rendering them 'non-issues' for correctional authorities. As a result, an important avenue for future research would be to conduct a survey that would evaluate the extent, frequency and severity of self-injurious, disordered eating, and substance using behaviour in prison, as well as the correctional responses to these three forms of self-harm. It is important that we begin to pinpoint more clearly when and why

criminalised women engage in self-harming behaviours – to do this requires that we conduct survey research and life history interviews.

The theoretical discussion of identity and citizenship generated in this work opens up a new vista of possibilities for securing changes in the conditions, programs, use of punishment, and the resources available to women in prison. My hope is that others will begin to theorise identity (politics) and citizenship and that they do so in a way that embraces empirical research and thus the voices of the individuals being 'theorised about'. In terms of moving forward, women's and prisoner's advocacy groups such as Canadian Association of Elizabeth Fry Societies (CAEFS), should embrace the discussion of citizenship proffered here as a way to structure their demands for change in the conditions of imprisonment experienced by our sisters (and brothers) inside. To engender a collectivising mobility amongst criminalised women may take a great deal of advocacy, as well as public education and awareness, but this is one avenue forward that offers the potential for change with respect to the conditions of incarceration experienced by women in prison in Canada. We should look at how female political prisoners in Ireland (Corcoran 2006) were able to collectivise and resist the conditions of their imprisonment. These women made citizenship claims based on their status as political prisoners. I believe that criminalised women should have the opportunity to make similar demands based on their psychiatric and biological identities and citizenship statuses.

Ultimately, theorising identity as the basis for new kinds of citizenship opens the door to a new vista of research as praxis. Demands for change based in discussions of citizenship, coupled with the important findings of the 2003 Canadian Human Rights Commission Report *Protecting Their Rights: A Systemic Review of Human Rights in*

Correctional Services for Federally Sentenced Women, should provide advocacy groups with the momentum, and the theoretical and political space with which to make valid legal demands for change in prison conditions for women in Canadian prisons.

Appendix A: Interview Schedule for Former Prisoners

I. Carceral Life

1. Can you describe what is/was a typical day for you in prison?

2. Can you describe what is/was a typical day for you outside prison?

3. What kinds of images did you have of prison/prisoners before you came to prison?

   a. Where did you get these images?
   b. Were they accurate images or descriptions? Explain.
   c. Describe how you felt when you first arrived in prison?
   d. What is/was the reality of prison when compared to media portrayals? Or other portrayals? Friends, family etc?
   e. How are/were you treated by staff and guards? How do/did you interact with them?

4. What surprised you most about prison?

II. Coping

1. How did you pass time when you were outside of prison? Prior to prison? Afterwards for any community-based participants?

   a. What activities or programs were you involved in?
   b. What behaviours and responses does a woman need in order to cope outside of prison?

2. How did you cope with pain, stress or sadness when you were outside of prison?

   a. What activities, responses, behaviours or thoughts do you use to get by?
   b. Why were these strategies the most effective outside prison?

3. How do/did you pass your time while in prison?

   a. What activities or programs are/were you involved in?
   b. What ways of responding, strengths, attitudes, or character traits does a woman need in order to do time comfortably?
   c. Can you describe any experiences of violence or other disturbing experiences that you have experienced or observed?

4. How do you cope with being in prison?

a. What activities, responses, behaviours or thoughts do you use to get by?
b. Why are these strategies the most effective inside prison?
c. Do you feel that you are the same person as you were before coming to prison? Explain.
d. Is it hard to make friends with or trust other prisoners? How do you make [keep? lose?] friends?

5. What prison programs have you taken, or are you taking now?

6. Do you feel that the completion of programs and undergoing counselling improves your chances at parole? Why or why not? And [how] do they help you otherwise?

7. Would you consent to continue taking any of these programs if there were no records kept about who completes the programs? If yes, which and why? If no, why not, or, doesn't it make any difference one-way or the other?

8. How do you see your responsibility for your offence today, in comparison to when you were convicted?

   a. Do you have sole responsibility for your offence? Why or why not?
   b. How did your actions affect others? And yourself? Explain.

9. Can you talk about your relationships with your family and friends since you've come to prison?

   a. How do you cope with the separation from family and friends?
   b. Has prison affected your relationships with family and friends? If yes, how?

10. What happens when you can't cope in prison? What happened when you couldn't cope outside of prison?

11. What constitutes being in a "crisis" while in prison? What would constitute a crisis if you were not in prison?

    a. Have you been you put in the care of medical or other professionals/experts? If yes, for how long? Did they help you through the crisis? Explain.
    b. Have you been placed in segregation? If yes, for how long? Did segregation help you through the crisis? Explain.
    c. Did your period in segregation impact how you feel about prison? About yourself? If yes, how?

12. What happens when you are in crisis (inside and outside of prison)?

13. Why do you feel segregation is used? (administrative segregation, disciplinary segregation?)

    a. Does segregation help you to cope? How or why not?
    b. Have you ever requested to go into administrative segregation? If yes, why?

c. How do you feel about the use of segregation for a woman in crisis?
d. What were your experiences of segregation like?
e. Is segregation used too frequently?

III. Identity

1. What characteristics would you say best described you before you came to prison? Now that you are in prison?

2. Has prison changed the way your feel about yourself? How and why? Are there any aspects about yourself that you feel you have lost and / or gained? since coming to prison?

3. Do you think that prison changed the way others (family, friends, and strangers) feel about/view you? And how you feel about them? How and why?

4. How have these images/perceptions of prison, prison life and what it means to be a prisoner affected how you feel about yourself and who you are?

5. What would you say it means to be a woman? What defines womanhood?

   a. Where did you learn this? From whom?
   b. What traits do you value in women?
   c. Are there different standards of femininity in prison as opposed to outside prison? Or do you mean variations of standards within prison?
   d. Are there natural differences between men and women? If yes, what are they?
   e. What defines you as a girl or as a woman?

6. How would you describe the stereotypes of women in prison? Where do you see / hear these stereotypes? Where do they come from?

   a. Do you feel that these stereotypes are accurate or inaccurate? Explain.
   b. Do you feel that any of these stereotypes describe you? How so? Or how not?
   c. How do you feel being labelled a woman prisoner will affect/has affected you upon release?
   d. Do/did you resist the stereotypes associated with being a woman prisoner? If yes, how?

7. Has prison changed your identity? How?

   a. Has prison altered how you define what being a woman means? Explain.
   b. Does/did prison alter your personality? How? In what ways?
   c. Has prison changed how you view others? How?
   d. If you spent time in segregation, did it impact how you feel about prison? About yourself? If yes, how?

8. Do you feel that the programs or the counselling have changed you in any way? If yes, explain.

a. Are you "the same person" you were at the time of your offence? Explain.
b. Do you resist any programming or counselling? If yes, how?
c. Does resisting programming or counselling impact a prisoner?
d. What are the advantages gained from the programs/treatment you have had?
e. What are the disadvantages of the programs/treatment you have had?
f. Is there anything that you would change about any of the programs or the counselling you have had? Explain.

9. To what extent do the programs or counselling make you focus on your status as an offender? A victim? A survivor?

10. Do/did the programs/ therapists/ staff make assumptions about women prisoners that aren't true? Explain.

IV. Life History

1. What was your home-life like before you came to prison?

   a. Can you describe any stressful events that occurred during this part of your life? How did you cope with that stress?

2. Were you and your family ever deprived of money?

   a. If yes, can you describe how being poor affected you and your family?
   b. How did you cope with being poor?

3. Did racism ever affect you or your family? If yes, how?

   a. How did you cope with the impact of racism?

4. Were you ever treated differently or negatively because of your sex?

   a. How did you cope with the impact of sexism?

5. At what point did you leave school? Why did you leave?

6. When you were growing up, who were your heroes?

   a. Were any of them women? If yes, what qualities did you like about these women?

7. Do you feel that women have a harder time in life than do men? Explain.

8. When you were growing up, what was missing most from your life?

   a. When were you the happiest? Saddest? Most angry? Most afraid?

   b. How did you deal with fear and sadness?

9. What does power mean to you?

a. How did you come to define or explain power this way?
b. Did you have power while you were growing up?
c. How did you gain or lose power?
d. Who around you had power?
e. Did anyone have power 'over' you while you were growing up? If yes, who?
f. How did they exert this power?

10. Was it easy or difficult for you to express your emotions as a child and as an adolescent?

    a. Fear, anger, frustration, happiness, sadness?
    b. How did you express these emotions?
    c. How did you cope with these emotions? What actions did you take?

V. Concluding Questions

1. What is/was expected of you while in prison? From the staff, other prisoners, yourself?

2. What is/was expected of you when you are released? From your family, CSC? Yourself?

3. How did you feel or how do you think you will feel to be released? Excited, thankful, scared, fearful, nervous, anxious, happy?

4. Was or do you think that your release will be a stressful event? How do you think you will cope?

5. What is the greatest misunderstanding about woman prisoners?

6. Is there anything that I haven't asked you about that you would like to talk about, or anything that you would like to ask me?

Appendix B: Interview Schedule for Staff

I. Job description

1. What is your job title and what is your job description?

    a. How much time do you spend with the women on a daily basis?
    b. How do you interact with the women? How do you spend your time with them?
    c. What is expected of you with respect to your job? From the women prisoners? The other staff members? Administration?

II. Perceptions of Prisoner Coping

2. From your perspective, do most of the women in this institution cope successfully with their imprisonment? Why or why not?

2. What do the women do to pass time while in prison?

    a. What activities or programs are they involved in?
    b. What behaviours and responses does a woman need in order to do time comfortably?
    c. Can you describe any experiences of violence or other disturbing experiences that you have experienced or observed in prison?

3. What do women do to cope with prison life?

    a. Positive ways they cope? (actions/ behaviours?)
    b. Negative ways they cope? (actions/ behaviours?)
    c. What methods of coping do you see as being the most effective inside prison?

4. Do you think that the women change or need to change their coping strategies when they enter prison? Why?

5. How do you think prison changes the women? Explain.

6. Do you feel that the completion of programs and undergoing counselling impacts the women's chances at parole? In what way (positively, negatively, or not at all)?

7. Do you think that the women would consent to continue taking any of these programs if they had no impact on their chances at receiving parole? If yes, which and why?

8. Do you think that the women would consent to continue taking any of these programs if there were no records kept about who completes the programs? If yes, which and why?

9. Do the women take responsibility for their offences? Does their level of acceptance of responsibility change across the course of their sentences?

   a. Do the women suggest that responsibility for their offences lies with someone else? If yes, who and why? Do the women accept responsibility for any misbehaviour in the prison?

10. What sorts of things trouble or stress the women the most?

    a. Family separation? Imprisonment? Substance abuse? Anger management?
    b. How do they deal or cope with these troubling things?

11. Do the women have much contact with their families?

    a. How do they cope with the separation?

12. Do the women ever resist prison rules?

    a. How do they resist?
    b. What are some of the things they try and resist?
    c. Why do you think they resist?
    d. How would you react to such resistance? What happens to the women when they resist?

13. How do you feel the prisoners treat you? And how do you feel you treat the prisoners?

III. Perceptions of Prisoner Identity

1. Do you think prison affects the self-esteem of individual prisoners? If yes, how?

2. Do you think that prison changes the way the women prisoners feel about themselves? How and why?

3. Do you think that the women's status as 'prisoner' changes the way others (family, friends, and strangers) feel about/view them? And how prisoners feel about others? How and why?

4. Can you describe the kinds of images you had of prison, prisoners, and prison life before you started to work in a prison?

   a. Where did you get these images?
   b. Were they accurate images or descriptions? Explain.
   c. What kinds of images do you now have of prison, prisoners, and prison life?

5. How do you think these images/perceptions of prison, prison life and what it means to be a prisoner affect how prisoners feel about themselves and who they are?

6. What are some of the general stereotypes that you are aware of regarding woman prisoners?

   a. Do you feel that these stereotypes are accurate or inaccurate? Explain.
   b. How do you think being labelled a woman prisoner will affect the women upon release?
   c. Do any of the women resist the stereotypes associated with being a prisoner? How?

7. Do you think being in prison changes the identity of the individual prisoner? How?

   a. Do you think there is a different standard of womanhood in prison when compared to being outside prison? Femininity? Explain.
   b. Does being in prison alter your personality? Or the personality of prisoners? How? In what ways?
   c. Do you think being in prison changes how you or prisoners view others? How others view you? Or how they view prisoners? How?

8. Do you feel that the programs or the counselling changes the prisoners in any way? If yes, please explain.

   a. Do you see changes in the women throughout their sentences? Positive/ Negative? Explain.
   b. Do any of the women resist programming or counselling? If yes, how?
   c. Does resisting programming or counselling impact a prisoner negatively?
   d. What are the advantages gained from the programs/treatment?
   e. What are the disadvantages of the programs/treatment?
   f. Is there anything that you would change about any of the programs/counselling that is available? Explain

9. To what extent do the programs or counselling make the women focus on their status as an offender? A victim? A survivor?

10. Do the programs/ therapists/ staff make any assumptions about women prisoners that aren't true?

11. What characteristics would you say best describe the prisoners?

12. What is the greatest public and / or general misunderstanding about woman prisoners?

IV. Policy and Procedure

1. From a staff perspective, how would you define a crisis? What kinds of things/actions/behaviours would constitute a crisis? Would you consider these examples as constituting a crisis if you were not in prison?

   a. What happens when a prisoner is in crisis (inside prison)?
   b. Is the woman put in the care of medical or other professionals/experts?
   c. Is segregation used? If yes, explain. For how long?
   d. How do the women cope with being placed in segregation?
   e. Do you think that a period in segregation can impact how the women feel about prison? About themselves? If yes, how?

2. What happens when a woman is in crisis?

   a. What are the procedures/policy invoked to deal with a woman in crisis?

3. What is the difference between administrative segregation and disciplinary segregation?

   a. For what reasons would a woman be placed in administrative or disciplinary segregation?
   b. How long can the women remain in administrative or disciplinary segregation?
   c. What purposes do administrative and disciplinary segregation serve? For the staff? Other prisoners? The institution? The individual woman?
   d. Are there any official reasons for placing women in administrative or disciplinary segregation with which you disagree? Explain.
   e. Do you feel that the staff is sometimes too quick or too slow to use segregation? Do they use it as a threat?
   f. How do the women react to being put in administrative segregation? Disciplinary segregation?
   g. How do you feel about the use of segregation for a woman in crisis?
   h. How do women in crisis react when they are placed in administrative or disciplinary segregation?
   i. Do the women ever request to go into administrative segregation? If yes, why?

IV. Concluding Questions

1. What is expected of you as an employee of the prison? From the administration? From other staff? From the prisoners? From yourself?

2. What do you think the public expects prisons to do for prisoners?

3. How do you think the women will feel to be released? Excited, thankful, scared, fearful, nervous, anxious, happy?

4. Do you think that their release will be a stressful event? How do you think they will cope?

5. What is the greatest misunderstanding about woman prisoners?

6. Is there anything that I haven't asked you about that you would like to talk about, or that you would like to ask me?

Appendix C: Information Sheet for Participants (Former Prisoners)

Title of Project: *Confined Identities: Women's Strategies for Coping in Prison*
This research is being conducted as part of the fulfilment of the requirements for the degree of Ph. D. for Jennifer M. Kilty, through the School of Criminology at Simon Fraser University, Burnaby BC.

I would like to ask you questions about your life before you came to prison, and about your life since your arrival in prison. I would like you to talk as freely as you can. I would also like to discuss what prison life is like for you, particularly how you cope with your imprisonment. I would also like to discuss your involvement in programming and any counselling you may have had in prison. Some questions are of a personal nature and if you are concerned or feel uncomfortable, I encourage you to request support.

The interviews will be tape-recorded so that I have the opportunity to listen to your voice rather than referring only to notes that I make throughout the interview. I will transcribe the taped interviews into written format, but no one other than myself will have access to either the taped or the transcribed interviews. No one associated with the Ministry of Community Safety and Correctional Services, CSC or the prison will have access to the tapes.

Your participation is voluntary. You may withdraw your participation at any time. You will have complete anonymity and confidentiality. Your name and any identifying features will not be recorded unless you request them to be. The tapes and the transcripts will be locked in a secure location that only I have access to. You may obtain copies of the results of this study by contacting Jennifer Kilty at the School of Criminology, Simon Fraser University, 8888 University Drive, Burnaby BC, V5A 1S6.

Goals of the research:

1. To understand how life changes for women who are in prison and how they cope with imprisonment.
2. To learn about women's views and experiences of imprisonment, and give them a space to be heard.
3. To learn about staff views and experiences of working with women prisoners.
4. To understand when and why segregation is used with women prisoners.
5. To provide reliable research results to the community, advocates, service delivery personnel and policy makers.

Appendix D: Information Sheet for Participants (Staff)

Title of Project: Confined Identities: Women's Strategies for Coping in Prison
This research is being conducted as part of the fulfilment of the requirements for the degree of Ph. D. for Jennifer M. Kilty, through the School of Criminology at Simon Fraser University, Burnaby BC.

I would like to ask you questions regarding your job duties and requirements. I would like you to discuss your involvement with the prisoners; for example how you interact with them generally or on a daily basis. I would like you to explain the steps taken when a woman is in crisis, as well as how you define a crisis for women in such a setting.

The interviews will be tape-recorded so that I have the opportunity to listen to your voice rather than referring only to notes that I make throughout the interview. I will transcribe the taped interviews into written format, but no one other than myself will have access to either the taped or the transcribed interviews. No one associated with the Ministry of Community Safety and Correctional Services, CSC or the prison will have access to the tapes.

Your participation is voluntary. You may withdraw your participation at any time. You will have complete anonymity and confidentiality. Your name or any identifying features will not be recorded unless you request them to be. The tapes and the transcripts will be locked in a secure location that only I have access to. You may obtain copies of the results of this study by contacting Jennifer Kilty at the School of Criminology, Simon Fraser University, 8888 University Drive, Burnaby BC, V5A 1S6.

Goals of the research:
To understand how life changes for women who are in prison and how they cope with imprisonment.

1. To learn about women's views and experiences of imprisonment, and give them a space to be heard.
2. To learn about staff views and experiences of working with women prisoners.
3. To understand when and why segregation is used with women prisoners.
4. To provide reliable research results to the community, advocates, service delivery personnel and policy makers.

Appendix E: Informed Consent Form

Form 2 – Informed Consent by Participants in a Research Study
Titled: Resisting Confined Identities: Women's Strategies for Coping In Prison
Investigator Name: Jennifer Kilty
Investigator Department: Criminology

The University and those conducting this research study subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of participants. This research is being conducted under permission of the Simon Fraser Research Ethics Board. The chief concern of the Board is for the health, safety and psychological well-being of research participants.

Should you wish to obtain information about your rights as a participant in research, or about the responsibilities of researchers, or if you have any questions, concerns or complaints about the manner in which you were treated in this study, please contact the Director, Office of Research Ethics by email at hweinber@sfu.ca or phone at 604-268-6593.

Your signature on this form will signify that you have received a document which describes the procedures, possible risks, and benefits of this research study, that you have received an adequate opportunity to consider the information in the documents describing the study, and that you voluntarily agree to participate in the study.

Any information that is obtained during this study will be kept confidential to the full extent permitted by the law. Knowledge of your identity is not required. You will not be required to write your name or any other identifying information on research materials. Materials will be maintained in a secure location.

Having been asked to participate in the research study named above, I certify that I have read the procedures specified in the Study Information Document describing the study. I understand the procedures to be used in this study and the personal risks to me in taking part in the study as described below.

Please read this form carefully, and feel free to ask any questions if you are unsure about anything. Please sign this form to indicate that you understand the following:

I have received the information sheet attached that explains the goals of this research project, and I understand them.

I understand that I am being asked to participate in interviews with Jennifer M. Kilty, and that my participation is completely voluntary.

I understand that the interviews will be approximately 1-2 hours long. I understand that the interviews will be tape-recorded and that they will be transcribed in typewritten format.

I understand that I may obtain a copy of the tapes or the transcripts of my interview, if I request them.

I understand that I may stop the interview at any time for any reason. I understand that I may withdraw from the research project at any time.

I understand that the interviews will be kept confidential. I understand that unless I choose not to be anonymous, any written results of this study will provide me with anonymity, and so my name and any identifying features will not be published.

I understand that the tapes and the transcripts will be kept in a locked and secure place, where no one other than Jennifer M. Kilty will have access to them.

I understand that I may obtain copies of the tapes, the transcripts, or the results of this study by contacting Jennifer M. Kilty at the School of Criminology, Simon Fraser University, 8888 University Drive, Burnaby BC, V5A 1S6 (jmk@sfu.ca).

I agree to participate in this research by granting interviews to Jennifer M. Kilty at times that we mutually agree on.

I understand that I may withdraw my participation at any time. I also understand that I may register any complaint with the Director of the Office of Research Ethics or the researcher named above or with the Chair, Director or Dean of the Department, School or Faculty as shown below.

Robert Gordon (Ph.D.)
8888 University Way | Simon Fraser University
Burnaby, British Columbia (Canada)
V5A 1S6

I understand the risks and contributions of my participation in this study and agree to participate:

Last Name of Participant: ________________________________
First Name of Participant: ________________________________
Signature: ________________________________
Witness if required: ________________________________
Date: ________________________________

References

Acker, J., Barry K. & Esseveld, J. (1991). Objectivity and Truth: Problems in Doing Feminist Research. In M. M. Fonow & J. A. Cook (Eds.), *Beyond Methodology: Feminist Scholarship as Lived Research* (pp. 133-153). Bloomington: Indiana University Press.

Addelson, K. P. (1991). The Man of Professional Wisdom. In M. M. Fonow & J. A. Cook (Eds.), *Beyond Methodology: Feminist Scholarship As Lived Research* (pp. 16-31). Bloomington: Indiana University Press.

Adelberg, E. & Currie, C. (1987). *Too Few to Count: Canadian Women In Conflict With the Law.* Vancouver: Press Gang Publishers.

Adler, P. & Adler, P. (1993). Ethical Issues in Self Censorship. In Claire M. Renzetti & Raymond M. Lee (Eds.), *Doing Research on Sensitive Topics* (pp. 249-265). London: Sage.

Adler, P. & Adler, P. (2007). The Demedicalization of Self-injury: From Psychopathology to Sociological Deviance. *Journal of Contemporary Ethnography, 36*(5), 537-570.

Alasuutari, P. (1995). *Researching Culture: Qualitative Method and Cultural Studies.* Thousand Oaks, CA: Sage.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders 4th Edition – text revision.* Washington DC: American Psychiatric Association.

Arbour, L. (1996). *Commission of Inquiry into Certain Events at the Prison for Women in Kingston.* Ottawa: Public Works and Government Services Canada.

Arrigo, B. A. (2002). *Punishing the Mentally Ill.* Albany NY: SUNY Press.

Astbury, J. (1996). *Crazy For You: The Making of Women's Madness.* Melbourne: Oxford University Press.

Baker, C. D. (2002). Ethnomethodological Analyses of Interviews. In Gubrium, J. F. & Holstein, J. A. (Eds.), *Handbook of Interview Research: Context & Method* (pp. 777-798). Thousand Oaks: Sage.

Baker, P. L. (2000). I didn't know: Discoveries and Identity Transformation of Women Addicts in Treatment. *Journal of Drug Issues, 30*(4), 863-880.

Bardone, A. M., Perez, M., Abramson. L. Y., & Joiner, T. E. (2003). Self-Competence and Self-Liking in the Prediction of Change in Bulimic Symptoms. *Wiley Periodicals Inc.,* 361-369.

Barron, Christie. (2007). *Governing Girls: Rehabilitation in the Age of Risk.* Burnaby BC: Unpublished Doctoral Dissertation, Simon Fraser University.

Bauman, Z. (1996). From Pilgrim to Tourist – Or a Short History of Identity. In Hall, S. & du Gay, P. (Eds.), *Questions of Cultural Identity* (pp. 18-36). Princeton NJ: Princeton University Press.

Becker, H. (1963). *Outsiders: Studies in the Sociology of Deviance.* London: Free Press of Glencoe.

Bekker, M. & Boselie, K. (2002). Gender and Stress: Is Gender Stress? A Re-examination of the Relationship Between Feminine Gender Role Stress and Eating Disorders. *Stress and Health, 18,* 141-149.

Bell, M. (2006). Re/forming the Anorexic 'Prisoner': Inpatient Medical Treatment as the Return to Panoptic Femininity. *Cultural Studies – Critical Methodologies, 6*(2), 282-307.

Benveniste, J., Lecouteur, A.& Hepworth, J. (1999). Lay Theories of Anorexia Nervosa: A Discourse Analytic Study. *Journal of Health Psychology 4*(1), 59-69.

Berk, R. A. & Adams, J. M. (2001). Establishing Rapport with Deviant Groups. In Miller, J. M. & Tewksbury, R. (Eds.), *Extreme Methods: Innovative Approaches to Social Science Research* (pp. 58-71). Toronto: Pearson.

Blaase, H. & Elklit, A. (2001). Psychological Characteristics of Women With Eating Disorders: Permanent or Transient Features? *Scandinavian Journal of Psychology, 42*, 467-478.

Blanchette, K. (2002). Classifying Female Offenders for Effective Intervention: Application of the Case-based Principles of Risk and Need. *Forum, 14*(1), 31-35.

Bloom, L. R. (2002). Stories of One's Own: Nonunitary Subjectivity in Narrative Representation. In Merriam, S. B. (Ed.). *Qualitative Research in Practice: Examples for Discussion and Analysis* (pp. 289-309). San Francisco: Jossey-Bass.

Bonin, M. F., McCreary, D. R., & Sadava, S. W. (2000). Problem Drinking Behaviour in Two Community Based Samples of Adults: Influence of Gender, Coping, Loneliness, and Depression. *Psychology of Addictive Behaviours, 14*(2), 151-161.

Bonnycastle, K. (2004). *Sex Offenders in (Con)text: Creating Choices in the Age of Risk.* Burnaby BC: Unpublished Doctoral Dissertation, Simon Fraser University.

Bonta, J., Pang, B. & Wallace-Capretta, S. (1995). Predictors of Recidivism Among Incarcerated Female Offenders. *The Prison Journal, 75,* 277–294.

Bordo, S. (1990). Reading the Slender Body. In Jacobus, M., Fox Keller, E. & Shuttleworth, S. (Eds.) *Body/Politics: Women and the Discourses of Science* (pp. 83-112). London: Routledge.

Bordo, S. (1992). Anorexia Nervosa: Psychopathology as the Crystallization of Culture. In Crowley, H. & Himmelweit, S. (Eds.), *Knowing Women: Feminism and Knowledge* (pp.). Cambridge & Oxford: Polity Press/ Open University Press.

Bordo, S. (1993). *Unbearable Weight: Feminism, Western Culture and the Body.* Berkeley, CA: University of California Press.

Bosworth, M. (1999). *Engendering Resistance: Agency and Power in Women's Prisons.* Aldershot: Ashgate Press.

Bosworth, M. & Carrabine, E. (2001). Reassessing Resistance: Race, Gender and Sexuality in Prison. *Punishment and Society, 3*(4), 501-516.

Boyd, S. C. (1999). *Mothers and Illicit Drugs: Transcending the Myths.* Toronto: University of Toronto Press.

Boyd, S. C. (2001). Feminist Research on Mothers and Illegal Drugs. *Resources for Feminist Research, 28*(3), 113-130.

Boyd, S. C. (2004). *From Witches to Crack Moms: Women, Drug Law and Policy.* Durham NC: Carolina Academic Press.

Boyd, S. C. (2006). Representations of Women in the Drug Trade. In Comack, E. & Balfour, G. (Eds.), *Criminalizing Women* (pp. 131-151). Halifax: Fernwood Publishing.

Bray, A. (1996). The Anorexic Body: Reading Disorders. *Cultural Studies, 10*(3), 413-429.

Breggin, P. R. & Breggin, G. R. (1994). *Talking Back to Prozac: What Doctors Won't Tell you About Today's Most Controversial Drug.* New York NY: St. Martin's Press.

Brickman, B. J. (2004). Delicate Cutters: Gendered Self-mutilation and Attractive Flesh in Medical Discourse. *Body and Society, 10*(4), 87-111.

Briggs, C. L. (2002). Interviewing, Power/Knowledge, and Social Inequality. In Gubrium, J. F. & Holstein, J. A. (Eds.), *Handbook of Interview Research: Context & Method* (pp. 911-922). Thousand Oaks: Sage.

Brown, A. (1998). Doing Time: The Extended Present of the Longterm Prisoner. *Time and Society, 7,* 93-103.

Bruch, H. (1978). *The Golden Cage: The Enigma of Anorexia Nervosa.* Cambridge, MA: Harvard University Press.

Brumberg, J. (1988). *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease.* Cambridge, MA: Harvard University Press.

Burns, M. (2004). Eating Like an Ox: Femininity and Dualistic Constructions of Bulimia and Anorexia. *Feminism and Psychology, 14*(2), 269-295.

Cameron, D. (2001). *Working With Spoken Discourse.* Thousand Oaks: Sage.

Cameron, D. (1990). Introduction. In Deborah Cameron (Ed.), *The Feminist Critique of Language: A Reader* (pp. 1-21). London: Routledge.

Canadian Association for the Advancement of Women in Sport (CAAWS). (1991). *Resources for Research and Action, A Policy Handbook: Strategies for Effecting Change in Public Policy.* Ottawa, ON: CRIAW.

Canadian Human Rights Commission (CHRC). (2003). *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women.* Ottawa: Canadian Human Rights Commission.

Cannon, L. W., Higginbotham, E. & Leung, M. L. A. (1991). Race and Class Bias in Qualitative Research. In M. M. Fonow & J. A. Cook (Eds.), *Beyond Methodology: Feminist Scholarship As Lived Research* (pp. 107-118). Bloomington: Indiana University Press.

Caplan, P. (1993). Introduction 2: The Volume. In Bell, D., Caplan, P. & Karim, W. J. (Eds.), *Gendered Fields: Women, Men and Ethnography* (pp. 19-27). London: Routledge.

Carlen, P. (2001). Death and the Triumph of Governance? Lessons from the Scottish Women's Prison. *Punishment and Society, 3*(4), 459-471.

Castel, R. (1991). From Dangerousness to Risk. In Burchell, G., Gordon, C. & Miller, P. (Eds.), *The Foucault Effect: Studies in Governmentality* (pp. 281-298). London: Harvester Wheatsheaf.

Charmaz, K. (2000). Grounded Theory: Objectivist and Constructivist Methods. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research* (pp. 509-535). Thousand Oaks, CA: Sage Publications.

Charmaz, K. (2002). Qualitative Interviewing and Grounded Theory Analysis. In Gubrium, J. F. & Holstein, J. A. (Eds.), *Handbook of Interview Research: Context & Method* (pp. 675-694). Thousand Oaks: Sage.

Chernin, K. (1983). *Womansize: The Tyranny of Slenderness.* London: Women's Press.

Chernin, K. (1986). *The Hungry Self.* London: Virago.

Chesler, P. (1972). *Women and Madness.* New York NY: Avon Books.

Christians, C. G. (2000). Ethics and Politics in Qualitative Research. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research* (pp. 133-162). Thousand Oaks, CA: Sage Publications.

Chunn, D. E. & Gavigan, S. A. M. (1988). Social Control: Analytical Tool or Analytical Quagmire? *Contemporary Crises, 12,* 107-28.

Chunn, D. E. & Menzies, R. (1990). Gender, Madness and Crime: The Reproduction of Patriarchal and Class Relations in a Psychiatric Court Clinic. *Critical Criminology, 1*(2), 33-54.

Christie, N. (2000). *Crime Control as Industry.* London: Routledge.

Coates, J. (1990). Thank God I'm a Woman: The Construction of Differing Femininities. In Deborah Cameron (Ed.) *The Feminist Critique of Language: A Reader* (pp. 295-320). London: Routledge.

Coffey, A. (1999). *The Ethnographic Self: Fieldwork and the Representation of Identity.* Thousand Oaks CA: Sage.

Cohen, S. (1985). *Visions of Social Control: Crime, Punishment and Classification.* Oxford: Polity Press.

Collins, P. H. (1991). Learning from the Outsider Within: The Sociological Influence of Black Feminist Thought. In Fonow, M. M. & Cook, J. A. (Eds.), *Beyond Methodology: Feminist Scholarship as Lived Research* (pp. 35-59). Bloomington: Indiana University Press.

Collins, P. H. (2000). *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment.* New York: Routledge.

Comack, E. (1996). *Women In Trouble.* Halifax: Fernwood Publishing.

Comack, E. (2000). The Prisoning of Women: Meeting Women's Needs? In K. Hannah-Moffat and M. Shaw (Eds.), *An Ideal Prison? Critical Essays on Women's Imprisonment in Canada* (pp. 117-127). Halifax: Fernwood Publishing.

Comack, E. (2006a). Introduction. In Comack, E. & Balfour, G. (Eds.), *Criminalizing Women* (pp. 58-78). Halifax: Fernwood Publishing.

Comack, E. (2006b). The Feminist Engagement with Criminology. In Comack, E. & Balfour, G. (Eds.), *Criminalizing Women* (pp. 22-57). Halifax: Fernwood Publishing.

Comack, E. & Balfour, G. (2004). *The Power to Criminalize: Violence, Inequality and the Law.* Halifax: Fernwood Publishing Press.

Connors, R. (1996). Self-Injury in Trauma Survivors: Functions and Meanings. *American Journal of Orthopsychiatry, Vol. 66*(2), 194-206.

Conrad, P. & Schneider, J. W. (1980). *Deviance and Medicalization: From Badness to Sickness.* St. Louis: The C. V. Mosby Company.

Cookson, H. M. (1977). A Survey of Self-Injury in a Closed Prison for Women. *British Journal of Criminology, 17*(4), 332-347.

Cope, N. (2003). It's No Time or High Time: Young Offenders' Experiences of Time and Drug Use in Prison. *The Howard Journal, 42*(2), 158-175.

Corcoran, M. (2006). *Out of Order: The Political Imprisonment of Women In Northern Ireland 1972-1998.* London: Willan Publishing.

Correctional Service Canada. (2002). Commissioner's Directive 850: Mental Health Services, Ottawa, ON: Correctional Service Canada.

Correctional Service Canada. (2002). Commissioner's Directive 001: Mission Statement, Ottawa, ON: Correctional Service Canada.

Correctional Service Canada. (2002) Commissioner's Directive 843: Prevention, Management and Response to Suicide and Self-Injuries, Ottawa, ON: Correctional Service Canada.

Correctional Service Canada. (2002) Offender Intake Assessment and Correctional Planning: Standard Operating Practices (700-04), Ottawa, ON: Correctional Service Canada.

Correctional Service Canada. (2002) Security Classification of Offenders: Standard Operating Practices (700-14), Ottawa, ON: Correctional Service Canada.

Covington, S. & Bloom. B. (2006). Gender Responsive Treatment and Services in Correctional Settings. *Women and Therapy. 29*(3/4), 9-33.

Cruikshank, B. (1994). The Will to Empower: Technologies of Citizenship and the War on Poverty. *Socialist Review, 23,* (4), 29-56

Cruikshank, B. (1996). Revolutions Within: Self-government and Self-esteem. In Barry, A., Osborne, T. & Rose, N. (Eds.), *Foucault and Political Reason* (pp. 231-252). Chicago: University of Chicago Press.

Crump, J. (1995). Literature Review on Women's Anger and Other Emotions. Ottawa: Correctional Service of Canada.

Curtis, B. (1995). Taking the State Back Out: Rose and Miller on Political Power. *British Journal of Sociology, 46*(4), 575-589.

David, P. & Johnson, M. A. (1998). The Role of Self in Third Person Effects About Body Image. *Journal of Communication, 37-58.*

Davis, A. Y. (1998). Racialized Punishment and Prison Abolition. In Joy James (Ed.) *The Angela Y. Davis Reader* (pp. 96-107). Oxford: Blackwell.

Davis, A. Y. (2003). *Are Prisons Obsolete?* Hammondsport NY: Seven Stories Press Open Media Series.

Dean, M. (1999). *Governmentality: Power and Rule in Modern Society.* London: Sage Publications.

Dear, G. E., Thomson, D. M. &. Hills, A. M. (2000). Self-harm in Prison: Manipulators can also be Suicide Attempters. *Criminal Justice and Behaviour, 27*(2), 160-175.

Deep, A. L., Lilenfield, L. R., Plotnicov, K. H., Pollice, C. & Kaye, W. H. (1999). Sexual Abuse in Eating Disorder Subtypes and Control Women: The Role of Comorbid Substance Dependence in Bulimia Nervosa. *International Journal of Eating Disorders, 25,* 1-10.

de Laine, M. (2000). *Fieldwork, Participation and Practice: Ethics and Dilemmas in Qualitative Research.* Thousand Oaks CA: Sage.

Dell, C., Fillmore, C. & Kilty, J. M. (forthcoming). Looking Back 10 Years After the Arbour Inquiry: Federal Corrections and the Construction of the Misbehaved Woman Prisoner. *The Prison Journal.*

Denisoff, E. & Endler, N. S. (2000). Life Experiences, Coping, and Weight Preoccupation in Young Adult Women. *Canadian Journal of Behavioural Science, 32*(2), 97-103.

Denzin, N. K. & Lincoln, Y. S. (2000). Introduction: The Discipline and Practice of Qualitative Research. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research* (2nd edition) (pp. 1-28). Thousand Oaks, CA: Sage Publications.

Denzin, N. (2001). *Interpretive Interactionism.* Thousand Oaks: Sage.

DeVault, M. L. & McCoy, L. (2002). Institutional Ethnography: Using Interviews to Investigate Ruling Relations. In Gubrium, J. F. & Holstein, J. A. (Eds.), *Handbook of Interview Research: Context & Method* (pp. 751-776). Thousand Oaks: Sage.

Diduck, A. (1998). Conceiving the Bad Mother: The Focus Should be On the Child to be Born. *UBC Law Review,. 32*(2), 199-226.

Dobash, R. P., Dobash, R. E. & Gutteridge, S. (1986). *The Imprisonment of Women.* London: Basil Blackwell.

Driscoll, K. & McFarland, J. (1987). The Impact of a Feminist Perspective on Research Methodologies. In W. Tomm (Ed.), *The Effects of Feminist Approaches on Research Methodologies* (pp. 185-204). Waterloo, ON: Wilfred Laurier University Press.

Dunbar, C., Rodriguez, D. & Parker, L. (2002). Race, Subjectivity & The Interview Process. In Gubrium, J. F. & Holstein, J. A. (Eds.), *Handbook of Interview Research: Context & Method* (pp. 279-298). Thousand Oaks: Sage.

Edwards, R. (1993). An Education in Interviewing. In Renzetti, C. M. & Lee, R. M. (Eds.), *Doing Research on Sensitive Topics* (p.181-197). London: Sage.

Faith, K. (1991). Resistance: Lessons from Foucault and Feminism. In Radtke, H. L. & Stam, H. J. (Ed.), *Power/Gender* (pp. 36-66). London: Sage Publications.

Faith, K. (1993). *Unruly Women.* Vancouver: Press Gang Publishers.

Faith, K. (2004). Progressive Rhetoric, Regressive Policies: Canadian Prisons for Women. In Price, B.R. & Sokoloff, N. J. (Eds.), *The Criminal Justice System and Women 3rd Edition* (pp. 281-288). New York: McGraw Hill.

Farber, S. (1990). Institutional Mental Health and Social Control: The Ravages of Epistemological Hubris. *The Journal Of Mind and Behavio,. 11*(3/4), 285-299.

Favazza, A. R. (1987). *Bodies Under Siege: Self-Mutilation in Culture and Psychiatry.* Baltimore: John Hopkins UP.

Favazza, A. R. (1989). Why Patients Mutilate Themselves. *Hospital and Community Psychiatry, 40*(2), 137-145.

Fetterman, D. (1998). *Ethnography: Step by Step.* Thousand Oaks: Sage.

Filipas, H. H., & Ullman, S. E. (2006). Child Sexual Abuse, Coping Responses, Self Blame, Posttraumatic Stress Disorder, and Adult Sexual Revictimization. *Journal of Interpersonal Violence, 21*(5), 652-672.

Fillmore, C. & Dell, C. A. (2000) *Prairie Women, Violence, and Self-Harm.* Winnipeg: The Elizabeth Fry Society of Manitoba.

Fine, M., Wies, L., Weseen, S. & Wong, L. (2000). For Whom? Qualitative Research, Representations, and Social Responsibilities. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research* (pp. 107-131). Thousand Oaks, CA: Sage Publications.

Flick, U. (1998). *An Introduction to Qualitative Research.* London: Sage.

Fontana, A. (2002). Postmodern Trends in Interviewing. In Gubrium, J. F. & Holstein, J. A. (Eds.), *Handbook of Interview Research: Context & Method* (pp. 161-176). Thousand Oaks: Sage.

Fontana, A. & Frey, J. H. (2000). The Interview: From Structured Questions to Negotiated Text. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research* (pp. 645-672). Thousand Oaks, CA: Sage Publications.

Fonow, M. M. & Cook, J. A. (1991). Back to the Future: A Look at the Second Wave of Feminist Epistemology and Methodology. In Fonow, M. M. & Cook, J. A. (Eds.), *Beyond Methodology: Feminist Scholarship as Lived Research* (pp. 1-15). Bloomington: Indiana University Press.

Fortin, D. (2004). *Program Strategy for Women Offenders.* Ottawa: Correctional Service of Canada.

Frank, E. S. (1991). Shame and Guilt in Eating Disorders. *American Journal of Orthopsychiatry, 61*(2), 303-306.

Frigon, S. (1995). A Genealogy of Women's Madness. In Dobash, R. E., Dobash, R. P. & Noaks, L. (Eds.), *Gender and Crime* (pp. 20-48). Cardiff: University of Wales Press.

Frigon, S. (1996). A Gallery of Portraits : Women and the Embodiment of Difference, Deviance and Resistance. In O'Reilly-Fleming, T. (Ed.), *Post Critical Criminology* (pp. 78-110). Scarborough: Prentice Hall.

Frigon, S. (1999). Une Radioscopie des Événements Survenus a la Prison des Femmes de Kingston en Ontario en Avril 1994 : La Construction d'un Corps Dangereux et D'un Corps en Danger. *Canadian Women's Studies/ Les Cahiers de la Femme, 19*(1-2).

Frigon, S. (2000). Corps, féminité et dangerosité: de la production du 'corps dociles' en criminologie. En Frigon, S. & Kerisit, M. (Eds.), *Du Corps des Femmes.* Ottawa: Les Presses de l'Université d'Ottawa.

Frigon, S. (2002). La Création de Choix pour les Femmes Incarcérées : Sur les Traces du Groupe d'Étude sur les Femmes Purgeant Une Peine Fédérale et de ses Conséquences. *Criminologie, 35*(2), 9-30.

Foucault, M. (1965, 67, 77). *Madness and Civilization: A History of Insanity in the Age of Reason.* London: Harper & Row.

Foucault, M. (1978). *The History of Sexuality Volume 1.* New York: Random House.

Foucault, M. (1979). *Discipline and Punish.* New York: Vintage.

Foucault, M. (1991). Governmentality. In Burchell, G. C. & Miller, G. P. (Eds.), *The Foucault Effect: Studies in Governmentality* (pp. 87-104). Chicago: University of Chicago Press.

Garland, D. (1985). *Punishment and Welfare: A History of Penal Strategies.* Brookfield: Grower Publishing Co.

Garland, D. (1990). *Punishment and Modern Society: A Study in Social Theory.* New York: Oxford University Press.

Garland, D. (1997). 'Governmentality' and the Problem of Crime: Foucault, Criminology, Sociology. *Theoretical Criminology, 1*(2), 173-214.

Garland, D. (2001). *The Culture of Control: Crime and Social Order in Contemporary Society.* Chicago: University of Chicago Press.

Geiger, B. & Fischer, M. (2005). Naming Oneself Criminal: Gender Difference in Offenders' Identity Negotiation. *International Journal of Offender Therapy and Comparative Criminology, 49*(2), 194-209.

Gergen, K. (2000). *The Saturated Self: Dilemmas of Identity in Contemporary Life (2nd Edition).* New York: Basic Books.

Giddens, A. (1991). *Modernity and Self-identity: Self and Society in the Late Modern Age.* Cambridge: Polity Press.

Gilbert, K. (2001). Introduction: Why are We Interested in Emotions? In Gilbert, K. (Ed.), *The Emotional Nature of Qualitative Research* (pp. 3-15). Boca Raton: CRC Press.

Glaser, B. G. & Strauss, A. L.. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.

Godderis, R. (2006). Dining In: The Symbolic Power of Food in Prison. *Howard Journal of Criminal Justice, 45*(3), 255-267.

Godderis, R. (2006). Food for Thought: An Analysis of Power and Identity in Prison Food Narratives. *Berkeley Journal of Sociology, 50,* 61-75.

Goffman, E. (1961). *Asylums*. New York NY: Anchor Books.

Goffman, E. (1963). *Stigma: Notes on the Management of a Spoiled Identity*. New York NY: Simon and Schuster.

Gooldin, S. (2003). Fasting Women, Living Skeletons, and Hunger Artists: Spectacles of Body and Miracles at the Turn of the Century. *Body and Society, 9*(2), 27-53.

Gorsuch, N. (1998). Unmet Needs Among Disturbed Female Offenders. *The Journal of Forensic Psychiatry, 9*(3), 556-570.

Grbich, J. E. (1991). The Body in Legal Theory. In Fineman, M. A. & Thomadsen, N. S. (Eds.), *At the Boundaries of Law: Feminism and Legal Theory* (pp. 60-76). New York: Routledge, Chapman and Hall, Inc.

Greaves, L., Pederson, A., Varcoe, C., Poole, N., Morrow, M., Johnson, J. L, & Irwin, L. 2004. Mothering Under Duress: Women Caught in a Web of Discourses. *Journal of the Association for Research on Mothering, 6*(1) 16-27.

Grossberg, L. (1996). Identity and Cultural Studies – Is This All There Is? In Hall, S. & du Gay, P. (Eds.) *Questions of Cultural Identity* (pp. 87-107). Princeton NJ: Princeton University Press.

Groves, A. (2004). Blood on the Walls. *Australian and New Zealand Journal of Criminology, 37*(1), 49-64.

Gubrium, J. F. & Holstein, J. A. (2000). Analyzing Interpretive Practice. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research* (pp. 487-508). Thousand Oaks, CA: Sage Publications.

Gunaratnam, Y. (2003). *Researching Race and Ethnicity: Methods, Knowledge and Power*. London: Sage.

Hall, S. (1980). Reformism and the Legislation of Consent. In National Deviancy Conference (Ed.), *Permissiveness and Control: The Fate of the Sixties Legislation* (p.1-43). London: Macmillan.

Hall, S. (1996). Introduction: Who Needs Identity? In Hall, S. & du Gay, P. (Eds.), *Questions of Cultural Identity* (pp. 1-17). Princeton NJ: Princeton University Press.

Hannen, M. (1987). Feminism, Reason, and Philosophical Method. In Tomm, W. (Ed.), *The Effects of Feminist Approaches on Research Methodologies* (pp. 31-50). Waterloo, ON: Wilfred Laurier University Press.

Hannah-Moffat, K. (1991). Creating Choices or Repeating History: Canadian Female Offenders and Correctional Reform. *Social Justice, 18*(3), 184-203.

Hannah-Moffat, K. (1995). Feminine Fortresses: Women-centred Prisons? *The Prison Journal, 75*(2), 135-64.

Hannah-Moffat, K. (1999). Moral Agent or Actuarial Subject: Risk and Canadian Women's Imprisonment. *Theoretical Criminology, 3*(1), 71-94.

Hannah-Moffat, K. (2000). Re-forming the Prison: Rethinking our Ideals. In Hannah-Moffat, K. & Shaw, M. (Eds.), *An Ideal Prison? Critical Essays on Women's Imprisonment in Canada* (p.30-40). Halifax: Fernwood Publishing.

Hannah-Moffat, K. (2000). Prisons that Empower: Neo-liberal Governance in Canadian Women's Prisons. *British Journal of Criminology, 40* (summer), 510-531.

Hannah-Moffat, K. (2001). *Punishment in Disguise: Penal Governance in Canadian Women's Prisons.* Toronto: University of Toronto Press.

Hannah-Moffat, K. (2005). Criminogenic Needs and the Transformative Risk Subject. *Punishment and Society, 7*(1), 29-51.

Hannah-Moffat, K., & Shaw, M. (2000). Introduction: Prisons for Women – Theory, Reform, Ideals. In Hannah-Moffat, K.& Shaw, M. (Eds.), *An Ideal Prison? Critical Essays on Women's Imprisonment in Canada* (p.11-27). Halifax: Fernwood Publishing.

Hannah-Moffat, K & Shaw, M. (2001). *Taking Risks: Incorporating Gender and Culture into the Classification and Assessment of Federally Sentenced Women in Canada.* Ottawa: Status of Women Canada.

Harding, S. (1986). *The Science Question in Feminism.* Ithaca: Cornell University Press.

Harding, S. (1987). Introduction: Is there a Feminist Method? In Harding, S. (Ed.), *Feminism and Methodology* (pp. 1-14). Bloomington: Indiana University Press.

Hartsock, N. (1987). The Feminist Standpoint. In Harding, S. (Ed.), *Feminism and Methodology* (pp. 157-180). Bloomington: Indiana University Press.

Harvey, L. (1990). *Critical Social Research.* London: Unwin Hyman.

Hay, P. (1996). The Epidemiology of Eating Disorder Behaviours: An Australian Community Based Survey. *International Journal of Eating Disorders, 23,* 371-382.

Healy, D. (2003). *Let Them Eat Prozac: The Unhealthy Relationship Between the Pharmaceutical Industry and Depression.* New York NY: NYU Press.

Heath, C. (2004). Analysing Face-to-Face Interaction: Video, the Visual and Material. In Silverman, D. (Ed.), *Qualitative Research: Theory Method and Practice* (pp. 266-282). London: Sage Publications.

Heney, J. (1990). Report on Self-Injurious Behaviour in the Kingston Prison for Women. Ottawa: Correctional Service of Canada.

Heney, J. & Kristiansen, C. M. (1997). An analysis of the impact of prison on women survivors of childhood sexual abuse. *Women & Therapy, 20*(4), 29-44.

Hepworth, J. (1999). *The Social Construction of Anorexia Nervosa.* London: Sage Publications.

Heritage, J. (2004). Conversation Analysis and Institutional Talk: Analysing Data. In David Silverman (Ed.), *Qualitative Research: Theory Method and Practice* (pp. 222-245). London: Sage Publications.

Hesse-Biber, S. N. & Yaiser, M. L. (2004). Difference Matters: Studying Across Race, Class, Gender and Sexuality. In Hesse-Biber, S. N. & Yaiser, M. L. (Eds.), *Feminist Perspectives on Social Research* (pp. 101-120). New York: Oxford University Press.

Hesse-Biber, S. N., Leavy, P., & Yaiser, M. L. (2004). Feminist Approaches to Research as a Process: Reconceptualizing Epistemology, Methodology and Method. In Hesse-Biber, S. N. & Yaiser, M. L. (Eds.), *Feminist Perspectives on Social Research* (pp. 3-26). New York: Oxford University Press.

Hesse-Biber, S. N., & Leckenby, D. (2004) How Feminists Practice Social Research. In Hesse-Biber, S. N. & Yaiser, M. L. (Eds.) *Feminist Perspectives on Social Research* (pp. 209-226). New York: Oxford University Press.

Hindness, B. (2002). Neo-liberal Citizenship. *Citizenship Studies, 6*(2), 127-143.

Hodgson, S. (2004). Cutting Through the Silence: Sociological Construction of Self-Injury. *Sociological Inquiry, 74*(2), 162-179.

Horii, G. (2000). Processing Humans. In Hannah-Moffat, K. & Shaw, M. (Eds.), *An Ideal Prison? Critical Essays on Women's Imprisonment in Canada* (pp. 104-116). Halifax: Fernwood Publishing.

Islin, E. F. (2004). The Neurotic Citizen. *Citizenship Studies, 8*(3), 216-235.

Hayman, S. (2006). *Imprisoning Our Sisters: The New Federal Women's Prisons in Canada.* Montreal: McGill Queens University Press.

Hooks, b. (1981). *Ain't I a Woman? Black Women and Feminism.* Boston MA: South End Press.

Hunt, A. (1999). *Governing Morals: A Social History of Moral Regulation.* Cambridge: Cambridge University Press.

Hunt, A. & Purvis, T. (1993). Discourse, Ideology, Discourse, Ideology, Discourse, Ideology. *The British Journal of Sociology 44*(3) 473-499.

Hyman, J. (1999). *Women Living With Self-injury.* Philadelphia PA: Temple University Press.

Irving, J., & Wichmann, C. (2001). *An Investigation into the Factors leading to Increased Security Classification of Women Offenders.* Ottawa: Correctional Service of Canada.

Jackson, M. (1999). Canadian Aboriginal Women and Their 'Criminality': The Cycle of Violence in the Context of Difference. *Australian and New Zealand Journal of Criminology, 32*(2), 197-208.

Jackson, M. (2001). The 'Risky' Business of Child Abuse Assessments in British Columbia. In Farrington, D., Hollin, C., & McMurran, M. (Eds.). *Sex and Violence: The Psychology of Crime and Risk Assessment.* London: Routledge Press.

Jager, S. (2001). Discourse and Knowledge: Theoretical and Methodological Aspects of a Critical Discourse and Dispositive Analysis. In Wodak, R & Meyer, M. (Eds.), *Methods of Critical Discourse Analysis* (pp. 32-62). Thousand Oaks CA: Sage Publications.

Jhappan, R. (1996). Post-Modern Race and Gender Essentialism or a Post-Mortem of Scholarship? *Studies in Political Economy, 51*, 15-63.

Jesseman, R. (2007). *Personal Communication.*

Johnson, J. M. (2002). In-Depth Interviewing. In Gubrium, J. F. & Holstein, J. A. (Eds.), *Handbook of Interview Research: Context & Method* (pp. 103-120). Thousand Oaks: Sage.

Jones, A. (1986). Self-Mutilation in Prison: A Comparison of Mutilators and Nonmutilators. *Criminal Justice and Behaviour, 13*(3), 286-296.

Jones, D. M. (1985). Bulimia: A False Identity. *Clinical Social Work Journal, 13*(4), 305-316.

Kendall, K. (1994a). Therapy Behind Prison Walls: A Contradiction in Terms? *Prison Service Journal, 96,* 2-11.

Kendall, K. (1994b). The Discipline and Control of Women. *The Journal of Human Justice 6*(1), 111-119.

Kendall, K. (2000). Governing Female Prisons through the Psychological Sciences. In Hannah-Moffat, K. and Shaw, M. (Eds.), *An Ideal Prison? Critical Essays on Women's Imprisonment in Canada* (pp. 82-93). Halifax: Fernwood Publishing.

Kershaw, A. & Lasovich, M. (1991). *Rock-a-bye Baby.* Toronto: Oxford University Press.

Keywood, K. (2000). My Body and Other Stories: Anorexia Nervosa and the Legal Politics of Embodiment. *Social and Legal Studies, 9*(4), 495-513.

Kilty, J. M. (2003). *From a Dangerous Woman to a Woman in Danger: The Case of Karla Homolka.* Ottawa ON: Unpublished MA Thesis, University of Ottawa.

Kilty, J. M. (2006). Under the Barred Umbrella: Is There Room for a Women-Centred Self-injury Policy in Canadian Corrections? *Journal of Criminology and Public Policy 5*(1), 161-182.

Kilty, J. M. & Frigon, S. (2007). From a Woman In Danger to a Dangerous Women, the Case of Karla Homolka: Chronicling the Shifts. *Women and Criminal Justice, 17*(3), 37-61.

Kirby, S. & McKenna, K. (1989). *Experience Research Social Change: Methods from the Margins.* Ontario: Garamond Press.

Leifer, R. (1990). Introduction: The Medical Model as the Ideology of the Therapeutic State. *The Journal Of Mind and Behavior, 11*(3 & 4), 247-258.

Lather, P. (1991). *Getting Smart: Feminist Research and Pedagogy With/in the Postmodern.* London: Routledge.

Leal, L., Weise, S. M. & Dodd, D. K. (1995). The Relationship Between Gender, Symptoms of Bulimia, and Tolerance for Stress. *Addictive Behaviours, 20*(1), 105-109.

Levi-Strauss, C. (1966). *The Savage Mind.* Chicago: University of Chicago Press.

Liebling, A. (1992). *Suicides In Prison.* London: Routledge.

Liebling, A. (1994). Suicides Amongst Women Prisoners. *Howard Journal, 33*(1), 1-9.

Liebling, A. (1995). Vulnerability and Prison Suicide. *The British Journal of Criminology,35*, 173-187.

Liebling, A. & Ward, T. (Eds.). (2004). *Deaths In Custody: An International Perspective.* London: Whiting and Birch.

Lincoln, Y. S. & Guba, E. G. (2000). Paradigmatic Controversies, Contradictions, and Emerging Confluences. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research 2nd Edition* (pp. 163-188). Thousand Oaks, CA: Sage Publications.

Litosseliti, L. & Sunderland, J. (2002). Gender, Identity and Discourse Analysis: Theoretical and Empirical Considerations. In Litosseliti, L. & Sunderland, J. (Eds.), *Gender, identity and discourse analysis* (pp. 3-42). Philadelphia: John Benjamins Publishing Co.

Littleton, H. & Breitkopf, C. R. (2006). Coping With the Experience of Rape. *Psychology of Women Quarterly, 30,* 106-116.

Lloyd, A. (1995). *Doubly Deviant, Doubly Damned: Society's Treatment of Violent Women.* London: Penguin Books

Lloyd, M. (1997). Feminism, Aerobics and the Politics and the Body. *Body and Society, 2*(2), 79-98.

Lofland, J. & Lofland, L. (1995). *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis 3rd Edition.* Belmont CA: Wadsworth.

Maden, T. (1997). *Women, Prisoners and Psychiatry: Mental Disorder Behind Bars.* London: Butterworth Heineman.

Maidment, M. (2006). We're Not All That Criminal: Getting Beyond the Pathologizing and Individualizing of Women's Crime. *Women and Therapy,29*(3/4), 35-56.

Malloch, M. (1999). Drug Use, Prison, and the Social Construction of Femininity. *Women's Studies International Forum, 22*(3), 349-358.

Malson, H. (1995). Anorexia Nervosa: Discourses of Gender Subjectivity and the Body. *Feminism and Psychology, 5*(1), 87-93.

Malson, H. (1997). Anorexic Bodies and the Discursive Production of Feminine Excess. In Ussher, J. M. (Ed.), *Body Talk: the Material and Discursive Regulation of Sexuality, Madness and Reproduction* (pp. 223-245). London: Routledge.

Malson, H. (1998). *The Thin Woman: Feminism, Post-Structuralism and the Social Psychology of Anorexia Nervosa.* London: Routledge.

Malson, H. (1999). Women Under Erasure: Anorexic Bodies in Postmodern Context. *Journal of Community and Applied Social Psychology, 9,* 137-153.

Malson, H. & Swann, C. (1999). Prepared for Consumption: (Dis)orders of Eating and Embodiment. *Journal of Community and Applied Social Psychology, 9,* 397-405.

Malson, H. & Ussher, J. M. (1996a). Body Poly-texts: Discourses of the Anorexic Body. *Journal of Community and Applied Social Psychology, 6,* 267-280.

Malson, H. & Ussher, J. M. (1996b). Bloody Women: a Discourse Analysis of Amenorrhea as a Symptom of Anorexia Nervosa. *Feminism and Psychology, 6*(4), 505-521.

Malson, H. & Ussher, J. M. (1997). Beyond this Mortal Coil: Femininity, Death and Discursive Constructions of the Anorexic Body. *Mortality, 2*(1), 43-61.

Marecek, J. (2002). Unfinished Business: Postmodern Feminism in Personality Psychology. In Ballou, M. & Brown, L. S. (Eds.), *Rethinking Mental Health and Disorder: Feminist Perspectives* (pp. 3-28). New York: Guilford Press.

Marshall, T. H. (1950). *Citizenship and Social Class and Other Essays.* Cambridge: Cambridge University Press.

Martel, J. (2000). Women in the Hole: The Unquestioned Practice of Segregation. In Hannah-Moffat, K. & Shaw, M. (Eds.), *An Ideal Prison? Critical Essays on Women's Imprisonment in Canada* (pp. 128-135). Halifax: Fernwood Publishing.

Martel, J. (2006). Les Femmes et L'Isolement Cellulaire au Canada: Un Défi de l'Esprit sur la Matière. *Revue canadienne de criminologie et de justice pénale,* 781-801.

Mathiesen, T. (1965). *Defences of the Weak.* London: Tavistock Publications.

McCormack, T. (1987). Feminism and the New Crisis in Methodology. In Tomm, W. (Ed.), *The Effects of Feminist Approaches on Research Methodologies* (pp. 13-30). Waterloo, ON: Wilfred Laurier University Press.

McIntosh, J. & McKeganey, N. (2000). Addicts' Narratives of Recovery from Drug Use: Constructing a Non-Addict Identity. *Social Science & Medicine, 50,* 1501-1510.

McLellan, A. T. (2006). What We Need is a System: Creating a Responsive, and Effective Substance Abuse System. In Miller, W. R. & Carroll, K. M. (Eds.), *Rethinking Substance Use: What the Science Shows, and What We Should Do About It.* New York NY: The Guilford Press.

McLellan, A. T., McKay, J. R., Forman, R., Cacciola, J. & Kemp, J. (2005). Reconsidering the Evaluation of Addiction Treatment: From Retrospective Follow-up to Concurrent Recovery Monitoring. *Addiction, 100,* 447-458.

Medicott, D. (1999). Surviving in the Time Machine: Suicidal Prisoners and the Pains of Prison Time. *Time and Society, 8,* 211-230.

Melossi, D. (2000). Changing Representations of the Criminal. *British Journal of Criminology, 40,* 296-320.

Menzies, R., Chunn, D., & Webster, C. D. (1992). Risky Business: The Classification of Dangerous People in the Canadian Carceral Enterprise. In McCormick, K. & Visano, L. (Eds.), *Canadian Penology: Advanced Perspectives In Research.* Toronto: Canadian Scholars' Press.

Menzies, R., Adamoski, R., & Chunn, D. (2002). Rethinking the Citizen in Canadian Social History. In Adamoski, R., Chunn, D. E. & Menzies, R. (Eds.), *Contesting Canadian Citizenship* (pp. 11-42). Peterborough ON: Broadview Press.

Menzies, R. (2002). Unfit Citizens and the BC Royal Commission on Mental Hygiene 1925-25. In Adamoski, R., Chunn, D. E. & Menzies, R. (Eds.), *Contesting Canadian Citizenship* (pp. 385-414). Peterborough ON: Broadview Press.

Merriam, S. B. (2002). Assessing and Evaluating Qualitative Research. In Merriam, S. B. (Ed.), *Qualitative Research in Practice: Examples for Discussion and Analysis* (pp. 15-33). San Francisco: Jossey-Bass.

Meyer, M. (2001). Between theory, method, and politics: positioning of the approaches to CDA. In Wodak, R. & Meyer, M. (Eds.), *Methods of Critical Discourse Analysis* (pp. 14-31). Thousand Oaks CA: Sage Publications.

Mies, M. (1987). Women's Research or Feminist Research. In Fonow, M. M. & Cook, J. A. (Eds.), *Beyond Methodology: Feminist Scholarship As Lived Research* (pp. 60-84). Bloomington: Indiana University Press.

Miller, D. (1994). Women Who Hurt Themselves. New York: Basic Books.

Miller, J. & Glassner, B. (2004). The 'Inside' and the 'Outside': Finding Realities in Interviews. In David Silverman (Ed.), *Qualitative Research: Theory Method and Practice* (pp. 125-139). London: Sage Publications.

Miller, W. R. & Carroll, K. M. (2006). *Rethinking Substance Abuse: What the Science Shows, and What We Should Do About it.* New York NY: Guilford Publications.

Millman, M. & Kanter, R. M. (1987). Introduction to Another Voice: Feminist Perspectives on Social Life and Social Science. In Harding, S. (Ed.), *Feminism and Methodology* (pp. 29-36). Bloomington IN: Indiana University Press.

Mitford, J. (1974). *Kind and Usual Punishment.* New York NY: Vintage Books.

Mond, J. M., Jay, P. J., Rodgers, B., Owen, C., & Beaumont, P. J. V. (2004). Beliefs of Women Concerning Causes and Risk Factors for Bulimia Nervosa. *Australian and New Zealand Journal of Psychiatry, 38,* 463-469.

Monture-Angus, P. (1999). Women and Risk: Aboriginal Women, Colonialism and Correctional Practice. *Canadian Woman Studies, 19*(1/2), 24-29.

Moradi, B., Dirks, D., & Matteson, A. V. (2005). Roles of Sexual Objectification Experiences and Internalization of Standards of Beauty in Eating Disorder Symptomatology: A Test and Extension of Objectification Theory. *Journal of Counseling Psychology, 52*(3), 420-428.

Morgan, S., Mienczakowski, J., & Smith, L. (2001). Extreme Dilemmas in Performance Ethnography: Unleashed Emotionality of Performance in Critical Areas of Suicide, Abuse and Madness. In Gilbert, K. (Ed.), *The Emotional Nature of Qualitative Research* (pp. 163-178). Boca Raton: CRC Press.

Morin, D., Roy, S., Rozier, M. & Landreville, P. (2005). Homelessness, Mental Disorder, and Penal Intervention: Women Referred to a Mobile Crisis Intervention Team. IN Chan, W., Chunn, D. E. & Menzies, R. (Eds.), *Women, Madness and the Law: A Feminist Reader* (pp. 127-146). London: Glasshouse Press.

Morin, S. (1999). *Federally Sentenced Aboriginal Women in Maximum Security: What Happened to the Promises of 'Creating Choices'?* Ottawa: Correctional Service of Canada.

Moulding, N. (2005). Disciplining the Feminine: The Reproduction of Gender Contradictions in the Mental Health Care of Women with Eating Disorders. *Social Science Medicine, 62,* 793-804.

Muller, B. J. (2004). (Dis)Qualified Bodies: Securitization, Citizenship, and Identity Management. *Citizenship Studies, 8*(3), 279-294.

Mykitiuk, R., Turnham, S. & Lacroix, M. (2006a). Prenatal Diagnosis and Pre-implantation Genetic Diagnosis: Legal and Ethical Issues. In Sharpe, N. F. & Carter, R. F. (Eds.), *Genetic Testing: Care, Consent and Liability* (pp. 189-218). Hoboken NJ: John Wiley and Sons Inc.

Mykitiuk, R., & Karpin, I. (2006b). Regulating Inheritable Genetic Modification or Policing the Fertile Imagination?: A Feminist Response." In Rasko, J. E. J., O'Sullivan, G. M. & Ankeny, R. A. (Eds.), *Ethics of Inheritable Genetic Modification: A Dividing Line* (pp. 193-222). Cambridge: Cambridge University Press.

National Implementation Working Group (NIWG). (2003). *Secure Unit Operational Plan: Intensive Intervention in a Secure Environment.* Ottawa: Correctional Service of Canada.

Naples, N. (2003) *Feminism and Method.* New York: Routledge, Taylor & Francis Books Inc.

Oleson, V. (2000). Feminisms and Qualitative Research at and into the Millennium. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research 2nd edition* (pp. 215-255). Thousand Oaks, CA: Sage Publications.

Orbach, S. (1993). *Hunger Strike.* London: Penguin.

Orsini, M. (2006). Illness Identities and Biological Citizenship: Reading the Illness Narratives of Hepatitis C Patients. Paper presented at the annual meeting of the Canadian Political Science Association, York University.

Palys, T. (2003). *Research Decisions: Quantitative and Qualitative Perspectives* (3rd Ed.). Scarborough: Nelson, Thomson Canada Ltd.

Pelissier, B. & Jones, N. (2006). Differences in Motivation, Coping Style, and Self-efficacy Among Incarcerated Male and Female Drug Users. *Journal of Substance Abuse Treatment, 30,*113-120.

Penfold, S. & Walker, G. (1984). *Women and the Psychiatric Paradox.* Milton Keynes: Open University Press.

Penfold, S. (2001). Drugged, Exploited, Labelled and Blamed: How Psychiatry Oppresses Women. In Menzies, R., Chunn, D. E. & Boyd, S. C. (Eds.), *[Ab]Using Power: The Canadian Experience* (pp.). Halifax: Fernwood Publishing.

Peters, D. K. & Range, L. M. (1996). Self-blame and Self-destruction in Women Sexually Abused as Children. *Journal of Child Sexual Abuse, 5(4), 19-33.*

Petryna, A. (2002). *Life Exposed: Biological Citizens After Chernobyl.* Princeton NJ: Princeton University Press.

Pimlott, S. Hanna, J. & Balton, M. (2005). I came to prison to do my time, not to get raped: Coping Within the Institutional Setting. *Stress, Trauma and Crisis, 8,* 157-177.

Piran, N. & Cormier, H. C. (2005). The Social Construction of Women and Disordered Eating Patterns. *Journal of Counselling Psychology, 52*(4), 549-558.

Piran, N. & Gadella, T. (2006). Eating Disorders and Substance Abuse In Canadian Women: A National Study. *Addiction, 102,* 105-113.

Pitts, C. & Waller, G. (1993). Self-Denigratory Beliefs Following Sexual Assault: Association With the Symptomatology Bulimic Disorders. *International Journal of Eating Disorders, 13*(4), 407-410.

Plumridge, E. & Chetwynd, J. (1999). Identity and the Social Construction of Risk: Injecting Drug Use. *Sociology of Health and Illness, 21*(3), 329-343.

Pollack, S. (2000). Reconceptualizing Women's Agency and Empowerment: Challenges to Self-Esteem Discourse and Women's Lawbreaking. *Women and Criminal Justice, 12,* 75-89.

Pollack, S. (2006). Therapeutic Programming as a Regulatory Practice in Women's Prisons. In Comack, E. & Balfour, G. (Eds.), *Criminalizing Women* (pp. 236-249). Halifax: Fernwood Publishing.

Pollack, S. (2007). I'm just not good in relationships: Victimization Discourses and the Gendered Regulation of Criminalized Women. *Feminist Criminology, 2*(2), 158-174.

Pollack, S. & Kendall, K. (2005). 'Taming the Shrew': Mental Health Policy with Women in Canadian Federal Prisons. *Critical Criminology: An International Journal, 13*(1). URL: http://www.springerlink.com/content/l85427n5hj4g/?p=b481761978cf4a1fb99c5719e879cda4&pi=10.

Powell, M. (2002). The Hidden History of Social Citizenship. *Citizenship Studies, 6*(3), 229-244.

Power, K., McElroy, J. & Swanson, V. (1997). Coping Abilities and Prisoners' Perception of Suicidal Risk Management. *The Howard Journal, 36*(4), 378-392.

Pratt, J. (1997). *Governing the Dangerous.* Sydney: Federation Press.

Probyn, E. (1987). The Anorexic Body. In Kroker, A. & Kroker, M. (Eds.), *Panic Sex in America.* New York NY: St Martin's Press.

Prus, R. (1996). *Symbolic Interaction and Ethnographic Research: Intersubjectivity and the Study of Human Lived Experience.* Albany: State University of New York Press.

Reinarman, C. (2005). Addiction as Accomplishment: The Discursive Construction of Disease. *Addiction Research and Theory, 13*(4), 307-320.

Reinarman, C. & Levine, H. G. (1997). Crack in Context: America's Latest Demon Drug & The Crack Attack: Politics and Media in the Crack Scare. In Reinarman, C. & Levine, H. G. (Eds.), *Crack in America* (pp. 1-52). Los Angeles: University of California Press.

Reinharz, S. (1992). *Feminist Methods in Social Research.* New York: Oxford University Press.

Rhodes, L. A. (1995). *Emptying Beds: The Work of an Emergency Psychiatric Unit.* Los Angeles: University of California Press.

Rhodes, L. A. (2004). *Total Confinement: Madness and Reason in the Maximum Security Prison.* Los Angeles: University of California Press.

Rich, E. (2006). Anorexic Dis(connection): Managing Anorexia as an Illness and an Identity. *Sociology of Health and Illness, 28*(3), 284-305.

Riessman, C. K. (2002). Analysis of Personal Narratives. In Gubrium, J. F. & Holstein, J. A. (Eds.), *Handbook of Interview Research: Context & Method* (pp. 695-710). Thousand Oaks: Sage.

Ristock, J. L. & Pennell, J. (1996). *Community Research as Empowerment: Feminist Links, Postmodern Interruptions,* Toronto: Oxford University Press.

Rose, N. (1979). The Psychological Complex: Mental Measurement and Social Administration. *Ideology & Consciousness, 5,* 5-68.

Rose, N. (1996a). Governing 'Advanced' Liberal Democracies. In Andrew, B., Osbourne, T. & Rose, N. (Eds.), *Foucault and Political Reason* (pp. 37-64). Chicago: University of Chicago Press.

Rose, N. (1996b). The Death of the Social? Reconfiguring the Territory of Government. *Economy and Society, 24*(3), 327-356.

Rose, N. (1996c). Identity, Genealogy, and History. In Hall, S. & du Gay, P. (Eds.), *Questions of Cultural Identity* (pp. 128-150). Princeton NJ: Princeton University Press.

Rose, N. (1998a). Governing Risky Individuals: The Role of Psychiatry in New Regimes of Control. *Psychiatry, Psychology and Law, 5*(2), 177-195.

Rose, N. (1998b). *Inventing Our Selves: Psychology, Power, and Personhood.* Cambridge: Cambridge University Press.

Rose, N. (1999a). *Governing the Soul: The Shaping of the Private Self (2nd edition).* London: Free Associations Books.

Rose, N. (1999b) *Powers of Freedom: Reframing Political Thought.* Cambridge: Cambridge University Press.

Rose, N. (2006). *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-first Century.* Princeton NJ: Princeton University Press.

Rose, N. & Miller, P. (1992). Political Power Beyond the State: Problematics of Government. *British Journal of Sociology, 43*(2), 173-205.

Rose, N. & Novas, C. (2003). Biological Citizenship. In Ong, A. & Collier, S. (Eds.), *Global Anthropology* (pp. 439-463). New York: Blackwell.

Rose, N. & Valverde, M. (1988). Governed By Law? *Social and Legal Studies,7*(4), 542-551.

Roseneau, P. M. (1992). *Post-modernism and the Social Sciences: Insights, Inroads and Intrusions.* New Jersey: Princeton University Press.

Ross, R. & McKay, H. B. (1979). *Self-Mutilation.* Lexington, MA: D.C. Health.

Russell, D. (1995). *Women, Madness & Medicine.* Cambridge: Polity Press.

Schram, S. F. (1993). Postmodern Policy Analysis: Discourse and Identity in Welfare Policy. *Policy Sciences, pp. 249-270.*

Serpell, L., Teasdale, J. D., Troop, N. A., & Treasure, J. (2004). The Development of P-Can, A Measure to Operationalize the Pros and Cons of Anorexia Nervosa. *International Journal of Eating Disorders, 36*, 416-433.

Shaw, M. (2000). Women, Violence and Disorder in Prisons. In Hannah-Moffat, K. & Shaw, M. (Eds.), *An Ideal Prison? Critical Essays on Women's Imprisonment in Canada* (pp. 61-70). Halifax: Fernwood Publishing.

Siltanen, J. (2002). Paradise Paved? Reflections on the Fate of Social Citizenship in Canada. *Citizenship Studies, 6*(4), 395-414.

Silverman, D. (2001). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction.* London: Sage Publications.

Sim, J. (1990). *Medical Power in Prisons: The Prison Medical Service in England 1774-1989.* Milton Keynes: Open University Press.

Sim, J. (2005). At the Centre of the New Professional Gaze: Women, Medicine and Confinement. In Chan, W., Chunn, D. E. & Menzies, R. (Eds.), *Women, Madness and the Law: A Feminist Reader* (pp. 211-226). London: Glasshouse Press.

Simpson, T. L. (2003). Childhood Sexual Abuse, PTSD, and the Functional Roles of Alcohol Use Among Women Drinkers. *Substance Use and Misuse, 38*(2), 249-270.

Simons, L., Ducette, J., Kirby, K. C., Stahler, G., & Shipley, T. E. (2003). Childhood Trauma, Avoidance Coping, and Alcohol and Other Drug Use Among Women in Residential and Outpatient Treatment Programs. *Alcoholism Treatment Quarterly, 21*(4), 37-54.

Smart, B. (2002). *Michel Foucault.* New York: Routledge.

Smart, C. (1976). *Women, Crime, and Criminology: A Feminist Critique.* London: Routledge & Kegan Paul.

Smart, C. (1995). *Law, Crime and Sexuality: Essays in Feminism.* London: Sage Publications.

Smith, C. (2002). Punishment and Pleasure: Women, Food and the Imprisoned body. *The Sociological Review, 50*(2), 197-214.

Smith, D. E. (1990a). *The Conceptual Practices of Power: A Feminist Sociology of Knowledge.* Toronto: University of Toronto Press.

Smith, D. E. (1990b). *Texts, Facts and Femininity.* London: Routledge.

Snider, L. (1994). Feminism, Punishment, and the Potential of Empowerment. *Canadian Journal of Law and Society, 9*(1), 75-104.

Snider, L. (2003). Constituting the Punishable Women: Atavistic Man Incarcerates Postmodern Woman. *British Journal of Criminology, 43*(2), 354-378.

Snyder, L. (2002). Confidentiality and Anonymity: Promises and Practices. In van den Hoonaard, W. C. (Ed.), *Walking the Tightrope: Ethical Issues for Qualitative Researchers* (pp. 70-78). Toronto: University of Toronto Press.

Stanko, E. (1997). Safety Talk: Conceptualizing Women's Risk Assessment as a 'Technology of the Soul'. *Theoretical Criminology, 1*(4), 479-499.

Stanley, L. & Wise, S. (1983). *Breaking Out: Feminist Consciousness and Feminist Research.* London: Routledge.

Stanley, L. & Wise, S. (1990). Method, Methodology and Epistemology in Feminist Research Processes. In Liz Stanley (Ed.), *Feminist Praxis: Research, Theory and Epistemology in Feminist* (pp. 20-60). London: Routledge.

Stanley, L. & Wise, S. (1991). Feminist Research, Feminist Consciousness, and Experiences of Sexism. In Fonow, M. M. & Cook, J. A. (Eds.), *Beyond Methodology: Feminist Scholarship As Lived Research* (pp. 265-283). Bloomington: Indiana University Press.

Stasiulis, D. (2004). Hybrid Citizenship, and What's Left. *Citizenship Studies, 8*(3), 295-303.

Status of Women Canada. (1996). *Gender-Based Analysis: A Guide for Policy-Making.* Ottawa, ON: Status of Women Canada.

Steiger, H., Gauvin, L., Seguin, J. R., Jabalpurwala, S., Stotland, S. (1999). Hypersensitivity to Social Interactions in Bulimic Syndromes: Relationship to Binge Eating. *Journal of Consulting and Clinical Psychology, 67*(5),765-775.

Stein, K. F. & Corte, C. (2007). Identity Impairment and the Eating Disorders: Content and/organization of the Self-concept in Women with Anorexia Nervosa and Bulimia Nervosa. *European Eating Disorders Review, 15,* 58-69.

Strauss, A. & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* Thousand Oaks, CA: Sage Publications.

Streigel-Moore, R. H. & Cachelin F. M. (2001). Etiology of Eating Disorders in Women. *The Counselling Psychologist, 29*(5), 635-661.

Streigel-Moore, R. H., Silberstein, L. R. & Rodin, J. (1993). The Social Self in Bulimia Nervosa: Public Self-Consciousness, Social Anxiety, and Perceived Fraudulence. *Journal of Abnormal Psychology, 102*(2), 297-303.

Sturza, M. L. & Campbell, R. (2005). An Exploratory Study of Rape Survivors' Prescription Drug Use as a Means of Coping With Sexual Assault. *Psychology of Women Quarterly, 29,* 353-363.

Suyemoto, K. L. (2002). Constructing Identities: A Feminist, Culturally Contextualized Alternative to 'Personality.' In Ballou, M. & Brown, L. S. (Eds.), *Rethinking Mental Health and Disorder: Feminist Perspectives* (pp. 71-98). New York: Guilford Press.

Sykes, G. (1958). *The Society of Captives.* Princeton NJ: Princeton University Press.

Task Force on Federally Sentenced Women (TFFSW). (1990). *Creating Choices*: Report of the Task Force on Federally Sentenced Women. Ottawa: Ministry of the Solicitor General.

Tedlock, B. (2000). Ethnography and Ethnographic Representation. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research* (pp. 455-486). London: Sage Publications.

Tewksbury, R. & Gagne, P. (2001). Assumed and Presumed Identities: Problems of Self-Presentation in Field Research. In Miller, J. M. & Tewksbury, R. (Eds.), *Extreme Methods: Innovative Approaches to Social Science Research* (pp. 72-93). Toronto: Pearson Education.

Tilka, T. L. & Subich, L. M. (2004). Examining a Multidimensional Model of Eating Disorder Symptomatology Among College Women. *Journal of Counselling Psychology, 51*(3), 314-328.

Titscher, S., Meyer, M., Wodak, R. & Vetter, E. (2000). *Methods of Text and Discourse Analysis.* London: Sage Publications.

Turell, S. C. & Armsworth, M. W. (2003). A Log-Linear Analysis of Variables Associated with Self-Mutilation Behaviors of Women With Histories of Child Sexual Abuse. *Violence Against Women, 9*(4), 487-512.

Ussher, J. M. (1991). *Women's Madness: Misogyny or Mental Illness?* Amherst: University of Massachusetts Press.

Ussher, J. M. (Ed.). (1997). *Body Talk: The Material and Discursive Regulation of Sexuality, Madness and Reproduction.* London: Routledge.

Valverde, M. (1998). *Diseases of the Will.* Cambridge: Cambridge University Press.

Van Boven, A. M. & Espelage, D. L. (2006). Depressive Symptoms, Coping Strategies, and Disordered Eating Among College Women. *Journal of Counseling and Development, 84*, 341-348.

van Dijk, T. (1993). *Elite Discourse and Racism.* Newbury Park CA: Sage.

Verbrugge, P. & Blanchette, K. (2002). The Validity of the Custody Rating Scale for the Initial Security Classification of Aboriginal Women. *Forum, 14*(3), 10-12.

Wagner, D. (1997). *The New Temperance.* Boulder CO: Westview Press.

Waller, G. (1993). Association of Sexual Abuse and Borderline Personality Disorder in Eating Disorder Women. *International Journal of Eating Disorders, 13*(3), 259-263.

Warren, C. (2002). Qualitative Interviewing. In Gubrium, J. F. & Holstein, J. A. (Eds.), *Handbook of Interview Research: Context & Method* (pp. 893-102). Thousand Oaks: Sage.

Weaver, G. D., Turner, N. H., Kristi, P. H. & O'Dell, J. (2000). Depressive Symptoms, Stress, and Coping Among Women Recovering From Addiction. *Journal of Substance Abuse Treatment, 18,161-167.*

Webb, S. (1990). Counter-arguments: An Ethnographic Look at 'Women and Class.' In Stanley, L. (Ed.), *Feminist Praxis: Research, Theory and Epistemology in Feminist Sociology* (pp. 205-220). London: Routledge.

Weber, L. (2004). A Conceptual Framework for Understanding Race, Class, Gender and Sexuality. In Hesse-Biber, S. N. & Yaiser, M. L. (Eds.) *Feminist Perspectives on Social Research* (pp. 121-139). New York: Oxford University Press.

White, M. & Hunt, A. (2000). Citizenship: Care of the Self, Character and Personality. *Citizenship Studies, 4*(2), 93-116.

Wichmann, C., Serin, R., & Abracen, J. (2002). *Women Offenders who Engage in Self-Harm: A Comparative Investigation.* Ottawa: Correctional Service of Canada.

Williams, A. (1990). Reading Feminism in Fieldnotes. In Stanley, L. (Ed.), *Feminist Praxis: Research, Theory and Epistemology in Feminist Sociology* (pp. 253-361). London: Routledge.

Wilson, J. (2004). Beyond Psychiatry: How Social Workers Conceptualise Women and Self-starvation. *Australian Social Work, 57*(2), 150-160.

Wincup, E. (2001). Feminist Research With Women Awaiting Trial: The Effects on Participants in the Qualitative Research Process. In Gilbert, K. (Ed.), *The Emotional Nature of Qualitative Research* (pp. 17-35). Boca Raton: CRC Press.

Wodak, R. (2001). What CDA is About – A Summary of its History, Important Concepts and its Development. In Wodak, R. & Meyer, M. (Eds.), *Methods of Critical Discourse Analysis* (pp. 1-13). Thousand Oaks CA: Sage Publications.

Yateman, A. (2007). The Subject of Citizenship. *Citizenship Studies, 11*(1),105-115.

Young, A. M., Boyd, C. & Hubbell, A. (2000). Prostitution, Drug Use, and Coping with Psychological Distress. *Journal of Drug Use, 30*(4), 789-800.