

“WE DON’T WANT THE LOONIES TAKING OVER”

*EXAMINING MASCULINE PERFORMATIVES BY PRIVATE SECURITY IN A
HOSPITAL SETTING*

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DEDICATION

To Genevieve, my fiancée, life-partner, and soul mate. I love you forever.

To the guards, for without your voices, bravery and trust, none of this would be possible.

To all the lives locked and lost in cells and cages

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ABSTRACT

After sixteen intensive months, I quit my employed position as a security guard at a local hospital. By drawing on my autoethnographic experiences in the form of “ethnographic fiction writing”, as well as eight interviews with my former male colleagues, I explore how the guards’ constructions of masculinity intersect with their security assessment and subsequent application of force, chemical incarceration, and other coercive security tactics on involuntarily-committed mental health patients. The narratives are framed by the available literature on gender and masculinity within the security, police, prison and military institutions, as well as the theoretical notions of gendered institutions (Acker), hegemonic masculinity (Connell & Messerschmidt), doing gender (West & Zimmerman), and Dave Holmes’s application of Foucauldian biopolitical power to forensic healthcare settings. These concepts are used in tandem with a creative methodological tool to reveal the “messy”, “bloody” and “gendered” ways in which hospital life unfolds between the guard, the nurse, and the patient prisoner. By escaping more traditional forms of academic writing, I am able to weave raw, sensitive and reflexive thoughts and emotions into the research design and analysis.

The analysis is divided into two narratives: “Us” and “Them”. “Us” emphasizes the gendered ways in which the hospital guard learns, reproduces, resists, lives up, or fails to live up to the masculine codes of the profession. Here, the guard must confront cultural demands to demonstrate physical prowess, authority and heroism during a patient battle. “Them” explores how hegemonic masculinity shapes the hierarchical and coercive relations between the guard, the nurse, and the patient, and reinforces psychiatrized discourses that promote punishment, pain, bureaucracy and control. Overall, these findings call for the abolition of physical restraint, chemical incarceration and other coercive security measures within our healthcare institutions, and encourage future research to give voice to the lived experiences of women guards and security management teams.

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CHAPTER 1: THE ONTOLOGICAL TRIGGER

Charles: It's like you know all the woman wanted to do was not be in her room. And yet they forced her to be in her room to the point where...they literally took away all her rights, they took away her freedom to walk, they took away her freedom to choose to take medication, they took away her freedom...to just stand.

Me: For being sick.

Charles: Yeah, exactly; sick even though she didn't portray, you know, any aggression. We have the ability to take away those rights because of you know different laws and regulations that we put into effect. We have the right to take someone's rights away if we deem them a danger to themselves. Even though we don't necessarily need...you know as much just cause as should be necessary.

Me: Sounds like a prison.

Charles: Essentially well it is right? It's...what *prison* do you have more freedom in? (...) You know you're not gonna be held down...pants ripped off to get a needle shoved you know...in your bum. To make you medicated so you lose your mind. You know some of these medications that they're actually feeding to people um...actually destroy some part of your brain where you know after prolong uses of it...essentially your intelligence will diminish.

Me: That's right.

Charles: And the thing is that, right there you're losing your rights to your mind. And then you gotta ask yourself what is sick?

Me: (...) What is sick?

Charles: Well it's like...because someone doesn't want to, you know, focus on the concepts of society, doesn't want to be you know...one of I guess the norm. We automatically consider them as outcasts. We automatically consider them as being sick. It's because they don't believe...in what the masses believe (...) I would rather you know...be the master of my own reality. Understand what I want to understand.

On March 08, 2010 I resigned from a security guard position at a local closed institution.

Working there however is not the same experience one might have at a provincial or federal detention center. The walls are sterile white. All the "cells" stretch alongside one long, narrow corridor. There are cameras and staff everywhere and security remains on-call a few floors below the ward, 24-7. Unless the doctors say so, there is no leaving.

If you have not already guessed, the closed institution I refer to is a local hospital that functions as a contemporary equivalent of the historic lunatic asylum. Here, the prisoners are the patients incarcerated against their will; the headmasters are the nurses, and the "screws" are "us" – the prison hospital guards. The reason I left this profession is best summarized in a passage

from the resignation letter I sent to the institution's Board of Governors the same night I resigned:

...I could no longer withstand the moral conflict I was experiencing as a result of my exposure to the hospital security department and mental health system. To summarize a description of the hospital's security team, management and psychiatric system, I would use the words broken and unjust. Each and every day, both voluntary and involuntary patients residing in [the hospital] encounter gross, neglectful violations of rights that are guaranteed to them under the Ontario Mental Health Act. Having developed a close personal relationship with a number of the security staff over this past year, I can assure you that I am not the only individual who is aware of this claim. However, I am perhaps the only individual who feels that expressing my dissatisfaction with the hospital may have any meaningful impact on its practices, as the bureaucratic style of management has created widespread feelings of indifference. Some of these individuals have worked at the hospital for fifteen years, and some as little as six months, but in either case most will admit (if approached) that they do not ethically support the use of force they must perform every day. Correspondingly, they will admit that any disobedience to the aggressive, illegal orders of health care staff will likely result in the loss of their job, or at the very least a sanction that will cause them both economic and personal hardship.

What my former colleague Charles and I have just described is the ontological trigger that catapulted us into a different view of the world. Laying our uniform, military boots, protection vest and tactical belt to rest signalled an intrinsic shift in our mentalities towards psychiatric patients – persons whom we spent months and months with interacting, monitoring, surveilling, restraining, punishing, and certainly at times, hurting. Instead of viewing these prisoners as dangerous, risky objects, Charles and I began to problematize the socio-legal context of their “treatment” and incarceration (see Chapter 1, Section VIII). Soon, we found ourselves in a position where we could no longer do the job. No longer abiding by the masculine codes of conduct that adjure all guards to “keep an image of more brutality and authority” (see p. 108), Charles was quickly terminated from his position without cause. Alternatively, my decision to quit came abruptly after witnessing the last of a series of chemical injections and physical restraints used on patients against their will.

This research ultimately departs from these accounts by engaging in a qualitative narrative analysis of the gendered performatives that shape the stories and lived experiences of the “prison” hospital guard¹. Importantly, this research draws a distinction between a gendered *performance* and *performative*. Originating from the Chicago School, a gendered performance is a dramaturgical concept that explains gender as literal acts, or demonstrations of the male or female character. Gendered performatives, on the other hand, refer to a substantial model of gender identity² that is temporally enacted in social arenas/cultures. As Butler (1988) explains,

If gender is instituted through acts which are internally discontinuous, then the *appearance of substance* is precisely that, a constructed identity, a performative accomplishment which the mundane social audience, including the actors themselves, come to believe and to perform in the mode of belief. If the ground of gender identity is the stylized repetition of acts through time, and not a seemingly seamless identity, then the possibilities of gender transformation are to be found in the...breaking or subversive repetition of that style (p. 520).

To investigate prison-hospital masculine security performatives, that is, the repetitive masculine behaviours that guards ontologically adopt, authoritate, and teach to their peers throughout the course of their duties and interactions with patient-prisoners, I used in-depth semi-structured interviews with eight former colleagues (all male) and divulge personal reflexive experiences through an autoethnographic form of narrative writing (see Chapter 4, Section V).

This methodological template enabled me to explore the following research questions:

RQ1a: How do private security guards in local hospitals construct gender and masculinity?

RQ1b: How do hegemonic discourses of masculinity contribute to the coercion of (patient) prisoners?

¹ I use “prison” hospital throughout this research as a conceptual term to describe the ways in which patients experience deprivation similar to prisoners of a penitentiary, jail, asylum, or other closed institution. I do not use this term to suggest that the institution studied in this research is a facility for the “criminally insane”.

² Drawing from Butler (1988), this research establishes that gender identity is imbued by the essentialized discourses of masculinity and femininity that differentiate what it means to act like a woman or a man. Alternatively, gender identity can be conceptualized as how a person understands her or his own sex, gendered self and body. This perspective deconstructs dichotomous understandings of gender categories (man or woman), and makes reference to persons who are able to create a “third gendered space” by blending, destabilizing and manipulating gender categories of masculinity and femininity (see Connell, 2009, Devor, 1989).

RQ2: How does hegemonic masculinity inform the guard's understanding of his role and responsibility towards the nurse and the patient?

Outline

This thesis is divided into seven chapters. Following the introduction, Chapter 2 contextualizes this research by exploring the topical literature on police, prison, military, and private security culture and masculinity. Subsequently, the chapter explores how masculinity is constructed as the “dirty work” (Dick, 2005; Tracey & Scott, 2006) of the criminal justice system. The focus then shifts to a review of the scholarly debates on psychiatric-based physical and chemical incarceration practices.

Chapter 3 builds the theoretical framework for this study by drawing primarily on Acker's (1990; 1992) theory of gendered organizations, Connell (1987 et al.) and Messerschmidt's (1993) concept of hegemonic masculinity and its role shaping gendered relations within institutions of social control, West and Zimmerman's (1987) notion of “doing gender”, and Holmes's (2012 et al.) work on violence in forensic healthcare settings.

Chapter 4 unfolds the chosen methodological approach. First, this chapter discusses the ontological and epistemological foundations of this research. Next, it explores the data collection process, including the reflexive politics, tensions and emotions that shape this study's ideological perspective and ambitions. The chapter concludes with a discussion on the method of analysis (narrative inquiry), as well as the ethical concerns and limitations of this research.

The analysis is divided into two narratives: “Us” (Chapter 5) and “Them” (Chapter 6). Chapter 5 explores how the guards construct hegemonic masculinity and resist, reproduce, live up, or fail to live up to the gendered codes of their profession. Chapter 6 then examines how masculinity disperses throughout the hospital and discursively shapes hierarchical and coercive relations between the guard, the nurse, and the patient.

Chapter 7 concludes the study by highlighting areas for future scholarly research, and by calling for the abolition of physical and chemical restraint practices in forensic psychiatric settings. Ultimately, this thesis endeavours to give voice to the gendered experiences of nine men belonging to a profession that I, and others (Rigakos, 2002; Singh & Kempa, 2007) argue is in dire need of academic attention.

CHAPTER 2: LITERATURE REVIEW

I – From public to private: The rise and expansion of private security

Recent research demonstrates that private security companies endorse and perform a reactive and punitive culture similar to modern public policing organizations (Singh & Kempa, 2007). These findings are understood in the context that many private security officers have professional aspirations to join the public police force (Rigakos, 2002). Subsequently, the current organizational and legal structure increasingly mirrors the paramilitary environment of public policing institutions (pp. 298-299). The drastic rise in private security agents is attributed to the overwhelming citizen demands that are placed upon public police, which limit the resources available for police to respond to low-level security threats to private property (Ericson, 2007). For example, the emergence of mass private property and quasi-public spaces such as shopping centres, market sites, securitized residential properties and healthcare institutions relegates the role of preserving order to business and private property owners. Huey, Ericson and Haggerty (2005) note that these structural shifts in policing are to some extent “predicated on the belief that the public police have failed to sufficiently meet the needs of citizens with means to employ their own security” (p. 146). Arguably, this has opened a door for private security officers to commit acts of malpractice, that is, take security measures into their own hands, away from the public legislation that attempts to regulate and monitor how officers use force, make arrests and detain persons (Lavigne, 2008).

Public policing sub-cultural studies are a useful point of entry to explore the intervention practices of private security organizations because there is evidence that the two industries are operating in a similar manner both managerially and culturally (Micucci, 1998; Monaghan, 2002; Rigakos, 2002). However there are conceptual points of departure for future police and security culture studies (Singh & Kempa, 2007). Specifically, there are few ethnographies or empirical

studies that observe the cultural practices of private security officers in Canada (Rigakos, 2002), let alone their gender/ed performatives in mental health facilities. This research fills this gap in the literature by examining data gleaned from interviews with eight hospital private security officers, as well as my own auto-ethnographic lived accounts of working as a security guard at a local psychiatric facility. These experiences reveal tensions in how local security officers proffer hyper-masculine performatives in hospital/healthcare settings that are too often described as facilitating patient-care, compassion and integration (Holmes & Murray, 2011, 2012, p. 27). For the sake of the guard's reputation and gendered status, he chooses to "wear" his masculinity so as to subordinate the feminine. Specifically, the guard must adopt brutal, oppressive, repressive, authoritative, decisive, muscular, and hierarchal codes of behaviour instead of engaging in and promoting acts that demonstrate compassion, understanding, forgiveness, sympathy, nurturance and freedom.

II – Alpha Masculinity: What we know and don't

A vast amount of literature is dedicated to conceptualising masculinity and its dangerous consequences within policing (Conti, 2011; Herbert, 2001; Kraska & Kappeler, 1992; Kurtz, 2008; Messerschmidt, 1993; Miller, Forest & Jurik, 2003; Moore, 1999), prison (Bandyopadhyay, 2006; Britton, 2007; Crewe, 2006; Jewkes, 2005; Kruttschnitt & Gartner, 2004; Shabaz, 2009) and military institutions (Albuquerque & Paes-Machado, 2004; Duncanson, 2009; Johnson, 2010; Shefer & Mankayi, 2007). Many of these studies draw a connection between institutional violence and the gendered performatives that police officers, correctional officers, and prisoners are demanded to reproduce. Yet despite this, there are no studies to date that explore how the gender performatives of hospital security officers resist or contribute to the disbursement of power and coercion within the hospital. Since research discovered similarities between the gendered performatives of police and security officers (Rigakos, 2002) and

psychiatric institutions have a long history of being theorised as a prisonlike environment (Donald, 2001; Holmes et al., 2012; Jain & Murthy, 2006; Wright, 1997), I draw primarily on literature that critically explores the construction of masculinity within policing/prison institutions, as well as the “prison” hospital practice of physical/chemical incarceration. This allows us to excavate the links that adjoin how the gendered experiences of security officers exacerbate or hinder coercive intervention within psychiatric facilities.

It is essential to note that there is no literature to date that richly describes the training services that contract or in-house security agencies distribute to private security officers that work with psychiatric patients. However, my lived experience as a security guard in a local psychiatric facility indicates that local hospital private security officers are predominantly trained in security measures rather than therapeutic interventions. Put simply, it is assumed that security’s focus is generally on power, control and restraint. This reflexive predisposition allows for theoretical links to be drawn from the available literature on police/prisoner masculinity to how hospital security agents accomplish hegemonic masculinity through the coercive and penal management of patient-prisoners.

Some research on the gendered nature of policing equates hegemonic police masculinity with macho stereotypes such as having a combative personality, resisting management, and romanticizing or materializing the desire to engage in physical aggression or fights (Herbert, 2001; Prokos & Padavic, 2002). Other field researchers indicate that police masculinity discredits opposing gendered behaviours through more discursive illustrations of dominance that appear in the socialized speech, tone, and gestures of police officers (Fielding, 1984; Herbert, 1998; Nolan, 2009). These institutionally regulated performatives are linked to both male and female officers’ experiences of occupational burnout (He, Zhao & Archbold, 2002; Kurtz, 2008), sexual harassment (Herbert, 2001; Miller, Forest & Jurik, 2003; Westmarland, 2001), marital

dissipation and a decline in health and job satisfaction (Howard, Donofrio & Boles, 2004), and even suicide (Berg et al., 2003; Hem, Berg, Marie & Ekeberg, 2001; Violanti, 1996; 2004).

Granted, these and other definitions of police masculinity are useful concepts to help explain both police and prison culture. Building on this literature, Evans and Wallace (2008) conceptualize prisoner masculinity within a broader set of engendering traits, referring to it as the “power, ambivalence towards femininity, domination and objectification of nature and the psyche, and the avoidance of emotion” (p. 485). Here, masculinity is equated with resistance to adopting emphasized feminine traits; according to the literature this notion is embedded in both policing and private security structures (Herbert, 2001; Kurtz, 2008; Manzo, 2004; Micucci, 1998; Miller, Forest & Jurik, 2003; Rigakos, 2002; Singh & Kempa, 2007). Moreover, heteronormative beliefs and gender performatives contribute to the occurrence of prisoner rape (Calderwood, 1987; Carlson, 2009; Eigenberg, 1989; 2000; Gear, 2007; Jenness, Maxson, Sumner & Matsuda, 2010) and cultural devaluations of homosexuality, femininity, and transgendered persons (Jenness, 2010; Kimmel, 1994; Schilt & Westbrook, 2009; Sumner, 2009; Tewksbury & Potter, 2005; Trammell, 2011).

By mobilising these topical studies, and in Chapter 3 the theoretical foundations of Acker, Connell, Messerschmidt, and West and Zimmerman, I explore how hegemonic masculinity shapes both the hospital security culture and institutions of social control at large. For now, Section III of this chapter briefly addresses the historical and modern typologies around which police institutions are structured, and their basis for perpetuating the formation and maintenance of gendered subcultures. Following that, I engage with the current literature on policing and prison masculinity and its implications for critical research on forensic healthcare settings.

III – Public policing as private: Historical police typologies

Public policing and private security are conflated enterprises. As Rigakos (2005) illustrates, policing is considered to be “[a]ny individual or organization acting legally on behalf of public or private organizations or person(s) to maintain security and/or social order while empowered by either public or private contract, regulations, or policies, whether verbal or written” (p. 271). While the question of gender still evades most debates on private security, critics suggest that the industry possesses limited public accountability, lacks adequate regulation and upholds poor standards of recruitment and training (Johnston, 1999; Jones & Newburn, 1998; Lavigne, 2008; Loader, 2000). This is demonstrated in the context that private security officers function on behalf of private enterprises, and therefore cannot act on their own discretion but only through the powers that are granted to all persons in the *Canadian Criminal Code* and provincial property/trespass acts (Murray & McKim, 2000; Rigakos, 2002). Indeed, these findings in conjunction with historical police traditions help explicate how the structural design/influence of the private security industry facilitates the emergence and growth of masculine security performatives.

There are six historical types of policing: labour-based, polemic, sentry-dataveillant, investigative, patrol and civic-sumptuary (Rigakos, 2005). Labour-based policing is the expenditure of human energy for the purposes of doing security work and extracting surplus value. While all styles of policing intersect, polemic policing involves embracing the paramilitary, lethal, warrior-based activities that attempt to safeguard individuals who are at risk of losing their status, money, power or lives. Sentry-dataveillant policing includes defensive, passive-intelligence gathering and distanced monitoring activities such as alarm response, the completion of intrinsic paperwork, and the adoption of a regulatory bureaucratic structure. Investigative policing is comparable to secretive reactive policing that is based on gathering

information through client concerns, citizen informants, or digital dispatch and victim reports. This type focuses on specific targets, namely individuals who are already accused of an offence. Patrol policing involves officers becoming active, visible deterrents, being on-call and alert, and observing activities on foot, horse, bicycle or motor vehicle. Likewise, patrol-policing is imperative for the emergence of mass exchange and commodity mobility. Lastly, civic-sumptuary policing refers to regulatory and civic concerns such as health, and economic, moral and sumptuary regulation.

Overall, this typology affirms that there are structural blueprints regulating the expanding market of the private security industry. As I demonstrate in Chapter 3, these structures are not distant from the theoretical traditions of hegemonic masculinity, and thus facilitate the growth, power and success of security institutions as masculine enterprises. That being said, I now turn our attention to the small but growing body of literature on private security cultures.

IV – Cultural explorations of private security guards

There is some, albeit very little, ethnographic research that explores the occupational sub-culture of Westernized private security companies. After completing a field study of Intelligarde, a Toronto-based contract private security company, Rigakos (2002) concluded that Intelligarde agents perform para-policing³ responsibilities at the levels of rhetoric and practice. These officers invade crack houses, participate in tenant evictions, and disrupt the business of so-called drug gangs in Toronto. In fact, Rigakos (2002) found that these guards construct their job as “crime-fighting within a ‘wannabe’ culture”, where private security officers aspire to participate in romanticized notions of so-called “exciting” careers in public policing (p. 30). Within this

³ Para-police are persons who perform legally sanctioned duties and responsibilities that go beyond those generally associated with the public police. Rigakos (2002) argues that private security companies/organizations bridge the gap between what is considered public and private space by stepping over boundaries on what is considered legally permissible powers of arrest and trespass enforcement for the citizen (or security guard).

para-policing working environment and model is the need to perform moralized cultural practices. These include looking busy, possessing a siege mentality, exemplifying solidarity and a drive to assist colleagues, negotiating the riskiness of perceived dangerous persons, managing status frustration or more specifically perceptions of disrespect and stigma that are associated with a negative image from the public police, and lastly, the embodiment of hyper-masculinity. Indeed, the informal occupational socialization of private security guards involves front-line officers engaging aggressive performatives that are commonly displayed in public policing organizations such as exerting dominance, physicality and control (see especially Conti, 2011; Prokos & Padavic, 2002).

Some empirical studies suggest that North American private security agencies are not organizationally harmonious, but rather fragmented groups that endorse distinct worldviews and occupational practices that are not necessarily concurrent with the goals set out by the security client (Bogard, 1996; Manzo, 2004; Micucci, 1998). For example, Manzo's (2004) study indicates that Canadian security officers' roles, responsibilities and behavioural expectations within private security culture have little to do with the objectives of their supervisors or mall management. Specifically, security officers interact irregularly and rarely with customers or visitors. While mall guards exhibit attitudes ranging from enthusiastically welcoming to outright cautious, their behaviours do not carry any significant notice to youth visiting the mall. Similarly, Micucci (1998) argues that the execution of security tasks is influenced by the methods in which loss prevention security officers' varying occupational styles congregate or diverge. Another study found that bouncers or doormen negotiate violence by imposing authority on insubordinate customers through "uncivilised" interventions (Monaghan, 2002). These guards engaged in group bullying, beatings, and violent ejections of civilians from their private establishment in spaces that are not under close surveillance. Further research could explore the

explicit presence of violence in private security subcultures where officers are encouraged or obligated to practice coercive intervention. More specifically, this research helps us to understand how private security officers in hospitals negotiate the countless responsibilities that drive them to exercise coercive force over patient-prisoners in a communicative, interactive setting with other security agents, public police, nurses and medical staff at large.

Another study that investigated the relationship between downtown Vancouver private/public police officers discovered that many private security officers are given informal discretion from their public counterparts to kick and physically displace youth who are found sleeping on sidewalks (Huey, Ericson & Haggerty, 2005). While some mall loss prevention officers rarely interact with public police in order to avoid generating extra work for both parties, others work in tandem with police on “sting operations in both public and private space” (Huey, Ericson & Haggerty, 2005, p. 163). Public police officers often construct themselves as embodying a supervisory role to private security officers, and categorize the privatized profession as beneficial to public safety. This hierarchy of power amongst policing and security agents reinforces in private security agencies some of the routine problematics in doing police work, such as modifying reports and incidents to avoid the process of completing detailed paperwork requirements (Bogard, 1996; Skolnick, 1966).

Other public police officers envision private security guards as their sidekick, or “lesser” companion in the hierarchy of policing work (Huey, Ericson & Haggerty, 2005). From this perspective, private security work is devoted to the less intense aspects of policing work, which includes moving vagrants from private property and managing petty crimes such as shoplifting. Notably, some public police officers confirm that there is a lack of sufficient training for private security guards, which may contribute to the repetitive public complaints that accuse private

security guards of mistreating citizens and overstepping their legislated boundaries of arrest, detainment and force.

Importantly, Section 17 of the *Ontario Mental Health Act* (1990) permits public police officers to take a person into custody to an appropriate place for examination by a physician when the officer has reasonable and probable grounds to believe that the person is a threat to cause bodily harm to himself or others, or has demonstrated a lack of competence to care for himself or herself. While this study focuses predominantly on how hospital security guards construct their gendered relationships with each other, nursing staff, and patient-prisoners, other research is directed to explore how hospital security agents negotiate a partnership with public police and medical staff when mental health patients' custody is transferred into the private space of psychiatric facilities. Now that we have reviewed the current literature on private security cultures, we can forthwith examine (in Sections V to VIII) the myriad of literature that explores the construction of gender difference and the practices of discrimination, violence and masculinity within public policing institutions. As discussed in Section VI of Chapter 3, the construction of gender differences negates the formation of status-equal friendships between men and women, which then bursts into widespread masculinized justifications for gendered inequality, dominance and violence (Connell, 2009, p. 43; Fenstermaker & West, 2002; Rouse, 2002; West & Zimmerman, 1989).

V – Gendered othering sparking stress and forceful intervention

Despite the rise of liberal feminist hiring initiatives in public policing (Burligame & Baro, 2005; Martin, 1991; Miller, 1998; Schultz, 1993), researchers find that the highly combative, derogatory, misogynistic attitudes of male police officers results in women's exclusion from meaningful positions of power in institutional policing structures and enterprises (Burke & Mikkelsen, 2005; Herbert, 2001; Miller, Forest & Jurik, 2003; Morash & Haarr, 2005;

Prokos & Padavic, 2002; Rabe-Hemp, 2007). Women are often expected by their male counterparts to conform to the physical standards and requirements of the masculine code, which involves laying arrests and resorting to force more frequently. Overall, these findings reiterate the industry's reliance on physicality to resolve incidents (Chappell & Lanza-Kaduce, 2010; Herbert, 2001; Kaufman, 1998; Kurtz, 2008). These onerous, dictatorial masculine values situate law enforcers in a gendered workspace that celebrates the use of force and marginalizes gendered outsiders who do not or cannot perform them to the same degree (Garcia, 2003; Gerson & Peiss, 1985; Prokos & Padavic, 2002).

Some suggest that masculine expressions – illustrated through acts of sexual harassment (Bird, 1996; Brown, 1998; Burke & Mikkelsen, 2005; Heidensohn, 1994; Hunt, 1990; Marion, 1998; Rabe-Hemp, 2007), discriminative recruitment/administrative methods (Brown & Sargent, 1995; Chappell & Lanza-Kaduce, 2010; Cohn, 2000; Darien, 2002; Dick & Jankowicz, 2001; Haarr, 1997; Lonsway, 2003; Morgan, Foster & Kolbert, 2000; Prokos & Padavic, 1991; 2002; Shear, 1996), or exclusion from social circles (Fletcher, 1996; Haarr, 2005; Waddington, 1999) – restrict women from entering policing, and obligate those who do join to perform the job in an unsympathetic demeanour (Remington, 1983) and to engage in a series of tough arrests and aggressive acts (Rabe-Hemp, 2007, pp. 263-264). The constant pressure to live up to these expectations is linked to the debilitating onset of stress and burnout (Brown & Carlson, 1993; Kurtz, 2006; 2008). Since there is evidence that private security organizations are governed by similar bureaucratic paramilitary structures (Murphy & Clarke, 2005; Rigakos, 2002, 2005), this research explores how gendered othering and discriminative security practices shape the prison hospital guard's attitude towards – and in some cases justification of – coercive intervention practices.

On that note, we now turn to Section VI, which examines how the normative and thus culturally accepted tropes of police masculinity interact with practices that emphasize the restraint, control and detainment of patient-prisoners, which is conceptualized as the “dirty” aspects of hospital security work.

VI – Policing as engendered dirty work

Unlike firefighters, the designated heroes of public safety, institutional workers such as police and correctional officers do the dirty work of the criminal justice system (Dick, 2005; Tracy & Scott, 2006). Coined by Everett Hughes in 1951, the expression dirty work refers to “occupational activities that are physically disgusting, that symbolize degradation, that wound the individual’s dignity, or that run counter to the more heroic of our moral conceptions” (cited in Dick, 2005, p. 1364). By constructing a hierarchy of criminal justice work, some police officers view themselves as assuming a less valuable and even tainted role in the management of crime control and security when juxtaposed to the more “professionally” categorized responsibilities that belong to lawyers, judges, and other higher court officials. Here, they express feelings of moral ambiguity over their potential to use coercive force against citizens (Dick, 2005, pp. 1364-1365; Waddington, 1999).

Accordingly, Rigakos’s (2002) ethnography indicates that private security officers perceive their occupation as “thankless grunt work” that is a required stepping-stone in acquiring a position with public policing agencies (Rigakos, 2002). Thus, unlawful demonstrations of force can be seen as a cultural response to the degrading, lowly (and widely-held and reproduced) perceptions of security work, or more specifically an avenue security guards access in order to gain notoriety, respect and admiration within their field, and from the public. Lastly, since nursing is generally viewed as taking on a compassionate and thus maternal function in healthcare (Holmes & Murray, 2011, 2012, p. 27), we must also question whether psychiatric

nurses rely on private security officers to do the dirty work of patient management. These interdependent roles may significantly impact how coercive intervention is practised and negotiated in psychiatric facilities.

Similarly, policewomen are historically constructed as embodying a nurturing or motherly role (Acker, 1990, p. 152), and are thus considered incapable of performing the masculine tasks that are typically associated with traditional policing (Sims, Scarborough & Ahmad, 2003). This gendered stereotype is further solidified within policing organizations that embody aggressiveness and machismo (Miller, 1998). Marginalization of women in policing exacerbates beliefs that women are unable to meet the conventional standards of police work, such as exhibiting high levels of aggression, strength, and force (Garcia, 2003). Moreover, the maternal role of women in a domestic setting impacts how policemen construct policewomen as incompetent figures in the department (Holdaway & Parker, 1998).

In addition, policewomen experience work-family conflicts more often than their male counterparts (Kurtz, 2008). For example, institutional discrimination can be attributed to the fact that some women take maternity leave, which subsequently leaves departments short-staffed (Brown & Carlson, 1993). These attitudes often push women into adopting administrative and secretarial “dirty” jobs within their department instead of participating more actively in “street-level” policing (Brown & Carlson, 1993; Holdaway & Parker, 1998). Alternatively, those who refuse to assume a clerical role risk the discomfort of feeling abandoned or unsupported by their peers. Not only do these studies raise obvious safety concerns for policewomen and citizens, but traditional studies of policing indicate that the judgment to execute force occurs more frequently when police discretion is limited (Rabe-Hemp, 2008). Even though some policewomen may live up to the institution’s masculine commitment to use violence, policemen still typically construct policewomen as less able and willing to physically restrain and arrest civilians (Wozniak &

Uggen, 2009). Overall, these findings demonstrate how police officers understand police work as an inherently masculine activity.

Nonetheless, it is overly simplistic to explain female self-control through the manifestation of emphasized feminine traits (Rabe-Hemp, 2008). As one Israeli case study illustrates, policewomen are not adjusting their gendered identity, but rather they are altering its meaning to accommodate the dominant traits idealized by the police institution (Moore, 1999). This fluid mixture of performatives distinguishes women's gendered experiences from those of their male counterparts (Rabe-Hemp, 2009). These findings have effectively steered this research to investigate how the hospital guard evolves his gendered identity to mirror or resist the physical/verbal expectations of nurses and physicians.

Next I explore the ways in which prisoners engage with subordinated masculinities as a resistant discourse. Section VIII then provides the legislative context for the practice of physical restraint and chemical sedative injections within Ontario psychiatric facilities, which carries us to a final overview of the literature that supports (IX), problematizes (X), and condemns (XI) the psychiatric practice of physical/chemical incarceration.

VII – Subordinated masculinity as a prison grenade

Prisoners can escape the pains of being unable to live up to the hegemonic discourses of masculinity by engaging with a subordinated masculine performative (Coles, 2008; 2009). In fact, it is not uncommon for men to reject gendered hegemony altogether, and to subsequently achieve gender status through a masculine discourse that resists, negotiates, or abandons the popularly perceived notions of how to walk, talk and act like a man (Bandyopadhyay, 2006; Coles, 2008; Connell & Messerschmidt, 2005; Messerschmidt, 1993, Richardson, 2007).

Prisoners and correctional officers are prime examples of groups that reformulate what ideal masculinity means to them in order to create their own standard. For instance, homosexual

behaviour is one way that heterosexual prisoners reassert a sexual identity/life when they are commanded by prison authorities to be celibate. While it has been identified that sex in men's prisons is traded, much like a commodity, in exchange for protection, emotional affection, security and companionship (Donaldson, 2001, pp. 592-593; Trammell, 2011), sexual acts that depart from the heteronormative standard that obligates men to obtain as many heterosexual partners as possible (Connell, 1995) may partially assist the individual to (re)gain the autonomy that total institutions displace (Bosworth & Carrabine, 2001). Likewise, it empowers prisoners' sense of manhood, as these subordinated expressions of masculinity create a hierarchy within the institution where "daddies" and "jockers" assert their control and dominance (heteronormative hegemonic traits, ironically) over "punks", "queens" and "catchers" (Donaldson, 2001, p. 594).

Not only do sexualized masculine practices regulate relationships between alpha-prisoners and subordinated prisoners, they also frame the interactions between psychiatric patients and nurses, and between patients themselves (Leyser, 2003). Specifically, Leyser (2003) observes how male patient-prisoners use verbal and non-verbal gestures to illustrate to forensic nursing staff and each other that they are worthy heterosexual specimens. This involves patients resisting to admit to private masturbation in an effort to prove one's sexual prowess and to avoid being branded a heterosexual—and thus masculine—failure (p. 348). At other times, masturbation is publicly practiced to display sexuality and manliness, and to adjust to the institution's assumptions of what a patient ought to be (Leyser, 2003, p. 353; Goffman, 1961, p. 107). These demonstrations play on the institution's assumption that residents are indeed "insane" even though they often challenge this label (Federman, 2012, pp. 298-299; Rosenhan, 1973). While not explicitly examined, Leyser's (2003) study hints at the gendered performatives that exist between, and that are collaboratively maintained by nursing staff, security officers, and patient-prisoners.

While different prisoners take on contrasting masculine roles within the total institution, each field of masculinity is seen as a resource where—like the alpha male and hegemonic female—one cannot exist without the other. More specifically, the experience of confinement to a degree unites some prisoners and correctional officers into forming a pro-social environment (Jewkes, 2005; Karp, 2010) that allows prisoners to unite their collection of experiences, belief systems, and moral views into a synthesized masculinity that resists hegemonic masculinity and ameliorates the pains of deprivation (Evans & Wallace 2008; Jewkes, 2005). The subordinated field of gay masculinity for example can be “fixed” in such a way that it embodies characteristics that compete with dominant definitions of masculinity. Homosexual men often view themselves as possessing a dominant position over what they call the extreme form of male gay masculinity—being a “fairy” or “queen” (Coles, 2008, p. 243). Some of Coles’ (2008) homosexual participants claim that being masculine is simply avoiding the so-called feminine behaviour that is commonly ascribed to the subordinated fairy or queen. Like some prisoners, these gay men feel that one can simultaneously be a “man” and homosexual so long as one possesses the physical capital and male mannerisms associated with hegemonic masculinity such as acting tough, confident and competitive.

In addition, Jewkes (2005) examines the connection between class and gender performatives, arguing that socio-economically oppressed males often undergo a smooth transition from the labour force to the prison. Once the young working class male becomes institutionalized, his desire for material satisfaction is often replaced by his immediate need to demonstrate his masculinity. Namely, his dissatisfaction with the mundane realities of having to work at manual labour or in a service job inspires him to accomplish hegemonic masculinity through more thrilling (though illegitimate) means, which includes performing tests of manliness such as preying on weaker men. Consequently, some male prisoners express subordinated

masculinity through aggression, threats, and bullying while others do so by engaging behaviours traditionally described as effeminate – such as the sharing of intimacy, romance, and sexual relationships (Jewkes, 2005).

However, playing the subordinated fields of masculinity may also be toxic, as these performatives may contribute to prisoners' resistance to participating in psychotherapy or other forms of mental health treatment (Kupers, 2005). Cultural codes of staying silent, which are common in masculine performatives, ultimately prevent prisoners from revealing their inner pains and deprivations. When clinical therapists acknowledge the structural factors that cause pain in a prisoner's life, express empathy to their feelings of gendered disrespect, and are honest about the limitations of treating individuals in the prison context, the prisoner's masculinized emotional barriers can begin to dislodge (Kupers, 2005). The context in which these discourses of resistance and masculinity emerge suggests the importance of examining the essentialized nature of security and masculinity discourses, as well as the role patient-prisoners and subordinated guards play in disrupting/reproducing normative and hyper-masculinities. As we will learn, the outcome for those who resist is not always a bright one.

VIII – Contextualizing restraint in local mental health facilities

The *Ontario Mental Health Act* (OMHA) (1990) regulates the care provided to voluntary/involuntary patients with mental health problems to ensure that psychiatric institutions facilitate a legally accepted minimum standard of care. This legislation provides legal safeguards that recognize patient autonomy to refuse treatment and to be informed of this right.

Simultaneously, the OMHA formally authorizes designated psychiatric facilities (provincial hospitals) to physically or chemically restrain involuntary patients for the purposes of preventing “serious bodily harm to the patient or to another person” (Ontario Mental Health Act, 1990: S.

1).

Certainly, these techniques physically restrict voluntary movement and independent functioning (Fairman & Happ, 1998). Thus, psychiatric hospitals have the ability to coercively enforce the use of these techniques on patients. To protect against this medical hazard, the OMHA (1990) places limits on the legal availability for “restraint”:

Plac[ing] under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient (see OHMA Definitions section).

Although the assessment of a patient’s “dangerousness” to themselves or to others holds no scientific meaning as a disorder/disease/offence (Federman, 2012, p. 297), and is most often asserted on psychiatric and healthcare patients when there is a *perceived* threat of assault (Mason & Chandley, 1999; Mason-Whitehead & Mason, 2012, p. 229), some nursing and psychiatric researchers argue that the practice of physical and chemical restraint is an intervention technique that sufficiently manages aggressive patient tendencies and outbursts (Gillespie, Gates, Miller & Howard, 2010; Liberman, 2006; Moylan, 2009). Other literature indicates that restraint practices can be replaced with non-violent intervention programs (Barton, Johnson & Price, 2009; Cleary, Hunt & Walter, 2010; Holzworth & Wills, 1999; Huckshorn, 2007), while more critical scholars contest that any coercive intervention within forensic psychiatry is a symbol and demonstration of institutional power, control and punishment (Mason, 2006; Holmes, Rudge, Perron & St-Pierre, 2012). To generate a better understanding of these tensions, the next three sections overview the debates on this form of psychiatric intervention.

IX – Restraint as patient management

Some healthcare researchers argue that reasonable use of force strategies are necessary to manage and deescalate aggressive behaviour that is conveyed by psychiatric patients (Gillespie, Gates, Miller & Howard, 2010; Liberman, 2006; Moylan, 2009). Specifically, the legal practice

of restraint and informal practice of seclusion are emergency measures that enable healthcare professionals to neutralize patient aggression (Delaney, 2006; Doeselaar, Slegers & Hutschemaekers, 2008), prevent staff injury (Crocker, Stargatt & Denton, 2010; Gillespie, Gates, Miller & Howard, 2010), and protect patients from inflicting harm on themselves or others (Allen, Lowe, Brophy & Moore, 2009; Lancaster, Whittington, Lane, Riley & Meehan, 2008). Some researchers state that restraint-reduction programs have not improved staff and patient safety (Lieberman, 2006). Instead, programs that educate staff on how to administer restraints compassionately can accommodate the productive recovery of involuntary acute psychiatric patients (Macy, 2007; Moylan, 2009; Whittington, Bowers, Nolan, Simpson & Neil, 2009).

Those who assume that it is clinically unrealistic to abolish the practice of restraint suggest that research should begin to evaluate the training programs of staff members that are required to use measures of force (Migon, Coutinho, Huf, Adams, Cunha & Allen, 2008). This may provoke a reduction in, and greater accountability towards, the “all too frequent” patient deaths and injuries that occur under psychiatric “care” (Mason-Whitehead & Mason, 2012, p. 224); that is, practices of physical/chemical restraint, seclusion, and the administration of medicine. At the very least, we must question how security officers are trained to negotiate risky patient behaviour with the threat or implementation of restraint, given the ramifications of such procedures.

X – Restraint as a human rights violation

Even though restraint and seclusion were practiced historically and are now commonly practiced in psychiatric facilities (Howell, 2010), their presence in healthcare interferes with the therapeutic models of recovery that health practitioners seek to facilitate (Ashcraft & Anthony, 2008). Some literature indicates that restraint practices can be reduced or eliminated from mental health facilities through the implementation of non-violent crisis intervention programs (Barton,

Johnson & Price, 2009; Cleary, Hunt & Walter, 2010; Holzworth & Wills, 1999; Huckshorn, 2007), by developing an understanding of the departmental cultural patterns that precipitate violent intervention (Ashcraft & Anthony, 2008; Bjorkdahl, Palmstierna & Hansebo, 2010; Curran, 2007; Lindsey, 2009), and by expanding the number of meaningful speaking positions accessible to hospital staff, patients and the public on the topic of psychiatric intervention (Power, 2012). Moreover, case studies evaluating the clinical effectiveness of physical-intervention training show that these programs do not lead to a significant reduction in the number of violent incidents occurring between staff and patients (Lake, Gray & Flach, 2010).

Hence, approaches that seek to build better relations between nurses and patients (Baker, Bowers & Owiti, 2009) often emphasize person-centred care (Barton, Johnson & Price, 2009; Huckshorn, 2004; Mayers, Keet, Winkler & Flisher, 2010). These workplace community-oriented strategies seek to identify the social and administrative risk factors amongst medical staff and patients that exacerbate coercive reactions to aggressive behaviour (Lancaster, Whittington, Lane, Riley & Meehan, 2008), as well as develop alternatives to managing aggression through punitive, restrictive methods. More specifically, these care policies can lead to a reduction in staff turnover, injuries, and the amount of time dedicated to coercive intervention (LeBel & Goldstein, 2005).

Notably, the majority of this literature fails to examine the qualitative relationships that form between the hospital guard and the patient-prisoner, and the role they play in shaping both the security and medical culture's attitudes towards coercion. Rather, it evaluates the organizational benefits and drawbacks of maintaining restraint programs, and investigates nursing attitudes that promote or discourage such forms of patient intervention (Whittington, Bower, Nolan, Simpson & Neil, 2009). This research aims to help to fill this gap in the literature

by exploring how masculinity shapes the hospital guard's understanding of his role as well as his responsibilities to nursing staff.

XI – Forensic psychiatry as systematically-flawed

Violence in forensic psychiatric settings originates from a myriad of sources and agents, yet patient-prisoners are the ones most often accused of exhibiting violent behaviours (Perron & Rudge, 2012, p. 103). Hospital policies, media representations of criminality, nurses and private security officers are all potential perpetrators or abettors to institutional violence when their mandate is to reproduce practices of “discrimination, exclusion, suspicion, and blame” (Holmes & Federman, 2003; Holmes, 2005; Perron & Rudge, 2012, p. 104). These “evil influences” (Mason, 2006) privilege concerns of institutional power, security and punishment, and social control over medical interventions, the result of which often leads physicians to assess psychiatric patients as dangerous, risky, and ill to the point of irrationality (Kilty, 2012). In this way, violence in healthcare is conceptualized as a product of the unsavoury structure, organization, meaning and functionality of the prison hospital (Perron & Rudge, 2012; Holmes & Federman, 2006; Jacob, 2012; Mason, 2006), all of which steer clear of any compassionate discourses that seek to enhance and empathize with patient-care.

We have now reviewed diverse bodies of literature that seek to configure definitions of policing and prisoner masculinity, as well as the paradoxical processes in which security, violence, and control unfold in psychiatric institutions. In Chapter 3, these topical studies become our ally in exploring Connell and Messerschmidt's broader conceptualization of hegemonic masculinity, and its influence in shaping gendered power relations between security officers, nursing staff, and patient-prisoners – or more inclusively, any agent captive within our institutions of social control.

CHAPTER 3: THEORETICAL FRAMEWORK

I – Gendered organizations

Joey: You can't go anywhere like usually you can't leave the floor. Because they expect that maybe you'll take off. You may have somebody watching you 24-7. Um...if you're somewhat immobile you'll have someone help you to the washroom; some of the most personal things you do at home that you think nothing of...you go take a piss in the toilet.

Me: Yeah.

Joey: What if someone had to hold your dick for ya?

Me: Right. Sounds like a prison.

Joey: Yeah...not even. Prisoners I'm pretty sure can go on their own. They have...yeah you're still being watched. But no one is going to hold your dick unless you want to. Haha.

Me: Unless you want to.

Joey: Yeah unless you're looking for it. It's a little...well it's a little different.

This research begins at the steps of a gendered organization (Acker, 1990; 1992) – or more concretely the hospital where I began my short career in private security in December of 2008. Drawing on Acker's (1990; 1992) theory of gendered organizations, it is established that gender plays a fundamental role in structuring the patriarchal culture of any organization or institution (Acker, 1990; 1992). Refuting the idea that gendered interactions between individuals and organizations are an outlier to more widespread gender-neutral processes (Kanter, 1977), Acker (1992) demonstrates that gendered experience is a complex component of an organization's "processes, practices, images and ideologies, and distributions of power" (p. 567). It is these processes that are responsible for the (re)production of constructs and images of gender, and their social translation into gender inequality/subordination within the workplace.

Indeed, gender relations between security personnel, nurses, and patients cannot be understood in their complexity without a gendered analysis of the patriarchal structures of the institution/organization (Acker, 1990, p. 141). This involves acknowledging that social relations are established through processes in which class, race, and gender divisions are inseparable and mutually reinforcing. The gender division of labour shapes relations between men and women

(Messerschmidt, 1993, p. 71) and provides feminist scholars with a theoretical lens to explore how masculinity emerges in a workplace as a practice of dominance over women and subordinated men's bodies (see demonstration in Robison, 2010). The narratives that I and eight other security guards, all of whom are former colleagues, construct in relation to our lived experiences within a local hospital are explored as insights into a gendered organization, or rather a space for work dominated largely by men in security (Rigakos, 2002) and by women in nursing (Jacob, 2012). As Acker (1990) highlights, simply the discursive production of male and female occupations reproduces power relationships that flow along gender lines:

It is the man's body, his sexuality, minimal responsibility in procreation, and conventional control of emotions that pervades work and organizational processes. Women's bodies – female sexuality, their ability to procreate and their pregnancy, breastfeeding, child care, menstruation, and mythic “emotionality” – are suspect, stigmatized, and used as ground for control and exclusion (p. 152).

Ergo, Acker (1992) suggests that gendered organizations are constructed for gendered bodies, which specifically accommodate the social, physical, and emotional lives of men. Organizations are gendered in relation to how they are numerically or bureaucratically dominated by women or men (Britton, 2000). Likewise, meaning and identity are constructed within gendered organizations through heteronormative distinctions between men and women and the masculine and feminine. These dichotomies condition workplace activities by drawing from the precedent social layers of “advantage and disadvantage, exploitation and control, action and emotion” (Acker, 1990, p. 141) and most important to this research – hegemonic masculinities (Connell, 1987; 1995; Connell & Messerschmidt, 2005; Messerschmidt, 1993). Acknowledging the theoretical and empirical presence of these dividing structural forces guides this research to explore how masculine security performatives resist, facilitate and/or intersect with our understandings of forensic nursing culture. These insights will assist me to analyze the organizational gendered power relations that govern the legislated (see Federman, 2012; Ontario

Mental Health Act, 1990) and cultural conditions underlying medicalized restraint, control and incarceration practices.

Building on Acker's (1990; 1992) theory of gendered organizations, Section II of this chapter examines how male power is established through the widespread consent of men (Gramsci, 1971; Lukes, 1974). Following that discussion, I unfold the theoretical layers, descriptions, and critiques of Raewyn Connell (1985 et. al) and James Messerschmidt's (1993) notion of hegemonic masculinity, and its role in shaping social relations within policing/prison institutions. Next, I discuss how these masculine security performatives are intrinsically linked to the process of "doing gender" (West & Zimmerman, 1987). Once I establish this theoretical framework as the primary point of departure for this research, I remark on the benefits of exploring forensic nursing cultures from a Foucauldian perspective (Holmes & Federman, 2006; Holmes, Rudge, Perron & St-Pierre, 2012) and its capacity for investigating the disbursement of power amongst security, patient, and psychiatric nursing cultures. Lastly, I conclude with a commentary on the social, feminist, and personal politics (Connell, 2009, p. 134) that fuel my drive to critically question gender and its impact on shaping/constraining the voices, health, and social relations of individuals who survive in institutions of social control.

II – Men, power, hegemony

Taylor: As much as it is uh...you know a downside to the job that I'm big is I can be intimidating. People are less likely to...get physical with me right off the bat. I've had patients tell me that 'You know what...if it was someone else I may have tried to fight' but he's like 'Looking at you...I don't have a chance in hell to beat you so I'm just gonna be nice to you.'

Me: You think sometimes they are impressed that...

Taylor: I've had it twice in the past couple years. Where you know...people won't even try because I'm a big guy but if...a five foot two female walks in there. Guess what's gonna happen? They're gonna push their luck because even at five foot four they're still bigger than the security guard.

The perpetual accumulation of power and powerful resources by certain men, the triumph of this power and dominance in men's practices, and the widespread social categorization of men with power informs critical masculinity studies to explore how power shapes patriarchies and institutions (Hearn, 2004, pp. 51-52). As Hearn (2004) discusses, the growth and delivery of men's power appears in many, if not all dimensions of our lives:

[P]ower is a very significant, pervasive aspect of men's social relations, actions and experiences...Men's power and dominance can be structural and interpersonal, public and/or private, accepted and taken-for-granted and/or recognized and resisted, obvious or subtle. It also includes violations and violences of all the various kinds (p. 51).

In theorizing how masculinity and men's power is reproduced, the concept of hegemony surfaces, which in this research refers to the idea that patriarchal power relations are sustained through the consent of men and, in different way, by some women. Not only do men actively reproduce their own consent, but also the dominant construction of women's consent (Hearn, 2004, p. 52). This is evident in discursive masculine practices that seek to alienate and/or silence women's bodies and voices (Houston & Kramarae, 1991; Simpson & Lewis, 2005) in our religious institutions (Crusemann, 2001), workplaces (Brunner, 2000; Martin, 2001; Skrla, Reyes & Scheurich, 2000; Yoder & Aniakudo, 1997), and domestic/marital relationships (Cavanagh, Dobash, Dobash & Lewis, 2001). Accordingly, masculine practices of silencing are linked to masculine practices of violence towards and against women, which reverberate in episodes of domestic/workplace/political violence, or in this case coercive incidents between the guards, the nurses, and the patient-prisoners.

This research draws on the broader understanding of hegemony, which Italian Marxist Antonio Gramsci (1971) formulates as the process in which a dominant class or group controls others through its definition of social situations, phenomena, and interactions. Hegemony operates on the notion that power is the capacity to dominate or influence individuals through

persuasion and/or punishment (Weber, 1978), and to distort others' interests through ideological conditioning (Lukes, 1974). Put simply, our wants and desires are not assembled subjectively, but are rather a product of an overarching political system that works against our genuine self-interests (Lukes, 1974, p. 34). Our ideologically conditioned interests relate subtly to the genuine interests we might pursue should we have optimal choice, which is paramount in producing widespread social desires and consent, or more bluntly, control.

Indeed, this conceptualization of power is the sustenance for overarching ideologies that shape our everyday ideas about gender and how we ought to “do it” (West & Zimmerman, 1987). Consent for these ideologies is backed by a collection of dominant or dominated political actors such as the state, academics, capitalists, legal institutions (Gramsci, 1971) or most important to this case – men (Connell, 1987; 1995; 2000; 2005). While this research recognizes competing understandings of power as widespread and discursive (Foucault, 1977), gendered power relations amongst private security guards, hospital nursing and psychiatric staff, and patients are examined primarily as a hegemonic tradition within security and hospital cultures. As Butler (2000) neatly summarizes, the concept of hegemony encourages us to explore “the ways in which [gendered] power operates to form our everyday understanding of social relations, and to orchestrate the ways in which we consent to (and reproduce) those tacit and covert relations of power” (pp. 13-14).

III – Hegemonic masculinity as heteronormativity

Jackson: Jerry is like the perfect security guard because I mean you got a guy who can speak calmly...can back it up physically. (...) Cynical; he may take some liberty that's a personality trait though. Very nice stuff...big as a fridge so if you did fuck with him he's going to put you down but...at times Jerry would be very like...‘Ok Sir I'm going to have to put you in a controlled position man, can you relax?’ And he'll put you on the ground. ‘I'm gonna hold you there gently, if you cannot breathe let me know and we will walk you through it’ as he's kicking your ass.

Drawing on Gramsci's (1971) discussion of hegemony, feminist scholars – most notably Connell and Messerschmidt – developed the concept of hegemonic masculinity as a form of masculinity and gendered practice that subordinates (rather than eliminates) less dominant masculinities, and constitutes the backbone of the patriarchal system of gender relations as a whole (Carrigan, Connell & Lee, 1985; Connell 1985; 1987; 1993; 1998; 2000; 2002; 2005; 2009; Connell & Messerschmidt, 2005; Messerschmidt, 1993; 1997). In any culture, hegemonic masculinity is the idealized, dominant and glorified construction of what it means to be a man and create a masculine performative (Messerschmidt, 1993, p. 82). In social practice, hegemonic masculinity establishes the gendered relations between men as well as between men and women. Masculine power is developed and maintained in the context of the contemporary and historical practices that shape the gendered division of labour, sexuality, and power (Connell, 1985; Connell 1995; Messerschmidt, 1993, p. 63).

Since gender is always relational, hegemonic masculinity is formulated alongside the notion of hegemonic femininity (renamed emphasized femininity) to “acknowledge the asymmetrical position of masculinities and femininities in a patriarchal gender order” (Connell & Messerschmidt, 2005, p. 848). While there is recent attention drawn to how new and resistant configurations of younger women's identities and practices are progressively acknowledged by younger men (Korobov, 2011), Connell and Messerschmidt (2005) hold that emphasized femininity primarily focuses on compliance to patriarchy (p. 848). Understandably problematic, femininity is constructed only in relation to masculinity; women's power only in relation to men's.

Although hegemonic masculinity is relatively stable and thought of as a complete answer to the investigation of gender, its definition is open to challenge and competition (Connell, 1995). As Hearn (2004) identifies, the concept may reflect differently amidst different cultures

and the most powerful performers of hegemonic masculinity may not hold the most power (p. 57). Yet, while some scholars struggle to see consistent fields of hegemonic masculinity emerge, and others accuse hegemonic masculinity as failing to account for the autonomy of gendered systems (Beasley, 2008; Donaldson, 1993; Hearn, 2004; Moller, 2007), this research will explore Connell's (1987; 1995) understanding that hegemonic masculinity – in all its fields, challenges and complexities – guarantees the dominant position of men and maleness over women, sexuality, patient-prisoners and other marginalized groups/organizations. The process of achieving such a “victory” involves the systematic repression of alternative masculinities and most importantly the strict, regulated upholding of the norms of a hetero-patriarchal society:

Hegemonic masculinity is constructed in relation to women and subordinated masculinities. These other masculinities need not be clearly defined – indeed achieving hegemony may consist precisely in preventing alternatives gaining cultural definition and recognition as alternatives, confining them to ghettos, to privacy, to unconsciousness. The most important feature of contemporary hegemonic masculinity is that it is heterosexual (Connell, 1987, p. 186).

Until competing fields of masculinity dethrone hegemonic masculinity (Coles, 2008; 2009; Connell & Messerschmidt, 2005), subordinated gender performatives will continue to be perceived by the hegemonic male as something weaker than, and unequal to the masculine. Hegemonic masculinity assumes a differentiation between masculine and feminine because it draws on the idea that men dominate women on a widespread, universal level. As this research and others demonstrate (Evans & Wallace, 2008; Jewkes, 2010; Prokos & Padavic 1991; 2002), even though hegemonic masculinity is not necessarily preserved by physical or social force when defended by men or women, it can threaten the stability and peacefulness of our social interactions, cultures, and institutions. Connell (2009) cautions us that,

Contemporary hegemonic masculinity, to take the most striking case, is dangerous, regardless of patriarchal dividend. It is dangerous because it provides a cultural rationale for inter-personal violence...It is harmful to men themselves; the masculinity reformers were on strong ground when they argued that men would be safer not fighting, would be

healthier without competitive stress, and would have a better life with improved relations with women and children (p. 143).

Keeping her warning close in mind, this research frames the hegemonic male or in this case “alpha-asylum security guard” as a person who is able to assert his claim to authority and achievement of machismo status through the subordination of other fields of policing masculinity (Connell, 1995). The circulation of hegemony is connected in part to one’s willingness to use violence, force, intimidation, and coercion to maintain a hierarchy of sexualities where the heterosexual man always prevails. Those thought to possess less masculine capital are accused of embodying a heightened femininity and lowered sexuality, or more explicitly a sexuality that is effeminate and thus unequal to the heteronormative sexual pursuits of the alpha male (Connell, 1995).

That said it is not safe to imply that all masculinities are defined in relation to strict dichotomies of heterosexuality and homosexuality or violence and non-violence. Rather, men may assert hegemonic masculinity in a number of different ways depending on cultural and structural conditions such as socio-economic status or race (Coles, 2008, 2009). For example, men in a higher socio-economic position may achieve hegemonic masculinity through romanticized notions of being the family breadwinner, which in many Western communities may gain respect (Messerschmidt, 1993). Alternatively, men in lower socio-economic positions may be restricted from holding this identity due to structural barriers such as employer discrimination (Embrick, Walther & Wickens, 2007). As a result, these individuals may earn masculine capital by seeking out multiple female sexual partners (Anderson, 2000) or by engaging in violent behaviour or crime (Messerschmidt, 1993; 1997). As such, this research understands hegemonic masculinity as the gendered ascendancy towards practices that emphasize authority, control,

competitive individualism, independence, and the capacity to use or threaten violence (Messerschmidt, 1993, p. 82).

Having built a working conceptualization of hegemonic masculinity, Section IV explores the criticisms of hegemonic masculinity from a realist and poststructuralist perspective.

IV – Criticisms

Some scholars argue that hegemonic masculinity is a blurred concept, meaning that we cannot be certain of its definition or the practices that reproduce its social authority (Collinson & Hearn, 1994; Donaldson, 1993; Hearn, 1996; 2004). Realist authors contend that hegemonic masculinity informs the creation of static typologies of men, and often devalues issues of power and domination that they claim are beyond the reaches of the patriarchal class structure. Understanding men's power is not predicated on the acknowledgment of one widespread, omnipresent system of power, and in such cases may be best understood in the context of other social/economic divisions. Put simply critics argue that masculinity as a concept is limited within a heteronormative conception of gender that essentializes male-female difference (Connell & Messerschmidt, 2005, p. 836), and fails to acknowledge difference and exclusion within gender categories (Collier, 1998). While Connell establishes hegemonic masculinity as a configuration of practices that subordinate women and men, the material practices that embody masculinity are not specifically defined (Schrock & Schwalbe, 2009). This leads to the objective categorization of men, which is problematic for scholars who explore categories of men as socially constructed meanings that are imposed on gender performatives. The questions surrounding what constitutes hegemonic masculinity and its relationship with patriarchal power relations was summarized by Hearn (2004):

Is it a cultural ideal, cultural images, even fantasy? Is it summed up in the stuff of heroes? Is it toughness, aggressiveness, violence? Or is it corporate respectability? Is it simply heterosexist homophobia? Is it the rather general persistence of patriarchal gender

arrangements? ...How exactly do the various dominant and dominating ways that men are – tough/aggressive/violent; respectably/corporate; controlling of resources; controlling of images; and so on – connect with each other? (p. 58).

Hegemonic masculinity acknowledges that there is a widespread, singular masculinity, but also recognizes the multiple masculinities within individuals who achieve a superior masculine status. Conceptualizing masculinity as plural allows us to unfold the structural inequalities and diversities amongst groups of subordinated men/masculinities such as Black or gay (Beasley, 2008; Coles, 2008; 2009), yet these differences are difficult to construct beyond their relation to the physical male body (Schrock & Schwalbe, 2009). This creates tension in the idea that not all masculinity is (re)produced in the same way. Attempts to categorize masculinity's fluidity and widespread nature create loaded distinctions between masculine identities, and subsequently conflate the meanings attached to these identities (Clatterbaugh, 1998). Men's practices, or more specifically the gender performatives that men "do" (see Section VI of this chapter) may be more complex and nuanced than the term hegemonic masculinity allows for (Moller, 2007).

Essentialist notions pertaining to the character of men impose a false and static definition on what post-structuralists contest is a fluid and contradictory reality (Collier, 1998). Connell and Messerschmidt (2005) acknowledge that this ontological position may not accommodate the dichotomization of sex (biological) and gender (cultural) categories because it naturalizes the body as a way of shaping meaning and understanding reality (p. 836). Instead, post-structural understandings of masculinity advance the discursive construction of identities (Coles, 2008, 2009; Petersen, 2003; Whitehead, 2002) and thus power as a more widely categorized, indirect and discursively accessed instrument (Foucault, 1977). The impact this alternative framework holds in shaping our recent and timely understandings of the practice of violence within forensic

nursing cultures (Holmes & Federman, 2006; Holmes, Rudge & Perron, 2012) and its implications for this research are examined in Section VIII of this chapter.

In spite of these limitations, this research holds that hegemonic masculinity embodies the power relations that shape and inform the gendered experiences amongst men, and between women and men. It seeks to further our understanding of how private security guards engage in power relations with other men, women, security staff, nurses, and patient-prisoners. Likewise, Connell and Messerschmidt's work provides us with concepts of hegemonic and subordinated masculinity to help unfold the gendered experiences of hospital guards within the context of the broader societal construction and production of masculinity. Next, I examine Messerschmidt's (1993) theory on structured action and gendered crime⁴, and its role in investigating how hetero-patriarchy, dominance, and violence are performative weapons used to display and (re)produce hegemonic masculinity within institutions of policing, security, and social control.

V – Gender relations shaping our action

Messerschmidt (1993) admonishes us of the impact social structures—that is, the regulated forms of interaction that over time restrict and transmit behaviour in particular ways—have on class, gender, race, and more broadly social relations (p. 63). Divisions of labour, sexuality and power are all examples of how social structures inform social relations. Messerschmidt (1993) argues that our social actions and interactions reproduce and transform these divisions (pp. 63-64), which simultaneously form a foundation for relations between men and women (p. 174). In other words, structure is realized through social action while social action is conditioned by structure. Since social structures enable and constrain our social action, it follows that women and men affect gender in ways that (re)produce patriarchal systems.

⁴ While I credit Messerschmidt with his theory of structured action and gendered crime, it is important to note that his concepts on gendered issues draw largely from Anthony Giddens' (1984) structuration theory.

Hegemonic masculinity may then be conceptualized as a collective agency, power, or widespread social structure that men access in order to demonstrate their status in relation to women and subordinated men. This power materializes through performativity, that is, the forms of expressive action that help us define, categorize, transform, and break gendered identity (Butler, 1988, 1997). Widespread consent to practices and definitions that constitute the masculine and feminine inevitably lead to the characterization of masculinity as a polar opposite to the (subordinated) feminine. Indeed, failures to accomplish masculinity are so feared and internalized by men that symbols of this power can be pursued through violence or the established threat thereof. The gendered division of labour, for example, weaves discourses of hegemonic masculinity with notions of being a good provider or breadwinner through success, victory and dominance (Messerschmidt, 1993, p. 67). It is when this identity is challenged or questioned that the hegemonic male must resort to his immediate resources such as his physicality to deter others from situating his gendered behaviour within the “shameful” categories of femininity and subordinated masculinity.

Gendered displacement primarily involves a man’s failure to demonstrate that he is a primary decision-maker and enforcer of his own decisions (Messerschmidt, 1993, p. 155). Thus unsurprisingly, the social situations in which we recycle and sometimes alter these gendered power relations are not only regulated by the workplace, family, and school, but also by the state:

As primary agents of the state, men experience the daily world “at work” from their particular position in society, thereby constructing specific cultural ideals of hegemonic masculinity... Depending upon the state agency, institutionalized practices define and sustain specific conceptions of masculinity that express and reproduce social divisions of labour and power as well as normative heterosexuality. In this way, state agents do gender in response to the socially structured circumstances in which they perform their work... one such social setting within the state [being] the police (Messerschmidt, 1993, p. 174).

The gender division of labour within both policing and security institutions is evident by the visible presence of more male than female officers (Rigakos, 2002). This division expands into greater gendered relations that are produced and reproduced within police forces. As demonstrated in the literature, policing and security institutions are a common dwelling for the practice of discrimination against women, subordinated men, and homosexuals (Garcia, 2003; Gerson & Peiss, 1985; Herbert, 2001; Miller, 1998; Miller, Forest & Jurik, 2003; Rigakos, 2002) in the forms of violence and physical intimidation (Chappell & Lanza-Kaduce, 2010; Kurtz, 2008), sexual harassment (Prokos & Padavic, 2002) and an overall resistance in appointing policewomen into higher positions of leadership or power (Burke & Mikkelsen, 2005; Rabe-Hemp, 2007). Nonetheless, police and security officers must negotiate societal gender relations with the gender relations occurring within their own institutional work culture (Messerschmidt, 1993, p. 175).

Ergo, this research unfolds the gender performatives that I and eight other male hospital guards access(ed) in a struggle to achieve and resist the hegemonic masculine agendas and responsibilities of our profession. Likewise, I analyze how masculinity is constructed in tension with security's requirement to appease psychiatric nursing staff, control patient-prisoner populations, and above all else – fit in. By applying Messerschmidt's (1993) model to our on-the-job lived experiences, we see how hospital security activities evolve from paramilitary orders into 'medals of masculinity', or practices that demonstrate one's detachment from subordinated fields of gender. More specifically, the narrative construction of these symbols modulates our understanding of the underlying gendered relations that shape how security agents "do" (West & Zimmerman, 1987) the "dirty work" (Tracy & Scott, 2006) of the "prison" hospital (Holmes & Federman, 2006, p. 17).

VI – Doing gender, accomplishing hegemony

Sean: You know, we're, we're trying to be the exact opposite of what we are rather than concentrating on...on trying to be a, you know better or stronger person. That's, that's our way of dealing with situations, it's to act macho and to, and to just appear really strong it's like uh, it's like a bluff charge almost...like for a rhino or an elephant...you have this...this faux chest-beating sort of thing.

Connell and Messerschmidt's argument that gender and masculinities are socially constructed draws on West and Zimmerman's (1987) concept of "doing gender". Doing gender refers to how we structure and organize our social interactions, performatives, and activities in a way that expresses gender and helps us construct the actions of others as gendered (West & Zimmerman, 1987). Here, gender is not thought of as an individual concept, but rather as something that is achieved in and through human interaction (Fenstermaker & West, 2002). This implies that concepts of gender are discovered through the collective meanings that people give to them (Deutscher & Lindsey, 2005, p. 5). As Connell (2009) illustrates, this groundbreaking framework heavily influences the Women's Liberation and queer theory movements:

The most widely influential body of theory was work that re-examined the founding categories of feminism...[a] paper called 'Doing Gender' (West and Zimmerman 1987) crystallized this approach and had a wide influence. Feminist philosophers re-considered the relationship of the body to gender categories. Some of them returned to an emphasis on the unbridgeable difference between women's and men's bodies, seeing gender always as embodied experience in which the supposed gap between 'sex' and 'gender' is reduced to nothing (p. 43).

In this direction, Connell (2009) further articulates that the embodied experience of doing gender is linked to the differences we construct between what is thought of as masculine and feminine. We create these differences overtly and subtly, or the decision may be unconscious. In each case, the actor engages with this process to defend the essentialist belief that gender is biologically linked or predetermined (West & Zimmerman, 1987, p. 127). Striking cultures and sub-cultures, these values perpetuate widespread assumptions about gender differences, which disallow status-equal friendships to form between men and women (Rouse, 2002). As soon as

gender is socially constructed as different, men with (the most) power can easily justify inequality towards women and subordinated men by claiming that gender difference/status correlates to social privilege (Fenstermaker & West, 2002). Successful, hegemonic men ultimately present their gender in social situations in order to satisfy the requirements of accountability, or in this case the demonstration of “security manhood”. That said doing gender does not always have to achieve or exceed standard conceptions of masculinity and femininity. Rather, it is primarily concerned with living up to the fluid, changing categories of gendered assessment (West & Zimmerman, 1987, p. 136).

Accordingly, Connell (1995) sees masculinity as a “place in gender relations, the practice through which men engage that place in gender and the effects of these practices in bodily experience, personality and culture” (p. 71). Hegemonic masculinity is therefore not constructed in advance of social interactions, but rather within them, and is dependent on social location (Connell, 1995, p. 35). These behaviours do not materialize in vacuums, but instead emerge in the form of patriarchal ideologies, discourses, and performatives. Nonetheless, the hegemonic male is situated at the dominant end of the gendered spectrum (Connell, 1995, p. 76).

Differences in what is considered masculine are significantly attached to statuses and identities within social groups (Connell, 1995). Individuals construct and reinforce differences in what it means to be a man through notions of class, race and sexual orientation. These constructions are linked to the social demonstration of physical prowess and violence, which often involves conquests to obtain as many female sexual partners as possible. Masculine guises such as these occur in everyday life and within institutional structures. Therefore, rather than seeking out definitions of masculinity, Connell (1995) encourages feminist scholars to focus on the processes and experiences through which men and women live gendered lives.

It is through the embodied reinforcement of dominant gendered traits that gender performatives transform from intrinsic properties into celebrated podiums for accomplishment. As Butler (1990) demonstrates, identities are then brought into this space or “reality” through action, instead of belonging to some predetermined, essentialist actuality. Our social interactions do not facilitate the spread of static gender categories, but instead allow all actors to venture onto a stage that rewards and punishes the (un)believable demonstration of hegemonic masculinity and consequent perpetuation of the gender dichotomy (Connell, 1987; 2009).

Essentialist understandings of the masculine as natural or innate (West & Zimmerman, 1987) create social spaces where individuals can conceptualize specific behaviours as embodying absolute maleness (Connell, 2005). Indeed, this process of “situated doing” (West & Zimmerman, 1987, p. 126) involves the construction of expectations of how hospital guards ought to react to situations concerning patient-prisoners. The “doing gender” lens therefore situates this research so as to explore how security, nursing, and psychiatric staff demand masculine, physical, and coercive security practices. More specifically, I investigate the social performatives hospital guards access to enhance their displays of gender. Given that policing and prison cultures are often associated with hegemonic masculine ideals such as violence, use of force, controlling conduct, ambivalence towards the feminine, assertiveness, self reliance, and the repression of homosexuality (Carlson, 2009; Evans & Wallace, 2008; Herbert, 2001; Kurtz, 2006; 2008; Manzo, 2004; Miller, Forest & Jurik, 2003; Tracy & Scott, 2006), I am further guided towards a gendered analysis of how doing gender through the achievement of masculine security activities/performatives reinforces hegemonic masculinity and its traditional attachment to prison and policing institutions.

VII – Implications for private security companies

Private security is an organization that like public policing embodies hegemonic masculinity (Rigakos, 2002). The subordination of women and homosexuality in practice and expression, coupled with romanticized notions of fearlessness, courage, heroism, physicality, intelligence, assertiveness, emotional strength and vows to follow authority, are the key markers of hegemonic masculinity as it is spread throughout private and public law enforcement organizations (Darien, 2002; Manzo, 2004; Miccuci, 1998; Moore, 1999; Prokos & Padavic, 2002; Rigakos, 2002). Thinking about these characteristics as masculine emphasizes the dichotomy of masculinity and femininity. As I articulated in Section V of this chapter, this dichotomy allows for hegemonic masculinity to translate into structured action, or put simply “what men do under specific constraints and varying degrees of power” (Messerschmidt, 1993, p. 81). Messerschmidt’s (1993) model frames this research to explore the cultural tensions and incompatibilities security staff face when demands to punish and control (Holmes & Federman, 2006; Jacob, 2012) are juxtaposed against socio-professional obligations to provide romanticized care, compassion, and patience – the traditional/patriarchal norms of femininity (Jewkes, 2005; Korobov, 2011, pp. 52-53).

Furthermore, the recent emergence of power in the form of security companies is a growing and visible symbol of the gendered state and the idea that it functions within a complex field of political forces (Connell, 2009; Ericson, 2007). More specifically, because the legitimacy of security relies on property rather than citizenship, private security organizations and companies evade (so far) any political pressure from feminists to enact cultural gender reform and equal opportunity for women, as these mighty advances in feminism are typically exerted on the state (Connell, 2009; p. 122). Yet the more conflated our conceptualizations of private and public police enterprises become (Rigakos, 2005), the more imperative it is for this research to

qualitatively analyze the relationship between hegemonic masculinity and the hospital as a state institution. Here, themes of bureaucracy and hierarchal control interlace with the masculine militant structure of the hospital security culture, or more specifically, the indoctrinated obligation bestowed unto guards to express utter, uncontested loyalty to their superiors.

Now that we have established that policing and prison cultures are empirically and theoretically linked to using violence and coercive force to establish and maintain order, this theoretical framework provides a point of departure to briefly discuss how power is dispersed within the “prison” hospital, and the impact it carries on forensic nursing practice and culture.

VIII – Building on the power modules within forensic nursing

Charles: You’re not in a position to make that judgment because you don’t know what this patient’s history is. You don’t know what this patient is capable of. This patient may be you know...an elderly woman...uh in appearance but you don’t know what she’s capable of. She could be able to do anything essentially. You don’t know if she’s uh...threatened someone before, harmed someone before...She might grab somebody around her. She could literally do anything—you don’t know who this person is. So in that term it’s a person who you have to obey to...is the uh physician or nurses because they know more of the history...You know if they don’t uphold it, it’s not really my place. If I could do something to prevent any kind of...mistreatment I would...but in the position that I was in as contract security...your word is nothing.

Me: Ok. Your word is nothing.

Charles: No. I, I made like I said, I’ve made statements about mistreatment before...and I’ve always been pushed aside, this is how it goes...Because you’re, you know...just a tool. That’s really what you are.

The theoretical foundations of Acker (1990; 1992), Connell (1985 et al.), Messerschmidt (1993) and West and Zimmerman (1987) provide a framework for analyses of the gendered power relations amongst men, and between men and women. In addition, these authors supply us with an epistemological lens to differentiate hegemonic from subordinated masculinities. In response, Foucault (1977) would criticize this approach for assuming that there is a collective agency or power in society. He suggests that power is broadly dispersed and functions subtly and intimately. This refers to a discursive process that unfolds through the ways in which we talk to

and discursively ‘make up’ and categorize people. Power ultimately emerges in two forms within (psychiatric) prisons: disciplinary and biopolitical (Foucault, 1977; 2003).

The prison hospital as a modern panoptical structure influences the individual and collective behaviour within its walls to accommodate disciplinary mechanisms that emphasize punishment, surveillance, and control. Foucauldian and other critical discourses help us to understand how psychiatric nursing and security cultures perpetuate coercive practices (Simons & Mawn, 2012; St-Pierre, 2012; Thomas, 2012) and control patient-prisoners through a disciplinary apparatus that facilitates the use of penal sanctions and infantilizing punishment/reward systems⁵ (Holmes & Federman, 2006; Holmes & Murray, 2011, 2012). Here the bodies of the condemned patients in relation to psychiatric health professionals mirror the bodies of prisoners in relation to correctional officers, both of which are subject to a myriad of identities, roles, and medical “expertise” (Holmes & Murray, 2012, p. 22). Bio-positivist shifts in thinking about psychiatry as a gateway into the so-called “truths” of our minds and emotions provide psychiatrists with the power to define, label and control notions of sickness and health and madness and sanity (Leifer, 1990). Psychiatric and psychological discourses perpetuate medicalized constructions of women as insane (Adler & Adler, 2007; Kilty, 2006, 2008, 2012), misbehaved/unfeminine (Dell, Filmore & Kilty, 2009; Kilty, 2012) and dangerous (Kilty & Frigon, 2007). As such, this research investigates the hospital guards’ gendered construction of mental illness, and how those notions intersect with their security assessment and subsequent application of force and chemical incarceration on patient-prisoners. As Holmes and Federman (2006) argue, the exercising of power over patient-prisoners is non-linear:

Control over captive populations within some forensic psychiatric settings still rely on old-fashioned techniques of control, the manipulation of caring professionals, the use of

⁵ For example, see Chapter 6, p. 103.

pacification techniques to obtain docility, and the outright use of power and fear to tame potentially recalcitrant populations...On the contrary, inquiry into the role of nurses reveals just how “capillary” power is. It comes from all sides of the *prison hospital* complex. It resides not in one institution or within one regulatory scheme, but attaches itself to bodies throughout the organization. Power infects everyone in forensic psychiatric settings (p. 17).

While disciplinary power renders the patient-prisoner as its object, biopolitical power intervenes ontologically, that is, it functions over the captive’s life itself and treats her as its means and its ends, “its object and its objective” (Foucault, 2003, p. 254). Moreover, disciplinary and biopolitical power do not operate neatly or symmetrically, but instead are complexly woven into practices that tow the fluid line between correction/healthcare and prison/hospital life (Holmes & Murray, 2011, 2012, p. 23). Biopolitical power treats patient-prisoner populations more generally in tandem with the “bogus” (Young, 2011) positivist principles of risk management and calculated prediction of unwanted, wayward behaviour (Foucault, 2003, p. 250). This allows for medicine and psychiatry to take on a regulatory function that is primarily concerned with normalizing knowledge, centralizing power, and enforcing disciplinary techniques on patients that perpetuate moralistic views on life (Holmes & Murray, 2011, 2012, p. 25). The moment a prisoner internalizes the rules and cultural codes of the hospital or total institution, they are as Goffman (1961) coins it, “mortified” – that is, stripped of their old life and identity and re-born into the world of the institution, where submission to authority is total and any autonomy one experiences, artificial. As Holmes and Murray (2012) conclude, Goffman highlights the asymmetry of institutional life with the real world and its incompatibility with the nursing principles of care, compassion, and community integration (p. 27).

That being said, this research holds that hegemonic masculinity is another axis of the “capillary” power infecting psychiatric facilities (Holmes & Federman, 2006, p. 17), which we see materialized in the hyper-masculine performatives of hospital security agents. Drawing on

the intrinsic tensions found in the professional mandates to coerce/control patients and to provide care (Holmes & Federman, 2006), this field research departs on a reflexive analysis of how the exercising of power within a forensic nursing unit interacts with and/or resists other cultures of the prison hospital, such as the security team. It is through this lens that the tropes of hegemonic and subordinated masculinities will reveal their hierarchical positioning and role in maintaining control of captives within a modern equivalent of the “lunatic” asylum – an institution several academics theorize as a kind of prison (Donald, 2001; Holmes et al., 2012; Jain & Murphy, 2006; Wright 1997).

On that note, we now turn to the chapter’s final section where I discuss the most reflexive lens that shapes this research – my personal politics.

IX – Personal gendered politics

The great majority of the very rich and powerful on planet Earth are men. They compete among each other for more wealth and power, and mobilize workforces of both men and women to do so. There is a good deal of violence on the planet, most of it by men, and a good part of it from armed forces, police and prison systems, overwhelmingly composed of men... Masculinities and femininities are generally constructed around these conditions, and many of the planet’s inhabitants accept them without protest. People who violate accepted patterns of masculinity and femininity suffer, and are sometimes killed (Connell, 2009, pp. 132-133).

So far in this chapter we have explored the processes and power dynamics that underlay constructions of masculinity, and the ways in which they flower in our everyday experiences and within social institutions. Of course, what sustain those social mechanisms are personal and political knowledges and processes, which recognize that there are gendered politics in our most intimate relationships, decisions and struggles (Connell, 2009, p. 137). For some, gender politics function on such a profound emotional level that the political may be difficult to perceive at first. Any person for example who seeks care, compassion, and safety may not revolt against

patriarchal institutions such as medicine, psychiatry, and psychology should they aim to preserve her or his wellbeing (Connell, 2009, p. 135).

As such, the controversy to imprison and restrain persons seeking—or thought to need—psychiatric “treatment” for the betterment of their health is an ideology I toyed with, questioned, and struggled with throughout my security experience. It is safe to assume that my views on this issue and subsequently this research are impacted from my exposure to death and morbidity, the perpetuation of gender discrimination and harassment within my workplace, and the routine engagement in prisoner restraining techniques that I cannot separate from pragmatic or legal definitions of violence. These experiences appear to me as symbols of the prison – an institution that is celebrated for its focus on punishment, control, surveillance and above all else hegemonic masculinity (Acker, 1992; Donaldson, 2001; Evans & Wallace, 2008; Jewkes, 2005). Just as Messerschmidt (1993) warned, I witnessed persons who could not withstand or live up to the culture’s masculine expectations use violence more frequently in incidents that concerned patient-prisoners. Other subordinated guards who would not resort to violence, or other hyper-masculine performatives, such as raising one’s voice to verbally restrict the movement of the patient, often suffered a form of discrimination, harassment, or marginalization that called into question the integrity of their gendered identity, or more specifically their competency within the field.

I cannot deny the impact these events, emotions, and frustrations have had on shaping the direction, intensity, and context of this research. Thus, in subsequent chapters I engage an autoethnographic methodology to fully capture the personal, political, and emotional dimensions of this research (see Chapter 4, Section V). Moreover, to claim that there is a hegemonic masculinity within our psychiatric facilities is to claim that there is a dangerous, deeply penetrating power structure that is informing how we “treat” and construct patient-prisoners as

irrational, dangerous, risky and evil. This research cannot escape its underlying political ambitions towards social justice, attraction to political avenues that lead to the improvement of our healthcare institutions, and desire to abolish institutions built on ideologies of punishment and control. I am inspired and obligated to “do” research, feminism, and social justice in politicized ways that pressure and highlight the need for change.

Therefore, this feminist research must push our personal boundaries and socializations in order to come to understandings of masculinity that are not bound to our own gendered subjectivities. It must not credit approaches that reserve studies of masculinity for men and studies of femininity for women (Edley & Wetherell, 2001; Riley, 2001), but err to the idea that all gendered bodies hold the potential to advance feminist goals (Alilunas, 2011). Many feminists warn that the practice of our gendered politics is messy and always personal. Yet at the heart of what I once thought was a nihilistic battle, we must—as my eighth and final participant announces in the closing minutes of our interview—be “passionate, forthright, and persistent”. Although gendered relations can emasculate, defeminize, and dominate us, they cannot take away our determination to seek out and enact change. Quite simply, it cannot take away our “balls”:

Me: And I remember...the guy...it was yeah, Ricky was in charge...you know of the incident and he just said...‘well you know...anybody that can do something about this won’t. You know...and anybody you know who wants to do something about this can’t. So there’s no point in doing it.’ And then it, like for me, it clicked and I thought you know, another couple years am I gonna start thinking that way? And I thought I gotta get the hell out of here.

Sean: (...) I’ve felt that hopelessness.

Me: Yeah.

Sean: When I was there. You know what I mean? I sent, I sent emails about that, about my concerns and stuff like that and they weren’t met. You know it’s just kind of brushed off...but um...but things will never change that way man. It’ll go on for...forever until someone has the balls to stand up and say something, you know what I mean? Until someone tries to make a difference.

Long sweeping, the goal of this research is to make that difference – to shake up the pillars of this institution by challenging its practices and by calling into question its authority to hinder autonomy of the body/mind. My desire to witness improvement in the way we care for vulnerable persons began when I resigned and wrote a letter of protest to the hospital administration team. As we all carry our humanitarian torches forward, let this research mark the end of a long passageway towards a brighter understanding and appreciation of persons we come to define as sick.

CHAPTER 4: METHODOLOGY

So far, I have reviewed the relevant literature pertaining to security, masculinity, and psychiatric practices so as to carve out the theoretical framework for this study. This chapter addresses the assembled methodological framework. To begin, Section I unfolds the ontological paradigm that informs the critical perspective I adopted in this research. Next, I acknowledge the epistemological lens and politics that give voice and meaning to the messy ways in which these knowledges, texts, and lived experiences are produced. I then describe and critically reflect on the research design itself, which leads to a concluding discussion on narrativity and the limitations of this research.

I – The critical paradigm

Joey: If you were still there now at this time we wouldn't be talking. If you were still an employee now you might have been [an in-house guard] but you also probably would have stopped you know...really paying attention. You would have just gone day by day...Ok up to [the in-patient ward] do a restraint come down. Up to, down to [Psychiatric Emergency Services]. Do a restraint. I think you would have been desensitized.

Me: Probably wouldn't be doing this interview.

Joey: No we wouldn't, we wouldn't...but you'd be desensitized anyway.

I, the researcher, hold a certain degree of authority over how my participants are represented (Walby, 2007, p. 1009). Put simply, this research is produced rather than influenced by my ontology, or fundamental worldviews on 'reality'. When adopting a critical paradigm the researcher is internally driven by a rallying call for justice, that is, "varying degrees of social action, from the overturning of specific unjust practices to radical transformation of entire societies" (Guba & Lincoln, 2005, p. 268). This lens informs critical researchers to uncover how "ontology itself constitutes the world" (Walby, 2007, p. 1017) and shapes the complexity of human interactions, rather than interrogate the world as a vast plain of discovery, or "Columbus project" (Sorokin, 1956). Unlike the constructivist paradigm, which holds that realities are

relatively and locally shaped (Best, 1995), critical theory takes the position that we share a “virtual reality” (Guba & Lincoln, 2005, p. 258). Specifically, social, political, cultural, economic, racial/ethnic, and gendered forces inform a collective understanding of the world, which problematically leads to the (re)production of gender hegemonies and systems of patriarchy (Wickramasinghe, 2006, p. 607).

The goal of critical research then, is to stimulate social or internal⁶ transformation through critique and reflexivity and to give voice to the subjective pains, stigmas and deprivations individuals experience from objectifying forces (Guba & Lincoln, 2005, p. 268). As Walby (2007) argues, “objectification cannot be avoided, but the difference to be made is the reflexive interventions that diminish this objectification in some way” (p. 1017). Thus, my analysis is guided by a reflexive voice that echoes my values and subjective insights into the hospital (Mauthner & Doucet, 1997; 2003). While this study’s limits regarding generalizability and representation (n=9 men) hinders this research from engaging in a “bogus” search for objective truth (Denzin, 2002; Young, 2011), the collaboration of multiple voices and reflexive layers of analysis accomplish my aim to expose the lived realities of hospital security guards. Ultimately, these experiences draw us to a messier albeit more nuanced (Deutsh, 2004) understanding of the gender hegemonies that steer and shape (at least) one form of carceral reality.

II – Gender as epistemology

Recent discussions on feminist theory and epistemologies bring forward the idea that realities constructed in and through knowledge making are an intrinsic part of the ways in which one experiences and pursues life (Wickramasinghe, 2006, p. 607). For this reason,

⁶ Such as ridding oneself of false consciousness.

Wickramasinghe (2006) calls for the conceptualization of gender as epistemology with regard to the ways in which feminist researchers use gender as political aspirations, theoretical constructs, analytical categories and methodologies (p. 606). Namely, our personal/politicized experiences of gender are at the crux of conceptualizing realities in formal knowledge (or epistemology) just as much as gendered realities *theorized* in knowledge mediate the *enactment* of realities and sense of self (or gender ontology). Acknowledging my political and transformative experiences with hegemonic masculinity as an epistemological steering device, I seek to produce knowledge that empowers individuals to transform the gendered nature of capillary and structural power relations that are manifest within the policies, institutional discourses, and broader socio-political structures and ideologies that oversee local psychiatric facilities (Wickramasinghe, 2006, p. 609). This process involves the theoretical examination of gender within academic discourses pertaining to private security and the governance of mental health.

To do this, I draw from a qualitative methodology (interviews and autoethnography) in order to give meaning and voice to personal narratives (Alasuutari, 1995b; Ezzy, 2002, p. 95) or stories about how a gendered security culture is “taken up, regularised, resisted, contested and transformed” (Jarviluoma, Moisala & Vilkkö, 2003, p. 7). While constructivists tend to encourage participants to take an active role in designing the research process and questions of inquiry (Best, 1995), I am obligated to “take control of [our] futures” (Guba & Lincoln, 2005, p. 269), that is, transform readers intellectually, speak as an authority on behalf of others (Alcoff, 2009, p. 118), and ultimately guide this research to its critical understanding of hegemonic masculinity and its role in shaping forensic healthcare settings. At the end of many interviews, participants left me with the message, “I just hope something good comes from all this.” With that in mind, I advance this research towards the transformative social vision we, the voices of this research, all took part in creating (Becker, 1967).

III – Politics

The interview and auto-ethnographic narratives presented in Chapters 5 and 6 are both constitutive of the account, that is, the ongoing gender relations (Wickramasinghe, 2006, p. 606), local sites, interpretations of transcription (Elwood & Martin, 2004; Walby, 2007, pp. 1009-1010) and fluid degrees of reflexivity (Mauthner & Doucet, 2003) that shape the production of the analytic text. By uncovering the gendered structures of the hospital that give life to institutional violence, resistance, and control, I aim to challenge the ontological ground that seeks justification for the coercion of patient-prisoners (Gillespie, Gates, Miller & Howard, 2010; Liberman, 2006; Moylan, 2009) – the same perspective I renounced in March of 2010. Even though this research is limited by the capacity of self-knowledge and representation, I call for the social transformation of the institutions that proliferate our experiences and deliveries of pain – a vision we as critical (feminist) scholars share (Becker, 1967; Mies, 1991). I admit to being emotionally invested in this research, and thus recognize that my former involvement in the restraint and coercion of psychiatric patients drives my motivation to petition for the social refuge of medically institutionalized persons.

IV – The Interview: Ethics, site, sensitivity

After obtaining ethical clearance from the University of Ottawa's Social Sciences and Humanities Research Ethics Board (REB) (Appendix A), I conducted eight in-depth, semi-structured interviews with male guards who work or formerly worked at local hospitals, all of whom are former colleagues. I conducted the interviews over the span of six months, in one session for each participant and in English; the interviews lasted between one and two and one half hours exclusive of taking short breaks. Every interview was held outside hospital grounds in order to allow the guards to be more comfortable discussing the sensitive, violent, and disturbing aspects of their work. I gave each participant the option to choose the location of the interview,

which consisted of public coffee shops, a mall lobby area, the participant's home, and a fast-food restaurant. I designed an interview guide (Appendix B) to assist me in posing open-ended questions about the participant's gendered role and life in the hospital. Due to the time constraints of this research, I could only recruit male guards between the ages of 23 and 30.⁷ Although I offered the research opportunity to multiple women, only one expressed interest and, unfortunately, was unable to participate.⁸ While it can be said that the sample size is small and limited in terms of generalizability and representation (Berg, 2009), my critical lens of inquiry focuses on the vivid details and deep nuances of each guard's story, instead of quantifying meaning (Crouch & McKenzie, 2006).

Initially, I employed purposive sampling by recruiting three former colleagues I had recently spoken with. The recruitment script (Appendix C) was verbally dictated to participants over the phone, or sent to them through a personal email that was not in any way linked to their workplace. In either case, participants were informed of the goals of this research, the voluntary conditions of their participation, and the issues of confidentiality and anonymity to help enable them to make an informed decision about participation (Shaw, 2008), and I gave them my contact information to convey my trustworthiness (Philaretou & Allen, 2006). I orally reviewed the informed consent form (Appendix D) with each participant before the interview began to ensure that they clearly understood the information, their rights to withdraw and concerns regarding anonymity and confidentiality. At the end of each interview, I reviewed and provided participants with a list of community resources and services (Appendix E) they could explore if they were feeling any stress or discomfort from the interview. If I gaged that the participant was

⁷ I withhold from sharing any additional demographic information of the participants to ensure that their identity remains anonymous to readers, colleagues, and their organization.

⁸ I recognize (in speculation) that the limited communication I had with female recruits may be linked to an uneasiness they may have towards speaking with me, a former male colleague, about the sensitive and gendered nature of their job.

comfortable referring me to other potential candidates, I asked him for the contact information of any colleagues he felt would be interested in taking part in this research. As Berg (2009) reminds us, snowball sampling is particularly helpful for researchers who are interested in studying sensitive topics or difficult-to-reach populations (p. 51). Finally, I asked each participant if he would like a copy of his transcript. To date, no participant has contacted me to obtain a copy of his transcript.

Researchers often engage in qualitative interviews to take part in the reconstruction and understanding of experiences/events they may not have shared with the participant (Ezzy, 2010), and to collect specific, guided data (Merton, Fiske & Kendall, 1990). In this case, interviewing my former colleagues provided us with a space to collaboratively piece together the masculine portrait of the alpha guard, and to discuss our experiences resisting, reproducing, or failing to live up to hegemonic masculinity. Due to the sensitive nature of the job, both my and the participants' questions, reactions, and gestures were at times intense, emotional, and direct. The interview allowed me to empathetically listen to the voices of the guards, and give them the opportunity to speak as experts in their own lives (Lundy & McGovern, 2006).

As we become entrenched in the ideas that unfold during the interview, which is often a highly charged setting, the in-depth lengthy contact with participants can sometimes dissuade researchers from fulfilling their ethical responsibility to be empathetic and compassionate (Dickson-Swift, James, Kippen & Liamputtong, 2006). Perhaps as a result of my inexperience conducting interviews (Roulston, deMarrais & Lewis, 2003; Wray, Markovic & Manderson, 2007), I encountered ontological tensions, discomforts, and disagreements with my participants during the discussion of sensitive topics, such as the legitimization of physical and chemical incarceration practices (Kvale, 2006). Hence engaging in "emotion work" (see Section VI), or reciprocal acknowledgment of each other's feelings during the interviews, was central to the

research process. As Dickson-Swift et al. (2006; 2009) warn, withholding feelings during the interview for the purposes of appearing professional can lead to an implosion of frustrations and stresses at the end of the research process.

As a result, I reminded participants before and during the interview of their right to refuse to answer questions and/or to withdraw from the study. In one case, a participant asked me to skip a sensitive question he felt presented a threat to the identity of a nursing staff member, while in another case, the participant reacted to one of my questions by requesting a break (Borochowitz, 2005). To remind myself of the areas the participant felt comfortable elaborating on, I took handwritten notes during the interview.⁹ Lastly, I protected the participants' identities by replacing their name with a pseudonym during transcription, and did likewise for any other names, places or institutions they mentioned.

V – Ethnographic “fiction” writing

Sean: I don't think it'll ever matter what I do in life or what direction I go or whatever. Whether I, I don't paint or...what it is...it's always going to come back into my life, it's always going to creep back in. You know, I went to the opposite side of the spectrum and was in the military and was...you know, very hard and angry and...you know, very aggressive. And it didn't matter you know, whether six years or whatever...it came back out, that *creative side*. You can never crush it.

Charles: I say to myself what would I rather do? Right, I have a choice. It's either shoot behind a gun or shoot behind a camera. One creates and one destroys. What do I want to do?

In order to amplify my voice and capture my feelings, sentiments, and creative thoughts as a hospital security agent, I chose to write six “ethnographic fictions” (Inckle, 2010).

Ethnographic fiction writing is an autoethnographic method that draws on the emotional and corporeal experiences of individuals who are involved in sensitive research (Inckle, 2010).

⁹ The interviews were also audio-recorded with participant consent. This process will be discussed later in this chapter.

Unlike decentralized research, autoethnography situates the researcher in the complex layers of time and space that build perceptions and interpretations of the “other” (Bryant & Livholts, 2007). Specifically, it captures the values, sentiments, and identities that steer and shape institutions, organizations, and systems of power and domination (Watson, 2000; 2003). This approach permits the incorporation of knowledge that stems from academic, personal and vocational contexts. At the same time, it evades ethical tensions that surface for researchers who need permission from their REB to retrospectively write about their sensitive and vulnerable experiences in the field (see especially Holland, 2007; Inckle, 2010; Juritzen, Grimen & Heggen 2011; Librett & Perrone, 2010; Schlosser, 2008).

I advanced this methodological tool by crafting the fictions in anecdotal form (McIlveen, 2009), and then situated them within the broader narratives emerging from the participants’ voices. That said, these self-crafted experiences are understood as a *partial* interpretation of my “real” life inside the hospital (for the *factist perspective*, see Alasuutari, 1995a), and are meant to serve as a reflexive “intervention” (Walby, 2007, p. 1015) in the beginning, middle, and end of the narratives presented in Chapters 5 and 6.

Given that I did not take any research field notes during my employment as a security guard, ethnographic fiction writing is my most accessible version of autoethnography. As such, the retelling of these stories enables me to import a greater reflexive and subjective position on the incidents that transpire(d) inside the hospital, as I have more flexibility in how I present and revise my data (McIlveen, 2009). By experimenting with creative literature tools such as metaphors, satire, and omnipotent narration¹⁰, I sought to disrupt the authority/power of the narrative text (De Freitas, 2007), and demonstrate what critical feminists call a “less oppressive

¹⁰ This is a style of narration where the author gives the reader the impression that s/he is all-knowing of the various plots, characters, symbols and meanings of the narrative. I experimented with this device throughout the analysis to preserve continuity of my critical, “transformative intellectual” voice (see Section VII of this chapter)

way of knowing” (Lather, 1991, p. 95). As De Freitas (2007) and one participant, Sean, claim, artistic data better recognizes the personal and political lenses through which we perceive the world, stressing the point that creative writing is a ‘messy’ road map to expressing ourselves.

VI – Autoethnography: Is it trustworthy? (...) Does it matter?

Critics claim that autoethnography is a scapegoat to practice self-aggrandizement (Sparks, 2002). As Phillips and Earle (2010) warn, there is a danger that autoethnographers privilege their own voices above those belonging to the participants, escaping into what they call an “infinite, narcissistic regress of self-conscious self-interrogations” (p. 362). In tidy, “clean” positivist research, this critique may hold water, but this research is too messy and grounded in lived experience to invoke that approach. As such, we cannot hide from the “personal, political, and partial endeavours” (Jewkes, 2012, p. 65) that catapulted me into the shoes of an ethnographer. As Ferrell (1998) argues, we must,

Reintroduce the humanity of the research into the research process and make a case for critical, reflexive, autobiographical accounts and understandings – for *profound self-disclosures* [emphasis added] and openness to the “subjective experience of doing research” – as part of the field research process (p. 24).

Thus, this (auto)ethnography counters both the positivist (Jewkes, 2012, p. 69; Young, 2011) and scripted (Piché & Walby, 2010) agenda of the total institution, hospital, prison, and government authorities by constructing a more untidy, inconvenient, but “virtually real” (Guba & Lincoln, 2005, p. 258) portrait of the institution. For these reasons, critical researchers can legitimately investigate social problems, and shape how we deal with them. As Katz (2004) boldly summarizes, all ethnographic fieldwork remains “politically and policy relevant” (p. 280).

Although I borrow Inckle’s (2010) “ethnographic fiction” approach to unfold my own lived experiences as a hospital guard, the events I describe are in no way, shape, or form “fabricated”. Indeed, there are fictional components to my stories. The dialogue is paraphrased as

accurately as my memory recollects. The names of those involved have been changed to protect the participant identities, and the times of the emergency calls are only an approximation.

Although these missing fragments fracture some areas of the narrative, it would be foolish to remove this reflexive intervention from the analysis. As Jewkes (2012) cautions, “the failure to acknowledge the degree to which our own identities and different social positions inform the research process and subsequent publications can seem, at best, naïve and, at worst, dishonest” (p. 69). Instead, we must take into consideration that a good story may be simple or complex, constructed or real. What is important is that it “reveals something of the self” (Jewkes, 2012, p. 72) for “others to take it in, and use for themselves” (Coles, 1989, p. 47).

VII – Dealing reflexively with data collection

Data collection and analysis methods are not neutral techniques but rather theoretical, epistemological, and ontological assumptions that reflect how our knowledge is constructed and produced (Maton, 2003; Doucet, 2008). Although reflexivity – the idea that meanings are made instead of discovered – is often acknowledged in social science research, it is rarely translated into the actual practice of data analysis (Mauthner & Doucet, 1997; 2003). The thick application of reflexivity on the analysis process enhances the subjective nature of knowledge claims, and increases the researcher’s awareness of how knowledge is acquired, organized, made sense of and claimed (Deutsh, 2004). As such, this section of the chapter provides a space for me to reflect on the attitudes, feelings, and emotions that shaped how I gave meaning and authority to the text (Walby, 2007, p. 1015).

Emotion Work

Inexperienced researchers must be aware that they are entering unknown territory and should thus express extra caution when they are researching sensitive topics (Johnson & Clarke, 2003). Critical feminists contend that journal keeping helps the researcher identify how her

subjective experiences and perspectives shape the research on all dimensions. As Hannem (2008) demonstrates:

The creation of these notes is in many ways an attempt to preserve as many memories of the fieldwork experience as possible, knowing that any single moment or musing could be a key part of the puzzle of understanding the lived experiences of the participants (p. 114).

After each interview, I wrote a journal entry to capture my feelings, reactions, and afterthoughts. These notes assisted me in transcribing the data, as I was reminded of the participant's tone and intonation as they spoke. At times, I experienced isolation, antagonism, and anxiety as some participants attempted to justify to me our participation in institutionalized violence. Simultaneously, I felt empathy towards my former colleagues – and friends – as my questions addressed sensitive issues and encouraged them to re-visit traumatic memories, therefore creating some emotional discomfort. I then felt remorseful about the impact my critical perspective had on my participants (Lalor, Begley & Devane, 2006) because for some, this is their livelihood, or as Troy bravely admitted to me, “All I know” (see Chapter 5, p. 95).

In addition, I had a strong need to resolve the guilt and anger I felt towards my former job, as well as to remonstrate the uncritical rhetoric of some participants that justifies violent restraint and control techniques. Bearing in mind my commitment to keep the personal political (Pile, 1994), I found it both difficult and irritating to tread lightly on issues that challenged my epistemology, that is, my way of knowing and understanding the hospital and all its pains and deprivations. Yet I understood my responsibility to allow the guards to speak freely and bluntly about issues we both, albeit at times in different ways, find important and pressing. At times, the participant and I would intensify each other's tension and disagreement (see Kvale, 2006 and Chapter 6, pp. 139-140) while on other occasions my instinctual response was laughter (see Chapter 5, pp. 84, 121). These discoveries assure me that the embodied experience of qualitative

research is as much emotional as it is laborious or cumbersome (Dickson-Swift et al., 2009).

Even though this research is not exhaustive of the guards' voices, ideas, or feelings, I am confident that the scope and themes presented in these narratives represent many of the lived experiences of the local, male hospital security agent (Corbin & Strauss, 2008, p. 149).

VIII – Narrative analysis

The narrative analyst examines the whole and purpose of a participant's account by placing their stories in the context of a broader narrative. This process translates seemingly meaningless events into meaningful, anecdotal accounts (Alasuutari, 1995b; Ezzy, 2002, p. 95). More specifically, narrative inquiry permits the researcher to be explicit about their political positioning (Ezzy, 2002, p. 101). Without doubt, I am entrusted with a great deal of authority to provide readers with an accurate interpretation of the participants' stories. Yet as a critical feminist researcher, I am obligated to make explicit the political intentions and ambitions of this research. Thus my objective throughout the analysis was not to search for general commonalities in the narratives (Poirier & Ayres, 1997), but rather to seek, excavate, and publicize the gender hegemonies that critically shape the broad, universal narrative of the hospital guard.

From an exclusively constructivist perspective (Best, 1995) and specimen perspective¹¹, a narrative is conceptualized as a single structure the storyteller uses to construct her own story (Alasuutari, 1995b; Bruner, 1991). Of course, this research treats the narrative as more than a single experience, story, or testament to life within the hospital. Instead, the text, voices, and themes in this research overlap with a broader, universal story about gender hegemony,

¹¹ The specimen perspective views the narrative as an example, a specimen of *one* story or *one* life-story, rather than a source that gives us a broad understanding of the person's life or personality. Unlike the *factist* narrative (which I employed), the specimen narrative does not seek or claim to be able to seek 'facts' of an event (see Alasuutari, 1995a, p. 48), and thus would remove any individual context from its story. Through this posture, I would not be able to assert that the narratives of this research hold any 'truth', that is, any tangible substance of the indefinable and unreachable reality of the hospital and performatives of hegemonic masculinity.

incarceration, social control, and power, and is thus more akin to the factist perspective. Put simply, I argue that there is some broad, implicit, “real” element to the stories we will soon read, reconstruct, and reproduce.

Centered voice

The employment of neutral and sterile language in decentralized social science research encourages multiple interpretations to be sought in the data and diminishes the authority of the researcher’s voice (Grbich, 2004, p. 69). The narrative voice, on the other hand, is largely heard in story form, and *guides* readers and listeners to an understanding of the multiple truths in people’s lives (Grbich, 2004, p. 81). While critics argue that the use of personal narratives only provides a therapeutic or self-indulgent outlet for the author (Phillips and Earle, 2010), the idea that research is inextricably linked to collectivizing issues, such as social justice goals and initiatives, suggests these narratives will transgress narcissism to provide insight into the lives of others (Grbich, 2004, p. 84).

Ergo, my voice is the centre of this research, that is, the primary tool I use to shape how readers understand and give meaning to the text. In order to “intellectually transform” (Guba & Lincoln, 2005, p. 269) the audience, or strengthen the reliability of my experiences and personal connection to my readers, I reflexively intervene in the data with my stewing anger, disbelief, and struggle. Such openness equips me with the emotional tools I need to challenge my academic critics (see Chapter 2, section IX) to espouse a critical ontology that ignites their potential to push for social change and action. As Grbich (2004) observes, “the combination of fact, fiction and feeling over spatial and temporal locations...not only appears as a more intense reflection of experience but also provides a better communication tool with which to reach out to the audience” (p. 87). In other words, these creative and autobiographical narratives fuse my

academic self with the personal; the scientist with the artist, or the side of one's self that Sean reminds us we "can never crush."

Transcription

The data analysis began with transcription. I transcribed the interviews verbatim in order to produce a more intimate representation of the guards' gestures, intonations, movements and tones (Bird, 2005). These visual and audible cues expose the concealed meanings and sub-texts that reproduce rather than portray the account (Brandenburg & Davidson, 2011; Hammersley, 2010), and encourage researchers to "go beyond *what* was said to *how it was said*" (Hannem, 2008, p. 116). Hearing our voices together over and over again reminded me of the unease, camaraderie, and anxiety of the interview space, which in turn helped me translate more precisely the guard's tone, pauses, laughter, and body language. Indeed, these nuances are clues to meaning that would have become lost if I designated the responsibility of transcription to a detached, "bloodless observer" (Ferrell, 2004, p. 293) who cannot tangibly relate to the subjective traumas, meanings, and reflections of the participants (McLellan, MacQueen & Neidig, 2003; Tilley, 2003).

Coding

Narrative coding is concerned with the deletion/selection of propositions found within a text (Alasuutari, 1995b, pp. 72-73). Thus, I needed to fracture and re-arrange events within the data so that they would create a plot, and unfold temporally (Poirier & Ayres, 1997). After I read the transcripts several times over¹², I coded each interview vertically to get a feel for the various themes that emerged independently or for each participant, with careful emphasis placed on the plot-structure, context, and phrasing of the text. I found that many participants began the

¹² This includes the ethnographic fictions. For the purposes of analytical clarity and consistency, I coded the ethnographic fictions in the same manner that I coded the interview data.

interview by discussing their family background. Here, most guards spoke to how their early involvement in (para)military programs such as the local reserves contributed to their beliefs on femininity, masculinity and authority. This then led to a discussion about their experiences being socialized in early adolescence to follow and respect the directions of their superiors—who are predominantly men—without question. Departing from these experiences to discuss the finer details of their life at home and migration into security work, the guards expressed how supporting and reproducing a fixed and patriarchal understanding of relationships between men and between men and women constrained their capacity to resolve conflict without verbal and/or physical authority in domestic (see Adelman, 2003) and closed institutional settings (the focus of this critical hospital research). I used these consistently-appearing themes to sketch out the linear elements of each narrative so that I could constantly evolve and build the two narratives as I coded each interview independently.

After I reached the point of thematic or theoretical saturation, the point where I could no longer see any sub-stories or texts emerging independently from each interview, I coded the data horizontally to develop and organize two broader narratives, “Us” and “Them” (Bell, 1999, Ezzy; 2002). More specifically, I reduced the data into categories of masculinity that, in many cases, coincided with categories developed in the literature review.¹³ In subsequent readings, I refined the data into more specific topics and subtopics (Lincoln & Guba, 1985). In other words, if I felt the stories were about guards’ relationships with each other I placed that section of the data within the “Us” narrative. On the other hand, if I felt the stories contributed more to our understanding of how the guards interact with the nurses and patients, I placed the text within the “Them” narrative. I stopped coding the data once it was organized in a temporal sequence. In

¹³ For example, physicality; violence; anger; loyalty to bureaucracy; militarism; authority; ambivalence towards femininity; essentialist/biological definitions of gender.

other words, the analysis was not complete until the narrative data could collectively be understood in a past, present and future context.

Validity

Ayres and Poirier (1996) assert that it is contradictory to “make science out of stories” (p. 164). Thus, I acknowledge that critical theory research cannot meet the validity criteria laid out by a positivist paradigm (Guba & Lincoln, 2005). Instead, validity corresponds to the degrees in which my research stimulates action towards social transformation and justice. The feasibility of my political objectives takes precedent over more traditional epistemic concerns (Hammersley, 2009). Put simply, this research ought to be evaluated for its capacity to stimulate critical thinking, social action, and transformation towards how we understand, treat and stigmatize persons we come to recognize as mentally ill. While I attempt to demonstrate validity in my experiential accounts by providing thick rich descriptions of the sites, sounds, feelings, and voices I encountered (Tracy, 2010), I am ultimately more concerned with providing my readers with a trustworthy, but broader understanding of the gendered concepts, structures, and forces that shape the prison hospital.

IX – Limitations

Where are the women?

The absence of women’s voices in this study prevents us from accessing the lived experiences of female security guards. Participant understandings of women’s role in security are not reflexively shaped, and therefore cannot illustrate a trustworthy, let alone “real” portrait of their experiences. Instead, participant voices mirror the ways in which dominant outsiders understand subordinate groups. With trepidation, we speculate on the lived “reality” of the female guard, that is, the ways in which she accomplishes, or fails to accomplish gender in a

masculine culture. But even without female representation, this research still pursues a feminist cause; it still “pushes back...against the shove of domination” (Butz & Besio, 2004, p. 353).

X – Conclusions

Ultimately, to be an ethical researcher is to be an honest one (Davison, 2004; Dickson-Swift, James, Kippen & Liamputton, 2006; 2009). Doucet (2008) reminds us that honesty helps break down the researcher-participant divide, equalizes the value of our experiences, and encourages participants to be more forthcoming with their own thoughts and feelings. In doing so, the researcher strives to transcend institutional influences that work to define and confine experiences within an established, finite ontology (Mathiesen, 1974), and regulate knowledge through biomedical (and often arbitrary) ethical parameters (Haggerty, 2004; Murphy & Dingwall, 2007). Since I made my research intentions and goals transparent (see Appendix D), and shared my genuine feelings and opinions during the interview, I am confident that these open exchanges helped to (re)establish trust between the participants and I, and evolved into an accurate representation of their lived experiences. The fluidity, intensity, and openness of our dialogue convince me that all of us, at some point or another, were provided with insight into our traumatic experiences. And on a more reflexive note, for some participants this research allowed them to let go of old pains, struggles, and demons and thus to come to terms with their participation in the reproduction of gendered oppressions.

Now that we have theoretically and methodologically situated this research, we move to the analysis that is the climax of this tale. The analysis is divided into two narratives. Broadly, Chapter 5 explores how the guards construct, reinforce, and resist hegemonic masculinity. Thenceforth, Chapter 6 examines how masculinity disperses throughout the hospital, and discursively shapes the relations between the guard, the nurse, and the patient.

CHAPTER 5: “US”

Summary

“Us” is a story about nine hospital security guards¹⁴ who pass, fail, and resist tests of masculinity they are culturally encouraged and expected to take up, reproduce and (re)distribute. This narrative first examines the militaristic and patriarchal settings that shape the hospital guard’s understanding of masculinity prior to his career in security. These social spaces educate incoming guards on the patriarchal norms of masculinity that are widely valued and reinforced in security (Rigakos, 2002; Micucci, 1998; Monaghan, 2002), policing (Fielding, 1984; Fletcher, 1996; Herbert, 1996; 1998; 2001; Nolan, 2009; Prokos & Padavic, 2002), prison (Acker, 1992; Bandyopadhyay, 2006; Bosworth & Carrabine, 2001; Donaldson, 2001; Evans & Wallace, 2008; Jewkes, 2005) and military work discourses, practices, and institutions (Albuquerque & Paes-Machado, 2004; Duncanson, 2009; Johnson, 2010; Shefer & Mankayi, 2007). To accomplish hegemonic masculinity, the “alpha” guard romanticizes his physical engagement with patient-prisoners to appear heroic (Huey, Ericson & Haggerty, 2005; Rigakos, 2002); he relies on physicality to control patient-prisoners (Connell, 1995; 2005; Messerschmidt, 1993; Prokos & Padavic, 2002), he enforces and obeys the heterosexual code of honour (Connell, 2009; Prokos & Padavic, 2002); and lastly, he takes part in the sexual belittlement and discrimination (Bird, 1996; Brown, 1998; Burke & Mikkelsen, 2005; Garcia, 2003; Gerson & Peiss, 1985; Prokos & Padavic, 1991; Rabe-Hemp, 2007) of his “weaker” colleagues – namely, women and subordinated men.

The early indoctrination of hegemonic masculine values begins during the early stages of the guard’s career, as security is the first challenge many pursue in order to obtain a more

¹⁴ The sample includes myself.

prestigious career in public policing (Rigakos, 2002, p. 30). The initial exposure to death, morbidity, chemical injections, and violence between the guard and patient quickly pressures the guard to adopt the tough, impenetrable persona he needs to cope with, and react “appropriately” to stressful and even traumatic events. His new ontology, or way of life (Foucault, 1977; 2003) is fortified by demonstrations of brute strength, authority, and yet also submission to his superiors during patient encounters (Connell, 1987; 1995, Messerschmidt, 1993). For some, the accomplishment of hegemonic masculinity is seen as heroic, while for others, it is “dirty” (Dick, 2005; Tracey & Scott, 2006).

The male guard carries little expectation that the female guard can match his competence, a belief that is predetermined by what is seen as her biological inferiority (West & Zimmerman, 1987). Instead, he constructs the role of the female guard as “complimentary” and “supplementary” to the physical aspects of the job that are managed predominantly by alpha men. Interestingly, the subordinated or “failed” guard is cast similarly as a kind of failed man, womanly in his weakness or inadequate demonstration of his capacity to physically overtake the dangerous patient-prisoner in a violent showdown. These guards are constructed as less valuable than their peers who express hegemonic masculinity (Coles, 2008; 2009; Kupers, 2005). Often times, both the alpha and subordinated male guard share this view, which demonstrates how both parties participate in the adoption and reproduction of these divisive discourses about masculinity.

The subordinated guard who resists the paramilitary structure, language, and practices of the job is culturally de-valued to the point of banishment, resignation, or termination. In fear of reprisal from his “front-line superiors” the guard is confronted with much pressure to reproduce the domineering, aggressive and coercive relationships that exist between security staff and patient-prisoners (Garcia, 2003; Gerson & Peiss, 1985; Prokos & Padavic, 2002, Rabe-Hemp,

2007). Some guards, such as myself, reconcile their contempt to take up and exhibit this role by withdrawing from the hospital. Contrariwise, those who continue working in spite of their growing tensions with the nature of the job encounter gendered stress and burnout (Brown & Carlson, 2003; Kurtz, 2006; 2008).

Part I – Follow my lead

“5-0-3 to 200.”

“Go ahead!”

“Can you get down to Psych-Emerg ASAP?”

“10-04, on-route.”

I walk tall alongside Glen to the call. He’s not my back-up, I’m his back-up. There’s a difference.

Glen re-positions his radio on the upper right portion of his uniform sleeve. It clips onto to the side of his protective vest. They’re not bullet proof, but people think they are. And we don’t tell ‘em any different.

We reach the elevators on the seventh floor. Five minutes ago, we just finished dealing with a neuro-patient who told one of the nurses to fuck off. He doesn’t see the need for us to be up there. Deep down, neither do I. But our last words to him are short, swift and frightening: “If we have to come up here again, there will be consequences.”

It buys us time to get down to Psych-Emerg, where a “real” call can happen.

I stand beside Glen in the elevator. I wait for him to push the ground floor button. Simultaneously, we pull our notebooks from our vest pocket and scratch in the time and purpose of the call. The cops always tell you in training that documentation saves your ass.

The elevator door opens, and Glen darts out the front door. Controlled, I follow. We hurry to Psych-Emerg – there are two sets of doors that require special identification. Without it, there is no getting in – or out.

We enter the ward. There are six patient rooms situated alongside each other. The nursing station is positioned in front of the rooms. Here, nurses work quietly behind a transparent barrier that allows them to watch the patients while staying protected from them.

The second I walk through the door, I hear the male patient shout to the male nurse that he’s not leaving. Antonio, 5-0-3, is sitting inside the nursing station. Glen motions to Antonio through the barrier that ‘we’re going in’. We take two steps forward, and are interrupted by Jordan's voice, “Glen don’t bother talking to him I’ve already tried. Its pointless.”

Glen stops. I stop. We wait for Antonio to step outside the nursing station. There are three of us now. We go in together.

I am the last to go in the room, standing between Glen and Antonio. The male patient, who I later learn is nineteen, stands in front of us, shaking. Antonio speaks,

“You gotta’ leave buddy.”

“I’m not fuckin’ leavin’!” the patient replies.

“Well, they’re saying you have to so if you don’t we’re gonna make you.”

And in slow motion, the patient’s whole body shakes. He looks left and right, and then darts towards the space between Antonio and I. Antonio grabs the patient and places him in a headlock. He pulls him towards the bed. Before he crashes on the mattress, Glen dives towards the patient, punching him three times in the area that connects his neck to his head. I make my move and grab the patient’s legs as we place him onto his bed. The slow motion ends and I hear the male nurse’s voice:

“Just call the fuckin’ cops we’re having him charged. He doesn’t wanna leave – we’re having him fuckin’ charged.”

My attention is quickly drawn back to the patient as Antonio and I press on the back of his knees to prevent him from kicking. Of course, he doesn’t kick. With his right arm, Glen presses on his cheek to force his face into the pillow. His one eye is exposed, revealing the trail of a tear that has plunged down the side of his face. With his left arm, Glen holds the patient’s wrist behind his waist. I watch him apply pressure, and the patient’s wrist bends towards his arm. Like a pig, he squeals.¹⁵

“OK! OK!” And finally, Glen says something,

“Wow I thought you wouldn’t be such a pussy guy there. I guess you’re just a pussy guy.”

The crying intensifies. The patient apologizes, and then explains to us that he doesn’t want to go back home. I stop looking in the patient’s eyes and stare down at the legs that I hold. I relax my grip and hear Glen laugh. I wonder, does he think it’s funny or does he think he needs to think it’s funny? I guess it doesn’t matter either way.

The male nurse comes back into the room. He holds in his hand a bucket where the four-point restraints are kept. The four of us each take one and tie it to the bed. The nurse draws up a sedative and injects it into his bare ass. We then turn him over and place each of his limbs in restraints. The patient doesn’t fight back. In my own mind I wish he would. I wish he’d just give us something to justify it all. But I know that isn’t how injustice works. There’s more to it than the blood that runs from the cut on his nose.

¹⁵ Coincidentally, this part of the attack corresponds to a scene in the film *One Flew Over the Cuckoo’s Nest* (Dir. Milos Forman, 1975), where a tough male orderly by the name of Washington (played by Nathan George) throws rebellious patient Randle Patrick McMurphy (played by Jack Nicholson) on the ward floor stomach-down, and applies force to his wrist, causing Randle to scream out in pain.

After the patient is restrained and sedated, we sit in the nursing station and write our versions of what happened in our notebooks. Glen is the last to finish. Surprise. We wait here until two male police officers arrive. One asks Antonio what the patient's mental status is. He replies that he just has anger management problems. At this point, Glen informs me that I can go back to the office, so I do.

Back at dispatch, my partner, Ed, greets me with enthusiasm: "That was a gong show!"

I suspect he's jealous he didn't get to participate. Most of the guys prefer not to watch the Psych-Emerg rooms from afar on our surveillance system, unless it's a female patient changing in her room, unaware. His next words, however, confirm what I thought I witnessed:

"It looks like Glen got a few punches in there."

"Yeah, he did." I reply. And that is the last we speak of it.

Eventually, the Security Supervisor enters our office with the two police officers to review the video footage. Appearing satisfied with what they see, the male police officers leave the office. On camera, I watch the police officers escort the patient off hospital property in handcuffs.

I take it we are the *heroes* since they charge him with assault.

This narrative serves as our departure point to discuss the militaristic, violent and sexist discourses the guard must adopt (Foucault, 1977; 2003) and reproduce in order to gain gendered status in a demanding and unforgiving hyper-masculine culture, and accelerate into a 'higher' career in public policing (Rigakos, 2002, p. 30). As such, the guard survives his peers' gendered assessment by using militant language, gestures, and apparel when dealing with patient-prisoners; by demonstrating an impenetrable persona and confidence; by 'rescuing' staff from perceived 'dangerous'/mad patients; and lastly, by relying on force and physical intimidation to solve incidents.

*A Military's Man's Man*¹⁶

The militaristic conditions the aspiring guard must adopt to do hospital security work include ongoing demonstrations of loyalty towards the rules, codes, and obligations that are

¹⁶ In most cases, the subtitles in Chapters 5 and 6 are not verbatim quotes from the participants, but are rather part of the larger "ethnographic fiction" exercise utilized in this thesis.

established by his superiors (Albuquerque & Paes-Machado, 2004; Duncanson, 2009; Johnson, 2010; Rigakos, 2005, p. 271; Shefer & Mankayi, 2007). In so doing, the guard adopts a new ontology (Foucault, 1977; 2003), where he rationally calculates and assesses the important information from the unimportant; the weak person from the strong; and the masculine character from the feminine. The guard's new interpretive lens is constructed as paramount in ensuring that he survives the tough and violent realities of the job. As hegemonic masculinity commands, this involves obeying authority while still reflecting an "air" of confidence (Connell, 1995; 2005; Herbert, 2001; Messerschmidt, 1993; Prokos & Padavic, 2002):

Sean: They'd always teach in the military is...is if you look keen, if you look confident...you're less of a target. And especially in urban areas...if you're patrolling and you're aware and you're watching your ass...People are less likely to attack you because you're gonna be more...resistant. You're gonna fight back harder...As opposed to being the guy that's...looking around at his feet...kind of kicking dust. And so, you kind of have that same idea that if you go into the hospital, if you have that air of confidence, you don't have to be a hard ass.

Ideally, the guard is able to diffuse potential 'situations' before they become violent through his aura of self-assuredness and control, along with the unspoken but visible threat of physical dominance. This disguise of confidence mirrors the militaristic notion that simply the presence of military power, image and authority creates a deterrent to attack (Johnson, 2010). Yet the guard's enthusiasm to invoke fear and intimidation in the patients by mimicking tactical police choreography, as Sean later reminisces, may warrant the opposite effect and instead provoke patient-prisoners into becoming aggressive and panicked out of fear for their safety, dignity and bodily integrity:

Sean: But a majority of time...it's almost as if we're like riot people. You know what I mean?

Me: Yeah I do.

Sean: You come in and there's...three people coming at you that are wearing all the same uniform, it's the same, same tactics as you know, SWAT. They all, walk and step...you know with their shields or whatever. It's like uh a mace, you look a lot bigger than what you are...Things get out of control, everyone wearing the same uniform. And, and

especially at [a local hospital] wearing the, the vests and, and whatever, walking in (...) You know, it's intimidating. Like it's...

Me: Very scary.

Sean: Especially when you have four or five people running for a call that didn't need that, you know? It's um...I don't know, I always just thought it was unnecessary. And...people who would be you know, 'here come...the cops'. People often seem to make light of situations they find disturbing or whatever.

However, getting in a fight, especially in the early stages of one's 'inexperienced' career, allows the guard to prove, in a 'heroic' manner, his physicality and worthiness to a hostile, demanding, and hyper-masculine troupe of men – many of whom are competitively driven to obtain promotions, notoriety, and recognition from senior authorities in order to excel and earn promotion into a higher status career in public policing (Rigakos, 2002, p. 30). Indeed, the more ambitious guard is able to prematurely achieve heroism. He establishes his heroic powers by sharing war stories about risky, "life-threatening" encounters he has with patient-prisoners (Conti, 2011; Huey, Ericson & Haggerty, 2005). While the media and many other social outlets largely reserve hero-status for firefighters, soldiers, and physicians (Tracey & Scott, 2006), initial displays of "warranted" aggressions are viewed as a rite of passage into hospital security culture (Rabe-Hemp, 2007). Consistent public demonstrations of physical dominance coupled with the permanent avoidance of long-term injuries to themselves, nurses, or patients ensure that the guard is able to handle the masculine demands of the job. And as Jackson illustrates, displaying brute force and authority over a patient-prisoner who is labeled as insane/dangerous makes the security team appear effective and efficient at diffusing incidents the ward staff deem threatening/risky (Kilty, 2006, 2008, 2012).

Joey: Simple scenario. We go up there...um patient is in the bathroom...one of the RNs...knock on the door, 'Come out'. No response. 'Come on [patient] take your meds.' (...) Guy is very aggressive...at the drop of a hat. Open the door...he was butt naked on the toilet taking a shit. Non-responsive to us, he's just sitting there...head down...not talking, not looking at anybody. No response. I'm at the door...kneels down to, to match his eye level while he's on the toilet. Put the hand on his shoulder... '[patient]...we need you to go back to your room. If you don't come with us...we're going to help you.' Which is code

for ‘We’re going to fucking grab you.’ So yeah. ‘We’re going to ‘assist’ you.’ ...Pull him down to the ground bare ass naked. Shit hanging off his ass. He’s uh, he’s uh a black belt or something. He’s really well...trained to hurt people bad. I would say kill. And he’s wrestling us, we have enough, enough guys they call a Code White¹⁷ we just...hold him down – the injection happens on the bathroom floor. Right in his ass. Two injections. Another nurse. Two injections. The mirror’s ok. He got a straight shot to the balls I don’t know how he handled it or whatever. Tough enough guy. Um...got him back to his room put him in restraints. And he’s out for the night.

Here, a patient remaining in the washroom for longer than what is deemed an appropriate time is constructed as enacting a deviant plot to avoid taking medication, or more simply, a challenge to the nurse’s authority. Because this particular patient holds the reputation that he is “trained to kill”, the guard justifies using coercive force on the grounds that the patient may become resistant and thus dangerous while nursing staff restrain, sedate, expose and humiliate him. Ergo, this scenario is ideal for the guard in two ways. Since the patient is constructed as risky and harmful, responding security guards are awarded with notoriety and status from their peers and ward nurses for subduing a potentially lethal threat. The patient, who one might argue is in a vulnerable position while seated naked on a toilet, represents a relatively easy mission for security given that he is clearly overmatched by the number of guards, supporting medical staff and sedatives present.

I wanna be a cop when I grow up

Often, the guard’s heroic efforts and pursuit of security work is closely linked to romantic aspirations to join a public policing agency (Rigakos, 2002, p. 30). Since he believes that hospital security mirrors the intensity of public policing work (Huey, Ericson & Haggerty, 2005), he is challenged to learn attitudes and practices that enhance his masculine character and prepare him for a long-term career in policing or security. To gage if the new guards have what it takes to

¹⁷ Code White means “aggressive patient”. When paged overhead, security and medical staff meet in the area that requires emergency assistance.

adopt some of the traditional images, demeanours, and responsibilities of police officers, senior officers evaluate them rigorously:

Jackson: You had a three-month probation training where you wouldn't even get a fucking ID badge, man. You weren't allowed to have access to anything...you didn't know, you didn't have anything. They were gonna make sure you were raised to work in the hospital because the hospital was and I think it always will be...a different beast. If you wanna be a cop but don't want to be a cop...because you're afraid to be a cop your whole life. Work at the hospital.

Demonstrating how the need to be a hero is intrinsically attached to the guard's need to maintain and display his “self-assuredness” and ability to control all security situations and events—regardless of its danger or potential to become violent—Jackson conceptualizes his job as subordinate in status to that of a police officer, which is seen as more exciting and dangerous than work within the prison hospital (Rigakos, 2002). In his eyes, the right to carry a gun and use lethal force comes with elevated masculine status, admiration, and respect. More specifically, by fighting crime and saving lives (Dick & Swift, 2005; Tracey & Scott, 2006), police officers are perceived as heroic by the public, whereas any acts of heroism that take place within the hospital are unlikely to reach the attention of the media. Not only does this barrier to public admiration spare the guard from enduring any embarrassment in the community should he fail to control a dangerous situation, but the lack of media attention protects the institution from receiving negative publicity in the event that a patient-prisoner is harmed and mishandled by security (Federman, 2012; Holmes & Federman, 2006; Jacob, 2012).

That said, while lacking the status and recognition of public policing, security work is the most accessible tool a guard has to inch closer to his heroic dream without following a more “innovative” pathway:

Charles: Most people...think of the idea of becoming a police officer is...cool. Because the mere concept that you're a figure of authority, right? You have a weapon. People respect you and you're fighting crime. So...that is appealing because of this superhero idealism that we're...you know, got at a young age (...) Through the media, through

television, through...novels you'd read...everything that kind of says police are amazing they want to protect us...it's fantasy. The closest possible way you can actually become a superhero is either be a police officer, being a firefighter you know being a, a physician or by being in the military because that's the only...area essentially that you can really save people's lives...without also being truly creative.

Charles insists that the guard's dream of doing police work revolves around a childhood fantasy to protect and save lives. Yet ironically, a clear divide exists between those who are afforded protection (medical staff), and those who are sentenced to pain, infantilization and control (Holmes & Murray, 2011, 2012). For some, the job will never live up to the responsibilities and demands given to soldiers, cops, and superheroes, while for others, the hospital uniform will evolve into a medal of masculinity – a proud and visible display of their heteronormative status and authority (Connell, 2009, p.143).

The job and uniform are enough for me

Sometimes, the subordinated guard is content with the masculine capital he receives just by wearing his “patches” and marching to drum of his own masculine beat. The uniform ensures that the public visibly recognizes him as a person who holds authority, power, and respect akin to that held by police officers. As such, the uniform provides a powerful boost in the guard's self-confidence and foreshadows his irrepressible ascent up the hierarchy of alpha or hegemonic masculinity:

Jackson: Literally it was like a summer it was one o'clock in the afternoon; our shift started at maybe three? We decided we would walk from our place to [a hockey stadium] and in our uniform down [a local street] because we were so—fucking—proud.

Me: (*laughs*) Ok.

Jackson: We thought we were cool because people were looking at us and are like 'Yayyy'...it was the uniform...it was...our official...piece of...shirt. You know what I mean? I had to look like...I'm not sure if the word cop crossed my mind but it looked...you know it was different.

Similar to filmic representations of soldiers returning home after war to parade the streets to receive public honours, Jackson experiences a heightened sense of pride by wearing his uniform

in public and in front of everyday citizens. The guard's apparel represents a symbol of both power and heroism (Chappell & Lanza-Kaduce, 2010; Johnson, 2010; Rigakos, 2002), which ultimately provides him with the thrilling feeling that he, alongside police and his fellow private crime-fighters, own the streets and anyone who dares to walk on them. As we will soon discover in Part II, taking ownership and control of the vulnerable persons who occupy the corridors and cells of this closed institution is a "different" and indeed "dirtier" (Dick & Swift, 2005; Tracey & Scott, 2006) beast than most "hockey" guards will ever face.

Part II – You're in! But it only gets worse from here

Day Three on the job. The phone rings. Call from Pathology. 10-98 arrival, meaning a patient has died somewhere in the hospital, and needs to be transported to the morgue. The other guards tell me our job is simple: we must register and place the body in the morgue freezer. I try not to show it, but I'm nervous. I hope the other guys can't tell. I haven't seen an open casket before, let alone a dead body.

"You ever seen a dead body before Johnson?" Johnson, they always forget the "t" in my last name. Ironical, considering these guys would never get near a penis.

"Yeah, at funerals and stuff." I lie.

"This one is going to be a corneal retrieval." Jerry tells me, the most senior, dedicated, respected guard.

What the fuck is that? I think. And then I say, "Oh cool." I learn later it's an organ donor procedure completed by a registered nurse who is specially trained to retrieve the corneas from a body after death. Apparently, it's the only organ they remove post-mortem. The more you know.

Our job is still simple, I am told. We are obligated to supervise the nurse while she removes the cornea from the cadaver. There's a security risk, and that's all I know.

At the morgue, Jerry shows me the booklet we use to register the incoming bodies. He is a large, muscular man, at 6'0 only a couple inches shorter than myself. His voice is direct and blunt. He is detached from the morbidity of this place, and I feel I must show him I can be the same.

We enter the freezer. Jerry shows me the cupboard where they store the babies. They are wrapped tight in a silk cloth. In my head, I start worrying where this is going. He closes the cupboard, thank God, and explains to me coldly that these are the miscarriages from the maternity ward. There are four people on stretchers beside us wrapped in a white bag. Jerry takes one of them and pushes it, him, into the room that attaches to the freezer. We open the door and I know it's the autopsy room. Sterile metal tables and metal blades glisten the room with a strange glow. This is surreal, for now. In six months, it better be nothing.

The “retrieval” nurse joins us. She is young and pleasant. Jerry speaks with her professionally, probing for information about her job. She takes the body out of the bag and I see that he is, or was, an old man, probably in his seventies. Dry trails of blood capture my eye in the area where they placed a catheter. Jerry, zoning in on my facial reactions, asks me with a grim smile, “How you doing there, Johnson?”

“Good...Good.” I reply.

“Just let me know if you start getting tunnel vision.”

What the fuck? I think.

The nurse does some kind of preparation procedure to the body’s eye. I couldn’t explain it then and I can’t explain it now. She tells Jerry that I’m lucky today because this is one of the rare times she is removing the entire eyeball. What luck!

At some point, she removes the man’s eye, allowing the folds of his eyelids to flap over the empty cavity. Jerry asks the nurse if we can see it. She cups the eye in both of her hands. The mucus from its tissue sticks to her rubber gloves. She holds it up to Jerry, and then she holds it up to me. I can smell it, I panic, I can smell it. Like stale eggs. In my peripheral vision I catch Jerry observing my face. He asks me again, with a grim smile,

“How you doin’ Johnson?”

“Well, it’s kind of fucked” I finally let out, with half a smirk. And he laughs. For the first time in my life, I am smiling at death.

And passing their test.

This section of the chapter explores how hospital security training initiatives do not prepare the guard for the violent, morbid and shocking events he will be exposed to throughout the course of his career. Even though the hospital guard is not given the same set of skills and legal permissions that are afforded to police personnel (Rigakos, 2002), the guard’s belief that he is just as powerful and capable of performing heroic feats ultimately encourages him to reproduce hegemonic discourses of masculinity that ban feminine displays of compassion and empathy towards patients (Evans & Wallace, 2009, p. 485; Prokos & Padavic, 2002). Although the alpha guard must perpetually demonstrate his immunity towards his grotesque and disturbing responsibilities, we learn that his emotional wellbeing is, as Dwaine elaborates, more “messed up” than what initially meets the eye.

Training? What Training?

The participants with whom I spoke were generally dissatisfied with the formal training classes they were required to take. Although the majority of the training programs tend to educate hospital guards on their legislative powers of arrest and non-violent alternatives to using force, they do not provide the guard with the tactical, masculine skills he needs to intervene with “dangerous” or “unstable” patients. These skills, they claimed, can only be learned on the job:

Me: How about the training? Tell me about that.

Troy: Completely useless...I’ve never used it...never used it.

Me: Never used it? What do they teach you there man?

Troy: Ummm...useless techniques that don’t work. I think it’s more for like maybe nursing homes, like older people maybe...It’s never going to work against some patients...Because anybody we deal with is just...is way too strong to...do these little holds...Like I don’t think I’d risk like a little...wrist-lock is gonna...is gonna help someone that’s trying to beat the living snot out of me.

Although the training of the job gives the guard the initial impression that he will only need to engage in a minimal amount of physical force and violence, the cultural expectations of physicality reflect the hegemonic masculine standard to use brute, oppressive and, if needed, uncontrolled force (Connell, 2009; Herbert, 2001; Messerschmidt, 1993). Messerschmidt (1993) explains how the hegemonic male resorts to his most immediate resource—his physicality—when his masculine identity is called into question in order to frighten others from categorizing his gendered behaviour as “shamefully” feminine (p. 67). As such, Troy mocks the prison hospital’s training program on the grounds that it does not teach or encourage him to use force freely, at his own discretion. If he and others were to follow such instructions, they would be obligated to resort to tactics that are constructed as less violent and thus more feminine, such as ‘talking a patient down’, or seeking a resolution through communication. Regardless of their efficacy (Ashcraft & Anthony, 2008; Barton, Johnson & Price, 2009; Bjorkdahl, Palmstierna & Hansebo, 2010; Cleary, Hunt & Walter, 2010; Curran, 2007; Holzworth & Wills, 1999;

Huckshorn, 2007; Lindsey, 2009), these non-violent strategies come with the sacrifice of adopting a subordinated, underprivileged masculine status.

In a similar vein, Jackson describes security-training programs as a tool management uses not to teach guards how to do their work, but rather to legitimize the establishment as a professional organization.

Jackson: We actually had a...training package. Uh you would sit through a class for four hours. It was taught by [the security supervisor] who...you would listen to their propaganda, what they stand for, their company goals, their mission, all this bullshit. Um...and then you'd have a quiz at the end. And it was a basic security test. And you could actually put this shit on your resume. You passed a basic security test.

Me: Mmm hmm.

Jackson: Doesn't mean fuck all.

Me: Right.

Jackson: It's not a real license.

Me: (*laughs*)

Jackson: It's, it's a stupid little quiz to join rent-to-kill [a term used to describe a local security company]. But it's what they use to differentiate...whatever to distinguish themselves.

Paradoxically, while the guards belittle the training programs as failing to teach them the necessary skills to handle violent confrontations with patients, they simultaneously describe themselves as private assassins, or perhaps less dramatically, muscle for hire. Clearly there is a distinction to be drawn between security training and the extensive and physically challenging training received by those in public policing and the military (Buerger, 1998; Conti, 2011; Johnson, 2010; Prokos & Padavic, 2002; Shefer & Mankayi, 2007; Wortley & Homel, 1993), such as the six month intensive training the RCMP provides to new recruits (Lavigne, 2008). A subordinated masculinity emerges as the guards claim to be equipped with physical and verbal skills akin to that of soldiers and cops, all the while possessing no real authority. Some might speculate that equating security work with the heroic actions done by police officers or soldiers creates a mockery of their work.

I got the job, but who said it would be this dirty?

Many security guards perceive their job as the “dirty work” (Dick, 2005; Tracey & Scott, 2006) of the hospital, that is, the grotesque masculine activities and responsibilities that degrade and wound the guard’s dignity (Dick, 2005, p. 1364). Commonly thought of as a “goon squad”, many guards believe their role is to provide nursing staff with physical back up and brute force “as per their job” (see p. 91), and regardless of the danger. Furthermore, most participants believe they are assigned the gruelling tasks that other, more legitimate healthcare staff such as nurses and personal care assistants would protest completing, such as registering cadavers in and out of the morgue. Although this job description is incompatible with healthcare practices that facilitate community, teamwork, compassion, and patient-care, noted components of the mission statements of several Ontario hospitals¹⁸ (Lakeridge Health, 2011; University Health Network, 2008; The Scarborough Hospital, 2012), Charles emphasizes that his participation in public displays of brutality, toughness, rule enforcement, and intimidation is not only part of the job, but the only way of doing it.

Charles: A security officer is a drone of the establishment. (...) Ok. They are the grunts. They are the muscle they are the brute force. They are not the ones to make...you know decisions. They take...what is the norm in our society and enforce it. They’re not there to prove a thing, to prove to a judge, they’re there to obey their superiors, such as the military. In the military we breed our infantry to be mindless drones who only obey orders. Even in an, an, an atmosphere of complete disaster, complete danger. We are willing to go out there and risk our lives. That’s something that most of us don’t even believe in...and yet in the military we are brainwashed in a sense...to put you know, flag and country above who we are. And it’s the same thing...security are essentially internal military that you know are more on the streets and patrol the people. They’re still mindless drones essentially that are obeying orders.

Drawing on Foucault (1977, 2003), Holmes and Federman (2006) argue that power in forensic healthcare settings strikes the inhabitant discursively and from many angles, taking full

¹⁸ These institutions were not studied for this project and do not have any affiliation with this research.

possession and control of the ontology that shapes her or his every action and belief (p. 17).

Charles points out that the guard is the same as any state policing agent – he draws on elements of hegemonic masculinity such as loyalty to authority (Connell, 2005) to learn and reproduce a deterministic, fixed way of understanding and communicating with his colleagues and patients. Gripping tightly to this monotonous and devolved way of understanding and doing security work, Troy asserts that his responsibility to be a “mindless drone” through compassionless demonstrations of hyper-masculinity outweighs the need for hospital agents to illustrate kindness, accommodation, and sympathy – noted characteristics of emphasized femininity (Jewkes, 2005; Korobov, 2011).

Troy: The thing is we have to be the bad guys...when there's a drunk that comes in and spits at you and tries to hit you, you can't be compassionate.

Me: You can't be compassionate?

Troy: Not when he's being combative I can't be like 'it's ok sir', no I have to defend myself in public with staff around me. I can be compassionate to a point but after, after that point I can't...I just can't do it...We're the bad guys. We can't be compassionate towards them because then people will walk all over ya.

Me: Right...what happens when you get a guard who thinks...really compassionately?

Troy: (...) I don't think it's ever happened (laughs).

Worried that people will “walk all over” him, Troy suggests that losing a battle with a patient because he resorted to a more nurturing technique will embarrass him amongst nursing staff and most assuredly, the other male guards. Next we explore how the guard's feelings of being all-powerful and in charge of danger exist in tension with nursing discourses that supersede complaints or concerns raised by security officers.

I'm powerful...but there's a pecking order

The “low status” of the guard's position in relation to nurses, doctors, and senior security officials who give him orders exacerbates his feelings of unimportance, and diminishes his belief in his ability to resist the “desensitizing” aspects of the job. Here, the alpha guard can be powerful in the sense that he demonstrates the capacity to dominate and assert force and restraint

upon the vulnerable patient. Yet in so doing, he reinforces the doctrine of nursing staff, who command him to follow their orders and directions at all times, regardless of their brutal or coercive nature (Holmes, 2003, 2005; Jacobs, 2012).

Me: What parts of the job do you think could transform someone into that? A ‘big piece of shit’?

Joey: Yeah anything we talked about doing restraints, desensitization of...you know people as problems. Their...you know their human rights, whatever you want to say. Knowing that no matter what they say we still have a job to do and we’re gonna restrain them anyway. Everything they complain about or bitch about is just background noise in the end. ‘We’re gonna put you down anyway.’ That’s desensitizing. You’re going in there with one goal only and that’s to do what you’ve been told to do. As per your job.

Perhaps even more desensitizing than having to commit gross violations and restrictions of the body (Dick, 2005; Tracey & Scott, 2006) is the sting of having to constantly take orders from a largely female group of nurses (Prokos & Padavic, 2002; Rabe-Hemp, 2007, 2009). As such, being viewed by women as an on-call team of macho warriors contributes to the guard’s feelings of dissatisfaction with the more dangerous aspects of the job. For instance, participants often discussed their fears of contracting HIV and other blood borne illnesses. Ed in particular described his fear after being stabbed with a needle, narrating that his “contract”¹⁹ status as a security officer aggravates his right to be treated as an equal to “in-house” staff:

Ed: The needle went out, poked me in the hand...first thing obviously happened I ended up washing my hand out. And um...I just stormed out from Emerg. Uh cuz I was furious of the whole situation I didn’t wanna...explode anyone who didn’t deserve it...Cuz they were...wanting me to pay for the uh...the meds...because I wasn’t a hospital employee, there was no way I was going to be able to afford that...I don’t think they were covered by OHIP...anyways after an hour of arguing they finally came to their senses...and this lady rushed me to Emerg to get a, a shot...yeah so then I finally got a shot um...enough pills to last me through the weekend because they schedule me an appointment...to get long-term medications.

¹⁹ Contract guards (such as myself) are assigned to work at the hospital through an external security agency (their employer), and thus are not credited with the same union rights or benefits as persons employed directly by the hospital.

Upset, Ed re-visits his feelings of isolation, worthlessness, and fatalism during this frightening period:

Ed: He didn't end up dying...but um I guess eventually somehow they got the blood I don't know whether they got his permission or not and it turns out he had...he had Hep B, Hep C, and HIV.

Me: Fuck.

Ed: Yep...so and it ended up being a month on the cocktail...uh and then six months of blood tests before I was finally cleared.

Me: That's a nervous time.

Ed: Oh no doubt. Yeah. Like even despite the fact that the doctor reassured me the chances of um...contracting anything from a...needle that's in open air...is 99.999 per cent. You know there's still that small little chance.

Me: Yeah.

Ed: Like...if I, let's just say if I had caught HIV...I wouldn't be dating her right now...There's that stigma that goes with it...you pretty much have to find another HIV positive person and the chances in my opinion I don't know the facts behind this...but in my opinion you know...a good chunk of them probably are...users of something.

Me: Ok.

Ed: You know...If I caught HIV I probably would have killed myself.

Ed's fear of contracting HIV reflects stereotypical masculine perceptions that HIV is a disease of gay men and drug users (Dej & Kilty, 2012, pp. 55-58). The stigma of the illness is clearly such a strong threat to his desired heteronormative status as an alpha male that he feels his only option would be to commit suicide. These fatalistic feelings are linked to Connell's (1987) assertion that contemporary hegemonic masculinity is most closely associated with heterosexuality (p. 186). Namely, in spite of Ed's performative as an alpha guard, he can be emasculated/subordinated by the prick of a needle. The gendered stigma and vulnerable image attached to having an HIV-positive sero-status removes his agency to attract and obtain a worthy heterosexual partner (the core of his gendered identity), which in turn weakens the alpha guard's assertion that he is in control of his sexual health, and thus can achieve his heteronormative sexual objectives effortlessly through his confident, competitive and charismatic demeanour (Connell, 1987, 2005). From Ed's perspective, engaging in heterosexual relationships with women who do not meet the moralized standards of femininity such as abstinence, purity and

cleanliness (Korobov, 2011) ensures the guard's descent into a subordinated field of masculinity, comparable to subordinated men who claim to be asserting masculinity through homosexual relationships (Coles, 2008, p. 243) and other forms of dominance (Donaldson, 2001).

Just because we're dirty, doesn't mean we're not tough

In spite of the degrading and more humiliating aspects of this job, the prison-hospital guard retains his masculinity through public demonstrations of toughness and aggression, particularly when it involves the masculine value of protecting women. Here, the guard's ability to learn how to maintain an impenetrable, warrior-like (Conti, 2011) force field around the female nurse's body is valued over the protection of both himself and the patient:

Jackson: I will take control of the situation. As best I can...if the guy beats me up in the room...and all the nurses are safe. I'll still be a hero. Because I kept them all safe. My job is to take the brunt so...I'm keeping him in this room...He's punching me kicking me but he's not punching them...I'm doing my job...Because security work is cop work...there are gonna be times where you have to be physical and maybe you'll get beat up. If you don't hurt somebody else that's ok...better you than them, because you're...the nature of your role is to protect.

Me: And who's 'them'?

Jackson: The people who are employed there...right? I can't say 'Whoa I didn't sign up for this. I'm not protected.' No man I know what I'm doing I know I could get fucked tomorrow. It's the job I signed up for.

Me: And how about protecting the patients?

Jackson: From what?

Once again drawing links to the heroic/dangerous tasks and conquests taken on by public policing agents (Rigakos, 2002; Tracey & Scott, 2006), Jackson demonstrates his belief that one of the guard's key responsibilities is to physically protect the establishment and their fragile female staff from the risky patients. The suggestion that patients are also in need of protection seems ludicrous to him, as the hospital guards characterize and surveil the involuntary patients the same way prison guards interact with and control prisoners – they are never at risk or in need of protection but are othered to the extent that they are utterly feared by hospital staff (Donald, 2001; Holmes et al., 2012; Jain & Murthy, 2006; Wright, 1997).

Aspects of hospital dirty work that do not involve interactions with forensic psychiatric patients include the daily exposure to death and grievous injury, as well as the written and physical registration of cadavers. Some guards reflect on their first encounter with a dead body with an air of dispassion. Others, like myself, are shocked by the responsibility it carries, and are afraid of the adverse reactions it may have on our mental wellbeing. Neutral, or as in Ed's case enthusiastic, reactions to gruesome and morbid events often serve to emphasize the guard's disconnection from feelings of compassion, sorrow and grief – emotions that if not carefully performed will be considered feminine:

Ed: It was a little awkward at first, I'm like 'Oh snap I'm next to a dead body.' But like I got used to that pretty quick. I find it fascinating more than anything. Like I found it pretty cool you know...seeing all the specimens and the morgue and...I got to watch a bit of an autopsy once...Yeah I got to watch him crack a rib open crack a rib cage open. It was awesome.

Troy: I remember one time a guy came in who had been hit by the train. The tunnel, like you could see right through his head pretty much...on the other side. And you see that's fine like...its ok. That's fine with me. I think maybe eventually in the near future sometime it could possibly take a toll but right now, it's not.

Desensitized to morbidity and even mortality, both Ed and Troy resist the suggestion that exposure to events involving blood, violence, and bodily mutilation will affect their tough psyches and unshakable aura of confidence. Although the majority of hospital guards initially claim that the continuous and unpredictable exposure to death and violence does not disturb them, Dwaine alludes to the detrimental impact it has on his emotional wellbeing:

Dwaine: This guy just pulled up to the front. And he...put a gun to his head...and pulled the trigger...and I saw the video and I don't know if it's just me being desensitized from society in general. It doesn't really...have the effect that you think it should. You know what I mean? The fact that that actually happens, it's kind of...alright it's kind of messed up.

Although the masculine performatives of the guards are entrenched in their character and gendered "substance" (Butler, 1988, p. 520) to such a degree that many are able to reproduce

during the interview the same fearlessness and invincible demeanour they bring with them to morbid calls and duties, this passage highlights the idea that hegemonic masculinity—although a dominating, dangerous and powerful series of gendered characteristics that controls and influences many men’s lives (Connell, 1987)—is not without its breaking points. Yet rather than contemplate the emotional consequences this type of work may have, Troy performs masculinity by prioritizing concern with the preservation of his job and character should he ever “fuck up”. Sean also explains that there is little support from senior guards or management before, during, or after these duties are carried out. Here, it is assumed that the guard will complete the tasks assigned to him by the book, regardless of how terrifying the experience may be:

Troy: If I ever fuck up I lose my job...Like you know what I mean? I’m not protected whatsoever with anything about this whole thing. And like...what else am I gonna do? Like this is all like...like this is pretty much all I know.

Sean: (...) It’s a pretty big responsibility because there was, you know, there was uh no room for error there. Sometimes people would sign bodies out to the wrong funeral homes and...they were telling us that we had to check the tags.²⁰ And I remember being upset about this. And they were saying...you have to open up the bag...And check the tag. Well [a local hospital] is the morgue, so anyone that’s burnt, anyone that’s in it, MVA²¹, anyone that’s a jumper...anyone that’s drowning or whatever. They’re there. See that shit I, I was not happy about it. And especially, you know if it was younger people or whatever, I have a really hard time with that. And, and there was no uh, introduction to this. There was no course, there was no uh...debriefing.

Failure to remain loyal and obedient to the chain of command and its established codes of conduct carry the threat of dismissal, as any challenge to the gruesome and more questionable roles and responsibilities given to the guard is automatically labeled as insubordination. The fact that the guard is practicing and learning skills that are typically non-transferable outside of hospital facilities constrains his self-esteem and capacity to seek work that is not related to this particular type of security work. In the meantime, the guard is forced to continue reproducing the

²⁰ Security must verify the identity tag that is clipped somewhere on the cadaver’s body.

²¹ Motor Vehicle Accident.

hegemonic values of toughness and resiliency to shocking and melancholic situations in order to survive a career Charles later admits he “doesn’t believe in” (p. 121).

Part III – Some of Us will pass, Others will fail, Few will resist

06:50 hrs: Arrive on-site. Receive overnight pass-ons from S/O ANDREWS and S/O MICHAELS. On-duty with Senior S/O PETERSEN and ER S/O ERICSON.

I close my evidence notebook and place it inside my protective vest’s pocket. I am anal-retentive about updating it. It passes the time.

I ask Ed how his night went. “Anything going on last night?” Really, I am asking him if he got to go to any calls that required his “hands-on” assistance. It’s a routine question because it gives the guys a chance to receive admiration for their heroic efforts, exaggerated as they may be.

“Nah, fuck all. But did you see the footage with Alicia Friday night?” Alicia is a new guard who got hired on at a higher rank than many of us will ever achieve. Most of the guys are pissed off. One, she is a woman. Two, she is a small woman.

“No, I haven’t even worked with her yet.” It’s only her second week here, but I already know a lot about her, or at least I think I do. A great majority of the day is spent evaluating her performance. Up to this point, I’ve been told she’s failed every test.

Ed brings up Friday’s surveillance footage from Psych-Emerg. He’s no whiz at computers, but this is the first camera we learn to operate, and for the most part the only one we pay attention to. He shows me footage of a male patient lighting a cigarette in front of the nursing station. Involuntary patients do this from time to time because they are restricted from going outside to smoke. For some, the patch isn’t enough.

After the patient lights his smoke, I watch Jordan, our biggest guard, walk up to the patient and gesture to him to put out the cigarette. When the patient refuses, Jordan grabs it from his wrist, and begins to wrestle with him. Ed points to the bottom right of the screen.

“Now watch this!”

I observe Alicia walk into the picture with her hands in her pocket. Excited, Ed covers her waist with his index finger. “You see that?!” Confused, Alicia appears like she doesn’t know what to do. Adriana, a fifteen-year veteran nurse to Psych-Emerg, walks up to Alicia and points to the patient, shouting something. Quickly, Alicia grabs the patient’s legs and together, Jordan and her bring the patient back to his bed and place him in four-point restraints. I know what Ed is going to say before he says it.

“Un-fucking-believable. How...the fuck...do they give her the senior position?” Jackson, a part time guard, cuts in.

“Why do you think? It’s obvious Brad wants to fuck her, he got her the job.” Brad has worked here for over twenty years, and is in charge of hiring the new staff.

“That isn’t right,” Ed replies. “I’ve been here four years busting my ass.” As the conversation goes on, Jerry, the weekend shift supervisor, finally steps out of his office.

“It’s an embarrassment on the department. If a two hundred pound patient loses it and she’s my back-up...what the fuck is she gonna do? It’s a liability to the hospital.”

19:50 hrs: Shifts ends. Give pass-ons to S/O JONES and S/O BLUTHERS.

“Anything happen today?” Troy asks me.

“Nothing man, but did you hear about Alicia in Psych-Emerg?”

“Oh yeah, bullshit eh?”

Three weeks later, Alicia resigns.

Part III of this chapter examines the consequences and nihilistic feelings the subordinated guard experiences when s/he, in spite of her or his “best” efforts, fails to fully live up to the gendered demands of the profession. We learn that obtaining alpha status is not only competitive amongst security members, but access is limited to those who can prove that they are not physically inferior. Often times, the assessment of one’s physical worthiness is dependent on biology, as opposed to ability and performance (West & Zimmerman, 1987).

We’ll dominate a man, but we prefer a woman

Perhaps even more alluring to the guard than being recognized as a hero or gaining an early exposure to the morbid events he believes he will need to cope with should he have a future in policing, is his responsibility to maintain a superior/authoritative position over women (Acker, 1990; Connell, 1987; 2005; Messerschmidt, 1993). Charles posits that this power is achieved if the guard enters the profession to dominate the gendered ‘other’.

Charles: If you’re an individual who seeks authority...you want to be superior. So if there’s a position where you can feel superior to a woman...that person is going to take that and is not really going to fight it...You know, some people do join police, security because they want to help people. But...there’s a lot who join because of the authority status because of...this, this presence that you are now powerful.

Like Jackson pointed out earlier with respect to the hospital being a setting that attracts persons who are too “afraid to become a cop” (see p. 83), Charles describes security institutions as convenient spaces men access to comfortably²² fulfill their need to dominate and discriminate against women (Acker, 1990). In other words, security managers and front-line male guards are able to discriminate against and even harass women guards without fear of serious reprisal from any higher institutional authorities. Biologically privileged, subordinated male guards who are unable to live up to culture’s patriarchal norms of masculinity will still be seen by other male guards as more capable of completing the physical (and thus most important) aspects of job than their female counterparts (West & Zimmerman, 1987).

That said, not every subordinated guard effortlessly overcomes the superiority complex of the alpha guard. Attempts to dethrone the alpha guard’s higher position in the “male” chain of command often times results in an act of domination taken against the subordinated guard. As Charles angrily recalls, the force required to silence the out-of-turn guard has no boundaries.

Charles: I guess in their opinion the longer you’ve been there the more superiority you had over the ‘newbies’. And that actually I would agree with...but it is your position to teach those that have less experience than you so they get to par with you. Not emphasize the fact that uh, you’re more superior. Not emphasize the fact that because I’ve been here longer you obey me...Glen actually stated to me umm...‘Ha...I’ve been here for longer than you I’m superior to you so I want you to go and do this patrol.’ When he was the one asked.

Me: Ok.

Charles: Yeah so right there I, I refused because of the fact that we’re equal, ‘you have no right to say that’. And then I was threatened with bodily harm.

This passage demonstrates how military values promoting utter submission to authority resonate from the core of this hyper-masculine sub-culture (Shefer & Mankayi, 2007). The domineering alpha guard quickly represses Charles, a guard very learned and experienced in

²² Unaffected by liberal feminist movements in public policing (Burligame & Baro, 2005; Martin, 1991; Miller, 1998; Schultz, 1993), private security companies are not governed by any specific industry safeguards that protect women from employer/peer discrimination and harassment (see Lavigne, 2008).

military language and practice, when he attempts to establish his equality and dignity within the unit. While Charles is given no alternative but to submit to his superiors, and become accustomed to his colleagues' confrontational and aggressive communicative techniques, female guards are depicted as a "special instrument" security may access when they must complete tasks that require genuine, "natural" displays of femininity (West & Zimmerman, 1987); namely, characteristics such as compassion, emotional security, and gentle nurturing (Acker, 1990, 1992; Korobov, 2011).

Joey: Um I think they have a great asset because when you get certain female patients who are in difficult situations...sometimes a guy just won't do. Because they've been raped, molested, abused...You have female presence. Maybe you have two females there...just because they're female...if they've never said a word, they never said anything...about themselves they just stood there. Just the fact that they're there. That...will make the patient feel a bit better. They may be less fighting as you're physically doing it. They may give up more...because a woman is there...They get strong muscular men, 'Yeah I'm the ladies man, I'm going to prove myself', they're messed up on a Form one²³, 'I don't care I'm gonna knock through these guys right now'...now you're getting punched in the face. You show up and say 'Just sit down in your room. Take your medication. You're not gonna hurt a lady.' Fuck...maybe he will hurt a lady...but chances are...he probably won't. So women's presence will be...like more of a calm way to diffuse a situation.

Joey demonstrates that while women are not respected for their ability to be a physical presence or "asset" to this work, they are thought of as instruments that may facilitate the work of the 'real' security officers (Rabe-Hemp, 2007, 2008, 2009; Remington, 1983). Should the woman fail to prevent a hostile patient from becoming aggressive through their silence and inherently gifted, gentle "presence", the alpha men are ready at all times to rescue weaker staff from an escalating situation. By heroically "saving" staff from violence, the male guard reproduces the security team's reputation as a physically capable goon squad, and publicly demonstrates his capacity to engage in decisive, heroic action. Nevertheless, the female security

²³ As discussed in Chapter 2, Section VIII, a Form 1 is an assessment order summoned by an attending physician, which authorizes psychiatric facilities to involuntarily admit an "unstable" patient for a 72 hour observation period.

guard's involvement with dangerous patients does not, of course, come without its risks (Brown & Carlson, 1993; Brown, 1998).

Ed: Again a lot of people are very chauvinistic and they won't follow the instructions of a woman...in general I don't have an issue with women working in the workplace...of course there is the issue that I raised earlier with, with Alicia who's very...tiny...if you have someone who's built like a tank...[but] you can pretty much swing her by her leg as a club.

Yet in spite of these opportunities for the female guard to take on an important, but subordinated position in the force, her role in hospital security is generally considered less valuable than the alpha man's (Brown & Carlson, 1993; Brown, 1998; Rabe-Hemp, 2007, 2008, 2009). Widespread beliefs in the male hierarchy displace the female security officer into a subordinated gender category where she is 'othered' and disregarded by her male colleagues. Escaping labels that devalue women's bodies and utility as security officers is not easy, as it is assumed that they are biologically inferior to men (West & Zimmerman, 1987).

Taylor: But right now...um the fact that I get...paid the same and I wear the same uniform but physically I'm expected to do more because of my large size...I absolutely think it's bullshit.

Me: Yeah?

Taylor: It's like...we have to deal with someone my size. Guess who's gonna be first in that room? Me. Guess where my co-worker's gonna be? In relation to me and the patient? Definitely somewhere behind me even if she's like next to me...a few feet back.

Jackson: I probably prefer Jerry or Brad or Jordan, you know, who kick ass a little harder than Jocelyn. But the sheer size of Jocelyn, she won't be pushed over so easily. Has a very...she won't be pushed against the wall.

Troy: What am I gonna do when the male is like 250 pounds? I'm gonna have to take the bulk of the work and I mean...is she gonna be able to have my, have my back if something happens you know? What if they get hurt or what if...due to their lack of...physicality like you know...like what if I get hurt after that because they can't hold down a leg or an arm? They're just simply not strong enough.

Indeed, the lack of trust male guards have towards security women is closely connected to their beliefs that she is physically inferior. Although Joey recognizes that women have the capacity to diffuse a situation through words or presence, Taylor, Jackson, and Troy all call into

question their utility and efficacy. They are tormented by the double responsibility of having to protect both the female nurse and the female guard. For these guards, the risk of the female guard succumbing to injury during a violent patient episode or restraint outweighs her potential to assist and compliment her male leader/guardian. The stress of having to be her protector when she is incapable but obligated to share the physical responsibilities of the job lead to feelings of resentment and envy over their paid position in the security force. All of these insights of course emphasize that physicality is the overwhelmingly privileged attribute in hospital private security culture. The other, more complex aspects of this work such as personal relations and communication in non-physical forms are culturally demeaned as subordinated security practices.

Get physical or get out

The threat and demonstration of physicality, brute force, and an aggressive demeanour are the elements that fuel the performative of hegemonic masculinity amongst security guards (Micucci, 1998; Monaghan, 2002; Rigakos, 2002). The ability to perform these attributes when dealing with patients is constructed as a requisite tool for survival on the hospital battlefield (Fletcher, 1996).

Jackson: And it works for some guards. If you're the size of a lion, and you don't particularly care about how you sound or come off and you don't back up anything you say then sure go for it. Go in and say 'Hey shut the fuck up. We're gonna do this to you, I'm gonna punch your lights out.' And you...can back yourself I guess there's no problem.

Me: There's no problem?

Jackson: Well...if you're going to worry about how you're going to physically diffuse a situation then yeah that's not a problem. If you can wrap someone up some days and you don't ever have to worry about how you look and sound to people and there's no complaints about how you physically go up to this guy. Sure. Go nuts. Beat the shit out of him.

To this point, many of the passages demonstrate that the alpha guard's first response is to "get physical" with patient-prisoners even though some have witnessed the positive effects of a

non-violent approach with women. Jackson stresses that it does not matter how they are perceived (as brutes) because they escape any consequences or negative attention. Even if some guards resist these widespread masculine performatives, these attitudes are so ingrained in the culture that many subordinated persons turn a blind eye to the atrocities alpha guards commit against patients. This ‘get of jail free card’ to express brutality furthers hegemonic discourses of masculinity that encourage and exacerbate the use of violence and coercion in hospitals, all in the name of “care” (Holmes et al., 2012).

The subordinated guard who opposes such tactics, or is considered by others as unable to reproduce hegemonic masculinity as a result of his “weak” demeanour/stature, is subsequently constructed as a lesser man. His ability to uphold the safety of other staff is discredited by the belief that he may not be able to control others or make critical decisions (Messerschmidt, 1993, p. 155) about the patient who, in rare cases, gets “out of control”:

Jackson: He said to me in no uncertain terms: ‘Congratulations on getting [an in-house security position]...I hope for your sake and the hospital that nobody gets hurt when you’re on duty. Because I just don’t think you can cut it...I think they made a mistake hiring you...you’re a nice guy, you’re good at administrative work but...sometimes there’s a point when you gotta be physical and...you don’t have it.’...Now did I hear from my co-workers I didn’t do a good job, they just said ‘Oh Jackson you know you could have put a little more force on him’(...)‘Someone got hurt because of you or someone got attacked because of you.’ ‘You’re a fucking failure.’ No one ever said that.

Me: But that would be damaging to you if

Jackson: –that would be damaging because I already knew I failed...I already knew it.

The guard who does not pass his informal on-the-job examination expects, or in Jackson’s case accepts, punishment, ridicule, marginalization, and embarrassment. Jackson identifies his failure as resulting from his inability to demonstrate to his colleagues that he can effectively use force and make and enforce his own decisions (Messerschmidt, 1993, p. 155). Agreeing with this as part and parcel of the code of masculinity, he uses his subsequent work experience to build his

confidence and reconcile any doubts his peers may have about his ability to be an independent and authoritative decision-maker.

Jackson: No one ever really talked about it but everyone always thought about it. And for the longest time I wasn't even allowed to work at [a local hospital] because the [local hospital] guards like Kirkland said 'I don't want him working here. We're all at fucking risk if he is'. I didn't know that though. I got a bullshit reason 'Well we don't want to overstrain you, you're working at [a local hospital] and [another local hospital]' and I asked them why and they said you know... 'It's too much extra...you already have a full schedule.' I come to find out over the years that...I was banned. (...) My sign of weakness was when that nurse got fucked up. A sign of weakness would not be if I said 'There is this guy here he looks kind of questionable you might want to come here and stand by because I don't know how it's going to go.' I realized I got to call back up sooner.

The widespread concern over Jackson's physical capabilities led to a loss in his work hours and thus salary, which institutional authorities framed as an attempt to avoid wearing him too thin. Both reasons however imply vulnerability in Jackson's character, which institutional authorities frame as a concern about not wanting to overtax him. Subordinated, Jackson considers himself less worthy than other guards who consistently demonstrate their capacity to be tough and resilient during violent conflict.

How can 'she' get in?

To be accepted as one of the true guards, that is the guard who is able to live up to the physical standards of hegemonic masculinity, the female must prove to her peers that she is masculine enough to execute the requirements of the job. She accomplishes this by adopting aesthetic symbols of "manliness", as well as by dominating others (Fletcher, 1996; Rabe-Hemp, 2007; 2009).

Jackson: Now she's got the short hair. Hands bigger than yours I'm sure...if you're gonna have women in security or law enforcement, she'd be your best, best employee. She sounded like a man. Acted like a man. Talked like a man. Walked like a man.

Me: How'd she look?

Jackson: Yeah. I mean you really couldn't tell if she had boobs but she had a very...cute face. But very manly. If you're gonna have a woman security guard in the hospital...she'd be it. She would basically be like a man...but a female.

Here, any display of dominance and success in a security culture is constructed as a masculine feat. Women are ultimately unable to ascend to the status of the alpha guard unless they transgress the patriarchal norms of femininity that require women to look petite and sound vulnerable to the point that they can be visibly identified as men. Ongoing pressures to accomplish hegemonic masculinity promote women to impose force at any given opportunity (Acker, 1990, p. 152; Kurtz, 2006; 2008) on patient-prisoners, the warranted objects of these displays of power. While any injuries sustained while combatting patient-prisoners aggravates notions of their heroism, the female guard is still respected for braving the good fight, noble to the masculine code of conduct that condemns physical withdrawal and cowardice. Although her gendered identity will remain subordinated, Taylor sees the female guard's supplementary partnership alongside the able-bodied man as "good enough" to get job done.

Taylor: And you know...she stuck it out and she was able to get the job done. Not as well as...say me who didn't get...shaken around. The guy was smaller than me and...his arm didn't move...Evelyn got tossed around but you know what...I trust her with my safety. Because she never once let go even though she got you know...launched into the chair pretty much. She held on until we've...the patient was in restraints.

Earlier in the narrative, the female guard is considered a security risk (Fletcher, 1996) in fear that she can be "swung around like a club" by the mythical 250lb patient, consequently adding to the protective burdens of the alpha guard(s). Yet here, Evelyn is respected (albeit in a supportive/subordinated role) because she held on and was not completely overpowered by the patient-prisoner. Thus, this passage reveals how multiple femininities/masculinities are hierarchically organized, enforced and reproduced within the hospital (Connell, 2009).

Similarly, Dwaine believes that lesbian guards in particular have an enhanced capacity to evolve into competent able-bodied security officers, so long as they dispose of their compassion or other characteristics that make up hegemonic femininity.

Dwaine: We usually think they [women] tend to be compassionate but...that wasn't always the case...I don't know how to word it but I want to say...are the uh...certain gendered females.

Me: Certain gendered females?

Dwaine: Of the uh...the kind that are a little...more stern.

Me: You mean lesbian.

Dwaine: (...) Yeah. More man...environment...some of them had the...the some of them had the...the more, the more stern by the book...no leniency kind of...tendencies.

Yet in the end, female guards who pass these tests are never liberated from their subordinated gendered status. To continue surviving, the female guard must exemplify an unemotional and undisturbed demeanour whenever around her male superiors (Acker, 1990, p. 152) who elaborate their sexual status and prowess through the telling of sexist “jokes”. Ultimately, their submissive presence preserves the heteronormative aura of the culture – one of the driving forces of hegemonic masculinity (Connell, 2009, p. 183). In one case, sexist jokes were constructed as an offensive tactic to uncover any intruding “feminists”.

Ed: I've found that...the security industry, the women that it attracts...I guess they expect it. I never, I don't think I've ever seen an issue...like once again very alpha male personalities...a lot of crude jokes being thrown around. A lot of sexist jokes.

Me: Right.

Ed: A lot of racist jokes you know?

Me: Yeah.

Ed: And...you just don't take it seriously. Now...if you had a woman who's very...I guess you can say feminist? Who was working in the department...I can see that being an issue.

Me: What do you mean when you say feminist, like?

Ed: Who can't take like...a joke towards women...Like they automatically get offended by it...and I've never had an issue cuz once again there's all kinds of...sexual comments and whatnot. Like...you know 'nice ass' and shit like that...that stuff's being said all the time in our department. And...I've never had a case where anyone...took offence to it.

Clearly, Ed's construction of feminism—or the ways in which women are unable to take a man's joke—completely misses the point that these patriarchal jokes and widespread cultural attitudes reproduce gendered discrimination and hegemonies (Prokos & Padavic, 2002; Rabe-Hemp, 2007, 2008, 2009). By excusing displays of sexual harassment and belittlement on the grounds that they are consistently performed by male guards, and mutually accepted and

reproduced by women, Ed demonstrates how the alpha guard—or men who temporarily access a privileged position of power through displays of hegemonic masculinity—fail to understand how a subordinated woman in such a hyper-masculine culture would feel in terms of her ability to challenge this kind of joke. Already not respected or trusted because of her lack of physicality, this cultural illustration of ambivalence towards the feminine (Evans & Wallace, 2009, p. 485; Prokos & Padavic, 2002) further restricts the female guard from gaining the dignity and respect she needs to be taken seriously in the event that she complains to her senior (and usually male) colleagues (Conti, 2011).

How can 'he' get in?

Even though some women are allowed to collect cultural status by responding indifferently to attacks on femininity, homosexual men represent too great a threat to the heteronormative order. Only a gay male's full consent to the guard's homophobic bullying will gain him cultural citizenship (Herbert, 2001; Miller, Forest & Jurik, 2003; Monaghan, 2002):

Ed: They say it to everyone, yeah the gay jokes are thrown...left right and centre at that place. Just makes me wonder if we ever actually had a gay guard there. How that would turn out.

Me: Oh we had Evelyn and we had...

Ed: Well gay male.

Me: Do you think that would work?

Ed: I think it would...as long as that gay person you know, can take the jokes...Because they're gonna hit him hard with those jokes...as long as he can take them I see him getting along with everyone.

While up to this point we have generally been presented with a cultural devaluing of femininity, Ed fears that gay (subordinated) masculinity strikes too big a blow to one of the core attributes that drives the security team – heterosexuality. And in some cases, these jokes can hurt heteronormative men too, and challenge/repress their gender assertion of subordinated masculinity. For example, Charles, a guard who attempts to accommodate patients, staff and

visitors with kindness and respect, was confronted with much social pressure to submit to his peers' sexual advances and interests in his fiancée, or perhaps more accurately, "female body":

Charles: And they met my fiancée a couple times and she is a very attractive woman. And because of the fact she is an attractive woman I sense a sense of jealousy within the security in [a local hospital] to the point that they made fun of me, because of her.

Me: Mmm hmm.

Charles: They're, almost calling her you know...a whore. But not in a negative way they'd be joking around like 'I'm gonna call, I'm gonna meet up [my fiancée] tonight', or um...'I'm calling her' or 'oh I saw [my fiancée] today with another guy' and this and that. They constantly bickered and bickered at that fact. (...) They took that joke...that was fully harmless and just you know...they took it out of proportion they just escalated, escalated.

Trying to unnerve Charles by aggravating his supposed weakness—his envy and affection for his fiancée—the guards play on the woman's virtue and fidelity, as though her sexual reputation reflects the status of her male partner or owner. Charles' refusal to express anger towards this sexist 'humour' demonstrates his participation in maintaining and reproducing this heteronormative and hyper-masculine culture and the broader refusal to let go of the conception that a woman's sexual activity is the possession and responsibility of her man.

We can't do this anymore

Participants acknowledged that guards often see meaningful resistance to these confrontational and aggravating masculine practices as limited due to fears of the potential repercussions from those in superior positions of power (Padavic, 1991; Prokos & Padavic, 2002). Thus any attempts by newer, "uneducated" guards to protect and care for patient-prisoners through kindness, emotional support, and compassion are inevitably oppressed (Jacob, 2012).

Me: So when you mentioned um...how you like to talk to patients, listen to them the best you could and make it better for them, how did the group...the other security guards

Charles: —that was a waste of my time.

Me: take to that?

Charles: That was a waste of my time. Waste of my breath, waste of my time. Like I said they didn't like the way that I talked to people. You know being super polite. They, they wanted to keep an image of you know, brutality of, of more authority.

Me: And did you ever try to, to adapt and live up to that just so you could...

Charles: –no not really.

Me: be accepted?

Charles: I'm my own person...I'm not going to try to become like them. I'm who I am...If were to adapt to how they were then I wouldn't have been let go...because I was doing my part, I was doing, I was doing the best I could. It's because I wasn't them...is the reason I was no longer there.

Similar to my revelation noted by my resignation on March 08, 2010, Charles came to the epiphany that his peers will not accept him unless he reproduces the norms of alpha masculinity. The reasons for his termination coincide with his failure to contribute to security's "image"—through demonstrations of "uncivilising" violence or the threat thereof (Monaghan, 2002)—that they are all-powerful superior beings that must be feared and obeyed at all costs. Namely, Charles refuses to greet prisoners with a masculine, demanding, impatient albeit anti-social performative (Connell, 1995; Micucci, 1998), and instead provides them with a sympathetic ear when they are experiencing emotional distress. Having no sympathy for persons who commit insubordination (Albuquerque & Paes-Machado, 2004; Duncanson, 2009; Johnson, 2010; Shefer & Mankayi, 2007), Charles is exiled by both his supervisors and peers from the militant institution, opening space for a new guard to enter who is less threatening to the established male code.

Yet not every guard's destiny is to quit or be fired from the establishment. Accordingly, Kurtz (2006; 2008) warns us that ongoing competitions between police officers to assert masculinity and gain gendered status within their organizations can lead to stress, burnout, and violence in both their occupational duties and domestic partnerships. After sharing with Joey a verbal retelling of the ethnographic fiction I titled *Follow my lead* (p. 72), he suggests, with

envy, that the persistent expectations of hospital guards to conform to the patriarchal norms of masculinity may be linked to the numerous injuries and bodily harms patient-prisoners endure.

Joey: The biggest joke to me is on management because they put so much...I don't want to say trust but they put so much back into him. Glen this, he's so great because he gives out parking tickets. He's a military guy. He's big and tall and he knows martial arts. He's a personable guy, he's confident, you know he's good looking; he's got his head on his shoulders all this good shit right? (...) I think that led to his overconfidence, which led to his idea that he'd get away with anything. So he got comfortable using tactics that he wouldn't normally have used in a hospital setting.

Me: Punching a kid in the head. That's a tactic?

Joey: (laughs) Yeah. I would say so. He was like that before, just the incidences were just not reported or not as severe but...like I said before he had uh elbowed a guy in the face everybody knows that...he had so many staff complaining about the parking tickets...like his aggressive demeanour, his attitude. Um...sexual harassment complaints about him from a nurse, which he's already been suspended for. He may have looked great but...it's like putting a piece of shit in a big paper box and putting you know, wrapping paper and making it look all pretty. You know by the box it's still a piece of shit.

Glen, the alpha guard, possesses all the characteristics of the hegemonic male, yet his aggressive and punitive actions against patients and hospital staff are misplaced. Just as Holmes and Federman (2006) establish, power in the “prison” hospital—or in this case hegemonic masculinity—attaches itself to all bodies throughout the organization and infects them at an ontological level so deep that their entire character or presentation of self is, as Joey puts it, “disguised” or seemingly transformed (p. 17). Ultimately, the number of violent and aggressive incidences that needed to take place before both the guards and management team began to question Glen's appropriateness as a hospital staff member serve as a testament to how widely glamourized, reinforced and envied patriarchal displays of disdain and brute toughness are within a hyper-masculine security institution.

That said, the tensions my former colleagues and I shared with respect to the violent and debilitating nature of our job began to unravel during the final moments of the interviews. While

initially resilient to my critical posture, many guards lowered their defensive stance towards the necessity of aggression in this work.

Charles: I do the job because the money is there.²⁴ I do it because it's a necessity. I do it above my own standards...like I said I am not aggressive towards people, I am extremely polite I do the best I can. I do it because it is a necessity...of the current...way. Right within the establishment. But I...don't appreciate what I'm doing. I know that it is wrong.

Troy: I don't...see why we're doing this...I don't see...I'm not a medical professional...I'm just a fuckin' security guard I don't really know...Don't get me wrong right I like doing it, I like communicating with patients and seeing...you know...what goes on. I just don't understand why we're doing what we are.

Overall, "Us" demonstrates that hegemonic masculinity's defence of institutional violence, authority, and control is tough but not impenetrable. No longer able to justify their involvement in at least some of their violent encounters with patient-prisoners, the story of "Us" ends with the realization of the "dangerous" (Connell, 2009, p. 143) and indeed moral repercussions of allowing hegemonic masculinity to be the "way" of security men's lives. It is when we liberate ourselves from the gendered constraints and controls on our behaviour that we realize we are not actually on a different side after all (Becker, 1967).

²⁴ For reasons just highlighted, Charles stayed in the security profession following his termination from the hospital.

CHAPTER 6: “THEM”

Summary

“Them” is a story about how “Us” – the gendered guards – interact with the “other” characters of the hospital, namely the patients and the nurses. Initially, guards perceive physical and chemical force as an emergency but necessary intervention to control and treat the dangerous, yet ill patient (Crocker, Stargatt & Denton, 2010; Delaney, 2006; Doeselaar, Slegers & Hutschemaekers, 2008). Working alongside the nurse, the guard situationally befriends the patient in an attempt to avoid a violent encounter and to achieve the objective of the prison-hospital, that is, to “make him stay” (see p. 117). To do so, the guard works to convince the patient that complying with the ward’s rules and expectations will grant them privileges (Holmes & Murray, 2011, 2012), as well as ensure their early release, even if “they aren’t going anywhere” (see pp. 134-135). In the event that the guard does require a ‘helping hand’, the male nurse serves as his sidekick. However, fearing that she is a physical and inferior liability, the female nurse is restricted from taking part in the “fun”, that is, any incidents that require physicality (Prokos & Padavic, 2002; Rabe-Hemp; 2007; 2008; 2009; Remington, 1983).

Should a guard challenge a nurse’s order to physically or chemically restrain the patient, the nurse typically reminds the guard not to question his authority figure (Connell, 1987; 1995; Johnson, 2010; Messerschmidt, 1993). In response, the guard either accepts the nurse’s medical expertise as a license to deliver pain, or expresses his embarrassment towards his “professional” obligation to participate in violence. At times, the guard’s humiliation is exacerbated by his uneasiness to take orders from a woman. In fear of reprisal from their distrusted manager, the guard avoids publicly expressing his shame, frustrations and concerns any further.

The escalating power struggles between the nurse and guard can threaten to deteriorate their alliance, which can then lead to discourses of blame—a survival feature of hegemonic

masculinity. Should this occur, the guards were found to try and mitigate their accountability to the patient's suffering by appealing to the standard of loyalty demanded by their superiors, no matter how "dirty" (Dick & Swift, 2005; Tracey & Scott, 2006) their orders were. Yet as the fear of patient injury and overdose heighten, some guards may resign their hegemonic status, in order to express a softer, subordinated masculinity (Coles, 2008; 2009; Evans & Wallace, 2008). This allows the guard, in his own mind, to tenderize his involvement in prisoner punishment by providing the patient with small favours and comforts as s/he is restrained and/or chemically injected.

No longer able to suppress their sympathy for the patient, some guards eventually condemn the hospital for what it is: a prison (Donald, 2001; Holmes et al., 2012; Jain & Murphy, 2006; Wright 1997). Although security managers and supervisors—or "chief guards"—were found to greet guard complaints with a militant ignorance and hostility (Duncanson, 2009; Johnson, 2010; Shefer & Mankayi, 2007), some guards maintained or increased their levels of and desire for resistance. By adopting a new politics, gender performative, and even way of life (Connell, 2009), the guard may swear a new oath: to pursue social and institutional transformation.

Part I – Hold, shield, expose, and inject. Please and thank you.

I've been here for four months. Some call me a veteran in an institution renowned for its high turnover in security. The guards always say it's nice to keep around the "good guys."

It's 03:00 hrs. I'm sleeping. I do this a lot. We do this a lot. I never dream though. Not here. And that's a lot more than we tell the pretty nurses, physicians, and volunteers that come to our office every morning to pick up keys after we've sipped extra large double-doubles. Well I drink green tea. What a joke that is. Maybe that's why I'm always selected to do the coffee run.

My partner wakes me up. He had a long career in the military. He's been through several divorces. He has kids. He's been to Psych-Emerg before. He only tells me this when we're alone. "CODE WHITE buddy! Your turn!"

White, what a sterile colour. It means “aggressive patient” in our language. We never say violent. “The action should wake me up!” I perform. I’m nervous, maybe not as much as before, but I’m nervous.

I hurry to the elevator. The other guards are scattered around the hospital. One stays in the general emergency room; one in the psychiatric emergency room; and another roams between buildings, patient floors and the morgue. Putting the bodies in and releasing them to the black coats (funeral home staff) is a full-time job.

I’m the first one to make it to the psychiatric ward. It’s the first time I am first. Finally, an opportunity to prove myself.

I penetrate the psychiatric ward entrance, and rush inside the nursing station. One of the nurses shouts,

“It’s over there!” I walk through the door that leads to the patient corridor. The nursing station barrier is cracked with a broken chair beside it. I look down, and see a heavy, middle-aged woman lying on the ground with four people on top of her. Two male personal care assistants hold her legs down, while another man presses her face into the ground. A female nurse crouches on her torso. Once the nurse sees me, she stands up and motions for me to take her position. I join in what the guys told me on my first day would be the fun I’d get used to.

“Be careful, she’s a spitter,” one of the men exclaim. The patient doesn’t react.

The three other guards arrive in minutes. I say minutes because that’s what I read in the report. It feels longer.

We place a mask over her face. It looks like a plastic version of the shield welders wear before they permanently scar and distort the metal. Irony.

We get the patient to her room standing up. It beats doing it the usual way. I have one of the arms this time. My reward for being first. On the way to her room the nineteen-year-old boy we held down last week turns away into his room. “You’re not next,” I wish I could tell him.

We get her on the bed. Limbs secure, I sit beside her face. The moments I spend restraining her arm tells me she isn’t going to spit. She asks me quietly, tears welting in her eyes:

“Can you move my mask please so I can breathe?”

I re-position it a little.

“Is that better?” I ask.

“Yes, thank you.”

That’s more than I would have said to the man accommodating my torture.

Health “professionals” flood the room. They enter with a tempered anger. One of the nurses speaks to the patient. “We’re just going to give you something to help you relax. We’ll take the restraints off when you’ve had some time to calm down.”

Still beside her face, I watch them draw up a tranquilizer in front of her. But this time it's a little different. I think they're mad this cow doesn't herd like the rest; doesn't obey like the rest. She isn't spared the humiliation of being exposed stomach-down, nor given the gift of underwear or a towel.

I watch her pants fall to her ankles. Glen smiles and turns his head 180 degrees. I can't tell if he thinks this is funny, or if he's feeling the raw shock of what I am. I find out later it's the latter when the jokes aren't cracked on the elevator ride back to the office. Instead, all I hear is the intense sound of pens scratching the evidence notebooks.

Injection ready, we finally turn her over on her stomach. The old position must have just been for show.

And as the needle went in her bare ass, I turned away.

But let's be realistic. I heard the 'ouch'. I saw the blood. I saw the tears.

I saw the exposure. All of it. In that moment. Because you can't ignore injustice. I couldn't ignore injustice. Not genuinely.

Part I of this chapter explores the hegemonic masculine discourses the alpha guard accesses in order to defend and reproduce this institution's unjust patient control/restraint practices. By relying on medical discourses that establish and reinforce the guard's legislated and informal authority to control, coerce, and pin down patient-prisoners, he is able to persistently deny moral culpability for his participation in gross violations of human rights. Instead, many guards attribute blame to female nursing agents for evading their biological obligations and predispositions to be sympathetic and nurturing (Acker, 1990). Instead of assuming a submissive role in the presence of security (Connell, 1987), nurses are constructed as engaging in "unladylike" demonstrations of dominance over patients, and perhaps more resentfully, control and influence over the actions and role of the alpha guard.

It's for their own good

The guard does not initially view the patient as a threatening figure, but rather as a vulnerable person who is in need of sympathy, listening, and medication (Fairman & Happ, 1998). When circumstances deteriorate between the patient and security, guards are often

remorseful towards any physical reaction they initiate. For example, even though Troy indicates that restraint practices are necessary emergency measures to subdue aggressive patients (Delaney, 2006; Doeselaar, Slegers & Hutschemaekers, 2008) and prevent staff/patient injury (Allen, et al., 2009; Crocker, Stargatt & Denton, 2010; Gillespie, Gates, Miller & Howard, 2010; Lancaster et al., 2008), the sympathies he demonstrated earlier in his career still resonate:

Troy: I thought sometimes all they really need is...for someone to just listen to them...six or seven times out of ten they're not going to go physical unless you go physical first.

Me: So what's it like then when you do have to get physical with...with women patients?

Troy: (...) Um...a lot of them actually break down. Near the end of it...they start crying...It's um not easy to take sometimes and obviously I'll feel bad, I have feelings right?

Me: Yeah. Yeah.

Troy: Like sometimes it just has to be done, it's for their own good.

Me: For their own good?

Troy: If they don't know what they're doing, they're mentally unstable...it's better that they're at least restricted and it's better than them at least hurting themselves right?

Me: Right. And you feel that they get help there?

Troy: They do...as bizarre as it may sound, you know being restrained to the bed is help, but it's...but at least they can't hurt themselves or somebody else for that matter right?

This guard is able to reconcile any sympathies he retains for the patient by convincing himself that physical force and restraint is justified if it prevents her from engaging in self-injury, or protects fellow staff members from patient violence. Troy's statement that female patients often "break down" and cry when confronted with security force implies a strong pity he has towards women whom he essentializes as weaker and 'hysterical' (Kilty, 2012), and in desperate need of a man's protection. Clearly, women who are able to demonstrate and abide by the alpha guard's definition of emphasized femininity (e.g. crying in lieu of physical resistance, such as spitting, biting or fighting) are constructed as more deserving of compassion and empathy than the unfeminine (Dell, Filmore & Kilty, 2009; Kilty, 2012) woman who verbally and/or physically resists the intrusive demands of security/ward staff. As Ed recalls, patients who are

overweight and female are not exempt from “wrestling” the coercive and mighty hand(s) of the hospital guards.

Ed: There was one...person who I think their arm did get dislocated...

Me: Oh what happened?

Ed: This is a long time ago. I don't remember the exact details but um...I think we were restraining her on the ground...And then uh...with their arm behind the back...and I guess it just lynched too far well...she was wrestling with us. A big girl.

Me: Right. Ok.

Ed: And uh I think her arm got dislocated but other than that I can't think of anyone whose...that was any patient that was injured. I've seen minor injuries to, to guards like little sprain here or there.

Ed's narrative demonstrates two key points. First, patient-prisoners are suffering grievous bodily injuries and ultimately a violation of their human rights to bodily integrity and security of person at the hands of guards; and second, guards use hyper-masculine discourses to mitigate the effects of violence towards patient-prisoners who embody masculine largeness, resiliency and resistance in the minds of those guards (Robison, 2010). At least for some guards, like Troy in the above quote, this is done so as to manage the emotional stress and toil that results from their use of force against female patients.

Let's pretend I'm here for you

The guard disguises any distrust he has of the patient by presenting himself as a friend who can offer advice. Infantilizing the patients, he convinces them that docile behaviour will accelerate their release from the hospital, and that breaking the ward's rules will extend their confinement (Holmes & Murray, 2011, 2012). Downplaying his authority, that is, playing the “good cop”, the guard uses his understanding of the system to encourage patients to be instrumental in their own incarceration (Foucault, 1977; Goffman, 1961; Holmes & Federman, 2006). This way, the guard secretly achieves the wants and desires of the establishment – to keep patient-prisoners inside.

Troy: I like to...sometimes make the patient believe that I'm on their side...regardless if it is true or not.

Me: Mmm hmm. How do you do that?

Troy: Umm...creative ways of saying things. Like...if the patient really wants to leave the hospital I'll tell him what I have to do in order to leave...but in order for that he has to give up at least a one night stay. Like for example, if someone is on a psych hold they can remove that anytime after the 24 hours.²⁵ And if he wants to go home, I go, look pal, I understand but you're not helping your case right now acting this way because everything is documented, and if they document that you comply...that is gonna help you maybe get home tomorrow or get more privileges that way.

Me: Mmm hmm.

Troy: So I make it kind of seem like I'm trying to help him...which I am. But I'm also...being able to get what I want and what the staff wants.

Me: Which is?

Troy: Which is for him to stay.

Cunning coercion and manipulation is indeed a part of the alpha guard's game. Underlying Troy's rehearsed exchange is a subtle authority that edges the patient into believing he is in control of his situation. This too is for his "own good" because the "written" consequences for refusing to cooperate are, as Troy explains with precision, determined and confining. Although the patient depicted here does not suffer bodily harm at the hand of security, the "control" and "authority" (Connell, 1987; 1995) of the situation never leaves the alpha guard's dauntless grip.

Many times, the patient's second encounter with the guard takes place after s/he has been sedated and restrained. Memories of patients who appear unstable are forgotten once the guard is introduced to the new and improved, often heavily medicated, patient. The patient's "stabilized" appearance reassures the guard that coercion is a necessary step in her recovery (Macy, 2007; Moylan, 2009; Whittington, Bowers, Nolan, Simpson & Neil, 2009). Any hesitance the patient demonstrates to recall the grim details of her encounter with security reinforces to the guard that no hard feelings remain.

²⁵ Normally, patients on a Form-1 are involuntary held for a minimum period of 72 hours. The attending physician however may revoke the Form after 24 hours if s/he deems the patient to no longer be a threat to him/herself or others.

Taylor: They usually remember going back in those restraints again. They usually remember that part. But it's funny because the part they don't remember is when they actually believe in how *good* they feel.

Me: What's it like for you when they get their property back from the office and you know a week ago you had just...been in an intense incident

Taylor: (laughs)

Me: —with them.

Taylor: They remember the incident, they don't remember you per se. Or remember exactly what happened. They usually don't bring it up. They don't bring it up. I'll say 'You look better than last time I saw you' and they go 'Last time you saw me I was in restraints.' Something like that.

Me: Like joke about it eh?

Taylor: Yeah...sometimes.

Taylor's experience of seeing a previously 'unstable' patient leave the hospital looking well and smiling legitimizes any confrontation he may have had with the patient as a necessary part of the process of getting well (Crocker, Stargatt & Denton, 2010; Delaney, 2006; Doeselaar, Slegers & Hutschemaekers, 2008). Saving face, the guard mitigates his participation in coercive practices by deferring to psychiatrized discourses that render his work instrumental in helping the vulnerable members of society to regain their sanity, and thus control/dominance over their actions, words and gestures (Connell, 1987). Unlike the last time they met, the patient is able to convince the guard he is 'better' by not acting out verbally or physically when Taylor reminds him of a potentially scarring incident. Satisfied that the patient is not permanently damaged from being tranquilized and strapped to a bed, most likely in four-point leather restraints, the alpha guard interprets his ambiguous gesture of goodbye as a symbol of appreciation towards his authority and medical responsibility to impose pain and punishment.

Nurses? We get along if they get along

Not every guard handles the patient on his own. At times, the guard needs the nurse to be his sidekick in battle (Thomas, 2012). To ensure that physically smaller and weaker healthcare staff are protected and safe (Manzo, 2004; Miccuci, 1998; Moore, 1999), guards may invite a

capable male nurse to assist him with tasks that require a helping hand. Camaraderie between the guard and the male nurse alleviates any fear that the patient may achieve physical victory:

Joey: Yeah, he's, he's actually one of my favourites...Because he doesn't put up with crap.

Me: Can you elaborate on that?

Joey: I trust Jeremy. I know that, that if I'm stuck in a situation there...and it got physical I know Jeremy...would come in there and give me a hand...it's happened before where he's helped me out and it's happened before where I've helped him out.

Me: Right.

Joey: He's there. He'll go physical, he'll back me.

As Joey indicates, male nurses who meet hegemonic masculinity's standard of physicality and aggression are expected to 'back' guards in the event that a patient attacks or is able to physically overcome the guard. Here, the 'alpha' male nurse is able to transcend the stigma of his 'effeminate' profession by successfully engaging in physical confrontations with patients (Pullen & Simpson, 2009; Simpson, 2004; Wingfield, 2009). This sidekick role affords the male nurse admiration and "enhanced leadership/responsibility" (Simpson, 2004, p. 349) from the guards. Hegemonic masculinity in this case overrides other markers of masculinity, such as the gendered "nature" of one's work or profession.

The female nurse on the other hand is excluded from sidekick candidacy on the grounds that she is a physical liability (Prokos & Padavic, 2002; Rabe-Hemp; 2007; 2008; 2009; Remington, 1983). Fearing that she is too vulnerable and will succumb to her biological inferiority, the guard forbids her from engaging with a patient who threatens the sanctity of her body.

Jackson: I know they'll do what they'll do, but there's obviously a few that I don't expect to come in and that's more than fine. Like if a nurse is pregnant and I'm getting my ass handed to me I don't expect her to come in and give me a hand, she can go back and lock the doors. I'll handle it...then come back in a couple of hours.

This passage establishes how the female's nurse's entrusted responsibility and ability to procreate is, as Acker (1990) puts it, "suspect, stigmatized, and used as grounds for control and

exclusion” (p. 152). Although Jackson acts chivalrously in response to his essentializing ‘duty’ to protect the helpless vulnerable nurse, Troy asserts that any woman they encounter on the job may be threatening to the guard’s sexual integrity on the grounds that she may use her feminine powers of manipulation to gain revenge on her male captors or counterparts by accusing them of sexual harassment. Indeed, the sexual integrity of the guard is an area of his masculinity that if called into question by his colleagues, will shatter the legitimacy of his heterosexual prowess (Connell, 1987, p. 106). To guard against this devastating blow, Troy uses the female nurse assisting him as a witness in a patient encounter to prevent the suspect patient from challenging his sexual legitimacy.

Troy: I would never go into a situation with a woman with the door closed.

Me: (...) Ok.

Troy: They definitely have more to play on than a man does. Like when it comes to that...there is stuff that they can say that a man won’t say...if I go to a situation with the door closed she can say something like I, I asked her to do stuff or something right? Like sexual things for example. Just to cover myself I always keep the door open for a woman. And they usually try to have a woman with me...just to make sure that she can’t say anything wrong. At all. And they just, I found that they become more manipulative than men. (...)

Me: Just the mental health patient women or women kind of in general?

Troy: Women kind of in general...even in mental health.

Me: Right.

Troy: And in general.

While both passages reference a gendered relationship with women (the first with female nurses; the second with a patient), Troy’s perspective paints the female agents of the hospital—the patients, nurses, and female guards—as inherently manipulative and untrustworthy characters. Since women represent a biologically predetermined threat to the order and established values of any hegemonic masculine culture (West & Zimmerman, 1987), it follows that the alpha guard must always tread lightly around a female figure, treating her with the utmost suspicion and caution. Simultaneously, this demonizing construction of women’s motives lends itself to the reproduction of hegemonic masculinity and women’s perpetual displacement

into a subordinated/inferior role (Connell, 1987), as women are seen as innately manipulative figures in dire need of a man's supervision and control.

Discourses of blame: They want us big and amenable

Not every nurse trusts the guard to get the job done. Jackson and Ed, who both demonstrate a weaker physicality in relation to their peers, discussed feeling emasculated by the nurses' expectation that they greet each problematic patient with an army of backup as a security precaution.

Jackson: When I would enter a situation...they would ask if other people were coming or, I don't know how to say it, but you just know that they weren't confident in my abilities. And they weren't feeling protected if I was there.

Ed: I think that if you're in that sort of industry, that's something you go through...a nurse will look at you because you're a bit smaller...or they'd say... 'I'd rather have him or...you know Jordan or somebody like that'.

Me: Who's huge.

Ed: He's just massive.

Me: (laughs)

Ed: But that's gonna be anywhere. That's like if you're...a 160 pound hockey player you're still gonna get looked at differently than someone who's 20 pounds heavier.

Indeed, the guards are not the only hospital agents who can understand hegemonic masculinity and perform it. Jackson and Ed demonstrate how different actors within this closed environment (Holmes & Federman, 2006, p. 17) reproduce hegemonic masculinity both discursively and through their actions as an essential component of the guard's makeup. They believe the nurses see illustrations of hegemonic masculinity as their professional responsibility (Rigakos, 2002), similar to how police officers (Darien, 2002; Dick & Jankowicz, 2001; Dick, 2005; Tracy & Scott, 2006), soldiers (Duncanson, 2009; Johnson, 2010; Shefer & Mankayi, 2007) and athletes (Adams, Anderson & McCormack, 2010; Anderson, 2009; Pringle, 2005) are summoned by their institutions and public audiences to appear and act tough, strong, aggressive, competitive and, if needed, violent.

Of course, the building tensions, distrust, and gendered demands between guards and nurses can lead to discourses of blame (Holmes & Federman, 2003), that is, the primary social survival feature of alpha guard masculinity. By using their assumed expertise in medicine and psychiatry as proof of their competence, the guard passes off the accountability of healthcare violence onto the nurse and doctor. Thus, any concerns the guard has for the wellbeing of the patient are trumped by the loyalty he must demonstrate to his medically licensed superiors (Connell, 1987; 1995; Messerschmidt, 1993). Put simply, security's role in dealing out force is but a minor cog in a grand system of discipline and control.

Troy: This girl kept just wanting to leave, she was completely like catatonic and...I don't remember at the time if the Mag-locks²⁶ there were locking so I, and she definitely needed to stay but...I didn't think that she needed restraints...actually when we put her in the restraints we changed her into gowns first but...there was nurses doing it mostly, we were standing by.

Me: Just watching her.

Troy: Well not watching her but watching the wall. And her putting her hands up.

Me: Yeah.

Troy: And uh...then we put her in restraints and she actually started to cry and she was like eighteen. I just didn't...like I don't think that she needed to be put in restraints for that.

Me: Mmm hmm. Did you, were you able to tell the nurses?

Troy: No I didn't. I don't want to tell them how to do their jobs it's their call...I didn't want to do it, but I did it. Because that's my job...I have to say to myself I'm not a trained professional. I don't know. The only person that knows in that room is that nurse or...whatever the doctor has ordered.

Even though the patient (against her will) submits to being forcibly changed into her prison uniform—a constant reminder that she is ill, mentally unstable, and in need of protection/treatment—she is put in restraints as a punishment for his disobedient outburst. While

²⁶ Patients are restricted from leaving the ward by powerful magnetic locks that secure all exits. As tested in front of me by some of my colleagues, it is unlikely that the lock can be breached by human force. To leave, a nurse, personal-care assistant, security guard or other staff member who holds the required access level on his or her identity card must scan the patient out. Any escape from the ward that is not verified by hospital staff is referred to security as a “Code Yellow” or “Missing Patient”, which then obligates each guard to search for and return the involuntary patient back to the floor. Should the patient escape successfully, security is required by law to inform police that s/he is large.

the alpha guard takes a hands-off approach when dealing with her, his uniform and wandering panoptic gaze serve as a subtle caution and reminder of his authority and willingness to use coercive force (Bandyopadhyay, 2006; Bosworth & Carrabine, 2001). While Troy is able to demonstrate his compassion for a ‘helpless’ patient, the loyalty he holds towards his paid instructions to practice violent restraint when it is “for their own good” (Fairman & Happ, 1998) remains the stronger of his convictions.

Similarly, Joey discussed his role as a security guard to be one of maintaining order but also one that requires him to be deferential to medical and psychiatric experts and their decisions to use force. Whether the security guards wish to or not, they believe that doing their job correctly requires that they follow the orders of the nurses and doctors.

Joey: Well I’m not the medical professional but sometimes you can tell, the person’s took the meds, they’re cooperating, they agreed to do everything. And a nurse will come in and say ‘Too bad he acted out—in restraints no matter what. I don’t care what’s happening now.’

Me: I remember that.

Joey: And we’re like ‘no’. Like he’s fine...and they’re like...‘no I’m the medical professional and you are security and you will do what I say’. You’re...the grunts. You’re...the...enforcers. You’re the whatever you want to pick...eggheads.

Me: And then what?

Joey: Then what? (...) We end up doing it. And they just go nuts again.

Here, Joey blames the nurse for aggravating the patient to the point that security is needed, while the nurse reinforces the construction of security’s role as a “dirty” goon squad (Dick & Swift, 2005; Tracey & Scott, 2006) by pressuring the guard to take down and coerce patient-prisoners at their demand. While the alpha guard often demonstrates enthusiasm and pride towards this “situated doing” (West & Zimmerman, 1987, p. 126) or demanded expectation of an aggressive police style, others are unable to challenge these practices in fear of reprisal.

Dwaine: They just call security...you never know...the patient...can be refusing to do something that’s completely within his rights to refuse. And just because the nurse doesn’t like it, you know, tie him to a bed...And you wouldn’t want to uh...go against the nurse’s order and then...have that patient actually harm somebody. You

definitely...you're at fault pretty much. Sometimes...it's better to take that path than the alternative.

Like Joey, a sense that patient restraint is the lesser of two evils allows Dwaine to escape blame for his role in administering pain onto patients (Federman, 2012). Despite having knowledge that their actions continually violate the patient's right to undergo a fair medical assessment by an attending physician before being restrained (*Ontario Mental Health Act*, section 15.1), the alpha guard implies that preventing the always-already unstable, incorrigible patient (Mason-Whitehead & Mason, 2012, p. 229) from inflicting harm on herself or a nurse is a necessary, albeit vindictive victory the security team must preserve. Any guard refusing to participate in violent patient confrontation and restraint risks being met with contempt and belittlement from the nurse, who consequently dismiss him as weak, insubordinate, and ineffective (Connell, 1987), which may cause him to feel emasculated.

Some guards, on the other hand, continue to worry that patients will equate security's presence with the threat of physical or chemical restraint:

Ed: Some nurses are like 'No no we don't even want you to talk to him we want to hold him down and medicate.'

Me: Mmm hmm.

Ed: Well...just give us a few minutes to chat.

Me: Right.

Ed: If he freaks out...you know medicate away I don't care. But we could resolve this without violence and then subject this patient to medication that they don't want...and once you medicate them...like that against their will...you lose trust with that patient. Right then and there...cuz they're gonna automatically assume that every time they see one of us 'oh great' they're gonna get another needle in the ass. You know?

Since many patients will only encounter security staff in a negative scenario where they are frightened, hurt, and humiliated, it is all the more important that physical intervention and chemical restraint only take place after concerted efforts have been made to communicate with and calm the patient verbally (Moylan, 2009). Yet pressures from nursing staff to restrain a patient for chemical sedation who, in the guard's eyes, has not behaved unreasonably reinforces

his “goon squad” status within the hospital and removes his ability to be viewed by patients as an empathetic or heroic character (Dick, 2005; Tracey & Scott, 2006).

Alternatively, not all guards link their resentment of nursing staff to the suffering that is done unto patients, but rather to the feminine role they are seen as adopting when they take orders from a woman. Obeying the demands of a woman, that is a person with a subordinated gender status, brings out a sexist anger in some guards – one of the only emotions hegemonic masculinity permits (Connell, 1987; 1995; 2005; 2009). Joey is able to re-assert his hyper-masculine status by trying to gain revenge by clutching to his biologically superior position over the authoritative, and thus “unfeminine” woman (Connell, 1987 et al.; Dell, Fillmore & Kilty, 2009). Confident that any outbursts from female nurses are a reflection of their physical and gendered insecurities, Joey takes orders stemming from a woman with a grain of salt.

Joey: Sometimes...like the nursing staff or whatever are oversensitive, and they're like 'He just told me I was a fat bitch. Get him out of here.' And if you go and talk to the patient yeah...they called her a fat bitch, but I mean like...they're gonna be calm, they're frustrated, you hear the story, you get them calmed down, you get them to agree not to open their mouths to the nurse again. And you don't hear from them again. Meanwhile if I took the nurse's advice...how many patients would I throw on [a local street] a day?

Me: Right.

Joey: Just because someone said something the wrong way or called some nurse a fat piggy. And she is fat.

Me: And she is fat?

Joey: And she is fat. Would I bang her? Yeah. (laughs)

Me: Ok.

Joey: You can put that in if you'd like.

Ergo, the alpha guard is dismissive of the effects these kinds of sexist statements may have on a woman's ontological security in a culture that coincidentally demands she present herself in a gentle, nurturing, sympathetic way (Jewkes, 2005; Korobov, 2011). And while Joey is completely insensitive on this front, he then also sexualizes the nurse he constructs as unattractive in order to reassert his heterosexual prowess, and thus hegemonic masculine security performative (Connell, 1987, p. 186).

Why stab 'em when you can strap 'em?

The guard negotiates his perceptions of the pain the patient experiences by encouraging the use of physical force over the injection of chemical tranquilizers. In spite of any emotional and thus feminine outbursts the guard may hear during the struggle, Ed suggests that physical restraint practices avoid the potential for overdose, and eventually work to relax the patient (Delaney, 2006; Doeselaar, Slegers & Hutschemaekers, 2008).

Ed: And my main concern...is over potential for over-medication...usually what I find works is if you just simply strap 'em down, eventually they'll calm down. They'll probably scream for an hour or two. But...usually once they're in restraints...after an hour, two, three hours, they'll calm themselves down. Uh I, I don't think it's necessary to keep giving them more and more and more Haldol®²⁷.

Me: Is there an incident where you...where you had a concern about it?

Ed: Um...who was it? (...) He liked to walk around a lot and it seems like they gave him a ton of medication. It wasn't quite enough to knock him out. But he was groggy as all hell and unstable on his feet. And they wanted to give him even more to see if they could knock him out and I'm thinking to myself, well...just restrain him...it was ridiculous...we never did knock the guy out in the end. We ended up...restraining him and he stayed awake the whole time. Like the guy's resiliency was off the charts.

Illogically, the subordinated guard's solution against a brutal measure is to mitigate that brutal measure by implementing what he thinks is a "softer" (Evans & Wallace, 2008) but which remains a brutal display of subordinated masculinity (Cole, 2008; 2009). As such, Ed demonstrates how hegemonic masculinity leaves the guard no alternative but to confine, humiliate, and dehumanize the patient-prisoner until s/he is silent and compliant. Dangerous enough to be described as what Connell (2009) calls "the most striking case" (p. 143), hegemonic or 'alpha guard' masculinity in this case is closely linked to the preservation and enforcement of violent punishments, hierarchy, and the institution's unspoken but heavily surveilled codes of conduct. Put simply, the end (neutralizing the prisoner) justifies the means,

²⁷ Haloperidol (Haldol) is an antipsychotic medication used not only for punitive purposes (as described above), but also for the treatment of schizophrenia and acute phases of delirium or mania.

irrespective of how barbarous, terrorizing, and lasting these circumstances may be (Holmes & Federman, 2003).

But perhaps even worse than the repercussions chemical incarceration carries on the patient's body are the emotional disturbances s/he experiences when restrained and sedated without remorse by security and medical authorities in the institution (Ashcraft & Anthony, 2008; Jacob, 2012; Perron & Rugde, 2012).

Charles: It came to the point where he uh...I guess did the superman move. Where he ran and jumped over us for the door. That's when we, you know...grabbed onto him, threw him onto the bed and we just kind of latched around and held him there so he got medication essentially, and we strapped him up and he was good to go.

Me: Restrained him.

Charles: Restrained him yeah...but um one thing I didn't like was uh...where there was aggression there was no like um...like remorse...for any of the patients. It was basically ok 'get back to bed I don't give a shit' and uh, 'do as you're told'. And that's it. (...) No one ever really listened to them...because...it's why they're there. Why they are in the mental ward essentially is because they're not clear minds so therefore people would take into account that what they say is not legitimate.

Ultimately, the overreliance on medications and security interventions to deal with patient resistance and conflict contribute to the guard's feelings of workplace stress, apathy and burnout (Kurtz, 2006; 2008). No longer does he question how compassion, care, and benevolence can be given to the patient, but instead he asks, for *how long*?

Part II – I can change, I can change

It's Saturday morning. Weekends are usually quieter. Management isn't around, most of the buildings are locked up, and some of the patients are given a weekend pass to go home. This is a privilege though, as only the best-behaved patients earn such a reward.

I'm on with Doug and Pierre, both of whom are above my rank. Doug is twenty-four, only three years older than myself. Like many of us, he holds a degree in criminology and volunteers in the military. He speaks fast and fluently. Pierre, on the other hand, is a soft spoken and gentle figure, only six months away from obtaining a position with the local police force. I prefer going to calls with him because his patience is stronger than others. At this point, I know patience can mean the difference between a fight and a struggle. In my mind, I prefer the struggle. On the outside, I appear as detached and apathetic as everyone else.

I am patrolling the ER waiting area. Doug, the ER patrol guard, is watching a woman in Urgent Care. Curious, I wander over to see how he is doing. When I arrive, I find him standing adjacent to the examination room's door, facing away from the patient. I cannot see her in the room, but I hear her mumbling frantically.

"How's she doing?" I ask Doug. He rolls his eyes.

"She's schizophrenic, they're forming her. She thinks she's Sting, the rock star."

By forming, he means incarcerating. But we never say that.

I sit on the reception desk in front of Doug and the patient's room. After a few minutes, I hear the patient cry out in fear of a man she believes is after her. I hear the paper on the patient's bed ruffle. Soon after, I watch her leave the room and dart towards the exit door. Before I stand up, Doug grabs the patient by the back of her shirt. Stopping her momentum, he manages to swing the patient around by her shirt, throwing her back into the examination room. She stumbles, trips, and then collides into a metal table. My mouth drops open. After pausing for a moment, I glance around the emergency room. I see the nurses. They are still busy. One comes to the patient's attention and I hear the patient yell to her, "Get that man away from me."

"Don't worry, he's not going to hurt to you," the nurse responds.

I don't know what to do. I look into Doug's eyes. He avoids me. A male patient walks over to Doug and expresses his contempt, "You didn't have to throw her like that. You can just grab her and hold her down!"

"Sir, sit down right now!" Doug sharply replies.

"You didn't have to do that," the patient mutters back, quieter.

"Sir, if you have a problem with how I handle things, you're welcome to make a complaint. Now go sit down over there."

The male patient doesn't look at me. I guess he feels my embarrassment is shame enough. I turn back to Doug. He's writing frantically in his notebook. As this goes on, the patient runs for the door again. This time, she gets out of the room. Hesitant, Doug waits. Then he runs after her. I follow.

By the time we get to the Observation ward of the ER, Pierre is holding her on the ground. I hear her scream, "Get him away from me!"

Pierre looks at me. His face is confused, and perhaps even a little hurt. There are now at least fifteen hospital staff members around her. I wander away from the swarm. My head is racing, and my face feels pale. I think my guilt is getting the better of me.

I walk back through Urgent Care. I see the male patient who complained to Doug sitting with his head held down, staring coldly into the floor. I swallow, and pace towards the man. Red-faced, I congratulate him for standing up to Doug, and indicate to him that this is not the first time something like this has happened, a detail my supervisor later warned me never to divulge again. Risk management, he calls it.

I give the patient the number he needs to make an official complaint with the hospital. He shakes my hand, and thanks me for my help.

And as I walk back to the office, I wonder why I don't feel guilty for abandoning what they all warned me I signed up for. Yet for the first time, I feel a little bit taller in my heavy black boots, even though I can't help but anticipate what my punishment will be.

Part II of this chapter examines the gendered ways in which security guards develop and resist sympathetic, nurturing, compassionate, “feminine” (Evans & Wallace, 2008; Korobov, 2011) feelings for patient-prisoners enduring gross and humiliating violations/invasions of the body. A line is drawn between the guards who abandon their support of restraint (Barton, Johnson & Price, 2009) and those who still maintain—for the benefit of their authority and permission to deliver pain (Connell, 1987)—that chemical and physical force is “for their own good” (Fairman & Happ, 1998).

It's a prison, but let me help anyway

In an effort to finally make things better, guards resist security hospital culture and practice by softening characteristics of their masculinity performative (Evans & Wallace, 2008). By resigning his hegemonic masculine performative, a guard may replace his unapologetic tough demeanour with a sympathetic ear. Although Charles still participates in coercive practices, his subordinated masculinity performative (Coles, 2008; 2009) allows him to provide the patient with small acts of kindness during the delivery of pain.

Charles: I'll make sure they're comfortable...as soon as we sit down I'll be like 'Look, if you need any water let me know and I'll grab you some right away. I'll make sure my main job is to make sure that you are safe in this area and you have no reason to feel threatened or anything like that.' But it's like I said, everyone has a price...I'm there...protecting something I don't believe in.

Charles's minor demonstrations of compassion allow him some measure of redemption from the admitted hypocrisy of supporting an institution he has lost his faith in. This courageous admittance of responsibility and ambition by the guard affords him with a new but still

contradictory/subordinated masculine role, quite similar to that of a gallant assailant: he participates in patient coercion and restraint, yet attempts to afford them small displays of sympathy. By continuing to steer the institution's violent and domineering practices, hegemonic masculinity once again demonstrates its rule over a competing alternative sympathetic set of gender performatives (Martino, 2008).

Yet for some, minor displays of disobedience cannot reconcile the shame and embarrassment the guard experiences when he participates in the harm, humiliation and degradation of another person:

Ed: In full view of everyone they had to strap someone down on a bed. Where we could of easily just...taken this person into a room and then did it...out of view of the general public...The whole Emerg could see it. Everyone in the waiting room. And...you know that's embarrassment to the patient, it's embarrassing for us...because this girl had to have been sixteen.

Me: Ok.

Ed: And... she's having an actual psychotic episode. We should have...we could have easily brought her into a room she wasn't that strong. She's a little bit heavy (...) It could just frighten people in the waiting room, like... 'oh this crap happens here normally' ...it makes us look bad...people think we're picking on some sixteen year old...or you might have someone...in the waiting room who may have mental issues and they might think they're next.

Even if the subordinated guard chooses to construct a 'softer' masculinity (Coles, 2008, 2009; Evans & Wallace, 2008) in which sympathy for humiliated and mistreated patients is acceptable, he must negotiate the stigma of being lumped into the same category as the alpha guard who abuses patients without remorse. Ed's embarrassment for a young female enduring the humiliation of being strapped to a bed in front of a busy waiting room demonstrates his contempt and frustration towards the often extreme and repressive restraint tactics that characterize both hospital policy and hegemonic masculinity. No longer interpreting the ward's rules and established security codes of conduct as masculine doctrine, that is, the ideal way a man ought to live and perform his gendered life (West & Zimmerman, 1987), the guard is finally able to

critique the use of force as an unnecessary and impatient punitive reaction to persons who, for reasons impertinent to the makeup of their sexual anatomy, require accommodation, care and compassion (Ashcraft & Anthony, 2008; Holmes et al., 2012; Lakeridge Health, 2011; Mason, 2006; The Scarborough Hospital, 2012; University Health Network, 2008).

Charles: Uh...she just didn't want to go bed. That's it...They forced her. She was praying.

Me: They forced her.

Charles: They called us up to assist...we came up, made the call, we forced her to her bed. We...held her down while they injected her with medication to make her calm down, but all she really wanted was...just to walk around. That's it. So I really felt, let her walk around and she's not really causing any harm to anyone. Especially in a sealed off location...and there's orderlies everywhere to assist the doctors...but we were still called up to take care of...this person because they just think they can go. Because they didn't obey the orders of the physician or the nurses.

The emergence of compassion, patience, and understanding (Korobov, 2011)—all subordinated tropes of femininity—critically transform the guard's political position on psychiatric treatment (Butler, 1988, p. 520; Connell, 2009, p. 143). As Sean, Charles and Dwaine all reiterate, any institution that does not exceed the standards, rights, and freedoms that are guaranteed to patients cannot be genuinely referred to as a place of treatment. Ultimately, the patient's restricted access to human rights coupled with their experience of isolation in a secluded and locked-down setting mirror the deprivations that occur as a result of incarceration (Donald, 2001; Holmes et al., 2012; Jain & Murphy, 2006; Wright 1997):

Sean: The sad thing is...I think that probably prisoners have more rights than the mental health patients.

Me: There you go.

Sean: (...) 'You have the right to remain silent' and then you say 'will be blah blah blah in a court of law'. I mean right from the beginning...they're giving you rights, they're giving you a phone call, they're giving you this...right to a legal attorney. And then they're people that have a mental breakdown or...their first episode of bi-polar disorder. And...do they get to call a lawyer?

Dwaine: It's...definitely not a very...nice setting like...the fact that you're in an area where...you can't get out – the doors are locked right? Like I mean it...as soon as that

kind of sinks in...you feel a threat there alone. Just the fact that...you're in a room or an area where you cannot get out...

Hospital patients are captives; often having committed no crime against society besides that of being 'different', they nonetheless experience gendered humiliation, abuse, degradation, confinement and a deprivation of their rights in a frighteningly similar fashion to the experience of prisoners (Donald, 2001; Federman, 2012; Jain & Murthy, 2006; Kilty, 2012; Wright, 1997).

If we fight dirty, so will they

As Foucault (1977) taught us, where there is deprivation, there is also prisoner resistance. As such, when prisoners are confined to a room with their belongings confiscated they are reduced to using their bodily fluids and excrement to resist prison staff (O'Keefe, 2006; Rhodes, 2004). To send a message to the nurses and the guards, Ed recalled how one female patient smeared excrement on her "bedroom" wall; following this, and while under the panoptic gaze of security staff, she was forced to wash herself. This reminds both the female patient-prisoner and the security guard that the prison hospital reserves the right to regulate resistance and even the most personal expressions of one's identity or selfhood (Goffman, 1961).

Ed: I almost vomited on [the in-patient floor] when this patient smeared her shit everywhere...she was shouting at the nurse... 'I have to go to the bathroom. I have to go to the bathroom.' They never brought her to the bathroom. So she shit on the floor and smeared it everywhere.

Me: (...) And when you got up there?

Ed: It was already...smeared everywhere the smell was disgusting...I had to take a couple minutes, kind of...compose myself and...put on one of the flu masks because that actually does help filter the smell a little bit. To deal with the situation. We ended up just having to escort her to the shower and...let her...on her own and

Me: –just security or?

Ed: Yeah. They just wanted us there...in case she freaked because she did have a history of acting out physically...but she never did.

The consistent endorsement of alpha guard masculinity and its prescription to invoke fear into women in the most violating and intrusive ways contributes to Ed's burnout and dissatisfaction with his career (Kurtz, 2006, 2008). Here, the female patient is punished not for her outbursts,

but for the constructed threat thereof (Mason-Whitehead & Mason, 2012, p. 229), which in turn reproduces the patriarchal assumption that mad/hysterical women are synchronously dangerous and unfeminine (Kilty & Frigon, 2007; Kilty, 2012).

Accordingly, Sean—a former member of the local military—realizes that visible and militant displays of masculinity in the form of protective vests, emergency call radios, and other tactile equipment such as handcuffs and police boots contribute to his negative image and the onset of patient resistance and even aggression or violence (Albuquerque & Paes-Machado, 2004; Johnson, 2010). For Sean, the de-militarization of the guard disables the public's gendered expectations and fear of him, all which contribute to the guard's incapacity to provide care, compassion, and help to the patient.

Sean: I don't think there needs to be...collared shirts and...shoulder flashes and that. The radios and the vests and whatever...in [another hospital]...they don't wear that. They wear slacks and like a golf shirt. And it says [the hospital] security. It doesn't say...SECURITY [distorted voice]. You know?

Me: I know.

Sean: *They're* not there...as the thug squad. They're there as...a different role...to help. You know, medical professionals. Sure they get called to calls where they have to hold down a patient...that's being combative, or that's being harmful to uh a nurse or doctor or whatever. Or another patient. But it's not...it's not...like police, you know?

Me: How many incidents were there of a vest protecting somebody from...

Sean: Yeah. None...none.

Me: None.

Sean: And it's sad because you get these people that come into security...and the reason is because they want to be a police officer someday. And so what's the first thing they want to do? Well they want to wear the uniform. And that vest. And those leather gloves. Even though...it's actually more of an advantage to let them know that you're not wearing a protective vest. I'm not by any means a small guy...with boots six-foot-four, two-hundred and twenty pounds...I'm coming up with this black, all black...radio...whatever...and I'm saying 'Look no ma'am you have to go over there.' You know, the difference between reaction of someone that came up in a golf shirt and said that...I think...I *know* I would feel different.

No longer buying into the value of the hyper-masculine performative, no longer seeking accelerated promotion to a higher career in public policing, and lastly, no longer believing that man is biologically entitled and responsabilized to exercise authority, physicality, toughness,

intimidation, and ambivalence to all that is feminine (Evans & Wallace, 2008, p. 485; Prokos & Padavic, 2002) or threatening/contradicting to hegemonic masculinity (Acker, 1990; Connell, 1987), the guard intensifies his resistance against his superiors. As we learn in Part III, senior private security officials react to insubordinate actions just as harshly and repressively as the “warrior hearts”²⁸ ticking in the police academy (Chappell & Lanza-Kaduce, 2010; Conti, 2011; Darien, 2002) or military institutions (Albuquerque & Paes-Machado, 2004; Duncanson, 2009; Johnson, 2010).

Part III – Shut the fuck up and be a man

The guard’s pursuit to relieve the pains and deprivations imposed on the patient-prisoner is met with hostility from all angles of the “prison hospital complex” (Holmes & Federman, 2006, p. 17). The newer, unadjusted guard who promises the patient-prisoner that they will not be harmed and will eventually be set free defies the established order of treating them as the enemy. If the guard befriends the patient-prisoner, he is criticized by nursing staff and fellow guards as lacking confidence in his ability to do the job – or “to do” his gender appropriately (West & Zimmerman, 1987). More specifically, his ability to handle the demands of the profession through the creation of a hegemonic masculine performative is called into question, and then belittled:

Jackson: I wasn’t very good at talking to them, I didn’t have uh good people skills as far as de-escalating the situation because I didn’t know what...to say or...well don’t make promises to the patients that you can’t keep...‘If you listen to what the doctor says you can get out of here soon.’

Me: Ok.

Jackson: They weren’t going anywhere.

Me: Right.

²⁸ The warrior-heart refers to the mythologized process in which police officers and recruits “strive for an idealized sense of what it means to be a police officer (i.e., strength) to the exclusion of a discredited idea of the [subordinated] lesser civilian characteristics (i.e., weakness).” (p. 411)

Jackson: It was detrimental to tell them because...you know, the medication's coming in injection and 'It's in a pill you can take it now.' Stupid stuff right?

Me: Why would you want to make those promises?

Jackson: Quickly diffuse the situation so I'd look better like I knew how to handle it but...that's not how we handle it right?

Charles: I would just talk to [the patients] as much as I could. If they needed some kind of confirmation I would call my superiors and ask, 'Can they do this...or how could we go around by doing this?' Most of the time it was a waste of my time because...you can't really do certain things... Like one male in the ward...wanted to go for a smoke. And I was escorting him down the stairs. Now I...we're not allowed to bring them down for a smoke because of the fact that they can run or do this and that. So I asked them...I didn't know he wasn't allowed. And they say 'No what are you doing you should know this' and...I had to bring him back up the stairs but he pleaded with me...for you know *ten minutes*. Even upstairs while we were putting him in the bed he wouldn't stop pleading with me, and it was just... hard to see that...No one enjoys seeing suffering unless you uh...have issues of your own.

Clearly, the issue underlying Jackson's poor people skills and Charles's restriction from being social is the all-too-apparent fact that every hospital security training initiative (formal and informal) seemingly revolves around taking physical control of a situation (Rigakos, 2002; Micucci, 1998; Monaghan, 2002; Moore, 1999; Shefer & Mankayi, 2007), instead of listening to and more positively interacting with patient-prisoners.

Fearing reprisal his superiors, the angry guard restrains himself from challenging the authority of the nurses and doctors. Outlets for stress do not materialize in the form of administrative complaints. Instead, the guard keeps it to himself or, at the very least, within the confines of the "office".

Sean: I never felt comfortable to say 'You know what I think, (whisper) 'I think you're wrong'. Like 'I don't think we should do that' or 'Do we really need to sedate them?'(...) If I ever said anything to anyone else in the hospital I would expect my...head to get bitten off...'Uh what do you know? You're just a stupid security guard so keep your mouth shut and do what we tell ya'. (...) We were the marionette and they were the...puppeteer.

Troy: This one time, there was like a man up there and... he wasn't aggressive... or anything like that and we brought him to his room and I guess the nurses asked him to have some medication and he said 'uh no' and from what I understand you can't force someone to have medication if they're not um...acting out. And he wasn't, he was sitting

on the bed. He's like 'I'll take the medication if you tell me everything is ok.' And the nurse refused to tell him that...And then she's like 'Turn him over'.

Me: Turn him over?

Troy: I'm like... 'No he's not aggressive so I'm not gonna put my hands on somebody'. She's like 'Turn him over'. I'm like 'No'. And we didn't end up turning him over and he kept asking us 'Is it cool is it cool is it cool?' And the nurses were like 'It's cool'. And he took the medication and went to sleep. Because the nurse said that. And then later I guess at the nurse's station they're like, 'Next time I tell you to turn him over, you turn him over'. I didn't say very much to her but...

Me: Yeah. When you got back down to the office you probably...

Troy: Oh yeah...I verbally abused the hell out of her back at the office.

In addition to the initial stress of conflicts with nurses and doctors over patient treatment in the heat of the moment, the guard must also suffer punishment from his superiors for his direct disobedience. When a nurse accuses a guard of stepping outside of his subordinated role, the guard's actions are quickly condemned and shamed by upper management. This bureaucratic disconnect between front-line security and management contributes to guards' feelings of helplessness. Rather than mediate the complaint, the guard is defeated by the harsh, anti-feminine (Connell, 1987; Evans & Wallace, 2008; Prokos & Padavic, 2002) militaristic/siege mentality (Rigakos, 2005, p. 271) that requires him to follow authority at all costs, and never, ever break the rules (Albuquerque & Paes-Machado, 2004; Johnson, 2010; Shefer & Mankayi, 2007):

Sean: They're saying there's three ways to deal with people. To coddle them. To encourage them. Or invoke fear.

Me: (...) Right.

Sean: ...And their immediate method was fear. Fear mongers...they wanted you to, to live in fear and, and anytime that you...you wavered out of their little...strict controlled environment they would...send you a nasty email...they wanted you to be the beaten dog in the corner. And keep you there. Because...if I had have been wearing a military uniform...I wouldn't ever question anything they ever would have said...it would have been accepted as fact.

We all share a critical reality (Guba & Lincoln, 2005, p. 258) with respect to our relationships with the security management team, herein referred to as the "chief guards". Sean establishes that the chief guard plays on the military training and background that many guards

have—that is, persons whom he interviewed and selected— by demanding them to follow his orders without question. The guard who challenges the chief guard’s fearful and intimidating tactics becomes entangled in a deep masculine power struggle. Nevertheless, the chief guard will continually reassert his authority and control by reprimanding and demoralizing the errant guard. As Joey painfully recalls, whether accusations of the guard’s ‘disloyalty’ are founded or not, a sure, certain and swift series of “uncivilising interventions” (Monaghan, 2002) will always await him (Beccaria, 1764).

Joey: They’re a reactionary team, not a proactive team. They’ll...hear of something...and then...it’s almost...as if someone walked up to...[the Security manager] slapped him in the face...he’d get out an email ‘I can’t believe you slapped me in the face’ blah blah blah. That’s what his reactions are like to any complaint he may hear about one of us. Whether it be founded or not. Whether it be the whole truth or not.

Me: Yep.

Joey: And that’s frustrating. It’s like...I can’t say I’d be the greatest manager but would I at least...hear both sides of the fucking story? It seems pretty fucking simple to me. But they don’t care. They’re embarrassed...if someone talks about their guard.

Me: Embarrassed?

Joey: ...Because security’s supposed to be the whole like ‘no one can do no wrong we don’t break the rules we enforce them’ you know? And they hear about someone breaking the rule it’s like ‘Oh my god I can’t believe you shamed me like that...you’ve embarrassed me. I hate you, you’re shit.’...and that’s not right. I fucking hate it. That’s not how you manage people. That’s not how you supervise people. That’s not how you run anything.

Security’s mandate to “enforce the rules” situates any (supposed) insubordination on the part of the guard as a deviant, personal affront to the militaristic, masculine code established and enforced by the chief guard. Through his prompt and reactionary methods of discipline and reprimand, the chief guard further subordinates and emasculates the frontline guard by refusing to allow him to respond to such accusations, or hear his “side of the story”. Quite similar to how male guards use fear to reproduce authority and dominance over each other, women, and patient-prisoners—the chief guard displaces his underlings’ attacks as simple, meaningless, unimportant gestures of insubordination. Hegemonic status, in this case, is awarded to the alpha chief for his

ability to seclude and subordinate his opponents (Connell & Messerschmidt, 2005)—persons whom he typically applauds for their competitiveness, bravery and interest in a higher paid position in security, military or public law enforcement (Rigakos, 2002, 2005). When guards resist or question the chief guards power or authority, they run the risk of being stripped of both their livelihood and “superhero” aspirations. Desperate to gain a reference into the police academy, as well as recognition for the courageous and valiant work he does on the “private hospital beat” (Dick; 2005; Tracy & Scott, 2006), the guard is left to grumble quietly and bitterly in the aftermath of the alpha chief’s fury.

In rare cases, the subordinated guard who does not rival the same militant aspirations of his hyper-masculine peers may still “attempt” to directly question nursing practices and the alpha chief’s blatant disregard for the prison hospital’s overuse of chemical and physical force. Yet Ed, already trapped within a subordinate gendered position due to his weaker physicality and contract status (Connell 1995), is devalued and snubbed by the management to the point that his ongoing complaints of misconduct on the part of nursing staff are not even met by the subtlest of replies.

Ed: There’s been many, many times where we’ve...where I’ve talked to [the Security Manager] about...[the in-patient ward] using us as a goon squad. There was many discussions, it was always put in shift notes and big bold letters: ‘This is absolutely ridiculous’ where...physical force should be you know...a last resort. We should be able to commun—they don’t allow us to communicate. There’s been many times where that issue’s been raised and...it never goes anywhere...you know, saying that we had a rapport with the patient. Nurse stormed in and said ‘Ok...hold him down and medicate him’. Right while we’re in the middle of building the rapport with the patient. And I never ever seen a reply from [the Security Manager] or [the Security Supervisor].

Failing to reply to a complaint or concern of the guard demonstrates a lack of the chief guard’s consideration of their workers’ views, and thus establishes a one-way or unidirectional flow of communication. Certainly demeaning, these displays of hostility fuel some hostility in the guard.

Will the hyper-masculine cycle end?

In many cases, alpha guards reproduce management's rejection of subtler control techniques so that suggestions made by subordinated guards to abolish brutal measures are often met with hostility by alpha guards. As Troy warns me, losing physical control of the patient-prisoner may open outlets for their revenge (Kvale, 2006):

Troy: Like fuck your employees, fuck everybody but just...make sure the patients are happy? The only way the patients are gonna be happy is if your employees are happy, and we're just supposed to sit there and take the bullshit abuse from them? Because everybody needs to be treated like I'm being treated by my own mother? That's the fuckin' stupidest thing I've ever heard in my life...Like a drunk comes in and like wants to beat and is spitting all over me and I'm supposed to take it like that? No.

Once again, the alpha guard strongly resists any implication by subordinated guards that patients suffer abuse or should be gently accommodated by guards. Rather, he ridicules the idea that 'dangerous' patients might be dealt with by means other than physical force (Gillespie, Gates, Miller & Howard, 2010; Liberman, 2006; Moylan, 2009), which in turn reasserts the hegemonic masculine position that no man is obligated or encouraged to "take bullshit abuse" from anyone (Monaghan, 2002), let alone a vulnerable, "sick" patient-prisoner.

Accordingly, in the final minutes of our interview together, I unfold to Joey the debilitating stress I endured on my *last day* (see Jenkins et al., 2010) as I witnessed a woman helplessly declare to us that she feels she is being sexually assaulted. Even more "dangerous" (Connell, 2009, p. 143) than the physical and emotional repercussions the patient will suffer in traumatic recollections of this event, and more "evil" (Holmes & Federman, 2006; Mason, 2006) than the routinized and legislated practices that influence medical staff to take on destructive positions of power over patient-prisoners, is hegemonic masculinity's ability to build a barrier in front of any critique that calls into question the legitimacy of the established order:

Me: And so I had just thought when...that needle was going in this woman actually feels that she's being raped.

Joey: I've heard that a lot from girls 'You're raping me. You raped me.' And I chalk it up to their confused mental state...It's well...do I believe they feel that way? Yes but do I think that me...having I'm gonna say of sane sound mind knowing that's not what's happening...better in control of thoughts and emotions than this patient at the time. Better...understanding of what's going on. See for this patient...they don't work in the hospital, they don't work with the nurses, period, so they don't know how we operate. But I know how we operate. I'd like to think I can tell a rape from uh...a medication administration.

Me: You know the mission statement for the...[local hospital]?

Joey: Uh...which one? Compassion?

Me: The one that's in your office.

Joey: Yeah (laughs) I don't really...

Me: What is it? What are the words?

Joey: Compassion care and...something else. Fucking...I don't remember (laughs)

Me: You think that, you think that incident I just described to you represented the mission statement of the hospital?

Joey: (...) Yep.

Joey's belief that he is better qualified than the supposed mad/hysterical woman (Kilty, 2012) to assess whether her encounter with hospital security violence qualifies as sexual assault demonstrates both his insensitivity to the female experience and his belief that women are helpless figures in need of a man's protection (Acker, 1990, p. 152). It can be argued that many women have been socialized to fear being held down against their will by one or more men. Thus, placing women in a vulnerable position where their bare buttocks are exposed in front of several male security officers who are simultaneously pinning each one of her limbs down might trigger some patient-prisoners to experience the feeling that they are being raped, or at the very least suffering an indignant, dehumanizing, gross invasion of the body and mind. Although the events described by Joey and I (and in the final ethnographic fiction titled *Last day* – below) may not meet the established empirical/legal criteria that condemns such an act as an assault (let alone sexual assault), I understand this incident as nothing less than a patriarchal, primitive, and criminal illustration of both the prison's and man's determination to reproduce physical and psychological rule over women and subordinated men (Connell, 2009, pp.132-133; Foucault, 1977; Goffman, 1961; Holmes et al., 2012; Kilty, 2012).

New gender, new beginning

For the subordinated guard who continues the “good fight”, that is, the guard who competes daily for the equality and sanctity of their gendered performative, there will be spaces for resistance. Unlike me, Taylor does not see resignation as a way to reconcile his indifferences and frustrations towards the mental health system and security industry. Yet while I am stifled by his determination to emotionally withdraw from these traumatic events, our ideological differences do not inhibit us from sharing a common goal to improve the system. Indeed, the final passages of our story remind us that institutional and social change is not accomplished by superheroes, but rather through the evaporation of “us versus them” dichotomies. This allows for differences to be celebrated, and essentialist perspectives on gender to be dissolved, all the ingredients necessary to dissipate the positivist bog(us) (Young, 2011):

Me: One of the last questions I have for you is I know when we were talking on the phone...you had mentioned in the last year you sort of, you’ve...stated that you...have started to see things my way.

Taylor: Yeah.

Me: At the hospital. What did you mean when you said that?

Taylor: Well...I was very...pro...um.....‘the man.’

Me: Right.

Taylor: You know in quotation marks...I just believed everything was...you know...set to me, I just believed that ‘oh yeah I guess that’s what should happen.’ And you know partially because...I started dating someone with...you know a mild...mental illness not like psychosis or anything but an eating disorder and it’s still a mental illness nonetheless.

Me: Mmm hmm.

Taylor: You know borderline personality to top it off. It’s like...I started seeing it more...the patient’s way...and I have put myself in their shoes you know figuratively. And you know I started to understand that maybe it’s not as...you know as black and white as they make it seem, you know at...staff meetings and...when nurses do this and that. I wasn’t 100% pro-establishment to begin with. I still had my own...mindset but...you know, at that point I just believed that you know do whatever...the authority tells you. You know that’s not to me more true than non...authority. So I started seeing a little more you know, in the grey area...which is why I’m doing this interview in the first place and I responded as soon as I saw it because

Me: —and I appreciate that.

Taylor: I believe that...you know with your mindset and your experience I think that you know can actually...make a difference.

Undoubtedly, the moment Taylor and I shared reflects how personal experience, maturity and reflexivity can dispel even the most widely celebrated ambition of hegemonic masculinity—to seek and impose authority. While the story shared here is at times riddled with struggle, chaos, and nihilism, it is not without courage, and it is not without resistance. The politics of gender are as omnipresent as the ongoing constructions and performatives of gender (Connell, 2009). Thus, hegemonic masculinity can never rule without an opponent; can never succeed in the presence of feminist resistance. As I conclude on my *last day* of the job, just stepping in the direction of change can create a sound.

Last day

04:00hrs. Approximately. A tired office, exhausted from another night of machismo, exaggerated anecdotes of sexual encounters, and routine chemical injections. I keep telling myself “this is *the* last night”. The last night since the nineteen-year-old kid got punched three times, thrown down bleeding with his wrist placed in a lock, and eyes put to tears that remind you of the spanked three-year-old you see in the supermarket every few months.

The nurses call. It goes something like this:

“Hello, security speaking.”

“We need a med-assist!”

“We’re on-route.” The phone slams.

And the three of us waddle over to the elevator. I don’t remember who was there. One guard recalls the girl he fucked, yes “fucked” two nights ago. He met her on an online dating site. Clearly he doesn’t sleep like the rest of us on our downtime.

Another guard comments how hot he thinks one of the psych-patients is on the E-Wing. I’m less turned on from their stories, and more nervous about how the call will calculate. I don’t perform the absence of fear as well as they do. I don’t want to get my ass kicked anymore. I’ve survived these sterile, blood-covered walls. But how? I’m not like them...*I was still wondering who to blame.*

We get to the unit. Our IDs give us clearance. There are gentle “hellos” and “how are you’s” exchanged with the nurses. The same nurses my buddy just told me in the elevator he wants to fuck.

“Thanks for coming guys! It’s at the end of the hallway.” One of nurses instructs us. Yes, that’s an order.

“Oh no problem, how did your exam go?” one of the guys ask.

“We’ll see I guess!” And the two of them laugh.

Next, the latex gloves go on. This is routine. We pick a fresh pair even though we all know we always keep an extra set in our pocket. Just in case. Just in case we get attacked by some crack addict in the tunnels. According to my trainer, this happens.

We confront her, “the patient”, at the end of the hallway. It isn’t hard because she is just standing there talking to the nurses about how she doesn’t like being in her room. We talk to her, pleasantly. Meanwhile, the nurses prepare a sedative.

I keep thinking what a pleasant girl she is. She has a British accent and tanned skin. She mentions that she is pregnant. It’s the first thing she makes clear to us. She must have seen this before, or gone through it.

The nurse takes one of the other guards and I aside. She tells us, quickly,

“She’s been known to be aggressive. We told her to go to her room.”

“Can she take it orally?” Someone usually asks.

“No, we’ve been there before. She’s not co-operative.”

“Right, let’s get this done.”

And we corner the woman.

“Ma’am, we need you to come to your room please.”

“Why, what are you giving me?”

“Come on, we’ll talk about this in your room.”

There are eight of us in total. Four nurses. Three security guards. And a back-up personal care assistant “just in case”. Most of the guys think they’re pathetic. But the more the merrier as the adage goes.

The curtain around her bed is pulled open. We first ask her to lie on the bed stomach-down. Then we demand her to lie on the bed stomach-down. This is to facilitate the exposure of her buttocks in the cold, sterile room. Routine.

She fights for a while. She doesn’t kick, punch, or yell. Just fights for a little while like most of them do.

There are voices in the midst of the struggle.

“You can’t have my necklace, it’s my religion.”

“Let’s cut the necklace, she might choke herself.” The nurses say.

“No!” I hear.

The necklace is cut off. She doesn’t kick, punch, or yell.

Then another voice. “Turn over on your stomach please.” By now, everyone has said it.

Time passes.

And there is the final image in a collection of images I have of bare-asses. I count four limbs in total: two legs and two arms. Each is pressed on firmly as the needle goes in. The patient manages to mutter one thing in middle of all this. It is quiet. I have to listen so I can hear it:

“I’ve never been so sexually assaulted in my life.”
I release my grip and leave the unit. I never come back.

Because I realized just being there was enough.

CHAPTER 7: CONCLUSIONS

Overall, this research builds on Connell and Messerschmidt's theoretical conceptualization by exploring how hegemonic masculinity shapes the carceral realities of the prison hospital guard. The emergence of hegemonic and subordinated masculine performatives emphasizes the bloodthirsty competition between the guards to establish their superior, heroic masculine status and authority. The struggle for gendered power entangles many victims, as female nurses, patient-prisoners, and subordinated guards are dominated either through physical force, punishment, intimidation (verbal or through uniform) or in some cases, persistent expressions of anger and apathy towards any feminized compassion, sympathy and concern they have for the safety, respect and care of patients (Lakeride Health, 2011; University Health Network, 2008; The Scarborough Hospital, 2012).

These discoveries warrant further investigation of the gendered experiences of male hospital guards, and invite scholars to give voice to subordinated groups, namely women and patient-prisoners. While I am not trying to achieve generalizability, it would be foolish to overlook the voices, experiences, and stories that remain silenced and unheard. In addition, I encourage researchers to engage in ethnographic fieldwork that more closely explores the bureaucratic relationships between security management teams and their front-line staff. I did not resign from my position at the hospital on good terms with the chief guard. Unsurprisingly, this prevented me from investigating the lived experiences of persons who mandate, inform, and enforce the masculine practices, values, and ontologies of private security officers. Future research (see preliminary study Franke & von Boemcken, 2011) that fills this gap can better our understanding of the paramilitary hierarchies and management strategies and training initiatives (see Birzer & Tannehill, 2001) that seek to engender, as Sean coins it, "the beaten dog in the corner" (see Chapter 6, p. 136).

More broadly, this research strongly urges the examination of women's voices in cultural private security research. The male guards in this study provided us with only preliminary insight into how women negotiate and resist the gendered pains of their subordinated status in relation to their male, alpha peers. Indeed, the countless references and allusions the guards made in reference to widespread practices of sexual harassment and discrimination warrant critical scholars to (re)visit the asylum in intense ethnographic form (Goffman, 1961). Secondly, this research implicates that there are missing details, stories, and power dynamic struggles yet to be observed; further insights into gendered hospital life may reveal how women are uniquely marginalized within an ever-growing militant (Rigakos, 2005), albeit "dangerous" (Connell, 2009) subculture.

On a brighter note, one of the participant's informed me that the institution studied in this research implemented a policy following my resignation that restricts male security staff from restraining or interacting with women alone. A certain step in the right direction, this policy will help ensure that vulnerable women are protected from the less subtle, more visible forms of masculine assault. That said, this measure will not safeguard the female patient from enduring the lived experience of "feeling" like she is being raped as she is pinned down by the thick hands of security men—all of whom hold the autonomy to gaze at the bare visible flesh on her buttocks while she is injected against her will with a chemical restraint; nor will this measure protect women from experiencing an unjust violation of their human rights to privacy, security of person and bodily integrity as security men surveil her room while she undresses and changes into her hospital "uniform". For these reasons, this research in no way attempts to recommend or consider mitigating policy strategies. In particular, the painful experiences heard in these narratives are not meant to inspire ways in which we can minimize the direct and collateral

damage that incarceration, punishment, pain, and hegemonic masculinity inflict on our bodies and minds. Rather, it presupposes that *any* coercive, violent, punitive, controlling, and restrictive security measure or patient intervention technique ought to be abolished within our psychiatric facilities, hospitals, prisons, and institutions at large (Barton, Johnson & Price, 2009). For if Charles' assumption about human nature holds water, that is, no human being truly enjoys witnessing suffering (see Chapter 6, p. 135), then the conclusion of this research is as simple, sharp, and transparent as the parting plea I was left with from the last patient with whom I had contact. Her words, coupled with our lived experiences, serve as a logical, empirical, and emotional testament to the certainty that healthcare violence does, in any form, produce and reproduce indifference, hurt, agony and anguish – the incontrovertible ingredients of injustice.

Thus, it is my hope—as a critical scholar, former security guard, and human being—that this research and the “forward step” the hospital has taken with respect to patient care will inspire mental health facilities to continue or to begin exploring psychiatric measures that do not instill force, pain, violence or any restriction of autonomy on persons we label as sick. As forewarned, some may criticize this research as but *one story*. In the same way reflexive sociology is dismissed for its “narcissism”, that is, for privileging the researcher's voice, experiences and feelings over the participant's (Philips & Earle, 2010, p. 362), some may seek to constrain these voices within the scientific boundaries of politically neutral space. But like all ethnographic fieldwork (Katz, 2004), this research is politically and policy relevant. I argue that nine voices are no less reliable than a “boring” (Ferrell, 2004) twenty thousand summarized without the felt emotion of real words, subtle meanings, and messy nuances offered in depth from the nine participants in this study. I raise a toast to cultural criminologists (Ferrell, 1998; Young, 2011) for calling out positivism on its “bogus” claims to objectivity and neutrality; for not exempting any person from reflexivity; for giving back authority to the single voice; for

revealing the ontological insecurity of bullies who call us untrustworthy, narcissistic, and self-indulgent; and for inspiring me to keep my research and lived experiences on the “edge”.

By and large, our narratives are meant to put the blood back into the portrait of the lunatic asylum; to paint over its sterile, blank walls with the desperate, struggling, screaming voices of its captives; to expose the patriarchies, deprivations, and pains that constitute its “evil influence” (Holmes & Federman, 2006; Mason, 2006). Although this research demonstrates that hegemonic masculinity is a pillar in one of our institutions of social control, no power is permanent; no wall is fortified against collapse. As Charles reminds us in the beginning of Chapter 1, beyond research, knowledge, and imagination lays our capacity to “be the masters of our own reality...to understand what we want to understand”. And this time, my gut feeling tells me there is always hope for social transformation. Just as we are human, we have room for compassion, open-mindedness, and empathy. Just as we are men, we carry the capacity to see kindness as strength, rather than as weakness.

REFERENCES

- Acker, J. (1990). Hierarchies, jobs, bodies: A theory of gendered organizations. *Gender and Society, 4*, 139-158.
- Acker, J. (1992). Gender institutions: From sex roles to gendered institutions. *Contemporary Sociology, 21*(5), 565-568.
- Adams, A., Anderson, E., & McCormack, M. (2010). Establishing and challenging masculinity: The influence of gendered discourses in organized sport. *Journal of Language and Social Psychology, 29*(3), 278-300.
- Adelman, M. (2003). The military, militarism, and the militarization of domestic violence. *Violence Against Women, 9*(9), 1118-1152.
- Adler, P. A., & Adler, P. (2007). The demedicalization of self-injury: From psychopathology to sociological deviance. *Journal of Contemporary Ethnography, 36*(5), 537-570.
- Alasuutari, P. (1995a). The factist perspective. In P. Alasuutari Researching Culture. *Qualitative Method and Cultural Studies* (pp. 47-62). London: Sage Publications.
- Alasuutari, P. (1995b). Narrativity. In P. Alasuutari Researching Culture. *Qualitative Method and Cultural Studies* (pp. 70-84). London: Sage Publications.
- Albuquerque, C.L., & Paes-Machado, E. (2004). The hazing machine: the shaping of Brazilian military police recruits. *Policing & Society, 14*(2), 175-192.
- Alcoff, L. M. (2009). The problem of speaking for others. In A.Y. Jackson & L.A. Mazzei (Eds.) *Voice in Qualitative Inquiry* (pp. 117-136). New York: Routledge.
- Allen, D., Lowe, K., Brophy, S., & Moore, K. (2009). Predictors of restrictive reactive strategy use in people with challenging behaviour. *Journal of Applied Research in Intellectual Disabilities, 22*, 159-168.
- Alilunas, P. (2011). The (In)visible people in the room: Men in women's studies. *Men and Masculinities, 14*(2), 210-229.
- Anderson, E. (2000). *Code of the street*. New York: W. W. Norton & Company.
- Anderson, E. D. (2009). The maintenance of masculinity among the stakeholders of sport. *Sport Management Review, 12*(1), 3-14.
- Ashcraft, L., & Anthony, W. (2008). Eliminating seclusion and restraint in recovery oriented crisis services. *Psychiatric Services, 59*(10), 1198-1202.
- Ayres, L., & Poirier, S. (1996). Virtual text and the growth of meaning in qualitative analysis. *Research in Nursing & Health, 19*, 163-169.

- Baker, J., Bowers, L., & Owiti, J (2009). Ward features associated with high rates of medication refusal by patients: a large multi-centred survey. *General Hospital Psychiatry*, 31, 80-89.
- Bandyopadhyay, M. (2006). Competing masculinities in a prison. *Men and Masculinities*, 9(2), 186-203.
- Barton, S., Johnson, R., & Price, L. (2009). Achieving restraint-free on an inpatient behavioural health unit. *Journal of Psychosocial Nursing*, 47(1), 34-40.
- Beasley, C. (2008). Rethinking hegemonic masculinity in a globalizing world. *Men and Masculinities*, 11(1), 86-103.
- Beccaria, C. (1995) [1764]. *On Crime and Punishments [Dei delitti e delle pene]*. Trans. Richard Brian Davies. Cambridge: Cambridge University Press.
- Becker, H. (1967). Whose side are we on? *Social Problems*, 14(3): 234-247.
- Bell, S. E. (1999). Narratives and lives: Women's health politics and the diagnosis of cancer for DES daughters. *Narrative Inquiry*, 9(2), 1-43.
- Berg, A., Marie, Hem, E., Lau, B., Loeb, M., & Ekeberg, O. (2003). Suicidal ideation and attempts in Norwegian police. *Suicide and Life Threatening Behavior*, 33(3), 302-313.
- Berg, B. L. (2009). *Qualitative Research Methods for the Social Sciences* (7th Edition). New York: Pearson.
- Best, J. (1995). Constructionism in Context. In J. Best (Ed.), *Images of issues: Typifying contemporary social problems* (pp. 337-354). New York: Aldine de Gruyter.
- Bird, C. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry*, 11(2), 226-248.
- Bird, S. (1996). Welcome to the men's club: Homosociality and the maintenance of hegemonic masculinity. *Gender & Society*, 10(2), 120-132.
- Birzer, M.L., & Tannehill, R. (2001). A more effective training approach for contemporary policing. *Police Quarterly*, 4(2), 233-252.
- Bjorkdahl, A., Palmstierna, T., & Hansebo, G. (2010). The bulldozer and the ballet dancer: Aspects of nurses' caring approaches in acute psychiatric intensive care. *Journal of Psychiatric and Mental Health Nursing*, 17, 510-518.
- Bogard, W. (1996). *The Simulation of Surveillance: Hypercontrol in Telematic Societies*. Cambridge: Cambridge University Press.

- Borochowitz, D. Y. (2005). Teaching a qualitative research seminar on sensitive issues: An autoethnography. *Qualitative Social Work*, 4(3), 347-362.
- Bosworth, M., & Carrabine, E. (2001). Reassessing resistance: Race, gender and sexuality in prison. *Punishment & Society*, 3(4), 501-515.
- Brandenburg, R. T., & Davidson, C. (2011). Transcribing the unsaid: Finding silence in a self-study. *Reflective Practice*, 12(6), 703-715.
- Britton, D. (1997). Gendered organizational logic: Police and practice in men's and women's prison. *Gender & Society*, 11(6), 796-818.
- Britton, D. M. (2000). The epistemology of the gendered organization. *Gender & Society*, 14(3), 418-434.
- Britton, D. M. (2003). *At work in the iron cage: Prison as a gendered organization*. New York: New York University Press.
- Brown, J. (1998). Aspects of discriminatory treatment of women police officers serving in England and Wales. *British Journal of Criminology*, 38(2), 265-282.
- Brown, M.C., & Carlson, R.D. (1993). Do male policemen accept women on patrol yet?: Androgyny, public complaints and dad. *Journal of Police and Criminal Psychology*, 9(1), 10-14.
- Brown, J., & Sargent, S. (1995). Policewomen and firearms in British police service. *Policing*, 18(2), 1-16.
- Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry*, 18, 1-21.
- Brunner, C. (2000). Unsettled moments in settled discourse: Women superintendents' experiences of inequality. *Educational Administration Quarterly*, 36(1), 76-116.
- Bryant, L., & Livholts, M. (2007). Exploring the gendering of space by using memory work as a reflexive research method. *International Journal of Qualitative Methods*, 6(3), 29-44.
- Buerger, M.E. (1998). Police training as pentecost: Using tools significantly ill-suited to the purpose of reform. *Police Quarterly*, 1, 27-63.
- Burke, R. J. & Mikkelsen, A. (2005). Gender issues in policing: Do they matter? *Women in Management Review*, 20(2), 133-143.
- Burligame, D., & Baro, A.L. (2005). Women's representation and status in law enforcement: Does CALEA involvement make a difference? *Criminal Justice Policy Review*, 16(4), 391-411.
- Butler, J. (1988). Performative acts and gender constitution: An essay in phenomenology and

- feminist theory. *Theatre Journal*, 40(4), 519-531.
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.
- Butler, J. (1997). *Excitable speech: A politics of the performative*. London: Routledge.
- Butler, J. (2000). Restaging the Universal: Hegemony and the limits of formalism. In J. Butler, E. Laclau and S. Zizek *Contingency, hegemony, university: Contemporary debates on the left* (pp. 11-43). London: Verso.
- Butz, D., & Besio, K. (2004). The value of autoethnography for field research in transcultural settings. *Professional Geographer*, 56(3), 350-360.
- Calderwood, D. (1987). The male rape victim. *Medical Aspects of Human Sexuality*, 21(5), 53-54.
- Carlson, M. (2009). *Man up or punk out: The role of masculinity in prison rape* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses database. (Umi No. 3383649)
- Carrigan, T., Connell, R. W., & Lee, J. (1985). Towards a new sociology of masculinity. *Theory and Society*, 14(5), 551-604.
- Cavanagh, K., Dobash, R., Dobash, Russell, & Lewis, R. (2001). 'Remedial Work': Men's strategic responses to their violence against intimate female partners. *Sociology*, 35(3), 695-714.
- Chappell, A. T., & Lanza-Kaduce, L. (2010). Police academy socialization: Understanding the lessons learned in a paramilitary-bureaucratic organization. *Journal of Contemporary Ethnography*, 39(2), 187-214.
- Clatterbaugh, K. (1998). What is problematic about masculinities? *Men and Masculinities*, 1(1), 24-45.
- Cleary, M., Hunt, G., & Walter, G. (2010). Seclusion and its context in acute inpatient Psychiatric care. *J Med Ethics*, 36, 459-462.
- Cohn, C. (2000). "How can she claim equal rights when she doesn't have to do as many push-ups as I do?": The framing of men's opposition to women's equality in the military. *Men and Masculinities*, 3(2), 131-151.
- Coles, R. (1989). *The call of stories: Teaching and the moral imagination*. Boston, Massachusetts: Houghton Mifflin Company
- Coles, T. (2008). Finding space in the field of masculinity: Lived experiences of men's masculinities. *Journal of Sociology*, 44(3), 233-248.

- Coles, T. (2009). Negotiating the field of masculinity: The production and reproduction of multiple dominant masculinities. *Men and Masculinities*, 12(1), 30-44.
- Collier, R. (1998). *Masculinities, crime and criminology: Men, heterosexuality and the criminal(ised) other*. London: Sage.
- Collinson, D., & Hearn, J. (1994). Naming men as men: Implications for work, organization and management. *Gender, Work and Organization*, 1(1): 2-22.
- Connell, R. W. (1985). Theorising gender. *Sociology*, 19(2), 260-272.
- Connell, R. W. (1987). *Gender and power: Society, the person, and sexual politics*. Oxford, England: Polity Press.
- Connell, R. W. (1993). The big picture: Masculinities in recent world history. *Theory and Society*, 22(5), 597-623.
- Connell, R. W. (1995). *Masculinities*. Cambridge: Polity
- Connell, R. W. (1998). Men in the world: Masculinities and globalization. *Men and Masculinities*, 1(1), 3-23.
- Connell, R. W. (2000). *The men and the boys*. Cambridge: Polity.
- Connell, R. W. (2002). *Gender*. Cambridge: Polity.
- Connell, R. W. (2005). *Masculinities*. Cambridge: Polity Press.
- Connell, R. W. (2009). *Gender*. Cambridge: Polity Press.
- Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender and Society*, 19(6), 829-859.
- Conti, N. (2011). Weak links and warrior hearts: A framework for judging self and 'others' in police training. *Police Practice and Research*, 12(5), 410-423.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd edition). Thousand Oaks, CA: Sage.
- Crewe, B. (2006). Male prisoners' orientations towards female officers in an English prison. *Punishment & Society*, 8(4), 395-421.
- Crocker, J. W., Stargatt, R., & Denton, C. (2010). Prediction of aggression and restraint in child inpatient units. *Australian and New Zealand Journal of Psychiatry*, 44, 443-449.
- Crouch, M., & McKenzie, H. (2006). The logic of small samples in interview-based qualitative

- research. *Social Science Information*, 45(4), 483-499.
- Crusemann, M. (2001). Irredeemably hostile to women: Anti-Jewish elements in the exegesis of the dispute about women's right to speak (1 Cor. 14.34-35). *Journal for the Study of the New Testament*, 23(79), 19-36.
- Curran, S. (2007). Staff resistance to restraint reduction: Identifying and overcoming barriers. *Journal of Psychosocial Nursing and Mental Health Services*, 45(5), 45-50.
- Darien, A. (2002). The alter ego of the patrolman? Policewomen and the discourse of difference in the NYPD. *Women's Studies*, 31(5), 561-609.
- Davison, J. (2004). Dilemmas in research: Issues of vulnerability and disempowerment for the social worker/researcher. *Journal of Social Work Practice*, 18(3), 379-393.
- De Freitas, E. (2007). Research fictions: Arts-informed narratives that disrupt the authority of the text. *Interchange*, 38(4), 335-350.
- Dej, E., & Kilty, J. M. (2012). 'Criminalization Creep': A brief discussion of the criminalization of HIV/AIDS non-disclosure in Canada. *Canadian Journal of Law and Society*, 27 (1), 55-66.
- Delaney, K. (2006). Evidence base for practice: Reduction of restraint and seclusion use during child and adolescent psychiatric inpatient treatment. *Worldviews on Evidence-Based Nursing*, 3, 19-30.
- Dell, C. A., Fillmore, C. J., & Kilty, J. M. (2009). Looking back 10 years after the harbour inquiry: Ideology, policy, practice, and the federal female prisoner. *The Prison Journal*, 89(3), 286-308.
- Denzin, N. (2002). Confronting ethnography's crisis of representation. *Journal of Contemporary Ethnography*, 31(4), 482-490.
- Deutsch, N. L. (2004). Positionality and the pen: Reflections on the process of becoming a feminist researcher and writer. *Qualitative Inquiry*, 10(6), 885-902.
- Deutscher, I., & Lindsey, L. (2005). *Preventing ethnic conflict: Successful cross-national Strategies*. Lanham, Maryland: Rowman & Littlefield Publishing Group Inc.
- Devor, A. (1989). *Gender blending: Confronting the limits of duality*. Indianapolis: Indiana University Press.
- Dick, P. & Jankowicz, D. (2001). A social constructionist account of police culture and its influence on the representation and progression of female officers. *Policing*, 24(2), 181-199.
- Dick, P. (2005). Dirty work designations: How police officers account for their use of coercive

- force. *Human Relations*, 58(11), 1363-1390.
- Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2006). Blurring boundaries in qualitative health research on sensitive topics. *Qualitative Health Research*, 16(6), 853-871.
- Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2009). Researching sensitive topics: Qualitative research as emotion work. *Qualitative Research*, 9(1), 61-79.
- Doeselaar, M., Slegers, P., & Hutschemaekers, G. (2008). Professionals' attitudes toward Reducing restraint: The case of seclusion in the Netherlands. *Psychiatr Q*, 78, 97-109.
- Donaldson, M. (1993). What is hegemonic masculinity? *Theory and Society*, 22(5), 643-657.
- Donaldson, S. D. (2001). A million jockers, punks, and queens. In D.F. Salo, T. A. Kupers & W.K. London (Eds.), *Prison Masculinities*, (118-126). Philadelphia, PA: Temple University Press.
- Donald, A. (2001). The wal-marting of American psychiatry: An ethnography of psychiatric practice in the late 20th century. *Culture, Medicine and Psychiatry*, 25, 427-439.
- Doucet, A. (2008). "From her side of the gossamer wall(s)": Reflexivity and relational knowing. *Qualitative Sociology*, 31(1), 73-87.
- Duncanson, C. (2009). Forces for good? Narratives of military masculinity in peacekeeping operations. *International Feminist Journal of Politics*, 11(1), 63-80.
- Edley, N., & Wetherell, M. (2001). Jekyll and Hyde: Men's constructions of feminism and feminists. *Feminism & Psychology*, 11(4), 439-457.
- Eigenberg, H. (1989). Male rape: An empirical examination of correctional officer's attitudes toward rape in prison. *The Prison Journal*, 69(1), 39-56.
- Eigenberg, H. (2000). Correctional officer and their perceptions of homosexuality, rape, and prostitution in male prisoners. *Prison Journal*, 80, 415-433.
- Elwood, S., & Martin, D. (2004). 'Placing' interviews: Location and scales of power in qualitative research. *Professional Geographer*, 52(4), 649-657.
- Embrick, D., Walther, C., & Wickens, C. (2007). Working class masculinity: Keeping gay men and lesbians out of the workplace. *Sex Roles*, 56(11), 757-766.
- Ericson, R. (2007). *Crime in an insecure world*. Cambridge, UK: Polity Press.
- Evans, T., & Wallace, P. (2008). A prison within a prison? The masculinity narratives of male prisoners. *Men and Masculinities*, 10(4), 484-507.

- Ezzy, D. (2002). Coding data and interpreting text: Methods of analysis. In D. Ezzy (Ed.), *Qualitative Analysis* (pp. 80-110). Victoria: Routledge.
- Ezzy, D. (2010). Qualitative interviewing as an embodied emotional performance. *Qualitative Inquiry*, 16(3), 163-170.
- Fairman, J., & Happ, M. B. (1998). For their own good?: A historical examination of restraint use. *H E C Forum*, 10,(3-4), 290-299.
- Federman, C. (2012). The mentally ill and civil commitment: Assessing dangerousness in law and psychiatry. In D. Holmes, T. Rudge, A. Perron & I. St-Pierre (Eds.), *(Re)thinking violence in health care settings: A critical approach* (pp. 297-314). Ottawa: Ashgate.
- Fenstermaker, S., West, C. (2002). Doing gender, doing difference: Inequality, power, and institutional change. London, UK: Routledge.
- Ferrell, J. (1998). Criminological *verstehen*: Inside the immediacy of crime. In J. Ferrell & M. Hamm (Eds.), *Ethnography at the edge* (pp. 20-42). Boston, Massachusetts: Northeastern University Press.
- Ferrell, J. (2004). Boredom, crime and criminology. *Theoretical Criminology*, 8(3), 287-302.
- Fielding, N. (1984). Police socialization and police competence. *The British Journal of Sociology*, 35(4), 568-590.
- Fletcher, C. (1996). "The 250lb man in an alley": Police storytelling. *Journal of Organizational Change*, 9(5), 36-42.
- Forman, M. (Director). (1975). *One flew over the Cuckoo's nest* [Film]. New York City: United Artists.
- Foucault, M. (1977). *Discipline and punish: The birth of the prison*, trans. A. Sheridan. New York: Pantheon.
- Foucault, M. (2003). *Society must be defended: Lectures at the Collège de France, 1975-1976*. Trans. D. Macey. New York: Picador.
- Franke, V., & von Boemcken, M. (2011). Guns for hire: Motivations and attitudes of private security contractors. *Armed Forces & Society*, 37(4), 725-742.
- Garcia, V. (2003). "Difference" in the police department: Women, policing, and "doing gender". *Journal of Contemporary Criminal Justice*, 19(3), 330-334.
- Gear, S. (2007). Behind the bars of masculinity: Male rape and homophobia in and about South African men's prisons. *Sexualities*, 10(2), 209-227.
- Gerson, J., & Peiss, K. (1985). Boundaries, negotiation, consciousness: Reconceptualising

- gender relations. *Social Problems*, 32(4), 317-331.
- Giddens, A. (1984). *The constitution of society: Outline of the theory of structuration*. California: University of California Press.
- Gillespie, G. L., Gates, D. M., Miller, M., & Howard, P. K. (2010). Workplace violence in healthcare settings: Risk factors and protective strategies. *Rehabilitation Nursing*, 35(5), 177-184.
- Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Doubleday.
- Gramsci, A. (1971). *Selections from the prison notebooks*. London: Lawrence & Wishart.
- Grbich, C. (2004). The position of the researcher. In C. Grbich *New approaches in social research* (pp. 80-93). Thousand Oaks: Sage Publications.
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin, & Y. S. Lincoln (Eds.), *The sage handbook of qualitative research second ed.* (pp. 253-291). Thousand Oaks: Sage Publications.
- Haarr, R. N. (1997). Patterns of interaction in a police patrol bureau: Race and gender barriers to integration. *Justice Quarterly*, 14(1), 53-85.
- Haarr, R. (2005). Factors influencing the decision of police recruits to drop out of police work. *Police Quarterly*, 8(4), 431-453.
- Haggerty, K. D (2004). Ethics creep: Governing social science research in the name of ethics. *Qualitative Sociology*, 27(4), 391-414.
- Hammersley, M. (2009). Challenging relativism: The problem of assessment criteria. *Qualitative Inquiry*, 15(1), 3-29.
- Hammersley, M. (2010). Reproducing or constructing? Some questions about transcription in social research. *Qualitative Research*, 10(5), 553-569.
- Hannem, S. N. (2008). *Marked by association: Stigma, marginalisation, gender and the families of male prisoners in Canada* (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses database. (Umi No. NR47466)
- He, N., Zhao, J., & Archbold, C. A. (2002). Gender and police stress: The convergent and divergent impact of work environment, work-family conflict, and stress coping mechanisms of female and male police officers. *Policing: An International Journal of Police Strategies & Management*, 25, 687-708.
- Hearn, J. (1996). Is masculinity dead? A critique of the concept of masculinity/masculinities. In M. Mac and Ghaill (Eds.) *Understand Masculinities: Social relations and cultural arenas*

- (pp. 202-217). Birmingham, UK: Open University Press.
- Hearn, J. (2004). From hegemonic masculinity to the hegemony of men. *Feminist Theory*, 5(1), 49-72.
- Hebert, L. A. (2007). Taking 'difference' seriously: Feminisms and the 'man question'. *Journal of Gender Studies*, 16(1), 31-45.
- Heidensohn, F. (1994). "We can handle it out here": Women officers in Britain and the USA and the policing of public order. *Policing and Society*, 4(44), 293-303.
- Hem, E., Berg, A., Marie, & Ekeberg, O. (2001). Suicide in police-a critical review. *Suicide and Life Threatening Behavior*, 31(2), 224-234.
- Herbert, S. (1998). The police subculture reconsidered. *Criminology*, 36(2), 343-369.
- Herbert, S. (2001). 'Hard charger' or 'station queen'? Policing and the masculinist state. *Criminology*, 36(2), 343-369.
- Holdaway, S., & Parker, S. (1998). Policing women police: Uniform patrol, promotion and representation in the CID. *British Journal of Criminology*, 38(1), 40-60.
- Holland, K. (2007). The epistemological bias of ethics review: Constraining mental health. *Qualitative Inquiry*, 13(6), 895-913.
- Holmes, D. (2005). Governing the captives: Forensic psychiatric nursing in corrections. *Perspectives in Psychiatric Care*, 41(1), 3-13.
- Holmes, D., & Federman, C. (2003). Constructing monsters: Correctional discourse and nursing practice. *International Journal of Psychiatric Nursing Research*, 8(3), 942-962.
- Holmes, D., & Federman, C. (2006). Organizations as evil structures. In T. Mason (Ed.), *Forensic psychiatry: Influences of evil* (pp. 15-30). New Jersey: Humana Press.
- Holmes, D., & Murray, J. (2011). Civilizing the 'Barbarian': A critical analysis of behaviour modification programmes in forensic psychiatry settings. *Journal of Nursing Management*, 19, 293-301.
- Holmes, D., & Murray, J. (2012). A critical reflection on the use of behaviour modification programmes in forensic psychiatry settings. In D. Holmes, T. Rudge, A. Perron & I. St-Pierre (Eds.), *(Re)thinking violence in health care settings: A critical approach* (pp. 21-30). Ottawa: Ashgate.
- Holmes, D., Rudge, T., Perron, A., & St-Pierre. (2012). *Re-thinking violence in healthcare settings: A critical approach*. Ottawa: Ashgate.
- Holzworth, R. J., & Wills, C. E. (1999). Nurses' judgments regarding seclusion and restraint of

- psychiatric patients: A social judgment analysis. *Research in Nursing & Health*, 22, 189-201.
- Houston, M., & Kramarae, C. (1991). Speaking from silence: Methods of silencing and of resistance. *Discourse and Society*, 2(4), 387-399.
- Howard, G. W., Howard Donofrio, H., & Boles, J. S. (2004). Inter-domain work-family, family-work conflict and police work satisfaction. *Policing: An International Journal of Police Strategies & Management*, 27, 380-395.
- Howell, A. (2010). "Sovereignty, security, psychiatry: Liberation and the failure of mental health governance in Iraq. *Security Dialogue*, 41(4), 347-367.
- Huckshorn, K. A. (2007). Building a better mental health workforce: 8 core elements. *Journal of Psychosocial Nursing and Mental Health Services*, 45(3), 24-34.
- Huckshorn, K. A. (2004). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services*, 42(9), 22-33.
- Huey, L. J., Ericson, R. V., & Haggerty, K. D. (2005). Policing Fantasy City. In D. Cooley (Ed.), *Re-Imagining Policing in Canada* (pp. 140-208). Toronto: University of Toronto Press.
- Hunt, J. (1990). The logic of sexism among police. *Women and criminal justice*, 1(2), 3- 33.
- Hughes, E (1951). Work and the self. In J.H. Rohrer & Sherif (Eds.), *Social psychology at the crossroads* (pp. 313-323). New York: Harper and Bros.
- Inckle, K. (2010). Telling tales? Using ethnographic fictions to speak embodied 'truth'. *Qualitative Research*, 10(1), 27-47.
- Jacob, J. D. (2012). Working in a violent environment: The pitfall of integrating security imperatives into forensic nursing. In D. Holmes, T. Rudge, A. Perron & I. St-Pierre (Eds.), *(Re)thinking violence in health care settings: A critical approach* (pp. 315-330). Ottawa: Ashgate.
- Jain, S., & Murthy, P. (2006). Madmen and specialists: The clientele and the staff of the lunatic asylum, Bangalore. *International Review of Psychiatry*, 18(4), 345-354.
- Jarviluoma, H., Moisala, P., & Vilkkio, A. (2003). *Gender and Qualitative Methods*. London: Sage Publications.
- Jenkins, N., Bloor, M., Fischer, J., Berney, L., & Neale, J. (2010). Putting it in context: The use of vignettes in qualitative interviewing. *Qualitative Research*, 10(2), 175-198.
- Jenness, V. (2010). From policy to prisoners to people: A 'soft mixed methods' approach to

- studying transgendered prisoners, *Journal of Contemporary Ethnography*, 39(5), 517-553.
- Jenness, V., Maxson, C. L., Sumner, J. M., & Matsuda, K. N. (2010). Accomplishing the difficult, but not impossible: Collecting self-report data on inmate-on-inmate sexual assault in prison. *Criminal Justice Review*, 21(1), 3-30.
- Juritzen, T., Grimen, H., & Heggen, K. (2011). Protecting vulnerable research participants: A Foucault-inspired analysis of Ethics committees. *Nursing Ethics*, 18(5), 640-650.
- Jewkes, Y. (2005). Men behind bars: "Doing" masculinity as an adaptation to prison. *Men and Masculinities*, 8(1), 44-63.
- Jewkes, Y. (2012). Autoethnography and emotion as intellectual resources: Doing prison research differently. *Qualitative Inquiry*, 18(1), 63-75.
- Johnson, B., & Clarke, J. M. (2003). Collecting sensitive data: The impact on researchers. *Qualitative Health Research*, 13(3), 421-434.
- Johnson, B. (2010). A few good boys: Masculinity at a military-style charter school. *Men and Masculinities*, 12(5), 575-596.
- Johnston, L. (1999). Private policing in context. *European Journal on Criminal Policy and Research*, 7, 175-196.
- Jones, T., & Newburn, T. (1998). *Private security and public policing*. Oxford: Clarendon Press.
- Kanter, R. M. (1977). *Men and women of the corporation*. New York: Basic Books, Inc.
- Karp, D. (2010). Unlocking men, unmasking masculinities: Doing men's work in prison. *The Journal of Men's Studies*, 18(1), 63-83.
- Katz, J. (2004). On the rhetoric and politics of ethnographic methodology. *Annals of the American Academy*, 595, 280-308.
- 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.
- Kilty J. M. (2008). *Resisting confined identities: Women's strategies of coping in prison* (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses database. (Umi No. NR46806)
- Kilty, J. M. (2012). It's like they don't want you to get better: Psy control of women in the

- carceral context. *Feminism & Psychology*, 22(2), 162-182.
- Kimmel, M. (1994). Masculinity as homophobia. In E. Disch (Ed.) *Reconstructing gender: A multicultural anthology* (pp. 132-139). Mountain View: CA: Mayfield Publishing Company.
- Korobov, N. (2011). Young men's vulnerability in relation to women's resistance to emphasized femininity. *Men and Masculinities*, 14(1), 51-75.
- Kraska, P. B., & Kappeler, V. E. (1992). To serve and pursue: Exploring police sexual violence against Women. *Justice Quarterly*, 12(1), 85-109.
- Kraska, P. B., & Kappeler, V. E. (1997). Militarizing American police: The rise and normalization of paramilitary units. *Social Problems*, 44(1), 1-18.
- Kruttschnitt, C., & Gartner, R. (2004). *Marking time in the golden state: Women's imprisonment in California*. Cambridge: Cambridge University Press.
- Kupers, T. (2005). Toxic masculinity as a barrier to mental health treatment in prison. *Journal of Clinical Psychology*, 61(6), 713-724.
- Kurtz, D. L. (2006). *Controlled burn: The gendering of stress, burnout, and violence in modern policing* (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses database. (Umi No. 3229972)
- Kurtz, D. L. (2008). Controlled burn: The gendering of stress and burnout in modern policing. *Feminist Criminology*, 3(3), 216-238.
- Kvale, S. (2006). Dominance through interviews and dialogues. *Qualitative Inquiry*, 12(3), 480-500.
- Laker, C., Gray, R., & Flach, C. (2010). Case study evaluating the impact of de-escalation and physical intervention training. *Journal of Psychiatric and Mental Health Nursing*, 17, 222-228.
- Lakeridge Health (2011). *Mission & Values*. Retrieved March 26, 2012, from <http://www.lakeridgehealth.on.ca/article.php?id=9TB-69U&navID=listMenuRootH>
- Lalor, J., Begley, M., & Devane, D. (2006). Exploring painful experiences: impact of emotional narratives on members of a qualitative research team. *Journal of Advanced Nursing*, 56(6), 607-616.
- Lancaster, G. A., Whittington, R., Lane, S., Riley, D., & Meehan, C. (2008). Does the position of restraint of disturbed psychiatric patients have any association with staff and patient injuries? *Journal of Psychiatric and Mental Health Nursing*, 15, 306-312.
- Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. New

York: Routledge.

- Lavigne, M. (2008). *Research and analysis of malpractice in the field of private security*. (Masters Thesis). Retrieved from ProQuest Dissertations and Theses database. (Umi No. MR48637)
- LeBel, J., & Goldstein, R. (2005). The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatric Services*, 56(9), 1109-1114.
- Leifer, R. (1990). Introduction: The medical model as the ideology of the therapeutic state. *The Journal Of Mind and Behaviour*, 11(3 & 4), 247-258.
- Leyser, O. (2003). Doing masculinity in a mental hospital. *Journal of Contemporary Ethnography*, 32(3), 336-359.
- Liberman, R. P. (2006). Elimination of seclusion and restraint: A reasonable goal? *Psychiatric Services*, 57, 576.
- Librett, M. (2010). Apples and oranges: Ethnography and the IRB. *Qualitative Research*, 10(6), 729-747.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA: Sage.
- Lindsey, P. (2009). Psychiatric nurses' decision to restrain: The association between empowerment and individual factors. *Journal of Psychosocial Nursing*, 47(9), 41-49.
- Loader, I. (2000). Plural policing and democratic governance. *Social and Legal Studies*, 9, 323-345.
- Lonsway, K.A. (2003). Tearing down the wall: Problems with consistency, validity, and adverse impact of physical agility testing in police selection. *Police Quarterly*, 6(3), 237-277.
- Lukes, S. (1974). *Power: A Radical View*. Basingstoke: Macmillan.
- Lundy, P., & McGovern, M. (2006). The ethics of silence. *Action Research*, 4(1), 49-64.
- Macy, D. (2007). Using electronic wristbands and a triage protocol to protect mental health patients in the emergency department. *Journal of Nursing Care Quality*, 22(2), 180-184.
- Manzo, J. (2004). The folk devil happens to be our best customer: Security officers' orientations to 'youth' in three Canadian shopping malls. *International Journal of the Sociology of Law*, 32, 243-261.
- Marion, N. (1998). Police academy training: Are we teaching recruits what they need to know? *Policing: An International Journal of Police Strategies & Management*, 21(1), 54-79.
- Martin, P. (2001). 'Mobilizing Masculinities': Women's experiences of men at work.

- Organization*, 8(4), 587-618.
- Martin, S. (1991). The effectiveness of affirmative action: The case of women in policing. *Justice Quarterly*, 8(4), 489-504.
- Martino, W. (2008). The lure of hegemonic masculinity: Investigating the dynamics of gender relations in two male elementary school teachers' lives. *International Journal of Qualitative Studies in Education*, 21(6), 575-603.
- Mason, T. (2006). *Forensic Psychiatry: Influences of Evil*. Totowa, New Jersey: Humana Press Inc.
- Mason-Whitehead, E., & Mason, T. (2012). Assessment of risk and special observations in mental health practice: A comparison of forensic and non-forensic settings. In D. Holmes, T. Rudge, A. Perron & I. St-Pierre (Eds.), *(Re)thinking violence in health care settings: A critical approach* (pp. 223-234). Ottawa: Ashgate.
- Mason, T., & Chandley, M. (1999). *Managing violence and aggression: A manual for nurses and health care workers*. Edinburgh: Churchill Livingstone.
- Mathiesen, T. (1974). The unfinished. In T. Mathiesen *The politics of abolition: Essays in political action theory*. Oxford: Martin Robertson.
- Maton, K. (2003). Pierre Bordieu and the epistemic conditions of social scientific knowledge. *Space & Culture*, 6(1), 52-65.
- Mauthner, N., & Doucet, A. (1997). Reflections on a voice-centered relational method: Analyzing maternal and domestic voices. In J. Ribbens & R. Edwards (Eds.), *Feminist dilemmas in qualitative research: Public knowledge and private lives* (pp. 119-146). London: Sage.
- Mauthner, N., & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology*, 37(3), 413-431.
- Mayers, P., Keet, N., Winkler, G., & Flisher, A. J. (2010). Mental health service users' perceptions and experiences of sedation, seclusion and restraint. *International Journal of Social Psychiatry*, 56(1), 60-73.
- McLellan, E., MacQueen, K., & Neidig, J. (2003). Beyond the qualitative interview: Data preparation and transcription. *Field Methods*, 15(1), 63-84.
- McIlveen, P. (2008). Autoethnography as a method for reflexive research and practice in vocational psychology. *Australian Journal of Career Development*, 17(2), 13-21.
- Merton, R., Fiske, M., & Kendall, P. (1990). *The focused interview: A manual of problems and procedures* (2nd edition). New York: Free Press.

- Messerschmidt, J. W. (1993). *Masculinities and crime: Critique and reconceptualization of theory*. Lanham, MA: Rowman & Littlefield Publishers.
- Messerschmidt, J. W. (1997). *Crime as structured action: Gender, race, class and crime in the making*. Thousand Oaks, CA: Sage.
- Messerschmidt, J. W. (2000). Becoming “real men”: Adolescent masculinity challenges and sexual violence. *Men & Masculinities*, 2(3), 286-307.
- Micucci, A. (1998). A typology of private policing operational styles. *Journal of Criminal Justice*, 26(1), 41-51.
- Mies, M. (1991). Women's research or feminist research? In Mary Margaret Fonow, & Judith A. Cook (Eds.), *Beyond methodology: Feminist scholarship as lived research* (pp. 60-84). Bloomington: Indiana University.
- Migon, M. N., Coutinho, E. S., Huf, G., Adams, C. E., Cunha, G. M., & Allen, M. H. (2008). Factors associated with the use of physical restraints for agitated patients in psychiatric emergency rooms. *General Hospital Psychiatry*, 30, 263-268.
- Miller, S. L., Forest, K. B., & Jurik, N. C. (2003). Diversity in blue: Lesbian and gay police officers in a masculine occupation. *Men and Masculinities*, 5(4), 355-385.
- Miller, S. L. (1998). Rocking the rank and file: Gender issues and community policing. *Journal of Contemporary Criminal Justice*, 14(2), 152-172.
- Moller, M. (2007). Exploiting patterns: A critique of hegemonic masculinity. *Journal of Gender Studies*, 16(3), 263-276.
- Monaghan, L. (2002). Regulating ‘unruly’ bodies: Work tasks, conflict and violence in Britain’s night-time economy. *British Journal of Sociology*, 53(3), 403-429.
- Moore, D. (1999). Gender traits and identities in a masculine organization: The Israeli police force. *Journal of Social Psychology*, 139(1), 49-68.
- Morash, M., & Haarr, R. (1995). Gender, workplace problems and stress in policing. *Justice Quarterly*, 12(1), 113-135.
- Morgan, F., Foster, V., & Kolbert, J. (2000). Promoting the moral and conceptual development of law enforcement trainees: a deliberate psychological educational approach. *Journal of Moral Education*, 29(2), 203-218.
- Moylan, L. B. (2009). Physical restraint in acute care psychiatry: A humanistic and realistic nursing approach. *Journal of Psychosocial Nursing*, 47(3), 41-47.
- Murphy, C., & Clarke, C. (2005). Policing communities and communities of policing: A comparative study of policing and security in two Canadian communities. In D. Cooley

- (Ed.), *Re-Imagining Policing in Canada* (pp. 209-259). Toronto: University of Toronto Press.
- Murphy, E., & Dingwall, R. (2007). Informed consent, anticipatory regulation and ethnographic practice. *Social Science & Medicine*, 65, 2223-2234.
- Murray, T., & McKim, E. (2000). Introduction: The policy issues in policing and contract security, Canadian Association of Chiefs of Police, *Police Futures Group Study Series*, 1, 4-14.
- Nolan, T. (2009). Behind the blue wall of silence. *Men and Masculinities*, 12(2), 250-257.
- O'Keefe, T. (2006). Menstrual blood as a weapon of resistance. *International Feminist Journal of politics*, 8(4), 535-556.
- Ontario Mental Health Act. (1990). R.S.O. 1990, Chapter M.7. Retrieved November 06, 2010, from <http://www.search.e-laws.gov.on.ca/en/isysquery/89dfb48a-0d96-492a-90ea28d7e7433cd7z/12/doc/?search=browseStatutes&context=#hit1>
- Padavic, I. (1991). The re-creation of gender in a male workplace. *Symbolic Interaction*, 14(3), 279-94.
- Perron, A., & Rudge, T. (2012). Exploring violence in a forensic hospital: A theoretical explanation. In D. Holmes, T. Rudge, A. Perron & I. St-Pierre (Eds.), *(Re)thinking violence in health care settings: A critical approach* (pp. 89-106). Ottawa: Ashgate.
- Petersen, A. (2003). Research on men and masculinities: Some implications of recent theory for future work. *Men and Masculinities*, 6(1): 54-69.
- Philaretou, A. G., & Allen, K. R. (2006). Researching sensitive topics through autoethnographic means. *The Journal of Men's Studies*, 14(1), 65-78.
- Phillips, C., & Earle, R. (2010). Reading difference differently? Identity, epistemology and prison ethnography. *British Journal of Criminology*, 50(2), 360-378.
- Piché, J., & Walby, K. (2010). Problematizing carceral tours. *The British Journal of Criminology*, 50(3), 570-581.
- Pile, S. (1994). Masculinism, the use of dualistic epistemologies and third space. *Antipode*, 26(3), 255-277.
- Poirier, S. & Ayres, L. (1997). Endings, secrets and silences: Overreading in narrative inquiry. *Research in Nursing & Health*, 20, 551-57.
- Power, P. (2012). Hospital policies regarding violence in the workplace: A discourse analysis. In D. Holmes, T. Rudge, A. Perron & I. St-Pierre (Eds.), *(Re)thinking violence in health care settings: A critical approach* (pp. 67-88). Ottawa: Ashgate.

- Pringle, R. (2005). Masculinities, sport, and power: A critical comparison of Gramscian and Foucauldian inspired theoretical tools. *Journal of Sport & Social Issues*, 29(3), 256-278.
- Prokos, A., & Padavic, I. (2002). "There oughtta be a law against bitches": Masculinity lesson in police academy training. *Gender, Work and Organization*, 9(4), 439-459.
- Pullen, A., & Simpson, R. (2009). Managing difference in feminized work: Men, otherness and social practice. *Human Relations*, 62(4), 561-587.
- Rabe-Hemp, C. E. (2007). Survival in an "all boys club": Policewomen and their fight for acceptance. *Policing: An International Journal of Police Strategies & Management*, 31(2), 251-270.
- Rabe-Hemp, C. E. (2008). Female officer and the ethic of care: Does officer gender impact police behaviors? *Journal of Criminal Justice*, 36, 426-434.
- Rabe-Hemp, C. (2009). POLICEwomen or PoliceWOMEN? Doing gender and police work. *Feminist Criminology*, 4(2), 114-129.
- Remington, P. (1983). Women in police: Integration or separation? *Qualitative Sociology*, 6(2), 118-135.
- Richardson, D. (2007). Patterned fluidities: (Re)Imagining the relationship between gender and sexuality. *Sociology*, 41(3), 457-474.
- Rigakos, G. S. (2002). *The new parapolice: Risk markets and commodified social control*. Toronto: University of Toronto Press
- Rigakos, G. S. (2005). Beyond public-private: Towards a new typology of policing. In D. Cooley (Ed.), *Re-Imagining policing in Canada* (pp. 260-319). Toronto: University of Toronto Press.
- Riley, S. (2001). Maintaining power: Male constructions of 'feminists' and 'feminist values'. *Feminism & Psychology*, 11(1), 55-78.
- Robison, K. M. (2010). *Gender at work on the force* (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses database. (Umi No. 3429072)
- Rosenhan, D. L. (1973). On being sane in insane places. *Science*, 179, 250-258.
- Roulston, K. (2010). Considering quality in qualitative interviewing. *Qualitative Research*, 10(2), 199-228.
- Roulston, K., deMarrais, K., & Lewis, J. B. (2003). Learning to interview in the social sciences. *Qualitative Inquiry*, 9(4), 643-668.

- Rouse, L. (2002). *Marital and sexual lifestyles in the United States: Attitudes, behaviours and relationships in social context*. Binghamton, NY: The Haworth Press Inc.
- The Scarborough Hospital. (2012). *Mission, Vision & Values*. Retrieved March 26, 2012, from <http://www.tsh.to/pages/Mission-Vision--Values>
- Schilt, K., & Westbrook, L. (2009). Doing gender, doing heteronormativity: 'Gender normals', transgendered people, and the social maintenance of heterosexuality. *Gender & Society*, 23(4), 440-464.
- Schlosser, J. (2008). Issues in interviewing inmates: Navigating the methodological landmines of prison research. *Qualitative Inquiry*, 14(8), 1500-1525.
- Schrock, D., & Schwalbe, M. (2009). Men, masculinity, and manhood acts. *Annual Review of Sociology*, 35, 277-296.
- Schultz, D. M. (1993). Police women in the 1950s: Paving the way for patrol. *Women and Criminal Justice*, 4(2), 5-30.
- Shabazz, R. (2009). 'So high you can't get over it, so low you can't get under it': Carceral spatiality and black masculinities in the United States and South Africa.
- Shaw, I. (2008). Ethics and the practice of qualitative research. *Qualitative Social Work*, 7(4), 400-414.
- Shear, K. (1996). 'Not welfare or uplift work': White women, masculinity and policing in South Africa. *Gender & History*, 8(3), 393-41.
- Shefer, T., & Mankayi, N. (2007). The (hetero)sexualisation of the military and the militarization of (hetero)sex: Discourses on male (hetero)sexual practices among a group of young men in the South African military. *Sexualities*, 10(2), 189-207.
- Simons, S., & Mawn, B. (2012). Bullying in the workplace: A qualitative study of newly licensed registered nurses. In D. Holmes, T. Rudge, A. Perron & I. St-Pierre (Eds.), *(Re)thinking violence in health care settings: A critical approach* (pp. 177-188). Ottawa: Ashgate.
- Simpson, R. (2004). Masculinity at work: The experiences of men in female dominated occupations. *Work, Employment & Society*, 18(2), 349-368.
- Simpson, R., & Lewis, P. (2005). An investigation of silence and a scrutiny of transparency: Re-examining gender in organization literature through the concepts of voice and visibility. *Human Relations*, 58(10), 1253-1275.
- Sims, B., Scarborough, K. and Ahmad, J. (2003). "The relationship between police officers attitudes toward women and perceptions of police models", *Police Quarterly*, 6(3), 278-97.

- Singh, A. M., & Kempa, M. (2007). Reflections on the study of private policing cultures: Early leads and key themes. In M. O'Neill, M. Marks, & A. M. Singh (Eds.), *Police Occupational Culture: New debates and directions* (pp. 297-320). Oxford, UK: Elsevier Ltd.
- Skolnick, J. (1966). *Justice without trial*. New York: Wiley and Sons.
- Skrla, L., Reyes, P., & Scheurich, J. (2000). Sexism, silence, and solutions: Women superintendents speak up and speak out. *Educational Administration Quarterly*, 36(1), 44-75.
- Sorokin, P. (1956). *Fads and foibles in modern sociology*. Chicago: H. Regnery Co.
- Sparks, R. (2002). Out of the 'digger': The warrior's honor and the guilty observer. *Ethnography*, 3(4), 556-581.
- St-Pierre, I. (2012). Foucault and the nexus between violence and power: The context of intra/inter professional aggression. In D. Holmes, T. Rudge, A. Perron & I. St-Pierre (Eds.), *(Re)thinking violence in health care settings: A critical approach* (pp. 127-142). Ottawa: Ashgate.
- Sumner, J. M. (2009). *Keeping house: Understanding the transgender inmate code of conduct through prison policies, environments, and culture*. (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses database. (Umi No. 3370096)
- Tewksbury, R., & Potter, R. (2005). Transgender prisoners—a forgotten group. In S. Stojkovic (ed.) *Managing special populations in jails and prisons*, New York: Civic Research Institute.
- Thomas, S. (2012). Examining nurse-to-nurse horizontal violence and nurse-to-student vertical violence through the lens of phenomenology.. In D. Holmes, T. Rudge, A. Perron & I. St-Pierre (Eds.), *(Re)thinking violence in health care settings: A critical approach* (pp. 143-162). Ottawa: Ashgate.
- Tilley, S. (2003). 'Challenging' research practices: Turning a critical lens on the work of transcription. *Qualitative Inquiry*, 9(5), 750-773.
- Tracy, S. (2010). Qualitative quality: Eight "big tent" criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10), 837-851.
- Tracy, S., & Scott, C. (2006). Sexuality, masculinity, and taint management among firefighters and correctional officers: Getting down and dirty with 'America's heroes' and the 'scum of law enforcement'. *Management Communication Quarterly*, 20(1), 6-38.
- Trammell, R. (2011). Symbolic violence and prison wives: Gender roles and protective pairing in men's prisons. *The Prison Journal*, 91(3), 305-324.

- University Health Network (2008). *A Message from our CEO*. Retrieved March 26, 2012, from http://www.uhn.ca/About_UHN/ceo/index.asp
- Violanti, J. M. (1996). *Police Suicide: Epidemic in blue*. Springfield, IL: Thomas Publisher.
- Violanti, J. M. (2004). Predictors of police suicide ideation. *Suicide and Life Threatening Behavior*, 34(3), 277-283.
- Waddington, P. A. J. (1999). Police (canteen) subculture: An appreciation. *British Journal of Criminology*, 39(2), 287-309.
- Walby, K. (2007). On the social relations of research: A critical assessment of institutional ethnography. *Qualitative Inquiry*, 13(7), 1008-1030.
- Watson, T. (2000). Ethnographic fiction science: Making sense of managerial work and organizational research processes with Caroline and Terry? *Organization*, 7(3), 489-510.
- Watson, T. (2003). Strategists and strategy-making: Strategic exchange and the shaping of individual lives and organizational futures? *Journal of Management Studies*, 40(5), 1305-1323.
- Weber, M. (1978). *Economy and society: An outline of an interpretive sociology*. Berkeley: University of California Press.
- West, C., & Zimmerman, D. H. (1987). 'Doing gender'. *Gender and Society*, 1, 125-151.
- Westmarland, L. (2001). *Gender and policing: Sex, power and police culture*. Portland, Oregon: William Publishing.
- Whitehead, S. M. (2002). *Men and masculinities: Key themes and new directions*. Cambridge, UK: Polity.
- Whittington, R., Bowers, L., Nolan, P., Simpson, A., & Neil, L. (2009). Approval ratings of inpatient coercive interventions in a national sample of mental health service users and staff in England. *Psychiatric Services*, 60(6), 792-798.
- Wickramasinghe, M. (2006). An epistemology of gender: An aspect of being as a way of knowing. *Women's Studies International Forum*, 29, 606-611.
- Wingfield, A. (2009). Racializing the glass escalator: Reconsidering men's experiences with women's work. *Gender & Society*, 23(1), 5-26.
- Wortley, R.K., & Homel, R.J. (1993). Police prejudice as a function of training and outgroup contact: A longitudinal investigation. *Law and Human Behavior*, 19(3), 305-317.
- Wozniak, J., & Uggen, C. (2009). Real men use nonlethals: Appeals to masculinity in marketing

- police weaponry. *Feminist Criminology*, 4(3), 275-293.
- Wray, N., Markovic, M., & Manderson, L. (2007). "Researcher saturation": The impact of data triangulation and intensive-research practices. *Qualitative Health Research*, 17(10), 1392-1402.
- Wright, D. (1997). Getting out of the asylum: Understanding the confinement of the insane in the nineteenth century. *Social History of Medicine*, 10(1), 137-155.
- Yoder, J., & Aniakudo, P. (1997). 'Outsider Within' the firehouse: Subordination and difference in the social interactions of african american women firefighters. *Gender & Society*, 11(3), 324-341.
- Young, J. (2011). The bogus of positivism. In J. Young (Chapter 4) *The Criminological Imagination*. Cambridge: Polity Press.

APPENDICES

Date (mm/dd/yyyy): 07/04/2011



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

*APPENDIX A - Ethics Approval Notice***Social Science and Humanities REB****Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Jennifer M.	Kilty	Social Sciences / Criminology	Supervisor
Matthew	Johnston	Social Sciences / Criminology	Student Researcher

File Number: 06-11-26**Type of Project:** Master's Thesis**Title:** Privately Policing the Asylum: The Gendered Narrative of Security Officers in a local hospital

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
07/04/2011	07/03/2012	Ia

(Ia: Approval, Ib: Approval for initial stage only)**Special Conditions / Comments:**

N/A



Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form.

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office

Leslie-Anne Barber
Protocol Officer for Ethics in Research

APPENDIX B – Interview Guide

Semi-Structured Interview Guide

Pseudonym: _____

1. Tell me about how you got involved in doing security work.
2. How did you become employed at the hospital?
3. What were some of the adjustments you needed to make when you initially became employed at the hospital?
4. How did you get along with the other security staff (male and female)?
5. Did you ever feel that security staff did not trust your competency as a security officer?
Medical staff? Mental health patients?
6. In your eyes what makes you a good security officer? What are your weaknesses in security?
7. Do others perceive you as weak in your profession?
8. Do you aspire to another profession? Other areas of policing?
9. Tell me about some of the memorable incidents you had dealing with mental health patients.
10. Describe to me some of your memorable Code Whites (violent patients).
11. Did you see yourself as a team member at the hospital?
12. What is the training like for your job? Is it adequate?
13. Tell me about some of moments where you were frightened on the job.
14. Are there any physical standards you think security should meet working in mental health?
15. What does it mean to be a man in security? A woman?
16. Can you talk to me about what you think might be an ideal image of a security officer?
17. If you do not meet up to this image, can you survive this sort of career?
18. How do you feel about taking part in restraint practices with mental health patients?
19. Do you feel that security is often in control of situations some might feel threaten the safety of the hospital?
20. What is it like working alongside nursing staff in mental health?

21. Has this job changed you in anyway?
22. Tell me about having to conduct duties in the morgue. How does this affect your job, if at all?
23. Tell me about your adjustments having to work shift work.
24. Were you ever promoted at the hospital? If yes, why do you think you were?
25. How does gender impact your job?
26. How do you cope with stresses of the job?
27. How do you resist certain aspects of the job?
28. Have you ever witnessed an incident you considered was “overly” violent?
29. What does reasonable force mean to you?
30. Do you see the hospital as an institution that facilitates patient care?
31. Can you tell me about any times where you were disciplined at work?
32. Can you tell me about any time where your peers were disciplined at work?
33. How do you see Management’s role in the hospital?
34. Do you think you will survive this career? Why/why not?
35. Is there anything else that you would like to share?

APPENDIX C – Verbal/Telephone Recruitment Script

Hello, I am a graduate student working under the direction of Assistant Professor Jennifer Kilty in the Department of Criminology, Faculty of Social Science at the University of Ottawa. I am conducting a research study to learn how private security officers perform, manage and resist aspects of their job while working in a mental health setting.

I am recruiting participants for semi-structured interviews which will take approximately 1-2 hours to complete. Should you choose to participate, you are free to choose where the interview takes place, as the nature of my questioning may be sensitive and I want you to be comfortable discussing events that may be emotionally distressing to you. Likewise, the interviews will be audiotaped unless you feel uncomfortable with this. The physical and electronic versions of the tapes will be kept for five years following the defence of my master's thesis.

Before you make a decision whether or not you would like to participate in this study, I would like you to know that:

1. You do not have to participate (talk with me) if you do not want to.
2. If you choose not to participate (talk with me), you will not suffer any negative consequences
3. If you initially decide you want to participate (talk with me) but change your mind later, we will terminate your participation in the study and you will have the decision whether or not any data you shared with me can be used in this research.
4. By participating you may experience distress and emotional/psychological discomfort before, during or after the interview.
5. The results of the research may be published, but your name will not be used. I ensure that the information you provide me with will be kept confidential and that you will remain anonymous. If you have any questions concerning the research study, please call me on my cell phone or my thesis supervisor Dr. Jennifer Kilty.

Do you have any questions? (answer questions)

Do you want to participate (talk with me)?

☐ Yes

☐ No



APPENDIX D – Informed Consent Form

Title of the study: Privately policing the asylum: The gendered narratives of security officers in a local hospital

Principal Researcher: Matthew Johnston

Graduate Student in the Department of Criminology, Faculty of Social Science, University of Ottawa

Thesis supervisor: Dr. Jennifer Kilty

Assistant Professor in the Department of Criminology, Faculty of Social Science, University of Ottawa

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Researcher Matthew Johnston and Thesis Supervisor Dr. Jennifer Kilty.

Purpose of the Study: The purpose of the study is to help us understand how private security officers manage and/or resist their job in a local mental health setting.

Participation: My participation will consist essentially of attending one interview for approximately 1-2 hours long during which I may be asked a number of questions—sometimes sensitive—pertaining to my employment in healthcare security and interaction with mental health patients, security officers and medical staff at large. The interview has been scheduled for _____ at _____ place during the time of _____.

Risks: Firstly, my participation in this study will entail that I volunteer some personal information, and this may cause me to feel emotional or to experience anxiety or distress before, during or after the interview. I have received assurance from the Principle Researcher that every effort will be made to minimize these risks. The Principal Researcher has provided me with a list of community and mental health services to access should I experience any negative or distressing feelings. Likewise, the Principal Researcher has assured me that he will contact a person of my choosing should I experience discomfort during the interview and subsequently wish to discontinue.

Secondly, I understand that permission from my employer to participate in this study has not been sought or obtained by the Principal Researcher, and the employer's awareness of my participation could result in me being negatively judged by the employer or my fellow colleagues. That being said, I have received assurance from the Principal Researcher that every effort will be made to minimize these risks. Particularly, no electronic communication about the study has been disseminated to a network that is affiliated with my place of employment to help

preserve my anonymity. Likewise, the Principal Researcher has adequately assured me that he will protect the confidentiality of the data I give during the interview.

Benefits: My participation in this study will help re-shape how local and academic communities perceive how mental health patients are treated in psychiatric facilities. Likewise, this knowledge can influence security agencies to re-think their managerial, training and recruitment strategies in the hope that security officials in a position of leadership will steer private security agencies to strengthening patient care.

Confidentiality and anonymity: I have received assurance from the researcher that the information I share will remain strictly confidential. I understand that the contents will be used only for research and analytical purposes related to the objective of the study and that my anonymity will be protected by replacing any information that may identify me in the interview transcripts with a pseudonym, and by never disclosing my participation to another person, participant or my employer. I understand that quotations from the text I share may be published, but that my identity will never be revealed in any publications.

Conservation of data: I understand that the data collected from the interview will be audio-recorded and electronically stored on a password protected computer at all times. The tape recordings of the interview will be kept in the Principal Researcher's home in a locked cabinet, to which no one else has access. Likewise, an electronic copy of the data will be kept on a usb key in a locked cabinet in Supervisor Dr. Jennifer Kilty's office, to which no one other than Dr. Kilty and the Principal Researcher has access. I understand that both the physical and electronic versions of the data will be conserved for a period of five years following the Principal Researcher's master's thesis defence.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, I understand that I have the choice to refuse any data gathered until the time of withdrawal from being used in this study.

Acceptance: I, _____, agree to participate in the above research study conducted by Matthew Johnston of the Department of Criminology, Faculty of Social Science, University of Ottawa, which research is under the supervision of Professor Jennifer Kilty.

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research.

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

Participant's signature:

Date:

Researcher's signature:

Date:

APPENDIX E – Project Debriefing

This study will help us understand how private security officers perform their job in a mental health setting. The interview you have completed today has asked you sensitive questions pertaining to incidents that may have been violent, coercive, embarrassing or difficult to talk about. Understandably, re-calling and discussing these events can lead to feelings of distress or anxiety.

If you feel you are in a position of distress or are having a difficult time right now, we encourage you to call your primary care physician or another mental health provider. There are effective treatments available to help cope with this stress.

Sometimes when people are distressed they think about harming themselves. In the event that you have these types of thoughts, there is an available Crisis Line.

If you have additional questions about this research or your feelings and attitude towards this research, you may contact me, Matthew Johnston, or my thesis supervisor, Dr. Jennifer Kilty

You may also consult the following resources in your community.

Thank you for your participation.

Matthew Johnston, Graduate Student, University of Ottawa, Faculty of Social Science,
Department of Criminology