opinion & debate

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Relationships between residents in secure psychiatric units: are safety and sensitivity really incompatible?

Since the 1960s, Western society has adopted a more liberal attitude to sexuality. Choice of sexual partners, sexual preferences, attitudes and practices are increasingly a matter of individual choice and freedom. These changes, however, have had little impact on the lives of psychiatric in-patients (Eiguer *et al*, 1974; Akhtar *et al*, 1977; Taylor & Swan, 1999). 'Mental illness,' it has been suggested, 'is one of the few disabilities where people run the risk of losing their freedom in order to receive in-patient treatment' (Cook, 2000). This loss of liberty and rights becomes more pronounced in secure settings where mentally disordered offenders can spend a substantial part of their adult (sexual/reproductive) lives. Prisoners in some US state prisons (of medium and low security) are afforded conjugal visits from their married partners, in view of the rights of the latter. Paradoxically, detention in secure units, which we consider a therapeutic and not a punitive measure, places constraints on the formation of new relationships and the maintenance of previously existing ones. New relationships are, in our experience, viewed with more concern than previously existing ones.

There are a number of historical, psychological, political and practical reasons why in-patient sexuality has not received the attention it should. Prohibition or regulation of sexual behaviour among patients tends to fit within a protective–moral discourse. Mental health professionals have legitimate concerns about these relationships: the capacity of patients to consent to sexual intercourse; management of allegations of rape; sexual exploitation of vulnerable patients; unsafe sexual practices; the trading of sex for money and drugs (Windle, 1997); the spread of sexually transmitted diseases; and unexpected pregnancies. There may be additional concerns by hospital staff about family and public disapproval and negative media responses. Much of this anxiety about sexual behaviour can be found in the general population. Openly expressed sexuality among psychiatric in-patients tends to bring to the fore irrational fears and prejudices about 'insanity'. For instance, in the 19th century some commentators argued that psychiatric patients should not be allowed to reproduce so they could not pass on their defective genes (Andrau, 1969). As with public opinion generally, 'professionals [were] most condemning of homosexual acts' (Commons *et al*, 1992). By taking the most cautious strategy possible, psychiatrists often deal with these complex issues by denying the sexuality of psychiatric in-patients (Kobbe, 1988; Cook *et al*, 1994). When overt, sexual behaviour among in-patients is still considered a clinical 'problem' (Buckley & Hyde, 1997).

Unwanted sexual advances

Studies have shown that relationships between psychiatric in-patients are not always reciprocal (Keitner *et al*, 1986; Nibert *et al*, 1989; Batcup, 1994). Warner *et al* (2004) found that of the unwanted invitations or actual sexual activities reported in their study, none of them had ended in sexual intercourse. A recent study (Hales *et al*, 2006) found little evidence of coercion into unwanted relationships in a high-security hospital. In fact, most of these patients reported that if coercion had occurred, this had been elsewhere. It is unlikely that sexual activity was permitted in the units where these studies were conducted. In the absence of evidence, it is difficult to say whether the effect of permitting relationships could be more coercion. There have been homicides reported within Broadmoor Hospital (Gordon, 2007) in the context of homosexual relationships. It may be pointed out that they did not take place within the framework of a policy in Broadmoor which was facilitative of in-patient sexual expression. Additionally, these extremely rare incidents do not merit a total ban on sexual expression; risk management should be in proportion to the (frequency of) risks posed.

Unsafe sexual practices

Studies have indicated a high level of unsafe sexual practices among people with mental illness (Cournos *et al*, 1994; Thompson *et al*, 1997; Windle, 1997). Involvement in the sex trade has been noted and associated with high cocaine misuse, sexually transmitted diseases and self-reported HIV infection (Windle, 1997). Other high-risk

opinion & debate

sexual practices reported in Windle's study (1997) include multiple sexual partners, anal sex with other men, intercourse with bisexual men and with prostitutes. Of this group only 15.9% had received any education about HIV and its transmission. Those who had received HIV education said they were more likely to have used a condom the last time they had sexual intercourse. One study observed HIV sero-prevalence in 5.2% men and 5.3% women (Cournos *et al*, 1994). A recent study found that most participants were able to define 'safe sex', but only a few reported practising it (Hales *et al*, 2006). All of these studies, however, were solely of people with mental illness and there are few controlled studies (e.g. Ramrakha *et al*, 2000). Therefore it is important not to infer that unsafe sexual practices are necessarily more common among people with mental health problems.

Unwanted pregnancies

A study by Baillard-Lapresle (Taylor & Swan, 1999) in a psychiatric hospital in France showed that out of eight reported pregnancies, in no case had contraception been used. Wignath & Meredith (1968) found that the rate of unexpected pregnancies in institutions (in the USA) was only a fifth that of the general population. The authors noted that despite the low rate, a single pregnancy in hospital was sufficient to threaten a whole programme because of adverse publicity. Little has changed in societal attitudes in the few decades since that study was published. It is important to note that pregnancies in the studies cited have taken place in the context of sexual prohibition.

Pregnancy management

Pregnancy in a female resident in a secure hospital unit would rightly be a cause of major concern. Pregnancy in such circumstances is rare, and generally would have been admitted already pregnant.

Staff will need a protocol for ensuring safety of both mother and child. Among other tasks, it will be important to explore the meaning of the pregnancy for the woman herself and for other patients on the unit. Sometimes, given a traumatic childhood or psychosis, pregnancy can seem very threatening and itself trigger self-violence or violence directed at others. Some patients may need support to accommodate the fact that they will never have the opportunity to have or to 'care' for their own children, or have a family. Some of the patients will have already had the devastating experience of having a child removed from their care.

Human rights

It has been suggested that psychiatric 'treatment' often includes coercion involving emotional intimidation, threats and bullying (Cook, 2000). There is a tendency to control every aspect of the patient's life – to manage the therapist's own anxieties, and to infantilise patients. Some argue that such treatment victimises or re-victimises individuals (Jennings, 1994). Article 8 of the Human Rights Act 1998 protects the in-patient's family and personal relationships. The issue of conjugal rights for detained in-patients could therefore be brought to the courts, especially for those in longer-stay units (Macgregor-Morris *et al*, 2001).

Practical issues

A psychiatric in-patient unit is not the most practical place in which to foster tender relationships between patients. Reasons include lack of safe and private space, inadequate staffing and lack of training about patient sexuality (Payne, 1993). Among secure unit residents, women will always be outnumbered by men, and there is a move towards single-sex units at all levels of security. Only a few psychiatric hospitals in Britain have sexual behaviour policies (Taylor & Swan, 1999). Most psychiatric hospitals have unwritten policies prohibiting all such activity. It has been pointed out that there is a greater likelihood of arbitrary responses by ward staff in the absence of a clear written policy (Davison, 1999; Ford *et al*, 2003). The lack of training of clinicians and resulting discomfort can lead to outright homophobia (Mosher, 1991). Those especially vulnerable to discrimination are in-patients with HIV (Cook, 2000). Mossman *et al* (1997) provide a model for hospital policies.

Single-sex wards

There has been a recent drive to segregate patients in mental health units into single-sex wards 'driven by concern about the vulnerability of women to sexual abuse and exploitation in mixed-sex secure settings' (Mezey *et al*, 2005). In a study by Hales *et al* (2006), however, of the two women who reported feeling coerced into a sexual act, one had been coerced on a single-sex ward. Hensley *et al* (2003) showed high levels of coercion between female prisoners in the US prison service, challenging the usefulness of segregating patients into single-sex wards in this regard. Mezey *et al* (2005) concluded that the 'development of single-sex secure units for women may not be justified on the grounds of safety issues alone'.

Psychiatric problems

Psychiatric patients may internalise societal disapproval of their sexuality. Histories of childhood and adult abuse and trauma, lack of self-confidence and very low self-esteem can affect one's predisposition to intimacy (Cook, 2000). The side-effects of psychotropic medication can diminish sexual performance and desire, causing erectile dysfunction in men and anorgasmia in women (Sullivan, 1993). Symptoms of paranoia and social withdrawal can impair patients' abilities to form or maintain relationships. Individuals may lack the interpersonal skills required to initiate relationships in a socially acceptable manner, or to negotiate safe sexual practices. Whole departments are

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opinion & debate

devoted to 'rehabilitating' psychiatric in-patients – to assess and help them with their daily living skills, education and occupation, but practical assistance with and support for intimate relationships has received little attention (Davison, 1999).

Patient relationships

There are arguments in support of institutional facilitation of patient relationships. Patients have not relinquished all their rights through involuntary detention in hospital. Where relationships between patients exist, they have been found to be similar to those between healthy people (Davison, 1999). Patients who are engaged in relationships often feel better as a result (Keitner & Grof, 1981). A relationship involving an in-patient could give hope to other patients; a healthy relationship might well be the panacea for a childhood of emotional deprivation; it could be turned into a therapeutic asset; it could provide an opportunity to understand the patient's difficulties and to work on them in a constructive way (Modestin, 1981). It would afford the individual an external motivator to engage with their clinical team and to make progress.

The prohibition of sexual activity between married couples, where one is an in-patient for several years, can lead to the partner 'at home' forming an adulterous relationship. It could also lead to a sexually frustrated husband or wife in a secure unit having opportunistic sexual liaisons, regardless of whether or not sexual relationships are banned in the unit.

From our own experience, patients experience jealousy where the sexuality of a member of staff member becomes evident, for instance when a female staff member falls pregnant. This does not in any way deter forensic staff from forming relationships (outside of the unit). It would be hypocritical to prevent patients from forming relationships because of concerns about provoking jealous feelings in other patients. An in-patient relationship may in fact give some hope to the other patients in the unit.

Conclusions

Secure units should have written policies which look to accepting patient sexuality and helping patients to manage their sexuality safely both within the unit and after they have returned to the community. All such policies should take into account relevant legislation, including the Sexual Offences Act 2003. The Act makes it unlawful for anyone to have physical relationships with a person who is 'unable to refuse because of or for a reason related to a mental disorder'. In Europe, test cases in secure settings have established the right to marry and found a family, but not the right to sexual intimacy (Fitzgerald & Harbour, 1999).

Clinicians should be mindful that residents on single-sex wards are also vulnerable to abuse, within the context of same-sex relationships. Equally, it should be recognised that mutually acceptable single-sex relationships are just as acceptable within institutions as outside. In deciding which aspects of relationships may be supported, safety is always paramount, closely followed by capacity for free consent. Secure units are, however, also rather public places, so the sensitivities of all who live or work there do have to be taken into account in drawing up policies.

Other aspects of safety include protection for sexually transmitted diseases. Sexual education and healthy relationship groups could be made routinely available to all patients. Provisions must be made for the availability of condoms or contraception for psychiatric in-patients, where appropriate, and policies about this should be transparent. Patients must be given the opportunity, within groups or in individual sessions, if they wish, to ventilate their sexual frustration, which too often is treated as pathology.

Declaration of interest

None.

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opinion & debate

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