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Examining professionals' perspectives on sexuality for service users of a forensic psychiatry unit

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ABSTRACT

Very little is known about the sexual activities of psychiatric patients during their stay in hospital and beyond. In this article, we have explored how mental health professionals working within a forensic psychiatric unit construct the issue of patient sexuality in order to ascertain the range of sexual possibilities open to patients. Drawing on interviews with twenty four participants — psychiatrists and clinical psychologists (clinical staff), we examined how participants made sense of patient sexuality and their clinical judgments in relation to them. Using a thematic analysis, we were able to identify a number of relevant themes emerging, including a) what the limits of acceptable sexual behaviour were judged to be, b) discrimination against transgender and same sex relationships, c) vulnerability among female patients and therapeutic efficacy, and d) an abject fear of patient pregnancy. Furthermore, a general concern throughout was the putative professional conflict between the clinical and ward staff. Further discussion regarding the potential for clearer policy on patient sexuality and further training for professionals is developed in the final section.

1. Introduction

1.1. Patient sexuality and staff angst

Despite increasingly liberal views about sexuality and sexual freedom in western societies (Akhtar, Crocker, Dickey et al., 1977; Giddens, 1992; Weeks, 2003), sexual behaviour among psychiatric inpatients is rarely addressed and provokes anxiety among mental health professionals when it is in policy and research (Mossman, Perlin, & Dorfman, 1997). The restrictions on sexual expression may be especially problematic within forensic inpatient settings where individuals may be detained for significant periods of their adult lives.

Health professionals working with psychiatric patients may have legitimate concerns about their patients' sexuality (Dein & Williams, 2008). These include concerns about the lack of capacity for certain patients to consent to sex (for instance a manic patient who is sexually disinhibited may engage in sexual activity with another patient), the exploitation of vulnerable patients (Windle, 1997), allegations of sexual assault or rape, the spread of HIV and sexually transmitted infections (Meade & Sikkema, 2005; Lagios and Deane, 2007), and unplanned pregnancies. Furthermore inpatient sexuality may meet with disapproval from families and the general public. Additionally, this may result in prurient and damaging media coverage and litigation against health organisations. Previous studies, for example, have highlighted the problem of unwanted sexual advances against psychiatric patients within inpatient units (Keitner et al., 1986; Nibert, Cooper, & Crossmaker, 1989; Batcup, 1994). Gordon, Oyebode, and Minne (1997) reported three incidents of homicide in Broadmoor hospital (a high secure forensic psychiatric hospital in England) within the context of homosexual relationships. These took place several decades ago. However, patients are not the sole cause of sexually inappropriate behaviour and sexual violence within hospitals. In the UK, the National Patient Safety Agency (NPSA, 2006) reported nineteen incidents of alleged rapes in mental health settings run by the National Health Service (NHS). Of these eleven (over 50%) were allegedly committed by professionals. Of the nineteen rapes reported by the NPSA (NPSA, 2006), eight were allegedly carried out by a patient and eleven by a member of staff. In this NPSA report, out of a total of 44,000 incidents harmful to patients within psychiatric hospitals 122 (less than 0.3%) were "sexual incidents," which included thirteen cases of exposure, eighteen of sexual advance, twenty-six of sexual touching, and twenty reports

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of consensual sex. Recent studies have found little evidence of sexual intercourse within psychiatric hospitals (Warner, Pitts, Crawford et al., 2004) or of sexual coercion, although ongoing work is needed (Hales, Romilly, Davison, & Taylor, 2006).

A number of studies have observed risky sexual behaviour involving psychiatric patients (see Meade & Sikkema (2005) for a systematic review), and one study (Cournos et al., 1994) noted HIV sero-prevalence among 5.2% male and 5.3% female psychiatric inpatients in New York City. However, few of these studies (for example, Ramrakha, Caspi, Dickson et al. (2000)) used controlled samples. In the USA Cates, Bond, and Graham (1994) and McDermott et al. (1994) found no differences in condom use between people with a diagnosis of severe mental illness when compared to controls; however one Italian study (Grassi, Pavanati, & Cardelli, 1999) found that people without a mental health diagnosis (60%) were more likely to use condoms on a regular basis when compared to psychiatric patients (35%). It is also difficult to generalise the results of the predominantly American studies to other parts of the world.

Another concern is the likelihood of unplanned pregnancies. However NPSA (2006) reported only three claims for compensation following unwanted pregnancies within NHS mental health settings between 2003 and 2005. Wignath and Meredith (1968) found that the rate of unwanted pregnancies in American psychiatric institutions was lower than that of the general population. There is no evidence that the prohibition of sexual contact on psychiatric wards will improve the safety of inpatients.

While much of the anxiety about sexuality and sexual health described above (unwanted pregnancies, "date rapes," and the spread of venereal diseases) can be found in society generally, the sexuality of psychiatric patients provokes fears unsupported by empirical evidence. These "irrational fears" may stem from historical prejudices about "insanity." For instance, in the 19th and early 20th centuries (when ideas of social Darwinism and eugenics were at their peak), some commentators argued that psychiatric patients should not be allowed to reproduce to prevent the transmission of their "defective genes" (Andrau, 1969; Joseph, 2003; Read, Bentall, & Mosher, 2005).

1.2. Autonomy and rights

The concerns and restrictions surrounding the sexual behaviour of patients in mental health settings raise a number of questions about the care-control dichotomy. In forensic settings such concerns may be heightened in that detention in such units is predicated on the patients' commission of and potential for harmful acts, sometimes of a sexual nature. The sense that they are dangerous and harmful people, regardless of the cause of this dangerousness, provokes additional surveillance, restriction on freedom and a tacit acceptance among the staff and the general public that punishment rather than rehabilitation is warranted. This is counterpoised by a modern view that the pursuit of intimacy and the desire for sexual expression between consenting adults, albeit within culturally prescribed parameters, is considered normal, natural and integral to being a human being (Giddens, 1992). Moreover, Article 8 of the European Convention on Human Rights emphasises the individual's "right to respect for a private life," which includes the right to sexual expression among consenting adults. The prohibition of sexual expression, during lengthy psychiatric admissions, can impact on the formation of new relationships and the maintenance of previously existing ones. This is particularly relevant in forensic settings where patients routinely experience lengthy admissions, and one in five patients in medium secure forensic services has been an inpatient for an excess of 5 years (Jacques et al., 2008).

Longer periods of detention are experienced in high-security forensic units. Importantly, for a significant part of that admission, forensic inpatients may be free of active symptoms and/or undergoing rehabilitative treatment. Additionally, an increasing number of patients in the UK are being admitted to secure facilities for the treatment of a diagnosis of personality disorder, rather than a severe mental illness (SMI), such as schizophrenia or psychotic depression. Patients with a diagnosis of SMI are also required to remain within these hospitals for a period of rehabilitation after the symptoms of their illness have subsided. These inpatients may possess the capacity to consent to sexual acts in spite of their detention.

Coid (1993) observed that the freedom afforded to inpatients to express their sexuality would be influenced by the attitudes of health professionals working within particular settings. Previous studies that have explored such attitudes among nursing staff, to the issue of patient sexuality (Bhui & Puffett, 1994; Cort et al., 2001; Higgins et al., 2006: Ruane & Hayter, 2008) suggest that nurses are generally antipathetic towards inpatient sexual freedoms. These studies suggest that nurses are mostly against inpatients having sexual relationships in a ward environment. Penna and Sheeha (2000) observed that although occupational therapists viewed patients having sexual relationships more positively, they felt constrained by the proscriptive culture of the services in which they worked. Commons, Bohn, Godon, Hauser, and Gutheil (1999) found that mental health professionals were most condemning of homosexual acts. Professional norms of consent and competence were not significant factors in decision-making. The authors urged professionals to reexamine their own prejudices (e.g., homophobia) to clarify their decision-making about institutional policies. In this study, we sought to explore the views of psychiatrists and psychologists, working within forensic services.

2. Aim of the study

We sought to examine the attitudes of psychiatrists and psychologists to inpatient sexual behaviour and their knowledge about institutional policies, their willingness, or otherwise, to permit sexual relationships involving patients, or conjugal visits from external partners. Additionally, we sought to explore what type or level of sexual behaviour might be permissible or denied to patients. We aimed to explore the extent to which allowance of expression of patient sexuality is influenced by moral, religious, institutional and practical considerations.

Ethical approval was obtained from Barnet, Enfield and Haringey NHS Mental Health Research and Ethics Committee, in the UK.

3. Method

3.1. Study design

This was a qualitative study. In this study we undertook semi-structured interviews with psychiatrists and clinical psychologists using an interview guide that was developed following a literature review and through group discussions held. This was then piloted on a small number of clinical staff and revised in accordance to feedback.

3.1.1. Interview guide

The definitive topic guide included nine questions which covered the following areas: (a) professionals' experiences of managing patient sexuality within secure settings, (b) their knowledge of local institutional policy (and whether one existed) in this regard, (c) the circumstances under which these relationships could be allowed, (d) the impact of resources availability, (e) views about the provision of conjugal facilities within secure settings, and (f) any personal beliefs which were influential in their thinking. The interview schedule included one or two vignettes intended to open discussion on patient sexual freedom. (All the participants were offered vignettes). The vignettes described difficult clinical scenarios such as inpatient pregnancy or male homosexuality to explore the issues that would arise, the ensuing team dynamics and feelings of health professionals. An exploration of each answer was sought, challenging the view expressed, with the aim of obtaining as much detail and reasoning for the perspective as possible.