

## **Abstract**

Sexuality in secure mental healthcare has been overlooked in both clinical praxis and academic research. In the UK, there exist no formal policies to inform staff approaches to managing inpatient sexuality. The limited research that has been undertaken in this field has found that often, prohibitive approaches are favoured, which may affect how inpatients conceptualise and experience their sexuality in the long-term. The aim of this study was to identify discursive constructions of inpatient sexuality, as articulated within semi-structured group interviews with inpatients and ward staff from a secure mental healthcare facility in England. The analysis identified constructions of inpatient sexuality within two overarching and conflicting discourses: one of the normalcy and legitimacy of sexual expression in human experience; and the other of risk, wherein sexuality needed to be regulated and obstructed. Inpatients' expressions of sexuality could often only be conceptualised in terms of "organisational misbehaviour", acts that violated the implicit norms and codes of the institution. It is suggested that recoding inpatient sexuality as misbehaviour could have implications for inpatients' long-term recovery.

**Keywords:** sexuality; mental health; secure institutions, organisational misbehaviour

## Introduction

Issues of sexuality in secure mental healthcare have been overlooked historically in both clinical praxis and the academic literature (Brown et al. 2014; Hunter and Ahmed 2016; McCann, 2010; Ruane and Hayter 2008). However, as many as 30% of people in secure mental healthcare report participating in some kind of sexual activity during their time as psychiatric inpatients, often in contravention of policies banning such contact (Warner et al. 2004). Furthermore, research findings suggest that fulfilling intimate and sexual relationships may be associated with positive adjustment to life in mental healthcare services, in the community after discharge, and with other positive mental health outcomes (Gilbert, Rose and Slade 2008; Kawachi and Berkman 2001). Sexuality is essential to the human condition, a fundamental aspect of “the totality of being a person” (McCann 2000, 134) and of vitality as “a manifestation of life, of being alive” (Stern 2010, 3). Consequently, it is paramount that more research is undertaken to explore how inpatient sexuality is managed in secure mental healthcare facilities, and to inform the development of evidence-based policies designed to ensure that inpatient sexuality is addressed appropriately. The purpose of this exploratory study is to provide insight into the prevailing discourses of inpatient sexuality in one secure mental healthcare facility (hospital) located in England<sup>1</sup>. A key concern is how these discourses intersect with broader norms and policies around appropriate and “risky” ward behaviour on the part of inpatients, and the dilemmas this creates for nursing and healthcare staff who are at the frontline in managing potential “misbehaviour”.

Secure mental healthcare facilities typically prohibit sexual or intimate relationships among inpatients (Brown et al. 2014; Deegan, 1999). The prohibitive approach is often justified within discourses that frame inpatients’ desire for intimacy as a distraction from treatment, and an antecedent to unintended harm (Hunter and Ahmed 2016; Ruane and Hayter 2008). There is a paucity of official advice for clinicians in how they might manage inpatient sexuality in secure mental healthcare. The Royal College of Psychiatrists’ (2017) report on sexual boundaries draws attention to inpatients’ rights under the European

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<sup>1</sup> Some people who reside in such facilities are referred to as “forensic” inpatients, because they either have a history of offending and are under a criminal justice section or are believed to pose too great a risk of harm to themselves or others to be cared for in general psychiatric services. The people who took part in the present study are referred to as forensic inpatients.

Convention of Human Rights (ECHR) to pursue romantic relationships, while noting that, according to ECHR, “[clinicians’] interference” may be warranted, for the “protection of [inpatients’] health” (p. 11). The report offers little further guidance to clinicians on the matter.

Research has identified that inpatients experience secure services as “anti-life” – the spaces remove both public freedoms and private comforts, distancing inpatients from their own sexuality and obscuring the sense of meaning in day-to-day life (Brown et al. 2014, 250). This can be understood in relation to the concept of “vitality” developed by Stern (2010) and Fuchs (2013), which emphasises that good mental health is rooted in a “prereflective, undirected bodily self-awareness that constitutes the unnoticed background of all intentional feeling, perceiving, or acting” (Fuchs 2013, 2). “Feeling alive” underpins a sense of engagement with others and with the immediate environment. However, such feelings may be reformatted within the secure mental healthcare environment, influenced by internalised expectations of what the psychiatric experience should be, and by the omnipresent discourse of risk (Jacob and Holmes 2011). Brown et al. (2014) use the term “amputated sexuality” to describe the novel sexualities that emerge as a consequence of being resident in secure mental healthcare spaces. Sexuality becomes an object of uncertainty, an aspect of the self – positioned in discourses of risk and danger – that should be forgotten or concealed. Of concern is that former inpatients may carry their transformed, amputated sexualities into the community upon discharge, and thus have difficulties in re-engaging with their sexual selves when there are greater possibilities for forming intimate and romantic relationships, away from secure services.

### **Staff attitudes**

It has been suggested that secure mental healthcare services in the UK are particularly prohibitive when it comes to inpatient sexual expression, compared to services in some other European countries (Tiwana, McDonald and Völlm 2016). In the UK, policies to determine how staff should respond to inpatient sexual expression are influenced largely by the attitudes and beliefs held by locally-employed clinicians and other staff members (Dein et al. 2016; Mossman, Perlin and Dorfman 1997). Beliefs that people in secure forensic mental healthcare should have sexual agency may conflict with beliefs held by some staff that inpatients are

undeserving of such freedom, given their offending history (Dein et al. 2016; Ruane and Hayter 2008). Regardless of professional background, staff tend to be unaware of policies concerning the management of inpatient sexuality, and generally assume that they do not exist (Dein et al. 2016).

Staff may then tend to view expressions of sexuality and desired intimacy by and between inpatients as instances of “organisational misbehaviour”. Organisational misbehaviour is a term developed by Vardi and Weiner (1996) to refer to actions that although not illegal, are perceived to violate the norms and codes of conduct of an organisation. In principle, acts of organisational misbehaviour are neither intrinsically good nor bad since their evaluation depends on the legitimacy of the norms and codes in question. Whereas some instances of organisational misbehaviour may be deliberately damaging to the organisation, they can also be attempts to preserve individual autonomy in the face of inflexible norms, or systematic resistance to inequitable power relations (Ackroyd and Thompson 1999). Organisational misbehaviour has been seen to be particularly acute in settings where tight control is exerted over sexuality and identity (Fleming and Spicer 2007).

## **The present study**

The literature on sexuality in secure mental healthcare is limited and, consequently, there is little data to inform approaches to managing inpatient sexual expression. The aim of the present study was to examine discursive constructions of secure mental healthcare inpatient sexuality, as produced by inpatients and staff at one secure facility in England. The study took a discourse analytic approach, influenced by Positioning Theory (Davies and Harré 1990), to identify how subject positioning in relation to discourses of inpatient sexuality may constrain and / or facilitate the possibility and legitimacy of inpatient sexual expression.

## **Methods**

### ***Data collection***

Data were collected via semi-structured group interviews, comprised of two to six participants, who were either all ward staff members or all medium or low security

("forensic") inpatients. Staff members were not present in inpatient interviews. Inpatient group interviews were homogenous in terms of gender: There were no mixed-gender mental healthcare wards in the service from where participants were drawn. Staff groups were mixed gender. Five group interviews were conducted with inpatients, and two with ward staff. Group interviews were run in meeting rooms in the wards from where participants were recruited. Each interview lasted for a duration of approximately 45 to 60 minutes. The interviewer was a 28-year-old, white British man.

The interview schedule was developed around a number of themes identified in the existing literature. Questions for inpatients were oriented towards eliciting discussion of intimate, emotional and/or sexual relationships that the participants had developed while residing in secure mental healthcare facilities, and during other times in their lives. They were asked to consider how such relationships were related to their mental health and to their experiences of being secure mental healthcare inpatients. Questions for ward staff were designed to encourage discussions of how inpatients' relationships and expressions of sexuality were, and should be, managed. The interviewer kept his input to a minimum and avoided sharing his perspective on the issues discussed. The group interviews were audio recorded and transcribed verbatim. The accuracy of the transcription was checked against the original recordings.

Group interview method was selected because it was appropriate for identifying how issues of sexuality in a secure mental healthcare setting were represented via the deployment of particular discourses. Given that the purpose of the study was not to collect autobiographical, experiential data, one-to-one interviews were not deemed necessary. A second reason was pragmatic: Accessing wards in a secure mental healthcare facility can be made difficult owing to concerns regarding researcher safety, unpredictable ward events, staff shortages etc., and arranging multiple individual interviews would have posed logistical and time issues. Third, it was hoped that by using group as opposed to individual interviews, there would be more diversity in communication (Kitzinger 1994). The group interviews conducted were characterised by anecdotal stories, jokes and mild teasing, reflecting their informal ethos – a likely consequence of including participants who were known to each other.

### ***Approach to data analysis***

A Foucaultian discourse analytic approach was taken, as this allowed for the identification of discourses that perpetuate the legitimacy of unbalanced power relationships, such as the one between the “psychiatrist” and the “inpatient” (Foucault 1987; Harper 1995). The procedure for conducting a Foucaultian discourse analysis set out by Willig (2013) was followed. Accordingly, the analysis focused on “discursive resources”, or how language was used to construct objects and subjects, and to delineate possibilities for lived experience (Willig 2013). One way that this is accomplished is by subject positioning: People use language to take up subject positions themselves (reflexive positioning) and by positioning others (interactive positioning: Davies and Harré 1990). People are also positioned by others, and by the dominance of locally-prevalent discourses, so they are not necessarily able to choose which subject positions they are able to take up (Parker 1992). Subject positioning has implications for the rights and obligations that an individual can stake claims on and ascribe to others (Moghaddam and Harré 2010). The focus of the analysis here was on how the speakers were positioned (and attempted to position themselves) within the discourses accessed during the group interviews, and how this positioning demarcated possibilities for experience (see Willig 2000).

Two authors (JR and JP) annotated the transcripts extensively with their initial observations, which were then compared to ensure that there was a standard approach to coding. One author (JR) then developed category labels for collections of references to the discursive objects of concern (referred to collectively as “sexuality”, and pre-determined as: sexual desire; sexual contact; solo sexual activity; feelings of attractiveness; romance; emotional / physical intimacy and relationships; sexual relationships). Category labels were developed in an iterative process of finding the most appropriate description for each collection of references. Authors JR and SB then examined more closely the different ways that the discursive objects were constructed, and then turned to identifying the “action-orientation” of the discourses, focusing on the speaker’s discursive practices to consider the purposes served by deploying particular discourses. Subsequently, the lead author (JR) examined how the positioning of subjects – including the participants’ reflexive positioning – within the discourses had implications for the subjects’ possibilities for action (what could be done) and for experience (what could be felt: Willig 2000). The author responsible for this

part of the analysis met with the other authors frequently, to discuss the coherence of the analysis.

## **Participants**

There were 26 participants in total: 16 inpatients (six women, 10 men) and 10 ward staff (three women, seven men). The inpatient participants were aged 18 – 36 years (median = 27 years). The ages of staff participants were not collected. Six staff members were healthcare assistants (HCAs), and there was one of each of senior staff nurse, staff nurse, nursing student, and activity co-ordinator.

Participants were selected by purposive sampling from one low secure and four medium-secure wards of the same mental healthcare facility, located in England. Access to the wards was controlled strictly. Inpatients were not free to leave the wards by their own volition. Average duration of stay on a given ward was 12 to 27 months; although many inpatients resided in a number of wards during their stay at the facility. To be considered for participation in the study, the inpatients had to be aged 18 or over and literate in English. Those who were experiencing cognitive impairment, were otherwise unable to provide informed consent, and / or whose participation was deemed unsuitable by clinical staff were excluded from participation. Recruitment of inpatients was done in consultation with ward staff and clinicians. Staff participants were recruited following direct, informal conversations about the study between the interviewer and the ward staff. No reward or financial incentive was offered to participants.

## ***Ethical approval***

Ethical approval was acquired from an NHS Research Ethics Committee and from the London South Bank University Ethics Panel. Participants gave written informed consent. They were told at the beginning of the group interviews and reminded throughout that they were free to suspend or terminate their participation at any point, and that they could choose not to answer any given question. They were also reassured that data would be kept confidential and would not be shared with clinicians or ward staff unless previously unknown information regarding criminal activity were disclosed. It was made clear to the inpatient participants that

the group interviews were not intended to be therapeutic, and that their participation (or lack of) would have no impact on their experience in the hospital. In the transcripts, participants' names were changed to pseudonyms and any potentially identifying information deleted.

## **Findings**

Inpatients discussed sexuality in broad terms, articulating their experiences of having intimate and sexual relationships, their sexual feelings (for example, feelings of being attracted to people, and being attractive to others), their sexual orientation and their hopes for sexual futures (see also McCann [2010]). Staff members were principally concerned with sexual contact between inpatients. In the context of secure mental healthcare, sexuality was constructed within two main discourses across inpatient and staff group interviews. They are referred to here as: "The normalcy of sexuality" and "Risk, vulnerability, and appropriateness". Tensions arose in the different constructions of sexuality within the two prevailing discourses: In the former, sexuality was seen as an intrinsic aspect of human experience to which inpatients were inevitably entitled and were determined to access; and in the latter, sexual expression was viewed as emblematic of misbehaviour and imbued with risk that staff members were determined to mitigate. The two main discourses surrounding sexuality were a synthesis of other, subordinate discourses, which are all described below, accompanied by illustrative extracts from the group interviews. In the extracts, three spaced full-stops indicate that content has been omitted for brevity. Content that appears in brackets was added by the authors.

### ***The normalcy of feeling sexual***

Inpatients often constructed "feeling sexual" in terms of biological inevitability, and used words like "needs", "urges", and "drives" to position themselves as "ordinary people" whose desire to enact their sexualities was natural and reasonable:

Interviewer: Do you guys think about sex in hospital?

Stephen [Inpatient]: Who doesn't?! [Group laughs].

Will [Inpatient]: We wouldn't be very healthy if we didn't would we?



For some inpatients, thinking about sex was not just “normal”, it was also a claim on health in a context where they were usually positioned as “the unwell”. Such elision of feeling sexual with being healthy was afforded greater legitimacy by references to the beliefs of medical staff regarding the inpatients’ sexual needs. For example, Will reported on conversations he had had with doctors about the effect of antipsychotic medication on his ability to masturbate:

Will: I’ve had past doctors say to me “Have you got any trouble masturbating?” and when I said when I was first on the medication that I did, they were very concerned. They said, “Well we need to reduce it then because it’s important for a young man to have that release”.

Age and gender formed part of the interpretative repertoire associated with the normalcy discourse. As in the extract above, male inpatients often described themselves as “young men” or “young lads” when they discussed masturbation or their desire for sexual contact with others: It was both appropriate and expected for young men to pursue this kind of sexual experience.

For one inpatient participant, Robyn, the sexual freedom associated with being a “young woman” was frustrated by her dual position as an inpatient who was confined within the walls of the mental healthcare facility:

Robyn [Inpatient]: I’m an eighteen year old girl. Of course I think about sex [group laughs].

Nicole [Inpatient]: Yeah. I think it’s different for each individual isn’t it?

Robyn: Yeah. All my friends are, you know...

Nicole: Trying new positions and doing it all [laughs].

Robyn: ...having sexual experiences, and I’m just sitting in hospital thinking, “Oh damn. I could be doing that but I’m not.”

Robyn contrasted her experience of inertia (“*sitting* in hospital”) with her friends’ sexual action: The hospital was a place where real-life action was suspended. As a young

woman, sexual experimentation was a known and legitimate possibility, but not for Robyn, because she was denied the freedoms to “do it all” while she resided as an inpatient. Robyn’s lack of opportunity to have sexual experiences did not mean that she was not a sexual person: She still thought about sex, and positioned in the normalcy discourse, in this respect she was like any other young woman.

Whereas for inpatients the normalcy discourse functioned to legitimise sexual feelings, and enabled inpatients to stake claims on ordinariness and health, for staff participants, it illustrated the futile struggle to try and contain inpatients’ (sexual) behaviour.

Alex [activity co-ordinator]: [Sexual contact between inpatients] is natural isn’t it, I suppose? It’s two humans. If they find each other attractive and they’re stuck here 24/7, I can’t see how they’re not going to. If they can get away with it, they’re going to do it. It is what it is really, isn’t it?

According to Alex, (illicit) sexual contact between inpatients was unavoidable because to be sexual was human nature; meaning that to try and prevent it was futile. Other staff participants suggested that inpatients were sufficiently wilful in their pursuit to be sexual that attempts at curbing their sexual relations could not be successful. As one participant explained, “They can spot a slight window, and they’ll use it.” Thus, sexuality was constructed as “misbehaviour”, and the inpatients positioned as sexual people who would exploit opportunities to misbehave, with the staff powerless to stop them.

### *Sexuality as “feeling alive”*

Some inpatients used a discourse of vitality, the experience of feeling alive and present in the world (Fuchs 2013), when they discussed sexuality:

Will: Someone’s sexual performing skills, if you like, is an important part of them, you know? What makes them there and exist.

For Will, sexuality was the bedrock of subjective experiences of existing as a whole person: Elsewhere, he spoke about the feelings of “completeness” he associated with having a “fulfilling” sex life (McCann 2000). Feelings of vitality and of having meaning in life may

contribute to mental health recovery. Will and many other inpatient participants associated their sexuality with positive mental health (Gilbert, Rose and Slade 2008). Feeling sexual made inpatients feel “normal” and could anchor them in “reality” – particularly important while they resided in a space that was “irreal”, where real life was suspended (Brown et al. 2014; Reavey et al. 2017). Thus, opportunities for sexual expression provided a line of contact with the normality associated with life outside the hospital.

### *Sexuality as a human right*

Within the broader normalcy discourse, sexual experience was also constructed as something that all people had a “right” to pursue. For Nathan, having mental health problems was not a sufficient justification for the imposed celibacy he experienced at the hospital:

Nathan: Just because I have an illness why should I be not allowed to have sex? . . . Just because I’m ill, why can’t I go to the pub for a few hours? I can understand it’s alcohol related and that’s one thing I’m in here for. I can understand that, and drugs are illegal so I can understand that . . . Why can’t I have sex, if I had a girlfriend? . . . It’s a human right.

Whereas the prohibition of substance use was legitimate, the prohibition of sexual contact was viewed as an injustice, because everyone had the legal and moral right to be sexual. To some inpatients, the hospital’s prohibitive approach felt like “discrimination”, because not every inpatient was equal in terms of their capacity (and lack of) to form consensual (sexual) relationships. From Will’s perspective, a more nuanced approach to managing inpatients’ sexual needs and desires was required from staff; but a lack of trust, and a prevailing discourse of risk, meant that absolute prohibition was favoured:

Will: And the higher functioning patients are not trusted to not abuse and exploit that. So relationships are seen as just a no-no. I would be very delicate with somebody who was vulnerable in that sense but they don’t trust that I would do that. That’s why it’s the way it is.

Inpatients described how staff held metaphorical “power of attorney” over their sexual and relational possibilities, which was a source of frustration: Nicole exclaimed, “I might be a vulnerable adult, but I’m thirty-frigging-six, you know what I mean?” To be denied sexual agency was experienced by inpatients as infantilising. However, for staff, inhibiting inpatient sexual contact was part of an overall responsibility for mitigating risk on behalf of people who could not manage it themselves:

John [healthcare assistant]: A lot of them view sex just as a moment in time of euphoria for whatever reason, and then don’t see any kind of negative aspects of it that could potentially happen. I don’t think they’re particularly informed on that.

Inpatients occupied incompatible dual positions of vulnerable (or dangerous) people who were oblivious to the risks associated with sexual contact, and of consenting adults who had the decision-making capacity – and the human right – to express their sexualities and develop relationships with others. For most of the staff participants, the risk and vulnerability discourse was sufficiently powerful to override the possibility that inpatients were suitably positioned to make their own relationship-related decisions.

### ***Risk, vulnerability and appropriateness***

Competing discourses of rights and risks – and the multiple positions occupied by inpatients – generated uncertainty, and staff were unclear as to the priorities and focus of the mental healthcare provision:

Kate [senior health care assistant]: What is the purpose of the ward and with these guys and moving them on? So how do you balance? It’s a kind of struggle for me because I can think people are entitled to have relationships, but in this environment we’re looking at risk, we’re looking at all these issues, and then balancing that up with the potential risks and everything that comes with their background and their rights to maybe have a relationship as any other person would have.

...

John [healthcare assistant]: I suppose it's a question of are we here to manage risk, or are we here to start reintegration?

Kate's liberal attitude regarding the human right to (sexual) relationships was discordant with the more conservative risk discourse prevalent in the hospital. While Kate was concerned about the purpose of the ward, John had a more existential concern regarding his purpose as a staff member. From his perspective, managing risk was incompatible with promoting "reintegration", because the former involved prohibition of sexual contact, whereas reintegration into the community included permissiveness towards sex and relationships. John's rhetorical question illustrated the uncertain terrain that staff members navigated. With a lack of clarity surrounding their role, staff participants often defaulted to the discourse of risk to rationalise their emphasis on managing inpatient safety, rather than supporting something that may contribute to the inpatients' recovery. The risk discourse justified the application of an (unofficial) blanket policy that inhibited inpatient sexuality, even though, from some staff members' perspective, this was tantamount to "punishment".

Although some staff acknowledged that inpatients had the capacity to make decisions regarding relationships, they also had various strategies in place to prevent relationships from forming. Managing the perceived risk associated with inpatients' expressions of sexuality required close surveillance, and implementation of obstructive strategies:

Interviewer: If two people start to partner off like that on the ward, is that tolerated or do people try to intervene and make that stop happening?

Ayo [senior staff nurse]: You can't really because most of our guys have consent. They're consenting adults. We can't really physically pull them apart. However, we would be observing the interactions very, very closely, because knowing your patient you know the risks and vulnerabilities of those people.

Ross [health care assistant]: It won't be like pulling them apart. It would be more every time they're together we'd have someone sit right near them and not letting them in the room on their own.

Here and elsewhere, a discourse of risk, vulnerability and appropriateness demarcated the allocation of power in the ward. Ward staff controlled the inpatients'

experiences and expressions of emotional intimacy, and the discourse policed the boundaries of permitted behaviours, and emotional experiences. Within this discourse, even the most innocuous of sexual expressions by inpatients– such as their discussing people they found attractive – were recoded as misbehaviour, and therefore warranted staff intervention.

### *Obstructing sexuality*

The risk, vulnerability and appropriateness discourse was used to rationalise the protocols in place that managed (and precluded) aspects of the inpatients' sexual expression. In two group interviews, inpatients described how ward staff managed inpatients' use of sex aids for masturbation, as illustrated:

Sophie [Inpatient]: You have to be supervised [to use a sex aid]. Like, you have five minutes then they come and check on you.

Stella [Inpatient]: You have to go to your contraband locker and ask them and then sign it out, and then you walk down the corridor with it [group laughs].

According to Stella, sex aids such as vibrators occupied the same status as other items of restricted use (“contraband”), constructing masturbation from the inpatients' perspective as an illicit or “naughty” activity, and one that could not be performed spontaneously or in privacy. Stella painted a comical picture, accentuating the absurdity of an arrangement that obliged someone to transport a sex aid from her locker to her room in plain view of others. It reinforced the lack of privacy the inpatients experienced and highlighted the sexualised rituals that took place between staff and inpatients. With the possibility for (unintended) voyeurism on the part of the staff (and other inpatients) and exhibitionism on the part of the inpatients, ward policies surrounding the use of sex aids confused professional and sexual boundaries. Masturbation was a possibility; but it was not a solo activity, because staff were inadvertently – though unavoidably – part of the experience.

In negotiating the constant surveillance by staff, and the system of rules and punishments that governed expressions of sexuality, inpatients sometimes engaged in intimate relationships “below the radar” of the ward staff. All inpatients reported that they had either participated in, or were aware of, sexual contact during their admissions, and

generally regarded non-abusive instances of this as beneficial, describing opportunities for shared intimacy as therapeutic, rehabilitative, and in keeping with their human rights. According to inpatients, staff members did not necessarily share these sentiments. Sophie described the staff members' unsuccessful attempts to disrupt a fledgling romantic relationship:

Sophie: They tried to stop it. Which didn't work [laughs].

Interviewer: How did you get around it?

Sophie: We just worked with a plan that we wouldn't sit near each other and that, and eventually they turned around and said, "You can sit back next to each other but there's no messing about and no touchy-touchy."

Sophie's actions were self-acknowledged misbehaviour and were compounded by the failure of the staff's strategy to keep her and her girlfriend separate. Once sexuality became recoded as a matter of organisational misbehaviour – rather than rights, desires or vitality – it was reduced inevitably to a play of defiance. Staff might have had their strategies for obstructing the formation of intimate / potentially sexual relationships, but some inpatients had counter-strategies in the form of shows of resistance against the oppressive discourse of risk.

### *Accountability*

Within the discourse of risk, the least qualified, trained and paid staff – who also had the greatest in-person contact with inpatients – were positioned as the most responsible for policing inpatient sexuality. From the perspective of the healthcare assistants who took part in group interviews, inpatient sexuality could *only* be considered as a matter of misbehaviour, because they were held accountable when it occurred:

*John:* [Our] current role is to ensure that [sexual contact] doesn't happen, essentially. It would be a huge concern whenever it has prospectively looked like it's going to happen or has happened. It's deemed as a failure on our part.

*Kate:* Yeah, it's a flaw. Like, "What happened there? Where were you?"

Risk of harm therefore extended beyond inpatient safety and well-being to the staff members' professional integrity. Some healthcare assistants were critical of the institution for providing insufficient training on matters like dealing with inpatients as sexual people. Kate claimed that policing inpatient sexuality was akin to "feeling in the dark", and Dave reported that healthcare assistants were expected to "use [their] life experiences" to make judgments regarding appropriate ways of managing sexuality on the wards. Healthcare assistants were experts by experience of contact with inpatients ("we are on the ward 99% of the time working alongside these guys"), and yet received "minimal training", and were excluded from any discussion about setting the norms and codes around sexual behaviour that they were expected to enforce rigorously. Inpatients identified inconsistencies in approaches to managing inpatient sexuality between staff members:

Interviewer: Do you feel that it's clear here what you are or aren't allowed to do?

Will: Well actually no, because all staff have a different interpretation of it. I can see patients sometimes play-fighting, some staff will just not say anything, other staff will say, "No. Stop that." Even if it's not sexual they might be kind of perceiving it as such. I've seen some patients having banter and play-fighting with staff and staff not complaining. They're smiling and doing it back and having a laugh and a joke. But other staff would be like, "No, no, no. Don't touch me at all." It varies from person to person.

Banter is a well-studied form of organisational misbehaviour, which is typically considered to be a means of disputing authority in a way that does not invite serious repercussions (Ackroyd and Thompson 1999). By framing interactions between inpatients and staff as "banter", Will (and others) constructed their exchanges as jocular and irreverent, and not intended to be taken seriously. However, from Will's perspective, there was inconsistency in how banter and play-fighting (which is inevitably tactile) were managed between staff members. A lack of clearly defined expectations of inpatients generated uncertainty over which behaviours were deemed appropriate, and which were prohibited and might result in punishment.

### *Liminality*



The pervasiveness of discourses of risk, vulnerability and appropriateness shaped many inpatients participants' expectations of their relational futures beyond the ward. Prior research findings suggest that during their stay in hospital, inpatients' sexuality is transformed by the ward-based rituals and the ethos of prohibition (Brown et al. 2014). In the present study, both inpatients and staff discussed how the recoding of sexual behaviour as misbehaviour could affect the inpatients' ability to have sexual relationships in the long-term. As one healthcare assistant explained, "They don't want to leave here with that baggage of 'I don't want to do that – it's naughty.'" For inpatients, the lack of opportunities to explore intimate and sexual relationships in hospital made them "scared" of exploring such relationships outside.

Nicole [Inpatient]: If you've had relationship difficulties like me for instance, and you've been in for a long time like us two, this is the best place to try [relationships], with the staff support, with your doctors. You know what I mean? To try relationships. Because at the end of the day, why chuck you in the community and you're going to meet the worstest man and get into the vulnerable-est situations, or the worstest woman? You know what I mean? Why not try a relationship here?

As a self-identified "vulnerable adult", Nicole saw the hospital as a place of safety, a secure base from where relationships might be explored. Here, an alternative position for staff within the discourse of risk and vulnerability was opened, one imbued with the responsibility for nurturing inpatients' sexual and relational selves, and scaffolding attempts at forming relationships, rather than frustrating them. Ironically, by "chucking" inpatients into the community without this support, inpatients were only put in greater risk. Although inpatients may have had opportunities for sexual experiences on their unescorted leave that preceded discharge, the prevailing conceptualisation of such experiences as misbehaviour meant that these opportunities were avoided. As Natasha reported, "I feel even if I look at another man I lose my leave."

Inpatients' sexuality was suspended in a liminal space, their potential constrained by the discourse of risk, and the associated prohibition. The potential longer-term risks of treating sexuality as organisational misbehaviour are demonstrated by these examples. If

inpatients are taught to experience their desires for intimacy as matters that are for the most part relative to the norms of the organisation, then the withdrawing of these norms that occurs following transition into the community leaves service users without a coherent framework in which to understand and explore their “sexual freedoms”. In other words, if service users are inculcated into a discourse where sexuality is viewed through the lens of infraction and naughtiness, then the prospects for their future capacity to form and maintain intimate relationships are likely to be compromised.

## **Discussion**

The outcomes of this study may be summarised as follows: 1) sexuality in secure mental healthcare was constructed by inpatients and staff members in discourses of normalcy, vitality, and rights, and in contradictory discourses of risk, accountability, and liminality; 2) the discourse of risk was sufficiently powerful to be “internalised” by staff *and some inpatients*, and as a result, expressions of inpatient sexuality were viewed inevitably as a matter of organisational misbehaviour; 3) a failure to properly engage with the desires and needs of patients around sexuality and personal relationships may create difficulties in both the management of behaviour on wards (i.e., lead to subverted sexual expression), and with respect to longer term recovery; and 4) the absence of formal policy around managing inpatient sexuality may place staff, particularly those who have the least power within the organisation (i.e., health care assistants), in a difficult position where the maintenance of locally negotiated norms is the most available solution.

As identified in previous research, the inpatient participants in this study positioned themselves as people who felt sexual but had few (or no) opportunities to express their sexualities in ways that were sanctioned by ward staff, or made possible by ward practices, including when they were afforded leave (Brown et al. 2014; Deegan 1999; Dein et al. 2016; McCann 2010). Sexuality was a preoccupation for the majority of the inpatients, but to use the nomenclature of Brown et al. (2014), it was manifest only in an amputated form: It was not embodied, but rather existed in a liminal space, temporarily suspended, but nevertheless of great salience. Inpatients deployed a discourse of the normalcy of sexuality, using rhetorical strategies that positioned them as “ordinary people” for whom sexuality was as essential a facet of human existence as it might be for anyone else (McCann 2000). Thus, the

ward staff's prohibitive approach to sexual expression was experienced by inpatients as misbehaviour, and they were infantilised, unable to make decisions surrounding their sexuality, and deemed incapable of doing so. Feeling sexual can be constructed as constitutive of feelings of vitality, wholeness, and contact with reality (Brown et al. 2014; Fuchs 2013; Tiwana, McDonald and Völlm 2016). It has been documented previously that living a meaningful life, which may include positive experiences of sexual and intimate relationships, is associated with mental wellbeing (Kawachi and Berkman 2001; Pitt et al. 2007). Future research may adopt experiential methodological approaches to examine more closely how sexuality is related to feelings of vitality among people who reside within secure mental healthcare facilities.

In order to escape the confines of the risk and vulnerability discourse, many inpatients in this study emphasised what they saw as their human right to feel sexual and to explore their sexual desires, as adults who had the capacity to make decisions (Dein et al. 2016). Although some staff positioned inpatients similarly, others drew on the risk discourse to rationalise their beliefs that inpatient sexuality had no place on the wards of a secure mental healthcare facility. Even those staff who constructed sexuality as human, and a human right, used this discourse to emphasise their positions of responsibility for the wellbeing of the naïve and vulnerable, those for whom sexual expression was not viable. Thus, the risk discourse was used to perpetuate and legitimise the staff's power to prohibit, or at least obstruct, the inpatients' "right" to sexual expression (Foucault 1987; Willig 2013).

The nature of the offences committed by some of the inpatients interviewed for this study was not recorded. Clinicians at the mental healthcare facility discouraged inpatients from dwelling on or discussing their offending histories as part of their pathway to recovery. It is acknowledged that some inpatients may have had histories of sexual offending, contributing to the reluctance of the staff to endorse any sexual expression (Ruane and Hayter 2008). Staff may have to obstruct sexual activity by those who have committed sexual offences, if they believe it to be harmful (Royal College of Psychiatrists 2017); but it is suggested that an approach that recodes all sexual expression as misbehaviour might itself be harmful, since it may drive sexual contact underground, with long-term implications for inpatients' future relationships (Brown et al. 2014).

Recovery and reintegration for inpatients may be the ultimate goal of secure mental healthcare services, but there may be uncertainty as to how sexuality can be accommodated

in these spaces where many other aspects of “real life” are suspended. In the present study, staff were positioned in uncertain roles, not clear as to how sexuality, risk, and the pursuit of inpatient recovery could be reconciled, and engaged in ongoing internal negotiation as to how to enact best practice. Inpatients experienced the inconsistency that arose from this lack of clarity, perhaps consequent of the apparent lack of training for ward staff, and absence of any formal policy or official guidance on managing issues of sexuality and relationships. Inpatient participants were adept at deploying particular discursive strategies that accentuated the humanness, inevitability, and at times, innocence of their sexual and relational needs; and in doing so highlighted the futility of uncertainty and prohibition of these fundamental aspects of human experience.

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