

Title: “You don’t even get a hug”: Negotiating sexuality and relational security in secure mental healthcare

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Abstract:

Relational security in secure mental healthcare can be conceptualised as an outcome of social climate—the physical conditions of the wards and the social relationships that play out within them. Staff knowledge and understanding of detainees in secure mental healthcare is seen as key to maintaining relational security, by facilitating staff responsiveness and personalised care. Discussions of relational security focus principally on patients’ therapeutic relationships, and less so on their relationships with other patients and visitors, which are policed closely within discourses of appropriateness and vulnerability. Patients’ needs and desires for emotional and physical intimacy are overlooked in daily ward life, academic enquiry, and clinical praxis. This chapter describes the experiences of two patients interviewed for our research into intimate and sexual relationality in forensic mental healthcare facilities in England. A case is presented for the development of policies that honour the intimate relational and sexual needs of people in secure care. It is argued that an absence of such policies and a culture of stringent sexual regulation produce disordered sexualities, enacted by patients in subversive and secretive ways. This poses a threat to relational security, and is conducive to neither the formation of effective intimate relationships, nor recovery from mental distress.

Keywords (<6): Sexuality; Intimacy; Relationships; Secure mental healthcare; Relational security; Mental distress

Introduction

Sexuality – including positive relational experiences with self and others – underpins mental health, contributes to recovery from distress, and contributes to “the totality of being a person” (McCann, 2000, p. 134). As such, sexuality is an important dimension of what Stern (2010) and Fuchs (2013) refer to as vitality, or the feeling of being alive. In secure mental healthcare¹ settings, some patients² report experiencing the wards as “anti-life”, spaces where meaning is obscured. In such spaces, sexualities exist in an “amputated” state, suspended in a liminal space until they may be re-embraced in the outside world (Brown, Reavey, Kanyeredzi, & Batty, 2014). These spaces are environments of prohibition, where intimate and sexual relationality, including sexual feelings and behaviours, becomes recoded as “misbehaviour” (Ravenhill et al., 2020). The chapter that follows first addresses the “outside-in”, introducing the concept of relational security and focusing on current practice (“the external”); it then provides an “inside-out” account of two forensic mental health patients’ experiences with sexuality (“the internal”), in order to argue for the need for policy and guidelines to support the wellbeing and recovery of these patients.

Outside-in: Relational security

Secure mental healthcare services in England are differentiated from general adult services on various factors. Unlike the latter, they are exclusively single-gender, and offer “halls of residence”-style accommodation, with access to leisure facilities, creative pursuits, and green spaces. They are also stratified according to the level of risk patients are believed to pose to themselves (low secure), and others (medium and high secure: NHS, 2022). Other mental health services, such as acute psychiatric wards, may have secure conditions in place, but whereas these provide short-term accommodation of up to 30 days, patients residing in secure services tend to stay for prolonged periods, with up to a fifth of those in medium secure and quarter of those in high secure services spending at least a decade in continuous detainment (Hare Duke, Furtado, Guo & Völlm, 2018). People residing in secure services are often referred to as “forensic” patients, either because they have a history of offending and are under a criminal justice section, or are believed to pose too great a risk of harm to be cared for in general mental healthcare. It follows that on these wards, concerns regarding care and security are inevitably, inextricably connected.

“Security” in secure mental healthcare is comprised of three elements: physical (or environmental, including the design of buildings, estates, and observation systems); procedural (e.g.,

¹ Secure mental healthcare services (also “secure services” and “forensic services”) in England provide accommodation and treatment to people experiencing mental distress, who require the provision of security. Patients may enter directly from prison, or from hospitals, sometimes following arrest.

² We use the term patient, as opposed to service-user, to acknowledge the involuntary nature of detention.

the monitoring of patients' movements and communications; risk management and contingency planning); and relational. The latter can be conceptualised in quantitative terms – for example, staff-patient ratio – but also encompasses qualitative aspects, such as the nature of relationships between patients and the care team (Kennedy, 2002; Tighe & Gudjonsson, 2012). These three elements are not mutually exclusive: for example, the physical design of the ward can determine the potential for and quality of in-person contact (see Reavey et al., 2017). All three contribute to ward “safety” and to therapeutic outcomes for patients. However, it is relational security that is arguably the most important for maintaining patients' therapeutic progress and contributing to recovery (Kennedy, 2002). Despite this, when compared to the attention paid in policy, training, research and ward practice to physical and procedural security, relational security has historically been “the poor relation” (Tighe & Gudjonsson, 2012, p. 185). There has been a great deal of attention paid to physical and procedural security, in policy, training, research and ward practice, but in comparison, relational security has been under-considered. This is likely owing to a lack of clarity surrounding how relational security should be defined and measured, (Chester, Alexander & Morgan, 2017). Whilst the quantitative aspects of relational security, often conceptualised via their connection to physical and procedural security, have been operationalised in terms of contact times, staff turnover, staff-patient ratios, etc., the qualitative aspects – including the nomenclature of “boundaries”, and “purposeful” and “therapeutic” relationships – are less well defined, and therefore harder to measure (Chester et al., 2017; Chester & Morgan, 2012; Tighe & Gudjonsson, 2012).

Though not synonymous, social climate and relational security are theoretically similar constructs. “Social climate” encompasses the physical conditions of mental healthcare wards, and the social relationships that play out within them (Doyle, Quayle & Newman, 2017). Relational security might be conceptualised as an *outcome* of the social climate within the ward. Academic interest in psychiatric “ward milieu” dates back to Caudill's ethnographic work in the 1950s (Caudill, 1958), but became formalised with Moos' studies into the differential effects of ward environments on the behaviour of patients and staff, and a growing understanding that the “social atmosphere” of psychiatric wards was likely to influence therapeutic outcomes (Moos, 1967). Moos' observations inspired him to develop the first measure of social atmosphere, the Ward Atmosphere Scale (WAS), that measured relationship dimensions and personal growth opportunities (which map onto relational security) and system maintenance dimensions (which speak to physical and procedural security: Moos & Haus, 1968).

Moos' work is credited with stimulating empirical enquiry into what is now more commonly referred to as “social climate”, and for providing a tool to measure previously unoperationalised

concepts, although it has not been without critique (Alden, 1978; Schalast, Redies, Collins, Stacey & Howells, 2008; Tonkin, 2015). Concerns also exist regarding the relevance of the scale for the 21st Century: the original authors report reading “One Flew Over the Cuckoo’s Nest” to inspire the development of scale items. More recently, Schalast et al. (2008) developed the Essen Climate Evaluation Schema (EssenCES), a measure of psychiatric ward social climate that has received consistent empirical support (Tonkin, 2015). The EssenCES encompasses three factors: therapeutic hold (e.g., “Staff take a personal interest in patient progress”); patients’ cohesion and mutual support (e.g., “The patients care for each other”); and safety (e.g., “Some patients are afraid of other patients”). However, the EssenCES was not developed to measure relational security *per se*, and the scale does not contain items relating to how staff use the information they have about patients, nor how decisions concerning patients are made, so it cannot reliably be used to operationalise this complex construct (Tighe & Gudjonsson, 2012).

Relational security in forensic mental healthcare

Official guidance for staff working in UK forensic mental healthcare, first published in the Royal College of Psychiatrists-commissioned handbook *See, Think, Act*, describes relational security as “the knowledge and understanding we have of a patient and of the environment, and the translation of that information into appropriate responses and care” (Allen, 2015, p. 5). Written for all staff, from clinicians to administrators to domestic staff, and developed in response to a number of “near-miss” security incidents, *See, Think, Act* (STA) comprises four domains: Inside world; Outside world; Team; and Other patients (Allen, 2015; Tighe & Gudjonsson, 2012). Elements in the “Inside world” domain emphasise the importance of knowing patients’ unique histories and “trigger points”, and ensuring that the physical environment is conducive to positive social interactions. The “Outside world” domain is concerned with the management of visitors, and the monitoring of patients’ interactions with people outside of the healthcare service. The “Team” domain centres on the importance of establishing clear boundaries and providing purposeful therapy. “Other patients” focuses on the implications of the dynamic produced by the mix of patients on the ward, and the need for staff to monitor how patients’ interactions with each other (Allen, 2015). Therefore, relational security as conceptualised by the Department of Health/Royal College of Psychiatrists provides a potential conceptual framework for developing policies to manage patients’ relationships both within and outside services.

The STA guidance, and the related tool, the *Relational Security Explorer* (RSE: Department of Health, 2022) emphasise *staff knowing patients’ individual circumstances and histories*, echoing the “personalisation” agenda set out in the National Health Service (NHS) England’s (2016) *Five-Year*

Forward View for Mental Health, which also advocates the importance of healthy and stable relationships for recovery. However, the heavy emphasis on the therapeutic benefits of positive *staff-patient* relationships in the STA guidance is inversely mirrored by the jarring absence of any mention of the potential for patients to form (potentially therapeutic) romantic, or emotionally and/or physically intimate relationships *with each other*, and/or to maintain similar, existing connections with people outside. The STA guidance directs staff to be “alert to the possibility of inappropriate attachments to other patients” (Allen, 2015, p. 25), and although it does acknowledge that connections with family and friends should be encouraged, there is no advice as to how staff might navigate patients’ *existing* romantic relationships. Formal guidance and policies to guide clinicians’ management of such relationships do not appear to be forthcoming: The Royal College of Psychiatrists’ (2017, p. 11) report on sexual boundaries in secure mental healthcare acknowledges patients’ rights to pursue romantic relationships during detainment, while noting that, “[clinicians’] interference” may be warranted, for the “protection of [inpatients’] health”. Consequently, individual clinicians, or more often other ward staff, are left to decide whether patients’ intimate/romantic relationships should be facilitated or obstructed, without any formal guidance as to how such decisions might be reached. Confronted with the reality of intimate and sexual relationships forming between patients, some of whom will be detained for many years, mental healthcare providers typically delegate responsibility to individuals – often the least trained, most precariously employed. This leads to the implementation of inconsistent and *ad-hoc* ward-based practices, typically centred on prohibition (Dein et al. 2016; Ravenhill et al., 2020).

Secure mental healthcare providers’ prohibitive approaches to patients’ emotionally and physically intimate relationships are often justified within discourses of vulnerability and risk, wherein patients’ desire for intimacy is constructed as discordant with treatment goals, symptomatic of mental distress, and likely to lead to more harm than good (Bartlett, Mantovani, Cratsley, Dillon & Eastman, 2010; Brown et al., 2014; Hunter & Ahmed, 2016; Ravenhill et al., 2020; Ruane & Hayter, 2008). Staff members’ beliefs that people in forensic mental healthcare should have the agency to initiate and/or maintain intimate and sexual relationships may conflict with beliefs regarding the patients’ rights to such freedom, given their offending history (Dein et al. 2016; Ruane & Hayter 2008). Other concerns held by staff include: doubts about patients’ capacity to consent to sexual activity; risk of sexual exploitation, abuse and violence; the potential for accusations of rape or abuse; the possibility of condomless sex increasing the risk of sexually transmitted infections and HIV transmission; pregnancy; and the possibility of transactional sex (Dein, Williams & Dein, 2007; Dein & Williams, 2008; Hunter & Ahmed, 2016; Quinn & Happell, 2016; Series, 2014). In the absence of clear policies, ward staff tend to be, understandably, risk-averse in the way they approach patient

sexuality, and are more likely to interpret intimate relationality – including sexual activity – as instances of “organisational misbehaviour”, or deliberate rule-breaking, rather than as attempts by patients to nourish an important aspect of their personhood (Ravenhill et al., 2020).

Given that detention in secure forensic mental healthcare services arises in part because the person is deemed unsafe to themselves and/or others, it is perhaps not unreasonable that “security” underpins discussions over the freedoms that patients should be able to access. For staff working in forensic mental healthcare, prohibition of intimate connections between patients – and the monitoring of “inappropriate attachments” – is fundamental to maintaining relational security. However, this overwhelming focus on risk management (Jacob & Holmes, 2011), and in particular the heavy emphasis on physical safety (Curtis et al., 2013), has obscured discussion around the potential benefits to relational security of supporting and facilitating intimate and sexual patient relationships where they are wanted and/or occurring. An illustrative example comes from efforts made by the UK’s Care Quality Commission (2018) to address the sexual safety of patients in secure mental healthcare, which focus almost exclusively on issues of consent and predatory behaviour. Although patently extremely important considerations, and part of the healthcare providers’ duty of care, sole focus on them obscures broader interpretations of sexual safety, such as managing emotionality and navigating “feeling sexual”.

Relational security and recovery

Providing support for personal recovery from mental ill-health has become one of the key goals for mental health services in England and Wales (NHS, 2016). Though its meaning remains contested, Shepherd, Boardman and Slade (2008) describe recovery as an individual’s right to a meaningful, hopeful and purposeful life, irrespective of the ongoing presence of “symptoms” of poor mental health. With their emphasis on managing risk, forensic services face significant challenges in honouring a commitment to a recovery-focused approach. Drennan and Alden (2012) suggest that it is necessary to distinguish between recovery in general mental healthcare, and recovery in forensic services specifically. “Secure recovery” acknowledges that offending behaviour can arise from mental and emotional distress, emphasises the need to manage risk as part of recovery, and embraces the principle of working towards the restoration of a meaningful *and safe* life (Drennan & Alden, 2012). Concepts like relational security provide a basis for advocating a *therapeutic* understanding of “security” (Kennedy, 2002), and are therefore, theoretically, aligned with a recovery-focused approach. Indeed, forensic patients identify positive relationships with staff, based on feeling respected, valued, and cared for (the cornerstones of the STA guidance), as crucial for facilitating recovery (Clarke, Lumbard, Sambrook & Kerr, 2016). Experiencing these positive staff-

patient relationships supports patients' self-esteem and facilitates self-discovery, by enabling a re-coding of relational expectations that, owing to adverse life experiences, were often built around feelings of loss, rejection, and mistrust (Clarke et al., 2016; Laithwaite & Gumley, 2007). The construction of a "new and improved" sense of self is one of the three overarching changes that forensic patients report as being constitutive of "recovery", along with making sense of the past, and understanding the role of mental ill-health in their lives. Developing a positive relationship *with the self* is a key aspect of recovery (Shepherd, Doyle, Sanders & Shaw, 2016).

It is perhaps unsurprising that relationships with staff are of such significance to forensic patients, given how few opportunities they have to develop and maintain relationships with other patients (openly at least), and even fewer with people outside of the service. However, notably lacking from the literature on forensic patients' perspectives on recovery is any mention of the role of positive *intimate* and/or *sexual* relationships. It is important that this is addressed, given the importance of sexuality to embodied self-hood, the risks associated with sexuality existing in an "amputated" or "liminal" state during periods of detainment, and the long-term implications of such for meaningful, "successful" relationality following community discharge (Brown et al., 2013; Reavey et al., 2022).

Inside-out: Patient experiences of intimate and sexual relationality in forensic mental healthcare

In this section, we present the experiences of two of the 29 patients we interviewed in our research on intimate and sexual relationality in forensic mental healthcare facilities and stepdown services in England (*Feeling sexual inside and out*). This project is part of a programme of research privileging patients' experiences of feeling and being sexual, and staff members' experiences of their patients' relationality and sexuality, which aims to inform the development of policies for people working in secure mental healthcare, so that intimate and sexual relationships, and the centrality of sexuality to personhood, are not overlooked in discussions of relational security or personal recovery. This project took place in a number of medium and low secure and "locked" facilities³, and in housing services oriented to providing scaffolded transition from secure care to unsupervised community living.

None of the mental healthcare services wherein we undertook research had established policies around managing patient intimate and sexual relationality. The research required the team to navigate pervasive concerns regarding risk, vulnerability, and the 'appropriateness' of engaging

³ Locked facilities, which provided in-hospital step-down services to prepare patients for community discharge, were retired in October 2021

patients and staff in forensic mental healthcare in conversations about sexuality and intimate relationships.

Our research was informed by contemporary phenomenological theory, in particular Stern's (2010) and Fuch's (2013) writings on vitality. Vitality describes how alive or well we feel at any moment. It is shaped by the circumstances of our existence, and describes our 'background' experience in relation to the world and others. In order to gather phenomenological descriptions of what it *feels like* to be a sexual being while living in secure care, we employed a multi-modal data collection approach, combining semi-structured interviews with a drawing methodology (Boden & Eatough, 2014; Reavey & Brown, 2021). At various points during the interviews, participants were asked to draw anything, either literal or abstract, that captured their feelings and experiences of being sexual – a concept that they were encouraged to interpret freely and broadly. Though the drawings made by participants were not treated as data *per se*, employing the multi-modal approach was intended to facilitate richer verbal responses relating to relationships, sexuality, and mental health, and to help participants articulate aspects of embodied experience that might otherwise be difficult to verbalise. Interview questions encouraged participants to use imagery and metaphor to help them convey their embodied feelings. To supplement the verbal data, we recorded in research diaries our observations of various aspects of the interview, including impressions of the ward environment, information provided to us informally by staff, interactions between those living and working on the wards, and participants' nonverbal behaviour during interviews. From these data, we produced richly descriptive profiles for each participant, charting experiences both within and outside secure care, and their embodied experiences of intimate and sexual relationality while detained on the wards. We present two of these participant profiles here.

The participant profiles selected illustrate the potential implications of a failure to attend to the intimate and sexual aspects of patients' relationalities while they are under treatment in forensic mental healthcare. Both patients were resident in the same mental healthcare facility in England at the point of data collection, though living in different wards. Both provided detailed accounts of their experiences of feeling and being sexual, and of the consequences of the services' failure to adequately support this area of their experience for their day-to-day lives, their long-term relational goals, and their mental health and recovery. The participants we present here – "Brianna", a 34-year-old woman, and "Jake", a 21-year-old man – were selected because their unique experiences reflect a range of potential consequences of overlooking intimate and sexual relationality for a *therapeutic interpretation* of relational security – and for patient care.

Brianna

Brianna is staying in a low secure ward for treatment for and recovery, having received a diagnosis of a personality disorder. She is from the Caribbean, but moved to the UK when she was 19. Brianna has been at the current hospital for four-and-a-half years, and was previously in prison. Brianna hears voices, and is particularly acquainted with one of them, hip-hop singer Trevian [name changed], who makes highly sexualised music videos featuring women who “twerk”.

Brianna is nostalgic about her time in the Caribbean, missing the days when she would “go to the dancehall, dancing with her friends... dancing with guys”. The dances would be “exotic”, “sexual”, “outrageous”, and involved “winding and twerking”. Now, Brianna “dance[s] every night in [her] room”: She “put[s] lingerie on, and stockings, and she just stand[s] around and dance[s] in there on [her] own”, the same dances [she] would dance in the dancehall. The voices “like it when [she] does that.” Trevian (who is the good voice; there are also bad voices) is “in [her] room” when she dances, and “he likes it when [she] dances around, and put[s] on heels”. Brianna believes that “Trevian is a guy who fancies [her],” and “wants [her] to be his girl.” According to Brianna, Trevian stands in her room “by the bathroom door, and he's never going to go away. And he's there night and day.” Trevian “sticks up” for Brianna, helping to “get rid of the negative voices” who are “bullying” and “controlling”. Brianna “loves Trevian, and will do anything to please him.” The dancing “makes [her] feel like... [she's] active, [she's] actually doing something . . . It keeps [her] occupied, it keeps [her] motivated, and it just makes [her] feel a lot better to do the little dance for a little while.” She hasn't told anyone else at about her dancing, because that “type of dancing is not exactly what [the staff] would have expected.” Brianna told the interviewer that he was the first person to whom she had related the details of her nightly dancing routine, and enjoyed sharing the information, because she was “bringing herself out to a stranger”.

Trevian “used to give Brianna a lot of orgasm[s]”, “but since of lately it's not happening to her anymore.” Brianna isn't sure why, but it could be that Trevian “didn't want [her] to do it [have orgasms] in the first place.” Brianna has told her Care Co-ordinator that Trevian no longer gives her orgasms, but she “didn't tell her how [she] feels” about it – she “didn't tell her that [she] actually misses it.”

Brianna thinks about her sexuality “all the time”. When in “the lonely mood”, she uses a vibrator, but this “has to be agreed in ward round before [she] can have it.” She “wish[es] that [she] could really do something, make love to somebody, kiss. [She] miss[es] kissing somebody.” That said, not being sexually active “makes [her] feel good about [her]self,” and makes her “feel clean.” She has come “into thinking that maybe it's for the best.” Brianna believes that patient sexuality “doesn't

really matter to staff”, and when it comes to patients being inactive sexually, “they look at that as something good”: Staff “think that [patients] deserve it, they deserve to not have a relationship, not to be sexually active.”

Brianna had found her own unique way of being sexual in the private space she inhabited on the ward, through erotic dancing intended for the man (albeit not an embodied being) with whom she experienced a close sexual relationship. Dancing contributed to Brianna’s positive mental health – it made her feel “active” and connected to the man she loved – and yet she had not shared her nightly routine with the healthcare workers charged with facilitating her recovery, uncertain as to how they would respond: The ward was not a place for dancing “like a stripper”, notwithstanding its potential therapeutic value. In accordance with the *See, Think, Act* guidance, Brianna’s Care Co-ordinator knew the *factual* elements of her “inside world”, including her voice hearing experiences, and even the sexual experiences her voices afforded, but did not know what it *felt like* to Brianna to have these experiences. If recovery can be conceptualised as inclusive of continued symptomology (Shepherd et al., 2008), then Brianna’s dancing might be facilitative of her recovery; but in a context where expressions of sexuality are framed as inappropriate (Allen, 2015), recoded as “misbehaviour” (Ravenhill et al., 2020), and interpreted in terms of symptomology (Brown et al., 2014), there is no opportunity for staff to explore the implications of these practices for the long-term wellbeing of the patient.

In the course of her interview, Brianna intimated a history of sexual exploitation by men, though (because care records were not accessed as part of our research) it is unknown whether this information were known by ward staff. Even if it were not, clinicians would no doubt have concerns over the extent to which Brianna’s clandestine nocturnal dance routines – enacted to please an audience of men, who had the power to govern her sexual pleasure – facilitated her recovery, or rather evidenced (and contributed to) sustained distress. However, with staff seemingly entirely unaware of her nocturnal pursuits, these concerns neither had the space to be realised nor addressed, and their potential to enable or constrain some sort of growth for Brianna remains unknown (Reavey et al., 2022).

Jake

Jake is staying in medium secure ward offering assessment and rehabilitation to young adults. He has been in secure services since he was 13 years old, having committed a criminal offence. Jake is currently in a relationship with a considerably older man, who is not a patient.

Jake entered secure services at a point where he was confused over his sexual orientation and did not have a reliable source of information about issues related to sexuality. Jake was prohibited from talking about his index offence when he was first in hospital, and he generalised this imposed silence to other issues of concern. Consequently, sexuality “became an extra thing [he] couldn’t talk about that was on [his] mind.” Jake had difficulties “becoming comfortable with being gay,” and “how [he] could express that.” Hospital staff were not wholly supportive of Jake’s desire to explore his sexual identity: “Some of the staff, bullied [him] a bit, and some of the bank staff said it was God testing [him].”

At one point, Jake had a “little bit of an encounter” with another patient, and staff “were really funny over it, and [he] got told how far it had set [him] back.” When Jake was able to take unescorted leave, “the first thing [he] wanted to do was to go on Grindr”, something he really had to “argue for.” Staff were not supportive of Jake’s request to use Grindr: They told him that he was “delaying himself getting out”, that his “priorities are all wrong,” and that he “should not be thinking about relationships until he was discharged.” Jake was undeterred: He wanted to experience “all of it, every little detail of it. [He] wanted to set up a profile, have people messaging him, and the thrill of it all, and end up meeting up with someone, and then go back to theirs.” When he was allowed to download Grindr, he “met someone and went back to theirs, and the staff told [him] [he]’d broken Section 17 of his leave, and they took [his] leave off [him].” Jake was “always told that patients could be honest with staff, but [he] had a lot of staff telling [him], ‘Don’t tell them, just do whatever you want to do, just don’t get caught doing it.’” It ended up that Jake “started meeting up with people and going back and just not telling staff [he]’d done it when [he] got home.”

Jake’s psychologist told him that if he were to meet up with someone he had met on Grindr, they should meet in a public place. On reflection, he thinks the psychologist must have meant somewhere like a hotel, but at the time, Jake thought that “the toilets of [a large exhibition centre] sounded fine.” Once again, when he was “honest” with the staff about the encounter, he was sanctioned with loss of leave. Jake thought that “by doing it there [he] wouldn’t be in trouble with [his] leave plan,” because it was a public place. Jake now refers to this incident as his “Dorian Green moment” (*Dorian Green is a character from the British television show “Birds of a Feather”, who is renowned for being promiscuous*). To Jake, meeting people for sex was worth the risk of losing benefits, because doing so “made [him] feel so complete and wanted, and everything [he] was missing in [his] life, it made [him] feel like he had. Not even the sex side of it, just the intimacy.” It was “an amazing feeling” to be “cuddled up, entwined with someone, safe and secure,” when “in hospital, you didn’t even get a hug off anyone,” and where “everything feels cold.” Jake sees his “sexuality and self-worth and mental health being entwined.”

Jake's relationship with his current partner – whom he met via Grindr – has not run smoothly. Once, Jake lost his leave because his partner “talked about breaking up because he couldn't cope with it all,” and in response, Jake “came up with the plan of running off to Benidorm,” a plan which Jake “ended up roping his partner into,” and that was eventually realised. He did it, “knowing [he] was going to get caught, because [he] wanted to prove to [his] partner how much [he] loved him.” When he was apprehended, Jake ended up in prison.

Jake had learned that sharing information about his sexual relationships with his care team was a mistake, because it resulted in punishment. A culture of silence around sexuality – along with homophobic attitudes among some staff – meant that Jake was forced to explore his sexual identity without many of the structures that would otherwise have supported his identity formation as a gay man. Reasonable expectations that the “freedom” afforded by unescorted leave might enable him to explore sexual relationships were shattered by staff members' recoding of his sexual desires as something that would detract, and distract focus, from his recovery. The temporal logics of recovery mean that focusing on “getting better” precedes any investment in intimate and sexual relationality: Infractions are not only “misbehaviour”, they are evidence of a failure in recovery. Patients are therefore obliged to navigate the tensions between the freedoms of the outside world – which can feel full of sexual possibilities – and the prohibitive, oppressive restrictions of the ward, where sexual feelings have to be “turned off”, and never spoken of.

It is perhaps understandable that ward staff and clinicians were keen to constrain Jake's keen sexual motivations, concerned that emotional and sexual immaturity could make him vulnerable to other men on the ward, and expose other patients to risk, especially in light of his earlier “encounter” with a ward mate). However, in Jake's case, a strong desire to explore his sexuality, his longing for romantic intimacy, his knowledge of the availability of sex and intimacy in the outside world, and his understanding that “keeping quiet” about these things was the most effective way of avoiding punishment, were a recipe for disaster. In the absence of a safe forum to help him manage his sexual feelings, Jake resorted to absconding, and was subsequently arrested – a substantial failure in relational security. Paradoxically – though not surprisingly – attempts at maintaining relational security via supposedly risk-diminishing practices (restriction and prohibition) actually *increase* the risk to ward and patient safety, and can have serious consequences for recovery.

Intimacy and sexuality in relational security

The experiences described by Brianna and Jake (the “inside-out”) highlight the threats to relational security, in particular to the wellbeing and recovery of patients, that arise as a

consequence of failures to account for intimate and sexual relationality in secure mental healthcare policy and local staff guidelines (the “outside-in”). In a context of inconsistent, *ad hoc* “rules”, unclear or contradictory communication, punishment for “infractions”, and the elimination of relational agency, patients like Brianna and Jake are forced to navigate an uncertain landscape, enacting their intimate and sexual relationalities in subversive, secretive, and potentially perilous ways. Brianna and Jake, like many of the forensic mental healthcare patients we spoke to, articulated a relationship between their intimate relationality and their recovery. For Brianna, the enforced hiatus in sexual activity with anyone but Trevian had made her feel “clean”, and her dancing gave her purpose and made her feel good; for Jake, sex and emotional intimacy supported his emerging sense of self, which underpins positive mental health, and contributes to recovery (Shepherd et al., 2015). That patient perspectives on this link between sexuality and recovery are largely missing from accounts of both relational security and recovery does not mean that intimate and sexual relationality has no role in either of these; rather, its role is obscured by a culture of sexual prohibition, and pervasive discourses of risk and appropriateness (Ravenhill et al., 2020). Insights from people like Brianna and Jake reveal that at least some patients feel sexual, enact intimate and sexual relationality, and experience (and can articulate) the connection between their sexuality and their mental health, yet official guidance on relational security, including its therapeutic potential, almost entirely overlooks the intimate and sexual relationships many patients engage in with themselves or others. Providing “purposeful” therapy, understanding patient dynamics, and knowing patients’ inner and outer worlds are fundamental for maintaining relational security (Allen, 2015), however, without an understanding of patients’ feelings and practices around sexuality, romance, and emotional and physical intimacy, it is hard to see how this can be achieved. The key to maintaining relational security, both in terms of risk-reduction and clinical recovery, must be the broadening of interpretations of the concept, to incorporate patients’ intimate relational desires and needs. The provision and implementation of clear policies should be underpinned by a more nuanced understanding of relational security, based on the principles that ward safety is a shared endeavour between facility management, clinical staff, ward staff and patients alike, and that sexuality must form part of initial assessments, and be addressed directly in care planning. Policies that involve patients in the conversation, where the potential for sexuality to contribute to recovery is explored *alongside* considerations of risk, would demystify patient sexuality, bring it to the open, and offer a framework for staff to work safely and positively with their patients on all issues relating to intimate and sexual relationality.

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