

# Institutional Capacity to Respond to the Ethical Challenges of Patient Sexual Expression in State Psychiatric Hospitals in the United States

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## ABSTRACT

Patient sexual expression in psychiatric institutions is a major clinical and administrative challenge. For this study, hospital facility directors were surveyed and asked about the existence and nature of formal policies regarding patient sexuality-related needs and staff preparedness to handle various forms of patient sexual expression. Consistent with prior studies, the survey findings show formal policies tend to enforce a punitive response to sexual behavior. More important, the results also reveal a workforce poorly prepared to negotiate the complex ethical issues that arise in addressing patient sexual expression in state psychiatric institutions in the U.S.

**Key Words:** patient sexual expression; psychiatric institutions; mental health care; state psychiatric hospitals; ethics

## Introduction

Sexual behavior among patients living in psychiatric institutions is relatively common, with approximately 30 to 70% of patients reporting recent sexual activity (Wright & Gayman, 2005; Buckley & Gutheil, 1999). Persistent concerns about sexual abuse, unintended pregnancies, and the spread of HIV and other sexually transmitted infections among psychiatric patient populations continue to fuel debate among treatment

providers (Dobal & Torkelson, 2004) and policymakers (Torbaty, 2011; Jackson & Marx, 2010) about the management of patient sexual expression in inpatient and residential settings. While researchers and practitioners have described many of the clinical challenges, surprisingly little is known about how well prepared treatment institutions are to address these situations or how they are responding. In this paper, we report findings from a brief survey of directors of state psychiatric institutions in the U.S. designed to examine the institutional capacity of hospitals to respond to the complex ethical and clinical challenges in this area.

## The Legal and Clinical Challenges of Patient Sexual Expression

Historically, the rights of persons in institutions have not been enforced (Perlin, 1997). It was not until 1971 in *Wyatt v. Stickney*, 1997 that the U.S. District Court for the Northern District of Alabama declared that involuntarily committed patients had a “constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition” (*Wyatt v. Stickney*, 1972). Following this declaration, the court found it necessary to clarify what “minimal constitutional standards” would mean for covered hospitals after the declaration failed to produce the intended results. In this clarification, the court ordered that “[t]he institution shall provide, with adequate supervision, suitable opportunities for the patient’s interaction with members of the opposite sex” (Ibid). While the court does not clarify exactly what this means, it is clear that the court anticipates the possibility of sexual interactions.

Regardless of the courts' directives, administrators and persons working directly with patients frequently maintain that allowing sexual contact will be detrimental to treatment and/or will leave the facility open to liability (Dobal & Torkelson, 2004; Ford et al., 2003). The minimum standards contemplated by *Wyatt* contained explicit language allowing the treating clinician great discretion in areas where there were concerns about treatment issues if the right was enforced. Additionally, a review of the case law indicates little in the way of litigation around issues of consensual sexual relations in psychiatric hospitals. *Foy v. Greenblot* (1983) is one of the few cases in which sexual activity on an inpatient unit is directly raised. Foy, an institutionalized adult declared incompetent, and her child, who was conceived and born in the hospital, sued for wrongful life. The court found arguments that the hospital should have provided additional supervision to prevent the interaction were not persuasive. The only argument the court found persuasive was possible negligence for failing to provide education regarding contraception (*Foy v. Greenblot*, 1983).

The most troubling issues in this area have revolved around whether or not an individual has the capacity to consent to sexual relations. Courts have tried to define consent in many ways: morality tests, totality of the circumstances test, nature and consequences test, judgment test, evidence of mental disability test, and nature of conduct test (Denno, 1997). In reality, however, while the courts recognize the right to sexual relations (*Wyatt v. Stickney*, 1972), they also recognize that persons who lack the ability to consent should be protected from harm (Ibid; Perlin, 1997). Despite this lack of clarity, courts continue to support the rights of persons with many types of mental health and mental disability issues to engage in sexual relations (Perlin, 2008 and 1997; Denno, 1997). Clinically, aside from formal legal declarations of incompetence, establishing competence to engage in sexual activity during treatment is further complicated by the dynamic nature of psychiatric symptoms, variation in patients' sexuality-related knowledge and experience, and institutional policies (Dobal & Torkelson, 2004; Warner et al., 2004; Fiesta, 1997). Unfortunately, case law in this area continues to be scarce (Perlin, 2008 and 1997). The courts generally appear to support the patients' right to engage in consensual sexual relations with other patients when cases are brought (Perlin, 2008; *Wyatt v. Stickney*, 1972). Consequently, concerns regarding consent and the impact on treatment continue to be very case-specific rulings, leaving providers with little concrete guidance.

At the frontlines, clinicians voice concern about other more immediate challenges that typically reflect concerns about maintaining an effective treatment milieu and protecting patients from sexual victimization. Indeed, clinicians report having to deal with a host of practical clinical challenges, ranging from responding to unwanted sexual advances/situations, to managing desired or planned sexual/romantic interaction, to controlling some patients' sexual compulsions (Dobal & Torkelson 2004; Warner et al., 2004; Ford et al., 2003; Buckley & Gutheil, 1999). These situations are clinically complex, in part, because they often pit individual patients' rights against either other patient's rights or institutional responsibilities to maintain safe and supportive treatment environments (Sy, 2001). As a result, many institutions have formally or informally endorsed "no sex" policies (Buckley & Robben, 2000). While these policies are often adopted because of institutional concerns regarding clinical outcomes and/or institutional liability (Ford et al., 2003), research also indicates that

they may be the product of more culturally conservative personal values and beliefs (Ruane & Hayter, 2008; Dobal & Torkelson, 2004; Wright & Martin, 2003). Nevertheless, recent research indicates that patients report a higher quality of life when they are allowed freedom of sexual expression in a safe manner (Shildrick, 2007; Ailey et al., 2003), suggesting that institutions could improve treatment environments and the quality of care by embracing policies and practices that support patient sexual expression.

Prior studies suggest that many institutions have formal policies regarding sex between patients, but the policies often have only limited utility in guiding clinical or administrative decision-making because of the complex ethical issues involved (Dobal & Torkelson, 2004; Buckley & Robben, 2000; Buckley & Hyde, 1997; Welch & Clements, 1996). While prior research has focused on analyzing the content of policies, these studies have neglected the institutional capacity to respond to sexuality-related issues during treatment. In this study, we surveyed state psychiatric hospital directors to better understand institutional capacity to respond to the complex ethical challenges in this arena.

## Methods

**Instrument.** For this descriptive, exploratory study, we designed a web survey for the directors of state-supported psychiatric institutions in the United States (N=192). We adapted survey items from the *Indiana Mental Health Services and HIV Risk Study – General Staff Questionnaire* to measure staff sexuality and HIV/AIDS-related knowledge and training as well as clinicians' readiness to respond to patients' sexuality-related needs (Wright, 2001). We also included items from *The Patient Sexual Rights Questionnaire* (PSRQ) by Buckley and Hyde (1997) to measure the nature and extent of policies regarding patient sexual expression. In addition, we included a series of questions to better understand institutional responses to patient sexual conduct. Specifically, we asked directors about the number of episodes of "sexual misconduct," a phrase that is widely used within psychiatric treatment and policy circles to describe "inappropriate" or "clinically problematic" patient sexual behavior. Because this general term lacks behavioral or clinical specificity, we asked respondents to distinguish between the overall prevalence of behaviors and situations that may be clinically challenging (minor) from those that may have more serious legal consequences (major):

1. In the past year, approximately what percent of patients have engaged in minor sexual misconduct (unwanted hand holding, kissing, etc.)?
2. In the past year, approximately what percent of patients have been subject to other patients' minor sexual misconduct (unwanted hand holding, kissing, etc.)?
3. In the past year, approximately what percent of patients have engaged in serious incidents of sexual misconduct (nonconsensual sex, sexual assault, sexual abuse, or rape)?
4. In the past year, approximately what percent of patients have been subject to other patients' serious incidents of sexual misconduct (nonconsensual sex, sexual assault, sexual abuse, or rape)?

Finally, we included several items to better understand the organizational structure of the institutions represented. In all cases, the director respondents were asked to answer the questions on behalf of their institution. Copies of the survey tool are available from the first author.

**Sample.** The sample was limited to state-funded, adult psychiatric hospitals in the U.S. The vast majority of prior legal and empirical research on patient sexual expression has focused on people with developmental disabilities. In order to control for important differences in the clinical populations served and in treatment settings, we restricted our sampling frame to adult psychiatric hospitals in order to concentrate this analysis on issues associated with treatment of adults with mental illness.

We obtained a list of hospital directors and their contact information from the National Association of State Mental Health Program Directors (NASMHPD) membership directory (<http://www.nasmhpd.org/>). Of the 204 facilities listed, 12 were excluded because they served exclusively either children and adolescents or persons with developmental disabilities. The final survey was sent to 192 directors, and 78 (40.6%) of them returned the survey after three reminders.

**Data Analysis.** All data were analyzed using the Statistical Package for the Social Sciences (SPSS). In this paper, we present descriptive findings regarding the institutional policies and responses and staff capacity as reported by the institutional leaders. For each analysis presented, we explored whether the responses varied based on the number of patients served, geographic location, and the presence/absence of written policies governing patient sexual behavior.

## Results

A wide variety of institutions of various sizes and from various locations across the U.S. responded to the survey. The largest number of respondents came from the South (N=31) followed by the Midwest (N=22), East Coast (N=17), and the West and Mountain Plains (N=8). Facilities reported an average daily census of approximately 360 patients (SD=864) and served an average of 1,194 (SD=1,369) patients per year. The mean occupancy rate for participating institutions was 93.6% with an estimated turnover of 37.1% annually.

Facility directors indicated that almost one-third of their patients (M=28.1%; SD=28.5%) were sexually active. They also reported that a relatively small proportion of their patients got pregnant while in their care (M=0.3%, SD=1.3%) or were known to be HIV positive or have AIDS (M=2.7%, SD 3.0%). Directors reported that only a minority of patients engaged in major and minor episodes of sexual misconduct (M=8.2%, SD 9.9% and M=0.9%, SD=2.0% respectively) or were the victims of major and minor sexual misconduct (M=6.7%, SD 8.7% and M=1.1%, SD=2.6% respectively). Interestingly, only a minority of the directors surveyed indicated that patient sexual behavior (N=22, 28.2%), HIV/AIDS or sexually transmitted disease (N=21, 26.9%), and reproductive issues (N=25, 32.1%) were “serious” or “very serious” problems in their facilities.

The majority of facilities reported having “formal policy, regulations, and/or laws” governing patient sexual behavior (N=48, 61.6%) and “the treatment, management, or prevention of HIV/AIDS and/or sexually transmitted diseases” (N=48, 61.6%). Only a minority of the institutions had established guidance regarding “reproductive health and behavior (pregnancies, abortion rights, access to birth control, etc.)” (N=26, 33.3%).

We also asked about the typical institutional response to instances of patient sexual misconduct. Directors reported that most often they conducted an “internal investigation” (N=33, 53.2%) or reported the episode to police or another social service agency to investigate (N=25, 40.3%). On occasion, they also sent the patients involved to another hospital or medical facility for an examination (N=13, 21.0%), isolated or increased patient monitoring (N=21, 33.9%), or provided special “counseling” to patients (13, N=21.0%). Facilities located in the southern region of the U.S. reported that they were the most likely to refer instances of patient sexual behavior to an outside hospital or to the police for investigation than facilities in other regions ( $p = .047$ ). Having a formal policy in place also increased the likelihood of responding to misconduct by referring to another hospital ( $p = 0.034$ ) or utilizing isolation and seclusion ( $p = 0.039$ ).

Table 1 presents responses to the individual items and the total scale scores describing the directors’ assessment of their institutions’ capacity to address patient sexuality-related needs. The directors indicated that a majority of their staff has knowledge about “sexuality-related issues” (N=42, 53.8%) and “sexuality transmitted diseases” (N=55, 70.5%). In terms of staff attitudes, directors reported that only a small minority felt comfortable talking about these issues with patients or endorsed including sexual expression into treatment planning. We also computed a total staff sexual attitude score by summing the individual responses. Total scores on this scale could range from 12 to 60 with higher scores indicating higher staff capacity to address patient sexual expression. The mean score for the 78 facilities was 35.2 (SD = 6.7; Cronbach’s  $\alpha=0.89$ ) indicating that the staff at most mental hospitals surveyed are not well prepared to address patient sexual needs.

We also queried the directors about their staff’s capacity to address HIV/AIDS (see Table 2). Interestingly, staff at state psychiatric hospitals appears significantly more prepared to address the specific issue of HIV/AIDS than sexuality in general. Indeed, the directors indicated that their staff was more knowledgeable and comfortable in addressing HIV/AIDS than sexuality in general. As above, we also calculated a total HIV/AIDS capacity score (Range 4-20, with higher scores indicating higher HIV/AIDS-related capacity). On average, facilities received a total score on the HIV/AIDS importance scale of 14.4 (SD = 2.0; Cronbach’s  $\alpha=.68$ ) indicating that they had a moderately high level of awareness of the importance of HIV/AIDS education in patient care.

## Discussion

Like prior studies, approximately two-thirds of the institutions we surveyed had formal policies governing patient sexual behavior (Dobal & Torkelson, 2004; Buckley & Robben, 2000; Buckley & Hyde, 1997). While the directors in our survey reported

sexual behavior and sexuality-related problems being somewhat less frequent problems than reported in these prior studies, our findings also indicate that HIV/AIDS is a much more prominent institutional concern than was evident in prior research.

**TABLE 1: DIRECTORS' PERCEPTIONS OF STAFF ATTITUDES, KNOWLEDGE AND SKILLS CONCERNING PATIENT SEXUALITY, SEXUAL BEHAVIOR, AND REPRODUCTIVE ISSUES, U.S. STATE PSYCHIATRIC HOSPITALS (N = 78)**

	To a great or very great extent	
	N	(%)
The staff knows a lot about sexually transmitted diseases.		
The staff is knowledgeable about sexuality-related issues.	55	(70.5)
When patients express interest in having a romantic relationship, staff members are supportive.	42	(53.8)
Your facility provides sexual education problems for residents.	33	(42.3)
Staff members educate patients about the sexual side-effects of medication.	30	(38.5)
Staff members discourage patients from talking about sexual issues.	28	(35.9)
The staff makes patients feel comfortable about talking about sexual issues.	27	(34.6)
Staff members believe that rehabilitation should include special efforts to help patients learn to manage sexual and romantic relationships.	20	(25.6)
The staff feels that dealing with sexuality is an important part of preparing patients for independent living.	19	(24.4)
The staff deals seriously with patients' sexual needs in their treatment plans.	19	(24.4)
The staff feels comfortable discussing patients' sexual needs and desires.	13	(16.7)
Staff members help patients identify ways that they can meet their sexual needs and desires.	11	(14.1)
	9	(11.5)
<b>TOTAL SEXUAL ATTITUDE SCALE SCORE</b>	<b>35.2</b>	<b>(6.7)</b>

Our analyses further reinforce prior studies' observations that policies and practices in U.S. psychiatric institutions reflect a generally "sex negative" or punitive approach to patient sexual expression. Very few institutions appear to be oriented around more therapeutic and supportive approaches, including comprehensive assessments of sexuality, monitoring medication sexual side effects, and incorporating the sexual/romantic needs into treatment plans. Prior research found that staff attitudes are primarily influenced by community sexual norms rather than clinical norms or standards (Dobal & Torkelson, 2004; Commons et al., 1992). The sex negative orientation to patient sexual behavior, thus, may simply be a reflection of more sex-negative society or community values.

Of greater concern, however, is the limited capacity of state psychiatric institutions to address patients' sexuality-related needs. Indeed, our findings suggest that while staff has basic knowledge and training, the majority of treatment professionals are not well prepared to address the more nuanced, psychosocial aspects of patients' sexual needs or behavior. Similarly, most staff members are well versed in the clinical management of HIV/AIDS and HIV testing, but only a minority of staff is comfortable talking about patients' sexual needs and desires or dealing with the topic in treatment planning.

There are important limitations to this study. Less than half of the state psychiatric institutions responded, so the survey results may not be representative and should be interpreted with caution. The survey results reflect the opinions of the facility administrators and probably do not adequately capture the diversity of opinions or experiences of front-line staff. Our study focused on longer-term state supported psychiatric institutions and may not reflect the experiences of shorter-term, acute-care, or private treatment facilities.

**TABLE 2: DIRECTORS' PERCEPTIONS OF STAFF ATTITUDES, KNOWLEDGE AND SKILLS CONCERNING HIV/AIDS-RELATED ISSUES, U.S. STATE PSYCHIATRIC HOSPITALS (N = 78)**

	Agree or Strongly Agree	
	N	(%)
This facility provides appropriate testing and management of HIV/AIDS.	66	(84.6)
Staff members feel that HIV/AIDS is a serious issue among people with serious mental illness.	51	(65.4)
Staff members are comfortable working with patients with HIV/AIDS.	51	(65.4)
This facility provides adequate HIV/AIDS-related mental health services.	48	(61.5)
	M	(SD)
<b>TOTAL HIV-RELATED SCALE SCORE</b>	<b>14.4</b>	<b>(2.0)</b>

## Conclusion

Patient sexual expression poses complex ethical challenges for clinical staff and administrators in state psychiatric institutions. While there has been some progress in the development of formal policies and procedures, the situational nature of patient sexual expression as well as the complex relationship between mental illness and sexuality demand that treatment providers be well prepared to intervene and balance the individual rights and needs of patients with protecting the group treatment milieu. Yet the findings from this study suggest that most state psychiatric institutions in the U.S. are poorly prepared to negotiate these complex ethical issues in their clinical work. Mental health policymakers should consider convening experts and hospital administrators to develop a consensus statement on best policies and practices in the management of patient sexual expression and expand staff education and professional development opportunities to help them address patients' sexuality-related needs more effectively.

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