

GUEST EDITORIAL

Sexual Behaviours and Serious Mental Illnesses

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ABSTRACT

This article briefly summarizes and highlights the invited articles in this special *JEMH* issue. Moreover it helps demonstrate some of the diversity of ethics-related situations and questions about sexual behaviours and activity that can arise in healthcare settings. The article concludes with three further considerations drawn from and recommended for daily clinical practice: the diversity of sexual orientations and gender identities, the value of comparing empirical/research findings with lived experiences with advocacy perspectives, and a rejuvenating recognition and engagement of the people whom mental health workers and organizations serve and help.

Key Words: sexuality; sexual activity; mental health; mental illness; ethics

Introduction

This special issue of the *Journal of Ethics in Mental Health* includes seven invited articles by various clinicians and academics who have thought a lot about ethical challenges raised when people engage in sexual expression and activity and have serious mental health conditions. Invitations were extended to people who have written about their lives with a mental health condition and become community advocates. Regrettably, the invitations were declined because of personal time constraints and competing responsibilities. Recognizing this shortcoming, it is incumbent on me to remind readers that *JEMH* welcomes first person perspectives regarding mental health (which includes substance use problems), support networks, treatment and care options, and advocacy and health policy efforts.

The aforementioned challenges have arisen in my ten plus years of work as a bioethicist, working first at an acute care hospital and a children's hospital, then at a mental health and addictions hospital. In fact, my very first consult was about patient sexual needs and preferences. The head unit nurse who requested my help realized that the divisions among the clinical team would not be adequately resolved by her simply agreeing with one group

or another. Team members' responses to a patient's request for sexual activity reflected different, seemingly opposing, norms: medical versus operational versus professional versus cultural versus familial.

The patient was caught at the epicentre of these clashing values. A few months earlier, I had attended a conference talk by a regional psychologist who routinely worked with individuals experiencing constraints on or barriers to their sexual behaviours and interests (e.g., mobility or physical restrictions, unfamiliarity with alternative techniques to feel or provide pleasure, intimacy, and gratification). Thankfully, she accepted my invitation to help the head nurse's team respectfully voice and practically work through their different perspectives so that the patient's request could be satisfactorily met.

Questions and situations involving patient, client, or resident (hereafter "client") sexual behaviours have varied considerably in my work. For example, providing analysis and advice about ethical considerations relating to a client's sexual needs while connected to a ventilator; sexual activity in a public washroom or outdoors on hospital property; "noisy" masturbation; "pornographic" magazines purchased during staff-accompanied walks; keeping such magazines in bedside tables; accessing adults-only websites on personal cell phones; a heavy smoker who has spent all of their monthly disability benefit and then exchanges sex for more cigarettes; proposed monitoring and restrictions when a client, who worked as a sex worker, entered a hypersexual phase associated with a mental health diagnosis; voiced intent to be sexually active although HIV positive; how condoms are accessed or provided; a client sitting on another's lap, having arms around each other, kissing; whether clients' bedroom doors must remain open whenever another person is in their room; clients unintentionally appearing sexually provocative by not wearing a bra; an older adolescent, whose hospitalization is court-ordered due to a sexual offense, undergoes late onset puberty; and leading the review and revision of hospital policy.

The Invited Articles

The topics of the seven articles in this issue are complementary but diverse, as reflective of both the complexity of mental health services and the complexity of human sexuality. Starting with the article by, Linda McClure, RN MSc from Thompson Rivers

University School of Nursing, she discusses barriers to staff proactively considering hospitalized clients' sexual needs and integrating such needs into their treatment and care plans. Data is provided showing that the sexual interests and well-being of people living with a mental health condition are significantly less than those enjoyed by the general population. Under the banner of "sexuality care," McClure recommends various steps healthcare workers and facilities can adopt to assist clients to not just avoid risks associated with sexual activity and mediate the impact of certain medications and psychiatric conditions, but more importantly, to help clients "regain a sense of who they are as sexual beings."

Eric R. Wright, PhD and Harold E. Kooreman, MA from Indiana University's Department of Public Health and Heather McCabe, JD MSW from IU's School of Social Work share results from their recent survey of government-funded psychiatric facilities in the United States. Responses from 78 facilities' superintendents, a sizeable number, show that illness risks tend to garner more attention than clients' reproductive needs and sexual interests. Although a majority of the facilities had a policy about clients' sexual behaviours---a change from earlier studies' findings---and about which staff knew, staff typically felt uncomfortable broaching the subject with clients or incorporating it into their treatment plans. Worries about legal liability for possible harms to clients explain some of this conservatism. Since mental health facilities continue to view sexuality and sexual activity too negatively, the authors propose a collective initiative to replace punitive and prohibitive approaches and responses.

Belluardo-Crosby's recent article (2011) noted the dearth of published reports about community-based programs for individuals who commit a sexual offense and who live with a mental health problem. The third article in this special issue helps fill this void. Its authors are J. Paul Fedoroff, MD from the University of Ottawa's Institute of Mental Health Research and Deborah Richards, CHMH MA(c) from Welland Pelham's Community Living agency. Their article focuses on people living with intellectual disabilities and, as captured in the article's title, whose sexual behaviours are potentially problematic because they can result in sexual offense. Twenty years' work at three Ontario clinics informs these authors' insights and recommendations. Their perspective, which I consider "the long view", brought to mind repeatedly the adage "If not us, who? If not now, when?"¹ Fedoroff and Richards point out sex-related behaviours that can qualify as "counter deviant" reflective of certain institutional practices, plus misconceptions that prevent these clients from achieving respectful and healthy sexual relationships. Ethically noteworthy is the authors' concession that---as mental health clinicians and administrators---"we might be wrong"---which means they work and learn *together, with* each client.

Sexuality in the context of recovery and schizophrenia is the topic of the article by Scott P. Van Sant, MD, Anthony O. Ahmed, PhD and Peter F. Buckley, MD of Georgia Health Sciences University. Psychiatric medications for schizophrenia often disrupt or impair people's sexual abilities and interests. In many instances, addressing worrisome or risky sexual behaviours with psychopathology and psychopharmacology measures can be more effectively replaced using a recovery approach. Moreover the authors remind readers that symptoms of schizophrenia include difficulties developing

and sustaining relationships, be they intimate (i.e., familial and close friendships) or sexual. Given the human importance of relationships, they explain some practice-based alternatives to replace disproportionate reliance on clinicians and teams' impressions or client self-reports about relational problems.

Barbara Walker-Renshaw L.L.B.'s article helps respond to common practice questions about appropriate and inappropriate criteria for assessing whether a hospitalized individual currently lacks the requisite abilities to consent freely to consensual sexual activity with another person. In my interactions with clinical staff, it is not uncommon for this question to arise and for clinicians and teams to spend a bit of time "getting clear" about such criteria, given the importance of sexuality and sexual activity in people's lives and well-being. While Ms. Walker-Renshaw's comments should not be presumed *legal* advice, they do indicate a reasonable analogy and guidelines for practitioners in Ontario.

Marcia Sokolowski, PhD is a bioethics co-director at Baycrest Centre for Health Sciences. Reading her article brought to mind the Canadian film "Away From Her," which portrays one kind of dilemma caused by the effects of progressive dementia on intimate and sexual relationships and the divergent familial and institutional responses. The film was heralded, in part, because it made public a not uncommon situation encountered by seniors, their families, and facilities' staff. Sokolowski presents an anonymized example of clients' evolving relationship while living in a long-term care/residential facility. During the ethics consultation, the clients, families, and staff provide information and their perspectives as to whether the new behaviours and relationship reflect authentic choices, meet the familiar criteria of informed consent, or are indicative of dementia's physiological damage to the brain. Of special note is the author's use of two less familiar, but ethically important, points: the relevance of relational autonomy and the difference between lived experience of intimate or sexual encounters and their meaning.

The final article concludes this special issue with a provocative position. Daniel N. Watter, EdD of the Morris Psychological Group explains how well-intended efforts to develop and provide more medical treatment for sexual difficulties can be short-sighted. Those experiencing such difficulties as well as those treating them should temper inclinations to rely on pharmacological measures. Too often, "desire cases become disease cases," suggests the author. Sex is more than "a mechanical process", which fits well with my past ethics consultations in which people had a variety of opinions about what was and was not ethically supportable. Watter's article concludes with a thought-provoking use of psychotherapist I.D. Yalom's connections between death and sexuality to illustrate how powerful sexual behaviours are for humans.

Concluding Thoughts

There is much to learn from these authors' articles. In 2001 the World Health Organization held that sexuality is central to our human-ness and affirmed its importance through the language of rights (Quinn & Browne, 2009). It is acknowledged widely that being healthy involves being sexually and intimately healthy. However, this does not seem to be explicitly or even implicitly

accepted in most healthcare settings. Mahieu and Gastmans (2011) refer to the iatrogenic loneliness caused by institutionalization. Degree and certificate programs spend little time on sexual behaviours, most of which can focus on reproduction and transmissible diseases.

As a result, too few healthcare workers proactively deal with or respond to clients' sexual and intimate needs. They lack nuanced and responsive interpersonal and communicative skills proportionate to the deeply personal nature of sexuality and intimacy and the widely variable nature of relevant values and norms. Policies are indeed important. So are "moral spaces" in which staff can safely ask questions, admit ambivalences, and examine personal versus professional perspectives (Walker, 1993). Furthermore, as illustrated at the beginning of this article, healthcare facilities can benefit significantly by seeking clinical guidance and skills development from specialists in the field.

I would like to add three other considerations. First, in working through an ethics consult, my understanding about sexuality expanded significantly... and it is now foundational to all my work. It began with an administrative employee requesting help updating a routine clinical form's options for "sex." The form listed "male" and "female" and the question was: is this still sufficient? Two co-workers specializing in diversity directed me to an internal, educational document and workshop, *Asking the Right Questions2*. While I understood how gender identity differs from sexual orientation, I hadn't realized how diverse each was. For instance, gender identity includes female, male, transsexual, transgendered, genderqueer, two-spirit, FTM (female-to-male), MTF (male-to-female), intersex, unsure, questioning, and individually-defined. Sexual orientation includes straight/heterosexual, lesbian, gay, WSW (woman who has sex with women), bisexual, MSM (man who has sex with men), queer, transsexual (person attracted to transsexual or transgendered people), polysexual, two-spirit, questioning, asexual, autosexual, unsure, and individually-defined.

I've since learned about cis-gender and cis-sexual groups and their challenges to existing categorizations, naming, and the ubiquitous use of "Other." It is important, too, to question assumptions that non-heterosexual clients can readily share intimate or sexual details with any healthcare worker (Quinn, Happell & Browne, 2011) as well as question tendencies to associate certain behaviours with a particular identity or orientation. The significance and meaning of a particular behaviour---what it expresses and how it is interpreted and by whom---can be individually-based or group-based.

A second consideration comes from presentations by two mental health researchers. One was a forensics psychologist who presented his research of people convicted of sexually assaulting women, the majority of whom are men. His findings have continued to show that it is sexual desire that motivated most research subjects, rather than a wish to dominate and control. The other presentation was by a psychologist researcher at an international forensic mental health services conference in which she summarized almost thirty years of research on intimate partner violence. The researcher explained that evidence continues to reveal that a non-trivial percentage of events involve women initiating violent, non-self-defensive behaviours against men. Both speakers discussed how these findings can challenge certain advocacy groups' positions. They

also invited their audiences to bring forward any countervailing studies. Each presentation highlighted for me the ongoing value of seeking out and paying attention to research that challenges common public discourse *in parallel with* seeking out and paying attention to public discourse that challenges research.

The third consideration turns us to Judith A. Cook's article (2000) about sexual expression and behaviours of people living with a mental health concern. She has researched and written extensively about the experiences and perspectives of people who live with a mental health condition. She compellingly reminds us that:

At the same time, however, people with psychiatric disabilities manifest considerable strengths. These include being more *accepting of difference* among other people and more tolerant of diverse and alternative viewpoints. Many consumers are very *self-aware* given that they receive so much feedback about their emotions and behavior from clinical and social service professionals. Those who have had years of experience with this disability often develop a set of *survivor skills* that stem from being forced to exist on very low levels of income, dealing with a capricious social service system, and coping with highly inadequate resources. They often are people with a *sensitivity to oppression* and a strong desire not to oppress others, given their experiences with curtailment of their own civil rights in the name of treatment. Finally, some consumers have a tendency to challenge "accepted reality," asking why things are as they are, and having the ability to envision alternatives, some of which are ideas that make others uncomfortable or uneasy by upsetting the status quo (197).

On behalf of *JEMH's* editorial board, my sincere thanks to the authors for accepting our invitation to share their knowledge, experience, concerns, and hopes about this topic. We hope this special issue encourages and helps mental healthcare workers and their organizations to begin the long overdue revamping and enhancing various practices and responses to clients' sexual and intimate needs, behaviours, interests, and well-being.

Footnotes

1. It is unclear who coined this rhetorical phrase first. It has been attributed to Hillel the Elder, John F. Kennedy, Robert Kennedy, Ronald Reagan, and Martin Luther King.

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Competing interests:

I serve as a contributing editor and Board member for JEMH.

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