SEX BETWEEN PSYCHIATRIC INPATIENTS

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This report reviews the literature on the subject of sexual activity between psychiatric inpatients. The author discusses the psychological reasons why patients engage in sexual activity as well as the possible psychological effects. In addition, the author discusses medical considerations including concerns about injury, pregnancy, and venereal disease and legal implications including issues related to wrongful life, wrongful birth and deteriorating mental condition resulting from sexual activity. The report also discusses ethical issues, staff attitudes and various options for management of sexual activity between patients.

On inpatient psychiatric units, patients display certain behaviors which are implicitly or explicitly prohibited (e.g., violence to others, suicidal acts, or sexual acting out). Although much has been written about physical assaults and suicidal behavior on inpatient units, surprisingly little has been written about sexual activity between patients. This report discusses the incidence of sexual activity between inpatients and reviews psychological, medical, legal, and ethical issues as well as staff attitudes and management considerations related to sexual activity between patients.

INCIDENCE

It is difficult to know the true incidence of sexual contact between patients since sexual activity is a private matter and many cases go unreported. Modestin found nine instances of overt sexual exchanges among 1,060 patients, with sixteen patients involved in the exchanges. The sexual interactions involved genital intercourse in five patients. His design consisted of procedurally requiring a report of all reported sexual contacts occurring on the unit in the period of study.[1] Akhtar, *et al.*, reported 34/1,120 patients had engaged in overt sexual activity during two years. Five/1,120 engaged in sexual intercourse.The design of Akhtar, *et al.*, was retrospective in that he met with each staff member and asked them to recall occur-

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rences of sexual involvement of patients during the prior two-year period.[2] Even though the true incidence of sexual contact between patients cannot be established, it seems probable that the incidence increases when the setting permits greater privacy and there is decreased nursing staff availability to supervise the patients. For example, in Akhtar's study, it was reported that most incidents occur in the patients' bedrooms and during evening hours when patients are afforded the most privacy.[2]

Keitner, *et al.*, suggest that emotional and sexual relationships between patients are most likely to develop on units with middle range lengths of stay (more than 2-4 weeks but under 3-6 months).[3] Nevertheless, as reported by Harticollis and Morgan, *et al.*, emotional and sexual relationships do occur between patients on long-term units[4,5] and in fact may even be more of an issue on units with chronic patients with longer lengths of stay.

Akhtar's study showed that psychiatric inpatients who engage in overt sexual behavior were more often younger, single, character-disordered or mentally subnormal than the remaining inpatient population.[2] Morgan, *et al.*, compared patients who displayed emotional interest in patients of the opposite sex with those that did not and found the former group to be less ill, less withdrawn, and less often schizophrenic,[5] i.e., patients who are better able to form relationships. On units with adolescents, sexual activity may even be more of a problem than on units with only adults. Nevertheless, sexual contact has been reported between patients from many different diagnostic and age groups.

Psychological Factors

It is unwise to generalize about psychological factors causing sexual contact or resulting from sexual contact between patients. Patients who engage in sexual contact on an inpatient unit likely do so for a variety of psychological reasons. The literature on this subject implicates a number of psychological factors and dynamics including: acting out staff's expectations,[6] proving masculine identity,[6] meeting dependency needs,[1,6] expressing aggression through sexual activity,[1] anger at staff,[6] compensating for feelings of loneliness, boredom, or emptiness,[4] response to hallucinations or delusions,[1,2] and acting out transference feelings about therapist.[4]

The psychological effects of sexual contact appear to depend upon many variables and are viewed differently by different observers. The range of psychological response of patients to sexual contact includes observations that the experience was harmful and caused ego disintegration and psychotic regression,[7] led to an emotional symbiosis that caused a decreased impetus towards independence, separation and growth,[6] retarded recovery,[8] and resulted in sexual promiscuity, acute decompensation or suicide when the patient experienced rejection at the end of the relationship.[4] Other reports suggest that emotional and sexual relationships may in fact have positive aspects because patients feel helpful to each other[7] or patients may learn how to handle relationships[3] or the patient may become more cheerful, energetic, and engaged in treatment.[4]

Medical Factors

When sexual contact occurs between patients on the unit, the major medical considerations relate to possible physical injury to the woman, consideration of

pregnancy prophylaxis, and venereal disease counseling. Pregnancy prophylaxis is important because psychiatric patients have high frequencies of contraceptively unprotected coitus, unwanted pregnancy, and unwanted births.[9]

Legal Implications

One of the legal implications of sex between patients is that a female patient may press legal charges against the hospital or the assailant, claiming rape as a result of her hospital stay.[2] Section 261 of the California Penal Code defines the crime of rape as occurring where the victim is "incapable through lunacy or unsoundness of mind, whether temporary or permanent, of giving legal consent." This issue of whether or not rape had occurred was reviewed in a recent case in a University psychiatric hospital involving sexual intercourse between an acutely psychotic woman and a man hospitalized with a severe character disorder. In that case, legal counsel stated that the patients were presumed competent and, therefore, capable of giving consent. The woman had not been judged incompetent and the California Welfare and Institutions Code specifically states that involuntary admission to a mental health facility does not presume incompetence (Section 5331) (Personal communication from University of California legal counsel). In another situation, a psychotic victim reported being raped in a locked facility. Although the district attorney's office believed that the rape had occurred, they decided not to prosecute because both victim and assailant were psychiatric patients, and it was felt that the psychotic victim would not be able to be a good witness nor give a rational, coherent history. Instead, the assailant was transferred to another locked facility (Personal communication from San Francisco District Attorneys' Office).

Another legal issue relates to the hospital's responsibility to prevent pregnancy.[2,10] In a recent case, a woman became pregnant at a mental health facility and both she and the child sued her conservator and the physicians at the facility for failing to provide adequate supervision. The court ruled that the hospital was not reponsible for her pregnancy and that hospitals should not infringe on patient's personal rights. The court stated that mental health professionals are expected to opt for the treatments and conditions of confinement, least restrictive of patients' personal liberties, that maximize patients' individual autonomy, reproductive choice, and rights of informed consent. Another part of the suit related to "wrongful life" filed by the infant. The court ruled that "wrongful life" damages only apply where there is a failure to diagnose and warn parents of the probability that an infant will be born with a disability and the infant is in fact born with that disability. In this case, the infant was apparently healthy and, therefore, no damages were awarded.[11] It is possible that hospitals could be deemed responsible for "wrongful life" if an infant with a congenital disability were born. Another part of the suit related to "wrongful birth" because the patient was not given contraceptive counseling nor was her pregnancy diagnosed until two weeks before she delivered, at which time it was too late for an abortion. The Court of Appeals ruled that the hospital might be responsible for damages if the patient could prove that she would have taken advantage of contraceptive care if it had been available and that she would have consented to an abortion or her conservator would have been able to obtain permission from the court to authorize an abortion. This certainly has implications for future legal actions.

Another legal issue relates to whether the hospital is negligent and liable when a patient engages in sexual intercourse and her mental condition worsens. A recent decision by trial court and confirmed by appeals court ruled that the hospital is not negligent because the medical treatment plan and medical judgment required that restrictions of the patient be kept at a minimum to restore confidence in herself.[12] The court ruled that keeping the patient in strict confinement may have curtailed her sexual activities but would not have helped her other psychiatric problems.[12]

Moral-Ethical Issues

There are ethical and moral issues related to the problem of sex between patients. One such issue concerns pregnancies which may result from sexual contact.[4] One report warns that the general public will loudly condemn the hospital administrator who does not keep illegitimate pregnancies in his institution to a minimum.[10] Another report points to the obligation to protect minors and the elderly from sexual and emotional exploitation and to the moral responsibility to assure the spouses of married patients that the patient will be protected while in the hospital.[3]

When patients' rights are considered, the rights under consideration sometimes appear to be in conflict. On the one hand, the patient should have the right to privacy and also have the right to make the decision about engaging in a sexual relationship. On the other hand, the patient has the right to be protected from exploitation during the course of a hospitalization. Some patients' rights advocates have taken the position that patients should be able to engage in sexual activity unless good cause exists for denial of that right. In those particular cases, sexual activity could be restricted accordingly (Personal communication from San Francisco Patients' Rights Advocacy Service).

Another ethical issue relates to the use of the morning-after pill for pregnancy prophylaxis with its potential long-term side effects.[13] In a recent case of sexual intercourse on an inpatient unit, the woman was deemed to be in a fertile period of her menstrual cycle and was not using contraception. The staff felt that the patient was too psychotic to give informed consent, so obtained consent from her legal guardians, her aunt and uncle. They wondered whether this was an appropriate decision for anyone to make besides the patient. They wondered whether it would have been more ethical to withhold the morning-after pill and have the patient make her own decision about abortion after she was no longer acutely psychotic. On the other hand, they postulated that the patient would probably not have wanted an abortion because she was a devout Catholic who opposed abortion. Yet, she also would not have wanted an illegitimate child which was conceived while she was in a psychiatric hospital. This ethical dilemma has no easy answer.

Staff Attitudes

Previous reports have described some of the different and conflicting attitudes that staff have about sexual contact between patients. Staff may feel angry at the male patient and ignore the female patient's seductiveness or they may feel angry because they perceive the sexual behavior as a challenge of their authority.[2] Staff members may feel angry about their powerlessness to prevent sexual contact:

"There's nothing we can do about it so they may as well go out and do it, and do it good."[6] Staff may be reluctant to confront patients because they are afraid of the anger that may be expressed if patients are expected to delay gratification.[6] Staff may also feel that a relationship is helpful to a patient and may give tacit silent approval by not reporting the event.[7] Staff may also deny or disbelieve the situation because of their own embarrassment or anxiety about male-female relationships[2,6,14] or they may react with overinterest, overindulgence, and voyeurism.[6] Staff may also feel uniformly negative about sexual interactions between patients because they feel only very disturbed patients are involved, ones who have impaired reality testing and limited ability to make decisions.[1]

It has been suggested[3] that it is always important to have a staff meeting to discuss sexual incidents on the unit and clarify conflicting attitudes on the part of the staff. When there is an unclear and passive approach to relationships between patients, problems on a unit are compounded. The patients, who expect something to be done, may escalate to attract attention. Each team member may react in an idiosyncratic way which may lead to an increase in the anxiety level of both patients and staff.[3]

Management

Several authors have stated that sexual activity between psychiatric inpatients should be strictly prohibited[2,6] and when it occurs patients should be isolated, given the opportunity to express needs verbally, and tranquilized if necessary.[2] Others have suggested approaches including conjoint therapy with the purpose of separating patients[7] or with the purpose of helping them develop their relationship.[3] In a survey of 70 inpatient psychiatric units in Canada, approximately 20% of the units said that they separated involved patients, 20% of the units supported relationships and 40% of the units used other approaches including common sense, confrontation, individual therapy sessions, group discussions, staff meetings, and discharge of patients. Staff on longer-term units tended to be more supportive of the involved patients and to use the situation more therapeutically than did staff on shorter-term units; this was possibly because it was known that the situation might well be repeated, since the involved patients were expected to be hospitalized together for some time. On shorter-term units, the tendency was to separate sexually involved patients.[3]

A previous report delineated a written policy based on the principle that sexual and emotional involvement between patients may either be helpful or harmful, depending on the situation.[3] The policy on that unit explicitly stated to patients: "If you develop a relationship with another patient, staff will get together with you to help decide whether this relationship is beneficial or detrimental to you and whether it would be to your advantage to continue or discontinue the relationship."

On the University of California, San Francisco, locked crisis intervention unit, with an average length of stay of two weeks, a position was achieved that seems appropriate for that program. Since most of the patients are acutely psychotic and have impaired judgment, the expectation is that they will not engage in sexual activity while they are hospitalized because of the potentially damaging psychological and medical effects. After they leave the hospital, they are free to engage in sexual

activity with whomever they please. The staff attempts to prevent sexual contact by including in the patient handbook each patient receives on admission the rules regarding the prohibition of sexual contact. When sexual contact does occur, the staff conducts an administrative and clinical review by meeting individually or jointly with all the involved parties, including each involved patient, the person who discovered and reported the incident, and the primary therapist of the involved patients. The purpose of the review is to learn more about the incident and why it occurred. The staff also tries to determine what effect it has had on the involved patients, what is the best psychiatric and medical treatment for the patients, and how further sexual activity can be prevented. The episode is also discussed in a staff meeting to enable staff to express feelings about the patients and the incident. When indicated, the incident is also discussed in a group with the other patients to deal with issues that other patients may raise, e.g., are they safe on the unit.

CONCLUSIONS

In this paper, the complex issues related to sexual activity between inpatients have been reviewed. Sexual activity will continue to occur between patients and each inpatient unit must struggle to develop a management approach and an understanding of each episode in the context of the dynamics of the individual patients and the philosophy of the particular unit. This paper has delineated some of the psychological, medical, legal and ethical factors that should be taken into consideration.

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