Abstract

Forensic mental health inpatients in medium secure settings have a limited capacity for sexual expression during their stay in hospital, due to a number of factors, including a lack of willingness on behalf of staff to engage with sexual issues, as a result of safety fears and ambiguity regarding the ability of the patient to consent. Furthermore, UK forensic medium secure units do not provide conjugal suites for patients to have sexual relations, with their spouse or other patients. To date, there is no empirical research on how forensic psychiatric patients (or service users) manage their sexuality, whilst in hospital and when released into the community. Here, we present an analysis of semi-structured interviews with patients at a UK medium forensic unit, in order to explore these issues further. More specifically, we examine how the public exclusion of sexuality from these units results in sexuality being experienced as sectioned off or amputated, such that a new form of sexuality emerges; one that has been cultivated by the psychologically informed practices operating within the unit. This process, we argue produces a Psychologically Modified Experience (PME), a new form of self-relation that continues to modify when released into the broader ecology of the community.

Introduction

Forensic mental health services in the UK are based around secure hospital units, varying from low to high security, that are embedded in local health services. Persons diagnosed with severe or enduring mental health issues who have entered the criminal justice system after committing a criminal offence – known as an 'index offence' – may be detained or 'sectioned' under the Mental Health Act (1983) and subsequently transferred to a secure unit for a significant, open-ended period of time. Two-thirds of forensic mental health service users spend over two years on a section, with twenty percent detained between five and ten years and eighteen percent between ten and twenty years (Rutherford & Duggan, 2007). This period of detention can occur at a critical period in the individual's development of adult sexuality and personal relationships, with over half of all patients being within an age range of twenty to forty years of age (Rutherford & Duggan, 2007). Sexuality and personal relationships are therefore significant issues for service users (Lowson, 2005). However, we have found in previous studies

(AUTHORS, 2007) that staff working in secure forensic mental health units express significant concerns around service-user sexuality.

When patients engage in sexual activity with one another, this raises a significant number of dilemmas for staff. This includes the impact of such activity on the health and wellbeing of the patients concerned, given their current state and the timing of the events concerned in relation to the duration of the stay on the unit. It also raises a concern for patient's rights and whether sexual activity has been consensual for all who are involved. We found (AUTHORS, 2007) that staff reported extensive discussions following reports of sexual activity amongst patients that dwelt at length on practical matters such the nature and duration of the activity, consent, exploitation and future consequences.

However, there is good evidence that positive experiences of sex and intimate relationships can increase the likelihood of stabilising mental health (Kawachi & Bergman, 2001). Gilburt, Rose & Slade (2008), for instance, have shown that the formation and maintenance of positive interpersonal relationships (including those of a romantic and sexual nature) improves services users' experiences of hospital stay and life in the community. Nevertheless, there are clearly deep-rooted aspects of current practices in forensic mental health services and the organisation of secure units that make patient sexuality a problematic object.

In previous work (AUTHORS, 2007), we have focussed on the staff perspective, such as that expressed above. Here we now turn to explore what it means for the service users themselves to be confronted with the institutional difficulties of managing sexuality and relationships. Service users have to literally incorporate this problem, since it has considerable significance for their daily conduct and how they relate to their own embodiment as sexual beings. In this paper we will present material drawn from interviews with both male and female forensic mental health service users currently on a section in a medium-secure unit in a large city in the UK. We will examine how local practices on the unit shape the way that service users relate to their own sexuality and personal relationships and explore how this

impacts on service users' ongoing understanding of their mental health. We will also consider the relevance of the transformations that occur in such self-understandings to an eventual return to the community.

Our discussion is structured in the following ways. First of all we will attempt to identify the key tangible features of current forensic mental health practice on secure units in the UK that render sexuality and personal relationships as problematic. We will then introduce the study we have conducted, and proceed to describe three themes emerging from the data that we refer to as 'exclusion', 'territorialisation' and 'amputation'. All three deal with the transformation of service users' self-understandings of themselves as sexual beings. We then offer the concept of Psychologically Modified Experience (PME), an analogy based on Genetically Modified Organisms (GMO's), in order to articulate something of how formal psychological knowledge around risk and mental health can restructure the individual experiences of service users. This allows us to speculate, in the concluding section, on how the self-understandings generated during time spent on the unit may shape the experiences of service users when they return to community life.

Managing sexuality and personal relationship in secure forensic mental health settings

Dein & Williams (2008) argue that there is a general lack of formal policy regarding intimate sexual relationships across forensic psychiatric services in the UK. In the absence of such policy at national level, individual units have tended to adopt a default position of prohibiting sexual activity amongst forensic patients during hospital stay, although visits from spouses and community leaves can be facilitated during the progression from an acute condition to rehabilitation (AUTHORS, 2007). This is often reinforced by an implicit assumption that service users will themselves want to give up on the idea of a sexual relationship for a few years until the 'disease' is well managed, or the risk to themselves or others, can be considered minimal (Deegan, 2001). In institutional terms this assumption reinforces the idea that engaging in sexual behaviours may be an obstacle to recovery, and that during periods where the service user is deemed to be unwell they are seen to potentially have a limited capacity to

consent to a sexual relationship.

This practice appears to be odds with the recommendations from a recent report by the Royal College of Psychiatry (2007) in the UK that stated that the decision to obstruct patient relationships should only be enforced when the patient is deemed sufficiently incapacitated, and have little understanding of their choices within a sexual encounter or relationship. However, these decisions are often left to the discretion of individual practitioners who do not have access to clear recommendations within their NHS unit, or have the facilities to provide a space for the expression of sexuality within inpatient settings. Intervention may then very often be based on individual staff member's personal tolerance regarding sexual conduct or their personal judgment regarding the relative vulnerability of the patient or their perceived predatory characteristics (Modestin, 1981; Civic, Walsh & McBride 1993). This occurs in a context where sexual activity in general psychiatric hospitals is more common than at once was thought, with some studies suggesting around thirty percent of patients engage in some form of sexual activity during their stay in hospital, despite the existence of a 'no sex' policy on most units (Warner, Pitts, Crawford, Serfaty, et al, 2004). As a consequence, there are no conjugal suites in the UK for detained persons. However, in some high security hospitals such as Broadmoor, patients are allowed a certain degree of freedom of sexual expressions; holding hands, but no sex (Dein and Williams, 2008).

It is notable both the extent to which sex is relatively absent from debates about forensic mental health services, and the relative absence of sex as a topic in clinical discussions with patients. This absence is intelligible within a discourse of otherness where the sane and insane are separated and treated differently, in effect prohibiting the procreation of insanity (Perlin, 2000, Goldenberg et al 2000; Deegan, 2001). Indeed, the possibility of any unplanned pregnancies within the unit and the potential for the genetic transmission of mental illness was discussed by some of the forensic mental health professionals interviewed in a previous study (AUTHORS, 2007).

In the case of forensic mental health services users, there is the additional factor of the 'index offence' – the criminal act that they have committed which has resulted in detainment under the Mental Health Act (i.e. sectioning) – which creates a kind of double exclusion on the grounds of both mental health and criminality. Hence the absence of clear or formal policy and practice (though not *concern* as such) regarding sexuality and relationships might also be seen within the context of a discourse of punishment and reparation where forensic mental health users are seen as undeserving of the liberty of sexual expression, and where if they do seek to engage with sexuality, it is treated with suspicion. This was the view also posed by mental health professionals (psychiatrists and clinical psychologists) interviewed for the previous study, who believed that society at large regarded a forensic mental health unit as a place of punishment, whose residents should not be entitled to sexual freedom and intimacy (Authors, forthcoming).

A pervasive discourse of risk, predation and vulnerability exists in relation to forensic mental health service user sexuality (and of course beyond, to general issues regarding the patient's own, and others' safety) (Sullivan, 2005). Discourses of sexual vulnerability and risk intersect with gendered discourses, such that women patients, who often have histories of child sexual abuse, are positioned as vulnerable and in need of protection from further harm and exploitation, given the potentially greater likelihood of sexual re-victimisation and abuse in adulthood (Coid et al, 2001). Men on the other hand are more likely to be positioned as sexually predatory. In general, staff may be concerned that patients with a history of child sexual abuse (especially women) may be less able to consent to sexual encounters and be at risk from physical and sexual attack, especially when located on a mixed ward (Batcup, 1994; Department of Health, 2002). Where men are positioned more readily as predatory and women as vulnerable, there is growing justification for the national implementation of single sex wards in forensic settings, in order to increase (female) patient safety (Department of Health, 1997, 2002 & 2003; Mezey, Hassell & Bartlett, 2005). However, in 2007 it was reported that the Department of Health had disclosed that eliminating mixed-sex wards was no longer an aim and up to a third of hospitals still continue to use them (Fleming, 2007).

In summary, the focus of clinicians in secure forensic mental health settings in the UK is on stabilizing the condition of service users. Whilst there is recognition of the potential benefits of sexual expression and personal intimate relationships, in the absence of formal policy to the contrary, sexuality is typically considered an obstacle to recovery. This is differentiated by gender, with female service users seen as 'at risk' and male services users seen as potential sexual predators. Furthermore, since clinicians are operating in the intersection of mental health law and criminal law, the loss of sexuality may be implicitly framed in terms of the appropriate withdrawing of civil liberties that follows a criminal offence. Taken together, these discursive features of forensic mental health services create a particular context for sexuality on secure units that includes – the use of single sex wards, the ommission of sexuality in diagnostic formulation, the attitude of staff towards sexuality and personal relationships, and the structuring of contact and community leave in relation to length of stay and rehabilitation.

Details of the study

The material discussed below comprises of our analysis of interviews with forensic mental health service users based in the same location to the staff and clinicians who participated in our earlier study (AUTHORS, 2007). This study then represents the experiences of service users who are engaging with the practices and views described in the earlier study.

Access and recruitment

Between November 2008 and September 2009 twenty participants, aged between 20 and 55, were interviewed by the first and third author at two medium secure forensic mental health units. The ethnic backgrounds of the participants were two African, nine African Caribbean, four White English, one White Jewish, one mixed Caribbean and White English and one Mauritian, one Sri Lankan and one mixed Iranian and white British. Eleven self-identified as working class and nine middle class and fifteen men and five women were interviewed in total. The participant sample reflects the typical (and disproportionate) proportion of Black and Minority Ethnic (BME) patients more nationally

(Rutherford & Duggan, 2007). The hospital contained patients from all wards, including rehabilitation wards, where supervised and unsupervised community visits were permitted. All of the wards were single sex, with less than twenty patients per ward, each with their own bedroom. The patient length of stay ranged between two and fifteen years. Most of the participants had been diagnosed with a psychotic disorder or severe depression and all were receiving medication via depot injection.

Participants were recruited directly through visits to the ward and informal discussions about the nature of the study and what would be required from them if they chose to participate. All participants were informed about the research during their appointment with a Consultant Psychiatrist, and were subsequently approached by the third author who had been working at the unit for a number of years prior to the study. Before direct contact with the patients was established, however, members of the professional forensic ward teams were consulted during a pre-ward round meeting to identify any patients who they felt were too distressed to participate in an interview. A list was drawn up of suitable patients and those patients were approached via informal discussion and the provision of relevant material about the study's aims and objectives. Participants whose index offence was sexual in nature were excluded from the study altogether, on the advice of the mental health team and the judgment of the authors more generally. Before access to patients or staff was permitted, ethical approval had been granted by the local NHS Research Ethics Committee and London South Bank University Ethics Committee.

Interviews

Verbal data was collected, via semi-structured interviews. An interview schedule was developed by authors one and two, based on their reading of previous literature, and using issues arising from a previous study conducted at the same unit with mental health professionals (AUTHORS, forthcoming). The interview began with participants talking about their lives, without being asked about their index offence or mental health diagnosis. However, if participants chose to discuss these issues, they were permitted to do so. Further questions were based around thoughts and feelings about sexual issues,

access to sexual activity and the general atmosphere on the ward, as well as staff attitudes towards sex, perceptions of the self, relationships in the past and potential relationships and sexual activity in the future. Furthermore, participants were asked to discuss the role that sexuality played (or did not play) in relation to their general well-being, mental health and recovery. Throughout, the interviewer used prompts and encouraged exploration of the issues with the participants, in order to check for meaning and to ensure understanding. The mental health team had pre-warned the research team about the possibility of difficulties with concentration levels, so this was taken into account throughout the interview process. The interviews were audio taped for transcription and ranged from 30 to 60 min.

Analytical approach

The interviews were transcribed in full. An initial thematic decomposition (Stenner, 1993) of the interviews was then carried out in order for a broad thematic map of the interviews to be established. All four authors were involved in the initial thematic analysis of the data. Here we present three themes that emerged from the analysis. We subsequently developed a theoretically informed concept – Psychologically Modified Experience (PME) – in an attempt to posit a process at work across the three themes. This concept brings into focus the way in which psychologically informed practices generate the novel sets of self-relations that were expressed to us in the interviews. We argue that this process is the transformation of service user's sexuality as a function of the way sexuality and personal relationships are managed in the secure unit. The PME concept is then a way of organizing inductively derived analytic points in relation to a broader knowledge of the setting and the practices that we have built up across our studies.

Findings & Discussion

In the following sections we explore sexuality in the context of life on the secure unit. We have emphasised that there are a number of aspects to how the unit is organised that may impact on services

users experience of sexuality and personal relationships. But it is also important to note that for service users sexuality is potentially further complicated by the use of neuroleptic and antipsychotic medication. This may result in a range of issues relating to sexual activity including erection and ejaculation difficulties in men, menstrual irregularities, vaginal dryness, anorgasmia in women, lactating breasts and enlargement of the breasts in both men and women (Kelly and Conley, 2004). Other potential side effects can include, shuffling gait, masked expression, bulging eyes, dribbling, weight gain and secondary complaints such as diabetes and a subsequent lack of sexual interest caused by the sedative effects of some of the medication (McCann 2000, Kelly and Conley 2004, Mackin, Watkinson and Young 2005, Fortier et al. 2000, Sullivan and Lukoff, 1990). Sexual expression is then a complex matter for service users.

Exclusion

In our study we chose not to discuss the nature of their index offence with participants. It was noticeable that where participants chose to refer to their offence it was always done in the context of 'being unwell' and contrasted with the rehabilitation process. In a secure unit, mental health is one of the major discourses in which to frame the life trajectory services users are following. The other discourse, of course, is the assessment of the risk a patient poses to themselves or others. Issues of health and risk are then often intertwined in how service users describe their progress through the duration of their section.

We asked all our participants whether on admission they had been formally asked by staff about sexual issues or their sexuality. The responses were overwhelmingly negative:

> I've got years experience, and the concept of sexuality doesn't come up. It doesn't come up, you know. I can only imagine that certain cases where the service user is convicted of rape or child molestation, of which I am neither, erm, then, erm obviously that is the main topic. The emphasis on sexuality is taboo, its terminus in many intents and purposes.

> I think they feel uncomfortable talking in any, any depth about my sexuality. I don't think they've been trained to - I don't think that they, they have the erm, the insight. I'm sure we could have a very sensitive discussion with them about it, but for some reason, there's a barrier and I can't understand why.

Both of the service users quoted here unequivocally state that sexuality is not a matter which staff invite them to discuss. As the second service user speculates, there may be reasons for this exclusion of sexuality, but these reasons are not entirely clear to patients. Furthermore, the exclusion of sexuality appears to begin with admissions interviews and then is maintained throughout further consultations. Some hospitals actively operate a 'no sex' policy (Warner et al, 2004), such that sexual activity is punished. This exclusion is perplexing on numerous grounds. It is well known, and reflected in diagnostic categories, that prior sexual abuse may be a factor in the development of a mental health crisis. Most surveys also point to the relatively high prevalence of these traumatic experiences amongst forensic mental health populations (Briere et al, 1997). At the same time, newly admitted patients to the ward will already be taking prescribed medication, mostly to manage psychotic and depressive symptoms. These will typically have an effect on sexual desires and functioning. Finally, since the ostensible purpose of sectioning is to stabilise mental health until the service user is able to return to the community, managing personal relationships and sexuality would presumably be one important aspect of the rehabilitation process.

Excluding sexuality from formal consideration does not, of course, banish it from the ward itself. Sexuality and relationships remain a concern for service users. One difficulty for service users is establishing how they can talk about sexual issues in the context of a focus on index-offence and rehabilitation relevant symptoms:

> I find that they're generally not approachable you know if it comes – you talk about the medication, you talk about you know they've got a checklist of things that they want to talk

about…And any deeper issues I find that I can't talk to them about it. No. No…The deeper issues no…You can talk about the medical side of things…and you know how you're feeling, whether you're experiencing symptoms, you know how – how are you coping on the medication with side effects and things like that. You know what's – you know in general terms how you are progressing, but deeper things, you can't talk to them about. I've tried and they just go back to their checklist…and just ticking boxes.

In this extract, a distinction is made between 'the medical side of things' and 'deeper issues', which include sexuality. Interactions with staff are described as being driven by a checklist. This defines what is and is not relevant in terms of the rehabilitation process and mental health more generally. Since sexuality (and other 'deeper issues') are absent from the contents covered by the checklist, a service user who wished to make sexuality a topic of discussion would need to explicitly frame their concerns around this issue with respect to 'symptoms' and the 'medical side of things'. The risk of attempting to do this is that the kind of psychologically oriented medicine that operates in forensic mental health services is medicine filtered through the law. It has two default positions in which sexuality might be relevant. Sexuality is either a sign of 'vulnerability' that may be seen as a threat to rehabilitation, or sexuality is an expression of 'predation', which risks reversing the transformation of the offender into a service user. To a great extent these are also gendered positions, with female patients seen as in need to being 'sheltered' from the risks of engaging with sexuality, in the name of maintaining their recovery from poor mental health, and with male services users seen as needing 'containment' from temptations that would potentially compromise their current medical-legal status.

Framing the terms in which sexuality is relevant in this manner creates an awkward self-relation for service users. It can result in a kind of willed deferral of sexuality as something that has to be hidden or ignored until the service user returns to the comparative freedom of the community:

Well I can't really talk about my sex life or my relationships. There are no women in here and

> um, I'm not looking for that type of relationship. When I'm in the community now, that might be a completely different thing, but um it's not something, which is my main focus. My main focus is for me to get off this err, this err Section and for me to have a normal life out there in the community.

The paradox involved in this strategy of self-management is that having a 'normal' sex life on return to the community is anything but straightforward. Initiating new relationships or returning to existing relationships as a forensic mental health service user is fraught with difficulties, not least amongst which is managing the disclosure of one's past and current status and dealing with the physical side-effects of medication on sexual functioning. Furthermore, given the comparative youth of the majority of patients in secure forensic mental health services, a large number of services users may lack significant life experiences with negotiating intimate relationships. As we will describe later on, the exclusion of sexuality and its enfolding into a discourse of vulnerability and predation leave service users significantly ill equipped to deal with the challenge of re-engaging with a deferred sexuality once they return to the community. It also means that service users are unwilling to even address these issues whilst they remain on the unit out of fear that their sexual behaviour will be treated as a threat to their rehabilitation.

Territorialisation

Sexual encounters are necessarily excised from the accounts service users provide to staff. Sexuality is literally sectioned off from adherence to the rehabilitation regime. This has the consequence that when services users do seize the opportunity to have sex it must be conducted in ways that give rise to precisely the kinds of concerns in which staff frame sexuality. Take the following example:

> sex is an organised act that two people come together and do - and they're going to do it wherever that is, you know, under a tree, at the end of a tunnel, they're still going to do it. Like, there's an old corridor. And there was a place where you hang your coats, where you can't see

> people when they looked down there. So I walked in and went to put my coat round there and they (two male patients) were having sex in the corner…and it's not the first time they'd done that actually, they'd done it somewhere else as well.

Because sex and sexuality cannot be openly acknowledged on the ward outside of the terms of a vulnerability/predation discourse, the two patients discussed here end up having sex under circumstances that are not only potentially risky, but could also be likely to be questioned as indicating a lack of sound judgement (i.e. as speaking to the vulnerability of one or both parties). When sexual and potentially sexualised acts are disconnected from their place in the ongoing experiences of service users, they become ambiguous and threatening signs. Being caught engaging in sexual behaviour is at the very least humiliating for service users, reinforcing a sense that of lack of privacy, and at worst can have ramifications for how progress towards rehabilitation is reviewed:

> I know they have to do the checks at night (..) when they're doing the checks, when they're doing their hourly checks, but it's a funny time - you get females doing the checks in the wee hours of the night when not only do you have all sorts in one's room, you have to, well talking about sexuality, if someone's masturbating then it can be very embarrassing to have a female pop their head up, you know, through the door whilst you're in full swing of things (…) Generally, most of the time there's a male doing the checks. But very often there's a female doing the checks. And I dread to think what the sights that many females have seen when they stick their heads (….) in the window at 1 o'clock in the morning. Yes, but there is that aspect of privacy in the (..) in search (..) in checks at night.

The bodies of service users are here effectively transformed into emitters of sexual signs which are taken as signifiers of progress in stabilising mental health. Deleuze & Guattari's (1988) concept of 'territorialisation' assists our understanding of this process. Territorialisation involves the isolation of particular qualities of a body that are then subjected to recoding (Author, 2001). On the unit, the

qualities in question are those normally associated with sexual expression. The isolation and extraction of 'sexual' qualities happens both through the discursive practices adopted in the unit, in particular the 'checklist' type application of categories for diagnosis and monitoring of forensic mental health, and through the physical organisation of the space in the unit, such as the distribution of public and private space, along with the routine monitoring of service users conducted at all time and in all aspects of how they inhabit the space. Territorialisation here transforms the qualities into 'signs' that signify vulnerability or predation, and whose ultimate referent is the supposed stability of the service users' mental health at any point. On the ward, there are no spaces where it is particularly safe to emit sexual signs – not even late at night in one's own room.

The exclusion of sexuality means that potentially sexualised aspects of some activities that routinely take place on the unit can be extremely difficult to manage for service users. For example, the delivery of depot injections, which are normally made into deep muscle tissues such as the buttocks, is fraught with concern on the part of service users:

> we are human beings and you know, it can be a little bit confusing sometimes when you've got a female coming in, giving you an injection…I mean it can be very confusing, you know, if - if - if, how can I say it, if it's okay for me to - to have a female come and give me an injection in my bum but it's not okay for me to, you know what I mean, stay overnight just to have sex with my girl, you know what I mean, and as far away, as close as you might agree with that, but it's actually it can be a bit confusing, you know…it's just the point of getting injections in your bum rather than in any other area of your body because that's - you know what I mean? It's like, you know, every month you get someone looking at your bum.

These routine encounters are difficult for service users to negotiate because they provoke a sexualised response. To expose a private area of one's body to a staff member would under any circumstances be problematic, but when it is conducted in the context where one must not emit 'sexual signs' it is, as the

participant above describes it, to say the least 'a little bit confusing'.

We might sum this up by saying that the territorialisation of sexuality in the unit *extracts* particular expressions from services users embodied acts, *isolates* and disconnects the expressions from how service users understand them in the context of their own mental health, *recontextualises* them in terms of a discourse of vulnerability/predation, and *reinserts* and *distributes* them anew as sexualised signs of mental health. In so doing it creates a new or novel form of relationship to one's own sexuality that service users are obliged to live out.

Amputation

Entry to the medium secure unit comes at cost of losing one's sexuality, which is left 'outside' and which one believes is to be recovered when one is discharged back into the community. Now of course it is worth noting that many other institutional settings have similar requirements – such as general hospitals, military service or prisons. However what makes mental health care services unusual in this respect is that sexuality and relationships may be seen to be pivotal to the very object of the practice itself. Unlike, say, a general hospital, where sex is not particularly associated with good recovery from a physical injury or disease, with respect to forensic mental health care, evidence tells us that positive experiences of sex and intimate relationships can increase the likelihood of stabilising mental health, making the exclusion of sexuality and relationship issues from the practice perplexing (Kawachi & Berkman, 2001). The exclusion of sexuality is not wholesale but rather creates a novel form of sexuality that comes to stand in its place. Furthermore, the psychological practices enacted on the ward that result in the exclusion of sexuality (Civic et al, 1993) cultivate a disconnected form of sexuality that does not link with the patients' previous vibrant and life-giving experiences of sexuality, as described below.

We will use the term 'amputated sexuality' offered by one of participants to describe this new form of sexuality that emerges on the unit:

P: I would say this place has amputated my sexuality. Definitely, it's – it's not my home, it's not – it's not a free environment and (…….) it's a – it's so anti-life. I just don't even think about sexuality in here and I grieve over that quite a lot. And (…..) I try and cope with this place on its own terms, you know and whatever it has to offer me I will engage with. So and try to make it a reality, its own reality but I still can't feel human enough to be a sexual being in this environment.

I: What – what is it about this environment do you think that makes you…

P: It's not my home. It's not my private home and there's no private space (…….) and (……) just not somewhere where I would choose to be, you know and all the things that you (……) take for granted when you aren't incarcerated so (…..) you know (…..) you – you know you go out for a drink, you can do what you want when you want more or less, obviously there are constraints on everybody. But that (……) sort of life force, that freedom that you have, that contributes to (……) erm your ability to be a sexual being really; it's to do with freedom

The salient features that this participant describes is a sense of sexuality being forcibly removed, cut off as a condition of inhabiting the space of the unit. One cannot, she states, be a sexual being in this environment since the space itself militates against all that gives life its vibrancy and sense of being 'at home'. The environment is 'anti-life', which has 'its own reality', a form of living without freedom, without privacy and with the complete absence of all that contributes towards the 'ability to be a sexual being'. Pitt, Kilbride, Nothard, Welford, and Morrison (2007) noted that active participation in life and meaningful activities form part of recovery, so the consequences of amputating sexuality reach far beyond matters of sexual satisfaction. It is not just the case that sexuality is off the agenda when it comes to discussing one's life on the unit and progress towards rehabilitation with staff. The arrangement of the space itself also undermines an ability to feel sexual in the way one is able to do at home. The contrast here is not between some kind of unmediated or 'natural' experience of sexuality that existed prior to detention and a mediated or 'impure' form of sexuality that emerges on the unit.

All sexual experiences and histories are complex, multi-faceted and highly mediated via our social and material environments (Butler, 1993; Weeks, 2003; Ahmed, 2006). The term 'natural' adds little to our understanding of this diversity. Nevertheless, it is noticeable that a reference to vitality or life appears in a number of accounts that describe what happens to sexuality on the unit, as in the following:

> I think it (sexuality) is relevant because I think it – I associate it with just general vibrancy…And – life force and a dynamic that's gone missing, it's disappeared. And it's (……) it's just – it's sort of marching down the street, it's running, it's skipping, it's all these sort of joyful and erm vibrant things you know it's (…….) it's just gone. Gone, you know.

A vibrant sexuality is one that is threaded into the broad range of emotions and forms of engagement that make up a life. It is part of the 'joyful' experiences that together lend living its tones and contours. By contrast, amputated sexuality is a way of relating to sex and sexual desires that is isolated and rendered as a matter of public concern (Lowson, 2005). It is sexuality turned into a set of signs that territorialised by the psychological concern for vulnerability and predation (or risk judged through intrusive surveillance) and indexed to the overarching trajectory of recovery. As such, sexuality becomes dangerous to express – since it may lead to negative outcomes in terms of the length of one's section. To speak of sexuality in this 'amputated' way is to necessarily articulate one's place in the ongoing organising of the unit. The cultivation of this new form of sexuality navigates the threat of continual surveillance, through which discourses of vulnerability and predation are enfolded and thus ever present.

By way of illustration we offer a small anecdote. One of us was interviewing a participant – a young man in his early twenties – in a side room facing the main nurses' station on one of wards. The interview was tense, in part because the researcher had not done a great job of communicating the aims of the study, but also because the participant had forgone the opportunity to step outside the unit to smoke a cigarette prior to the interview. The interviewer asked one of the final questions on the prepared schedule: what kinds of changes would the participant like to see made on the unit to better

support the sexual needs of service users? The participant leaned back and began to describe at some length how they would like to see strippers (i.e. exotic dancers) brought into the unit. They would dance in a room very much like this one, with patients crowded outside. A sliding curtain would be installed which could be raised by placing money in a slot – in other words, a peep show. The young man leant forward to act out how he would be staring at the stripper as he put in his money. The researcher was aware that in this enactment they were being placed in the role of the stripper and could see, behind the participant, the window over which the curtain would rise and fall.

This is the form sexuality can take on a forensic mental health unit, when it is formally excluded from discussions of mental health and turned into a sign that can be understood more readily with respect to risk, vulnerability or predation. The unit is an incubator of 'amputated sexuality', a new form of understanding oneself as a sexual being. On the one hand we might say that in a curious way this is a kind of revivified sexuality. For example, the young man described above might be characterised as demonstrating 'resistance' to the institutional management of sexuality (and indeed to being asked about private sexual matters by a researcher). His response to the exclusion of sexuality is to demand its return to the unit in an extreme and crude form. Similarly, the behaviour of the two men described in the last section, who took the opportunity when it arose to have sex on the unit, might also be characterised as resisting the prevailing norms of the unit. In Deleuze & Guattari's (1988) terms, we might see a moment of 'deterritorialisation' at work here, where sexuality becomes unbound or 'decoded' from its usual points of reference. But this moment is, we argue, very rapidly subjugated to a second moment of coding where sexuality is now referred to a discourse of risk and predation. The image of the 'peep show' is explicitly about surveillance, where sexuality is an object for the predatory gaze of the viewer. It entirely reflects the sorts of concerns about gender, sexuality and risk that result in the exclusion of sexuality from the unit, and echoes the practice of surveillance ('doing the checks') describes by other service users. We might then see this response as evidence of a 'self-fulfilling prophecy': making sex unspeakable ensures that its return in precisely the terms it was deemed problematic.

Our participants describe a form of sexuality that is immobile, where one is unable to move, to participate in the ongoing flow and movement of experience and life (where one can run, jump and skip). This amputated and immobile form of sexuality is thus potentially easier for staff to monitor, observe and potentially intervene in if it is static and hence contained. So we could say then that the practice on the ward has cultivated a more manageable form of sexuality, precisely because it is static hence locatable and observable at any given time. The minimisation of risk is also the potential consequence of this new version of sexuality and self-relation, as immobile bodies and minds are easier to contain than moving, free and expressive ones. One can have a form of sexuality, on the condition that it is territorialised and immobilised by a psychological practice. But on the other, this comes at the high cost of disconnecting sexuality from the broader range of emotional and 'vibrant' experiences in which one's sexual being had been developed.

Psychologically Modified Experiences

Our analysis of the material from the study has so far shown that whilst sexuality is formally excluded from the practices adopted in the secure unit, it nevertheless reappears both as a concern for service users and as an activity on the unit that can attract attributions of 'risk' and 'predation'. Service users come to relate to themselves as sexual being in a particular way, which we have named, using the words of one of our participants, as 'amputated sexuality'. What the data is telling us is that service user sexuality is being transformed. What we know from our experiences as researchers and from the existing literature is that this transformation is in all likelihood related to the manifest ways in which sexuality and intimate relationships are treated in forensic mental health practice and settings. The question then is around what form this relation between experience and setting/practice takes. How can we understand the process whereby service users relationship to themselves as sexual beings is transformed?

In order to do this, we offer a concept based upon an analogy as a way of organising our inductively

derived findings. Genetically modified organisms (GMOs) are organisms whose genetic structure has been modified through the deletion of genes or the addition of DNA molecules from other sources.. The qualities of a given GMO have been altered through progressive refinement, such that they are able to thrive and display particular attributes in conditions that would not otherwise favour such development. For example, corn can be progressively genetically modified to promote resistance to pesticides or to insects themselves. The science and industry underpinning GMO's, and in particular transgenic plants, has often been considered controversial, since it appears to be an artificial intervention into the natural world – such as with the accusation that GM food products are 'Frankenstein food'. The response to this accusation has been to point out that since the very beginnings of agriculture, humans have intervened, shaped and transformed the natural world to their own ends, through selective cultivation, breeding and other forms of mundane experimentation. Morton (2009), for example, argues that the very concept of 'nature' as in some way distinct to the human world has become an obstacle to ecological thinking, since it blinds us to the shifting, complex interconnections between all living organisms. We cannot say with any real meaning where 'nature' ends and 'culture' starts – GMO is merely an extension of this longstanding historical transformation of the natural world.

We want to propose that an analogy with GMOs is helpful if we think of the diversity of human experiences as constituting an 'ecology', along the lines originally suggested by Gregory Bateson (1973) and latterly by Felix Guattari (2000). Both authors seek to oppose a dualistic model of mind and its environment with a network model, where what is referred to as 'mind' names a sub-set of interactions between people and their environment that transcend classical subject-object divisions. Thinking is a practical activity is not solely located in the brain – it is mediated and distributed throughout the embodied engagement of persons with the world (a point also central to the 'extended mind' paradigm in current cognitive science). If this is so, then we might think of there being forms and patterns of sense-making and meaning that are situated within particular sociocultural settings which develop over time . To inhabit a particular sociocultural setting is then also to exist in a given ecology of possible

experience defined by the ways of making sense of and engaging with the world defining that setting.

If we think of sexuality in this 'ecological' manner, we can see that at particular times and places there is both diversity and constraint, in terms of what forms of experience appear to thrive best. We can also see that this selection of experiences is not arbitrary, but is instead actively driven by moral and political practices (Weeks, 2011). An ecology of experiences is not in any sense 'natural', but rather the ongoing outcome of interventions that seek to promote and cultivate particular behaviours and proscribe others. The diagnostic categories utilised psychological and psychiatric practices, for example, attempt to regulate and manage the experiences associated with mental health along particular lines. In doing so they may introduce 'novel' elements into the experience-ecology. For instance, mental health service users are encouraged to reframe distress in terms of a discourse of diagnosis, illness and medical management (AUTHOR, 2012).

Drawing on the analogy with GMO's, we will call these new forms of experience that emerges in a given sociocultural experience ecology as 'Psychologically Modified Experiences'. PMEs are experiences that are produced when persons are obliged to use a particular category as the means of self-understanding in the context of engaging with psychologically informed practices. A PME is a 'hybrid' experience in that is produced by combining and blending existing experiences with new elements. For example, an individual reporting that they hear voices is likely to be informed that this experience is a sign or symptom of an underlying psychotic illness. Thus any potential meaning that service user may associate with this experience becomes subordinated to formal psychiatric knowledge (Bentall, 2003). This makes PMEs simultaneously highly concrete – in that they incorporate existing lived experience – and highly abstract – in that they are combined with very general conceptual categories derives from psychological knowledge. Like GMOs, the development of PME's requires both highly technical knowledge and specialised environments (such as the ward system in secure mental health care). However, the PMEs which are inculcated in the specialised environment pass back into the broader experience-ecology carried by the person who has learned to make sense of their lives

using the categories associated with the PME.

The concept of a Psychologically Modified Experience (PME) based on an analogy with GMOs allows us to speculatively draw together the themes inductively derived from the data. We want to propose that the three themes that we have identified in the data are indicative of an underlying process whereby the self-relation that a forensic mental health service user has to themselves as a sexual being is transformed by the practices enacted on secure wards. This process begins with the exclusion and deferral of sexuality on entry to the secure unit. Discussion of sexuality does not appear to be a feature of initial assessments, and thereafter is not encouraged in interactions with staff. In its place, discourses of risk and predation abound as the means of reframing or 'territorialising' sexualised signs and behaviours. This is reinforced by everyday ward observations and by the kinds of institutional responses that typically follow from reports of sexual activity, as we described in the introduction. As a consequence, service users come to feel detached from their own sexuality, which is experienced as lacking in vibrancy and 'life' along with being potentially threatening. This 'amputated' form of sexuality becomes the sanctioned way in which to relate to oneself as a sexual being without inviting attributions of either vulnerability or predation.

Conclusions and Implications: Amputated sexuality 'in the wild'

We want to conclude our discussion with some speculation about what happens when 'amputated sexuality' is taken outside of the limits of the unit. If the novel form of sexuality experienced by our participants is the product of territorialisation that occurs within the secure unit then this mode of understanding oneself as a sexual being is carried into the rehabilitation process and into eventual release from the section back into the community (Pitt et al, 2007). This means that the psychologically modified experience of 'amputated sexuality' is released into the broader ecology of experience. Exiting the unit and returning to the community involved a series of stages, such as living in a hostel, and remaining in contact with community mental health teams who are there to assist with forging new social ties and maintain existing ones (Wolfson, Holloway & Killaspy, 2009). Whilst service users may

feel that they will at this point be able to pick up their sex life and personal relationship where they left off before being sectioned, this is typically not the case. There is also no formal policy on how service users might be prepared to re-engage this aspect of their life. For example, a recent report on rehabilitation of service users in the community makes no mention of how to assist individuals in developing or maintaining sexual or intimate relationships (Wolfson, Holloway & Killaspy, 2009). Instead the importance of 'social ties' is emphasised, alongside employment and poverty, which of course are known obstacles in relation to sustaining positive mental well being (Warner, 1994). However, a number of the participants we spoke to emphasised the importance for privacy in the rehabilitation process, so that intimate relationships can thrive. There is a continuing lack of privacy and a need to negotiate with psychological services during this rehabilitation period. Take the following example:

> But it's like getting the relationship, going through the arch at first. Like the hostel that I'm going to they're telling me that I have to sign in. How's my partner gonna feel about signing in? It's just for fire purposes, but when they come to see you...they question you about it. It's like they're in your business. Relationships should be private and personal, not public.

Here a service user describes the problems of establishing relationships whilst living in a hostel. Many such facilities do not allow guests to stay overnight. Where they are allowed on the premises itself, they are required to sign in. Whatever the purpose is of this practice, it amounts to a surveillance of personal relationships and makes it necessary for the service user to explain their status at a point in the relationship before it is possible to spend time alone together. In other words, the service user either needs to disclose their history and mental health status as a necessary precursor to intimacy, or is forced to conduct their relationship outside of their living space, and hence under conditions which have the potential for greater risk. And such behaviour is itself highly likely to be coded in terms of a vulnerability/predation and hence overall risk discourse (Sullivan, 2005).

In this way, we speculate that is it likely that amputated sexuality will remain the default mode for service users to relate to themselves and to others sexually. This is especially likely to be the case when service users begin relationships with one another. Clearly if one's daily life is structured around living in a hostel and attending day care centres, then fellow service users constitute the most likely set of potential partners (Angell, 2003). This has the added advantage of removing some of the barriers to disclosing one's identity, since there is already a shared understanding. Nevertheless, as this participant describes it, service users may feel there are risks to such relationships:

> Like when I go raving and find a girl we'd be in a relationship and within a month of sleeping with her. But now since I haven't been clubbing and I haven't been raving and that and I've been in a hostel, where I've got to be back at a certain time, and going to certain drop-in centres and meeting girls that are mentally ill as well. That's one of the issues (…) being around girls with mental illness. I don't wanna be around a girl that (...) if you have an argument with her she cuts herself, or thinks about committing suicide. Or she's so drunk she can't make love to you or whatever

What we see here is that amputated sexuality has become the frame in which this particular service user understands personal relationships with fellow service users. 'Girls that are mentally ill' are described here as highly vulnerable and emotionally unstable in the context of a personal relationship. We might say that amputated sexuality as an understanding of self and other has become so resilient as a way of engaging with personal relationships that it has in effect 'driven out' other potential understandings of sexuality.

When PMEs are released into the broader ecology of experience, the features of them that have been artificially strengthened or made resistant within psychological practice, becomes particularly pertinent. Since they have no existing place in the ecology they have a tendency to thrive, to take over the ecological niche, and in so doing drive out the other forms of experience. They become, in effect, one of the only experiences left available within the ecology. What this means is that when those

experiences return to psychological practice – when they are brought back for inspection – then they confirm the 'truth' of the practice itself. Psychological practice makes its own theories real by modifying experiences such that they become what now passes for reality (see Authors, 2012), and then demonstrates this by pointing to their presence in the social world - a 'self-fulfilling prophecy'. Like GMOs, releasing PMEs into the ecology makes it impossible to ever go back, to separate out supposedly naturally occurring experiences from ones that have been modified by psychological practice.

Forensic mental health service users develop amputated sexuality during their time on the unit. This becomes the way they understand and enact sex and personal relationships. It is reasonable to assume that they take this form of sexuality with them back to the community, where it may now become the framework for negotiating new relationships in the context of their history and their patterns of daily life that remain structured around engaging with mental health care services. As a consequence, other forms of sexuality may be driven out or fail to thrive. What we believe may then happen is that on occasions where forensic mental health service users report sexual or relationship issues back to their community psychiatric nurses or to consultant psychologists, they do so using the terms of this psychologically modified experience, which then becomes the context in which decisions about their progress in the community, or perhaps the need to be sectioned again are taken. The feedback loop is closed. Service users' behaviour is seen to confirm the discourse of vulnerability and predation precisely because that is now one of the few commonly available ways in which the individual service user can make their experiences visible. In the same way that can no longer eat 'unmodified' foods once GM crops are released into the wild, so one can no longer engage in 'unmodified' psychological experience once PMEs have 'gone feral'. But whilst the long term risks of eating GM foods remains unknown, we know only too well what the negative and potentially disastrous effects are for forensic mental health service users from 'amputated sexuality'.

So what is to be done? If it is the case that, as we have described here, secure forensic mental health

services in the UK transform the sexuality of patients during the course of their section, then this raises questions over both rehabilitation and the structuring of existing practices. At this point, we argue, whilst there is considerable anecdotal evidence, not enough is formally known about how service users initiate or resume intimate relationships on return to the community. It seems to us that, given the evidence of the potentially beneficial effects of such relationships on long-term mental well-being, more data is needed here in order to inform community based care. Crucially, we need to know if the self-relation to sexuality that is developed whilst on a secure unit becomes part of what is subsequently deemed problematic when the service user engages with community services or re-enters secure services (in a manner we might call, in a sense, 'iatrogenic'). At the same time, we would support the willingness within forensic mental health services to engage in a debate about how current service provision manages patient sexuality (see AUTHORS, forthcoming). Such a debate would tackle the challenges that exist to incorporating sexual matters into the rehabilitation process, which would include an acknowledgement of the transformative character of psychiatric care and intervention, as well as an active engagement with the prior and current life histories that shape the service user's orientation towards sexuality and intimate relationships. In short: sexuality and intimacy is a problem for both service users and service providers – the lack of formal acknowledgement offers little help in solving this mutually shared problem.

Acknowledgments

We are very grateful to Gavin Sullivan for comments and helpful suggestions on an earlier version of the paper.

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