CLINICAL PSYCHOLOGISTS' TALK ABOUT INPATIENT SERVICE USERS' SEXUAL EXPRESSION AND ITS IMPLICATIONS ON RESTRICTIVE PRACTICE: A FOUCAULDIAN DISCOURSE ANALYSIS

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A thesis submitted in partial fulfilment of the requirements of the University of East London for the Professional Doctoral Degree in Clinical Psychology

May 2024

ABSTRACT

Background

Sexual expression is restricted in psychiatric inpatient settings, supported by a risk-focused body of literature, often produced by medical professionals. Little research has been conducted into the nature of clinical psychologists' views, influences, and roles.

Aims

This study sought to understand how clinical psychologists talk about inpatient service users' sexual expression and its impact on restrictive practice. Several sub-questions were developed:

- How do clinical psychologists construct inpatient service users' sexual expression?
- What discourses influence clinical psychologists' talk about inpatient service users' sexual expression?
- How do clinical psychologists describe their roles and responsibilities in relation to inpatient service users' sexual expression, and how does this relate to restrictive practice?

Method

To contrast with literature characterised by quantitative studies, a social constructionist qualitative approach was taken, using semi-structured interviews conducted with 15 UK clinical psychologists. Foucauldian Discourse Analysis (FDA) highlighted constructions, roles and responsibilities, and the influence of wider discourses.

Findings

The clinical psychologists constructed inpatient service users' sexual expression as being risky, pathological, conflicting with social norms, useful for recovery, and a

part of being human. These constructions allowed the participants to adopt roles as protectors, diagnostic experts, and moral governors, which tended to support restrictive practice, and pseudo-occupational therapists and advocates, which tended to resist restrictive practice.

Discussion

By using FDA, it has revealed systemic, intra-team, and social power dynamics in relation to sexual expression and restrictive practice. These findings are used to suggest new approaches to research and practice.

Conclusion

The clinical psychologists' talk was nuanced, reflecting their thought and care, and the difficulties of resistant practice within a medicalised setting. They are subject to the disciplinary structures of the hospital and consequently recreate medicalised and risk-focused discourses which support restrictive practice. However, they also use discourses which have been under-represented in the literature and resist this.

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ABBREVIATIONS

BPD	Borderline Personality Disorder
DA	Discourse Analysis
DSM	Diagnostic and Statistical Manual of Mental Disorders
FDA	Foucauldian Discourse Analysis
HIV	Human Immunodeficiency Virus
HPD	Histrionic Personality Disorder
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer/Questioning +
MDT	Multidisciplinary Team
NCCMH	National Collaborating Centre for Mental Health
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses

ACKNOWLEDGEMENTS

I am grateful to the participants. It was apparent to me that each cared deeply for the inpatient service users and colleagues with whom they worked. They generously gave time from their working lives to contribute to this research and my learning, and responded to my often-difficult questions sensitively, honestly, and considerately.

To my director of studies, Dr Hannah Eades, for her open-mindedness, gentle exploration, and honesty. To Dr Kenneth Gannon for believing in the importance of this topic, and to Dr Lisa Walker and Dr Paula Corredor Lopez for believing in me.

To HMS – for swapping war stories that inspired this thesis and for holding my madness, EH – for supporting me from beginning to end and celebrating my successes, and EO – one of the bravest, most authentic warriors. To SH – the kindest heart with the most open door, RH – for not losing sight of queertopia, AB – for the gift of friendship, and DA – for talking Foucault and eating the ramen. To the women of my family, who are the strongest, most caring people I have known.

Finally, I dedicate this thesis to inpatient service users. By the grace of privilege, I cannot fully realise your struggle. My intention is that this thesis starts a conversation within clinical psychology and beyond that reclaims your power. I remain humbled by you.

1. INTRODUCTION

1.1. Overview of Introduction

This thesis aims to understand how UK clinical psychologists talk about inpatient service users' sexual expression, and the implications of their talk on restrictive practice. This introduction will share my positionality, define key terms, and explore sexual expression via NHS policy and human rights principles. As this thesis draws on Foucauldian theory (see Appendix A for a glossary), constructions of sexual expression will be identified in historical medical and psychological discourses. These shape contemporary *"*conditions of possibility*"* (Appendix A), present in the analysis of contemporary literature which follows. By considering gaps in extant research, I will develop the rationale for this thesis and its research questions.

1.2. Reflexivity

The social constructionist epistemology underpinning this thesis sees knowledge as subjective (Mannheim, 1952). Accordingly, I will contextualise professionals who produce discourses on sexual expression by their positionality, so it is appropriate to first contextualise this thesis by my subjectivity (Hook, 2001). This is inseparable from the research (Bourke, 2014) and was explored in a reflexive log (Appendix B). To make these effects explicit, I will attend to this subject throughout my thesis.

I am white, queer, and non-binary, and often perceived as heterosexual and female. Through my queerness, I am aware that constructions of 'sex' can support or limit human rights and sexual expression. I am 35 and have only lived in southeast England, where I worked as a psychiatric hospital healthcare assistant before undertaking clinical psychology training. Many of my relatives have worked as healthcare assistants and carers. The value of caring has motivated the creation of the research questions as part of a search for practices which resist restrictive practices and better meet inpatient service users' needs.

In hospitals, I experienced unwanted sexual touching and proposals from inpatient service users, while feeling that I invaded their privacy. I questioned how their sexuality is encountered by professionals and how this is related to restrictive practices. As I began my doctorate, I wondered about the role of clinical psychologists, further shaping the research.

Being queer and mad, I have experienced harm which well-meaning professionals inflict on sexualities, including pathologisation, medication side-effects, and conversion therapy, priming my interest in restrictive practice and sexual expression. Foucauldian Discourse Analysis (FDA) reflects my view that practices cannot be understood without identifying the power relations behind them.

My experiences have been shaped by being white, a mental health professional, and an outpatient. Consequently, I have 'blind spots' (Luft & Ingham, 1955). To expand my lens, I have consulted with a former inpatient service user and a carer from the University of East London's People's Committee, and have read inpatient service users' testimonies (Deegan, 1999).

1.3. Language

Foucauldian theory suggests that discourses "facilitate and limit, enable and constrain what can be said, by whom, where and when" (Willig, 2013, p. 130). I therefore selected terms carefully as they shape what can be said in relation to them within this thesis. Their meaning is co-constructed between their users and audiences, and hence how they are interpreted is dependent on the reader. To guide this interpretation I offer a rationale for my selection here.

1.3.1. Inpatient Service Users

"Inpatient" acknowledges hospitals' dominant medicalised discourses. It reflects that professionals determine people's status under the Mental Health Act (1983), which can compromise personhood.

Conversely, the suffix "service user" communicates that professionals should serve patients in a marketised healthcare system (McGregor, 2001; NHS England, 2021). Describing people as "inpatient service users" therefore reflects tensions between

medical power and consumer 'choice. Although I use this single term, I will note how inpatient service users' experiences differ, according to intersectionality, status under the Mental Health Act (1983), and through pathologisation.

1.3.2. Sexual Expression

For this thesis, I have chosen to acknowledge the constructed nature of sex which can differ intersectionally and individually (Cinthio, 2015; Ho & Sim, 2014; Pitts & Rahman, 2001; Randall & Byers, 2003). I therefore leave this up to participants to define in their interviews. As such, I adopt a broad definition of 'sexual expression.' This includes: "Sexual thoughts, wanted sexual behaviours, and occurrence of sexual behaviours," (Ridley et al., 2008, p. 308). I intend this to allow the participants' to talk to extend beyond sex and include what they consider to be sexual expression. The term 'sexual expression' has been used extensively in existing research (Buckley & Hyde, 1997; Buckley & Robben, 2000; Di Lorito et al., 2020; Ravenhill et al., 2020; Ruane & Hayter, 2008; Tiwana et al., 2016; Warner et al., 2004) and so is well-recognised. It includes a wide range of behaviours, including those which have previously been explored in relation to inpatient service users, including dress (Tiwana et al., 2016); talking, cuddling and kissing (McCann et al., 2019); masturbation (Kazour et al., 2019); and socialising with potential partners (Ruane & Hayter, 2008).

I do not consider non-consensual behaviours to be sexual expression, as they express aggression (Groth & Burgess, 1977; Seifert, 1993). However, they may justify restrictive practices, as the literature review will demonstrate. Hence, related talk will be analysed.

1.3.3. Restrictive Practices

The Department of Health (2015) defines restrictive practices as: "Deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently" (p. 14). These practices are used to "take control of a dangerous situation" (Department of Health, 2015, p. 14). However, according to inpatient service users, they can be used for "compliance and coercion" (Health and Social Care Committee, 2021). They are imposed frequently on people with learning disabilities (NHS Digital, 2023) and racialised people (Payne-Gill et al., 2021). A distinction is made in policy discourse between "unnecessarily restrictive

practices" and "least restrictive practices," whereby the latter protect the inpatient service users' rights where possible (Department of Health, 2015). Yet a meta-analysis found that restrictive practices cause physical and psychological harm to inpatient service users and professionals regardless (Butterworth et al., 2022).

1.3.4. Discourse and Power

For Foucault (1972), discourses (Appendix A) are a:

> Complex beam of relationships that function as rules: prescribe what must be set in the relationship, in a discursive practice, so that it refers to this or that object, so that it brings into play this or that statement, so that it utilises this or that ensemble, so that it organises this or that strategy. (pp. 122-123).

Discourses create objects, and include rules about who, when and how they can be spoken about and what can be done with them. They are present in all practices, including institutional ones (Foucault, 2004). Foucauldian power is being able to "define the world or a person in such a way that allows you to do the things that you want" (Burr, 2015, p. 80).

For Foucault (1978), discursive rules can change depending on the context. Hall summarises Foucault's view of discourse as "a group of statements which provides a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment" (p. 44). Thus, examining rules and groupings can reveal how power operates in different contexts (Burr, 2015). This can form part of an archaeology, which documents the formation of discursive rules, or a genealogy, which traces the roots of discourses (Foucault, 1978, Appendix A).

Such examination may contrast with how we usually interact with discourses. For Foucault (1972, p. 22), they are "groupings that we normally accept before any examination." Foucault (1980) therefore developed the concept of 'power/knowledge' (Appendix A) to describe how power is created when talk is seen as truth. Opposing discourses can become 'othered' (Burr, 2015).

1.4. Psychological and Medical Views of Sexual Expression in a Historic Context

1.4.1. Foucault and the Value of Historically Contextualising Discourse

For Foucault (1977a, 1977b) genealogical and archaeological (Appendix A) analysis is useful for understanding the origins of current knowledge practices. Rose (1979) used it to form a critical view of psychology, while Foucault (1973, 1978) deconstructed both sexual and medical knowledge.

I view sexual expression as a changing object of knowledge produced by medics and psychologists. In this section, I detail the historical "conditions of possibility" of sexual expression so that contemporary discourses can later be critically understood (Hook, 2001). The analysis is symbolic and incomplete, as only surviving sources can be examined.

It is also limited by my selection of Western post-Enlightenment texts. For Foucault (2014), the Enlightenment led to the emergence of disciplinary institutions and a scientific state apparatus, of which European medicine was part. These discourses contextualise dominant contemporary professional discourses on sexual expression in the UK, although influences may exist.

1.4.2. Professional Power/Knowledge and Sexual Expression

Western physicians medicalised discourses on sexual expression. By imposing their power/knowledge, they gained biopower: widescale control of people's bodies (Appendix A).

By incorporating religious narratives into medical discourses, professionals legitimised their authority. Doctors leveraged Natural Law (Aquinas, 1274/2003) to make themselves the 'voice of nature' and deem extra-marital sexual activities, such as masturbation, as unhealthy (Laqueur, 2003; Venette, 1750). Accordingly medical discourses upheld the heteronormative values of monogamous, reproductive marriage.

As Western empiricism grew (Marr, 2003), professionals were concerned with observable behaviours, including masturbation (Graham, 1783), 'sodomy' and

prostitution (Turner, 1717), and ‘nymphomania’ (De Bienville, 1775). Medical discourse superseded Christian ethics as doctors constructed madness as a moral choice (Foucault, 1977b), and discourses such as *Hell on Earth, or the town in an uproar* (1729) suggested that sexual deviance could spread. This empowered doctors to detain people in asylums, to punish deviance and prevent contagion (Foucault, 1977b; Kelleher, 2012).

Discourses on sexual expression had the action (Appendix A) of conserving growing medical power/knowledge. Physicians such as John Hunter (1791) argued that reading about sex could be harmful, so professionals prefaced books with apologies and the warning that they should not fall into the hands of laypeople (*Onania: Or, the Heinous Sin of Self-Pollution, and All Its Frightful Consequences, in Both Sexes, Considered*, 1723; Porter & Hall, 1995; Rousseau & Porter, 1992; S. A. Tissot, 1832; Venette, 1750). Sexual references were made in Latin (Beddoes, 1802; *Onania: Or, the Heinous Sin of Self-Pollution, and All Its Frightful Consequences, in Both Sexes, Considered*, 1723), gatekeeping professional knowledge.

Although it grew its biopower, producing discourses about sex also risked damaging reputation of the medical profession, which could undermine its power. Consequently, physicians disciplined their colleagues (Appendix A). In a book review, Charles Gilbert Chaddock (1893) expressed that texts such as psychiatrist Richard von Krafft-Ebing’s *Psychopathia sexualis* were “repulsive” and fed “prurient curiosity” (p. 93). Work on sex could damage careers: at the turn of the century, John R Baker was declined a professorship, Ambrose King was ostracised by colleagues, and Henry Arthur Allbutt was struck off (Porter & Hall, 1995). Power relations governed what could be said and done in relation to sexual expression.

As psychology developed as a profession, its discourses challenged existing norms, including those arising from medical discourse. It became subject to governmentality (Appendix A) when, in the 1800s, police made links between “free love, anarchism, and books of the psychology type” (Porter & Hall, 1995, p.160), and the distributor of such texts, George Bedborough, was trialled (Regina v. Bedborough, 1898). In the 20th Century, such books were kept in a locked case at the British Museum, which psychologists struggled to access (British Sexological

Society, 1920; Porter & Hall, 1995).

1.4.3. Sexism

Medical and psychological discourses on sexual expression could have the action of pathologising and marginalising female sexual expression. Hence, they reproduced the power of the male professionals who created them.

Enlightenment medics positioned women as vulnerable to 'pathologies' such as 'love sickness' (Ferrand, 1990) and masturbation (Tissot, 1766), as they were 'less rational.' They reproduced Ancient Greco-Roman medical discourses, which positioned women as having 'inferior constitutions' which caused masturbation (Crawford, 2006). For Galen and Hippocrates, marriage cured 'sexual madness' and women who refused it were 'hysterical' (Krasny, 2020).

Since sexual expression was 'pathological,' it required medical control. Masturbation indicated 'nymphomania,' even well into the 20th Century (Groneman, 1994; Kiernan, 1891; Mills, 1885; Pawson Chunn, 1887; Payne, 1859; Krafft-Ebing, 1931), and could be treated by admission to an asylum (Fowler, 1848). William Acton (1875) claimed that: "the majority of women (happily for society) are not troubled with sexual feeling" (p. 212). Conversely, female sexuality was 'othered' and associated with madness: asylum staff reported that female detainees masturbated, exposed themselves, and requested sex (Groneman, 1994).

Women confessing (Appendix A) fantasises was enough for medics to consider discipline in an asylum. Consultations provided surveillance (Appendix A). One female sought the advice of Horatio Storer (1856) regarding 'lascivious dreams' (Groneman, 1994). Storer felt that "It would probably be necessary to send her to an asylum" (p. 85). Following this threat, the dreams reduced.

Empiricism was used by medics to 'other' sexually expressive women, and decide who should be confined (Appendix A) for society's benefit. George Rohé (1892) found that three-quarters of female psychiatric patients had pelvic abnormalities, and Cesare Lombrosso and Guglielmo Ferrero (1893) argued that women's criminality was linked to libido and masculinity.

At the turn of the century, empiricist medical discourses developed eugenic themes which suggested that sexual pathologies were hereditary. For George Williamson (1898), women who read about sex or behaved sexually would produce 'libertines' or 'wantons' (p. 359). Doctors and scientists suggested that reproduction should remove 'weakness' (Dugdale, 1900; Galton, 1901; Pearson & Moul, 1925) and increase 'positive' characteristics (Davenport, 1912; Galton, 1919). As marriage became even more tightly disciplined and more reproduction encouraged, feminist Rebecca West (1913) described "the animal life that the Eugenics Society orders women to lead" (p. 3).

In the last century, pathologisation of female sexuality continued. Psychologist Sigmund Freud (1927) infantilised clitoral masturbation. Stigmatisation is continued through the Diagnostic and Statistical Manual (Steinberg Gould, 2011). Diagnoses including Borderline (BPD) and Histrionic (HPD) Personality Disorders pathologise sexualised behaviour (Steinberg Gould, 2011) and are more commonly applied to women (American Psychiatric Association, 2013; Moini et al., 2024). Professionals have constructed people with BPD as seductive, and as a professional threat (Frías et al., 2015). Some have refused to see people with this diagnosis (Markham, 2003), and Fagin (2004) has written that people with HPD "pose difficulties in in-patient settings" (p. 140), as "many careers have been blighted because of inappropriate crossing of sexual boundaries" (p. 140).

1.4.4. Heteronormativity

Medical and psychological discourses on sexual expression have had a heteronormative action orientation. Enlightenment professionals constructed healthy sexual expression as being in marriage, which controlled lust (Venette, 1750), and produced children (Porter & Hall, 1995). Masturbation was thus a 'false pleasure' (Flandrin, 1981), linked to weakness (Graham, 1783). Prescriptions for masturbating women included clitoridectomy (I. B. Brown, 1866), and spiked rings for men (Porter & Hall, 1995).

In the 20th Century, Havelock Ellis (1893) suggested that homosexuality was natural, and Krafft-Ebing (1931) argued that male homosexuality was common, although 'degenerate' (Lang, 2021). For Freud (1927), female bisexuality was common. Yet the first edition of the Diagnostic and Statistical Manual (DSM)

described homosexuality as a ‘sexual deviation’ (American Psychiatric Association, 1953). Activism, including by psychologists, changed this so that only distress about sexual orientation was pathologised, and in 2013, homosexuality was removed from the DSM (American Psychiatric Association, 2013).

Despite this, non-heteronormative expressions remain pathologised, including gender dysphoria and paraphilic disorder (American Psychiatric Association, 2013). Heteronormativity has thus continually underpinned professional discourses on sexual expression.

1.4.5. Racism

Western medical and psychological discourses on sexual expression have created and recreated racism and xenophobia. Empiricism was used to ‘other’ racialised people’s sexualities. Charles White (1799) described how he and professionals at anatomical schools had measured Black men’s genitalia (p. 61). Further, Sarah Baartman and another female, labelled as ‘The Hottentot Venus’ (Gilman, 1985), were exploited through pseudo-scientific exhibitions (Scully & Crais, 2008) of their pelvic anatomy (Loftus, 1814).

Instead of recognising colonialisation’s harm, doctors falsely described racialised people as having “under-developed nervous systems” (Summers, 2010, p. 70), which made it difficult to live in allegedly ‘civilised’ societies’ (Bevis, 1921;. One study concluded that wearing clothes led to sexual dysfunction (Keller, 2001, p. 307) and Hunter McGuire and G. Frank Lyston (1893) wrote that Black people’s sexuality “resembles similar sexual attacks in the bull and elephant” (p. 17). Discourses of sexual pathology and risk were thus formed in ways that were, and still continue to be, deeply harmful to racialised people.

Racist sexualisation and pathologisation continued to overlap. Black people were more frequently diagnosed as manic (Gilmore Ellis, 1893; Summers, 2010, p. 76) which Dr Duncan Greenlees (1894), continuing animalising discourses, described as arising from “the lower animal passions” (p. 6). Consequently, Louis (2022) identified descriptions in US newspapers of Black women labelled as ‘insane’ as “violent, disruptive, or dangerous” (p. 31).

Dehumanising discourses were overt in the eugenic construct of *'polygenesis'* – the myth that White people were a separate species to Black people. Similarly, the eugenicist Charles Féré (1888) argued that sexual reproduction between racialised people could increase 'degeneracy' (p. 106). These racist narratives caused harm by legitimising segregation in asylums, which, for Black people, were separated again by gender to prevent sexual contact ('Report of the Government Hospital for the Insane to the Secretary of the Interior,' 1900; Summers, 2010), demonstrating how Black people's sexual expression was constructed as more dangerous.

1.4.6. Ableism

Physically and psychologically disabled people's sexuality has similarly been disciplined through medical and psychological discourses. French psychiatrist Bénédict Morel (1857) constructed psychological problems as causing heritable pathologies. The action orientation of his discourses was to support confinement of people in remote asylums to prevent reproduction, as supported by Karl Pearson (1912) in the UK.

Compulsory sterilisation of disabled people was proposed through the Mental Deficiency Act (1913), the Sterilisation Bill ('Parliamentary Debates,' 1931), and the Departmental Committee on Sterilisation (1934), in which psychiatrists and other medics gave evidence. In Germany, through the Nazis' Aktion T4 programme, 400,000 people (Zeidman, 2020), as selected by psychiatrists (Lifton, 1986, p. 64) were subjected to this inhumane procedure.

Today, disabled people are positioned by medics as non-sexual (H. Brown, 1994; Shakespeare, 1996), or threatening (Dein et al., 2016). Contrastingly, intellectually disabled people are sexually victimised in hospitals (Tomsa et al., 2021) and rates of sexual abuse towards physically disabled people are higher (Mailhot Amborski et al., 2022). Removal of children from people with intellectual disabilities is common (Wilson et al., 2014), and in sex education classes for people with intellectual disabilities, contraception is emphasised, both limiting reproductive sex (Choice Support, 2023; Family Planning Association, 2013). Professional discourses on disabled people therefore resemble eugenic discourse and undermine sexual expression.

1.4.7. Conclusion to Historical Contextualisation

Historically, psychological and medical discourses have created and recreated the power of the often white, male, able-bodied, heterosexual professionals who generated them. By pathologising the sexual expression of others, professionals developed power/knowledge supported by technologies such as expertise, confinement, confession, and surveillance. Those whose experiences did not constitute 'knowledge' became subjugated.

1.5. Contemporary Issues Relating to Sexual Expression

Today, the issue of inpatient service users' sexual expression is adjacent to other issues, such as human rights; NHS policies; and restrictive practice.

1.5.1. Human Rights to Sexual Expression

Sexual expression is safeguarded by international treaties and national laws. The Universal Declaration of Human Rights (1948) upholds the right to privacy, freedom of expression, and family life. These rights are included in the European Convention of Human Rights (1950) and the UK Human Rights Act (1998).

The United Nations' Beijing Platform for Action (1994) states that women have "the right to decide freely and responsibly on all matters related to their sexuality," while the United Nations Convention for the Rights of People with Disabilities (2006) states that "discrimination relating to marriage, family and personal relations shall be eliminated." Further, the rights of inpatient service users to sexual expression are recognised in the United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991), which states that "the environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age."

1.5.2. NHS Policy and Sexual Expression

In the UK, inpatient service users retain all rights, except the right to liberty if they are unsafe (Mental Health Act, 1983). However, restrictive practice can violate rights (Curtice & Sandford, 2009; Dudley et al., 2012; Steinerte et al., 2012). NHS policy has remained silent on sexual expression rights, instead prioritising risk.

Since 2012, wards must be single gender (Department of Health, 2010), to support "privacy and dignity" (Care Quality Commission, 2019, p. 3), hence limiting heterosexual contact. Sluggishness in segregation led to a Care Quality Commission (2018) report into "sexual safety" on psychiatric wards, which included a content analysis of 60,000 incident reports, identifying 1,120 "sexual incidents," the most common being "nakedness or exposure" (p. 8). It admitted that this included "contexts where this was clearly non-sexual." It also included 82 incidents labelled simply as "other." It is unclear which incidents caused harm.

Despite this, the "sexual incidents" were relabelled as "1,120 sexual *safety* incidents" by the National Collaborating Centre for Mental Health's (NCCMH's) Sexual Safety Collaborative (2020), set up in response to the report. It released psychiatric sexual safety standards (2020), which led to the creation of trust-level policies (Devon Partnership NHS Trust, 2022; Leeds and York Partnership NHS Foundation Trust, 2021; Rotherham Doncaster and South Humber NHS Foundation Trust, 2021), and the outlining of staff and patient protections in a new NHS England charter (2023). Despite occasional exceptions, such as the NCCMH's (2020) still risk-sensitive guideline that patients should masturbate in private, policies fail to support inpatient service users' sexual expression.

1.5.3. NHS Policy and Restrictive Practice

Following the Winterbourne View scandal (Plomin, 2012), the UK government aimed to reduce restrictive practice. The Mental Health Act Code of Practice (Department of Health, 2015) laid out new principles, including use of the "least restrictive option" (p. 8). This sparked a Welsh consultation (Welsh Government, 2019), and, in England, a change programme and target to reduce restrictive practice by 33% (Royal College of Psychiatrists, 2019).

Yet recent policies perpetuate restrictive practice. Oxevision cameras record inpatient service users in their rooms (Oxehealth, 2023) and the National Survivor User Network (2023) has highlighted their impact on sexual privacy. Further, in 2023, the health secretary planned to exclude trans women from female NHS wards, positioning them as a 'safety concern' (*Trans Women May Be Banned from Women's NHS Wards*, 2023). This was preceded by media discourse that male patients who "temporarily self ID can access female wards" (Beckford, 2023).

However, 102 Freedom of Information requests made to trusts found no evidence of such complaints (Richards, 2022), and so it was unfounded fears of sexual harm which restricted trans women's rights.

1.6. Contemporary Psychological and Medical Views of Inpatient Sexual Expression

Having laid out the historical and policy discourses around inpatient service users' sexual expression, I will now review contemporary literature. I will analyse it by identifying professional groups' subject positions (Appendix A) and the power relations which their research creates and recreates, plus the actions which are resultantly made possible.

1.6.1. Selecting a Literature Review Strategy

This review uses a scoping approach. Unlike systematic reviews, scoping reviews do not narrow the question or range of methodologies included (Arksey & O'Malley, 2005). Instead, they gauge the extent of existing research (Arksey & O'Malley, 2005; Grant & Booth, 2009). Accordingly, I will map literature on inpatient service users' sexual expression, including its location, participants and methodologies.

Using these findings, I will identify research gaps (Arksey & O'Malley, 2005; Ehrich et al., 2002). These will inform my creation of a research question, selection of a methodology, and identification of participants. Further, as Anderson (2008) argued, scoping reviews contextualise current practices by identifying the knowledge that supports them – relevant for this study's Foucauldian approach – and demonstrating how new knowledge could be created to support alternative practices.

1.6.2. Conducting the Scoping Review

Steps used for this literature review are outlined below so that the research remains transparent and credible (Spencer & Ritchie, 2012; Yardley, 2000). The steps are based on Askey and O'Malley's framework (2005) and Levac, Colquhoun, and O'Brien's builds (2010).

1.6.2.1. *Step 1: Developing a question for the literature review:* As the purpose of this literature review was to scope existing research on inpatient service

users' sexual expression, I developed a broad question with a defined scope and target population*:*

> *"What is said about inpatient service users' sexual expression, how is it said, and by which professionals?"*

1.6.2.2. *Step 2: Identifying relevant studies:* Both database and reference searching were employed. PsycINFO, SCOPUS, and Google Scholar were systematically searched using the terms: (mental* OR psych*) AND (inpatient OR hospitalised OR hospitalized) AND sexual. These focused results on psychiatric hospitals, and reduced results which used 'sex' to refer to biological characteristics.

Although it introduced language bias (Egger et al., 1997), I restricted searches to English, which is the only language I speak fluently. For relevancy, I intended to analyse papers published in the last decade only. However, the paucity of results and the lack of change in practices meant that I used a 25-year period (between October 1997 and October 2022, the date of my research proposal). I later updated the search period to August 2023 so I could include the most recent literature.

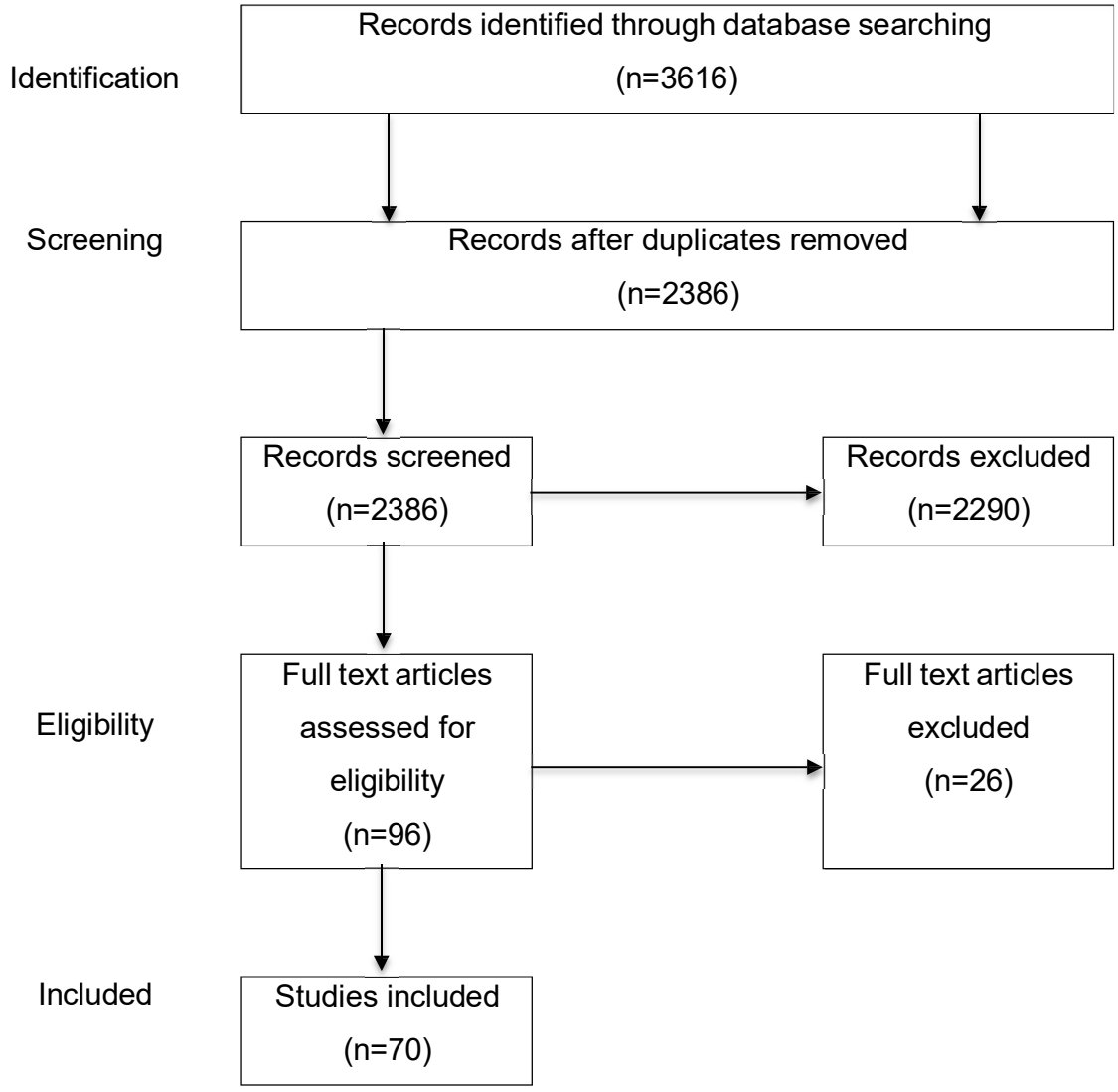
1.6.2.3. *Step 3: Study selection:* The PsycInfo search identified 1,228 results and SCOPUS returned 1,387 results, all of which I reviewed. Google Scholar returned 86,900 results, and I reviewed the first 1,000. For the reference search, citations in relevant papers were checked to locate additional papers (Horsley et al., 2011), but I found no further relevant papers. I recorded results in MS Excel and removed duplicates, leaving 1,230 papers.

I screened the titles and abstracts of each paper and used inclusion and exclusion criteria to decide relevancy (Arksey & O'Malley, 2005). Only original studies relating to inpatient service users' sexual expression were included. I excluded papers which studied child populations, as they require consideration of different legal, developmental, and ethical issues. I manually filtered these, as including terms such as "adult" and "child" when searching the databases could not achieve a good level of filtering, as adulthood was often implied, and excluding those which used the term "child" eliminated papers which referred to reproduction or abuse.

I reviewed the remaining papers in their entirety. Papers which did not fit the inclusion criteria were excluded before their data was charted. Inclusive of 31 duplicates, 58 PsycInfo papers were considered relevant, alongside 56 papers from Scopus and 13 from Google Scholar, as shown in Figure 1, using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) methodology (Tricco et al., 2018).

Figure 1

PRISMA flow diagram



1.6.2.4. *Step 4: Charting the data:* I charted key contexts, issues, and themes. I recorded the below data in MS Excel (Appendices C, D and E):

- authors' names;
- year published;
- title;
- aim;
- key findings;

- country;
- authors' professions (established through Google searches if not described);
- sample characteristics and size;
- data collection method;
- analysis method;
- study location; and
- key themes.

Funding was rarely mentioned, and was thus not included.

1.6.2.5. *Step 5: Reporting the results:* The results of the literature search are synthesised and reported below, using both Askey and O'Malley's (2005) quantitative approach, and qualitative description, advocated by Levac, Colquhoun, and O'Brien (2010).

1.7. Findings

1.7.1. Professional Authorship of Inpatient Sexual Expression Literature

Medical professionals (psychiatrists, nurses and physicians) comprised 71.6 per cent of authors (Table 1), and hence the literature privileges medicalised perspectives. Psychiatrists made up more than half (56.47 per cent) of authorship. Psychologists' views on inpatient service users' sexual expression were difficult to discern from the literature, as they authored just 13.56 per cent of papers.

Table 1

Professional Authorship of Inpatient Sexual Expression Research

Profession	n	%
Psychiatrists	179	56.47
Psychologists	43	13.56
Nurses	30	9.46
Researchers	23	7.26
Physicians	18	5.68
Statisticians	9	2.84
Students	7	2.21
Social workers	3	0.95
Sociologists	3	0.95
Managers	1	0.32
Psychotherapists	1	0.32
Total	317	100

1.7.2. Data Sources in Inpatient Sexual Expression Literature

Data sources reflect the technologies surrounding inpatient service users' sexual expression, including databases, ward staff, hospitals, mental health trusts, laws, and community workers (Table 2).

Professionals comprised 7.09 per cent of sources. Medical professionals' perspectives have been centred, making up 77.73 per cent of professional sources. Psychologists comprised just 3.65 per cent.

Table 2

Data Sources in Inpatient Sexual Expression Research

Data sources	n	%
Inpatient service users	24,649	88.64
Nurses	1,262	4.54
Inpatient service users' records	496	1.78
Outpatients	254	0.91
General population	207	0.74
Staff (unspecified)	197	0.71
Psychiatric hospitals	144	0.52
Psychiatrists	119	0.43
Management	112	0.40
Healthcare assistants	105	0.38
Psychologists	72	0.26
Males with epilepsy	52	0.19
Physicians (not psychiatry)	46	0.17
Legal	40	0.14
Police forces	23	0.08
Mental health trusts	12	0.04
Social workers	10	0.04
Residential/community care/occupational therapists	5	0.02
Human resources	2	0.01
Activity coordinator	1	0.00
Total	27,808	100

1.7.3. Countries in Which Inpatient Sexual Expression Has Been Studied

Research was conducted in predominantly white, Western nations (Table 3), which represented 88.58 per cent of the sample. This reflects racialised people's marginalisation across behavioural research (Henrich et al., 2010) and in Western

sexual expression discourses. The UK produced the most papers on sexual expression. This may be because of uncertainty as to what is permissible in hospitals, as the professional attitudes and policy themes will expand upon, or because there is more cultural anxiety around sex, as reflected in historical discourses.

Table 3

Countries from which Samples are Drawn in Inpatient Sexual Expression Literature

Country	n	%
UK	20	28.57
US	13	18.57
Australia	7	10.00
Germany	6	8.57
Canada	5	7.14
Spain	3	4.29
India	2	2.86
Italy	2	2.86
Switzerland	2	2.86
Poland	1	1.43
Norway	1	1.43
Lebanon	1	1.43
China	1	1.43
Portugal	1	1.43
Taiwan	1	1.43
South Africa	1	1.43
Belgium	1	1.43
Israel	1	1.43
Hong Kong	1	1.43
Total	70	100

1.7.4. How Inpatient Sexual Expression is Studied

To understand how inpatient service users' sexual expression was studied, I reviewed methodologies. Statistical methods were most used (77 per cent) (Table 4), although data collection and analysis differed by topic, as will be explored below.

Table 4

Methods of Analysis in Inpatient Sexual Expression Literature

Method	n	%
Descriptive statistics	42	50.00
Inferential statistics	23	27.38
Thematic analysis	12	14.29
Narrative analysis	1	1.19
FDA	1	1.19
Text analysis	1	1.19
Thematic decomposition	1	1.19
Framework analysis	1	1.19
Ethnography	1	1.19
Labelling theory analysis	1	1.19
Total	84	100

1.7.5. What Research says about Inpatient Sexual Expression

To understand what is said about inpatient service users' sexual expression, I identified research themes and counted relevant papers (Table 5). As papers could be relevant to multiple themes, some were counted several times.

'Sexual expression risks' was the most-explored theme. This may be because 72.06 per cent of authors overall came from medical backgrounds, and may work within a paradigm of preventing and remedying problems, known as problem-oriented care. (Mold, 2022; Stratmann, 1980; Weed & Zimmy, 1989).This complemented historical professional discourse which constructed inpatient service users' sexual expression as dangerous. Each theme will now be explored in more detail.

Table 5

Themes in Literature on Inpatient Sexual Expression

Theme	n	%
Sexual expression risks	40	57.97
Professional perspectives on sexual expression	15	21.74
Psychological benefits of sexual expression	13	18.84
Sexual function	12	17.39
Policies on sexual expression	9	13.04
Total	89	128.98

1.7.5.1. *Sexual expression risks:* More than half (51.08 per cent) of all the papers on the risks of inpatient service users' sexual expression were produced by psychiatrists, part of the 71.94 per cent of medical authors. The power/knowledge of physicians is thus privileged here. Knowledge was commonly produced using questionnaires (42.86 per cent), which were often medicalised measures: for example, the HIV (Human Immunodeficiency Virus) Risk Screening Instrument (Chandra, Carey, Carey, Shalinianant, et al., 2003), the Alcohol Research Center Intake Interview (Windle, 1997) or the Sexual Aggression Scale (Tuomi Jones et al., 2007). Similarly, reviews of inpatient service users' charts were the third most used method (21.43 per cent), while blood tests and health screenings were also employed. As medicine focuses on detecting and remedying problems, studies using medical methodologies create discourses of risk. Other methodologies challenged dominant medical discourses: for example, Fish's (2016) interview participants criticised nursing practice. Inpatient service users

were otherwise absent from authorship, reflecting that research is something ‘done to’ them.

Literature on this theme constructed sexual expression as risky by identifying a vast number of dangers, including:

- Sexually transmitted diseases (Gunewardene et al., 2010; Landi et al., 2020; Menon & Pomerantz, 1997; Niven et al., 2022; Quinn & Happell, 2015b; Windle, 1997);
- Especially HIV (Magagula et al., 2012; Wright & Gayman, 2005)
- Pregnancy (Landi et al., 2020; Quinn & Happell, 2015b; Xia, 2021);
- teratogenesis (Cole, 2000; Goldstein et al., 2021; Landi et al., 2020; Niven et al., 2022);
- Abuse (Fish, 2016; Foley & Cummins, 2018; Gebhardt & Steinert, 1999; Hales et al., 2006; Kang et al., 2020; Mandarelli et al., 2010; Nitschke et al., 2009; Nobels et al., 2021; Pilling, 2021; Quinn & Happell, 2015b; Sahay et al., 2000; Sansone et al., 2011; Schlup et al., 2021; Tuomi Jones et al., 2007; Warner et al., 2004);
- ‘Inappropriate’ sexual behaviour (Bardell et al., 2011; G. V. Hughes & Hebb, 2005; Kang et al., 2020).

Some authors constructed *all* inpatient service users’ sexual contact as a risk, regardless of outcome (Marcus et al., 2021). Hence, the subject position of inpatient service user did not permit sexual expression.

Resulting from this, professionals constructed their responsibilities. These included the prevention of sexual expression (Buckley & Wiechers, 1999; Chandra, Carey, Carey, Prasada Rao, et al., 2003; Fish, 2016), and management of medical risks (Cole, 2000; Foley & Cummins, 2018; Goldstein et al., 2021; G. V. Hughes & Hebb, 2005; Magagula et al., 2012; Needham et al., 2023; Xia, 2021). Sometimes there was agreement over practices (Cole et al., 2003a). However, responses could be inconsistent to medical problems (Quinn et al., 2011), record-keeping of incidents was “patchy” (Cole, 2003), and professionals were uncertain as to how they should deal with the consequences of sexual expression (Quinn & Happell, 2015b). Uncertainty could lead to conflict between clinical and ward professionals

(Dein et al., 2016). How responsibilities differed between professions was not explored. The risks identified and heterogenous practice resembles historical psychological and medical discourses on sexual expression.

Further, reflecting historic eugenicism, Dein (2016) described an “abject fear of patient pregnancy” (p. 15), which was also considered a risk in other studies (Landi et al., 2020; Quinn & Happell, 2015b). One professional described the “genetic aspect” of a schizophrenic patient’s pregnancy as “disastrous” (Dein et al., 2016, p. 20). Paternalist discourses reframed pregnancy prevention as being in patients’ best interests (Landi et al., 2020), precluding capacity. This increased professionals’ power.

Like historical literature on sexual expression, the sexual expression of some social groups was constructed as being riskier. Forensic settings comprised 6.67 per cent of studies in the risk theme (Dein et al., 2016; Hales et al., 2006; G. V. Hughes & Hebb, 2005; Nitschke et al., 2009; Quinn & Happell, 2015b, 2015a; Ravenhill et al., 2020), and the sexual expression within them was usually constructed as threatening. Subjects were described as “sexual sadists” (Nitschke et al., 2009, p. 685), “sexually aggressive” (Tuomi Jones et al., 2007, p. 51), and “sexually abusive” (G. V. Hughes & Hebb, 2005, p. 95). This limited the possibilities for inpatient service users’ sexual expression.

Men’s sexual expression was also constructed as dangerous. A sexual aggression measure was developed using only male participants (Tuomi Jones et al., 2007). One participant interviewed by Dein et al. (2016) spoke of: “women being victims and men are seen in a kind of a different way” (p.19). Females were positioned as vulnerable. G. V. Hughes and Hebb (2005) wrote: “some of our female patients present with disinhibited sexual behaviours or through lack of knowledge and understanding leave themselves vulnerable to inappropriate sexual advances from male patients” (p. 98). Dein et al.’s (2016) professional participants “rationalised” their concerns about female patients, by referring back to a duty of care to protect vulnerable patients” (p. 19).

Chandra et al. (2003) constructed women’s sexual expression as risky because they were more active than men, even though risk-taking was evenly distributed.

This mirrors historical constructions that women are less libidinous, and that their sexual expression is pathological.

Older people were rarely considered in a sexual context. Half (52.73 per cent) of Nobels and colleagues' (2021) sample of older inpatient service users spoke about experiences of sexual assault for the first time through the research. Further, older people's sexual expression was constructed as 'inappropriate' (e.g. Bardell et al., 2011).

Mirroring historical ableism, inpatient service users with certain diagnoses or histories were constructed as vulnerable, including those who were psychotic (del Mar Baños-Martín et al., 2017), had suffered sexual trauma (Chandra, Carey, Carey, Shalinianant, et al., 2003; McGarry, 2019; Quinn & Happell, 2015b), or had a BPD diagnosis (Sansone et al., 2011) or learning disabilities (Fish, 2016). Reflecting an intersectional 'double burden' Fish (2016) observed professional 'protectiveness' towards women in a learning disability hospital, reducing possibilities for sexual expression.

Overall, contemporary literature has constructed inpatients service users' sexual expression as risky, potentially because medical discourses have dominated. This precludes discussion of the benefits of sexual expression, and contrasts with discourses targeted at the general population which have a sexual imperative (Attwood & Smith, 2015). Like historical professional discourses, medicalised risk discourses tightly govern sexual expression for some groups, including disabled people, criminals, and women. The extent to which these groups are subjugated by non-medical professionals remains to be seen.

1.7.5.2. *Professional perspectives on sexual expression:* Nurses were most likely to produce discourses on professional perspectives on sexual expression (37.5 per cent). Contributions were also frequently made by psychiatrists (27.5 per cent), and psychologists (20 per cent).

Qualitative methods were favoured: two-thirds (66.67 per cent) of studies used interviews. All were conducted individually, except for Ravenhill et al. (2020) who used groups. Where quantitative data was collected (33.33 per cent), only questionnaires were used. For qualitative data, thematic analysis was most

common (40 per cent). Apart from Ravenhill et al.'s FDA (2020), quantitative methods tended not to acknowledge professional power.

The literature reflected heterogenous professional perspectives. Some believed that inpatient service users' sexual expression was normal: "They are sexual beings and … they remain sexual beings, whether they are here for a week, 10 weeks, a year, or 10 years" (Quinn & Happell, 2015a, p. 124); a human right (Di Lorito et al., 2020, p. 227); and potentially inoffensive: "as long as what people do is not offensive to others...[it] is acceptable [in the hospital]" (Dein et al., 2016, p. 18).

Many studies demonstrated that professionals constructed inpatient service users' sexual expression as harmful or pathological (e.g. Buckley & Hyde, 1997; Cole et al., 2003a; Dobal & Torkelson, 2004; Ruane & Hayter, 2008), or non-existent (Dein et al., 2016; Quinn et al., 2011). Why professionals might have different attitudes towards inpatient service users' sexual expression was under-explored.

Potentially harmful practices were named, including lack of privacy (S. D. Brown et al., 2014; Fish, 2016); pathologisation (S. D. Brown et al., 2014); mixing inpatient service users considered vulnerable with those who had committed sexual offences (Fish, 2016); prohibiting partners' contact (Fish, 2016); prescription of contraception without consent (Landi et al., 2020); and barriers to contraception (Quinn & Happell, 2015b). However, it was unclear which restrictive practices were undertaken by which disciplines and why.

Professionals felt that they were at risk from inpatient service users' sexual expression. They feared that their careers might be damaged by client pregnancy (Cole et al., 2003a), assault (Cole et al., 2003b), and litigation (Buckley & Robben, 2000). They constructed ward areas as public spaces, inappropriate for sexual expression (Dein et al., 2016; Fish, 2016), and lack of privacy made them prohibit sexual expression (Landi et al., 2020).

Fear may drive surveillance: following one incident described by McGarry (2019) cameras and increased rules were introduced, and professionals felt they could "cover themselves" (p. 177). Conversely, when sexual activity occurs on leave,

staff may ignore it (Landi et al., 2020), de-responsibilising themselves.

Indeed, fear may be generated by uncertain responsibilities. Professionals were unsure whether they should discuss sexuality and assess risk (Quinn et al., 2011; Quinn & Happell, 2015b), influence partner choice (Cole et al., 2003a), or discuss sexual expression with management (Ruane & Hayter, 2008). Fear of discipline therefore restricted talk about sexual expression, but the extent to which this may apply to senior professionals is unknown.

Variances in opinion may arise from professional subject positions. Dein's (2016) research described a "cultural conflict" (p. 17) between clinical and ward professionals, which developed in the absence of sexual expression policy, and that clinicians' liberal attitudes prevailed. However, in Cole, Baldwin, and Thomas' (2003a) study, doctors and nurses were most likely to view sexual expression negatively. Hence, opinions on sexual expression may differ by professional group.

Personal values contributed towards perspectives on whose sexual expression was risky, with the burden borne by LGBTQ+ inpatient service users. Professionals interviewed by Dein (2016) described trans people as "seductive" and wearing gender-appropriate clothes as "offensive" (p. 19). In one case described by Fish (2016), an inpatient service user's bisexuality was deemed such a specialist issue that it required transfer to a different therapist, and in another, a 19-year-old was deemed "too young" to attend an LGBT group (p. 652). In others, homosexuality was spoken of as the product of a single-sex environment, and associated with exploitation (Quinn & Happell, 2015b). Racialised LGBTQ+ inpatient service users faced double discrimination, as professionals constructed homosexuality as more "acceptable" for white people (Dein et al., 2016, p. 19).

In summary, discourses on professionals' views have not determined how perspectives may differ according to profession, and psychologists' views have been under-explored. Neither have discourses acknowledged power.

1.7.5.3. *Psychological benefits of sexual expression:* Not all papers problematised inpatient service users' sexual expression; some identified psychological benefits. Authors were most likely to be psychiatrists (31.82 per

cent), researchers (22.73 per cent), or psychologists (15.91 per cent). Questionnaires (68.42 per cent) were most common, followed by interviews (26.32 per cent), and a focus group (0.53 per cent). All sampled inpatient service users, with the exceptions of Quinn and Happell (2016) and Ravenhill et al. (2020), who sought the opinions of nursing professionals and an activity coordinator. The extent to which other professional groups believe sexual expression benefits inpatient service users is therefore unknown.

In some cases, sexual expression was constructed as supporting recovery. For Ma et al. (2018), there was a correlation between reduced psychiatric symptoms and quality of sexual life, while patients who masturbated had better cognitive and emotional functioning, according to Kazour et al. (2019). Relational aspects were also highlighted: in Cole, Baldwin, and Thomas' (2003a) study, 46.2 per cent of professionals thought that inpatient service users' sexual relationships benefitted their health. Having relationships was a positive feature of inpatient service users' sexual expression for 40 per cent of respondents (Cole et al., 2003b). Other professionals believed that relationships could convey feelings of normality (Quinn & Happell, 2015a), and partners could support recovery. Conversations about sexual wellbeing helped patients to 'feel better' (Landi et al., 2020). Yet how such conversations – or their absence – are influenced by professional power dynamics is uncertain.

The importance of intimacy and sexuality was also challenged, as Siu et al. (2012) found that only 37 per cent of inpatient service users and 56 per cent of professionals thought they were important for recovery. Discourses on sexual expression's benefits were also moderated by ageism, as sex was seen as most valuable for adults prior to middle-age (S. D. Brown et al., 2014; Hales et al., 2006). In one case, only married inpatient service users were studied, reflecting heteronormativity (Perlman et al., 2007).

The desire for sexual expression was often unfulfilled: almost half (44 per cent) of inpatient service user participants in Gomez-Sanchez-Lafuente's (2021) study identified intimate relationships and 31.3 per cent identified sexual expression as unmet needs. Nurses did not encourage partnerships within the hospital but encouraged partners to take leave together (Quinn & Happell, 2015a).

Professionals suggested that inpatient service users use uncomfortable spaces such as bathrooms to masturbate, and the lack of support for relationships meant that inpatient service users met sex workers while on leave (Landi et al., 2020). Relationship breakdown was common and could be psychologically detrimental (Hales et al., 2006), and increased isolation (Landi et al., 2020), especially for women (Hales et al., 2006). More information is required as to why teams feel unable to support sexual expression, despite recognising its benefits.

In summary, some professionals construct sexual expression as having benefits. Notably, psychologists were absent from samples and may hold different perspectives. Overall, research is limited and has excluded older and unmarried inpatient service users.

1.7.5.4. *Sexual function:* As the benefits of sexual expression received little attention, it follows that there is scant discussion of inpatient service users' sexual function. Reflecting the medicalisation of the literature, authors were primarily psychiatrists (58.57 per cent), followed by researchers (14.29 per cent), and nurses (12.86 per cent). Every study of sexual function used questionnaires, reflecting historical discourses which exert power/knowledge through empiricism.

Sexual function was constructed as valuable to inpatient service users. "A satisfying sex life plays an important role in the personal and social recovery of patients," for Błachut (2022, p. 1222). Yet a third (33.34 per cent) of papers on this topic studied only males (Błachut et al., 2022; Johnsen et al., 2011; Liu et al., 2022; Westheide, Helmstaedter, et al., 2007), and none studied only women. This perpetuates historical discourses that have abnormalised female sexual enjoyment. How this influences practice remains to be seen.

Three studies (Johnsen et al., 2011; Liu et al., 2022; Westheide, Cohen, et al., 2007) focused on medication as a cause of sexual dysfunction. The role that psychological factors may have on sexual dysfunction is comparatively under-explored, apart from del Mar Baños-Martín et al. (2017), who studied the impact of depression, and Martin et al. (2011) who found that sexual dysfunction was related to lower levels of social contact, especially amongst women. This may reflect psychologists' low levels of authorship and participation.

Discourses on inpatient service users' sexual functioning are therefore medicalised and prioritise male sexuality. Psychological factors that contribute to sexual dysfunction are poorly represented.

1.7.5.5. *Policies on sexual expression:* A small group of papers studied hospital policies. Psychiatrists (40 per cent), psychologists (36 per cent), and students (8 per cent) were most likely to research this theme. Most (70 per cent) used questionnaires, which allowed comparisons between settings. The remainder (30 per cent) used interviews, which sometimes elucidated professional perspectives. Studies on policies were likely to originate from the US and UK (both 44.45 per cent). The literature reflected that sexual expression policies are most common in the US: they were present in 25 per cent (Buckley & Wiechers, 1999), 38.28 per cent (Buckley & Robben, 2000), 60 per cent (Dobal & Torkelson, 2004) and 82.46 per cent (Buckley & Hyde, 1997) of hospitals. This may explain the number of papers from this region. Conversely, papers from the UK tended to focus on forensic settings (Dein et al., 2016; Poole, 2020; Quayle et al., 1998; Tiwana et al., 2016), whereby the issue of risk may have encouraged research in these settings.

Management comprised 20 per cent of participants, reflecting their policy role. Importantly, inpatient service users were the second most sampled group (17 per cent), while psychiatrists were the third most sampled (4 per cent). Just 2 per cent of participants were psychologists, and it was unclear what their relationship to policies was.

In the UK, policies played a minor role in practice relating to inpatient service users' sexual expression outside of forensic settings. In a survey of professional attitudes, Dein (2016) found that most staff were not aware of policies and therefore assumed that they did not exist. Resultantly, many used their judgement to make decisions on inpatient service users' sexual expression, mirroring findings from Ruane and Hayter (2008) about the role of personal values in decision-making. In some units, however, policies may be overtly communicated. Regarding a learning disabilities ward, Fish (2016) described a noticeboard where rules for contact between inpatient service users were displayed. Prioritisation of policies and

personal values may differ between settings, and perhaps professional groups.

Where policies are in place, effects can be mixed. Resistance (Appendix A) might entail responses being seen as inappropriate, according to Brown et al.'s (2014) study of UK hospitals. Further, policies may have more restrictive effects when risk is perceived as greater (Hales et al., 2006). The increased prevalence of policies in UK forensic settings, in comparison to non-forensic environments, suggests that rules have been used to control risk. Indeed, UK forensic settings had the most prohibitive policies, while hospitals in Germany, the Netherlands, Spain, and Latvia provided conjugal suites (Tiwana et al., 2016). In the UK, provisions have been limited to sex education programmes to reduce risk (Quayle et al., 1998). How different professionals interact with policies remains to be seen. In the US, where policies are more common, policymaking and provision may vary according to the extent to which sexual expression is constructed as a problem.

Sex was considered as a "clinical problem" by 88 per cent of Buckley and Hyde's (1997) respondents, the majority of whom were in settings with related interventions, but when surveyed by Buckley and Weichers (1999), sex was considered "an infrequent problem" by professionals, perhaps explaining policy infrequency.

Restrictive policies may not achieve their purpose: despite the existence of a policy banning sex, 32.28 per cent of 127 inpatient service users questioned by Buckley et al. (1999) were sexually active. Further, they may encourage professionals to problematise sexual expression: Dobal and Torkelson (2004) found that the existence of policies related to sexual expression being seen as a clinical problem. Alternatively, policies may be met with professional resistance (Ruane & Hayter, 2008), although who resists and why is unknown.

Research into policies on sexual expression reveals an absence of rules in non-forensic settings in the UK, and a potential reliance on personal judgement. Forensic settings stand apart, with the existence of policies potentially reflecting how these are risk-focused environments. Provision for sexual expression appears to be more liberal in other European countries. Professional attitudes towards policies also appear to be mixed. Like other areas of sexual expression research,

the ways in which professional responses may differ by profession are unknown.

1.8. Summary of Literature on Inpatient Sexual Expression

This literature review revealed what is said and done about inpatient service users' sexual expression in research, and by whom. The perspectives of medical professionals have been centred in authorship and participation. An appreciation of the extent and nature of research into inpatient service users' sexual expression was sought. Professionals, often from medical backgrounds, tended to construct inpatient service users' sexual expression as risky, with the action orientation that it should be prevented, as reflected by the policy theme. Privileging risk-focused medical discourses meant that literature which explored the psychological benefits of sex, or which looked at the impact of restrictive practices, was marginalised.

Professional perspectives on inpatient service users' sexual expression have been explored, but with little attention to how different professional subject positions produce varying perspectives. Filling this research gap is important, considering that UK professionals operate in a policy vacuum and rely on personal decision-making, as reflected by the literature review. As a result of medicalised authorship, methodologies, such as statistical analysis, use of scales and questionnaires, medical chart reviews, and physiological testing were also favoured. Qualitative methodologies may bring more diversity to the literature.

1.9. Rationale for Research

This thesis studies clinical psychologists' perspectives on inpatient service users' sexual expression. As medical perspectives have dominated, psychologists' views have been under-represented in both authorship and participation in the existing body of literature. The roles of clinical psychologists in relation to sexual expression are therefore unknown. Although they have occasionally been included in samples, they have never been studied as a discrete group, despite some evidence that the action orientation of discourses can differ by profession. This study is the first to do so.

It is vital to understand clinical psychologists' views because the literature review

has identified that professionals frequently make decisions about inpatient service users' sexual expression using their personal values, and this is especially important in the UK, where policy is absent. It is important to understand how they may be influenced by historic and contemporary discourses on sexual expression, especially those which discriminate, as these discourses prevent the psychological benefits of sexual expression. With greater awareness of psychologists' roles, the extent to which they can help other professionals to reflect on these issues can be identified. Overall, this study is the first to understand how psychologists support or restrict inpatient service users' sexual expression.

1.10. Research Questions

Three research questions were developed:

- How do clinical psychologists construct inpatient service users' sexual expression?
- What discourses influence clinical psychologists' talk about inpatient service users' sexual expression?
- How do clinical psychologists describe their roles and responsibilities in relation to inpatient service users' sexual expression?

These questions were underpinned by a social constructionist epistemology and were answered using qualitative data which was subjected to FDA.

2. METHOD

2.1. Overview of Method Chapter

Here, I will offer an outline of this study's method. I will detail co-production, followed by the research's social constructionist epistemological position. I will justify why I used Foucauldian Discourse Analysis, recruitment, data protection and ethical approval. I will then offer reflexive considerations.

2.2. Co-production

As a queer, disabled, and mad person, I interpret Foucault's (1973, 1978) writings as arising from his marginalised position as a homosexual inpatient service user. As FDA stems from these texts, it can helpfully demonstrate how professional power marginalises inpatient service users' sexual expression.

Having used psychiatric hospital services, but never as an inpatient, I have blind spots in my understanding. I used co-production to improve my awareness. A representative from the University of East London's People's Committee fed back on my proposal during a single teaching session that was arranged as part of my doctoral course. As an older person and an inpatient service user's carer, she informed me about historic practices, including isolation faced by inpatient service users, neglect of sexual expression, and hospital visits from sex workers. Her participation was 'engagement,' the fifth step on the 'Ladder of Co-production' (National Co-production Advisory Group, 2023). She was not as personally invested in this topic as the lived experience consultant mentioned below, and was able to share valuable historical context regarding how inpatient service users struggled to engage in sexual expression on wards which reinforced to me the importance of this topic. I explained the nature of Foucauldian Discourse Analysis and how this attended to power, and she agreed that this could be an important way of understanding this subject. Further, I shared various semantic options for referring to inpatient service users with her, and she identified which were most meaningful, influencing my choice.

Through sex positive and disability activism, I sought consultancy from a former inpatient service user. She is anonymised but consented to me sharing that she has been employed by a disability rights organisation, was disciplined for engaging in sexual intercourse while in hospital, and was stigmatised by professionals due to her diagnosis and sex work. She received no compensation; rather, she believed that it was important to explore professional attitudes to inpatient service users' sexual expression.

Her involvement was between steps six ('co-design') and seven ('co-production') on the 'Ladder of Co-production' (National Co-production Advisory Group, 2023). As the research was my responsibility, our relationship was unequal. However, she influenced strategic decisions, including how inpatient service users were described, as discussed in the introduction; the interview schedule, for instance, the positioning of a question about restrictive practice; and the use of FDA, which she felt could reflect professional power.

2.3. Social Constructionist Epistemology

Epistemologies – theories of how things are known (Ferrier, 1854) – shape data collection and interpretation (J. Hughes, 2012). This thesis was underpinned by a social constructionist epistemology, which posits that understandings of the world are not true reflections of it but are a product of language. Therefore, inpatient service users' sexual expression and clinical psychologists' roles are constructed through systems of meaning shaped by society, culture, and time (Burr & Dick, 2017).

I reject claims of truth (Burr & Dick, 2017) made in professional discourses because knowledge is not absolute. This challenges previous literature's empirical understandings of inpatient sexual expression. Rather, data can be considered more fully by examining the context in which it is produced (Burr & Dick, 2017).

Following Potter and Wetherell's (1987) argument that talk is not neutral, this thesis considers talk in relation to the discourses available to clinical psychologists, including historical and contemporary literature, and social and policy contexts, as set out in the introduction.

2.4. Qualitative Approach

Qualitative methods are often concerned with "the particular situations and experiences of the individuals participating in the study" (Yardley, 2000, p. 215). I therefore chose to use a qualitative approach, as it could explore how contexts shape professionals' constructions of sexual expression. Further, quantitative approaches, often underpinned by positivism, may disregard the subjectivity from which knowledge is produced. Instead, this thesis recognises the influence of participants' and the researcher's positionality.

There were few texts on sexual expression which included clinical psychologists' perspectives, so it was necessary to develop material. Observations of Multidisciplinary Team (MDT) meetings might have enabled the collection of relevant data; however, my presence might have significantly altered talk. Further, access would have been difficult. A focus group might have provided relevant data, but due to clinical psychologists' busy schedules, it might have been difficult to arrange.

I chose individual interviews, as they have successfully been used to research professional perspectives (Dein et al., 2016; Fish, 2016; McGarry, 2019; Poole, 2020; Quinn et al., 2011; Quinn & Happell, 2015a, 2015b, 2016; Ruane & Hayter, 2008). Personal viewpoints could be expressed without homogenisation, as might occur within a focus group. They provided confidentiality when speaking about sexual expression, which included discussions of unwanted behaviours. Interviews are encouraged by FDA's developers (Walkerdine, 1998; Willig, 2013), as they explore talk outside of published discourses (Willig, 2013).

For Fadyll and Nicholls (2013), interviews involve a subjectification (Appendix A) of the individual by the interviewer – in this case, I subjectified individuals as clinical psychologists.

Potter (2002, p. 541) suggests that data should pass the 'dead social scientist' test, unchanging whether the interviewer is dead or alive. However, the researcher cannot be seen as neutral if the Foucauldian argument that "power is everywhere" is accepted

(Foucault, 1978, p. 16). Subjectification always occurs through the selection of a topic, question or participant group, and analysis. In the participant information sheet, I explained that I would be interviewing clinical psychologists so participants could understand how they were being positioned and respond in their discourse.

2.5. Foucauldian Discourse Analysis

Although social constructionism challenges the idea of absolute knowledge by contextualising it, Khan and MacEachen (2021) criticised it for ignoring power. FDA adds flesh to social constructionism's "bare bones" (Khan and MacEachen, 2021, p. 2) by exploring power. It therefore offers an advantage over other social constructionist methodologies, such as Discourse Analysis (DA), which instead focuses mostly on what talk means.

For Foucault (1978), power is relational. Through discourses, it produces knowledge, through which power operates. These discourses determine what can be said and known. FDA can show how psychologists, through their discourses on inpatient service users' sexual expression, are subject to power and exert it over others, producing, reproducing, and resisting it. Unlike other DA methods, it recognises social contexts, and so the influence of material resources and social practices can be explicated.

FDA is described as a 'top-down' approach by Gray Brunton and colleagues (2018). Instead of focusing on micro-level discourse, like DA can, it demonstrates how subjectivity is impacted by societal discourses. Identifying subject positions reveals how people adopt and assign roles through talk and the duties they resultantly acquire: for example, 'doctor' and 'patient' (Gray Brunton et al., 2018). This is important for understanding how clinical psychologists construct their roles in relation to inpatient service users' sexual expression.

FDA has been used once to explore professional perspectives on inpatient service users' sexual expression (Poole, 2020). Uniquely, it recognised power, but examined only policymakers in forensic units, continuing to leave the role of clinical psychologists under-explored.

2.5.1. Approach to Foucauldian Discourse Analysis

Multiple approaches to FDA have been proposed. As it was widely recognised and suitable for a novice researcher, I used Willig's (2013) six-step approach, as below.

2.5.1.1. *Step 1: Identifying discursive constructions:* Within transcripts, I highlighted all the ways of talking about sexual expression to understand how it could and could not be spoken about.

Highlighting included implicit references such as inpatient service users' sexual expressions being referred to as 'stuff': for example, "Patients can't do some of that stuff but everyone else can go home and do whatever they like" (P2) and "One of the things you notice is that when people become less acute that stuff stops" (P14). Implicit talk may suggest that aspects of sexual expression were 'unknowable' or 'unspeakable.'

2.5.1.2. *Step 2: Comparing discourses to find their differences*: I clustered similar constructions together to understand how they could be part of the same discourse (Appendix F). The reference *"*It can be a sign of dementia" (P2) constructs sexual expression as pathological, whereas describing it as "just a normal human urge" (P7) suggests that it is part of being human.

2.5.1.3. *Step 3: Identifying action orientations:* I questioned what might be gained from constructing sexual expression in a particular way at a particular time to consider what talk might achieve. Where inpatient service users' sexual expression is described as "just a normal human urge," it is minimised and normalised (Appendix A), and empathy may be sought for a shared 'human' experience.

2.5.1.4. *Step 4: Subject positions:* People take up roles through talk, known as 'subject positions.' They can convey rights and duties for people who leverage different discourses. The same participant said: "As a psychologist you are constantly thinking about people's needs" (P7). As psychologists are concerned with human needs, she is responsibilised (Appendix A) to consider sexual expression.

2.5.1.5. *Step 5: Subject positions*: These open or close specific actions as discourses expand or limit what can be said or done. I mapped possibilities for action in relation to discourses presented. As a clinical psychologist who is responsible for considering inpatient service users' sexual needs, Participant 7 described her role as*: "*reminding teams that actually […] this is perfectly normal" (P7).

2.5.1.6. *Step 6: Subjective consequences of discourse:* Having taken up a particular position, a subject may then see, think of and feel the world through this lens. This may be reflected in "images, metaphors, storylines and concepts" (Davies & Harré, 1990, p. 46).

Participant 7 experienced colleagues as forgetful, as they did not consider the human need of sexual expression*:*

> I think sometimes teams can get, quite understandably, can get quite caught up in the risks and worries about people's safety, which absolutely is, you know, an enormous part of our jobs in this role. Umm but sometimes can sort of forget about maybe basic human needs as well. (P7)

2.5.1.7. *Resolutions:* A seventh stage was proposed by Gray Brunton et al. (2018), who accepted Budds, Lock and Burr's criticism that FDA positions people as passive users of discourse with limited agency. Gray Brunton et al. noted that individuals are active, as they can resolve tensions between discourses and develop unique narratives. As clinical psychologists used multiple discourses relating to inpatient service users' sexual expression, I considered the strategies they used to navigate between them.

In the quotation above, the participant could understand her team forgetting sexual expression, as they had different positions: they were not clinical psychologists and did not have the same responsibilities as her.

Foucault (1970) was critical of science as a relationship between a knower and an object in which concepts were created within set rules. As such, I used these steps as a template rather than as prescriptive rules. For example, sometimes my

analysis moved backward and forward between steps with new interpretations. This freed me from rigid analysis, which might have compromised interpretation.

2.6. Creating a Sample

2.6.1. Inclusion Criteria

Inclusion criteria ensured that the interviewees were people who were most likely to provide information relevant to the research question. People could participate if they consented and:

- Were qualified clinical psychologists, and;
- Had worked in a UK adult psychiatric inpatient setting in the last three years or did so currently.

Only clinical psychologists were included, as I sought to understand the perspectives of this under-sampled group. To capture data from a coherent group, other types of psychologists and those outside the UK were excluded. Those working in child and adolescent settings were excluded, as sexual expression presents different moral and legal issues here.

Clinical psychologists who did not have inpatient experience from the last three years were excluded, as their recollections may be less reliable (Tully & Meyvis, 2017). Three people who were interested in participating were excluded, as they belonged to other professions.

2.6.2. Recruitment Method

Using these criteria, I undertook purposive sampling via digital media. I posted on platforms such as X, Facebook, and LinkedIn, and on the British Psychological Society's forum (see Appendix G for examples). Participation was also promoted through an interview I gave on the podcast *Locked Up Living* (Jones & Murphy, 2023). All contained an invitation to email me.

It might have been useful to adopt maximum variation or homogenising sampling, where participants were selected based on having worked in different or similar types of units. However, criteria were kept broad, as there are only 12,000 clinical

psychologists in the UK (Health and Care Professions Council, 2017), and fewer in inpatient units. Despite this, the method naturally formed a diverse sample of clinical psychologists.

Due to the small population size, I also used snowball sampling to leverage professional networks. Clinical psychologists who were aware of the research (either through participation, social media promotion, or word-of-mouth) shared study information and my email address with contacts.

2.6.3. Sample Characteristics

I recruited n=15 participants. Following Nelson's (2016) criticism that aiming towards 'saturation' is vague, this was considered sufficient, as these interviews provided a range of perspectives.

Using a short demographic information form (Appendix H), participant background information was collected and is shared here to describe the varied characteristics of the overall group. However, this information is not given in order to show that the sample is representative of UK clinical psychologists as achieving representation was not a sampling goal. Neither is it meant to categorise or fully describe the people interviewed, as the language used remains a social construction.

Due to the General Data Protection Regulation's (2016) principle of collecting minimal data, and the need to maintain anonymity within a small professional community, I requested only the most relevant information, namely: gender, sexuality, age, and work settings from the last three years and currently. These factors may determine the discourses to which the participants had access.

Participants self-described their gender and sexuality, as this best supported their expression. Categories for settings aided analysis and were based on NHS Data Model descriptors (NHS, 2023), as these reflected the UK's full range of settings available and were recognisable. Splitting current and present workplace data acknowledged the effect recent experiences might have (Glanzer & Cunitz, 1966). Tables 6 and 7 describe the sample's characteristics.

Table 6

Sample Personal Characteristics

Characteristic	%	n
Gender		
Female	10	66.67
Male	4	26.67
Transmasculine	1	6.67
Sexuality		
Bisexual	3	20.00
Heterosexual	10	66.67
Queer	2	13.33
Age (years)		
≤29	1	7.14
30-39	7	50.00
40-49	4	14.29
50≥	2	14.29
Total	15	100.00

Table 7

Sample Professional Characteristics

Setting	Current setting n	Current setting %	Setting in last three years, but not current n	Setting in last three years, but not current %	Total %
Acute adult mental health care	9	45.00	1	8.33	10
Acute older adult mental health care	2	10.00	1	8.33	3
Adult high dependency rehabilitation	1	5.00	1	8.33	2
Adult learning disabilities	1	5.00	1	8.33	2
Adult high secure	2	10.00	1	8.33	3
Adult medium secure	3	15.00	1	8.33	4
Adult low secure	0	10.00	1	8.33	3
Mother and baby	0	0.00	1	8.33	1
Adult admitted patient continuing care	0	0.00	1	8.33	1
Adult community rehabilitation unit	0	0.00	1	8.33	1
Adult longer term high dependency rehabilitation unit	0	0.00	1	8.33	1
Adult personality disorder	0	0.00	1	8.33	1
Total	20	100.00	12	100.00	32

Table 8

Sample Recruitment

Recruited via	n	%
Word of mouth	9	60.00
Digital media	6	40.00
Total	15	100.00

2.7. Data Collection

2.7.1. Recruitment

Potential participants were instructed to email my university email address. They could thus express interest confidentially, rather than commenting on social media posts or communicating via previous participants.

I used email to screen potential participants to ensure that they met inclusion criteria, and provide them with the participant information sheet (Appendix I) and consent form (Appendix J). They were encouraged to ask questions to be answered over email or discussed via MS Teams. If they agreed to participate, then we both signed the consent form. I saved a copy on my UEL OneDrive and shared a copy with the participant. I then arranged a mutually convenient interview time. I advised participants that we should both join the interview from a place where we would not be overheard or interrupted.

2.7.2. Interview

The interviews lasted on average 48.75 minutes (range 27.5 – 62.75 minutes), which allowed in-depth discussion without being unnecessarily burdensome to the often-busy participants. Each was conducted over Microsoft Teams. I did not feel that conversations were resultantly ‘stilted’; Microsoft Teams is now commonly used in the NHS (Clement et al., 2021) and meant participants could speak at a

time convenient for them. Microsoft Teams also offers increased security in comparison to other videocall platforms (Gauthier & Husain, 2021), protecting participants.

My interview protocol (Appendix K) covered three different areas through 14 questions, which sought to answer the study's research questions:

- How clinical psychologists perceived their roles and responsibilities relating to inpatient service users' sexual expression;
- How clinical psychologists constructed inpatient service users' sexual expression, and how these constructions differed depending on the nature of the sexual expression and whom it involved;
- What influenced clinical psychologists' talk about sexual expression.

It contained only open questions, which allowed participants to share more information (Wang & Yan, 2012, p. 238). Being semi-structured, it allowed me to clarify meaning and ask more questions about salient aspects of talk (Galletta, 2013, p. 72). As I conducted interviews, I saw trends in participant responses, which helped me to decide when to request more information but required me to concentrate on individual meanings rather than assuming similarity. Allowing participants to say all they wanted to before I returned to interesting areas meant that I did not immediately alter the trajectory of their talk. Notetaking allowed me to fully concentrate on their talk while retaining such information.

I adopted a conversational style, so I could change pace and question order to allow fuller responses (Qu & Dumay, 2011). I positioned myself as naïve and curious, and gave 'backchannel' acknowledgements (Yngve, 1970) such as 'yes,' and 'mmm' to provide encouragement and minimise my impact on talk. This supported discussion of the potentially difficult topic of sexual expression.

I captured audio using Microsoft Teams, and saved the resulting .mp4 files in a password-protected folder on my UEL OneDrive. File names contained the participants' pseudonyms, but no identifying information. A pseudonymisation log was created in Microsoft Excel and saved in a second password-protected folder on OneDrive. I did not share the demographic information form with participants

until after the interviews. Hence, questions about age, gender, sexuality, and the settings in which they had worked did not affect how they positioned themselves in interviews.

I sent a debriefing sheet to participants immediately after their interview (Appendix L). It contained organisations they could contact for additional support and contact details of my supervisor and the Research Ethics Committee should they need to complain. It recapped how I would use information, and re-shared my contact details in case of questions or feedback.

2.7.3. Transcription

To maintain confidentiality, within 48 hours of each interview, I transcribed the audio verbatim. I used Jeffersonian notation (Jefferson, 2004) to convey elements of the participants' speech that were relevant to power and subjectivity, including changes in pitch, stutters, emphasis, and non-verbal vocalisations. An explanation is given in Appendix M, and a sample is provided in Appendix N.

With close-knit professional networks in mind, I redacted information which could identify a participant, service, or another individual. The transcripts were titled using only the participant's pseudonym and saved in a third password-protected file on One Drive.

2.8. Ethics

UEL's Research Ethics Committee approved the project (Appendices O, P and Q). NHS ethical approval precluded as I did not involve present or former service users or their carers, or use confidential patient information, or cells or tissues. I adhered to the British Psychological Society's (2021) Code of Human Research Ethics, including by respecting "the autonomy, privacy and dignity of individuals," upholding "scientific integrity" and "social responsibility" and "maximising benefit and minimising harm" (p. 6).

In compliance with the General Data Protection Regulation (2016), I collected minimal data, which was processed as participants provided explicit consent. As explained in the participant information sheet, I will only retain data as required.

Transcripts and completed demographic questionnaires will be retained until October 2024 to allow for the project to be written up. Afterwards, only the supervisor will keep a copy, and will store them on UEL's One Drive for five years. They will also keep signed consent forms for one year.

2.8.1. Consent and Reciprocity

It was important that people did not feel obliged to participate, especially as consent was pertinent to the topic. The participant information sheet told participants that they would not receive any special benefits from their involvement, including financial compensation. Rather, the interviews might allow them to reflect on practice.

As I am a trainee recruiting qualified clinical psychologists, this might have reduced power imbalances between myself as a researcher and participants (Råheim et al., 2016). However, many were recruited via word-of-mouth and power imbalances might have existed in these networks. To minimise the possibility of coercion, information about who participated in the study was only accessible to my supervisor and me.

Diverse motivations meant that a broad range of attitudes to sexual expression could be explored, from those simply wanted to assist a trainee to others who were deeply concerned about it.

2.9. Reflexivity

Social constructionism posits multiple readings of reality and so I consider reflexivity throughout my thesis, as designing, carrying out, and writing up this study have been influenced by my values and experiences in a way Whitaker and Atkinson (2021) describe as inescapable. Reflection with my supervisor and keeping a journal (Appendix O) have aided my awareness of the research as a reflexive process, and I share some considerations below.

2.9.1. Epistemology

My adoption of social constructionist epistemology and use of FDA are linked to my experiences as a queer person. The constructed nature of sexuality is particularly

obvious to me from this standpoint, as I feel that constructing experiences as ‘sex’ and assigning social value to them are often dependent on context and can marginalise people. Social constructionism recognises this, which I find personally validating as a queer and disabled person. As my research developed, I drew from this epistemology when making decisions such as not defining sexual expression in interviews, or sexual orientation on the demographic information form. Rather, I was more interested in what participants thought was relevant, as this reflected their subjectivity.

2.9.2. Recruitment

My choice to recruit clinical psychologists was influenced by my review of the literature, which demonstrated that their roles, responsibilities, and perspectives in relation to inpatient service users’ sexual expression were largely unknown. Additionally, I was influenced by my own experience of psychologists occupying positions of power within hospitals, and my historical knowledge of how they have sometimes taken a critical view of medical practices (Eysenck, 1977; Micale & Porter, 1994, p. 432; Sedgwick, 2015). I therefore wondered if they might sometimes resist restrictive practices related to sexual expression, and if they could be facilitators of change. In part, this represented my own desire to perform such a role, and as such, my recruitment of clinical psychologists might also be seen as a quest for a role model.

As I was recruiting from social media, I was often exposed to distressing posts. Psychologists could position trans people as sexual perpetrators on these platforms, testaments of sexual assault were common, and I came across a psychiatrist who questioned whether his patients ever had sex. I have refrained from citing individual posts here, as I see them as representative of wider discourses. Exposure to this talk helped me to understand the nature of professional discourses on sexual expression but added to the feeling of being under threat during a time when transphobia is perpetuated by the prime minister (Gutteridge, 2023) and the media (Gwenffrewi, 2021; Montiel-McCann, 2023), when Brianna Ghey’s murderers were trialled (Crown Prosecution Service, 2024), and when I was personally experiencing overt discrimination. Although there were times when I avoided this talk to protect my wellbeing, I eventually found that it steeled my motivation to analyse talk and locate liberatory discourses.

2.9.3. Data Collection

My choice to use interviews shaped the nature of how the participants and I interacted. An “interview society” has been identified by Atkinson and Silverman (1997), who noted that researchers can become preoccupied with how subjects feel about a matter. While constructing my methodology, I questioned whether my experiences of conducting therapy might have led to me choose a method of data collection in which I was most comfortable. I was also concerned that too great a focus on subjective experience might lead me to lose sight of the operation of power which FDA interprets. However, as I deepened my understanding of FDA, it became clear that it was interpreting participants’ subjectivity which allowed me to answer the research questions.

3. ANALYSIS

3.1. Overview of Analysis

This chapter details the FDA of transcripts produced from interviews with 15 clinical psychologists who had worked in UK inpatient settings. I will offer a reminder of the FDA approach in relation to my research questions and explain the ordering of my analysis before I present it.

3.2. Summary of Approach in Relation to Research Questions

I analysed transcripts separately, in the order in which interviews occurred. Following Willig's (2013) steps, I identified constructions of inpatient service users' sexual expression by highlighting implicit and explicit references, reflecting how it could and could not be spoken about. This answered my first research question: "How do clinical psychologists construct inpatient service users' sexual expression?" At this stage, the analysis was grounded in the data.

I compared constructions and located them within wider discourses, which answered my second research question: "What discourses influence clinical psychologists' talk about inpatient service users' sexual expression?" This necessitated moving beyond the transcripts to locate constructs in historical and contemporary talk.

Next, I considered the action orientation of talk, asking what participants might gain from constructing sexual expression in a particular way at a specific point in the text. This provided additional information to answer the first research question.

I then considered subject positions in talk. By ascribing these to themselves and others, participants suggested rights and responsibilities. This partially answered the third question: "How do clinical psychologists describe their roles and responsibilities in relation to inpatient service users' sexual expression?" This question was also answered by considering how constructions and subject positions opened and closed possibilities.

I also explored participants' subjectivity. Participants' feelings, thoughts, and experiences were shaped by subject positions, giving me more information about why discursive repertoires were used. This helped me to answer all three questions.

Finally, I considered conflict and resolutions between discourses. Discourses were hierarchically ordered or used only in specific contexts, adding to my response to the first question. Participants then modified roles and responsibilities, deepening my answer to the third question.

A summary of these steps in relation to the research questions is given in Appendix R, and a worked example of how discourses were identified is given in Appendix S.

3.3. Ordering of Analysis

As Foucault (1972) was concerned with 'discursive formations' – statements with similar effects – I have used quotations from across the data to complete the analysis. This research is concerned with clinical psychologists as a group, rather than individual talk, which is prioritised in other forms of discourse analysis.

All participants' talk drew on multiple discourses and supported and resisted restrictive practice. Similarities in constructing and maintaining professional power reflect the shared resources available to the clinical psychologist group. Perspectives therefore should not be understood as originating in individuals or solely a matter of personal ethics.

3.4. Analysis of Transcripts

3.4.1. Inpatient Service Users' Sexual Expression is Risky

Constructions: Inpatient service users' sexual expression was most commonly constructed by the participants as risky:

- "Risk to themselves" (P3)

- “Sexual expression does cross boundaries and does put people at risk” (P12)
- “There’s concerns about legality, there's concerns about risk, their own safety, safety and others, health risks” (P6)
- “They're worried about STD risk and you're worried about risk of pregnancy, but you're also worried about emotional risk” (P6)

Here, sexual expression was constructed as dangerous to the inpatient service users and to others, and as causing psychological and physical harm.

3.4.1.1. *Discourses:* Risk talk drew on medicalised discourses, as infection and pregnancy were also identified as concerns in both historical and contemporary literature. These concerns had been used in sexist and eugenic discourses to control the sexualities of women, prisoners, and learning-disabled and Black people. Employing these discourses within risk talk had similar and perhaps unintentional effects, as will later be explored in the analysis of positions created by this talk.

3.4.1.2. *Action orientation:* Worst-case scenarios were reified with real-life examples. This talk was oriented to elicit fear and persuade me that risks were real, based on clinical psychologists’ experience. Highlighting experience built their power/knowledge:

- “My experience of, of some of some of my patients having gone through experiences like that, it does worry me that, you know, they they maybe sometimes struggle to express their sexual needs and or kind of engage in sexual behaviours that keep them generally safe” (P2)
- “It's personal experience as well. For example, we had a service user on the ward… went on to commit a serious act of violence” (P11)
- “Thinking down kind of worst-case scenario levels, they themselves might be sexually victimised” (P11)
- “I’m aware of somebody who fits in that bracket who was actually murdered” (P11)

These evidence-based arguments trumped my inexperience as a trainee. My

(unspoken) views might not have had the same empirical foundations, and therefore may be considered less true:

- “Gosh, see the stuff you see on wards. Honestly, Rebecca, they don’t, they don’t prepare you for this in psychology at all” (P14)
- “I don’t know if you’ve been on an acute ward, but it’s literally like alarms going off all the time, like very serious self-harm all the time, aggression” (P9)

3.4.1.3. *Positionings:* The clinical psychologist participants gained power by positioning themselves as protecting others from risk, in the same way as historical professionals who gatekept knowledge and confined others for the good of society:

- “We need to protect both the females on the ward but also male staff on the ward, but also the, the actual individual” (P15)
- “Protecting the service user and protecting people around them if, if needed” (P11)
- “Our job is to keep people safe” (P14)

This powerful protector role was reinforced, positioning other members of the team as fearful. Using empirical evidence, and describing ‘them’ rather than ‘us’ in talk, they positioned themselves as separate and superior to the team and its anxieties. This allowed for fears to be shared without me perceiving that they might be afraid, which may have undermined both colleagues and my perceptions of their competency, and might have compromised their ability to survive this work:

- “He starts touching teenage girls, you know there was real, like, fear within the team that that would happen” (P11)
- “There's a real fear in services that sexual expression is going to mean sexual abuse” (P12)
- “The worst nightmare for a team is the idea that somebody on the ward is sexually assaulted by another patient” (P12)
- “If I asked them what they were most afraid about between service users, it would be one service user raping another” (P12)

Similar separations are present across discourses and each time create power over colleagues, as I will later demonstrate.

Staff, females, trans people, people who are younger, those with learning disabilities and those of higher socioeconomic status were positioned as vulnerable:

- “Male patients have exposed themselves to female staff” (P10)
- “There is a vulnerability for […..] trans women” (P14)
- “They've been quite early in the process or potentially are feeling, you know, gender fluid or something, then they are going to be seen as at risk” (P5)
- “It's definitely age stuff and in that dynamic so well, especially vulnerable young women” (P2)
- “Somebody sort of was a bit more vulnerable again, working in a learning disability context”
- “A bit more vulnerable to this. Maybe not very worldly wise would be a a colloquial way of describing that people who are a bit sheltered and yeah. Yeah, I think there might be class stuff” (P2)

Male and Black inpatient service users, and those with a forensic history, were positioned as perpetrators.

- “Often men, sadly, but men on the ward where they've been forcing themselves upon their wife” (P3)
- “The guy that brought the sex toys back was a hulking great black guy” (P1)
- “Concerns about criminality, especially for folks that are involved with sex workers, that already have a forensic history” (P6)

Positioning inpatient service users in this way might have often been unconscious and was not always viewed uncritically by the participants. However, by drawing from established discriminatory discourses, which created and recreated biases already embedded in society, it also had the effect of strengthening their own talk, albeit problematically.

3.4.1.4. *Subjectivity:* Separation from the team and its fear was protective. No participants spoke of non-consensual experiences: rather, this was seen as something others – the separate "nursing bunch" – experienced. This dismissive tone was continued as sexual expression was minimised as "that stuff":

- "There are things in place to overtly keep me safe and I am, you know, I, I am not a vulnerable person in that setting" (P14)
- "The nurses and HCAs, the nursing bunch, have to deal with it more directly" (P2)
- "I don't get bothered by that stuff" (P14)

Fear was not delineated by the protector position; rather, it offered feelings of safety.

3.4.1.5. *Practices:* Having constructed sexual expression as risky, and positioned themselves as protectors, disciplinary technologies aimed at protection were legitimised. Foucault (2008) described 'biopower': the control of life's processes, such as sexual expression, to produce 'docile bodies.' Here, disciplinary technologies included ward rules; gender segregation; ward transfers; and use of seclusion – all desirable to protect this population by ensuring docility.

- "Rules are meant are meant to be for safety reasons" (P5)
- "The blanket boundary is that service users, that we should <u>all</u> keep our hands to ourselves" (P12)
- "People would typically be kind of quickly moved into a, like, gender, like a one-gender ward (P6)
- "Seclusion would likely be used if there was a risk to someone else" (P12)

3.4.1.6. *Conflict and resolution:* Risk discourses conflicted with human rights talk and overrode inpatient service users' decisions. By describing this conflict as "hard" or "tricky," the participants preventing me from seeing them as uncaring.

- "It's really hard to make these decisions and try and protect someone when it is kind of going against their will" (P3)

- “Sometimes we have women who come onto the ward and it's tricky. Because then you get into all the politics about you can't police what women wear” (P14)

A psychological resolution of talking, not enforcing, was proposed:

- “There's a need to be curious about what's going on in that everyday sexual expression. And I don't think we do that enough. In conclusion!” (P14)

Psychological curiosity implied a passive approach whereby risk and human rights could be explored and meant the clinical psychologists no longer had to take a position within the conflict. The ending of this talk suggested that the conflict was resolved. However, what might be thought or done because of curiosity remained unsaid.

3.4.2. Inpatient Service Users’ Sexual Expression is Pathological

3.4.2.1. *Constructions:* Using language of signs, symptoms, assessment, and diagnoses, the clinical psychologist participants constructed inpatient service users’ sexual expression as pathological:

- “A sign of dementia” (P2)
- “Part of their illness” (P6)
- “People that are that are hyper manic and oh my gosh, they're so […] often sexualised” (P14)
- “A data point I think in in terms of assessing because one of the things you notice is that when people become less acute that stuff stops” (P14)

3.4.2.2. *Discourses:* These constructions also resembled historical medical discourses, in this case in ways whereby sexual expressions were empirically observed and constructed as a sign of ill-health. The psychologists’ talk reflects how increased sexual activity may be seen as part of mania – similar to how it has historically been constructed as nymphomania.

3.4.2.3. *Action orientation:* Because sexual expression was

constructed as psychologically disordered, it was logical that psychologists should treat it, as this was within their abilities and duties. Sexual expression was constructed as §being like any other pathology, suggesting that it required no special thought in practice, or discussion in the interview.

- “You respond to it as any other expression of a mental health disorder” (P14)

Participants used pathologising talk when service users became distressed. As clinical psychologists alleviate distress, intervening in sexual expression was legitimised:

- “People's experiences of coming out of episodes and saying, oh my God, I wish I didn't do that” (P4)
- “When he kind of returns to a more kind of stable mental health, he might actually be quite embarrassed or traumatised” (P15)
- “Questions about psychosis and mania with that person, people were thinking about that like are they going to regret, regret that afterwards” (P2)

Distress allowed practices to be constructed as being in inpatient service users’ interests. It delegitimised inpatient service users’ perspectives, as they could not know what they wanted, whereas psychologists did, producing psychological power/knowledge based on “people’s experiences” and of “trauma,” “psychosis” and “mania.”

3.4.2.4. *Positionings:* Participants positioned themselves as diagnostic experts, conveyed through psychological language with paternalistic, and ironically, tactile connotations. This minimised forceful practices and replaced sexual intimacy with a therapeutic relationship.

- “Hold in mind what what is healthy and to […..] hold and contain […..] and maintain good boundaries […..]” (P14)

They juxtaposed other professionals as misunderstanding and unempathetic:

- “Staff got quite freaked out. Actually, he had a horrific, horrific trauma background from such a young age and and and staff really struggled actually to to understand” (P14)

Again, this separating talk produced psychological power over colleagues. It implied that colleagues were not competent and hence “freaked out.” Psychologists had the diagnostic and emotional power/knowledge to reduce distress relating to sexual expression. They were therefore protected from feeling distress themselves.

Often, participants constructed sexual expression as pathological when it pertained to people considered sexual, especially older people, people with acute mental health conditions and learning disabilities, and females. Distress could therefore be seen as unintentional, as inpatient service users were not expected to express themselves in this way. Rather, their sexual expression was a product of illness.

- “Some women I've worked with who have a lot of trauma who get into that repetition compulsion place where when they start struggling with trauma stuff. They act out seeking safety or seeking connection through impulsive sex” (P6)
- “Women themselves have said afterwards, ‘I don't know that I would have chosen to have sex with that man if I wasn't unwell’” (P4)
- “In learning disability settings or in settings for people who are particularly unwell I guess what one might often say that actually it may well be that the intention is not to […….] so you, uh, to to sort of to to essentially to sort of intend to rape or whatever it might be” (P13)
- “In dementia services, we're unlikely to say ‘That's inappropriate don't say that again,’ or you know, ‘You're upsetting that person’ because it's not deliberate” (P3)

Psychological power overrode justice when inpatient service users were responsibilised to accept care. This drew from neoliberalism’s biopower, whereby people are responsible for maintaining their health (Foucault, 2008; Tink et al., 2020):

- “Acknowledge that as part of your mental health presentation you

may need some additional support around that, in the same way that you need support around your anxiety or your depression" (P14)

Subjectivity: Within pathologising talk, language such as "unpleasant" was used, which might be used to describe bodily emissions, infections, or pain. Participants might have felt disgusted, repulsed, uncomfortable around sexual expression, especially when it was an integral part of their work. Formal language allowed these feelings to be somewhat speakable, as professionalism was maintained.

Emotion could be expressed in a way that was acceptable and did not compromise participants' positions as clinical psychologists. Further, by sharing these feelings, it might also have made this position more bearable, and hence sustainable.

- "It's normally in a quite unpleasant way towards staff or other service users" (P12)
- "Female staff are faced with an unpleasant surprise" (P2)

3.4.2.5. *Practices:* Constructing sexual expression as pathological legitimised pseudo-medical practices. Inpatient service users were constructed as unwell, and psychologists were responsible for intervention, which was critical to both health and professional integrity. Surveillance monitored symptoms and "markers" and prevented "incidents" – language that was similar to that used in the pandemic. Participants could not discharge inpatient service users or allow them to leave their rooms until sexual expression ceased, containing the illness, which could also be controlled with medication.

- "One incident of […..] actual kind of a sexual act, maybe two in the ten years I worked there. Because we kind of ↓ monitor things really well" (P14)
- "Consider a medication adjustment. You know, and that that might be part of their mania" (P6)
- *"*A marker of, well, you're not in control of yourself, you're not boundaried or you're you're not […..] you're sort of disinhibited in some way" (P13)
- "If they're further on in their recovery and closer to discharge

and those kind of inappropriate sexual expressions are still there, that might be more concerning" (P8)

- "It might kind of get in the way of discharge or recovery" (P8)
- "Let's just usher you back to your room" (P10)
- "The person is directed back to the room" (P15)

Historically, confinement contained an illness, and this is replicated in the participants' suggestion that people should stay in their rooms or hospital while engaging in sexual expression. Prescription also remained a favoured disciplinary technology; however, instead of anti-masturbation devices and clitoridectomies, medication was favoured.

3.4.2.6. *Conflict and resolution:* Many participants expressed a desire to limit pathologisation and described it as being something other professionals did, inferior to the psychological technology of formulation.

- IN: "Who is it who tends to do that pathologising of patients' sexual needs?"
  P4: "I mean mostly medics and mostly psychiatrists" (P4)
- "I don't subscribe to this idea of sort of well or not, or mental disorder or not" (P5)
- "Have we thought about what their sexual needs are as opposed to just, what is their illness?" (P4)

Complete resistance to pathologising talk may not have been possible in the hospital environment. The last quotation reified both pathology and sexual needs. To end illness, facilitate discharge, and contain distress, restrictive practices were necessitated. Pathologising talk was also pragmatic:

- "I have to negotiate that language day to day to get the best. Yeah, ↑ so so it's a bit of a, um, it's probably a little bit of a compromise' (P5)

However, pathologising talk was limited by discourses about sexual expression being a part of being human, understood in a Rogerian-like way of seeing the 'whole person.' A resolution balanced discourses and separated the person from

the illness, like the medical mantra of treating the person, not the illness:

- “It's important to look at the person from a ↑ whole person perspective and not immediately just because somebody's admitted to an inpatient ward immediately start to see everything they do as a sign of, quote, unquote illness” (P11)
- “If they continue that whilst they’re mentally unwell or acutely unwell, well then it, it's probably more of their personality rather than the illness” (P15)
- “It's important not to pathologise it as a state or yeah, as a state or a trait” (P14)

Clinical psychologists therefore adopted dual positions, as diagnostic and holistic practitioners. They could use dominant pathologising discourse and associated restrictive practices, while remaining critical, powerless, and not responsible for their effects.

3.4.3. Inpatient Service Users’ Sexual Expression Challenges Social Norms

3.4.3.1. *Constructions:* Inpatient service users’ sexual expression was constructed as a problematic challenge to social norms. Participants recreated rules about what could not and should not be done in a hospital, especially when visible to others, reinforcing surveillance as a disciplinary technology.

- “This is not the place to do this” (P14)
- “Sometimes people are just being, you know, inappropriate” (P5)
- “Does the behaviour fit the context? And if it doesn't, then what's going on here?” (P11)
- “There is also limits to what sexual expression can be expressed and what it might look like to others” (P1)

3.4.3.2. *Discourses:* Like historical physicians who judged sexual expression using moral discourses, participants made judgments about which behaviours were socially good. Mental and social disorder were conflated, like historical discourses that constructed madness as an immoral and socially harmful choice. Historical asylum workers described detained people as sexually deviant,

and similarly hospitals were described by participants as places where social norms might disintegrate.

Adopting the position of moral governor allowed clinical psychologists to impose values and define a moral order in which they could justify restrictive practices as being for the good of society, inpatient service users, and colleagues, as I will show.

3.4.3.3. *Action orientation:* This talk had the action orientation of suggesting that permitting sexual expression within hospitals was unthinkable and the restrictive practices used by clinical psychologists and their colleagues were common sense and unquestionable:

- “Nobody would think that that sexual acts on an acute ward are OK” (P14).

Permitting sexual expression was equated with having “no rules” and collapse of moral order, and therefore could not be desired by me. Talk resembled a Kantian categorical imperative and historical discourses where sexual expression could cause an outbreak of deviance in a community, like the tract of Sodom and Gomorrah:

- “If it is that there’s no rules we could all take our clothes off and that would be fine” (P1)

Some participants noticed similar talk amongst colleagues. One speculated on how social disorder was associated with mental disorder:

- “One staff member said, ‘Ohh, I don't think they should [be allowed to have sex], I don’t think they should, you know they this is a hospital, there needs to be some order…’ But it's really struck me as well, you know, it's potentially this view that sex is sort of disordered” (P13)

The adjacency of discourses around social norms to pathologising discourses is shown in this talk. Combining ideas about sickness and immorality strengthened the action orientation that sexual expression must be restricted. However, it might

also have also weakened talk. Like risk talk, discourses around social norms were sometimes criticised, and positioned as something that colleagues did. This also reduced their responsibility for restrictive practices.

3.4.3.4. *Positionings:* By suggesting that without rules, chaos could spread within the hospital, psychologists positioned themselves as having a moral foresight. They therefore gained a responsibility to enforce rules:

- "The idea that the social microcosm, like we bring uh, the ways the, the norms, the rules of society, which could easily be seen to fall away when you come into a place like this" (P1)

In this talk, the hospital was constructed as separate from society, like Foucault's (1977b) 'mad ships' or historic, and sometimes present-day, hospitals in remote locations. As psychologists passed between the outside world and the world of the hospital, they were responsible for bringing the norms of society to the hospital to avoid the fall of social structures, as Sodom and Gomorrah had experienced. The position of clinical psychologist was therefore one which resembled that of a moral missionary, teaching and rehabilitating people as part of their duty of care.

- "Our duty is to sort of help shape people's interactions to be more appropriate" (P5)
- "You need to remind people that that they must do private work in private places" (P6)

The participants often positioned men as engaging in sexual expressions which contradicted social norms – in the below case, nudity:

- "I can think of men that do that, because the shower room is just across from their dorm" (P14)

People from minoritised cultural groups, including travellers, were also positioned in this way, as will be explored later in this section.

Educating inpatient service users required talking about sexual expression.

Paradoxically, in addition to positioning themselves as conveying social rules, the participants also positioned themselves as being outside of them, gaining the power to behave differently:

- “Nobody quite knows what whether we can talk about it or not, and again, psychology, I think probably out of all the disciplines is given permission to talk about that” (P1)

The association of psychology and sex talk was historic, as my introduction demonstrates. Like these past psychologists, speaking about sex had costs. Participants became singularly responsible for conversations which colleagues were reluctant to have, undermining psychologists’ power:

- “My nursing colleagues would go ↑ ‘Oh, it’s not appropriate,’ so they would shut down that conversation ↓ ‘It’s not appropriate – go and have that conversation with the psychologist.’ Oh, so that will be <u>me</u> again” (P14)
- “It often falls onto psychology because we are the ones who are in the places that we're not wanted. We ask those uncomfortable questions and ↑ we're a bit less inhibited.” (P3)

3.4.3.5. *Subjectivity:* Being solely responsible for sex talk might have led to clinical psychologists feeling isolated or abused, as colleagues gave them tasks that they were unwilling to do themselves, and they worked in places where they were “not wanted.” This reminded me of how sex workers are seen as outsiders, abused, and working in difficult locations. Participants’ ostracisation and lack of inhibitions might have given them greater empathy with inpatient service users.

3.4.3.6. *Practices:* To reintroduce social norms to inpatient service users, restricting the display of pornography, personal contact, and nudity was legitimised.

- “Naked pictures of women on the walls is, is in inappropriate for an inpatient setting” (P1)
- *“*Have a conversation with both and say, like, this is not the place to do this” (P14)

- “We certainly don't encourage people to use the communal areas while they are topless, say for example, or bottomless, or, or fully naked. And so we have to work with them about […] and kind of how they […] again what's appropriate and what's not” (P15)

Participants felt that colleagues should adhere to restrictions too. Like Foucault’s (1977a) description of the panopticon, in which the uncertainty of being watched meant that people governed themselves, colleagues were responsible for ensuring that they were seen as behaving correctly, in relationships with colleagues and inpatient service users, and how they physically presented:

- “He'll see like staff hugging each other, and he's like, ‘Well, ↑ why can <u>they</u> do it?’ like it should be inappropriate for everybody” (P9)
- “Sexual expression, it's also (….) an issue for staff relationships” (P11)
- “When I have trainees I say, you know, that you need to think more about what is your private and public space” (P14)
- “Lots of our, my nursing or HCA staff – it hasn't happened in psychology yet. Who knows? It might just be a matter of time – who go for the fillers and the Botox and and, and, it's, it's to my mind as an older woman, it's quite a pornified look and, and so I do kind of wonder what, what that brings into the mix, particularly when people are acutely dysregulated” (P14)

Colleagues engaged in socially inappropriate practices, whereas psychologists constructed themselves as knowing and behaving better. Judging others thus increased their power/knowledge.

Using social norms to judge sexual expression meant staying of abreast of cultural changes. Foucault’s (1978) ‘repressive hypothesis’ describes how society is mistakenly seen as becoming more permissive. This thinking presented in participants’ talk and allowed them to take the position of being more socially aware and therefore more liberal than the ward or trust, while restricting sexual expression, which fell outside of the norms of society.

- “Having your kind of ear to the ground about what, where you know what

direction society is moving in and that was what was not acceptable in the 50s is probably acceptable now" (P15)

- "Have frequent kind of CPD updates on, on the in the areas and, and, um [….] again, re-evaluating the, the, the ward and the trust values as well" (P15)

3.4.3.7. *Conflict and resolution:* Constructing sexual expression as something which should be governed by social norms led to conflict when participants acknowledged that ideas about what was appropriate differed. While psychological power/knowledge was seen as better than that of colleagues, this conflicted with the liberal principle of allowing for difference.

Problems were described as "complicated," "interesting," or "difficult"; however, racism or sexism were not nameable in the interviews, and there was little evidence of these terms being used in practice. This may be because participants might have feared losing power as moral governors if they accounted for discrimination.

- "I'm white and a male, so the world is set up for my kind of norms, right? So yeah, and a lot of those other staff aren't white male, so that, that, that would, you know, […..] I think yeah, it's interesting" (P1)
- "Quite large travelling community here and there, so sexual expressions can be really <u>complicated</u> with them because they have much more traditional gender roles" (P2)
- P1: "When you've got a staff team, some of whom are Muslim, you […]"
  IN: "Mmm*."*
  P1: "↑There is so much going on in the room to have that conversation that that, that, that, that, that would be a definite sort of, you know, if you've got strong opinions? […] Uh, that that or, or very close connections with some aspect of the person. I think it makes those conversations a bit more ↓ difficult"

Because they positioned themselves as being more liberal than colleagues, clinical psychologists found a resolution that drew from liberal political discourses which distinguish public and private spheres. Here, greater freedom can be enjoyed at

home, as it does not undermine the liberty of others in society. Constructing public and private areas in the hospital had similar effects:

- “And there's a question about is this their space in their room to stick things up?” (P1)
- “What you do in your private time and your private room with the door closed is fine” (P10)
- “There might be a need for this person to have naked pictures, and if they are legal and they are kept somewhere away and when he wants to look at them, he can look at them” (P1)
- “I think there is, bearing in mind the cultural and ethnic differences, but also having some sort of shared idea of what’s acceptable” (P2)

Although inpatient service users might have gained some power to undertake some practices, this was still subject to permission being granted by psychologists, who had taken power from their colleagues by positioning themselves as more aware of societal norms.

3.4.4. Inpatient Service Users’ Sexual Expression Can Support Recovery

In addition to constructions which tended to support restrictive practice, the participants constructed inpatient service users’ sexual expression in ways that could resist restrictive practices. One of these was that sexual expression supported recovery.

3.4.4.1. *Constructions*: Sexual expression was psychologised, constructed as providing “strength,” “joy,” “pleasure,” “self-soothing,” and improving mood.

- “Sexual expression is hugely important for people's identities and can actually be an enormous source of strength (….) and, and can be an area of people's lives where they experience enormous joy and pleasure and self-soothing and connection to their bodies” (P12)
- “She kept saying to my trainee, ‘If I could just have sex with my husband, that would really improve my mood’” (P3)
- “Thinking just about kind of people's physical and mental health, the benefit

for orgasm is a good example, it's incredible" (P12)

- "People are going to have a nice release of hormones and afterwards it's going to make them feel good" (P7)

3.4.4.2. *Discourses:* The construction of sexual expression as being important for recovery constructed a sexual person as a healthy person. This appeared to draw from the sexual imperative discourse and the sex positivity of third-wave feminism, which constructs sexual liberation as a desirable goal. The idea of recovery drew from medical discourses, whereby behaviour could be empirically observed as a sign of health and should be supported through rehabilitation. Constructing sexual expression as useful for recovery therefore made it a matter of freedom, but also healing, which fell within the remit of the psychologist participants, and therefore was something they should strive for.

3.4.4.3. *Action orientation:* Constructing sexual expression as useful for recovery brought it into the realm of psychology and under the jurisdiction of the participants, who could judge its value based on its mental health benefits.

Sexual expression was normalised as something which would be done at home and which was therefore acceptable, and, using the language of rehabilitation, participants' talk suggested that it should be encouraged by both me and the participant. Empathy was sought for inpatient service users who went through the 'difficult' experience of being in hospital, and masturbation was constructed as being helpful to surviving this.

- "We want them to do things that they would do at home. So that it's not such a difficult experience being in hospital and and that does include kind of masturbation" (P8)
- "An individual on the ward who wants to masturbate as a way of self-soothing or as self-pleasuring or relating to their body, in my mind, is absolutely acceptable and should be, you know, supported?" (P12)
- "People are encouraged to like, maintain their social support and like their relationships" (P8)
- "People are often very restricted on wards which and they don't have a lot of opportunities for pleasure or joy or positive feelings, and it regulates

people's nervous systems" (P7)

3.4.4.4. *Positionings*: In addition to having expertise about sexual expression because it was part of the expertise that clinical psychologists had in relation to mental health, the participants also positioned themselves as both advocates and people who could make changes in the environment to support recovery, in the same way that an occupational therapist might. Sexual expression was in inpatient service users' interests, but was not supported by the restrictive practices and disciplinary technologies of the hospital environment, including surveillance, controlled movement, and rules. The participants therefore positioned themselves as being responsible for making the ward environment more conductive to it. They gained discursive power by positioning themselves as approachable and sensitive to inpatient service users' needs:

- P3: "How do you want your visiting time with your loved one. What would you do if you were sat next to him on the sofa?"
  IN: "Mmm."
  P3: "Normally, do you even sit next to them on the sofa? Do you sit on separate sofas? You know, how would you like to express your love with each other and how can we facilitate that?" (P3)
- "There was one or two people who brought it up because they, they felt quite ashamed of bringing this up to their psychiatrist" (P4)
- "It's been my role to advocate for sexual expression" (P3)

In recovery talk, inpatient service users were sometimes positioned as seeking emotionally intimate rather than lustful sexual relationships, which may be because they felt that these interactions were more likely to have psychological benefits. This took place in a context where extra-marital sex and masturbation had historically been constructed as sinful and pathological.

Similarly, it was physical sexual expressions which tended to be named in risk or pathologising talk, or that which referred to social norms. This infantilised inpatient service users, again positioning psychologists in a paternalistic role.

- “We have actually had a ↑ marriage as a result of a relationship develop on the ward, and actually for those two people, that was really cool because they both had severe injury, mental health problems and and it was a slow burn” (P14)
- “What gets them closer to being discharged, that for me is something that I hold as very important and that's definitely influenced the way I see umm service users develop ↑ friendships with each other, develop relationships, probably more on the friendship side” (P11)
- “It's about how do we help couples to have some quiet time together to be allowed to hold hands” (P3)

3.4.4.5. *Subjectivity:* Psychologists had positioned themselves as professionals who know inpatient service users’ needs the best and were hence responsible for advocating for them in the hospital – an environment unconducive to sexual expression. However, the extent to which hospital environments could truly be changed was limited, and this might have been a frustrating experience. While participants could gain discursive power in the context of their interviews, doing so on wards might be more difficult:

- “It just feels on the ward that it’s very functional. You come in, you, you get better enough and then you go home. There's no kind of being a ↑ human being, ↑ being well, and maybe there's something too about expressing yourself sexually” (P3)
- “I can imagine that the ↑ looks on my colleagues faces if I suggested that we, for example, purchase some sex aids for members on our ward” (P12)
- “He had some things that he wanted to use our psychology space for. And one of those was to speak about his his own experiences of sexual violence. But what the team wanted, what the team were bringing was they wanted help to manage him, in inverted commas, on the ward and part of managing him in their eyes meant how to stop him masturbating”

3.4.4.6. *Practices:* Narrow possibilities for practice meant that talking about sex was the main possibility for intervention, and often this would simply be talking about its absence.

- “I'm like, well, I can't actually find you a girlfriend, but we could talk about, like, what? You know, how things have been for you when you had a girlfriend in the past?” (P10)
- “The actual reality of implementing it isn't something that I've really come across. As I say, I tend to be more the person who just tries to open up conversation about it, really” (P3)

3.4.4.7. *Conflict and resolution:* Participants wondered if constructing sexual expression as useful for recovery might be risky or irrelevant for some:

- “I wonder if someone is so poorly that they’re having ECT, that they're considered to not have capacity. They could be very, very unwell, that they they cannot think about sex, kind of. We ↓ <u>think</u> they can't” (P3)

However, as this quote demonstrates, participants countered and resolved this by recognising their own positionality, that “we” as professionals might have a different perspective to other people.

3.4.5. <u>Inpatient Service Users’ Sexual Expression is Part of Being Human</u>

3.4.5.1. *Constructions:* Participants frequently constructed inpatient service users’ sexual expression as being an important and shared part of being human. It was constructed as being supported by human rights, reflecting its importance.

- “Sexual expression is very important for people's lives” (P1)
- “I think sexual expression [……..] is […….] part of life” (P14)
- “It's kind of something you might describe as kind of being healthy or being a human right or something that we should be able to express” (P11)
- “Sexual expression is so important to all of us” (P3)

3.4.5.2. *Discourses:* Evoking human rights drew from liberal political discourses. The idea of sexual expression being shared by all humans was egalitarian, while suggesting that it is something that “we should be able to express” resembled talk regarding free speech. This talk therefore drew upon clinical psychologists’, inpatient service users’ and my highest context: being

human beings. As explored later, this somewhat overcame issues of difference by drawing on a supposedly universal value system, which made their talk difficult to oppose.

3.4.5.3. *Action orientation:* Constructing sexual expression as a human right made it a legal responsibility. This removed the possibility of questioning it, both in the interviews and in the hospital.

Whereas the social norms discourse was problematic when considering difference, positioning sexual expression as a human right universalised its importance, albeit from a white, western, liberal human rights perspective (Maldonado-Torres, 2021; Tascón & Ife, 2008). Further, the clinical psychologists were not imposing their moral judgements; rather, they were agents of a wider system of justice, in which they had required codified rights and duties that they might have seen as depending less on their perspectives. Their speech had the action orientation of precluding the talk about differences and responsibilising them for upholding rights, but not deciding what these rights were.

Because sexual expression was constructed as universal and as a human right, the hospital was characterised as an environment in which such a right might be violated. Instead of rationalising these practices, or admitting involvement in them, participants' talk was oriented towards suggesting that such practices were dehumanising and made no sense in the context of inpatient service users' wellness. Hence, they were not responsible for these practices, as they were not understandable to participants.

- "I don't know how you can separate people's identity and also how they express themselves in general from, from a stay here" (P5)
- "You know, it's the same as just understanding someone's interests and like giving them nothing to do. And then expecting them to be fine and judging how well they look, you know? And so I think, yeah, there's probably a lot more that can be done just and understanding people" (P5)

3.4.5.4. *Positionings:* Within the discourse of human rights, the position of

advocate was made available. Participants positioned themselves in this way and gained power by suggesting how important this role was.

- “From a human rights perspective, I think everyone has a right to express their sexuality and, and to not be judged”
- “I think we have a really big responsibility to to sort of uphold people's human rights” (P13)

This role came with the duty to understand inpatient service users. This approach was like other person-centred practices undertaken by psychologists. This may be a way of implying that as psychologists, these professionals were uniquely equipped to be advocates, as they understood issues such as expression, identity, interaction, and normal behaviour power/knowledge:

- “A duty to, to understand how people want to express themselves, how they identify, how they want to be spoken to, what constitutes normal, in quotation” (P5)

This was reflected by the participant’s talk, although the moral obligation for other professionals to do this work was emphasised too, even if they might not be as well-equipped.

- “A lot of people think that psychologists are the ones equipped to do this. I think we are too, but it doesn't mean you can't do it at all” (P5)

3.4.5.5. *Practices*: From the position of advocate, asking questions that were critical of the status quo, including other professionals’ responses, became legitimate practices. This led to imagining new practices through which sexual expression could be supported, some of which resembled ‘positive risk-taking.’

- “We clinical psychologists have a role in asking questions. I do think if other staff ask that, if if we if we take time to do that, other staff will also say ‘Do we need to do that?’” (P2)
- “So I think it's probably a chunk of someone that's like not taken into account, but but perhaps like we should” (P9)
- “We had this sexual safety training, but I don't know that we've come at it

from the other side, from the sexual expression and personal autonomy and freedom side, like this is an important part of people's lives and people should be able to to express their sexuality" (P2)

- "I tend to say, well, 'Do we need to do that?' We've cut down on lots of other restrictions that we had in the ward." (P2)

3.4.5.6. *Subjectivity:* Holding a position of power in an environment where inpatient service users' rights were not fully realised may have been an uncomfortable role for participants. Positioning themselves as advocates may have relieved potential feelings of guilt or dissatisfaction at what could not be changed. Working within the system but against it may have made their roles sustainable.

- "I personally feel a bit of a sort of a […] an advocacy and sort of protective er part of responsibility if you like, to sort of uphold that, that sort of uphold people's sort of rights to sexual expression" (P13)
- "I hope that in the years that I have worked on the wards that I've always been able to advocate on behalf of the service users to ensure that their rights as human beings are being um respected" (P15)

When sexual expression was constructed in other ways, participants might have felt frightened, worried, or shocked. However, when it was part of being human and a matter of rights, feeling afraid was no longer delineated. Rather, participants suggested that they might feel grateful for inpatient service users reminding professionals of their identity and personhood.

- "Being naked and sometimes shouting about sex and sex-related themes, and I kind of thought of that as reminding everybody that they are ↑ sexual people and you have a have a sexual identity" (P2)

3.4.5.7. *Conflict and resolution:* Although their talk suggested opposition to the hospital's discipline, from their position within the hospital system, participants dealt with conflicting concerns, predominantly arising from the risk discourse. For example, concerns about risks to others were reconstructed in this talk as the rights of others not to be exposed to sexual expression.

- “Maybe it's seen as a bit less important than people, people’s safety in other ways” (P2)
- “He can do what he wants with his own body um provided that it is in a safe, respectful way that does not traumatise or impinge on anyone else's rights, to not see that if they don't want to” (P12)

Here, the construction of sexual expression rights as being overridden by other people’s rights meant that talk that positioned sexual expression as part of humanity could exist alongside talk constructing sexual expression in other ways, such as risk, which might be seen as having a greater claim to truth.

- “I have learned the value of sometimes having higher order protective processes, which aren't necessarily how I would like something to be handled in the most sensitive, delicate way, because there are certain legal frameworks and things that do protect people um with a blunter decision” (P5)

This resolution reflects the ways in which discourses might be ordered hierarchically by the clinical psychologists. The presence of risk constructions as both strengthening and conflicting with other constructions reflects that risk was often the dominant construction for participants. While the human rights discourses had a legal element, the legal culpability for allowing risk appears to trump this, making the maintenance of safety the highest order process.

4. DISCUSSION

In this chapter, I will explain how my analysis addresses the research questions, explore reflexive considerations in relation to this portion of the research, and critically review methodological limitations. I will explain how this thesis adds unrepresented discourses to the literature and synthesise its findings, before suggesting directions for research and practice.

4.1. Summary of Analysis in Relation to Research Questions

The research is the first to explore how clinical psychologists talk about inpatient service users' sexual expression. I will summarise how this has been achieved by addressing the below sub-questions:

- How do clinical psychologists construct inpatient service users' sexual expression?
- What discourses influence clinical psychologists' talk about inpatient service users' sexual expression?
- How do clinical psychologists describe their roles and responsibilities in relation to inpatient service users' sexual expression?

My answers are not exhaustive; they balance the need to convey nuanced, dilemmatic, and complex speech within the confines of a thesis. The talk reflects intricate power relations and the deep consideration clinical psychologists gave to the subject.

4.1.1. How Do Clinical Psychologists Construct Inpatient Service Users' Sexual Expression?

The clinical psychologists constructed inpatient service users' sexual expression in a multiplicity of ways. I interpreted five key constructions, present across the data set:

4.1.1.1. *Inpatient service users' sexual expression is risky:* Most commonly, participants constructed sexual expression as a physical and

psychological risk to inpatient service users and professionals. Non-consensual or heterosexual sexual expression, or that which involved sex toys or physical contact, was constructed as risky.

4.1.1.2. *Inpatient service users' sexual expression is pathological:* Casual sex; sexual expression in hospital, especially outside of bedrooms; talk of sexual assault; and women's sexual expression were constructed as pathological.

4.1.1.3. *Inpatient service users' sexual expression challenges social norms:* Any kind of sexual act, sex talk, nudity, and displaying pornography were constructed as challenging social norms.

4.1.1.4. *Inpatient service users' sexual expression can support recovery:* Masturbation; marriage and marital sex; relationships; sitting next to each other; 'slow burn' relationships; friendships, and holding hands were constructed as supporting recovery.

4.1.1.5. *Inpatient service users' sexual expression is part of being human:* This covered a wide range of sexual expressions, positioned as normal behaviours to which inpatient service users had a right.

4.1.2. What Discourses Influence Clinical Psychologists' Talk About Inpatient Service Users' Sexual Expression?

Within the interviews, participants recreated wider discourses to strengthen their talk. However, while using several discourses added nuance, it could also generate contradictions and conflicts, to which participants created resolutions.

4.1.2.1. *Medical discourses:* Risk-focused and pathological constructions drew on medicalised discourses found in the literature. Reinforcing the validity of wider research, the same risks were identified: infection transmission, pregnancy, and non-consensual sexual behaviour. The dominance of these discourses might have arisen from hospitals' medicalised environments and the privileging of psychiatry in management structures.

This research has shown how risk and pathologising talk often arose in relation to

marginalised social groups, recreating discourses presented in the review of historical and contemporary literature, and changing how contemporary research should be understood. Black people were reconstructed as sexually threatening, sexual women were positioned as a danger to themselves, and disabled people were seen as vulnerable. This research suggests that medical discourses supporting restrictive practice in relation to sexual expression may have moved from explicit eugenicism to concerns around capacity. Considerations of risk were also tempered with discourses which could resist restrictive practice.

4.1.2.2. *Social order:* Participants constructed inpatient service users' sexual expression as conflicting with social norms, drawing on historical descriptions of asylums as sexualised, normless, and amoral places (Groneman, 1994). The participants associated sexual expression with the breakdown of order. Social norms discourses could marginalise racialised people, including travellers, whose sexual expression was constructed as conflicting with hospital norms. Like Kant's categorial imperative, there was an implication that behaviour should be universal, and like the tale of Sodom and Gomorrah, some cultures were 'othered' and positioned as sexually deviant (Genesis 19-24; Kant, 1993).

4.1.2.3. *Rehabilitation:* Discourses of rehabilitation were used to construct sexual expression as useful for recovery and reduce restrictions around it. Rehabilitation is valued in the NHS (NHS England, 2017; NHS Improving Quality, 2017) and in wider medical practice (Eapen et al., 2021) and positioned as being in the patients' interests. Using this discourse allowed the participants to position themselves as representing the will of the NHS and inpatient service users.

4.1.2.4. *Humanity and human rights:* Participants drew upon liberal human rights discourses when constructing inpatient service users' sexual expression as part of being human. Consequently, they invoked a 'universal' moral system.

Resultantly, participants often constructed sexual expression as important to everyone. This perpetuated a sexual imperative and meant that their talk ran into the same problems as human rights discourse by promoting white, Western,

secular, Enlightenment values (Maldonado-Torres, 2021; Tascón & Ife, 2008).

4.1.3. How do clinical psychologists describe their roles and responsibilities in relation to inpatient service users' sexual expression, and how does this relate to restrictive practice?

4.1.3.1. *Protectors:* When clinical psychologists constructed inpatient sexual expression as risky, this created a responsibility to protect people. This delineated restrictive practices, including ward rules; gender segregation; ward transfers; and seclusion.

4.1.3.2. *Diagnostic experts:* Pathological constructions led participants to position themselves as diagnostic experts. In this role, they upheld restrictive practice. Inpatient service users were, as patients, obligated to accept treatment, including monitoring of sexual expression as a symptom, medication, staying in hospital, and containment to their room.

4.1.3.3. *Moral governors:* Participants' experience of the world outside of the hospital and their duty of care meant that they adopted the role of moral governors. They assumed responsibilities to bring the norms of the society to the hospital and shape sexual expression to become socially acceptable. This restricted inpatient service users, as the clinical psychologists reminded them of what was appropriate, prevented nudity and the display of pornography, and stopped physical contact.

However, drawing on social norms could resist restrictive practice too. The participants described a responsibility to stay abreast of cultural changes. They positioned themselves as responsible for reviewing ward practice and trust values accordingly, which may reduce restrictive practice.

4.1.3.4. *Pseudo-occupational therapists:* When participants constructed inpatient service users' sexual expression as useful for recovery, they took on the role of pseudo-occupational therapists. They gained the responsibility for adapting the restrictive hospital environment.

4.1.3.5. *Advocates:* Within talk constructing inpatient service users' sexual expression as being useful for recovery and part of being human, the clinical psychologists adopted the role of advocates. They positioned themselves as uniquely able to discover inpatient service users' preferences, explore ways in which their needs could be met, and defend their liberty, resisting restrictive practice. Such a position may have arisen from the clinical psychologists also experiencing restriction within the hospital's medicalised system.

4.1.4. Summary of Analysis

This research has demonstrated that the clinical psychologists had a wide repertoire of discourses on inpatient service users' sexual expression. Much of this – especially talk relating to human rights and recovery – has been missing from studies on this topic and is almost entirely absent from UK policies. Consequently, this study has amplified its presence within the literature.

The research has demonstrated that there may be discourses which are more thinkable or sayable by clinical psychologists, as they were both said by these professionals and interpreted by a trainee clinical psychologist. This study therefore suggests that clinical psychologists may have a unique contribution to make to work relating to inpatient service users' sexual expression. This will be expanded upon as I consider the practical and research implications of this study.

Simultaneously, medicalised discourses of risk and pathology could support restrictive practice and dominate some participants' talk. Few studies in this area have examined power. This study has linked the use of risk-focused and pathologising discourses to working within medicalised hospital environments, which participants described as having disciplinary technologies to maintain docility and order. Participants explained how resisting these could reduce their power, reflecting a subjective experience of inpatient clinical psychologists.

Overall, the creation and documentation of talk as part of this study has therefore increased the ways in which inpatients' sexual expression can be thought about.

4.2. Reflexivity

I shall now revisit the topic of reflexivity and explore how my positionality – which developed while producing the thesis – shaped its findings.

4.2.1. Epistemology

This research was underpinned by a social constructionist epistemology, which has been under-used in existing research and offers a new way of understanding discourse. As a queer person, I recognise that perceiving dominant ideas – especially those relating to sex – as social constructions can open up new ways to think, speak, and behave. My analysis was therefore guided by the hope that there might be ways of understanding inpatient service users' sexual expression beyond the risk-focused and pathologising discourses present in extant literature. Such findings are therefore privileged in this study. However, as I spoke with participants and analysed their talk, my understanding of the complexity of decision-making around inpatient service users' sexual expression deepened, adding nuance to my analysis.

This study has been conducted in the field of clinical psychology, and thus makes an important contribution to a body of literature dominated by medical professionals. It has also determined what is knowable: I have undoubtedly favoured psychological viewpoints due to my own profession. There has been lengthy conflict for professional power between psychologists and psychiatrists (Schindler et al., 1981), and Read and Moncrieff (2022, p. 1406) have described an ongoing "guild war." Resultantly, I may see psychological practices as superior.

Despite this, I have consciously remained critical of my own profession. Further, as I continued in my analysis, I became increasingly aware of how I too replicate discourses. I hope that this sympathy has balanced the analysis and generated insight into clinical psychologists' roles and their constraints.

Further, presenting the research as a thesis which forms part of a doctoral training course reflects my desire to gain power/knowledge. Readers should be conscious that this research is only one possible 'truth' of many. The thesis reflects the academic disciplinary technologies which surround it, including the need to use recognised recruitment and analysis methods, ethical codes, and standardised presentation.

To talk about sexual expression, I had to construct it. I was careful to leave it to the participants to define what exactly was meant by terms such as “sexual expression” and “restrictive practice.” This broadened the range of talk: for example, discussion of sexual expression included a wide range of behaviours which I considered relevant, such as making sexual slurs, desiring a partner, and wearing revealing clothing. Nonetheless, my constructions, which arose from my sex-positive outlook, shaped the interviews: one participant commented on how the term “sexual expression” sounded like a “good thing,” which contrasted with the risk discourses they employed. Resultantly, talk should be considered a joint construction between the interviewer and participants (Bonham & Bacchi, 2017; Kvale, 2007), whereby my own values shaped the talk of participants, who chose to participate in the study, through the language used in the study materials; my judgement of what was relevant to the research questions; and my analysis of talk. Sex-positive positions have been missing from previous research, and I see their inclusion through this research as one of its benefits.

4.2.2. Recruitment

I chose to recruit clinical psychologists, as I wished to produce knowledge relevant to my field and contribute to a body of research where they have been under-represented. However, my choice was also influenced by my professional aspirations to be a psychologist who recognises and works against social inequalities. Indirectly, I sought confirmation that such work is possible through this thesis, and consequently the analysis focused on resistance to restrictive practices. Having completed the research, my faith that liberatory practices can be undertaken has been bolstered, although it has been increasingly tempered by testimonies of fear, frustration at medicalised practices, and the desire to protect inpatient service users, and this brought balance to my analysis.

4.2.3. Data Collection

I collected information on participant characteristics, as detailed in section 2.6.3. This was intended to describe relevant characteristics of the sample, however it could be argued that such data collection was at odds with the social constructionist nature of the research, and that the participants communicated

what was relevant through their talk in the interviews. Positionality was often named by participants, but relevant aspects may also have been unsaid potentially due to differences in power, both between the participants and me, and in our social contexts more broadly.

Further, I acknowledge that the characteristics about which I collected data are also social constructions. They were just some of many which I could have asked about; for example information about ethnicity and religion could have also been included in the questionnaire. When designing the research, I chose not to collect this data however, as it may have compromised participant confidentiality and promoted racialisation of participants. Despite this, these two characteristics were relevant in relation to the operation of whiteness which I later interpreted in participants' talk.

Some participants commented on me training at UEL. They speculated that my thesis might have a social justice angle or be "rule-breaking." They might have felt that this allowed them to do the same in their responses, or that they should have withheld more conservative answers. This might have encouraged me to produce such findings, as I detail in a reflexive log excerpt (Appendix O).

While interviewing, I noticed my feelings of satisfaction or dissatisfaction towards participants' explanations based on my scepticism towards restrictive practice. There were times when I took participants' justifications at face value when I agreed with them, and probed deeper into statements that I felt were less justified. Accordingly, the analysis may be more critical of talk supporting restrictive practice. However, criticality has been almost entirely absent from previous research, and so I hope this study helps to redress professional power by questioning practice.

4.2.4. Analysis

While transcribing interviews, I was aware of how my attitudes could be conveyed in my tone or by asking further questions. The talk I have included in this write-up similarly centres resistive actions alongside restrictive practices. While this is pertinent to the research question, I also acknowledge that it is an expression of my values, which evolved throughout the research process as I appreciated the pressures clinical psychologists experienced.

Some clinical psychologists participated because they wanted to help a trainee, and to honour their contribution, I was initially reluctant to be critical of their talk in my analysis. Yet I recognised that criticality upheld inpatient service users' interests, and I hope that this is also important to participants. I further understand that participants' talk as being produced from the discursive resources available to them as clinical psychologists. I therefore analyse it from this perspective, rather than one of personal ethics. The findings are based on my interpretations, not the discovery of 'truth,' and are one of many ways in which talk could be considered.

4.3. Methodological Evaluation

4.3.1. Method of Evaluation

'Traditional' ways of evaluating research, such as assessing validity and reliability, are not appropriate to qualitative studies that rest on social constructionist foundations that reject 'truth' (J. Smith, 1990; J. K. Smith, 1984). My evaluation of this research's methodology therefore combines criteria developed by Spencer and Ritchie (2012) and Yardley (2000) for qualitative research, and Antaki (2003), for discourse analysis.

4.3.2. Sensitivity to Context

4.3.2.1. *Substantive context:* In addition to examining contemporary professional literature to understand how inpatient service users' sexual expression is discussed, my literature review explored historical texts to contextualise present discourses. Yet my sampling of historic material is not a complete picture of changing and varied discourses over several centuries and is shaped by which texts survive. Hence, I have only intended to symbolise discourses which I deemed relevant.

Theoretical context: The study's method and analysis has also been contextualised by Foucauldian theory, exploring the operation of power (Foucault, 1980), especially within sex (Foucault, 1978) and psychiatry (Foucault, 1973). This has focused my analysis on what talk achieves and how it becomes dominant. This has been neglected in the literature. The impact of exploring power is wide-ranging: both current knowledge and practice should be re-evaluated through this lens.

Demographic data collection:

Interview context: As well as exploring the context in which inpatient service users' sexual expression takes place, I have considered the context of the interviews between myself and participants. The talk the participants and I co-constructed in the interviews may not represent discussions which take place within the MDTs, consultations, or therapeutic sessions within the hospital for a variety of reasons, expanded upon below. I did not strive for objectivity; rather, by drawing upon the context outlined below, talk was created, which generated under-explored discourses on sexual expression, as produced by the clinical psychologists who spoke with me. This study has therefore expanded the ways in which inpatient sexual expression can be understood.

Simply talking about practice may have evoked some of the disciplinary structures around clinical psychologists: when asking about practices and policies, I sometimes felt as if I were "testing" their knowledge. I wondered if this meant that they spoke more about what they *should* do, rather than what actually happened. Had I not shared the same professional background as them, there might have been less need to show 'best practice' – on the other hand, my limited experience of working in this field may have offered some reassurance that I understood the pressures of the role.

At times, the interview was a Foucauldian 'confessional' (Foucault, 1978, Appendix A), as participants presupposed the 'revelatory' nature of the research and admitted their shortcomings, and I 'bore witness' to their struggles (Muriel, 2004). This encouraged talk which might have been unsayable or thoughts which might have been unthinkable in the context of the hospital.

As I appear as female, women participants might have found it easier to speak with me, while men might have been concerned about appropriateness, especially considering my junior status. I noticed male participants finding it difficult to refer to objects such as masturbation or sex toys, and I was conscious of the intersection of gender and professional norms and how my interview questions contravened these norms. This may reflect the difficulties in talking about sexual expression within professional teams.

Being a trainee allowed me to occupy “the space between” insider and outsider status (Kanuha, 2000), which Dwyer and Buckle (2009) described as advantageous, and allowed me to speak with the participants in unique ways. At times, participants positioned themselves as educating me. Through this, they created power/knowledge and verbalised elements of practice which may be taken for granted. This allowed me to ask questions from a naïve position, which encouraged participants to talk about their values.

At other times, participants used psychologised and professional language and referred to “we,” including me in professional groupings. Some asked if I had worked in a hospital, perhaps to ascertain whether I would understand their experiences. Others were curious about my topic choice; this may have been an attempt to discover shared experiences. I ‘parked’ these questions until after the interview, focusing on participants’ experiences. The possibility of a shared culture meant that rationales for thoughts and behaviour were not always given. As I conducted more interviews, I asked questions about these ‘obvious’ truths. This, and my attempts to hide my experiences, may have positioned me as an outsider and altered talk. Consequently, the data that was made available for analysis was determined by my insider and outsider status.

During interviews, I did not consciously reveal unseen aspects of my positionality or talk about my experiences, even though this might have created conversational safety. I wondered what participants might have said had aspects of my positionality been more obvious, or different – for example, they might have been more reluctant to support restrictive practice had they known that I was a service user whose sexuality had been impacted by psychological practice. On the other hand, allowing some parts of me to be unknown reflected that the readership of this thesis was unknown, allowing participants to share only the information they were comfortable with a stranger knowing. While withholding some information might have reduced the data available for analysis, it also upheld participants’ privacy.

4.3.3. Transparency, Credibility, and Coherence

4.3.3.1. *Transparency:* Using a stepwise approach to FDA may be

seen as a disciplinary technology. However, it was important to demonstrate "explicit and systematic analysis" (van Dijk, 1990, p. 14) so readers could understand my process, especially in an area of research where FDA has only been used once previously. I therefore chose to use a synthesis of Willig's (2013) and Gray Brunton et al.'s (2018) processes in this study to improve transparency. Sharing the steps in relation to both the research questions and the data has demonstrated how my interpretations have been derived from the data. I have also provided an annotated excerpt of a transcript in Appendix N alongside key documents demonstrating recruitment processes to show my use of "clear-cut procedures" (Yardley, 2000, p. 218).

I have also been transparent by disclosing my positionality and engaging with the research method reflexively, so that the ways in which my personal attributes have shaped the work can be understood by the reader. However, I am aware that the research and I are inextricably linked and that it is impossible to fully convey every aspect of myself that has influenced its production in this thesis. Further, despite my commitment to demonstrate where social inequalities might be recreated, interviews are read differently depending on socio-cultural context (Gubrium & Koro-Ljungberg, 2005), and my blind spots (Luft & Ingham, 1955), including whiteness, will have shaped my analysis.

4.3.3.2. *Credibility:* My analysis was carried out alongside discussions with both my supervisor and a former inpatient service user, which gave me insight into how credible my interpretations were from their viewpoint. This feedback helped me to understand when further explanation of my interpretations was required. I did not use it for triangulation or as a reliability check, as I recognised that the research was contextualised by my positionality and did not aim to discover an objective 'truth' (Seidel & Kelle, 1995). How credible it appears to readers is therefore also dependent on how they coordinate its meaning, which will be shaped by their own positionality.

4.3.3.3. *Coherence:* I have attempted to present this thesis and its research methods as clearly and coherently as possible, employing a clear structure, avoiding jargon unless necessary, and providing definitions where technical terms are used. Nonetheless, I have used professional language in the

interview materials, questions, and write-up, and I am aware that this has shaped both the talk and how readers and I approach it. Participants' talk might have differed if an informal setting and language had been used. However, the professional and academic disciplinary technologies that surround the production of this thesis offered little alternative and may reflect the way in which talk occurs within other professional settings. The range of experiences and perspectives the participants shared with me cannot be fully shared within the confines of this thesis, and the analysis will be further condensed as I work towards publication.

4.3.4. Methodological Rigour

4.3.4.1. *Complete data collection:* Inpatient service users' sexual expression is a complex topic, and not all available discourses will have been shared in interviews. Yet the large sample (n=15) allowed a wide range of discourses to be identified, and permitted comparisons across interviews. The average interview length of 48.75 minutes allowed me to appreciate how talk could develop, including when different discourses might have been drawn upon. However, a smaller sample might have allowed the transcripts to be explored in more depth.

Retrospectively, it could be argued that collecting demographic information from participants was unnecessary. Participants often named their positionality in their talk, deciding what was relevant to the discourses they employed themselves, from the common perspective of being employed as a clinical psychologist. On the other hand, understanding people's gender and sexuality helped me interpret the discourses through aspects of people's positionality which were unseen, aiding the co-construction of meaning.

4.3.4.2. *Complete analysis:* I have avoided under-analysis or over-quotation in my analysis (Antaki et al., 2003) by offering an analysis of power and practice rather than summaries of talk. Simply "spotting" discursive features may lead to under-analysis, for Antaki et al. (2003, p. 28). When identifying constructions, subject positions, action orientations and conflict, I have described their function rather than just their existence. Linking participants' talk to wider discourses has prevented me from engaging in 'circular discovery' (Antaki et al., 2003; Widdicombe, 1995).

False survey can lead to methodological under-analysis, according to Antaki et al. (2003, p. 27), who described how findings can be generalised to larger groups without evidence. The findings of this research are drawn from 15 clinical psychologists who are not representative of the wider population, and hence are not horizontally generalisable. However, the discourses they use bear resemblances to wider discourses, and therefore have vertical generalisability (Polit & Beck, 2008).

4.3.4.3. *Materiality:* Hook (2001) criticised some FDA methods, such as those developed by Parker (1992) and Potter and Wetherell (1987), for ignoring material factors in power. I have attempted to avoid this by considering the hospital environment, inclusive of its rules, observation, and professional dynamics, as an influence on the clinical psychologists' talk.

4.3.4.4 *Consistency and thoroughness:* Reflecting the importance of consistency (LeCompte & Goetz, 1982), I returned to the data over 11 months, revising my analysis until it was a stable Foucauldian interpretation of all data. The analysis was not monolithic: "negative cases" (Spencer & Ritchie, 2012, p. 239) were explored through the presentation of conflicting discourses, adding nuance to the findings and enabling greater integration with existing research.

4.3.4.5 *Defensibility:* To ensure that it is defensible (Patton, 2002), throughout this thesis I have provided a rationale for decisions such my scope, method, recruitment, data collection, and analysis – each of which was communicated as being part of a logic of enquiry that supported my answers to the research questions.

4.3.5. Commitment

As a queer, mad and disabled person who has experienced iatrogenic damage to my sexuality, furthering rights to inpatient service users' sexual expression is important to me. However, my investment in inpatient service users' sexual expression is limited by having never experienced inpatient care.

I have committed to understanding the philosophical and methodological ideas

which are the foundations for this thesis. Since I wrote my undergraduate thesis on the history of dyslexia from a Foucauldian perspective, I have read and re-read Foucault's works. Revisiting texts through this thesis and discovering new ones such as *Bio-history and Bio-politics* (Foucault, 2014) has deepened my engagement with the topics of sex, psychiatry, and power. Using FDA despite it being a lesser known and occasionally poorly defined method reflects my commitment to Foucault's theory, and to social constructionism.

4.3.6. Contribution, Impact, and Importance

Critical research generates new possibilities, according to Kvale (1995), while Oliver (1992) believed that the contribution of research should be assessed on whether it delivers emancipatory change. My method has created talk and actions which resist restrictive practices, and the analysis offers a way in which these discourses can be thought about in relation to power, applying a critical lens to psychology. Through this, I have aimed to increase the possibilities for ways in which professionals can behave when working with inpatient service users' sexual expression.

Simply talking about inpatient sexual expression on wards was "dangerous" for some participants. By using interviews as part of my research method, a version of this talk could take place. Many commented on how the interviews were interesting, had "made them think," and helped them to reflect on their values and develop criticality of their own practices. Many even proposed practices which they said would be unacceptable to colleagues. Gaining a critical view of the system in this way is essential for change, according to Wuest and Merritt-Gray (1997, p. 302).

This study has extended beyond producing a thesis and included encouraging critical discussion of discourses of inpatient service users' sexual expression. I took part in an interview with the *Locked Up Living* podcast, which has a psychiatric and psychological audience (Jones & Murphy, 2023). I discussed the impact of ward restrictions, how sexual expression could be perceived as resistance, part of being human, and a marker of health, and the nature of professional responses. I have also been invited to review a paper on inpatient service users' sexual expression for the *Journal of Forensic Psychiatry and Psychology*, and offered my feedback

based on my own research. I am also due to present my research to a sexual health service. I intend to continue to encourage resistant talk, including through opinion pieces in magazines such as *The Psychologist*, by publishing this research in an academic journal, and through lived experience networks, such as the National User Survivor Network.

4.4. Comparisons and Contributions to Extant Literature

I will now synthesise this study with previous research, which can be re-evaluated in relation to this study's methodology and findings.

4.4.1. Introduction of Psychological Views

Prior to this research, clinical psychologists were under-represented as authors and participants and had not been studied as a discrete group. This study has introduced their perspectives to the literature. It has demonstrated their uniqueness due to their greater focus on recovery and human rights in comparison to professionals previously studied, broadening discourse.

4.4.2. Conflict in Professional Teams

Divisions within teams over inpatient service users' sexual expression were noted by Dein (2016), and evidenced by present participants. FDA built on this by showing how conflicts may be fuelled by differences in professional power, for example when clinical psychologists were unwillingly responsibilised for sexual expression work.

4.4.3. Sexual Function Work is Done by Clinical Psychologists

Often produced by medics, 17.39 per cent of papers in my literature review concerned sexual function. This study suggests that in practice, clinical psychologists talk about sexual function with inpatient service users, sometimes instead of medics. Until this study, clinical psychologists' involvement in discussions around sexual function in psychiatric hospitals had not been included in research. Who undertakes work relating to sexual expression may reflect the operation of professional power within the hospital.

4.4.4. Absence of Policy Talk

Existing literature (13.04 per cent) explores the nature and influence of policies on sexual expression, suggesting their importance. But for the clinical psychologist participants, policies were seen as changeable with social norms, were rarely spoken of, and could not be named, perhaps because they are less frequently used in the UK. The absence of policy talk bolsters Dein's (2016) finding from UK research that most professionals were not aware of such protocols.

4.4.5. Use of Personal Values

This study upholds the finding that personal values impact decision-making. Ruane and Hayter (2008) showed how nurses could find policies too permissive. This research has suggested that often clinical psychologists may find policies too restrictive. This may suggest a cultural divide between disciplines, as participants constructed nursing professionals as being more conservative and fearful of risks. The FDA demonstrated how differences in values could be difficult to talk about and that power shaped whose personal values were seen as legitimate.

4.4.6. Dominance of Risk Discourse

Discourses of risk allowed participants to exert power through their talk. Risks identified both by participants and previous studies included:

- Infection transmission (Gunewardene et al., 2010; Landi et al., 2020; Magagula et al., 2012; Menon & Pomerantz, 1997; Niven et al., 2022; Quinn & Happell, 2015b; Windle, 1997; Wright & Gayman, 2005);
- Pregnancy (Dein et al., 2016; Landi et al., 2020; Quinn & Happell, 2015a);
- Non-consensual behaviour and abuse (Chandra, Carey, Carey, Shalinianant, et al., 2003; Cole, 2003; Cole et al., 2003b; Fish, 2016; Foley & Cummins, 2018; Gebhardt & Steinert, 1999; G. V. Hughes & Hebb, 2005; Kang et al., 2020; Mandarelli et al., 2010; Marcus et al., 2021; Nitschke et al., 2009; Nobels et al., 2021; Pilling, 2021; Quinn & Happell, 2015b; Sahay et al., 2000; Schlup et al., 2021; Tuomi Jones et al., 2007).

Professionals had previously expressed their own risk-based fears in studies conducted by Cole et al. (2003a, 2003b) and Buckley and Robben (2000). However, here the FDA demonstrated that the clinical psychologists maintained power by siting fear with colleagues. This may be because the term 'sexual

expression' had positive connotations and did not permit such fears to be expressed, or because clinical psychologists could legitimise their concerns by framing them as protecting colleagues from harm.

Men (Chandra, Carey, Carey, Prasada Rao, et al., 2003; Fish, 2016), inpatient service users with a forensic history (Nitschke et al., 2009), and racialised people (Pilling, 2021) were positioned in both the literature review and participants' talk as people who might put others at risk, delineating restriction of their sexual expression. Similarly, the same social groups were identified as being at risk, namely people with learning disabilities (Fish, 2016), professionals (McGarry, 2019; Quinn & Happell, 2015b; Schlup et al., 2021), and women (Chandra, Carey, Carey, Prasada Rao, et al., 2003; Chandra, Carey, Carey, Shalinianant, et al., 2003; Cole, 2003; Cole et al., 2003b, 2003a; Dein et al., 2016; del Mar Baños-Martín et al., 2017; Fish, 2016; Goldstein et al., 2021; Niven et al., 2022; Quinn & Happell, 2015a; Sahay et al., 2000; Sansone & Sansone, 2011).

However, in this study, LGBTQ+ people were not positioned as riskier, contrasting with Dein et al.'s (2016) findings. Rather, heterosexual sex was constructed as dangerous because it meant that 'vulnerable' women might interact with male 'perpetrators.' This may be because attitudes towards LGBTQ+ people have liberalised (Frankenburg et al., 2023), there is increased cultural focus on sexual assault (Levy & Mattsson, 2019), or because clinical psychologists' views were generally more permissive.

4.4.7. Connecting Sexual Expression to Pathology

Pathologising discourse is dominant in both research and the participants' constructions of inpatient service users' sexual expression. This study demonstrated how it exerts clinical psychologists' power/knowledge as experts.

Pathologies mentioned by participants overlapped with those present in other studies. These included:

- HIV and other infections (Chandra, Carey, Carey, Prasada Rao, et al., 2003; Chandra, Carey, Carey, Shalinianant, et al., 2003; Gunewardene et al., 2010; Magagula et al., 2012; Windle, 1997; Wright & Gayman, 2005);

- Stroke (Bardell et al., 2011);
- Sexual dysfunction (Acuña et al., 2010; Bowers et al., 2014; Cohen et al., 2007; Johnsen et al., 2011; Liu et al., 2022; Lourenço et al., 2010; Ma et al., 2018; Martin et al., 2011; Perlman et al., 2007; Westheide, Cohen, et al., 2007; Westheide, Helmstaedter, et al., 2007);
- Addiction (Meade & Sikkema, 2005);
- BPD (Sansone et al., 2011);
- Bipolar disorder (Mandarelli et al., 2010; Sansone et al., 2011);
- Schizophrenia (Acuña et al., 2010; Kazour et al., 2019; Mandarelli et al., 2010);
- Psychosis (del Mar Baños-Martín et al., 2017; Johnsen et al., 2011; Pilling, 2021; Westheide, Cohen, et al., 2007; Westheide, Helmstaedter, et al., 2007);
- Dementia (Bardell et al., 2011);
- Depression (Cohen et al., 2007; Lourenço et al., 2010; Sahay et al., 2000);
- Sadism (Nitschke et al., 2009).

However, in contrast to the existing literature, many participants also criticised pathologisation, instead normalising and empathising with inpatient service users' sexual expression. Their power/knowledge became based on more personal understandings, which they often constructed as not being shared by other colleagues, and indicated that clinical psychologists' roles may at times be more aligned with inpatient service users' views. These critical viewpoints have been absent from research and could check restrictive practice.

4.4.8. Locating Decision-Making in Social Norms

Previously professionals' speech has leveraged social norms discourses, with acts being permitted if they were deemed socially acceptable (Dein et al., 2016) or restricted if they were 'inappropriate' (Bardell et al., 2011; G. V. Hughes & Hebb, 2005; Kang et al., 2020). This study suggests that similar concerns may be present for clinical psychologists, who also talked of social propriety, taking into account the attitudes of the people around inpatient service users. It reflects how the participants were subject to social control themselves, making decisions based on what others may think.

Further, the clinical psychologists were unsure as to whether they could have conversations about sexual expression. This builds on Quinn, Happell and Browne's (2011) finding that nurses were unsure about whether sexual expression could be legitimately discussed with inpatient service users, and Ruane and Hayter's (2008) finding that nurses were reluctant to discuss it with management. Disciplinary control is therefore exerted over many professionals.

Participants designated areas of wards as either public or private to resolve the conflict between upholding social norms and rights. Similar resolutions were adopted by professionals, according to both Dein et al. (2016) and Fish (2016). However, the difficulty of escaping observation – as in Bentham's (1791; Foucault, 1977a) panopticon – may cause inpatient service users to reframe their sexualities as deviant, as suggested by Ravenhill (2020).

4.4.9. Acknowledging Humanity

Previously, professionals interviewed by Quinn and Happell (2015a) acknowledged that inpatient service users are sexual beings, regardless of hospitalisation. The FDA has amplified this discourse by exploring the ways in which this aspect of humanity can be acknowledged by professionals, and has shown how power operates so that sexual expression remains an unmet need (Gomez-Sanchez-Lafuente et al., 2021). It has shown how inpatient service users' sexual expression can be constructed as a human right, which has only been sufficiently explored by Di Lorito et al. (2020), where 60 per cent of hospital professionals considered restrictions on sexual expression as breaching rights. By recreating this discourse, it may increase the extent to which human right discourses can be used to resist restrictive practices.

4.4.10. Shared Ideas of Recovery

Studies on the benefits of sexual expression comprised a quarter (21.74 percent) of extant literature, although recovery narratives formed a smaller proportion. Amongst the clinical psychologists, recovery was a common justification for supporting inpatient service users' sexual expression.

In both this study and that produced by Quinn and Happell (2015a), professionals

thought sexual expression could reintroduce ‘normal’ life. Landi and colleagues (2020) and Hales et al. (2006) reported that partners could be regarded as carers, although in the FDA, partners were considered stakeholders in sexual expression. This may be because psychologists focus on interpersonal needs.

For both Brown et al. (2014) and Hales et al. (2006), sexual expression was important to younger adults. However, clinical psychologists’ talk in this research reflected its importance to older adults too.

4.5. Implications for Research

The findings of this study have implications for existing research, which are discussed here. As my primary audience is clinical psychologists, who are scientist-practitioner-advocates (Fassinger & O’Brien, 2004), this section is divided into implications for research, clinical practice and policy.

4.5.1. Reducing WEIRDness

The literature review has shown how academic discourses relating to sexual expression have lacked reflexivity, including acknowledgement of the positionality from which their conclusions have arisen. This study has been the first to analyse the existing research body based on the authors’ context.

Authors of future studies should endeavour to be transparent about the context from which their work was produced. This will support realisation of the value of perspectives from beyond WEIRD (Western, Educated, Industrialised, Rich and Democratic) nations, which have dominated authorship on inpatient service user sexual expression.

4.5.2. Reducing the Dominance of Medical Discourse in Research

Similarly, the literature review has shown how medical professionals have led research into inpatient service users’ sexual expression. Consequently, medicalised constructs, namely sexual expression as pathological and risky, have dominated the existing body of research.

The FDA has shown that, in contrast, while medicalised constructs also permeate clinical psychologists’ talk, these professionals can leverage alternative discourses,

namely those relating to social norms and the experience of being human. With these differences in mind, future studies could better acknowledge how the professions of the authors and participants have influenced the results.

Further, studies may also explore the subjective experience of non-medical professionals in hospital settings and how they negotiate working within multiple paradigms. This may further increase the number of discourses available on topics including sexual expression, reduce the limitations on what can be said in research, and increase the ways in which phenomena can be understood.

4.5.3. Studying the Operation of Power in Teams

This analysis demonstrates that power/knowledge, through discourse, can shape how restrictive practice is applied and to whom. It is therefore vital to understand how power impacts working dynamics in areas beyond sexual expression. Research should be conducted into ways in which power structures operate within teams and governance structures, including when conflicts relating to practice arise or some constructions are unspoken. It may be useful to explore how existing power structures, such as NHS hierarchies and discrimination, which further inequities, can be dismantled and more egalitarian practice achieved. To avoid perpetuating inequalities, this research could be led by minoritised and marginalised people and supported by those with greater power.

4.5.4. No Research About Us Without Us

While inpatient service users made up 88.64 per cent of data sources in extant literature, they were not represented in authorship. Their sexual expression has therefore been viewed through a professional lens. Including this group is important not just for understanding the experiences of the people for whom we work, but to remain modest in professional power/knowledge over other people's bodies and minds. Future research may move beyond consultancy and focus on testimonies from inpatient service users.

4.5.5. Evidencing Positive Risk Taking

The voicing of alternative discourses through this research has meant that constructions of inpatient sexual expression as supporting recovery and part of being human have been better represented.

Currently, only the value of restrictive practices has been well-evidenced in previous research. For example, there is extensive research into policies that prohibit sexual expression and the ways in which they can be effective. To balance this, it may be useful for research to be conducted into the ways in which positive risk-taking can be implemented in hospitals. This could include offering greater privacy, access to sex aids, opportunities to maintain and form relationships, and considering sexual function in relation to medication could all be explored. The impact on risk incidents, both sexual and non-sexual; inpatient service user wellbeing; and service users' relational networks can all be studied, although this may need to be done incrementally to be feasible within the NHS' risk-averse culture.

4.5.6. Power and Perpetration

Risk discourses have been centred in policy and research relating to inpatient service users' sexual expression, and staff team members have been positioned as vulnerable to sexual assaults from inpatient service users, as suggested by trusts' sexual safety policies. As a professional who has experienced unwanted interactions with inpatient service users, I consider this issue to be important. However, the risks presented by professionals were rarely attended to in extant research or in this study, although evidence shows that professionals can also present sexual risks to inpatient service users (Mulhern et al., 2024; Torjesen & Waters, 2023). The body of literature may benefit from understanding these risks and the impact they have on inpatient service users and colleagues.

4.6. Implications for Practice

4.6.1. Assessing Sexual Wellbeing

As sexual expression can be an important part of people's lives, on the basis of the accounts of clinical psychologists interviewed in this research, it could be argued that it should be assessed alongside other aspects of inpatient service users' wellbeing. Professionals of all types should be supported to ask about sexual wellbeing, so that it is no longer considered to be a dangerous

conversation. When inpatient service users suggest there are problems with this area of their lives, use of metrics, such as the Sexual Wellbeing Scale, may help professionals identify areas for interventions to focus on and to measure progress.

4.6.2. Restrictive Practice and Positive Risk-Taking

The participants in this study spoke of how harm might arise from medicalised and restrictive practices such as confinement, monitoring, and medication. Discourses of positive risk-taking (Morgan, 1996) are present in other areas of healthcare (Blood & Wardle, 2018; Felton et al., 2017; National Institute for Health and Care Excellence, 2024) but have not been introduced to research on inpatient service users' sexual expression other than in this study. Participants spoke in favour of practices such as the provision of sex toys, spaces for intimacy, and talking about sex. Consultation with inpatient service users about how their needs could be better supported and which positive 'risks' would be most meaningful to them could help identify the most important areas of improvement.

4.6.3. Making Space for Multiple Positions in Decision-making

When supporting and responding to inpatient service users' sexual expression, professionals of all disciplines may find it useful to acknowledge their positionality and that norms around sexual expression are not universal. Decision-making in MDTs and in meetings with inpatient service users could introduce additional perspectives of inpatient service users' sexual expression beyond those which are risk-focused, and these may check restrictive practice, professional power, and social inequality by increasing the discourses which professionals may draw from, and hence their possibilities for action.

4.6.4. Considering Human Rights

Uniquely, the participants drew upon human rights discourses. However, there was no evidence of them being considered by colleagues, and in the extant research, they were only adequately explored by Di Lorito et al. (2020). While discussion of human rights is often part of training in relation to the Mental Health Act (NHS England, 2024), professionals may not realise its relationship to sexual expression, and links may need to be more explicit.

Including training on human rights, including in relation to sexual expression, should be included in clinical psychology doctoral courses and training for other

professions. A critical approach (Patel, 2020) may recognise that human rights discourses may have value for inpatient service users, but that these constructions are based on white, Western, rationalist values that may not represent the people to whom this talk is applied. Hence, considering the limitations of codified human rights and what else might be considered important to people is similarly important.

4.7. Implications for Policy

4.7.1. Guidance on Distinguishing Sexual Abuse

Currently, policies around sexual expression in psychiatric hospitals in the UK only deal with sexual abuse. While these are important, bolstering policies with guidance on how to discern sexual abuse from sexual expression may help professionals acknowledge that not all sexual behaviour in psychiatric hospitals is harmful and enable them to make distinctions in practice.

4.7.2. Supporting Sexual Expression

Secondly, the clinical psychologists' talk has expressed that finding ways to engage in sexual expression can be difficult on wards, but that this may have benefits for wellbeing, and that it is also part of being human. New policies and guidelines are therefore required which enable inpatient service users to find spaces, resources and relationships which support sexual expression. In particular, the sharing of examples of best practice may inspire professionals to deliver change and draw upon an evidence base.

4.7.3. Legal Activism

Where hospitals impinge upon inpatient service users' sexual expression unnecessarily, inpatient service users should be supported to challenge restrictive practice. Professionals, Trusts, and disability rights groups should support inpatient service users to use complaints systems. Further, where these systems fail, use of the judicial system to create case law may help protect inpatient service users' rights.

4.8. Conclusion

This study has been the first to explore how clinical psychologists talk about

inpatient service users' sexual expression. It has been the first to study their practice in this area, and has demonstrated that they construct it as risky, pathological, and conflicting with social norms, but also as useful for recovery and as part of being human. While the first two constructions were dominant discourses within both the extant and historical literature, the others represent new and uniquely psychological contributions to academic discourse around inpatient service users' sexual expression.

These constructions allowed the clinical psychologist participants to adopt positions including protectors, diagnostic experts, and moral governors, which supported restrictive practice. However, they could also adopt the roles of pseudo-occupational therapists and advocates, whereby their practices resisted restrictions. Consequently, the clinical psychologists' talk was often fraught with dilemmas, uncertainties, and frustrations – all of which represented the depth of thought and care they brought to these issues.

Exploring clinical psychologists' practice in this area has consequently shared new possibilities for practice that can challenge medicalised understandings and balance by drawing attention to rehabilitation and human rights. I hope that this study provides reflective material for readers working in inpatient settings.

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APPENDICES

APPENDIX A:

Foucauldian Analytical Terms

An explanation of the Foucauldian analytical terms used in this study is provided below. Foucault resisted definition, and the meanings of these terms would often change over time. However, to aid the reader, the way in which these concepts are used in this thesis is outlined below.

Action Orientation

In FDA, this term describes the interactional work done by a discourse. It is the social action that the talk accomplishes – its goal or purpose (Edwards & Potter, 1992). Linguistic clues can signal the speaker's intent.

Archaeology

Foucault (1970, 1973, 1977b, 2004) developed this method of analysing discourse to 'excavate' knowledge by identifying rules and strategies which determine how a subject can be spoken about, what can be known about it, and what can be done in relation to it.

Biopower

A method by which populations are managed by exerting power over bodies (Foucault, 1978). "The set of mechanisms through which the basic biological features of the human species became the object of a political strategy" (Foucault, 2007, p. 1).

Confession/Confessional

For Foucault, confession was originally a method through which religious power was exercised through the disclosure of sins to priests. As society became secularised in the 1700s and 1800s, doctors replaced priests, and confession became a method through which data could be gathered about transgressions and used to develop methods of social control. Foucault (1978) identified confessionals as an area of life where sex talk was socially permissible.

Conditions of Possibility

In *The Order of Things,* Foucault (1970) used this term to describe the underlying structures which make certain ways of knowing possible in an historical and social context. This can be expressed through theories and practices. By understanding the conditions of possibility, we can challenge them.

Confinement

People who are deemed dangerous to society are confined to maintain social control. For example, people considered mad or unreasonable (‘abnormal’) were detained in the 1600s in a movement Foucault (1977a, 1977b) named ‘The Great Confinement.’ This does not have to take place within the physical walls of prisons or asylums: it can refer to any rules which separate people.

Discourse

For Foucault (2004), discourse is a set of related statements containing regularities: “a certain way of speaking” (p. 6). However, it can also extend beyond speech and refer to any set of rules, practices, and ideas that shape how we talk, think, and behave. These can be embedded within institutions. Discourses change and are dependent on their contexts.

Discipline

One way in which power can be exerted; the exertion of social control over individual bodies, and with minimum force. It is done through the organisation of space and use of surveillance, often through institutions such as hospitals, asylums, prisons, and schools.

Genealogy

A method of analysis which recognises the relations of power and subjectification of people (Foucault, 2003). It demonstrates how ways of being – especially those which might appear to be without history – have come to be as they are and how they can marginalise people. Knowledge developed from this can be interruptive and lead to liberating options (‘Genealogy,’ 2014).

Governmentality

In Foucault’s later work, he argued that governmentality took over from power/knowledge and described techniques governments use to make subjects governable. It includes the idea of ‘self-governance’ (Foucault, 2008, 2010, 2011), which includes self-surveillance and self-regulation as methods of self-control.

Normalisation

A disciplinary practice to control human bodies (Foucault, 1977a). An ideal form of conduct (‘optimal model’) is constructed and then individuals are rewarded or punished based on their conformity to it. Those who conform are considered ‘normal’ and those who do not are thought of as ‘abnormal’ (Foucault, 2007).

Power/Knowledge

For Foucault, power is based on knowledge creating and recreating itself. Those with power shape knowledge about the world and the subjects within it, and create an accepted truth (Foucault, 1978).

Resistance

Resistance is present everywhere in power relations according to Foucault. It is not external to power: rather, it "plays the role of adversary, target, support or handle" (Foucault, 1978, p. 95).

Responsibilisation

The idea, internalised by individuals, that they are responsible for what happens, or does not happen, to them. Duties that originally may have belonged to the state – or to no one at all – become those of the individual (Lemke, 2001).

Subject Position

The idea that statements are made from specific positions which are coded into discourse. Identities are thus agents in discourse and aspects of discourse (Foucault, 2004).

Subjectification

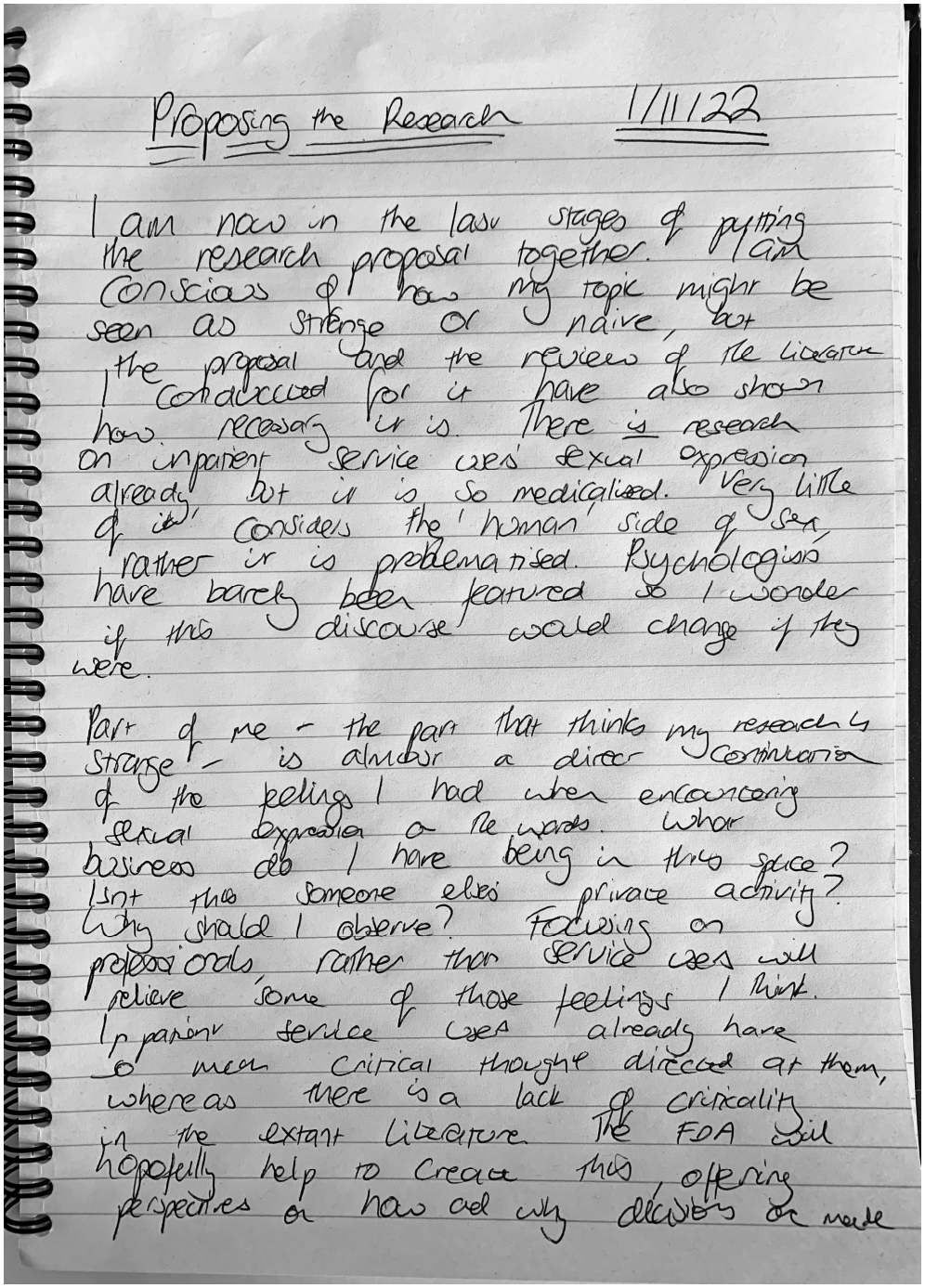
A reference to both how an individual is subject to control and dependence: "the different modes by which, in our culture, human beings are made subjects" (Foucault, 1982, p. 208), and how an individual is bound to their identity through self-knowledge and a conscience (Drefus & Rabinow, 1983).

Technologies (of Power, of Self, of Truth)

The methods and procedures through which individuals are governed or produced so that they integrate into political and economic structures. Used as a way of challenging the neutrality of power relations by constructing them as both powerful and prohibitive (Foucault, 1977a, 1978).

APPENDIX B:

Reflective Log Excerpt 1



Proposing the Research 1/11/22

I am now in the last stages of putting the research proposal together. I am conscious of how my topic might be seen as strange or naive, but the proposal and the review of the literature conducted for it have also shown how necessary it is. There is research on inpatient service users' sexual expression already, but it is so medicalised. Very little of it considers the 'human' side of sex, rather it is problematised. Psychologists have barely been featured so I wonder if this discourse would change if they were.

Part of me - the part that thinks my research is strange - is almost a direct continuation of the feeling I had when encountering sexual expression at Rewards. What business do I have being in this space? Isn't this someone else's private activity? Why should I observe? Focusing on professionals, rather than service users will relieve some of those feelings I think. Inpatient service users already have so much critical thought directed at them, whereas there is a lack of criticality in the extant literature. The FOA will hopefully help to create this, offering perspectives on how and why decisions are made

APPENDIX C:

Summary of Aims and Findings of Reviewed Studies

Authors' names and year published	Title	Aim	Key findings
Acuña et al., 2010	A comparative study of the sexual function of institutionalized patients with schizophrenia	To assess sexual function in patients with schizophrenia and compare it to people with schizophrenia who are not hospitalised and those without any mental illness	Of people hospitalised with schizophrenia, 71 per cent of males and 57.1 per cent of females experienced sexual dysfunction, compared with 10 per cent of males and 50 per cent of females with schizophrenia who were not hospitalised. Most areas of sexual function were impaired amongst patients with schizophrenia
Bardell et al., 2011	Inappropriate sexual behaviour in a geriatric population	To describe inappropriate sexual behaviour in a geriatric population, to identify contributing factors, and to	Right frontal lobe stroke, poor performance on cognitive tests, and dementia were associated with inappropriate sexual behaviour. Atypical antipsychotics such as

		review interventions to reduce these behaviours	olanzapine and risperidone reduced inappropriate sexual behaviour but also had adverse effects
Błachut et al., 2022	Sexual disorders in men treated in a psychiatric ward	To assess the impact of the dual diagnosis of addiction and mental illness on sexual dysfunction	Sexual dysfunctions occurred in 83.6 per cent of patients. Treatment lasting more than five years had a stronger association with sexual dysfunction (p=0.007). Dual diagnoses of mental illness and addiction were more strongly associated with anorgasmia (p = 0.0145) and excessive sexual needs (p = 0.035) in comparison to people with one diagnosis
Bowers et al., 2014	Sexual behaviours on acute inpatient psychiatric units	To assess types and frequency of sexual behaviour in patients during the first two weeks of admission to psychiatric hospitals	Sexual dysfunctions occurred in 83.6 per cent of patients. Treatment lasting more than five years had a stronger association with sexual dysfunction (p=0.007). Dual diagnoses were more strongly associated with anorgasmia (p = 0.0145) and excessive sexual needs

			(p = 0.035) in comparison to people with one diagnosis
Brown et al., 2014	Transformations of self and sexuality: Psychologically modified experiences in the context of forensic mental health	To explore how forensic psychiatric patients manage their sexuality	A psychologically modified experience is produced through a new self-relation that is changed when people are released into the community
Buckley & Robben, 2000	A content analysis of state hospital policies on sex between inpatients	To understand state hospitals' policies on sex between inpatients	Inpatient sex was not permitted by 14 of 31 policies, while 12 emphasised the autonomy of patients. Five said that staff should receive special training. Hospitals vary in their attention and management approaches to sexual behaviour
Buckley & Hyde, 1997	State hospitals' responses to the sexual behavior of psychiatric inpatients	To determine psychiatric hospitals' responses to inpatient sexual behaviour	According to 88 per cent of respondents, sexual behaviour was a clinical problem. Most had a policy addressing such behaviour, and 75 per cent had psychoeducational interventions

Buckley & Wiechers, 1999	Sexual behavior of psychiatric inpatients: Hospital responses and policy formulation	To understand how hospitals respond to inpatient sexual behaviour and the nature and existence of their policies	A formal sexual policy existed in 25 per cent of hospitals. Sexual behaviour was an infrequent problem according to 72 per cent
Chandra, Carey, Carey, Prasada Rao, et al., 2003	HIV risk behaviour among psychiatric inpatients: Results from a hospital-wide screening study in southern India	Understand correlates and prevalence of sexual risk behaviour among psychiatric patients	Women were more likely to be sexually active (50 per cent) than men (36 per cent), but equally likely (6 per cent compared to 5 per cent) to take sexual risks. Sexual activity was associated with being younger, married, being diagnosed with a disorder other than schizophrenia, and a history of drug use. Risky sexual behaviour was associated with being male, using tobacco, and drug and alcohol use
Chandra, Carey, Carey, Shalinianant, et al., 2003	Sexual coercion and abuse among women with a severe mental illness in India: An exploratory investigation	To determine the prevalence of sexual abuse, to identify clinical and sociodemographic correlates, to understand associations with HIV risk behaviour, and to find out if self-	Sexual coercion was reported by 30 per cent of women. Women with a history of abuse were more likely to engage in HIV-risk behaviour ($p<.001$). Only 3.5 per cent of charts contained information about coercion

		reports of sexual coercion were recorded in charts	
Cohen et al., 2007	Sexual impairment in psychiatric inpatients: Focus on depression	To understand prevalence of sexual dysfunction, especially in relation to depression	There was a high overall prevalence of sexual dysfunction, which was highest amongst people with depression. People taking antidepressants suffered more frequently and more severely from impaired sexuality
Cole, 2000	Out of sight, out of mind: Female sexuality and the care plan approach in psychiatric inpatients	To identify how issues of sexuality are taken into account for female psychiatric inpatients of a child-bearing age	Eighty per cent of women who were not described as taking contraceptives were taking at least one drug that is not advised during pregnancy. Of these, 53 per cent had a sexual partner
Cole et al., 2003	Sexual assault on wards: Staff actions and reactions	To identify staff practices after a sexual assault of a patient, and to understand their emotional responses	There was agreement amongst staff over actions to be taken and low levels of anger around sexual assault. Weariness was identified, especially amongst consultants. Women inpatients were described as most vulnerable to abuse and

			exploitation. Staff felt they may be blamed in the case of sexual assault
Cole et al., 2003a	Sex and segregation: Staff attitudes explored	To understand staff views of mixed sex wards and sexual activity between inpatients	Inpatients had sexual relationships that were detrimental to their health, according to 92.5 per cent of staff, who also favoured single sex wards. Doctors were more likely to believe that patients' lives would be better on single sex wards and that sex was common between inpatients. Gender and age did not seem to affect responses
Cole, 2003	Sexual assaults in psychiatric in-patient units: The importance of a consistent approach	To establish the level of consistency in managing sexual assault allegations and to assess the quality of data recording	There was little consistency between cases and patchy data recording
Dein et al., 2016	Examining professionals' perspectives on sexuality for service users of a forensic psychiatry unit	How staff construct inpatient sexuality, including the range of sexual possibilities open to inpatients	Themes identified were: a) what the limits of acceptable sexual behaviour were judged to be, b) discrimination against transgender and same sex relationships, c)

			vulnerability among female patients and therapeutic efficacy, and d) an abject fear of patient pregnancy. Some conflict between clinical and ward staff was described
del Mar Baños-Martín et al., 2017	Sexual behavior in patients with psychosis admitted to a hospital unit	Describe information on sexuality of inpatients	Sexual delusions occurred for 24 per cent of patients, and these were more frequent amongst women. Women also had more emotional symptoms, especially persecutory delusions. There were few reports on sexual dysfunction. Overall there was little recognition of sexuality amongst patients
Di Lorito et al., 2020	Staff views around sexual expression in forensic psychiatric settings: A comparison study between United Kingdom and German-speaking countries	Explore staff views on inpatient sexual expression in UK and German contexts	UK staff had more conservative views and felt more strongly that patients should not be allowed to engage in sexual intercourse or other sexual expressions, and that they should not be provided with condoms or conjugal suites, given privacy for masturbation, or have the

			right to raise a child. The study called for further research to identify personal and system-level issues influencing staff views
Dobal & Torkelson, 2004	Making decisions about sexual rights in psychiatric facilities	Understand staff perceptions of sexual activity and the prevalence of sex education programmes and policies	A sexual policy was in place in 60 per cent of facilities, 69 per cent had sex education programmes for staff, and 83 per cent had sex education programmes for residents
Fish, 2016	‘They've said I'm vulnerable with men’: Doing sexuality on locked wards	To understand how sexuality is done on a locked ward for women with intellectual disabilities	Staff were concerned about the client mix on the unit, and were protective towards women service-users. Physical contact was highly regulated and all spaces were described as public, so women were not given privacy to explore their sexuality. Staff positioned women as asexual and sexually vulnerable, which prevented inpatients from learning to make informed choices about sexual partners

Foley & Cummins, 2018	Reporting sexual violence on mental health wards	To understand the extent of sexual violence towards inpatients	There were large variations between mental health trust and police recording of sexual offences taking place on mental health units
Frieh, 2020	Stigma, trauma and sexuality: The experiences of women hospitalised with serious mental illness	To understand how women experience sexuality and perceive men and masculinity	Inpatient trauma increased the salience of stigma and potential for retraumatisation. Labelling perpetuated self-stigma, which threatened women's self-esteem, safety, and trust in others
Gebhardt & Steinert, 1999	Should severely disturbed psychiatric patients be distributed or concentrated in specialized wards? An empirical study on the effects of hospital organization on ward atmosphere, aggressive behavior, and sexual molestation	To understand whether ward atmosphere, aggressive behaviour, and sexual molestation would change if severely disturbed patients were distributed over several wards instead of locked single sex wards	Across all wards, there was an improvement in atmosphere and a reduction in aggression. The impact on sexual molestation was unclear
Goldstein et al., 2021	Reproductive health in an inpatient psychiatric unit: A retrospective chart review	Understand how reproductive health is discussed with female inpatients of a child-bearing age	A fifth (19.59 per cent) of encounters involved discharge while taking a teratogenic medication and 50 per

			cent had recent substance abuse. Fewer than 10 per cent of encounters recorded contraceptive use and only one case talked about the reproductive effects of medication, although a third (33.8 per cent) had previously been pregnant and two patients were pregnant on admission
Gomez-Sanchez-Lafuente et al., 2021	Met and unmet needs in an inpatient psychiatry setting in Spain	Determine inpatients' perceived needs and identify risk factors for patients with a greater number of unmet needs	Intimate relationships were the most common unmet needs (44 per cent), followed by company (40.7 per cent) and daytime activities (38.7 per cent). Three or more unmet needs were related to the following variables: Brief Psychiatric Rating Scale score (p=0.004), Personal and Social Performance score (p = 0.013), marital status (p=0.018), employment status (p=0.009) and voluntary admission (p=0.032)

Gunewardene et al., 2010	Prevalence of hepatitis C in two inpatient psychiatry populations	Determine the prevalence of hepatitis C amongst inpatients	3.2 per cent of patients had hepatitis C
Hales et al., 2006	Sexual attitudes, experience and relationships amongst patients in a high security hospital	To study relationships among inmates of high security hospitals	Patients talked reliably about the relationships, and did not lose interest in these when they were incarcerated. Having information on these is important to give safety and support
Hughes & Hebb, 2005	Problematic sexual behaviour in a secure psychiatric setting: Challenges and developing solutions	To understand the prevalence of previous sexually abusive behaviour amongst the forensic psychiatric population	Patients who raised concern regarding sexually abusive behaviour were not usually sex offenders and might not suit traditional treatment programmes
Johnsen et al., 2011	Sexual dysfunction and hyperprolactinemia in male psychotic inpatients: A cross-sectional study	To determine the prevalence of sexual dysfunction and hyperprolactinemia in male patients, and establish whether there is an association	Half of patients reported diminished sexual desire and a third reported erectile and ejaculatory dysfunction. No association was found between prolactin levels and sexual dysfunction

Tuomi Jones et al., 2007	Development of a clinical instrument to record sexual aggression in an inpatient psychiatric setting	To describe the development and use of a clinical instrument to record sexually aggressive behaviours in an inpatient setting	Two people (11 per cent) engaged in at least 57 incidents of sexually aggressive behaviour within a four-month time-frame. Most of these behaviours were not otherwise noted
Kang et al., 2020	Exploring behaviours of concern including aggression, self-harm, sexual harm and absconding within an Australian inpatient mental health service	To explore the nature and outcome of behaviours of concern amongst inpatients	Behaviours of concern were documented for 18.2 per cent of patients. These patients also tended to show higher rates of drug use and homelessness, and were admitted for longer. Self-harm and sexual harm tended to occur outside of business hours
Kazour et al., 2019	Sexual desire and emotional reactivity in chronically hospitalized Lebanese patients with schizophrenia	To study the emotional reactivity of schizophrenic inpatients with a high level of sexual desire	Patients who masturbated had a significantly higher mean emotional score, higher cognitive functioning score, higher motivation score, higher motor deficit score, higher sensory perception score, higher SBQ score, and higher emotional reactivity

Landi et al., 2020	Affective and sexual needs of residents in psychiatric facilities	To understand how sexuality and affectivity are expressed by inpatients	Interventions were coded as: (a) contraception and sexually transmitted disease prevention; (b) affective needs; (c) personal experiences; (d) regulation of sexual relations; (e) professionals' openness towards the topic; (f) professionals' responses to inpatients' sexual behaviours; and (g) inpatients' proposals. Affective and sexual relations are a common occurrence within psychiatric hospitals even if needs are not addressed and no assistance is given in relation to management
Liu et al., 2022	Sexual dysfunction in chronically medicated male inpatients with schizophrenia: Prevalence, risk factors, clinical manifestations, and response to sexual arousal	Assess incidence and risk factors of sexual dysfunction in males and their clinical correlations to sexual arousal in male schizophrenic patients	Nearly one third of young and middle-aged chronically medicated male inpatients with schizophrenia had sexual dysfunction. They experienced less pleasure and had higher avoidance motivation when exposed to erotic stimuli than

			patients not experiencing sexual dysfunction
Lourenço et al., 2010	Depression and sexual desire: An exploratory study in psychiatric patients	To identify the relationship between depression and sexual desire in psychiatric inpatients	Increased depressive symptomology related to lower sexual desire
Ma et al., 2018	Sexual activity, sexual dysfunction, and sexual life quality among psychiatric hospital inpatients with schizophrenia	To estimate the prevalence of current sexual activity, sexual dysfunction, and sexual attitude and influence of factors amongst schizophrenic inpatients	Current engagement in sexual intercourse was reported by 41.3 per cent of inpatients. Women over 50 had higher rates of sexual dysfunction. Patients under 50 demonstrated a relationship between BPRS group (mean score >2.5 vs ≤2.5), sexual dysfunction ($p<.001$), sexual life quality ($p<.001$), and sexual satisfaction ($p=.006$)
Magagula et al., 2012	A survey of HIV-related knowledge among adult psychiatric patients: A South African study	To determine the level of knowledge about HIV among inpatients	Excellent knowledge of HIV was demonstrated by 92 per cent of patients. There was no association between knowledge and risk behaviour ($r=-0.11$)
Mandarelli et al., 2010	Competence to consent to sexual activity in bipolar	To investigate capacity to consent to sexual relations	Patients with schizophrenia were less able to consent to sex than

	disorder and schizophrenic spectrum disorders	using the Sexual Consent Assessment Scale, as developed by the authors	those with bipolar disorder; this was independent from symptomology. Schizophrenic patients tended to know less about birth control and were more likely to be seen as having problems with metacognition
Marshall et al., 2016	Paraphilias in adult psychiatric inpatients	To understand the prevalence of paraphilias amongst inpatients	A paraphilia was experienced by 13.4 per cent of inpatients in their life time. The most common were voyeurism (n = 9 [8.0 per cent]), exhibitionism (n = 6 [5.4 per cent]), and sexual masochism (n=3 [2.7 per cent]). Patients who screened positive for a paraphilia had significantly more psychiatric hospitalisations (p=.006) and were more likely to have attempted suicide. Patients with paraphilias were more likely to have been sexually abused (p=<.001). 13.3 per cent of paraphilic patients were

			diagnosed with a paraphilia on admission
Marcus et al., 2021	Defining patient safety events in inpatient psychiatry	To use the Institute of Medicine patient safety framework to define risk events	All sexual contact was defined as a risk event due to concerns about "consent, sexually transmitted diseases, and possible pregnancy" (p. 4)
Martin et al., 2011	Social relationships and activities among married psychiatric inpatients with sexual difficulties	To examine the relationships and social activities of married inpatients with sexual difficulties	Sexual difficulties were experienced by 10.7 per cent of people, and these were related to dysfunctional social relationships and lower likelihood of social contact, especially for women. "Assessment of sexual function should be seen as part of comprehensive psychiatric care to support recovery" (p. 307)
McGarry, 2019	‘Hiding in plain sight’: Exploring the complexity of sexual safety within an acute mental health setting	To explore the mechanisms and structures that were put into place following the investigation of a staff sexual assault	Four themes: ‘Feeling betrayed’: The relational context of the ward environment’; ‘Doing what we were meant to be doing’: Quality of leadership’; ‘Covering yourself’: Safeguarding practice; ‘The

			subtleties of abuse': Complexities of safeguarding.' Call for "clear organizational structures of support, a clearer understanding of 'sexual safety,' and education and training which explicitly addresses recognition and complexity of sexual violence" (p. 171)
Menon & Pomerantz, 1997	Substance use during sex and unsafe sexual behaviours among acute psychiatric inpatients	To find out whether inpatients used drugs before or after sex, and whether this related to unsafe sexual behaviours	40 per cent of male patients and 36 per cent of female patients used alcohol at least once during sex in the last six months. For men, there was an association between crack cocaine use and inconsistent condom use and sex with a high-risk partner. For women, alcohol usage was associated with receptive anal sex
Needham et al., 2023	Acceptability and feasibility of sexual health screening in psychiatry inpatients	To understand if inpatients would welcome sexual health screening and investigate the	Sexual screening should be offered to all inpatients, according to 95.6 per cent of inpatients. All participants had sex since their last screen

		practicalities of delivering the assessments	
Nitschke et al., 2009	Severe sexual sadism—An underdiagnosed disorder? Evidence from a sample of forensic inpatients	To explore the rate of identified sexual sadism prior to forensic hospital admission in comparison to screening	Unrecognised sexual sadists more closely resembled non-sadistic sex offenders than accurately diagnosed sadists
Niven et al., 2022	The sexual and reproductive health of female psychiatric inpatients: An area needing more attention?	To determine rates of reported sexual trauma and domestic violence, rates of sexual and reproductive health screening, and associations between the two	Sexual trauma was experienced by 49.4 per cent of inpatients, and 38.8 per cent of women had experienced sexual violence. Rates of screening for pregnancy (56.9 per cent) and sexually transmitted infection risk (18.8 per cent) were low. Of patients prescribed a mood stabiliser, 20 per cent had experienced a discussion about their reproductive effects. A lack of effect (p>.6) was found between sexual trauma history and reproductive health screening
Nobels et al., 2021	‘Breaking the silence’: Sexual victimisation in an old age	To identify sexual victimisation over patients' lifespans and	Sexual victimisation occurred in 57 per cent of patients' lifetimes, and 7

	psychiatry patient population in Flanders	within the past 12 months, its correlates and disclosure	per cent had experienced this in the last 12 months. Interviews were the first time patients had disclosed sexual victimisation for half of patients
Perlman et al., 2007	Prevalence and predictors of sexual dysfunction in psychiatric inpatients	To identify the prevalence and predictors of sexual dysfunction in inpatients	Sexual dysfunction was less prevalent amongst inpatients (17 per cent) than community patients. Severe depression, antidepressant usage and cardiopulmonary conditions predicted sexual dysfunction
Pilling, 2021	Sexual violence and psychosis: Intersections of rape culture, sanism, and anti-black sanism in psychiatric inpatient chart documentation	To understand how rape culture informs how professionals document sexual violence against patients with psychosis	Themes identified were: normalisation of sexual violence, sexual violence reconfigured as delusion, pathologising the impact of sexual violence, what about the perpetrators? Invisibilising acts of sexual violence, and sexual violence as a symptom of psychosis
Poole, 2020		To explore hospital policy-makers' understandings of	

	Exploring hospital policy makers' understandings of forensic inpatient sexualities	forensic detainees' sexualities and how these relate to practice and their vision of a policy governing sexual expression in hospital	Three themes were identified: risk and uncertainty, artificial realities, and detained bodies
Quayle et al., 1998	Sexual knowledge and sex education in a secure hospital setting	To evaluate sexual knowledge and sex education in a secure hospital	Sexual knowledge was improved by education programmes for both sexual offenders and non-offenders
Quinn & Happell, 2015b	Exploring sexual risks in a forensic mental health hospital: Perspectives from patients and nurses	To explore sexual risks from the perspectives of patients and nurses	Risk was a major theme. Subthemes from nurses included sexual safety, sexual vulnerability, unplanned pregnancies, and male sexuality issues. Subthemes from patients included risks associated with sexual activity, access to information and sexual health care, unplanned pregnancies, vulnerability, and male sexuality issues. Knowledge was well-articulated but support was considered lacking by patients

Quinn & Happell, 2015a	Consumer sexual relationships in a forensic mental health hospital: Perceptions of nurses and consumers	To explore nurses' and patients' perceptions of sexuality in a long-term mental health unit	Benefits of, and barriers to, sexual relationships was a major theme. Subthemes for nurses included 'supportive factors' and 'potential dangers,' reflecting their qualified support. Subthemes for inpatients included 'therapeutic,' 'feeling normal,' 'restrictions and barriers,' and 'lack of support and secrecy'
Quinn & Happell, 2016	Supporting the sexual intimacy needs of patients in a longer stay inpatient forensic setting	To explore nurses' and patients' perceptions of sexuality in a long-term mental health unit	The theme of supporting sexuality was identified, and had four subthemes: for nurses, it depends on the setting; need for guidelines; and consent, and for patients – it depends on the setting; and need for support
Quinn et al., 2011	Talking or avoiding? Mental health nurses' views about discussing sexual health with consumers	To investigate how nurses assess and support patients' sexuality	Sexuality was considered important by the nurses, but many were reluctant to enquire about patient concerns and ignored the issue or referred it to another clinician. Four themes were identified: "talking

			about or avoiding sexuality concerns with consumers; sexuality is not an important priority; refer to others, as talking about sexuality is not 'my' job; and sexuality is poorly addressed by others"
Ravenhill et al., 2020	Sexuality, risk, and organisational misbehaviour in a secure mental healthcare facility in England	Identify how inpatient sexuality is constructed in staff discourses	Two constructions: "one of the normalcy and legitimacy of sexual expression in human experience; and the other of risk, wherein sexuality needed to be regulated and obstructed." (p. 1382). Inpatient sexual expression was often only constructed as 'organisational misbehaviour,' which may impact recovery
Ruane & Hayter, 2008	Nurses' attitudes towards sexual relationships between patients in high security psychiatric hospitals in England: An exploratory qualitative study	To explore nurses' attitudes towards psychiatric forensic inpatients' sexual relationships	Nurses rejected permissive policies, as they thought they might lead to abuse and exploitation. Practices and attitudes were dominated by personal values that restrict patient experience and undermine

			professional mores, but also seemingly uphold a duty of care
Sahay et al., 2000	Sexual victimization and clinical challenges in women receiving hospital treatment for depression	To examine the prevalence of sexual victimisation amongst female inpatients with depression	Amongst female inpatients with depression, 65 per cent reported sexual violation. For 52 per cent, this was both in childhood and adulthood. Body image, self-esteem and internality were poorer for those who had been victimised, especially if this was in both adulthood and childhood
Sansone et al., 2011	Sexual behaviour and borderline personality disorder among female psychiatric inpatients	To explore sexual behaviour in inpatients with borderline personality disorder	Patients who were positive on the BPD measures tended to have a greater number of sexual partners, to report having been raped by a stranger, and to have been coerced to have sex

Schlup et al., 2021	Prevalence and severity of verbal, physical, and sexual inpatient violence against nurses in Swiss psychiatric hospitals and associated nurse-related characteristics: Cross-sectional multicentre study	To investigate the prevalence and severity of violence against nurses and whether there was a relationship to nurses' characteristics and the type of violence they experienced	73 per cent of nurses said they faced verbal violence, 63 per cent experienced violence against property, 40 per cent were subject to verbal sexual violence, and 14 per cent experienced physical sexual violence. Thirty per cent had been seriously assaulted in their lifetimes. All characteristics were associated with violence, especially a history of sexual assault
Siu et al., 2012)	Mental health recovery for psychiatric inpatient services: perceived importance of the elements of recovery	To understand the perceived importance of recovery elements through the development of a questionnaire	Intimacy and sexuality was the second-lowest ranked aspect of psychological recovery according to inpatients (37 per cent) and the lowest ranked according to staff (56 per cent).
Tiwana et al., 2016	Policies on sexual expression in forensic psychiatric settings in different European countries	To explore how sexual expression is handled within forensic settings	No country had a national policy on sexual policy, although many had local policies or shared practices. The UK was the most exclusive and prohibitive and its protocols were

			based on risk-aversion and did not emphasise patients' sexual needs
Colón Vilar et al., 2016	Assessment of sexual fantasies in psychiatric inpatients with mood and psychotic disorders and comorbid personality disorder traits	To investigate the nature and frequency of sexual fantasies in psychiatric patients	Participants scored highest on intimate sexual fantasies, and then exploratory, impersonal and sadomasochistic fantasies. Patients with higher cluster B scores scored significantly higher for all sexual fantasies. Patients with high cluster A scores scored lower on intimate fantasies. Scores were within the normative range of non-clinical samples
Warner et al., 2004	Sexual activity among patients in psychiatric hospital wards	To understand the nature and frequency of sexual activity	Participation in sexual activity was reported by 30 per cent of patients, and 10 per cent said they had intercourse. All sexual activity was consensual. Only 2 per cent of patients mentioned using condoms. Staff responses were congruent with patient responses

Westheide, Cohen, et al., 2007	Sexual dysfunction in psychiatric inpatients. The role of antipsychotic medication	To understand the mechanism of antipsychotic agent-induced sexual dysfunction	50-75 per cent of patients reported at least minor sexual dysfunction when treated with either prolactin-increasing anti-psychotics or prolactin-neutral medication. No association between the type of treatment and sexual impairment was found
Westheide, Helmstaedter, et al., 2007	Sexuality in male psychiatric inpatients: A descriptive comparison of psychiatric patients, patients with epilepsy and healthy volunteers	To examine sexual behaviour and sexual dysfunction in psychiatric patients	Sexual dysfunction was more severe when illness was acute and during the premorbid phase for psychiatric patients. Psychiatric patients were generally more sexually impaired than those suffering from epilepsy
Windle, 1997	The trading of sex for money or drugs, sexually transmitted diseases (STDs), and HIV-related risk behaviours among multisubstance using alcoholic inpatients	To identify whether trading sex for money or drugs was associated with self-reports of sexually-transmitted infections including HIV, and perceptions for future probable infection	Trading sex was associated with higher cocaine abuse, and infections, including HIV. These patients also perceived themselves as being at greater risk of infection

Wright & Gayman, 2005	Sexual networks and HIV risk of people with severe mental illness in institutional and community-based care	To examine sexual networks and HIV risks amongst inpatients	Community patients are more likely than hospitalised patients to be sexually active and engage in risky sexual behaviour. Hospitalised partners tend to have more transient sexual relationships with partners who also have a mental illness
Xia, 2021	Improving contraceptive and family planning awareness on a perinatal inpatient unit	To assess a contraceptive intervention	Unplanned pregnancies were reported by 53 per cent of patients before intervention. All felt that they were able to make informed decisions about their contraception on discharge

APPENDIX D:

Background and Methodologies of Reviewed Studies

Authors	Country	Author professions	n	Sample characteristics	n	Data collection method	Analysis method
Acuña et al., 2010	Spain	Psychiatrists	5	Psychiatric inpatients with schizophrenia/schizoaffective disorder	75	Mini-International Neuropsychiatric Interview	Descriptive statistics
				People living in the community with schizophrenia/schizoaffective disorder	41	Positive and Negative Syndrome Scale for Schizophrenia and Changes in Sexual Function Questionnaire	
				People with no mental illness	152		
Bardell et al., 2011	Canada	Psychiatrists	3	Psychiatric inpatients with inappropriate sexual behaviour	10	Chart review	Inferential statistics
					10		
Błachut et al., 2022	Poland	Psychiatrists	5	Male psychiatric inpatients	140	International Index of Erectile Function	Inferential statistics

		Researchers	1			IIEF-5 Sexological Questionnaire	
Bowers et al., 2014	UK	Psychiatrists	1	Psychiatric inpatients	522	Questionnaire	Descriptive statistics
		Researchers	2				
Brown et al., 2014	UK	Psychologists	2	Forensic psychiatric inpatients	20	Semi-structured interviews	Thematic analysis
		Researchers	2				
Buckley & Robben, 2000	US	Psychiatrists	1	Psychiatric hospitals	31	Questionnaire	Descriptive statistics
		Students	1				
Buckley & Hyde, 1997	US	Psychiatrists	1	Psychiatric hospitals	57	Questionnaire	Descriptive statistics
		Students	1				
Buckley & Wiechers, 1999	US	Psychiatrists	2	Psychiatric hospitals	56	Questionnaire	Descriptive statistics
Chandra, Carey, Carey,	India	Psychiatrists	3	Psychiatric inpatients	618	Chart review	Descriptive statistics

Prasada Rao, et al., 2003							
		Psychologists	2			Structured interview	
		Statisticians	1			Alcohol Use Identification Test (AUDIT), Drug Abuse Screening Test (DAST-10), HIV-Risk Screening Instrument (HSI)	
Chandra, Carey, Carey, Shalinianant, et al., 2003	India	Psychiatrists	2	Female psychiatric inpatients	146	Chart review	Descriptive statistics
						Structured interview	
		Psychologists	2			Sexual Experiences Survey, Alcohol Use Identification	Inferential statistics
		Statisticians	1				

						Test (AUDIT), Drug Abuse Screening Test (DAST-10), HIV-Risk Screening Instrument (HSI)	
Cohen et al., 2007	Germany	Psychiatrists	5	Psychiatric inpatients	587	Questionnaire	Comparative statistics
		Statisticians	1				
Cole, 2000	UK	Psychiatrists	1	Female psychiatric inpatients	56	Chart review	Descriptive statistics
Cole et al., 2003	UK	Psychiatrists	2	Nurses	35	Questionnaire	Descriptive statistics
		Statisticians	1	Physicians	24		
				Health care assistants	50		Text analysis
Cole et al., 2003a	UK	Psychiatrists	1	Nurses	35	Questionnaire	Descriptive statistics
		Psychiatrists	2	Psychiatrists	23		
		Statisticians	1	Healthcare assistants	49		
Cole, 2003	UK	Psychiatrists	1	Case notes	177	Chart review	Descriptive statistics

Dein et al., 2016	UK	Psychiatrists	3	Psychiatrists	16	Individual interviews	Thematic analysis
		Psychologists	1				
		Social workers	1	Psychologists	8		
		Researchers	1				
del Mar Baños-Martín et al., 2017	Spain	Nurses	6	Psychiatric inpatients with psychosis	293	Chart review	Descriptive statistics
Di Lorito et al., 2020	UK	Psychiatrists	3	Psychologists	62	Questionnaire	Inferential statistics
	Germany	Nurses	1	Legal	40		
				Medics	22		
	Switzerland			Social workers	10		
				Residential /Community Care/Occupational Therapy	5		
Dobal & Torkelson, 2004	USA	Nurses	2	Management	112	Questionnaire	Descriptive statistics

Fish, 2016	UK	Researchers	1	Females psychiatric inpatients with learning disabilities	Not stated	Individual interviews	Ethnographic
Foley & Cummins, 2018	UK	Psychologists	1	Police forces	23	Freedom of Information requests	Descriptive statistics
		Social workers	1	Mental health trusts	12		
Frieh, 2020	US	Sociologists	1	Female psychiatric inpatients	55	Interviews	Labelling theory
Gebhardt & Steinert, 1999	Germany	Psychiatrists	2	Ward staff	162	Ward Atmosphere Scale	Descriptive statistics
				Psychiatric inpatients	183		
Goldstein et al., 2021	US	Physicians	2	Records from female psychiatric inpatients	158	Chart review	Descriptive statistics
		Psychiatrists	1				
Gomez-Sanchez-Lafuente et al., 2021	Spain	Psychiatrists	2	Psychiatric inpatients	150	Camberwell Assessment of Needs	Inferential statistics
		Researchers	2			Brief Psychiatric Rating Scale	Descriptive statistics

		Psychologists	1			Personal and Social Performance	
Gunewardene et al., 2010	Australia	Psychiatrists	3	Psychiatric inpatients	Unknown	Blood test	Descriptive statistics
Hales et al., 2006	UK	Psychiatrists	4	Forensic psychiatric inpatients	25	Semi-structured interviews	Thematic analysis
Hughes & Hebb, 2005	UK	Social workers	1	Psychiatric inpatients	145	Questionnaire	Descriptive statistics
		Psychologists	1				
Johnsen et al., 2011	Norway	Psychiatrists	5	Male psychiatric inpatients	72	Positive and Negative Syndrome Scale (PANSS) Calgary Depression Scale for Schizophrenia (CDSS) Clinical Drug and Alcohol Use Scales (CDUS/CAUS)	Inferential statistics

							Clinical Global Impression—Severity of Illness scale (CGI-S)	
							Global Assessment of Functioning—Split Version, Functions scale (GAF-F)	Descriptive statistics
							Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)	
							UKU Side Effect Rating Scale (UKU-SERS Pat)	
							Blood testing	
Tuomi Jones et al., 2007	USA	Psychiatrists	4	Male psychiatric inpatients	18		Modified Overt Aggression Scale (MOAS)	Descriptive statistics

		Psychologists	2			Sexual Aggression Scale	
Kang et al., 2020	Australia	Psychiatrists	4	Psychiatric inpatients	179	Audit	Thematic analysis
		Nurses	2				
		Managers	1				
Kazour et al., 2019	Lebanon	Psychiatrists	2	Psychiatric inpatients	60	Sexual Behaviour Questionnaire (SBQ)	Descriptive statistics
		Psychologists	1			Positive and Negative Syndrome Scale (PANSS)	Inferential statistics
Landi et al., 2020	Italy	Psychiatrists	5	Psychiatric inpatients	13	Focus groups	Thematic analysis
		Psychologists	1				
		Physicians	1				
Liu et al., 2022	China	Researchers	1	Male psychiatric inpatients with schizophrenia	162	Positive and Negative	Descriptive statistics
		Psychologists	3			Syndrome Scale (PANSS)	

		Physicians	1			Sexual Experience Scale	
		Unknown	11				
Lourenço et al., 2010	Portugal	Psychotherapists	1	Psychiatric inpatients	89	Beck Depression Inventory (BDI)	Inferential statistics
		Psychologists	2			Sociodemographic Questionnaire	
Ma et al., 2018	Taiwan	Statisticians	1	Psychiatric inpatients with schizophrenia	317	Sexual Experience Scale	Inferential statistics
		Researchers	3			Sexual Behaviour Scale	
		Nurses	1			Sexual Attitudes Scale	Descriptive statistics
						Brief Psychiatric Rating Scale	
Magagula et al., 2012	South Africa	Psychiatrists	3	Psychiatric inpatients with schizophrenia	113	Structured interviews	Descriptive statistics
		Statisticians	1			AIDS Risk Behaviour Knowledge Test (AIDS-KT)	

Mandarelli et al., 2010	Italy	Psychiatrists	6	Psychiatric inpatients with schizophrenia and bipolar disorders	85	Sexual Consent Assessment Scale Brief Psychiatric Rating Scale	Inferential statistics
	US	Psychiatrists	3			Raven's Standard Progressive matrices	Descriptive statistics
Marshall et al., 2016		Researchers	1	Male psychiatric inpatients	112	Structured Clinical Interview for DSM-IV	
		Physicians	2			Sexual Disorders Module, Male Version	Inferential statistics
		Statisticians	1				
Marcus et al., 2021	USA	Statisticians	1	Psychiatric inpatients	1000	Chart review	Descriptive statistics
		Psychiatrists	1				
		Researchers	1				
Martin et al., 2011	Canada	Nurses	1	Married inpatients	11,982	Resident Assessment Instrument Mental Health	Descriptive statistics
		Researchers	2				Inferential statistics

McGarry, 2019	UK	Nurses	1	Mental health professionals and allied health professionals	8	Individual interviews	Thematic analysis
Menon & Pomerantz, 1997	USA	Psychiatrists	2	Psychiatric inpatients	239	Individual interviews	Descriptive statistics
		Nurses	1				Comparative statistics
		Psychologists	3				Inferential statistics
		Unknown	1				
Needham et al., 2023	UK	Psychiatrists	4	Psychiatric inpatients	113	Semi-structured interview	Descriptive statistics
		Physicians	3			Sexual health screening	
Nitschke et al., 2009	Germany	Psychiatrists	5	Psychiatric inpatients	535	Chart review	Inferential statistics
Niven et al., 2022	Australia	Psychiatrists	1	Female psychiatric inpatients of child-bearing age	160	Chart review	Descriptive statistics
		Physicians	4				Inferential statistics

Nobels et al., 202	Belgium	Psychiatrists	5	Old age psychiatric inpatients	100	Structured interviews	Descriptive statistics
		Researchers	2				
		Physicians	2				
Perlman et al., 2007	Canada	Researchers	3	Psychiatric inpatients	3717	Minimum Data Set for Mental Health, Version 1 (MDS–MH 1.0)	Descriptive statistics
		Psychiatrists	2				Inferential statistics
		Nurses	1				
Pilling, 2021	Canada	Researchers	1	Records from female psychiatric inpatients	161	Chart review	Thematic analysis
Poole, 2020	UK	Psychologists	3	Psychiatrists	8	Individual interviews	Thematic decomposition
				Psychologists	2		
				Nurses	1		
				Human resources	2		
Quayle et al., 1998	UK	Psychologists	3	Male forensic psychiatric inpatients	96	Questionnaire	Descriptive statistics
Quinn & Happell, 2015a	Australia	Nurses	2	Nurses	12	Individual interviews	Thematic analysis

Quinn & Happell, 2015b	Australia	Nurses	2	Nurses	12	Individual interviews	Thematic analysis
Quinn & Happell, 2016	Australia	Nurses	2	Nurses	12	Individual interviews	Thematic analysis
Quinn et al., 2011	Australia	Nurses	3	Nurses	14	Individual interviews	Framework analysis
Ravenhill et al., 2020	UK	Psychologists	4	Healthcare assistants	6	Group interviews	FDA
				Nurses	3		
				Activity coordinator	1		
Ruane & Hayter, 2008	UK	Nurses	2	Nurses	10	Individual interviews	Thematic analysis
Sahay et al., 2000	Canada	Psychologists	2	Female psychiatric inpatients with depression	60	Questionnaire	Inferential statistics
						Body Cathexis Scale (BC)	
						Global self Esteem Scale (GSE)	
						Levenson Locus of Control Scale	

Sansone et al., 2011	USA	Psychologists	1	Female psychiatric inpatients with and without a Borderline Personality Disorder diagnosis	126	Questionnaire	Descriptive statistics
		Psychiatrists	2			Borderline Personality Scale of the Personality Diagnostic Questionnaire-4 (PDQ-4) Self-Harm Inventory (SHI)	Inferential statistics
Schlup et al., 2021	Switzerland	Nurses	3	Nurses	1128	MatchRN Psychiatry study	Descriptive statistics Inferential statistics
Siu et al., 2012	Hong Kong	Psychiatrists	1	Psychiatric inpatients	101	Questionnaire	Descriptive statistics
		Students	5				
Tiwana et al., 2016	UK	Psychologists	2	Forensic psychiatry experts	14	Questionnaire	Narrative analysis
		Psychiatrists	1			Semi-structured interviews	Thematic analysis

Colón Vilar et al., 2016	Israel	Psychiatrists	4	Psychiatric inpatients	133	Structured Clinical Interview for DSM-IV	Inferential statistics
		Psychologists	3			Wilson Sexual Fantasies Questionnaire	
Warner et al., 2004	UK	Physicians	1	Psychiatric inpatients	100	Questionnaire	Descriptive statistics
		Psychiatrists	5				
				Staff	27		
Westheide, Cohen, et al., 2007	Germany	Psychologists	1	Psychiatric inpatients	587	Questionnaire	Inferential statistics
		Psychiatrists	14			Medication	
		Physicians	1				
Westheide, Helmstaedter, et al., 2007	Germany	Psychiatrists	5	Psychiatric inpatients	351	Questionnaire	Inferential statistics
		Physicians	1	Healthy male controls	55		
		Psychologists	1	Males with epilepsy	52		

Windle, 1997	USA	Psychologists	1	Multisubstance using alcoholic inpatients	802	Interviews Alcohol Research Center Intake Interview, Behavioral Risk Survey Chart review	Inferential statistics
Wright & Gayman, 2005	USA	Sociologists	2	Psychiatric inpatients	188	Structured interviews	Descriptive statistics
				Community psychiatric patients	213		
Xia, 2021	UK	Psychiatrists	1	Psychiatric inpatients on a mother and baby unit	Unknown	Questionnaire	Descriptive statistics

APPENDIX E:

Thematic Analysis of Reviewed Studies

Authors	Risks	Professional views	Psychological benefits	Sexual function	Policy
Acuña et al., 2010	NO	NO	NO	YES	NO
Bardell et al., 2011	YES	NO	NO	NO	NO
Błachut et al., 2022	NO	NO	NO	YES	NO
Bowers et al., 2014	YES	NO	NO	NO	NO
Brown et al., 2014	NO	NO	YES	NO	NO
Buckley & Robben, 2000	NO	NO	NO	NO	YES
Buckley & Hyde, 1997	NO	YES	NO	NO	YES
Buckley & Wiechers, 1999	YES	NO	NO	NO	YES
Chandra, Carey, Carey, Prasada Rao, et al., 2003	YES	NO	NO	NO	NO
Chandra, Carey, Carey, Shalinianant, et al., 2003	YES	NO	NO	NO	NO
Cohen et al., 2007	NO	NO	NO	YES	NO
Cole, 2000	YES	NO	NO	NO	NO

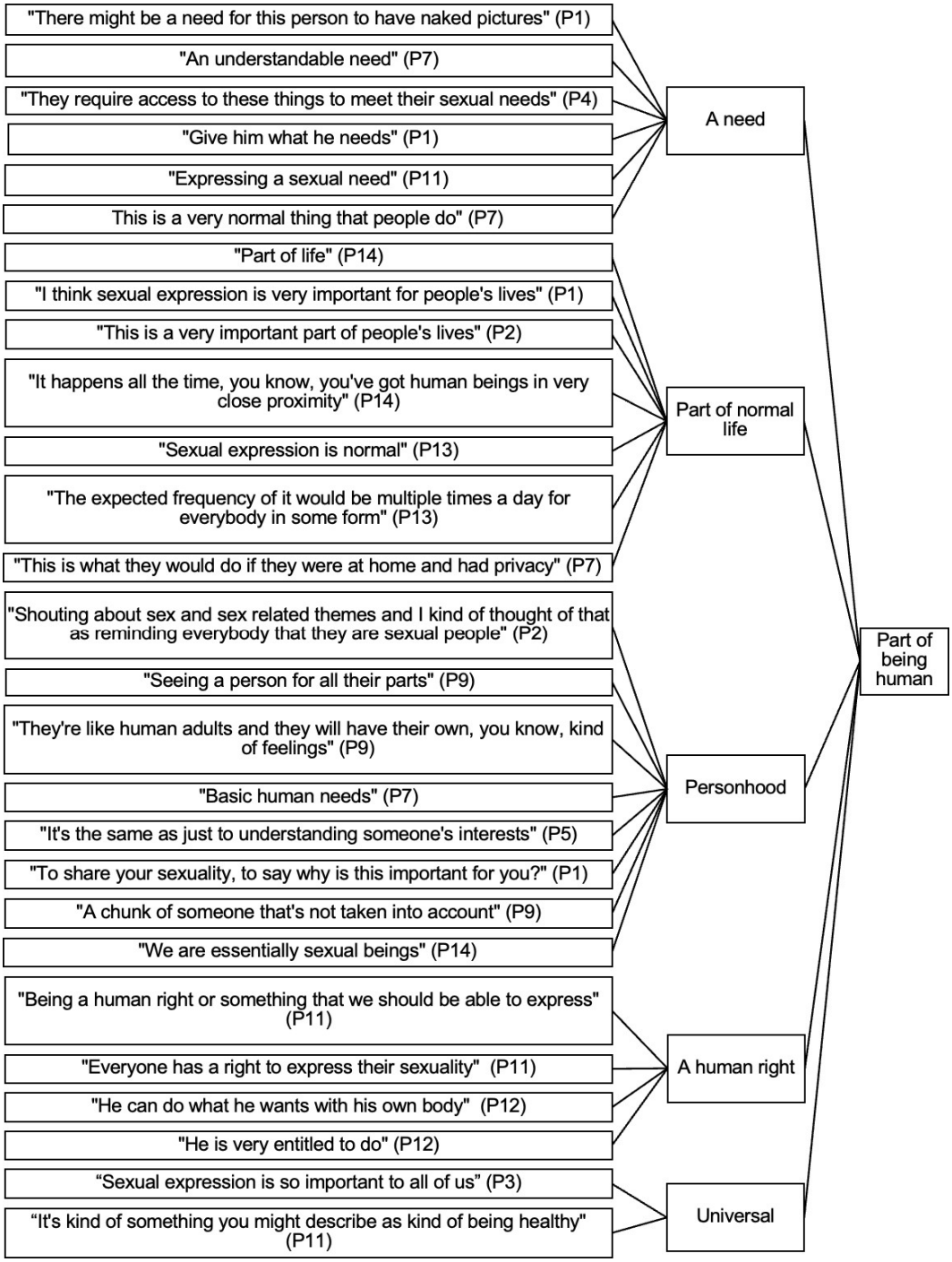
Cole et al., 2003	YES	YES	NO	NO	NO
Cole et al., 2003a	NO	YES	NO	NO	NO
Cole, 2003	YES	NO	NO	NO	NO
Dein et al., 2016	YES	YES	NO	NO	YES
del Mar Baños-Martín et al., 2017	YES	NO	NO	YES	NO
Di Lorito et al., 2020	NO	YES	NO	NO	NO
Dobal & Torkelson, 2004	NO	YES	NO	NO	YES
Fish, 2016	YES	YES	YES	NO	NO
Foley & Cummins, 2018	YES	NO	NO	NO	NO
Frieh, 2020	NO	NO	NO	NO	NO
Gebhardt & Steinert, 1999	YES	NO	NO	NO	NO
Goldstein et al., 2021	YES	NO	NO	NO	NO
Gomez-Sanchez-Lafuente et al., 2021	NO	NO	YES	NO	NO
Gunewardene et al., 2010	YES	NO	NO	NO	NO
Hales et al., 2006	YES	NO	YES	NO	NO
Hughes & Hebb, 2005	YES	NO	NO	NO	NO
Johnsen et al., 2011	NO	NO	NO	YES	NO
Tuomi Jones et al., 2007	YES	NO	NO	NO	NO
Kang et al., 2020	YES	NO	NO	NO	NO

Kazour et al., 2019	NO	NO	YES	NO	NO
Landi et al., 2020	YES	NO	YES	NO	NO
Liu et al., 2022	NO	NO	NO	YES	NO
Lourenço et al., 2010	NO	NO	YES	YES	NO
Ma et al., 2018	NO	NO	YES	YES	NO
Magagula et al., 2012	YES	NO	NO	NO	NO
Mandarelli et al., 2010	YES	NO	NO	NO	NO
Marshall et al., 2016	NO	NO	NO	NO	NO
Marcus et al., 2021	YES	NO	NO	NO	NO
Martin et al., 2011	NO	NO	YES	YES	NO
McGarry, 2019	YES	YES	NO	NO	NO
Menon & Pomerantz, 1997	YES	NO	NO	NO	NO
Needham et al., 2023	YES	NO	NO	NO	NO
Nitschke et al., 2009	YES	NO	NO	NO	NO
Niven et al., 2022	YES	NO	NO	NO	NO
Nobels et al., 2021	YES	NO	NO	NO	NO
Perlman et al., 2007	NO	NO	NO	YES	NO
Pilling, 2021	YES	NO	NO	NO	NO
Poole, 2020	NO	YES	NO	NO	YES

Quayle et al., 1998	NO	NO	NO	NO	YES
Quinn & Happell, 2015a	YES	YES	NO	NO	NO
Quinn & Happell, 2015b	YES	YES	NO	NO	NO
Quinn & Happell, 2016	NO	YES	YES	NO	NO
Quinn et al., 2011	NO	YES	NO	NO	NO
Ravenhill et al., 2020	YES	YES	YES	NO	NO
Ruane & Hayter, 2008	NO	YES	NO	NO	NO
Sahay et al., 2000	YES	NO	NO	NO	NO
Sansone et al., 2011	YES	NO	NO	NO	NO
Schlup et al., 2021	YES	NO	NO	NO	NO
Siu et al., 2012	NO	NO	YES	NO	NO
Tiwana et al., 2016	NO	NO	NO	NO	YES
Colón Vilar et al., 2016	NO	NO	YES	NO	NO
Warner et al., 2004	YES	NO	NO	NO	NO
Westheide, Cohen, et al., 2007	NO	NO	NO	YES	NO
Westheide, Helmstaedter, et al., 2007	NO	NO	NO	YES	NO
Windle, 1997	YES	NO	NO	NO	NO
Wright & Gayman, 2005	YES	NO	NO	NO	NO
Xia, 2021	YES	NO	NO	NO	NO

APPENDIX F:

Identification of Discourses from Constructions



APPENDIX G:

Social Media Study Advertisement

APPENDIX H:

Demographic Information Form

University of East London

Demographic Questionnaire

Thank you for taking the time to participate in this research project. Please complete the below questionnaire, which collects information about you and the setting in which you work. This information will be used in the study's write-up and publication to contextualise your interview responses.

Remember: in the study you will be known only by your participant number. Any information which could reasonably be used to identify you – such as your name or the name of the place where you work – will not be used.

Participant number:	
Gender: *Please write in.*	
Sexual orientation: *Please write in.*	
Age: *Please write in.*	

Adult mental health inpatient settings where I have worked <u>in the last three years</u>:		
	Currently:	**In last three years, but not currently:**
Acute adult mental health care	☐	☐
Acute older adult mental health care	☐	☐
Adult eating disorders	☐	☐
Mother and baby	☐	☐
Adult learning disabilities	☐	☐
Adult high dependency rehabilitation	☐	☐
Adult low secure	☐	☐
Adult medium secure	☐	☐
Adult high secure	☐	☐
Adult neuro-psychiatry/brain injury	☐	☐
Adult admitted patient continuing care	☐	☐
Adult community rehabilitation unit	☐	☐
Adult longer term high dependency rehabilitation unit	☐	☐
Adult mental health admitted patient services for the deaf	☐	☐
Adult personality disorder	☐	☐

Thank you for completing this questionnaire.

Further Information, Contact Details and Complaints:

For further information about the study or to ask questions or raise concerns, please do not hesitate to contact me using the details below:

Rebecca Morgan
Trainee Clinical Psychologist
[redacted]
u2195620@uel.ac.uk

In the case of questions, concerns, or complaints, you can also contact my research supervisor:

Dr Hannah Eades
Clinical Tutor
School of Psychology, University of East London, Water Lane, London, E15 4LZ
h.eades@uel.ac.uk

Or you can contact the University of East London's School of Psychology Research Ethics Committee:

Dr Trishna Patel
Research Director
School of Psychology, University of East London, Water Lane, London E15 4LZ
t.patel@uel.ac.uk

APPENDIX I:

Participant Information Sheet

University of East London

Version 12/6/23

School of Psychology
University of East London
Water Lane
London
E15 4LZ

The Principal Investigator:

Rebecca Morgan
[redacted]
U2195620@uel.ac.uk

Consent to Participate in a Research Study

You have been invited to take part in a study of how clinical psychologists construct the sexual expression of residents of mental health inpatient settings.

This letter is intended to give you the information that you need to consider when deciding whether to take part in this study.

Before you decide whether to take part or not, please read this document carefully to understand what the study involves and why it is being done. You may like to discuss it with other people. I will be pleased to answer any questions you may have.

Study title:

Clinical psychologists' talk about inpatient service users' sexual expression and its implications on restrictive practice: A Foucauldian discourse analysis

Who is conducting this research?

My name is Rebecca Morgan and I am a trainee clinical psychologist. This research is being conducted as part of my clinical psychology doctoral thesis project. I will submit the final write-up to the University of East London as part of my course.

Why have I been asked to participate?

I am interested in conducting interviews with clinical psychologists who have spent at least one year in the last three working in UK mental health inpatient settings. You do not need to have any specialist knowledge regarding inpatient sexual expression; rather, it is your thoughts, feelings, and experiences that I am interested to hear.

Do I have to take part?

You do not have to take part in this study. It is important that everyone who takes part in the study gives their consent freely.

What's involved?

If you agree to participate, I will ask that you complete a short demographic information form which collects basic background information such as your gender, sexuality, and the type of settings in which you have worked in the last three years.

Following this, I will request that you allow me to interview you once for approximately 60 minutes. I will prepare a few key questions but also ask some others based on the

information you give me. I will not be judging you based on what you tell me, and I hope that our conversation will feel relaxed and informal.

The interview will take place over Microsoft Teams, with which you may already be familiar, as it is well-used in the NHS. I know that you are likely to have a busy professional life, so this will also eliminate travel time and allow us to stay safe, as Covid-19 remains prevalent. Microsoft Teams has security features that protect the privacy of our conversation. The interview will take place at a time which is convenient for us both and I am happy to rearrange it if you need me to.

What will happen to the information that I tell you?

To speak with you on Microsoft Teams, I will need to contact you via email. I will record our conversation using Microsoft Teams and transcribe it. I will then remove any information that might reasonably identify you or someone else, and replace your name with a participant number and a different, unrelated name of your choosing (this is known as 'pseudonymisation'). However, if there is someone who knows the situations you describe well, such as a colleague or patient, then they may be able to identify you once the study is completed and shared. To support my work and that of the examiners who will assess my thesis, my supervisor, Dr Hannah Eades, may read the pseudonymised transcript with identifying information removed. No other person will be given access to the transcript. I will store your name and email address, and separately, the anonymised transcript and recording of our interview as password-protected files on the University of East London's security-protected and encrypted OneDrive.

I may use pseudonymised demographic information and quotations from you in my thesis. The thesis will be read by examiners and will be publicly accessible via the University of East London's Institutional Repository (known as 'ROAR'). I also intend to share my thesis with participants who are interested in reading it. Further, it may also be published in an academic journal or other professional titles. Again, in all cases, you will be referred to by a pseudonym and no information that could reasonably be used to identify you will be used.

Once the audio recordings are no longer needed for university approval, the recording of your interview will be deleted. This is likely to be in October 2023. I will delete your email address at the same time unless you have indicated on the consent form that I have given you that you wish to be updated about the study's progress.

I will delete my copy of your transcript in September 2024, and the research supervisor will keep an anonymised copy of the transcribed interview for up to five years from the date the interview was conducted. This will allow them to assist me in working towards any publication of the findings. For the same reason, they will also retain a copy of your signed consent form for up to a year after publication. All data collected for this study is kept in accordance with the University of East London's Data Protection Policy.

Why participate?

If you choose to share information with us, it will help increase professional understanding of how clinical psychologists relate to the sexual expression of inpatient service users of mental health inpatient settings. This information could be used to improve clinical psychologists' practices and the quality of life for residents. You may also find it professionally and personally helpful to reflect on your experiences.

Are there any risks involved?

I hope that participating in this study is a worthwhile experience. I recognise that talking about work on inpatient wards and sexual expressions can be challenging and can bring up difficult thoughts and feelings about what you may have seen or experienced.

If you choose to take part in the study, please tell me if you feel distressed before, during or after the interview. If I notice that you are distressed, then I may ask how you are and if you would like to pause or stop the interview. I cannot provide therapeutic support directly; however, I can direct you to organisations that may be able to assist you further.

Will taking part be safe and confidential?

I will respect your privacy and safety at all times. You may ask questions before the start of the interview, throughout, and at its end. You do not have to answer all the questions I ask, and you can stop the interview or take a break at any time – you will not be required to provide a reason for doing so in any of these situations.

I have a responsibility to tell someone who may need to know or may be able to help if I am worried about the risk of harm to you or someone else, including people under your care, or if there is a breach of law. If this is the case, I will discuss this with you first, where possible.

What will happen if I want to withdraw my information?

If you take part but later decide that you would like to withdraw your information, then you will be able to do so up to 21 days after the interview was conducted by contacting me (Rebecca Morgan) using the details at the end of this letter. There will be no disadvantage to you for doing so and you do not have to give a reason why you have made this decision. After 21 days, I will have started to analyse the information and it will not be possible to withdraw it from the study.

Who has reviewed this study?

The study has been reviewed and approved by the University of East London's School of Psychology Research Ethics Committee.

Thank you for considering whether to participate in the study.

Please feel free to ask me any questions. If you would like to participate in the study, you will be asked to sign the attached consent form before your interview and you will be given a copy, co-signed by the researcher, to keep. You should keep a copy of this letter for reference.

Yours sincerely,

Rebecca Morgan, Trainee Clinical Psychologist
12/6/2023

Further information and contact details:

For further information about the study or to ask questions or raise concerns, please do not hesitate to contact me using the details below:

Rebecca Morgan
Trainee clinical psychologist
[redacted]
u2195620@uel.ac.uk

In the case of questions or concerns, you can also contact my research supervisor:

Dr Hannah Eades
Research supervisor
School of Psychology, University of East London, Water Lane, London, E15 4LZ
h.eades@uel.ac.uk

Or you can contact the University of East London's School of Psychology Research Ethics Committee:

Dr Trishna Patel
School of Psychology, University of East London, Water Lane, London E15 4LZ
t.patel@uel.ac.uk

APPENDIX J:

Consent Form

University of East London

Consent to Participate in a Research Study:

Clinical Psychologists' Talk About Inpatient Service Users' Sexual Expression and its Implications on Restrictive Practice: A Foucauldian Discourse Analysis

Please **initial** in the boxes and sign below to confirm you understand and agree to the following:

1. I have read the participant information sheet dated 12/6/23 (version 12/6/23) for the study mentioned above, and have been given a copy to keep. I have considered the information, and the nature and purposes of the research have been explained to me. I have been given the chance to ask questions, which have been answered to my satisfaction. ☐
2. I understand that my involvement in this study will remain confidential to the researcher and their supervisor unless there is a risk of harm to myself or another person. I understand that information that could reasonably be used to identify me will be removed from interview transcripts, which will be stored by the researcher and their supervisor as outlined in the participant information sheet. I understand how the information I give could be included in the study. The researcher has explained how data will be kept during and after the study and how the study might be shared. ☐
3. I hereby freely and fully consent to participation in the study. I understand that I can withdraw at any time without giving a reason and will be at no disadvantage should I do so. I understand that if I withdraw more than three

weeks after the interview takes place, then the researcher reserves the right to use my pseudonymised data in the study. ☐

Please indicate here if you would like the researcher to share the study's findings with you once completed. If you tick 'yes,' they will retain your email address for this purpose.

Yes ☐ No ☐

_____	_____	_____
Name of participant (BLOCK CAPITALS)	*Date*	*Signature*
_____	_____	_____
Name of researcher (BLOCK CAPITALS)	*Date*	*Signature*

APPENDIX K:

Interview Protocol

Interview Schedule

Title:

Clinical psychologists' talk about inpatient service users' sexual expression and its implications on restrictive practice: A Foucauldian discourse analysis

Research Questions:

- How do clinical psychologists construct inpatient service users' sexual expression?
- What discourses influence clinical psychologists' talk about inpatient service users' sexual expression?
- How do clinical psychologists describe their roles and responsibilities in relation to inpatient service users' sexual expression?

Before Joining Meeting:

- Open interview schedule
- Log into Teams ten minutes ahead of interview time

In Meeting, Before Recording:

- Greet participant and thank them for joining

- Explain purpose of interview, estimated duration of 60 minutes
- Recap main points of participant information sheet - confidentiality, pseudonymisation, ability to stop or pause, right to withdraw
- Ask and answer if any questions regarding participant information sheet. 'Park' any questions about myself until the end of the interview
- Re-confirm consent to participate
- Request to start recording and begin interview

Interview Questions:

- As a clinical psychologist, what responsibilities do you have in relation to inpatient service users' sexual expression?
    - Prompt: In what ways is your role important in relation to sexual expression?
- Who else is responsible for inpatient service users' sexual expression?
    - Prompt: How is responsibility shared?
- What kinds of sexual expression do inpatient service users engage in?
    - Prompt: How do you see service users engage in sexual expression?
- How do you decide if sexual expression is permissible?
    - Prompt: Are there some sexual expressions that are always ok?
    - Prompt: How about ones which are 'noes'?
- What would concern you about sexual expression?
    - Prompt: How do your decisions differ based on the nature of the sexual expression?
    - Prompt: And how do they differ depending on who is involved in the sexual expression? What about the gender, age or ethnicity of the people involved?
- How is sexual expression managed on the ward?
    - Prompt: What difficulties does management of sexual expression present?
    - Prompt: What elements of management are easier?

- How would you like sexual expression to be managed differently on the ward?
    - Prompt: What prevents those things from happening?
- What is it like when you discuss inpatient service users' sexual expression with colleagues?
    - Prompt: When do you tend to discuss sexual expression with colleagues?
    - Prompt: What is that like?
- What is it like when you discuss sexual expression with inpatient service users?
    - Prompt: When do you tend to discuss sexual expression with inpatient service users?
    - Prompt: What is that like?
- How do your personal values and beliefs affect your decisions in relation to inpatient service users' sexual expression?
    - Prompt: Do your own beliefs and values affect how you approach inpatient service users' sexual expression?
- When might restrictive practice arise in relation to inpatient sexual expression?
    - Prompt: Can you think of a time when restrictive practice has been used in relation to sexual expression?
- Is there anything else that you would like to tell me that is relevant to this topic?

After Interview:

- End recording
- Ask participant about their experience of being interviewed
- Ask if they have any questions and answer these
- Thank them for their time
- End call

APPENDIX L:

Debriefing Document

Debriefing Document

Thank you for taking the time to participate in this research project. This document is a reminder of the aims of the study, why it is being conducted and how data will be analysed. You may find it useful to retain this document so you can refer to it in future.

Study Title:

Clinical psychologists' talk about inpatient service users' sexual expression and its implications on restrictive practice: A Foucauldian discourse analysis

Aims:

It is hoped that this study will help increase professional understanding of how clinical psychologists think and feel about the sexual expression of service users of mental health inpatient settings and their related actions. This information could be used to improve clinical psychologists' practices and the quality of life for inpatient service users. You may have also found it professionally and personally helpful to reflect on your experiences.

Your Contribution and How Data Will Be Analysed:

Your involvement in this project has been to give an hour-long interview with me via MS Teams. You will already be aware that the interview has been audio recorded. I will now transcribe the interview, removing any information that may identify you. I will then explore the meanings within the narrative using Foucauldian discourse analysis.

Data Retention:

Once the audio recordings are no longer needed for university approval, the recording of your interview will be deleted. This is likely to be in October 2023. I will delete your email address at the same time unless you have indicated on the consent form that I have given you that you wish to be updated about the study's progress.

I will delete my copy of your transcript in September 2024, and the research supervisor will keep an anonymised copy of the transcribed interview for up to five years from the date the interview was conducted. This will allow them to assist me in working towards any publication of the findings. For the same reason, they will also retain a copy of your signed consent form for up to a year after publication. All data collected for this study is kept in accordance with the University of East London's Data Protection Policy.

Previous Research:

Many people find sexual expression a difficult topic to talk about, especially when it relates to service users of mental health inpatient settings – and practice can be even more challenging.

Previous studies have shown that NHS staff are unclear about their roles, that there is little guidance on this topic, and that decisions often rest on the values of individual staff. If you feel similarly, you should know that you are not alone. You may find it useful to contact some of the support services listed below.

Further Support:

Organisation:	Support provided:	Contact details:

NHS Staff Wellbeing Hubs	Free and confidential mental health support for NHS professionals. See geographically-organised list.	www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs
Victim Support	Practical and counselling support if you have been the victim of a crime.	www.victimsupport.org.uk 08081689111
Male Survivors Partnership	Links to national and local support services for male survivors of sexual abuse, rape, and sexual exploitation.	www.malesurvivor.co.uk 08088005005
Rape Crisis	24/7 rape and sexual abuse support line and counselling for victims and survivors.	www.rapecrisis.org.uk 08085002222
Samaritans	24/7 listening and support service for people experiencing emotional distress.	www.samaritans.org 116123 jo@samaritans.org FREEPOST Samaritans Letters

Withdrawal:

If you decide that you would like to withdraw your information, then you will be able to do so up to 21 days after the interview was conducted by contacting me using the details at the end of this letter. There will be no disadvantage to you for doing so and you do not have to give a reason why you have made this decision. After 21 days, I will have started to analyse the information and it will not be possible to withdraw it from the study.

Sharing the Research:

I may use quotations from you in my thesis. The thesis will be read by examiners and will be publicly accessible via the University of East London's Institutional Repository (known as 'ROAR'). Further, it may also be published in an academic journal or in other professional titles. Again, in all cases, you will be referred to by a pseudonym and no information that could reasonably be used to identify you will be used.

In the consent form, you indicated whether you would also like to receive a copy of the paper, in which case I will send this to you once finalised. If you wish to change your initial decision, please contact me using the details below.

Further Information, Contact Details and Complaints:

For further information about the study or to ask questions or raise concerns, please do not hesitate to contact me using the details below:

Rebecca Morgan
Trainee Clinical Psychologist
[redacted]
u2195620@uel.ac.uk

In the case of questions, concerns, or complaints, you can also contact my research supervisor:

Dr Hannah Eades
Clinical Tutor
School of Psychology, University of East London, Water Lane, London, E15 4LZ
h.eades@uel.ac.uk

Or you can contact the University of East London's School of Psychology Research Ethics Committee:

Dr Trishna Patel
Research Director
School of Psychology, University of East London, Water Lane, London E15 4LZ
t.patel@uel.ac.uk

APPENDIX M:

Glossary of Transcription Symbols

Symbol	Explanation
.	End of a sentence implied by downward intonation
,	Shift in speech, like a grammatical comma
?	Upward intonation
↑	Shift into upward pitch
↓	Shift into downward pitch
Underscored speech	This text is stressed, via pitch or amplitude
(.)	Each dot within the brackets indicates a pause of around a tenth of a second between speech
[text in square brackets]	Relevant non-verbal communication, for example, [laughs], [coughs]

APPENDIX N:

Excerpt from Transcript

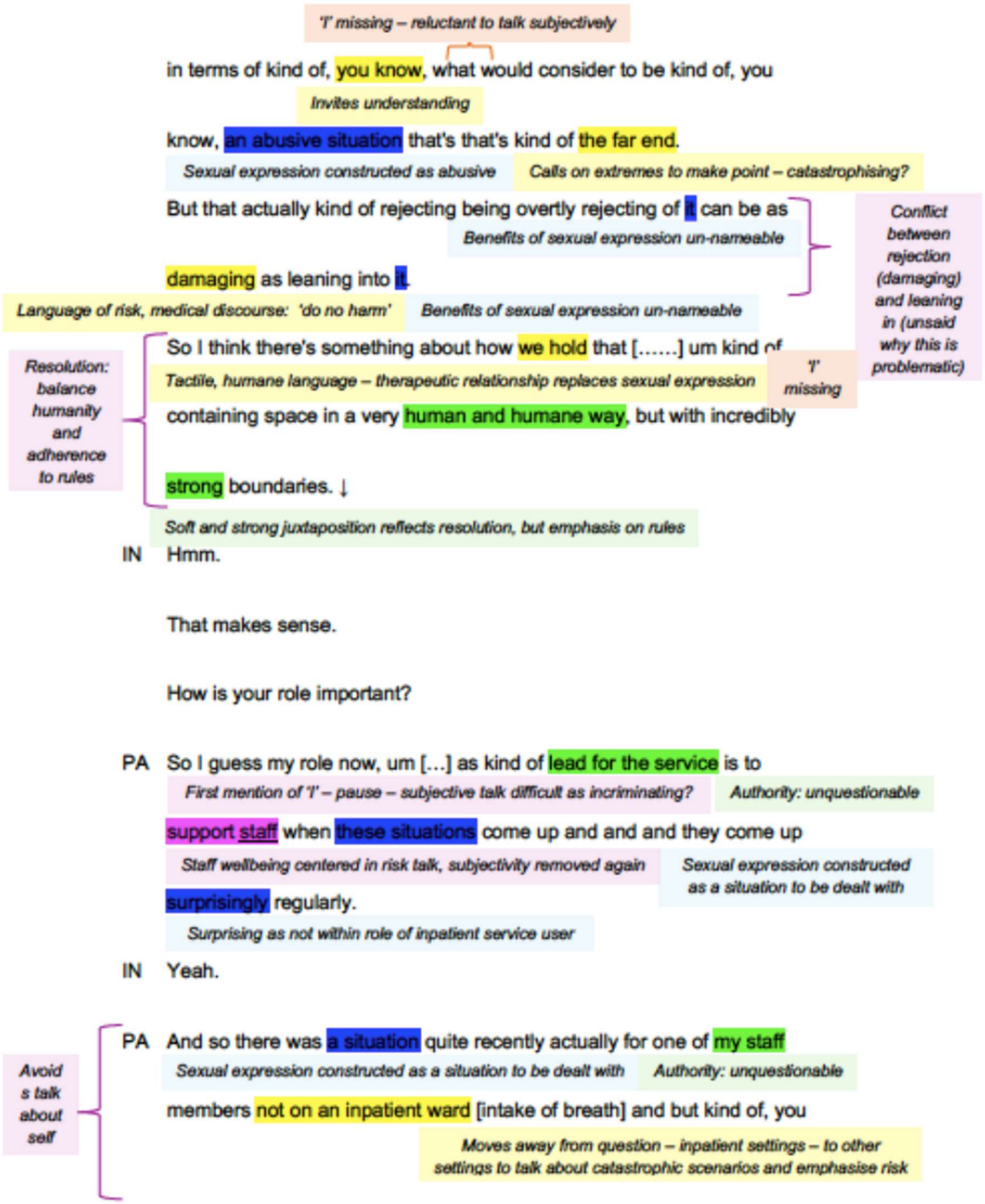


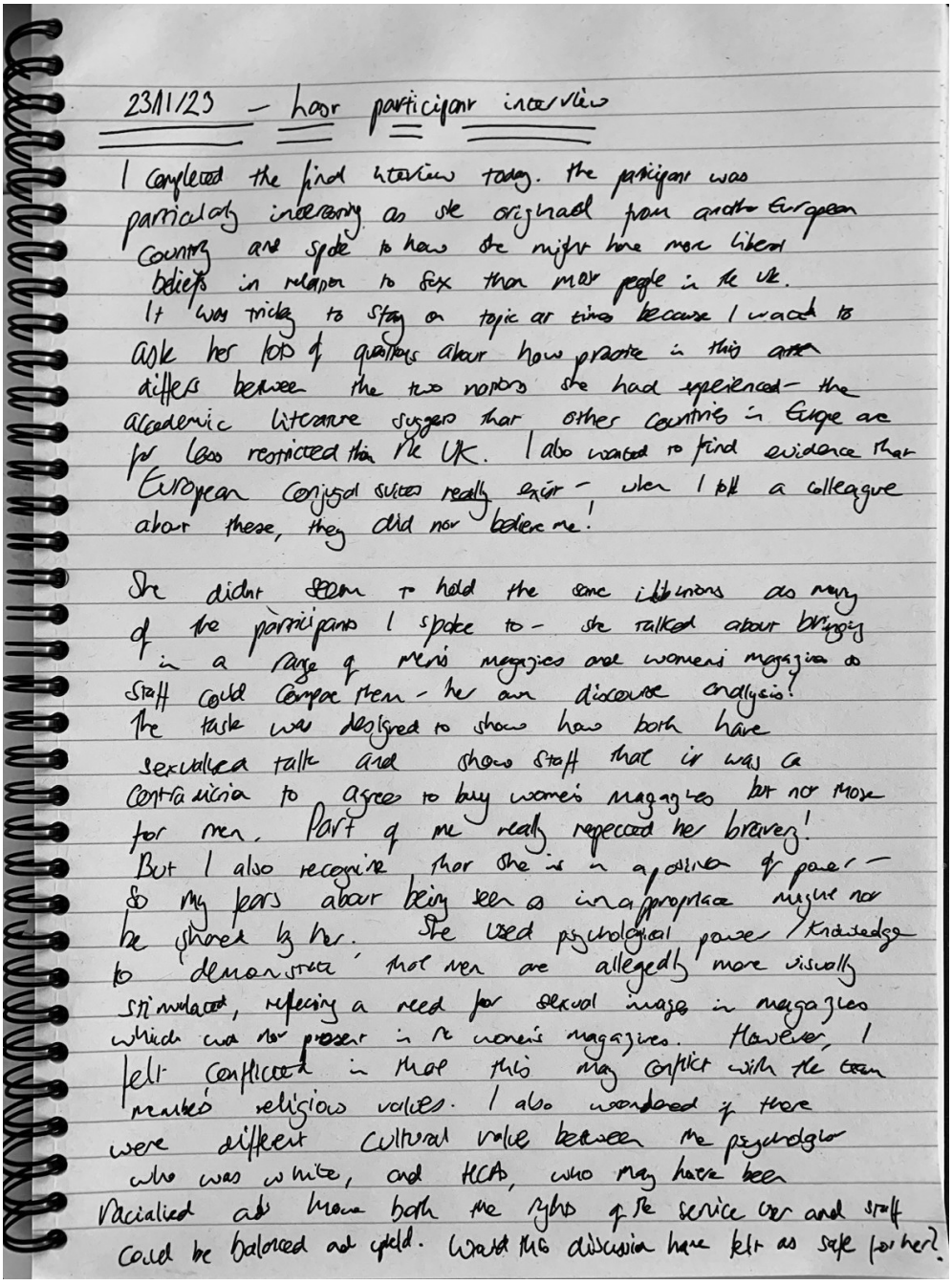
Table L1

Analysis key

	Constructions of sexual expression
	Positioning
	Action orientation
	Subjectivity
	Conflict and resolution

APPENDIX O:

Reflective Log Excerpt 2



23/1/23 – hour participant interview

I completed the final interview today. The participant was particularly interesting as she originated from another European country and spoke to how she might have more liberal beliefs in relation to sex than most people in the UK. It was tricky to stay on topic at times because I wanted to ask her lots of questions about how practice in this area differs between the two nations she had experienced – the academic literature suggests that other countries in Europe are far less restricted than the UK. I also wanted to find evidence that European conjugal suites really exist – when I told a colleague about these, they did not believe me!

She didn't seem to hold the same inhibitions as many of the participants I spoke to – she talked about bringing in a range of men's magazines and women's magazines so staff could compare them – her own discourse analysis! The task was designed to show how both have sexualised talk and show staff that it was a contradiction to agree to buy women's magazines but not more for men. Part of me really respected her bravery! But I also recognise that she is in a position of power – so my fears about being seen as inappropriate might not be shared by her. She used psychological power / knowledge to demonstrate that men are allegedly more visually stimulated, reflecting a need for sexual images in magazines which was not present in the women's magazines. However, I felt conflicted in that this may conflict with the team members religious values. I also wondered if there were different cultural value between the psychologist who was white, and HCAs, who may have been racialised as Asian – both the rights of the service user and staff could be balanced and upheld. Would this discussion have felt as safe for her?

APPENDIX P:

Approval from UEL Research Ethics Committee

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details	
Reviewer:	**Hanna Kampman**
Supervisor:	**Hannah Eades**
Student:	**Rebecca Morgan**
Course:	**Professional Doctorate in Clinical Psychology**
Title of proposed study:	**CLINICAL PSYCHOLOGISTS' TALK ABOUT INPATIENT SERVICE USERS' SEXUAL EXPRESSION AND ITS IMPLICATIONS ON RESTRICTIVE PRACTICE: A FOUCAULDIAN-INFORMED DISCOURSE ANALYSIS**

Checklist (Optional)			
	YES	**NO**	**N/A**
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐

Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐

All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **<u>before</u>** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **<u>must</u>** be submitted and approved **<u>before</u>** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the

	candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments
Please clearly detail the amendments the student is required to make
What an interesting and meaningful study – good luck with it. Here some suggestions to go through with your supervisor: **4.9. You state that you will not keep the details, but before you did mention that you will keep emails if they wish to be informed.** **Appendix B: Please note that if you are posting / advertising in e.g., facebook groups, you must seek for the approval of those that run/own these pages even if in the public domain.**

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	

If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**Hanna Kampman**
Date:	**22/05/2023**
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee	
RESEARCHER PLEASE NOTE For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.	

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments (Student to complete)	
I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	**Rebecca Morgan**
Student number:	**2195620**
Date:	**22/05/2023**
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

APPENDIX Q:

Title Change Form

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents	
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**Rebecca Morgan**
Programme of study:	**Professional Doctorate in Clinical Psychology**
Title of research:	Clinical psychologists' talk about inpatient service users' sexual expression and its implications on restrictive practice: A Foucauldian-informed discourse analysis
Name of supervisor:	**Hannah Eades**

Proposed title change	
Briefly outline the nature of your proposed title change in the boxes below	
Old title:	Clinical psychologists' talk about inpatient service users' sexual expression and its implications on restrictive practice: A Foucauldian-informed discourse analysis
New title:	Clinical psychologists' talk about inpatient service users' sexual expression and its implications on restrictive practice: A Foucauldian Discourse Analysis
Rationale:	Using Foucauldian Discourse Analysis rather than Foucauldian Informed Discourse Analysis

Confirmation		
Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature	
Student: (Typed name to act as signature)	**Rebecca Morgan**
Date:	**25/03/2024**

Reviewer's decision		
Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the research study and will not impact the process of how the data are collected or how the research is conducted.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**26/03/2024**	

APPENDIX R:

Relationship Between Analysis and Research Questions

Research Question	Aspect of Analysis
How do clinical psychologists construct inpatient service users' sexual expression?	Identifying constructions Considering action orientations Ideas about subjectivity Noting conflicts and how they are resolved
What discourses influence clinical psychologists' talk about inpatient service users' sexual expression?	Identifying discourses Ideas about subjectivity
How do clinical psychologists describe their roles and responsibilities in relation to inpatient service users' sexual expression, and how does this relate to restrictive practice?	Interpreting subject positions Considering impact on practices Ideas about subjectivity

APPENDIX S:

Grouping of Constructions of Inpatient Service User Sexual Expression by Discourses Using Action Orientations

Excerpts	Action orientations	Overall Discourse
"Very small comments to very extreme forms of behaviour"	Sexual expression can be extreme and therefore risks harm	Inpatient service users' sexual expression is risky
"For the staff it's a hard thing to sit with"	Sexual expression can be difficult for staff and therefore risks harm	
"Sometimes it's evocative, the more extreme end"	Sexual expression can be extreme and therefore risks harm. Evocative as evoking potentially difficult emotions in participant which could cause harm	
"He just had a bag full of sex toys of of the most amazing proportions and and different colours and shapes and it was extraordinary"	Sexual expression as abnormal	Inpatient service users' sexual expression challenges social norms
"It spoke to his sexuality and it was too much	Sexual expression conflicts with the norms and values of other staff	

because of their faith and their background” “I think naked pictures of women on the walls is is in inappropriate for an inpatient setting”	Sexual expression is inappropriate in a hospital, conflicts with participants values	
“He's telling us something here. About what he's missing on the ward for sure”	Ward made to be more homely through sexual expression	Inpatient service users’ sexual expression supports recovery
“I get that there might be a need for this person to have naked pictures”		Inpatient service users’ sexual expression is part of being human