

# Professionals' Attitudes towards Sex between Institutionalized Patients

MICHAEL L. COMMONS, Ph.D.\*  
JUDI T. BOHN, B.A., Ed. M.\*\*  
LISA T. GODON, B.A.\*\*\*  
MARK J. HAUSER, M.D.†  
THOMAS G. GUTHEIL, M.D.‡

*Decisions about institutionalized patients' sexual activity were not influenced by professional norms of: (1) competence of a patient to engage in sexual activity, (2) degree of consent, but were influenced by conventional norms of (3) nature of sexual activity, (4) location of sexual activity, (5) the sex of the initiating patient (6) sex of the other patient.*

"Sexual intercourse is for normal people!"  
*Interviewer to patient with schizophrenia, 1968*

## INTRODUCTION

Sexual activity among institutionalized patients has always been an issue of concern to institutions (sexual relations between staff and patients will not be discussed in this component of the research). Patients inevitably engage in mutual sexual activity.<sup>1</sup> Mental health professionals seem to have some insights into the effects of patient sexual relations<sup>2</sup> but little consensus. These insights, moreover, have generally not been translated into institutional policy, nor have they been empirically tested. Not surprisingly, institutional policies about such activity vary widely<sup>3</sup>; they may be realistic, unrealistic, rational, irrational, sensible, or nonsensical, or often out of synchrony with what actually happens.<sup>4,5</sup> Staff may be instructed, or may independently decide, to "look the other way" or may exercise "overzealous

\*Lecturer and Research Associate, Program in Psychiatry and the Law, Massachusetts Mental Health Center, Department of Psychiatry, Harvard Medical School. **Mailing address:** Program in Psychiatry and the Law, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115-6196.

\*\*Research Assistant, Dare Institute, Cambridge

\*\*\*Assistant to the Legislative Director, Office US Senator Kent Conrad.

†Clinical Instructor, and Research Associate, Program in Psychiatry and the Law, Massachusetts Mental Health Center, Department of Psychiatry, Harvard Medical School.

‡Co-director, Program in Psychiatry and the Law, Massachusetts Mental Health Center; Professor of Psychiatry, Harvard Medical School.

prohibition." Administrators and clinicians may be able to exercise considerable reporting discretion or may be required to report all incidents for a mandated full investigation.

For many reasons, even in those institutions that allow some form of sexuality, no written policy may exist condoning such activity.<sup>3</sup> One reason may be clinicians' fears of being held liable for the harm that can arise from sexual contact. Some institutions have strong prohibitions against any form of sexual activity between patients, but most report extensive sexual activity.<sup>6</sup> Morgan and Rogers find that although a restrictive written policy may lead to lower rates of sexual activity between inmates, no institution controls patient interaction to the extent that some sexual contact does not take place.<sup>1</sup>

Three forces may change this status quo. Patient advocacy groups represent two such forces by, on the one hand, advocating the right of patients to engage in sexual activity when they are *competent* and *consenting*,<sup>6</sup> and, on the other hand, advocating that patients should be protected from sexual assault, abuse, exploitation, unwanted pregnancy, and now AIDS. The third and most important force is the increasing threat of AIDS itself. All of these factors heighten clinicians' uncertainty and fear of liability.

Guidelines concerning sexual activity among hospitalized mental patients that take these issues into consideration seem to be badly needed. Most institutions have policies relevant to many aspects of patient social behavior, but both clarity and consistency of guidelines are entirely lacking.<sup>3,5</sup> This component of our research presents an example of how the institutional context of decision making about patients' sexual activity may be assessed by studying professional responses to such activity.

## THE STUDY

### HYPOTHESES

We examined the following six factors that we thought might influence staff decisions:

- a. Competence of patient to engage in the activity
- b. Degree of consent in or consensual nature of sexual relationship
- c. Nature of sexual activity (e.g., hugging vs. genital relations)
- d. Location of sexual activity (e.g., in bedroom vs. on grounds)
- e. Sex of the initiating patient
- f. Sex of the other patient

We reasoned that a number of staff characteristics might also influence the decision-making process since mental health professionals themselves

may carry prejudices shared with the general population about the effects of sexual activity on patients. This study explores both their prejudices and their insights. By understanding these perceptions we hope to provide an empirical basis for developing guidelines that will promote a balance of many competing claims, rights, and interests. In addition, educational material could be developed for staff members that would promote patient responsibility with regard to sex, particularly as it involves complex issues such as contraception<sup>2</sup> and AIDS.

We hypothesized that mental health professionals, both as members of the community at large and as professionals, would have conventional moral views towards sexual activity. Kohlberg defines three stages of social reasoning that are termed conventional.<sup>7</sup> This conventional period (Moral Stages 3, 3/4, and 4) begins at the onset of postelementary school education and extends across the life-span of all but a small portion of the population. This period generates the conventional norms of adulthood. Reasoning at each stage of this period incorporates enough logic to find its most elaborate expression in some current adult philosophy. The vast majority of the population performs at these conventional stages. Among mental health professionals, however, professional norms could compete with other social norms.

We hypothesized that subjects using conventional stages of reasoning with community norms would be (1) fearful of homosexual activity (homophobic); (2) would show greater disapproval of homosexual activity, especially male homosexual encounters, than heterosexual activity; (3) would make decisions based on the sex of the individuals (sexist); (4) would find male-initiated heterosexual activity more acceptable than female-initiated heterosexual activity; and (5) would find activity occurring in a bedroom more acceptable than open sexual activity on the grounds of the institution.

We also hypothesized that subjects using conventional stages of reasoning with professional norms might consider the parental-clinical implications of sexual activity and thus emphasize its nature in decision making. These norms emphasize professionally designated benefits for the subject. But because in this situation professional norms are applied without patient consent, the patient is protected at the cost of being treated like a child. For example, subjects might be more likely to approve of hugging between two patients than sexual intercourse due to fears of unwanted pregnancy, venereal disease, and sexual exploitation. We also reasoned that professional norms might make the location of sexual activity a factor. We hypothesized that subjects would be fearful of the negative therapeutic effects of open

sexual activity on other patients. As a result, they would tend to show greater approval of sexual activity occurring in the privacy of a bedroom.

The postconventional period (Moral Stages 5 and 6) begins sometime after adolescence; however, fully postconventional thinking and action appear after early adulthood.<sup>8</sup> Some contemporary philosophies and social theories use postconventional arguments. These philosophies and theories may embody social and psychological approaches to medical and legal ethics. In fact, some researchers have reinterpreted philosophical,<sup>9,10</sup> and scientific<sup>11</sup> debates in terms of conventional versus postconventional arguments. In any known society, only a small portion of members achieves postconventional stages of reasoning.

At beginning of Moral Stage 5, the first stage in this period, people justify actions on the basis of universal abstract principles. Many such principles can be found in the works of philosophic, political, and religious thinkers. A number of modern societies also articulate these.<sup>12</sup> Moral Stage 5 principles are general in their application, irrespective of the person affected. The specific content of the principles may be contingent upon the society in question. People are assumed to have different interests and expertise. Society is seen first as a creation of individuals and second as the context in which people develop.

Finally, we hypothesized that subjects using postconventional stages of reasoning with professional norms might consider the effects of patient-regulated sexual activity in developing or enhancing patient autonomy. Consideration of such benefits might compete with conventional-stage considerations of parental clinical norms. In postconventional reasoning, competence and consent are the driving forces behind evaluating the meaning of patient sexual relationships—whether or not they are part of the patient's rights and evaluating what clinical costs and benefits they might entail. Competence and consent represent the factors that professionals would be predicted to consider when devising treatment plans and institutional policies. Autonomy and competent consent both require postconventional reasoning to generate them in the first place. Yet, both concepts can be appreciated and used at the higher conventional stages when such policies are in force in institutions. Because such institutional policies generally do not exist, however, we suspect that subjects using conventional reasoning may ignore competence and consent, even when applying professional norms. Therefore, we expected that even competent, consenting individuals would be viewed (inappropriately) as being incapable of participating in normal adult sexual behavior.

### METHOD

#### SUBJECTS

The sample consisted of 131 mental health professional subjects, 69 males and 58 females (4 whose sex was unspecified). The subjects ranged in age from 25 to 79 years. Most of the subjects, holding positions ranging from mental health aide to psychiatrist, were employed by state institutions for the mentally ill. The subjects were drawn from audiences at risk-management lectures in several states in differing demographic areas.

#### INSTRUMENTS

We designed a series of narrative vignettes to assess how the six factors earlier noted affected the subjects' perceptions about sexual activity among patients. Each questionnaire presented two different versions of a vignette and posed a series of questions about them.

#### *Vignette A*

C. C. is a 55-year-old woman [man], who is provocative to the men [women] clients and frequently sexually teases them. C. C. entices the men by saying, "I'll give you a dollar if you hug [have sex with] me in the bedroom [on the grounds]." The clients are able [unable] to refuse C. C.'s advances effectively. If a client says yes, following what that client relates as a consensual [nonconsensual] sexual relationship, C. C. reports being taken advantage of to the staff. If a client says no, C. C. reports that the client "kicked me in the crotch."

#### *Vignette B*

There is a couple, client M. W. and client D. M. M. W. is a woman [man], D. M. is a man [woman]. They have a consensual [nonconsensual] sexual relationship. They hug [have sex with] each other in the bedroom [on the grounds]. Both are able [unable] to refuse the other's advances effectively.

There were 64 variants (cells) of vignette A and 64 variants of vignette B. Vignette A was very detailed and explicit. Vignette A quoted some of the hypothetical patient's own language in describing the activity and type of relationship. This version implied that the provocative and aggressive "first patient" could be manipulating the victimized "second patient."

Vignette B, in contrast, was a simple, brief, and coolly objective statement giving the basic facts of the relationship and activity. Vignette A's richly contextual narrative, then, was contrasted with a very schematic narrative (Vignette B) to compare the effects of these two forms of presentation.

Each vignette was constructed by placing one value of each of the six

independent variables (competence, degree of consent, form of sexual activity, location of sexual activity, sex of initiating client and sex of other client) into one of the core stories in the vignettes shown on p. 575. Three questions then followed each vignette.

1. Do you approve or disapprove of the sexual activity described?
2. Would this be therapeutically healthy or unhealthy?
3. How would the outside community view this sexual activity, tolerable or intolerable?

As shown in table I, subjects were asked to rate responses on a scale of 0 to 5, with 0 representing the strongest negative response (e.g., disapprove, unhealthy, intolerable) and 5 representing the strongest positive response (approve, healthy, tolerable). Respondents were also asked to explain why they gave the particular rating. These responses can be scored as corresponding to Kohlberg's stages of moral development.<sup>8,13</sup>

**PROCEDURE**

Each subject responded to one of the 64 variants of vignette A and one of the 64 variants of vignette B. Having 64 variants of each type of vignette allowed for the analysis of 6 truly independent variables ( $2^6 = 64$ ). Analyses of covariance were performed separately in regard to each of the three question responses. Covariates were version of vignette (A vs. B) and heterosexual vs. homosexual activity.

Table I JUDGEMENTS ON SEXUAL ACTIVITY

---

1	How much do you disapprove or approve of the sexual activity described?
	----- ----- ----- ----- -----
	0      1      2      3      4      5
	Disapprove <span style="float: right;">Approve</span>
2	Why?
3	Would this be therapeutically unhealthy or healthy?
	----- ----- ----- ----- -----
	0      1      2      3      4      5
	Unhealthy <span style="float: right;">Healthy</span>
4	Why?
5	How would you deal with this sexual activity?
6	How would the outside community view this sexual activity?
	----- ----- ----- ----- -----
	0      1      2      3      4      5
	Intolerable <span style="float: right;">Tolerable</span>
7	How would the community respond to knowledge of this sexual activity?
8	Why?

---

### RESULTS

This group of professional subjects responded at the conventional stage by restating societal norms as hypothesized. In response to the first question, "Do you approve or disapprove of the sexual activity described?" the respondents rated most highly (indicating approval) consensual, heterosexual relationships that occurred in a traditional (bedroom) environment. Indeed, location of the sexual activity was highly significant ( $p = 0.0037$ ), with activity located on the grounds of the institution ( $M = 1.4310$ ) meeting with much greater disapproval than activity in the bedroom ( $M = 1.6539$ ). Contrary to our predictions, the respondents approved more highly of a female patient rather than a male patient initiating sexual activity with a consenting partner of either sex. There was very strong disapproval of a male nonconsensual homosexual relationship occurring on the grounds of the institution ( $M = 0.8000$ ).

Our protocols elicited a strong current of male homophobia. Conversely, the female partner as initiator was widely approved. In the mainstream of society, it is the male who is traditionally accepted as the initiator. This study then suggests that within an institutional setting, this behavioral expectation of males and females is reversed. We wonder, given the conventional view of women needing protection, whether female-initiated activity decreased respondent anxiety about coercion of women.

In regard to the second question of the activity being therapeutically healthy or not, respondents reacted strongly to the aggressive tone of Vignette A and the detailed narrative. Location was highly significant ( $p = 0.0066$ ), consistently indicating less tolerance for sexual activity that takes place on the grounds of the institution than in the bedroom. This was predictable because the bedroom, in addition to being the more traditional setting, is also considered to be the healthier environment.

Form of sexual activity was significant ( $p = 0.0115$ ), but little distinction was made between the therapeutic value of a patient being involved in simple hugging ( $M = 1.5009$ ) and having sex ( $M = 1.5667$ ). Subjects seemed concerned about any form of sexual activity occurring between patients.

Most strikingly, the analysis of therapeutic impact indicates that consent—hypothesized to be a central and determinative issue—is not a driving factor. Questionnaires revealed little difference for a patient of either sex initiating an activity with a consenting or a nonconsenting "partner" ( $M = 1.6721$  versus  $M = 1.6715$ ). Perhaps this indicates that staff do not find either form of activity, whether it be consensual or not, to be therapeutically beneficial. Again, male-initiated activity with a consenting "partner" was considered least therapeutic ( $M = 1.3438$ ).

The activity viewed as relatively "most therapeutic" involved a patient (male or female) hugging a nonconsensual female ( $M = 2.1333$ ) although even this is still seen as slightly antitherapeutic. Although hugging a female is predictably viewed as relatively more therapeutic than having sex, one would have thought hugging a consensual partner would have been preferable to hugging a nonconsensual female.

The activity viewed as "least therapeutic" was a patient (again, male or female) having sex with a consenting male ( $M = 1.1852$ ). From a professional standpoint, the fact that the person who received the sexual advance was consenting should make having sex relatively more therapeutic than if sex were forced. Hence, nonconsensual sex should have been considered even less therapeutic. This expectation was not fulfilled by the data.

In the section on community tolerance for activity, staff thought that the community would find it more tolerable to have a male patient initiating some form of activity with a female, whether on the grounds or in the bedroom ( $M = 1.9206$ ), while the least tolerable was a male-initiated interaction with another male. This, again, would be the traditional social view. As noted above, however, females were identified as the more acceptable initiators within the institution. These data suggest that the respondents make a distinction between institutional and community attitudes towards sexual behavior. Significantly, staff classified sex on the grounds as antitherapeutic. In this case the community view and institutional view would coincide.

The perceived community view again showed little difference ( $M = 1.5897$  and  $M = 1.5756$ ) between a patient of either sex initiating some form of sexual activity with a consensual or nonconsensual male in the bedroom; again, consent is, puzzlingly, treated as irrelevant.

A highly significant factor was the community tolerance of a male initiating some sexual activity with a female either on the grounds or in the bedroom. The least tolerable was a male initiating some activity with another male. This finding is consistent across questions, indicating a strong aversion to male homosexual activity and confirming our "homophobia" hypothesis.

No matter which dependent variable was selected, the most significant factor was the version (detailed vs. schematic) of the vignette ( $p = 0.0001$ ). However, we cannot yet discriminate among possible interpretations of why vignette version mattered so much.

## DISCUSSION

Of the six factors (competence, degree of consent, form of sexual activity, location of sexual activity, sex of initiating client, and sex of other



client) only location and form proved to be significant. Although we had hypothesized that consent and competence would be significant factors, they were not. One possible explanation is that our respondents disbelieved that the hypothetical inpatients could be competent or consenting. If respondents viewed patients in the vignettes as incompetent even when the opposite was stated, and if they disbelieved their consents even though the vignettes said they occurred, then the usual social norms would not apply. Under those conditions one would not expect to find competence and consent making a difference. This last interpretation is somewhat unlikely, however. The results may be indicative of strong biases, such as those against sexual activity promoted by an aggressive, manipulative person. Nevertheless, bias would not alter the fact that staff found it to be irrelevant whether the participants in the activity were competent and consenting—the norms used by law and due process. The subjects were more concerned with the type and location of sexual activity than with the consensual or nonconsensual nature of the relationship or the patients' assessed competence to ward off advances.

The core implication of our study is that mental health professionals must reexamine their own prejudices (e.g., homophobia) to clarify their decision making about institutional policies. Later components of the research will further test the parameters of reactions to institutional sexuality.

The findings also suggest the need for more instruction, or at least consciousness-raising, as to the importance of competence assessment in regard to decision making by psychiatric patients. Although autonomy and competence-consent both require postconventional reasoning to generate, an understanding and consideration of their role in decision making can take place at the higher conventional stages, provided that the institutional policies embody such principles and norms. Greater awareness of these issues should foster authenticity of choices and genuinely informed consent.

### SUMMARY

Sexual activity among institutionalized patients has always been an issue of concern to institutions. Despite this fact, there has been little consensus about how patient sexuality should be dealt with. Nor have clinical insights with respect to patient sexuality been empirically tested. Given the diversity of beliefs and policies in this area, guidelines concerning sexual activity among hospitalized mental patients seem to be badly needed.

We examined the following six factors that we thought might influence staff decisions: (1) the competence of a patient to engage in sexual activity, (2) the degree of consent, (3) the nature of sexual activity (e.g., hugging vs.

genital relations), (4) the location of sexual activity (e.g., in bedroom vs. on grounds), (5) the sex of the initiating patient (6) the sex of the other patient. We hypothesized that mental health professionals, both as members of the community at large and as professionals, would have conventional moral views (as defined by Kohlberg) towards sexual activity. Supporting this hypothesis, of the six factors listed above, only location of the sexual activity and form of the sexual activity affected judgments on sexual activity significantly. The professionals interviewed appeared to be most condemning of homosexual acts, and least condemning of hugging. Although we had hypothesized that profession norms of consent and competence would be significant factors, they were not. The core implication of our study is that mental health professionals need training on competence assessment and its use in decision making and must reexamine their own prejudices (e.g., homophobia) to clarify their decision making about institutional policies.

*Acknowledgments.* The authors appreciate the extensive editorial and conceptual help of Archie Brodsky and Adam Kearney and the assistance of Raymond S. Meinert, Jr., in the preparation of this manuscript. Harold Bursztajn, M.D. and other members of the Program in Psychiatry and the Law assisted in refining the instrument.

## REFERENCES

1. Morgan, R., & Rogers, J. (1971). Some results of the policy of integrating men and women patients in a mental hospital. *Social Psychiatry*, 6(3), 113-116.
2. Shaul, S., & Morrey, L. (1980). Sexuality education in a state mental hospital. *Hospital & Community Psychiatry*, 31(3), 175-179.
3. Keitner, D., & Grof, P. (1981). Sexual and emotional intimacy between psychiatric inpatients: Formulating a policy. *Hospital and Community Psychiatry*, 32, 188-193.
4. Keitner, D., Baldwin, L. M., & McKendall, M. (1986). Copatient relationships on a short-term psychiatric unit. *Hospital and Community Psychiatry*, 37, 166-170.
5. Wignall, C., Meredith, C. (1968). Illegitimate pregnancies in state institutions. *Archives of General Psychiatry*, 18, 580-583.
6. Akhtar, S., Crocker, E., Dickey, N., Helfrich, J., & Rheuban, W. (1977). Overt sexual behavior among psychiatric inpatients. *Diseases of The Nervous System*, 38, 359-361.
7. Kohlberg, L. (1984). *Essays on moral development Vol 2. The psychology of moral development. Moral stages, their nature and validity.* San Francisco: Harper & Row.
8. Colby, A., & Kohlberg, L. (1987). *The measurement of moral judgement Vol 1 Theoretical foundations and research validation.* New York: Cambridge University Press.
9. Armon, C. (1984a). Ideals of the good life and moral judgment: Ethical reasoning across the life span. In M. L. Commons, F. A. Richards, & C. Armon (Eds.), *Beyond formal operations Vol 1 Late adolescent and adult cognitive development* (pp. 357-380). New York: Praeger.
10. Armon, C. (1989). Individuality and autonomy in adult ethical reasoning. In M. L. Commons, J. D. Sinnott, F. A. Richards, & C. Armon (Eds.), *Adult Development, Comparisons and applications of adolescent and adult developmental models*, 1, (pp. 179-196) New York: Praeger.
11. Commons, M. L., Miller, P. M., & Kuhn, D. (1982). The relation between formal operational reasoning and academic course selection and performance among college freshmen and sophomores. *Journal of Applied Developmental Psychology*, 3, 1-10.
12. Reiser, S. J., Bursztajn, H. J., Gutheil, T. G., & Appelbaum, P. S. (1987). *Divided staffs, divided selves: A case approach to mental health ethics.* Cambridge, England: Cambridge University Press.
13. Colby, A., & Kohlberg, L. (Eds.) (1987). *The measurement of moral judgment: Vol 2 Standard form scoring manuals.* New York: Cambridge University Press.