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Safety of female patients in sexually-integrated acute  
psychiatric wards in Aotearoa New Zealand

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## Abstract

This qualitative study researched the experiences of seven women and one man who have either been admitted to, or worked in, a mixed-sex psychiatric ward in Aotearoa New Zealand. Its purpose was to examine the safety of female patients in sexually-integrated acute psychiatric wards.

There is only a small amount of international literature on this subject and even less from Aotearoa New Zealand. This research gives the women ex-patients involved in the study a voice. As mental health workers, the nurses provide a perspective from the 'other side' which also paints a strong picture of life for women patients in a mixed-sex psychiatric ward.

Only one of the ex-patient participants had experienced both a single-sex and a mixed-sex ward and was able to make a comparison between the two. All ex-patient participants would have preferred a single-sex ward and spoke of events ranging from 'feeling uncomfortable' to being physically attacked by men in a mixed-sex ward. Several referred to the lack of privacy in sharing facilities with men. The treatment of female patients by some male staff was also seen as a problem by both ex-patients and staff participants.

The nurses and patients recount a number of stories in which female patients were raped, intimidated or had their privacy invaded by men on the ward. This research comes to focus on the fact that women patients in mixed-sex psychiatric wards are often not believed when they complain of being sexually/physically assaulted or harassed by men on the ward. I analyse this assertion from a feminist perspective and propose that at times, a gender bias operates which favours the claims of male patients over female patients. I conclude that sexually-integrated acute psychiatric wards are not necessarily a safe environment for female patients and suggest a physical (structural) change may be all that is required to ensure greater comfort and safety of female patients in psychiatric wards.



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Several forms relating to confidentiality and other ethical considerations in this study were not used, and therefore not indexed.

The terms 'sexually-integrated wards' and 'mixed-sex wards' are used interchangeably.

To maintain confidentiality, the names of specific hospitals will be replaced with xxxxxxxx.



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# Chapter One

## Introduction

*I believe that when one is unwell, the environment in which one finds oneself becomes a significant factor in the ability to heal.*

Being admitted to a psychiatric ward can be a traumatising experience for anyone. Central to this for some people is the reality of having to share accommodation and facilities with others who are often strangers, and with whom one may not necessarily choose to spend time. In mixed-sex wards men and women of diverse cultural, religious and social backgrounds are brought together in a relatively small physical environment. And just like the wider community that it resembles, mixed-sex wards contain both positive and negative aspects of human nature and behaviour.

For women, this can mean that the risk of physical and/or sexual abuse and/or harassment that exists on the 'outside' exists also in the mixed-sex ward and may even be greater. Given that those who are admitted to an acute psychiatric ward are often very unwell, the need for a safe environment is imperative. This thesis begins by asking whether a mixed-sex ward allows for a therapeutic environment in which women can begin to heal.

The literature shows that until the 1960s, mental health in-patient facilities in Aotearoa New Zealand were segregated by sex. Since then, and as part of an international trend, there has been a gradual phasing out of single-sex wards. Although written accounts of the arguments which drove this change in mental health service provision are minimal, what does exist demonstrates that this shift



was seen to be in line with the wider issue of moving away from institutional care and towards rehabilitation, more efficient use of hospital resources, and the positive impact mixed-sex wards have on male patients (refer chapter two).

I have also used in this thesis literature from the United States of America and Australia, but most of the information I have regarding mixed-sex psychiatric wards was written in the United Kingdom over the past twenty years and is the basis of chapter two, the literature review.

This literature suggests that the mixing of women and men in the same ward has been seen as a problem, particularly around the safety of women (Altounyan,1993; Warner,1994; Feinman,1988; McMillan,1992; Cohen,1992). Significant among these issues was the incidence of rape and physical assault. The United Kingdom literature noted multiple incidents of rape in mixed-sex psychiatric wards (Feinman,1988; McMillan,1992; Cohen,1992). One of the participants in this study also reports a sexual assault whilst residing in a mixed-sex psychiatric ward (refer chapter six).

The real rate of assault on female patients will no doubt be hard to determine. Those that are reported here in this study represent a few cases where the women felt able to speak out. Typically, psychiatric patients are among the most vulnerable in any society. The ability to speak out may be hindered by a number of factors leaving us unaware of the real issues that influence the environment that women find themselves in when needing acute mental health in-patient services.

The issue of women's safety in mental health services in Aotearoa New Zealand was also a concern of some since de-segregation. In 1989 the Mental Health Foundation of Aotearoa New Zealand established a Patient Advocacy Service. This provided a forum for patients to express their concerns. In 1991 the service



raised concerns about the safety of female patients. The issues of fear, safety and sexual assault on female patients in mixed-sex psychiatric wards in Aotearoa New Zealand was subsequently discussed in a 1992 report titled 'Safety of Women in Mental Health Services' produced by the Auckland Area Health Board. This document was the only local one I could locate on this topic and I was driven by this lack of information and discussion. I could find no accounts of mixed-sex wards by women patients themselves in this country, nor could I find any documented discussion on the motivation behind mixing of sexes in psychiatric wards in Aotearoa New Zealand.

In my methodology section (chapter three), I have critiqued positivism from a feminist perspective. Thus this chapter 'Perspective and Methodology' provides an overview of feminist epistemology, research theory, methods and methodology. Within this I draw from the works of Harding (1986,1989), Bunkle (1992), Reinharz (1992), Stanley (1983) and Oakley (1981) among others. The link between scientific rationalism and gender is discussed, as is the intention of feminist research to minimise the power imbalance that exists between researched and researcher. The methodological orientation and corresponding research methods used in feminist research are guided by the principles of feminist theory. Essentially, feminist research seeks to identify that which subordinates women to men. At the same time however, feminist research acknowledges the multiple realities of women (Smith and Nobel-Spruell,1986, Reinharz, 1992, Wise, 1990).

The second part of chapter three outlines my own process in gathering data for this study. I interviewed four women ex-patients and three women and one male nurse. All but one identified as Pakeha. One identified as both Maori and Pakeha. I sent verbatim copies of the transcripts to all the participants who had requested this. No alterations were requested or made. The ex-patient sample was purposive in that I needed women who had been in a mixed-sex psychiatric



ward in Aotearoa New Zealand. I conducted all interviews and transcribed all the tapes myself. I analysed the data collected from the interviews using a process of content analysis.

Chapter four provides selections from the transcripts of the nurses. This data fell into two categories: 'on the change from single to mixed-sex wards'; and 'on the safety of women patients'. Three of the nurses described how they were opposed to mixed-sex wards in terms of the dangers for women patients. The fourth had mixed feelings noting the vulnerability of women on the one hand but the normalisation of the environment on the other. Some of the nurses went on to describe incidents that put women patients at risk of serious harm (including rape) that they had witnessed. Others mentioned the inappropriateness of placing male rapists with sexually victimised women patients in close sleeping proximity.

Three themes emerged in chapter five from the data provided by the ex-patients. Privacy and 'space invasion', 'safety and comfort', and, 'on being lesbian'. All the ex-patient participants said that they had felt unsafe on a mixed-sex ward. Each had a story to tell. Some also had negative experiences with male staff. A male staff member sexually assaulted one and the other had been intimidated, restrained and had her pants pulled down by male staff wanting to give her medication.

One of the things I was interested in with this group was whether or not they were told that they were going to be hospitalised with men. None of them were informed, but being extremely unwell, none of them cared much at the time. They all did come to care at some point however. One even ran away to get away from the men. Others described a lack of privacy at having men sleeping in close proximity to women with only curtains separating them, of men being able to observe them in the showers and of being unable to lock shower or toilet



doors. Another spoke of her fear of male patients in psychiatric hospitals first because she was so young, secondly, she felt that whether true or not, her perception was that the hospital was full of sexual predators. Thirdly, this woman witnessed a lot of violence at various institutions over time, none of which was carried out by women.

Standing out for me from the international literature, the Auckland Area Health Board document and the transcripts was the issue of women patients not being believed when they alleged physical or sexual harassment/assault. Indeed, often such allegations have been dismissed as being 'part of her *illness*'. At the same time however, male patients are sometimes excused of abusive behaviour because it was 'part of *his illness*'.

In chapter six I ask what causes this gender bias that sees women often not being believed? and attempt to answer with a feminist analysis of women and mental health. This chapter begins with an overview of women's vulnerability to sexual assault in general, then focuses specifically on how this risk is increased in a mixed-sex psychiatric ward. I then look at the classification and treatment of women who are (seen to be) mentally unwell since the Victorian era in Western society. Within this, I draw mainly from the work of Valerie Ussher (1991), Phyllis Chesler (1997) and Elaine Showalter (1985) and discuss female sexuality and deviance; women, madness and social control; and the controversial treatments of moral management and surgical genital mutilation.

Concluding on a more contemporary note, chapter six also looks at work that suggests some mental illness diagnoses are gender biased. Unipolar depression for instance is diagnosed in twice as many women as men. In this section, I refer to two studies that claim that clinicians view female patients differently from male patients, with the behaviour of the latter being more highly valued than the former.



In the seventh chapter I challenge the notion of 'normalisation' in a sexually-integrated psychiatric ward environment, and whether the attainment of such creates a therapeutic environment for women patients. I conclude with a recommendation for structural changes which would create safer wards for women patients, and finally, identify unanswered questions and possible next steps for further research.



## Chapter Two

### A Review of the Literature

#### From segregation to de-segregation

##### The process of normalisation

There is a lack of rigorous research as to why the policy of mixing women with men in psychiatric wards was introduced. Anecdotal evidence however points strongly to the belief that mixed sex wards - introduced here in the 1960s - were seen to be a progressive development that would provide a more 'normal' environment and therefore one which was more conducive to recovery and rehabilitation. (Altounyan,1993; Batcup,1997; Burgess,1994; Cleary,1998; Swan,1994; Warner,1994).

Normalisation theory is generally associated with Goffman (1961) who referred to psychiatric hospitals, like prisons, as 'total institutions', which he defined as:

'...a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life' (xiii).

Such institutions, he pointed out, are characterised by two main groups within, the inmates and the staff, with the former being enforced to comply with rules and authority established by the latter. Goffman claimed that residents of psychiatric institutions are isolated from the community and lose the ability to



self-determine their lives. Rather, as a 'patient', inmates take on a new identity resulting in damaged self esteem and indeed '...psychiatric hospitals can actually render patients less capable of functioning in society than they were before they entered' (Nibert, Cooper and Crossmaker, 1989:343).

In the process of normalising the living environment of psychiatric hospital residents, the move to de-segregate occurred alongside the move to de-institutionalise and with the exception of special hospitals, most psychiatric hospitals today are not the long stay or maximum-security institutions that they were before the 1960s. Both long and short stay hospitals have dealt with the issue of de-segregation, however.

### **Eiders ward**

In 1985 the Eiders ward at Ashworth Special Hospital in Britain was opened as a mixed-sex ward accommodating 20 patients - 10 of each sex. What was significant about this ward was that it provided assessment, treatment and pre-discharge facilities to patients with specific sexual behavioural problems (Swan, 1994). The following issues were considered while the ward was in the planning stages:

- 1 'Mentally disordered offenders often have difficulties forming and maintaining relationships with the opposite sex; these problems can contribute to their offending behaviour and their continuing psychopathology;
- 2 The problems of assessment and, therefore, prediction of future dangerousness are limited if such patients are placed in sexually segregated unit;
- 3 Residence in sexually segregated units may even foster the development of further forms of deviant behaviour and place additional barriers in the way of the rehabilitative process;



- 4 The principles of normalisation, seen universally as both therapeutically and ethically desirable, require that gender integration be introduced to mirror conditions in society outside' (ibid:35).

Critics of Eiders Ward raised the issues of safety of female patients, meaningful consent to transfer to a mixed sex ward, and placement of some women in this ward as a pre-requisite to a transfer out of Ashworth. The Mental Health Act Commission went so far as to say of Eiders Ward: 'Women patients are placed there to test out whether male offenders can behave appropriately in a mixed environment' (ibid:36). Certainly item number two above lends some credibility to this suggestion.

Swan (1994) denies that the creation of an environment that benefits male patients over female patients was ever intended and, although he does not elaborate, claims that steps were taken to minimise the risks associated with placing patients who were either sexual aggressors or sexual victims together. Seven and a half years after opening, Swan sees the result as successful and the gender-integrated environment of Eiders Ward a therapeutic one.

### **The calming effect of mixing the sexes**

Two and five years after Eiders ward opened, it was reported that patients who were moved there required fewer major tranquillisers than when they were on a single-sex ward (ibid). The percentage of male and female patients requiring less medication is not specified and would be of interest because a reduction in male violence is another factor that is seen to be a positive outcome of mixed-sex wards (Firn,1995). If the need for less medication was higher for males than females, this could further support the argument that women patients are being used to modify the behaviour of male patients.



### **What say the patients?**

There is little recorded evidence of patient opinion of ward integration at the time it occurred, however it would be fair to assume that some patients saw the change to mixed sex wards as positive. Janet Frame reports in a recent biography of her life, '[The] mixing of the male and the female patients relieved the tensions in the ward, and also diminished the demand that female patients often make to 'see the doctor - when what they want is to see a man' (King, 2000:302). Frame was referring to a psychiatric hospital admission that occurred in the 1960s. It was nearly thirty years later before patients themselves were asked what they thought of mixed sex wards.

### **Studies of preference**

In Britain in 1992 a survey was carried out by the Bethlem and Maudsley Trust of 150 in-patients (seventy-nine men and seventy-one women) regarding mixed sex wards (Thomas *et al*,1992). The findings showed that 57% (85) of the participants preferred a mixed sex ward (32 of these were women), 24% (36) had no preference, and 19% (28) would have preferred to be in a single sex ward. Of the women who preferred a single sex ward, 27% (19) said they 'would have felt safer within a woman-only unit because there was less violence and more privacy' (p.59).

Acts of violence on the ward were feared, and some women reported being harassed by men who had entered their rooms, particularly at night. One felt that men can be very 'sexual' in their behaviour towards women, and others simply said they felt nervous in the company of men and felt they would benefit from an all-women environment. Five women also preferred to be cared for by an all-women nursing staff. The questionnaire did highlight issues of women's safety at night-time but it essentially concluded that most patients felt that a mixed-sex



ward was more balanced and 'normal' and that the majority felt safe.

Another smaller survey was carried out in the acute wards of the Royal Cornhill Hospital in Aberdeen over a one-month period by Alyson Kettles (1997). Forty-six patients (roughly equal numbers of men and women) ready for discharge participated in the survey that elicited their views on single and mixed-sex wards and their preference for mixed or single-sex accommodation. Thirty-nine percent agreed strongly with the statement that men and women behave better in a mixed-sex ward while 6% disagreed strongly. Sixty-seven percent agreed with mixed-sex participation in social ward activities and 93% felt that communal areas facilitated socialization (ibid:57).

The majority (90%) of all surveyed in the Kettles study felt safe during their hospital stay and eighty percent felt relaxed about approaching and talking to staff of the opposite sex. Of those who did not feel comfortable approaching a staff member of the opposite sex, some felt this was due to past experiences (for example, a woman with a history of sexual abuse felt unable to discuss her problems with a male staff member) (ibid:57).

Eight percent (not broken down into men and women) indicated that they preferred a single-sex ward. Seventy-two percent were happy with the sleeping arrangement of separate sleeping areas within a mixed sex ward, while 20% felt that they would prefer to have a choice of sleeping arrangements (ibid:57).

An Australian study carried out by Cleary and Warren (1998) on ten women patients found that although most participants had not experienced a single-sex ward, they preferred mixed-sex wards and saw this to be an important aspect of social interaction. Specific reasons for this preference were that segregation would be like isolation, that it is more interesting with men, and that it reflects conditions on the 'outside'. Despite reporting incidents which made them feel frightened or vulnerable, most respondents said they felt safe during their stay in hospital (ibid:37).



It is significant that so many women, 27% (19) in the Thomas (1992) study said they would have felt safer in a women-only environment, and that 10% of respondents in the Kettles (1997) study did not feel safe during their stay in hospital. It is also significant that the samples in all three studies were living in mixed-sex wards at the time of the survey possibly making it difficult for them to envisage, let alone request, an alternative. There is evidence to suggest that research based on patients' preference for mixed-sex wards conducted while they are in one tends to favour the mixed-sex ward. According to Batcup (1997) retrospective studies have presented a different picture, with many (amount unspecified) respondents saying it was distressing to share hospital facilities with people of the opposite sex ( Batcup,1997:1020).

## **Women, mental health and mixed-sex wards - issues of relevance**

### **Sexual assault and harassment**

By the 1980s concerns regarding the practice of mixed-sex wards were appearing, particularly in relation to the safety of female patients. In Britain, accounts provided by patients, nurses and health officials described incidents from harassment, exposure of genitals and masturbation and forced oral sex (Altounyan,1993, Warner,1994), to abduction and rape (Feinman,1988, McMillan,1992, Cohen,1992) in the wards. According to Feinman (1988), incidents such as these were a daily occurrence in mixed-sex wards.

Some of the stories taken from the above articles paint a horrific picture of life for some women in mixed sex wards. In 1994, one woman told of being woken in the night to find a sexually aroused man by her bed. Physically unhurt, she was able to alert staff, but the emotional consequences continued (Warner, 1994). In another case, a woman being admitted to Hackney Hospital was mistakenly taken to the intensive care ward where she was left alone in a cubicle and raped



by a male patient (Cohen,1992). Two other rapes and several attacks on women patients were reported in that, plus one other hospital in the same area in the same year (1991). In 1988 a psychiatric registrar reported that two female patients had been raped in a lift that had been stopped between floors in the hospital (Anon,1988). This same doctor witnessed more than once, male ex-patients patrolling the hospital grounds and abducting female patients.

An Australian inquiry into human rights and mental illness published in 1993 found that sexual assault of female patients by male patients who had access to the same facilities as them was significant. One male nurse included in his submission the following:

'In February 1990 a young male patient assaulted a female patient in the courtyard...The assault took place in full view of nurses, ward cleaners and patients in the adjoining ward. The victim was so impaired she could give no account of it. The male patient refused to [answer] any questions...no witnesses were prepared to come forward and make statements...The response of nursing and medical staff was to ensure that the matter was dealt with at ward level, specifically, to ensure that no one in the hospital administration discovered what had occurred...After making a brief note in the patient's file, the matter was apparently forgotten' (Human Rights and equal Opportunity Commission,1993:274).

The inquiry made note of the fact that they had heard repeated allegations of sexual assault by women who found themselves in particularly vulnerable non-segregated areas.

'Women are subject to sexual harassment and abuse from male patients and staff within these [mixed] units. When they complain to staff, women are ignored, blamed, not believed or told not to worry about it. For example, a young woman who had been sexually abused in the past complained to staff when a male patient continually masturbated in front of her. She was told to keep out of his way' (ibid:594).

A psychiatrist in private practice gave evidence to the inquiry of his knowledge of and views concerning women patients who had been sexually abused whilst in a mixed-sex ward.



'In my opinion these women are the tip of the iceberg and demonstrate that not enough is being done to ensure the sexual safety of disturbed women. If a woman is locked up for her own safety it is ironic that she thereby suffers worse abuse in the place which is supposed to protect her' (ibid:595).

## Fear

Findings of international research show that women are considerably more afraid of crime than men (Shirley *et al*, 1998). Predominantly women are afraid of being raped which, highlights their reaction to fear of other crime. Rape is the crime that is 'almost entirely perpetuated upon women'. Moreover, it is the crime that is so intensely feared that for many women it has become the 'ever present terror' (Stanko, 1985 cited in Shirley *et al*, 1998). An Auckland study on fear and crime concluded that women's fear of victimisation is connected to the fear of being raped (ibid).

Fear of physical and sexual assault in mixed-sex wards was common amongst the women in the studies referred to in this chapter. They reported feeling constantly afraid that an assault on them might take place at some point while they were in hospital. One patient, quoted in a British study, reported that rather than finding asylum at the hospital she was admitted to, she was always afraid of being raped or sexually abused (Feinman, 1988). The Cleary and Warren study (1998) found that many of the respondents in their Australian study reported feeling physically unsafe at times and another British study (Lovell, 1995) found that all patients had witnessed some form of violence and felt frightened. It is therefore interesting to note that in the studies mentioned above, most participants said they felt safe.



## Vulnerability

There are several factors that come together to make women patients more vulnerable to these fears and assaults. First, sexual harassment and assault of women by men are common features of everyday life in our society. Secondly, certain mental illnesses result in sexual disinhibition and female patients can find themselves in situations where they can easily be taken advantage of. The manic phase of Bipolar disorder for instance can leave woman sexually disinhibited. 'Promiscuity can be a symptom of mental illness. The old limits disappear. They let their hair down. Women do things that they later regret and for at least 50% of women, sexual relationships in mental hospitals are not therapeutic' (Feinman,1988:17).

The sexual disinhibition of male patients too can be distressing for women patients.

'Some patients are 'disinhibited' while under psychiatric care, their normal code of social behaviour towards others simply disintegrates. It means that patients may do and say offensive things quite unintentionally while on a ward. It is not an uncommon sight to see patients masturbating or stripping in public, which when witnessed by a female patient can be traumatic' (Altounyan,1993:21).

Third, women are often acutely ill and heavily sedated whilst in hospital leaving them vulnerable to assaults and less able to fight off their attackers. The Australian inquiry into human rights and mental illness also referred to the vulnerability of some women patients who may suffer from impaired decision-making processes.

'After he had sex with me I felt so ashamed. I felt this was the bottom of the barrel - in a psychiatric ward and just a thing to be used. I was so muzzy from the medication I couldn't resist and at the time I felt it was probably my fault I got raped' (Human Rights and equal Opportunity Commission, 1993:594).



### **A symptom of her illness**

Others too it seems have difficulty deciding if these attacks are real. In 1993 British documentary *Public Eye*, investigated the issue of one woman in Britain who claimed to have been ignored when reporting a sexual assault, only to find many more had been harassed, abused and even raped (Altounyan, 1993). Most nurses during this investigation declined to be interviewed, but one former nurse put forward the notion that nurses become desensitised to patient experiences. This is more likely to occur when the patient is labelled mad, and therefore, presumptions about the accusations are likely to be arrived at (ibid).

Another study claimed that disbelief was a central problem facing abused women throughout the services resulting in beliefs that favour the abuser. This disbelief is usually phrased that 'its all part of her illness', or consent was given, ignoring the power imbalance, or often she is blamed for the abuse ('she was manipulative, impossible and had no sense of boundaries')(Copperman, 1992). Some staff also reported having had trouble being believed when taking incidents to their managers. Too often complaints against other patients or staff have been seen as part of the patients illness or 'not proven'. Granted the situation is difficult, 'some very disturbed patients will adamantly declare themselves Mother Teresa one minute and with just the same amount of conviction tell you they have been sexually assaulted the next' (Altounyan, 1993:21). Regardless, claims of assault must be taken seriously and adequate procedures of investigation and action taken.

### **A history of abuse**

According to Islington's Women in Mental Health centre administrator Brid Grially, female psychiatric patients are particularly vulnerable because of past experiences that have contributed, or lead to their illness. 'Never mind the medical model, there is usually a reason why people go round the bend. In



women it is often some form of sexual abuse. Many are incest victims. Others are in violent relationships' (Feinman,1988:16). The evidence to support previous abuse as a factor in female admissions to psychiatric hospitals is strong. One British study showed that 40% of female psychiatric patients were victims of childhood sexual abuse (Thomas,1992), another found that 72% of hospitalised female psychiatric patients reported to have been sexually and/or physically abused by men (Bryer et al.,1987). The American study by Nibert, Cooper & Crossmaker (1989) found that 60% of female patients interviewed reported that they had been raped and 46.7% reported that they had been sexually assaulted in a manner other than rape whilst a review of 15 New Zealand studies showed that fifty percent of female patients reported childhood sexual abuse and forty four percent reported physical abuse (Read & Argyle, 1999).

## **European Psychiatric Hospitals and Aotearoa New Zealand: A brief history**

Not long after European colonisation of Aotearoa New Zealand, asylums were built as a means of dealing with the mentally unwell. Colonisers brought with them values and beliefs of nineteenth century Europe and, according to Haines & Abbot (1985), they 'ignored the mental health practices of the Maori people and features of these were not incorporated into early social policies' (p.45).

The first asylums were built in 1844 in Auckland and Wellington. These early asylums were attached to gaols and were publicly funded by subscriptions. Public hostility to lunatics however meant that there were problems with this method of finance (ibid). The 1846 Lunatics Ordinance Act gave recognition to the problem of mental illness and allowed for the 'apprehension and safekeeping of dangerous lunatics' (Tennant,1989:13). The Act envisaged the need for state lunatic asylums, and the first of these opened in 1854 in Karori (Haines &



Abbot, 1985).

Once provincial governments were replaced by central government in 1876, the state took charge of the administration and funding of the country's eight existing asylums (ibid). However, psychiatric hospitals were administered separately to medical hospitals and other health services until 1972 when, on April the first of that year, administration was transferred to regional hospital boards (Hunter Williams, 1987).

In her book on Porirua Hospital, Wendy Hunter Williams (ibid) outlines some key changes noted in annual reports of the hospital in 1975. Significant among these is 'the integration of the patients and increased unlocking of the wards' (ibid:282).

Extensive inquiries have failed to uncover other written documentation concerning the planning of sexual integration of psychiatric wards in Aotearoa New Zealand, but the Auckland Area Health Board document discussed further in this chapter states that the process of integration began in the 1960s.

### **The Mental Health Act 1969**

In the early stages of sexual-integration there was legislation in place to protect vulnerable female patients. Section 113 (2) of the Mental Health Act 1969 made it illegal for anyone to have or attempt to have sexual intercourse with a mentally disordered woman or girl who is a patient in a hospital under this act. The issue of consent was addressed also where it stated in sub section (5) 'It is no defence in any such prosecution that the woman or girl consented'.



## **The Mental Health (Compulsory Assessment and Treatment) Act 1992**

The Mental Health (Compulsory Assessment and Treatment) Act 1992 replaced the Mental Health Act 1969. This Act is silent on the issue of it being an offence to attempt to, or to have sexual intercourse with any woman in hospital and under this Act.

Yet, as the following section demonstrates, in the same year (1992) it was reported that the issue of the safety of women in psychiatric hospitals was a real concern.

### **'A disturbing trend in hospital care' - The 1992 report**

In August 1992, the Auckland Area Health Board released a report titled 'Safety of Women in Mental Health Services'. The report briefly addressed the main issues relating to women's safety before specifying actions to address what they referred to as 'a disturbing trend in hospital care' (p2).

The report began by pointing out that in 1989 the Mental Health Foundation with the support of the Auckland Area Health Board established the Patient Advocacy Service. This service was designed to provide a forum for patients to express any concerns about their care. By 1990, the Advocacy service had raised the issue of the safety of female patients in psychiatric hospitals. These concerns reflected those already raised by Mental Health Services management, Clinicians, and District Inspectors.

In the Auckland Area Health Board document (1992), it is noted that reporting to the Area Health Boards Review Committee on 16 October 1992, the Advocacy service cited numerous complaints by women patients who had either experienced incidents of sexual harassment or violation, or who felt unsafe at



night. To ensure confidentiality and to avoid causing any distress, the Advocates requested that their submission be raised "in committee".

In November 1991, Drs Wong, Strachan and Rankin presented their project report to the Review Committee on 'sexually integrated wards'. The authors noted that it was difficult to estimate the frequency of sexual assaults over the past three decades and that minimal emphasis has been given to patient rights, advocacy, sexual abuse, male violence, information systems and review procedures.

The Wong et al study (refer AAHB document 1992) asserts that while there are benefits associated with mixed-sex wards, there has been a sudden increase in the number of incidents (sexual and aggressive) reported since 1989. They note a number of reasons for this and the report adds that the establishment of the Advocacy service should be noted also.

The Area Health Board document points out that sexual desire and consent should be viewed with the vulnerability of the mentally ill female patient in mind and that special precautions need to be taken to protect them from sexually aggressive men. The document also notes that previous sexual abuse of women may relate to the development of their mental disorder and sensitisation to sexual harassment.

## **Conclusion**

It is clear that mixed-sex psychiatric wards were introduced in an effort to 'normalise' the environment. It is also clear that alongside this development, the physical and sexual safety of women patients within these wards became an area of concern. Harassment and abuse of female patients by males varies from walking into women's showers, toilets and bedrooms, to masturbation, exposure and rape. Yet significant within this chapter is that complaints by women



patients have often been ignored or dismissed as being 'part of her illness', or 'it can't be proven because she is mentally unwell'.

The focus of this research is on the impact that mixed-sex wards has on women patients and therefore, it lends itself easily to the feminist methodological process. In the following chapter I present the perspective which drives this research and conclude with descriptions of my own process.



## Chapter Three

### Perspective and Methodology

'The significance of research within both the physical and social sciences can be identified by the ways in which the activity and outcomes shape both our social structure, and our understanding of the world in which we live. These methods of inquiry have, to varying degrees, acquired the legitimacy and power to define and determine the overall outlook of a culture, its philosophy, morality, social theory and sciences' (Smith, 1986:135).

#### Introduction

This research investigates the experiences of women who have at some point in their lives, been admitted to an acute psychiatric ward in Aotearoa New Zealand. Using my own experiences as a starting point for this research, and my own belief that the interests of women are universally subordinated to those of men socially, politically and economically, I come from a feminist theoretical framework and use feminist research methods.

Beginning with an outline of feminist epistemology, this chapter will move on to look at feminist research including methodology and the methods employed by feminist researchers. Within and amidst this, I will discuss my own research process and procedures.



## **Feminist epistemology**

As a method of inquiry, traditional (positivist) social research is inextricably linked to the origins of 'science' (as we have come to know it), and the corresponding 17<sup>th</sup> and 18<sup>th</sup> century ideas regarding the ontological descriptions of the world, and the epistemological prescriptions of how this world should be investigated (Hughes,1991:9). With the separation of mind from matter, reason and rationality provided the principles for objective, neutral, value-free empirical research on which science claims its legitimacy.

Along with other schools of thought, the struggle for feminist research in both the physical and social sciences is the resistance to 'other' ways of knowing. Indeed, by its very existence, feminist research challenges and questions 'what counts as knowledge?' and exposes power dimensions intrinsic to this 'neutral' activity. These points have been further highlighted by the recent emergence of a feminist critique of science which presents the activity as one which is andocentric, racist, sexist, classist and homophobic, serving to privilege men at the expense of women (Harding,1986), '...science at every turn of fashion has established 'factual findings' which illustrate that women are biologically inferior to men' (Bunkle,1992:63). The ideological equation of science has shaped the forms, questions and goals of scientific research and it is the gap between women's experience and the existing epistemologies, which Sandra Harding (1986) asserts has generated distinct theoretical responses to science. One of these, feminist standpoint, bases its argument on the proposition that knowledge is determined by the position of the knower. Those who occupy the dominant position, have a restricted view of the world that limits their ability to identify and rectify problems, whereas those in non-dominant positions have a vantage point that allows them to see the assumptions and limitations of the dominant framework.



The feminist critique highlights the connection between science and politics, and those who hold this position argue for the recognition of a distinct woman's way of knowing to improve science. The dominant epistemology and methods of science have resulted in a view that sees only one half of the world it sets out to describe (Cockburn,1994). Feminists instead locate themselves in the picture, as investigation conducted under the strict guidelines of impartiality and separateness generates inadequate and biased results. Insisting that the knower and the known are inseparable and challenges some of the most basic tenets of modernist epistemologies (Fee,1986). The link between scientific rationalism and gender is significant to the feminist challenge in that rationalism undermines sciences claim to 'objectivity'. However, this position does not require that objectivity is attainable nor valuable, rather it makes the claim that a feminist epistemology is the only way of achieving this objectivity (Harding,1989). To accept this position, one would have to agree that a deliberately 'politicised enquiry' would necessarily be a more objective one.

Harding (1986) argues that one of the major impediments to the acceptance of 'other ways of knowing' lies in the fact that science has become so institutionalised: '...neither God nor tradition is privileged with the same credibility as scientific rationality in modern cultures' (Harding,1986:16) and any attacks on its epistemic privilege are considered tantamount to blasphemy.

Whilst the social sciences have acknowledged that the scientific framework is an imperfect tool in which to study people, it still seeks to align itself with science and institutes the scientific approach to gain acceptance. The objectivity of the natural sciences has remained the standard by which the social sciences have been judged (Heckman,1990). Feminist epistemology carries the tradition of reflexivity into the conduct of inquiry, gaining insight into the assumptions about gender relations that underlie it (Fonow,1991). The awareness intrinsic to the perspective of the 'outsider within' further enables the researcher to challenge the knowledge claims of 'insiders', and the resulting discrepancies and



anomalies e.g. the omission and distortion of facts, and pay particular attention to the unexamined stages of the research process (ibid). The feminist critique presents a range of assertions concerning the treatment of women under the scientific paradigm. It links clearly the political dimensions within the discipline and thereby exposes the neutrality claim as a myth.

## Feminist Research

Feminist research highlights the inadequacy of traditional positivist research, or more specifically, its use in either rendering women invisible, or distorting women's multiple 'realities'. In doing so however, feminist research has not merely added a gender dimension to existing research processes. Rather, by basing itself on the principles of feminist theory, feminist research has challenged the very foundations on which the existing scientific paradigm bases its authority. From this, feminists have moved to develop methods of inquiry that aim to minimise the power imbalance that exists both in the 'real world', and the discipline of research.

This section is divided into three interwoven parts. The first, **what constitutes feminist research?** introduces briefly the nature, philosophy and aims of feminist research. The second part outlines the **origins and development of feminist research**. Within this, questions relating to the purpose and methods of positivist research (as a means of acquiring knowledge), and their relevance to women, are discussed. Finally, the third part examines the **methods and methodology** utilised by feminist researchers, focusing on how 'knowledge' is acquired and the value stance, which drives the investigation/s.

### What characterises feminist research?

There is some debate among feminist scholars as to what actually constitutes feminist research. Some argue for a modification of existing research while



others see the need to break completely from pre-existing conceptualisations (Smith,1986). It is possible however to locate a number of principles that feminist research includes. Some of these are summed up in the following statement, that feminist research

'...involves an ongoing criticism on non-feminist scholarship, is guided by feminist theory, and may be transdisciplinary, aims to create social change, strives to represent human diversity, includes the searcher as a person, frequently attempts to develop special relationships with the people studied and frequently defines a special relationship with the reader' (Reinharz,1992:61).

These issues are repeated and added to by other feminist scholars who argue that Feminist research be based on feminist theory, carried out by women, for women, to improve their daily lives (Stanley,1983), and that it is committed to changing the oppression of women (Roberts,1981). A non-exploitive relationship between the researched and researcher is emphasised including co-operation and mutual respect (Oakley,1981; Mies,1983) and within this, the presence of the researcher is acknowledged as an integral part of the process (Stanley,1983). Finally, feminist research queries the ownership of research outcomes and attempts to create a specific methodology based on feminist ideology (ibid:22).

At the same time however, feminist scholars are aware of the dangers of essentialism, and recognise that women are oppressed in different and multiple ways: '...the experience of 'women' is ontologically fractured and complex because we do not all share one single and unseamed material reality' (ibid).

### **Origins and development of feminist research**

As part of a critical left wing academic tradition in the social sciences, feminist critiques of existing (positivist) social science theory emerged in the 1960s. The



main elements of positivism which feminists and others criticised at this time, were the assumptions that research needed to be neutral, value free and draw a distinct separation between the researcher(s) and the subject(s) or phenomenon under investigation (Smith,1986:135). This approach was further attacked for its elitism, inherent class bias, and scientific irrelevance (Mies,1983:183). Aware of a gender lag within this traditional form of research, feminists of the 'second wave' moved on to advance their own responses to traditional research (Smith,1986:135), focusing in the 1970s on the invisibility/exclusion and distortion of women's experiences. Reflecting the presence of those who acquired the power to define and control the process, existing research exuded male values and perspectives and focused on questions, which were of specific concern to men (ibid:136). Women's voices, perspectives and description of the world they inhabited, were either missing, or distorted enough to be subsumed under the dominant view (ibid). Feminist researchers at this stage aimed to redress the omission of women's experience in research and develop processes and methods that resulted in research *for* women, rather than research *on* women. By the 1980s, questions were being asked as to what actually counts as knowledge and who controls it (Stanley,1983:29-31). The link between positivist research, how knowledge was obtained, and male ideology, became the focus. It was argued that mainstream positivist research, dominated by male ideology, presented a distorted view of the world, and therefore suffered problems of reliability and validity. The focus on objectivity, detachment, hierarchy, one-dimensional instruments, and the role of the researcher as an objective and detached observer -in effect, the methodological orientation of traditional research - was seen to be incompatible with the aims of feminist research. It was argued that quantitative methodology emphasised rationality, detachment and distance and de-emphasized intuition, subjectivity, feeling, complexity and integration and was based on hierarchical, manipulative and elitist relations between the researcher and the researched (Jayaratne,1991:40).



### **Methods and methodology**

The methodological orientation and corresponding methods employed by researchers reflect, essentially, the aims and purpose of the research. For feminist research, these interrelated activities are guided by the principles of feminist theory. As noted above, feminist research aims to remove the androcentric bias of the quantitative framework. The value stance of feminist research is closer to, and therefore predominantly relies upon, methods drawn from qualitative methodology. Based in interpretive theory, qualitative methodology rests on the belief that social reality is constructed and negotiated, and therefore subjective rather than objective. It assumes the social world is always a human creation, not a discovery. Consequently, an interpretive approach tries to capture reality as it is, namely as seen and experienced by the respondents, studies a small number of respondents; no random sampling techniques; attempts to present the information gathered verbally, in a detailed and complete form not in numbers or formulas and uses no quantitative measures or variables. It also perceives the researcher and the researched as two equally important elements of the same situation. Respondents are not reduced to variables, units or hypotheses, but are seen as parts of the whole. It employs research procedures that produce descriptive data, presented in the respondents' own words, their views and experiences (Sarantakos,1993).

Feminist scholars argue that quantitative data has been unable to achieve these aims as the personal and subjective are exempt from analysis, resulting in the concealment of women's experiences. Qualitative research on the other hand, 'allows for women's experiences to be articulated or conceptualised...fully and in their own terms...through a more human, less mechanical relationship between the researcher and the researched' (Jayaratne,1991:93). To facilitate this process, feminist researchers rely primarily on the methods of in-depth interviewing, life histories, participant observation, ethnographic and ethnological studies, deconstruction and seminological analysis. However, the



creative energy of feminists has resulted in the development of new methods designed to transcend the superficial and provide depth of meaning to the feminist research process. These include 'consciousness raising, group diaries, dramatic role play, genealogy & network tracing, non-authoritative and neutral research, conversation dialogue, using intuition or writing associatively, identification instead of keeping distance, structured conceptualisation and speaking freely' (Sarantakos,1993:63). The significance of these methods (and methodology) to feminist research is multifaceted. The very process can be used to reveal and expose some of the relations of power women experience everyday. Feminist theory and research seek to take such experiences and bring them into the mainstream of social science investigation and writing. By transcending the superficial past that which can be scientifically 'measured', this type of research can challenge the ways in which social relations are viewed. Unlike traditional methods, critical methods are used to break down taken-for-granted concepts and rebuilding them into new entities. 'In doing so they lay bare the essential concepts of the research and the use of this for revealing what is really going on' (Harvey,1990 cited in Sarantakos,1993:64). In addition, the methodology and methods employed by feminists reflect a commitment to changing women's lives rather than conducting research as a purely academic exercise. This possibility for change can occur on both a personal level through (re) empowerment, and through wider social/structural changes. Referring to the method of 'life histories' Mies (1983) states: 'Only when women use their own documented, analysed, understood and published history as a weapon in the struggle for themselves and for all women will they become the subjects of their own history' (135 ).

Many of these principles and practices were incorporated in research carried out by Munford (1992) entitled 'Care-giving: The Invisible Work of Women'. This work investigated the experiences of women 'caregivers' of people with intellectual disabilities. Half of the respondents were unpaid carers for their own children, the other half paid carers in institutions. The aim of Munfords research



was to explore the caregiving experiences of these women; discover and document the women's perceptions of their daily lived experiences, and to examine the ways in which power relations have operated to structure and control women's lives. Munford used in-depth interviewing to explore how the women themselves *felt* about their roles in the household or the organisation for which they worked, *their* definitions and views as to what care-giving is, why *they* felt it was them who were the primary care-givers, and finally, their understanding as to why women's paid and unpaid work is devalued. Through the process of 'telling their own stories' not only was an accurate picture of the respondents' experiences located, it allowed the respondents themselves to 'name their world' and take control of their lives. Within this process, Munford sought to establish a reciprocal, non-hierarchical relationship with the respondents. The goals of the research, outcomes and possibilities for (and commitment to) change were discussed with the respondents. This process allowed for dialogue and feedback rather than 'interrogation', which many women have suffered at the hands and minds of traditional 'knowledge seeking' researchers. Munford used her examination of women's perceptions of the care-giving role to illustrate how these experiences are socially constructed and given meaning. The usefulness of this research can be located in its use of accurate (self-defined) documentation of women's experiences to break down existing ideas, and further, to use this information to influence and evaluate current community care policies and their implications.

Qualitative methodology and methods have enabled the feminist research process, and, in doing so, have challenged the 'value free' stance of traditional research. Not surprisingly, these methods - charged with being politically motivated and 'unscientific' - have not been warmly welcomed by the mainstream academic community (Fonow,1991), encountering negative reactions and strong resistance. Punishment has been noted by the rejection of publication (Jayaratne,1991). However, whilst the commitment to qualitative research is non-negotiable for feminist researchers, they have recognised the value of



quantitative research methods to support their own distinct methods of inquiry. The problem, it came to be argued was not so much the methods themselves but the ways in which these methods have been used (Stanley,1983; Smith,1986; Harding,1986). Feminists in ways consistent with feminist values and aims can in fact use quantitative methods. The data obtained by quantitative tools can be used for instance, to document the rates and incidences of 'crimes against women' such as teenage pregnancy, incest and sexual harassment (Smith,1986:29). Such data could be used independently, or to support qualitative research. Jayaratne and Stewart argue that there are limitations to both quantitative and qualitative research and '...while quantitative research may have been used in the past to obscure the experience of women, it need not always be used in that way' (Jayaratne,1991:97). Qualitative research is able to portray the complexities of life, quantitative research provides the data from which to generalise (ibid). Essentially, this combination of methods, or triangulation, can strengthen the study design, providing cross-data validity, and thus, making it less vulnerable to errors linked to any one particular set of methods (Patton,1990).

## **Gathering data for this study**

Official documentation regarding the move from single to mixed-sex wards both in this country and overseas proved to be unobtainable. I relied instead on one local report and several international studies, which looked at the situation post de-segregation. Most of these originated from UK where there has been concern over the safety of women in mixed sex wards. Some articles concerning mixed-sex wards come also from the United States of America and Australia. The local study was a 1992 report on the safety of female patients in mixed-sex wards. I used all this information to both influence and compare my own data gathering from:



### **In-depth interviews**

I used in-depth personal (face to face) individual (one person at a time) interviews with all the respondents in this study. The questions (Appendices A-B) were a mixture of closed (fixed response) questions and semi-structured open-ended (no fixed responses) questions. The closed questions sought information regarding the respondents' age, ethnicity, sex, sexual orientation, experiences of mixed and/or single sex wards, time of first and last admissions (ex-patients), and what hospitals admitted to/worked for.

The **open-ended questions for nurses** explored the experiences of participants in the following areas:

- \*Rationale and reaction to the change from single to mixed sex wards.

- \*The creation (or not) of a therapeutic environment.

- \*Difficulties encountered.

This basic line of questioning flowed freely with each individual telling her/his own story and putting their views across quite clearly. The issue of the safety of female patients in mixed-sex wards came up with every interview and was discussed in some detail.

The **open-ended questions for ex-patients** were slightly different for those who had been in both single and mixed-sex wards and those who had been in mixed-sex wards only. Essentially they explored the experiences of participants in the following areas:

- \*Awareness on admission as to whether the ward was mixed sex or not.

- \*Feelings on being admitted to a mixed sex ward.

- \*Incidents of feeling unsafe on a mixed sex ward and staff responses.



Those who had experienced both single and mixed sex ward were asked which they preferred.

### **Sample seeking**

Word of my study spread through friends and acquaintances that work in mental health. Some of the people who eventually became participants had heard about the study and contacted me. Other names were given to me, usually with a comment like 'I'm sure she'll have something to say on the matter'. I contacted them and if they were interested, we arranged a meeting. I knew one ex-patient participant and two nurses personally. One I approached, the other two approached me. I was unable to use the interview given by one ex-patient participant as she was too unwell at the time.

I wrote to each person with information about the study. Nurses were sent an introductory letter (Appendix C). Separate versions of the introductory letter were sent to ex-patients in Auckland (Appendix D) and Wellington (Appendix E) because the Health Advocacy services which looks after research participants was different for each region. Once a time to meet had been arranged, I sent each participant a confirmation of meeting letter (Appendix F). I travelled to Wellington to interview three (ex-patient) participants. I interviewed one at her place of work and the other two at the home of one of them. All were interviewed during the day. Each interview took no longer than one hour.

All interviews were tape-recorded. I transcribed the tapes myself within a few days of each interview. This way all the information was still fresh in my mind. (I had a confidentiality form for transcribers drafted but I preferred to transcribe them myself so this was not used). The tapes were transcribed verbatim and included all the umms and ahhs.. After much consideration however, I decided not to include these 'umms' and 'ahhs' in the final form because I felt it took away too much from what the participant was saying.



I sent copies of the verbatim interviews to all those participants who had requested a copy with a note asking them to inform me if they did not agree with anything. None of the participants felt that any corrections were needed. I then began the data analysis.

### **Data analysis**

My decision on how to go about analysing the data from my interviews was influenced primarily by the work of Shulamit Reinharz (1992) - specifically, Reinharz's description, explanation and examples of feminist content analysis (ibid:145-163).

Content analysis in research is methods used to analyse the content of texts and can be either qualitative or quantitative. Reinharz asserts that within content analysis, the study of 'texts' does not refer merely to written documentation. Indeed the 'text spectrum' is broad and some examples in feminist studies include fashion, fairy tales, billboards and Girl Scout handbooks (ibid:146).

Pattons description of this method is that it is '... the process of identifying, coding, and categorizing the primary patterns in the data' (1990:381). He follows this with a description of his detailed process of coding and classification, necessary he asserts, to avoid chaos (ibid:382). My own process of coding and categorising were influenced by this work.

I began by making several copies of the transcripts and putting the master copy in a safe place. Firstly, I read through the transcripts and noted each point of relevance by title on both the transcript, and the paper I was keeping information on. From the transcripts of the ex-patients, three themes emerged from this data:

\*Privacy and space invasion

\*Safety and comfort

\*On being lesbian.



Using different coloured highlighters, I coded each of the points into a theme. Some passages served different themes so I used the transcript copies to cut and paste.

With the transcripts of the nurses I followed the same process as for the ex-patients and developed two main themes:

\*On the change from single to mixed-sex wards, and

\*On the safety of women patients.

The points I chose to include were those that were relevant to the thesis topic and gave background information and/or said something about the experiences of female patients in mixed-sex psychiatric wards. As some participants heard about my study and approached me, it was highly probable that they had at least some concerns about mixed-sex wards, and at most, felt passionately about these concerns. With this in mind, every positive, or slightly positive statement about mixed-sex wards was used in the final analysis.

## **Ethical Issues**

My research was subject to (and approved by) three Human Ethics Committees:

\*The Human Ethics Committee of Massey University

\*Auckland Ethics Committee (Health Funding Authority), and

\*Wellington Ethic Committee (Health Funding Authority).

I attended interviews with The Human Ethics Committees of Massey University and the Auckland Ethics Committee (Health Funding Authority). I posted my



application to the Wellington Ethics Committee (Health Funding Authority).

There are some major principles in the Codes for Ethical Conduct for the above organisations, which I agreed to observe:

\*Minimisation of harm

\*Informed consent

\*Confidentiality.

\*Social Sensitivity

I will address each of these briefly.

### **Minimisation of harm**

As I am a woman, a consumer of mental health services, and as I have experienced being a patient in a mixed-sex ward, I consider myself to be an 'insider' in this research and therefore perhaps more able to establish a relationship of trust with my ex-patient participants. For feminist research particularly, being an insider is an acceptable position from which to conduct research (Finch,1984:81). However this is also seen to be problematic in relation to minimisation of harm.

Janet Finch argues that when the interviewer and interviewee are both women, a relationship of ease and trust almost always occurs and that this is especially so when the interview takes place in the interviewees' own homes (ibid:74). She bases this belief on the grounds that firstly, women are more likely to experience, and therefore become used to intrusive questioning into their private lives. Secondly, an informal interview conducted in the interviewees' home can create an atmosphere of intimacy. Thirdly, women's social and political position makes it more likely that women will welcome someone to talk to (ibid).

But it is this special relationship between women that Finch argues leaves the



interviewee vulnerable to the potential for exploitation (ibid:81). Private and personal information given freely has the potential to be used against the interests of those women who have given it, to those whom they were so easily able to talk. Finch asserts that the possibility of this occurring is minimised when the interviewer/researcher handles and uses the data they have generated (ibid).

I was open to the interviewees about my mental health issues and that I had been a patient in a mixed-sex ward. I was also open about the fact that I had worked in mental health before becoming ill. I also conducted all my own interviews and transcribed all my own tapes. I seek to give the participants a voice in an area that they have not been asked to speak about in the past.

### **Informed Consent**

Consent was sought and given before the interviews took place (Appendix G). Each participant was also given a certain length of time following the interview in which they could change their mind. A transcript (if they asked for one) was sent to them in this time frame and they had time to respond to me with any changes they wanted. No one responded. It was following this period of time that I began work on the transcripts but it had been made clear to each participant that they could withdraw from the study at any time.

### **Confidentiality**

Each participant self selected a pseudonym, which I used in the transcript. I ensured that their real identities were kept secure. There was one participant who was both an ex-patient and a worker in mental health. Her information was used as an ex-patient and I was careful transcribing her interview so she could



not be identified.

Another issue was that some participants referred others so they will quite possibly identify these people from their transcripts. Each participant was aware of who referred him or her and that this may be the case.

### **Social Sensitivity**

I let it be known that I wanted to include lesbians in this study as well as heterosexual women. This is because I believe that any study on women should include the values and beliefs of both orientations. I did not push for the 'lesbian perspective' however, I was merely open about being lesbian myself and sensitive to the culture. Only one of the lesbian participants spoke of being lesbian in a mixed-sex ward.

All of my ex-patient participants identified as Pakeha although one identified as Maori also. I understand that some Maori Mental Health Services are culturally specific and felt this study too small to include the specific and complex issues involved for Maori female mental health patients in mixed-sex wards.

The following two chapters are taken from the interviews of the nurses and the ex-patients.



## **Chapter Four**

### **The Nurses**

Four psychiatric nurses were interviewed in this study, one male and three female. Their self-selected names are George, Janus, Sharon and Mary. Three were aged between 50 and 54 years and one between 45 and 49 years. All identified as Pakeha, three as heterosexual and one as lesbian. All lived in Auckland and had worked in psychiatric hospitals in Auckland.

Each nurse chose the time and place of their interview. Two chose their place of work, two chose their home and all were during the day. All agreed to allow me to tape record the interview.

#### **On the change from single to mixed-sex wards**

I began by asking all of the nurses if they were working in a psychiatric hospital when the changes from single sex to mixed-sex wards occurred. The hospital that George began his psychiatric nursing in had already introduced mixed sex wards. Janus began working in psychiatric hospitals in 1981 and whilst most of the changes had occurred by then, there were still some single sex wards and she worked on one. Mary remembers some of the wards in her hospital being single sex, though she worked in a mixed sex ward at the time. Sharon was working in a single sex ward at the time it became mixed.



George remembers that the change to mixed-sex wards was seen as a positive move.

**George:** Well, I think that they were brought into being in the early to mid '70s to break away from the old military style tradition that was the psychiatric hospitals prior to that and...so that was seen in a very positive light...and that there was a more liberal atmosphere and part of that more liberal and open atmosphere, less authoritarian atmosphere was the mixed-sex ward.

Mary believed that the change from single to mixed-sex wards was brought about as a means to positively alter the behaviour of male patients.

**Mary:** I think most of it was that they thought there would be less violence from the men. There would be less swearing, there would be um...sort of...it would lower the tension in the wards....Quite a few objected to it...I know that a lot of people had input saying that they had worked in other places where there had been mixed, and they hadn't liked what had happened to the women. It seems as if it was ok for the men.

According to Janus, the problems lay in acute care and within that, there was contention among the nurses around the issue of mixed-sex wards. She herself felt quite passionate about it:

**Janus:** ...most staff thought it was a good idea but there were a number of staff, mostly women but some of the male staff also thought it was a bad idea. I was really unhappy with it, really unhappy with it...because a lot of the nursing that I did was in acute mental health nursing and I felt that women were extremely vulnerable...they were often physically vulnerable they were psychiatrically vulnerable, they were often not used to being in um...large institutional settings and some of the women had bipolar disorders...were often quite sexually dis-inhibited and there were



a wide range of people on the wards.

Janus then talked about the closure of one particular hospital and the integration of criminally insane men to mixed-sex wards.

**Janus:** ...so there was a mixture of people who were...had a range of psychiatric disorders and there were people there who also had very vast criminal histories - gang associations. There were a really wide variety of people. And also around the same time and within my family I had an aunt that had a...a very bad bout of depression and should have been hospitalised. And as a family we made a decision to not hospitalise her on the basis that she would have to go into a mixed-sex ward and we felt she was too vulnerable. She was physically small, she was weak, she was extremely depressed, and we felt she was in no position to defend herself from the inevitable attacks that were likely to happen once she got there. So we made a decision to nurse her at home and within the extended family, organised a 24hr watch for her, and when it got too much for us we employed nurses from the bureau to help us do that. So that was where I kind of sat with it all.

George felt that women on the acute wards were vulnerable not only to the men on their ward, but also to opportunistic ex-patients.

**George:** The geriatrics wards seemed to be fine to me. The long-term wards by and large didn't appear to have a great deal of problems in it, but the acute wards certainly did as a result of being mixed-sex.

There were a lot of former patients who were out in the community who would come back and visit the acute wards and would target acutely unwell females who were recently admitted and who were in no position to give consent to sex and these men would be looking to isolate them and get them down into their rooms and we had to keep an eye out for those



men and we even had a black list of men who had been caught...who had just been coming primarily to have sex with any woman who appeared to be acutely mentally unwell and therefore unable to consent, who didn't really know what was going on. ...The second problem was that the men in the ward itself that...since you had a whole variety of people in a sense taken almost at random from society and popped into a ward, you were going to get people who...men who were violent towards women and there did not appear to be any recognition of this among the staff and no steps appeared to be in place to protect women in those circumstances and in fact a lot of the staff prided themselves in that there was just a whole series of single rooms and men and women were just admitted into what room happened to be empty, so...

**Diane:** So they could be placed next to each other?

**George:** Oh yeah. And I remember on one occasion, there was a mongrel mob member who had been charged with and convicted of gang rape and in the room next to him was a 16 year old incest survivor, and I tried to persuade the authorities that this fellow should not be in that ward and from their response to me I gathered they could not understand why I was concerned and believed it was much to-do about nothing since there was no evidence that he had attacked her...I really had no basis for suggesting he leave.

**Diane:** Were there others that complained like you? Who brought these things to the attention of their superiors....bosses?

**George:** Yeah, bringing it to the attention of the supervisors and principle nurse and some of the charge nurses, there were quite a lot of people who were very concerned about the potential for abuse and the actual abuse that was going on. There was also a lot of concern at the lack of awareness amongst other staff. Say for instance on one occasion I had



discovered that a female patient had expressed fears to the staff that a male had entered her room and tried to kiss her. The staff said to this patient that they thought she was making a mountain out of a molehill. They also became irate when she asked if this fellow had ever had any convictions for sexual abuse of females, which he had. And they said that she had no right to be inquiring about confidential details about another client. They took the tack, the civil rights of this fellow, and completely ignored the danger that this woman felt that she was in and I thought with good reason that she felt she was in....This is not a natural situation. That whole basis of the mixed-sex wards was how people in the real world carry on. But in the real world we simply do not have...you know...Joe and Mary Bloggs suddenly occupying the bedroom next to us in our house.

According to George, a lot of staff felt that the men and women should be left to develop sexual relationships while in hospital. This is in itself interesting considering the 1969 Mental Health Act was operating at the time which made it a criminal act for anyone to have sex with a woman or girl in hospital under the Act.

**George:** During the late '80s and early '90s as a result of a lot of complaints by patients and by staff, the authorities began to acknowledge that there were problems in those wards and so took to setting aside wings of bedrooms for female only or male only. In one ward where it was not possible...a staff member was required to sit in the wing of an evening and staff were alternated. A number of staff were very irate about this and said they didn't think that they should be on what they called 'sex duty'. They regarded it that...the patients were likely to engage in consenting sex and that they were being required to prevent this which they felt was the patients own right and when it was put to them that the patients were often not in a position to give consent due to their mental



un-wellness, and that there was....because of the nature of some of the male clients that they were abusive towards females, they then became irate about the civil liberties of the male clients.....That they were innocent until proven guilty....so there was a lot of resistance from some staff to the initial efforts to provide a safer environment for female patients.

Sharon saw a positive side to mixed sex wards.

**Sharon:** ...in fact a lot of the women responded in a really positive way, they started to take more care of their appearance and stuff like that. ...I don't recall that there was too many problems at that stage. And there was the sorting out to do about facilities, toilets, bathing facilities and privacy issues around you know, women being kept in their own place in terms of where they undressed and where they slept. It certainly wasn't mixed in terms of you know bedrooms being next to each other or anything. It was kept segregated around those sorts of things. They only mixed jointly over the days.

On her own opinion of mixed sex wards, the creation of a therapeutic environment and the safety of women, Sharon was divided.

I've got a mixed opinion about it actually. I see it both with a negative and a positive aspect in terms of I think that it's not only women actually but it's more majority women, that there's people that when they come in very unwell that they're very vulnerable and they often make poor judgements about their behaviours, and when they become well um...they realise that they have been taken advantage of because they were unwell and their judgement was impaired and it's had some terrible effects on their lives. Obviously people aren't going to tell staff about things that happen to them in my experience, that they consent to when they're unwell. Because it's very much us against them....so we don't often get to hear about stuff until after the event which is a pity and people...it's often



covered up for some obscure reason. Probably for all the reasons people who aren't unwell that it happens to, you know, shame, it must have been my fault, I must have asked for it, all that sort of stuff. So I would say as a professional working in that environment, that only a percentage of those incidents are actually reported to staff....you know if someone is really vulnerable obviously, if they're really, really unwell, and you watch them like a hawk. But then they start to improve and you don't watch them so closely. But often their judgement is still impaired. They're still impulsive, they're still disinhibited around a lot of things. So from that point of view it's a real negative, that it does pose people at risk when they're vulnerable. And I say...that's both genders, both sexes male and female but more predominantly obviously for female in my experience...though I do know of cases where men have been raped by other clients...the positives are I think it normalises the environment for a lot of people who don't live in same sex relationships or environments outside of hospital...that they do live in ...heterosexual surroundings, environments, and it normalises a lot of stuff for them. It also exposes them to different ways of thinking, different opinions.

George argued that where abusive males were out of the picture, mixed sex wards could work well.

**George:** So where you've got males and females who know each other relatively well and males who are not abusive, then the worst aspects of all male or all female environments get ameliorated so in an all male environment you can get sort of a bit of a macho culture going on but with a sort of a mixed-sex area, that macho culture is broken down a bit and males are a bit more open about talking about their feelings and similarly the worst aspects of female culture where you can sort of get women being fairly catty and bitchy, that also gets broken down. So, in an ideal setting it can work fairly well, and I've been in some wards where I believe



that was the case. Where there were no abusive men in it and it operated well, but again all it takes is for one abusive male to be admitted and you just never know when that is going to happen and the whole culture can be destroyed overnight. It's tricky.

Both George and Janus concluded this section with their opinion of the overall suitability of mixed sex wards for women.

**Janus:** I've been talking about all the negative things about mixed sex wards, so I've just been thinking...about what were the benefits, and I cannot think of one single benefit either in the short term or the long-term wards. I can't think of one benefit for women. There may have been benefits for men. I think probably for men the environments were a lot less violent than they might have been in the all male environments...

**George:** I think that there is a strong belief that this is the most humane way to go and that staff who remember the single-sex wards associate it also with other features like the authoritarian and often quite inhumane and brutal behaviour of not only individual staff but the whole system, it was a dehumanising system and that they associate all those things. Whereas you know it is very possible to have a single-sex area and have a humane approach to the people within those areas...

A lot of staff would say that when you would introduce the idea of single-sex wards 'we don't want to go back to that era'. They saw it as a whole package rather than seeing that you were...you know you'd moved forward and along more humane lines, and that was the improvements that you were making. Now as you were viewing the improvements you could see that some areas of those improvements actually made were quite unsafe for women so modifications were needed but still heading in the direction of making it humane not in the direction of that authoritarian dehumanising. But it appeared to be difficult for some of them to be able to conceptualise,



that it could be a forward step and not a backward step.

## The safety of women patients

Some of the nurses had particular stories or observations that they had encountered around the safety of women.

**Mary:** ...Like if a woman came in very depressed she had no ability to say 'stop it', or 'don't', or 'no', or 'I don't like that' or 'I don't like you watching me while I'm getting washed'. So if she was depressed and quite introverted she couldn't do that. So they were like victims, not victims, prey, I think preys a better word to use. So people would watch out for these quite quiet depressed women. And they were the ones who often got touched, got preyed upon.

**Janus:** Women were *a/ways* unsafe in a mixed-sex ward....their safety was compromised on a daily basis, for instance I remember one woman saying to me she was sick of the men always wandering into the women's toilets...or into the showers, and she said to me 'no matter how mad I get, or how psychotic I am, I never ever wander into the men's toilets. No matter how disorientated, no matter what is going on for me, I never mistake the men's toilets for the women's'. So she had an analysis, she had a sense that some of these men would say 'oh well, look, it was a bit of a mistake...I got lost or I ended up in the women's toilets by mistake'. And I think she felt that it was just a load of cobblers that in fact the men...there was nothing confused or psychotic about their presence in the toilets, and unfortunately a lot of the staff - male and female - also took the view that oh well you know we'll excuse him because he's not very well at the moment or he's hallucinating. So when you talk about attacks, it was ...just daily, the women's bedrooms weren't locked. Most of



the time the women slept in dormitories, but occasionally they were in single rooms, and unless the door was locked from the outside and they were in seclusion...there was actually never any safe space that they could be in the ward.

Where men were excused for their intrusive behaviour because of *their being unwell*, Mary noted that when women reported these behaviours, they were not believed because *they were unwell*. Describing the physical layout of beds and dormitories she points out:

**Mary:** ...four beds in this room and they were women and then the next room would be four beds and they might be men. And then across the way it might have been four women and four men, whichever.

**Diane:** Right.

**Mary:** And then some single rooms. So of course the men had easy access, there were no locked doors.

**Diane:** So the men had easy access to the women's rooms.

**Mary:** And many times I'd hear patients...I'd hear women patients saying that people had touched them in the night or somebody had grabbed them and very frequently it was all put down to their condition....she's a bit paranoid, that sort of thing.

**Diane:** If you were able to design policy to create the ideal therapeutic environment for women psychiatric patients, would it be a mixed-sex ward?

**Mary:** No, no no. Not at all. No. I think that some way that you could integrate it which would say something like you know a couple of weeks, if you in for 6 or 7 weeks, you know when they're out of the acute phase,



when they're starting on recovery and they are fully functioning...then I think for rehabilitation I could see that we'd have mixed wards. But when people are what I call mentally ill, they need to be separated.

But women were not only being walked in on in the shower, or being fondled. They suffered more serious assaults.

**Diane:** Were you aware of any incidents where women had made complaints of being raped?

**George:** Yes, yes.

**Diane:** And what happened?

**George:** Well in one case the police were brought in...no charges followed because the female in question had a psychotic disorder and that would have been quite easy for defence attorneys to say that she imagined the whole thing....and they didn't have any forensic evidence and the staff who saw the male patient leave her room, but there was no um...identification of him actually sexually assaulting her. Another woman was raped and she threw herself off Carrington Bridge and caused massive injuries to herself, and the male patient in question continued to be in the same hospital. And there was a rape carried out of a female patient in one of the wards who was really unable to make herself understood, she was mentally unwell and had a very low IQ, was quite brain damaged...Well I was a ward charge that day and I was back at the ward with the patients who hadn't gone out. The other staff came along and unfortunately they didn't follow procedure and nobody was at the back making sure all the patients were in visuals and when they came around the building, one of the male patients from another ward attacked her and raped her. This was witnessed by other staff. But again the police said the question of consent would arise and a defence lawyer



would say it was...no evidence that it was not consenting, so... And of course she couldn't say one way or another because she couldn't make herself understood....and there was a few too of the nature of females going down to the acute wards to visit other people and then coming back to the long term wards and saying that one of the male patients had sex with them and they tried to stop him but he kept on going and the sad thing about it was that they didn't even appear overly distressed by this which I took to be that it was something that had happened to them on several other occasions and they were annoyed and just accepting that this was part of life in the psychiatric hospital for them.

Women with a diagnosis of bipolar disorder were seen by some to be particularly vulnerable.

**Mary:** When they are manic and become quite dis-inhibited... I've seen it many, many times, women becoming dis-inhibited you know, taking their clothes off and dancing sexually in front of men. Being very, very provocative. Extremely sexually provocative and completely contrary to what they would normally have been. So that when they've actually come down and they've been told what they've been doing, you know, they're absolutely appalled and then they go into a deeper depression because of the shame of what they've been doing.

I've seen and stopped many men touching the women up and I used to particularly...when I did work on the mixed wards at xxxxxxxx and I was a D shift charge then, that was the evening charge, I used to watch very carefully and make a note to make sure the students...watch out for the vulnerable ones. You know, someone who was very depressed, anxious, anybody who was manic. Basically just to keep an eye on the women.

**Janus:** I suppose I've talked a lot about acute psychiatric settings, some of the issues I'm thinking about in the long-term setting, a lot of the



patients that...women I've worked with had been there for a long time, they were very institutionalised so that when they came into contact with the men...a lot of the women traded things like sex for cigarettes so sex was kind of comodified and seen as a tradable commodity, and they would allow themselves to be abused sexually I suppose, I don't know that they saw it like that...for cigarettes, for food....

**Diane:** Did the staff know that the comodification of sex was occurring?

**Janus:** Yes.

**Diane:** And was there any policy around it?

**Janus:** No. And there was no...I mean they all knew where it took place. There was a place in xxxxxxxx Hospital that used to...is now called the Stables...that used to be called...um, it used to be an old cow shed, I don't know whether it was a stables or a cow shed but it was some kind of animal barn, and it had old mattresses down there and the staff knew that that's where the women were taken. There was never any patrolling of those areas, there was never any attempt to stop the males going down there, it was...it was pretty common knowledge. So that...I suppose the point I'm trying to make in this great ramble is that there was a whole kind of reframing of sexual abuse as um...as a kind of...as a legitimate trade you know like a sexual encounter was seen as a legitimate exchange for a cigarette and that is how it was framed.

Janus also felt that female patients had reason to be concerned with male staff also.

**Janus:** ...The female patients weren't just at risk from male patients, I think at times there was some male staff who also had um...questionable professional boundaries and sometimes under the guise of being a supportive or kindly...women were taken out at the weekends and that



kind of thing so I think women were also at risk from staff as well.

**Diane:** ...Male staff has come up with every single one of my consumers that I've interviewed. When I'm asking them about mixed-sex wards I ask them about male patients but male staff comes up each and every time around privacy. And I'm sure there's a lot more restrictions today, like today you wouldn't have a male staff member taking a female patient out on weekend or anything like that, I'm sure you wouldn't.

**Janus:** Well I'd hope you wouldn't.

**Diane:** But issues of privacy...like having your pants pulled down to be given an injection by a male is quite disturbing for some women.

**Janus:** Very disturbing.

**Diane:** So generally, what is your opinion of male nursing staff with women patients?

**Janus:** (Laughter) Well, see I suppose...one of the arguments...I'll come back to your question in a minute...but one of the arguments around the mixed-sex ward stuff was that in psychiatric hospitals at that time, or up until 1981 when I started there, there were many many long term men and women patients. So there was this popular myth that it's normal for men and women to live in the world together therefore we want to create as normal circumstances as we can within the institution, therefore it is normal to mix male and female patients.

**Diane:** Now this was the rationale behind the change yes?

**Janus:** Right, that's right yes. So men and women need to learn how to live with each other and when the women go out into the community they're going to be with men anyway. And I agree with that, yes that's



true. However, the difficulty I had with it was a lot of these women that I was looking after were vulnerable either because they were extremely acutely ill...and needed...and weren't in a position to make um...necessarily safe decisions in relation to their own relationship to men. And that many of the long term women were women with...not always, but sometimes, with diminished intellect...diminished physical capability and they also needed some...to be afforded some kind of protection. And it may have been ok for them to have something to do with some sorts of men and not others. I mean, in my life I choose to live with men and have friendships with men, but that doesn't mean to say that I automatically want to end up in a mixed ward with all men....there are some men I steer very clear of...so, I suppose that this rationale of men and women having to get along together somehow is flawed... So I think that it was....for a lot of the time it was more appropriate for women to be looking after...female nurses to be looking after women in the hospital, however, there also needed to be some element of choice and I think there was some very gentle nice male nurses around who were very safe for women to be around.

Sharon thought that what staff *didn't* know about was important.

**Sharon:** ...I think a lot of it is hidden. And I'm sure that a lot more goes on than staff even know about...and perhaps if that was reported honestly and things were examined, systems would change. But I don't know that for sure.



## **Chapter Five**

### **The ex-patients**

Four women who had been patients in a mixed-sex psychiatric ward in Aotearoa New Zealand were interviewed for this study. Their self-selected names for this study are Siobhan, Julie, Sue and Rebecca. They were aged between; 25 and 49 years. Three identified as pakeha and one identified as both pakeha and Maori. Three identified as lesbian and one as bi-sexual. Three lived in Wellington and one in Auckland.

Each of the women chose where the interview would take place. I interviewed two at their places of work, and the other two in one of the women's home on separate occasions.

#### **Admissions**

Not one of these participants were notified before being admitted, or, on admission, that they were going into a mixed-sex ward. Sue was underage at the time of her first admission and did not get told much while Julie said she just assumed the ward would be mixed. All felt that they were far too unwell at the time to consider whether or not the ward was mixed. Rebecca recalled being 'very uncomfortable' when she realised she was on a mixed-sex ward as did



Siobhan:

**Siobhan:** They took me to the admission station which was a section and I was very unwell...and they left me there...told me to stay there while they went and got my room ready and they also told me that if I moved they would put me in lock up. I didn't know what a lock up was at that stage. And while I was standing there a couple of men walked past and gave me the once over. And that's when I thought 'I don't want to be here'. I didn't want to be on a wing where they were going to lock me up with men. So I left. I ran away. I was very sure of that. Yeah...that was probably the first time I considered that that was going to happen.

## Privacy

Ward design did not lend itself to privacy which was an issue for all the women. Often sleeping arrangements saw the male patients being placed in bedrooms right next to female patients. Some women spoke of men walking uninvited into their bedrooms. For some women, privacy could not be attained even in the shower. In one facility the showers were in with the woman's toilets and even where they were not, women in this study spoke of men - either patients or staff - walking in on them in the shower. Women only areas were rare, privacy almost impossible.

**Diane:** ...Was there any...in relation to privacy, was there anything about the ward design that you noticed, for instance was there woman only areas?

**Julie:** Yeah...at that time they had an acute section which wasn't really an acute section like they have now but, like where everyone went when they were first admitted and in that bit they had women on one side, they had four beds of women on one side and another four beds of men on the



other side and that was located virtually next to the women's area of the ward and the men's area of the ward was way down the other end...Because I've been in quite a few times, they didn't even put me in there, they would put me straight in the women's end. Because I didn't like being there with the guys.

**Diane:** Right. So there was two parts. One had women only and one had both?

**Julie:** Yeah.

Siobhan felt as though she had no privacy from men whatsoever.

**Siobhan:** I had no privacy. I felt that men could look into my room at any time they wanted....The ward wasn't structured so men and women were at least on different sides of the ward even...There was men in rooms right next door to me.

**Diane:** Really?

**Siobhan:** Yeah

**Diane:** So the sleeping arrangements weren't segregated.

**Siobhan:** No.

**Diane:** Was there any woman only space at all?

**Siobhan:** No. No. You couldn't go anywhere without men being there. And even the showers...It's built in a quad so there's a square in the middle and around the outside...the buildings around the outside and in the middle there's a quad and the showers of course...on the outside. And showers have windows...not clear windows but that showery type stuff...you can't actually see through them but you can see peoples



shapes. There's no curtains so one of my main problems was that anyone could stand there and watch me have a shower and see what I was doing through the window...and that's where everyone smoked.

**Diane:** In the quad?

**Siobhan:** In the quad. Right outside the shower area. And what I did was I used to crawl on my hands and knees all around the shower area to have a shower so men, who often made comments through the windows, couldn't see....I asked. I actually asked....to even put shower curtains over the windows. I complained about that and they said 'cause people might hang themselves because there's locks and you can lock yourself in and people might hang themselves from the curtains'.

Sue also remembers having little privacy from the men on the ward.

**Sue:** I think there was some sort of division created between males and females like dormitories, it's very much a dormitory situation that I was in...males had access to your rooms just by virtue of walking across the corridor. You know, there wasn't any physical barriers that would prevent people from going into each others dorm...

This lack of privacy extended to the showers:

**Julie:** They had women's toilets and men's toilets and the showers were in with the women's toilets. You couldn't lock any of the doors, they just had magnets on them....And even in the showers they just had curtains or whatever, and there was nothing to stop anybody from wandering straight in, including the male staff. You know just wandering straight in.

**Diane:** Did they?

**Julie:** Yeah, they used to. But in the new ward they've got locks on the



doors...they're single cubicles and mixed-sex so anybody can use them.

**Diane:** They're not segregated into men's quarters and women's quarters?

**Julie:** Because they've got a shower in the toilet up next to where the women are and where the men are, they tend to be lift like...the women tend to use the one...but there's also another one further around the corner so you can use those. But it's a much greater sense of privacy because you can actually lock the doors.

**Diane:** When you couldn't lock the doors when you were in there, did you yourself have male staff walk in while you were in the shower?

**Julie:** No I didn't.

**Diane:** But you saw it happen?

**Julie:** Yeah. And you always knew that there was a possibility that there could...

Even where the showers were single sex:

**Sue:** ...Males did go in there.

**Diane:** Males did go in there. Like what for?

**Sue:** My belief was they used to go in to have a look (laughter) to be quite honest. And you'd hear a sort of scream and the nurses would bundle somebody out. And a lot of the males would say 'oh I didn't mean to, I just sort of went in there by mistake' and stuff like that, but I think there was an element of basically just trying to have a look at the females yeah, preferably with their clothes off.

**Diane:** So you had to be vigilant all the time really.



**Sue:** Well it meant you had really quick showers...and there was this sense of having someone looking at you...I think because essentially it lends itself to feeling like you are being observed anyway, because in a lot of instances you are being observed by staff. Not engaged, observed, which is quite different. So you do feel that you are being watched which I don't think is conducive to wellness at all especially if you have some sort of paranoia. I mean it's perfectly justified paranoia.

## **Fear, Safety and comfort**

I asked all the participants whether there were instances during their admissions when they felt uncomfortable or unsafe being on a mixed-sex ward. It is my belief that living in an atmosphere where such feelings exist, hinders ones ability to heal. As we will see in the following section, the women spoke of living with a general **fear** of the men in relation to physical and sexual assault. Of the **discomfort** of being confined with men who are exposing themselves and masturbating in front of the female patients. One woman told of being physically followed and touched by male patients and another, of men climbing into bed with women and fondling them. Another woman suffered the horror of being sexually assaulted by a male staff member while on the ward. This continues to have an impact in terms of **fear, safety** and **comfort** every time she is admitted. Another reason one of the woman felt **unsafe** at times was that the night shift of nurses often slept on the job which meant that the men could come into the woman's rooms without being noticed.

**Rebecca:** There was a guy running around with just pyjama pants on and he was exposing himself...staff did hardly anything to start with and...because I kicked up a stink they eventually told him he couldn't come out into the open area unless he was dressed. And even then he'd just put undies on...And then I kicked up a stink about that one and he'd



wear shorts but they were...like he'd sit so that you could see everything. So I used to just go off and supposedly isolate myself...run away actually. Run away from the ward or I'd go somewhere where it was just me. I didn't want to be around anybody because whatever I said was just...she's neurotic you know, she's depressed, she's just...she's antisocial...stuff like that. Because the men were everywhere, with everybody, in the smokers room, just wherever. And I didn't want to be around that particular guy or any of the other guys either.

Sue said she felt unsafe in a mixed sex ward almost continuously.

**Sue:** I felt very fearful of the males because a) I was very young and relatively naïve to be honest and there seemed to be this sense of it being filled with sexual predators to be honest. I mean whether that was true or not that was my perception of it. And I was small in stature and small in size and very much felt fearful of the males who all seemed very big and large and unpredictable, and predisposed to violence, I saw a lot of violence at various institutions. And it always seemed to be perpetrated by males, the females...I never saw any violent acts by women, although I know they did occur, I never actually witnessed any, and my experience of women out there had been that they were actually very supportive and nurturing....but yeah I did used to feel quite unsafe and I would never put myself in the position of being alone with another male...I would always stay in the open as such...also there was a lot of males taking their clothes off, a lot of masturbation etc. And I had never been witness to that sort of thing before.

This fear disappeared when she was admitted to a single-sex ward.

**Diane:** Did you notice a difference then...I don't know whether it would have been an obvious difference or conscious difference being with all women...you know that constant fear that you said you had being with



men, had that disappeared when you were with all women?

**Sue:** Yeah. Males did come to the groups but they were physically in a different building so you were physically separated, and not only that, they couldn't just come, there was like a common area where you would have coffee and things like that where you would mix with the males who were attending the groups and of course what some males did was they didn't actually stay, they actually came and went, so they just came for like maybe two days out of the week. They came to different sessions and stuff like that. So the males that actually stayed there were very, very few in number and the ones that did stay were physically separated from us by buildings and farms and stuff like that....yeah I certainly felt a lot safer in that situation than I had in any of the others.

Julie talked of being harassed by male patients:

**Julie:** Even like the first time I was in there some guy came up and put his arms around me sitting on my bed.

**Diane:** Came into your bedroom?

**Julie:** Yeah. It wasn't...I mean it was just a cubical.

**Diane:** Right.

**Julie:** But the last time I was in hospital I had a guy following me around all the time which was very uncomfortable. Its just because if your...if your relatively young and your female your just considered as being...it's just open slaver basically, they'll just try anything.

**Diane:** Did you ever complain to the nurses?

**Julie:** Yeah, yeah.



**Diane:** And what did they do?

**Julie:** They'd try and keep people away from you and that but still there's a limited amount of things that they can do. And the other person's got as much right to walk around as you have so...It's just feeling really uncomfortable about being around some of the guys. I've been in so many times it's hard to remember specific incidents except I remember one guy that ...came up to me and just kept trying to put his arms around me all the time, that was horrible, but I met him again later on when he was well and he was fine. Most of the time I have managed to keep away from it all. I would certainly prefer to be away from it all.

But it was an incident with a member of staff which most affected Julie's physical and emotional safety.

**Julie:** I'm pretty sensitive to when I go into hospital because I was sexually abused by one of the nurses....and that has just sort of left me feeling really cautious about what happens when I go in. I don't like it at all.

**Diane:** What happened with that?

**Julie:** That resulted in him getting charged by the police and to getting sentenced to two years in prison. And loosing his job. That was really nasty that whole thing because everyone seemed to have an opinion about me whether it was right or wrong...

**Diane:** Whether what was right or wrong?

**Julie:** Whether what happened was my fault or his or nobody's fault or...

**Diane:** There was debate about that? You mean amongst the staff?

**Julie:** Yeah.



**Diane:** Interesting. I would love to have heard the argument how it could have been your fault.

**Julie:** (Laughter) Well, according to the judge...because this went all the way up to the Court of Appeal in the end because the judge gave him a really light sentence...it was my fault because it happened at night on the ward and I was in my nightdress (laughter).

This incident continues to impact on Julies' life

**Julie:** I went into the hospital a couple of months ago and I was absolutely terrified because I came across one of the staff who was actually on the night that this happened, and I was in a state already because I was high anyway and I just went really high. That was enough for me and I wanted to get out and I'd gone in voluntarily...I've always gone in voluntarily and this time I wanted to leave so I packed everything up, packed my bag and left. Except as I was leaving, I ran into my psychiatrist in the corridor who stood there and said 'ICU'. So I ended up under the Mental Health Act for the first time in my life.

**Diane:** Because you were leaving?

**Julie:** Yeah. And it took me a long time to calm down. I was in a real state.

**Diane:** And part of the reason you wanted to leave was because staff were on that night...the same staff were on that time as were on that night when you were assaulted?

**Julie:** Yeah.

**Diane:** Right. It makes it a bit difficult for every time you go into hospital doesn't it?



**Julie:** Yeah. Yeah. But that's not really about being in a mixed-sex ward. That could have happened in any type of ward. I get uptight anyway about being in hospital just because...it just makes things worse because of having male patients around.

On the topic of comfort and safety Siobhan also mentioned male staff:

**Siobhan:** It kind gets broken in two categories. One male patients and the other is male staff.

**Diane:** Tell me about both.

**Siobhan:** In ICU where I spent a lot of my time, it was mainly staffed by men. There was usually one woman down there and three men. I often got a male staff nurse as my carer. You're not allowed to have anything in your possession, so I had to ask him for everything from toilet paper to tampons. He had to sit there and listen to my conversations...just nothing was personal from men, and I found that really hard. I found it so hard that I tried twice...on two occasions, tried to hit the staff member, the nurse that was on...which caused me to be restrained, and which again, male staff did it...if you needed to be restrained women staff didn't come running. The men did it, and they restrained you. And twice I got told to 'stay still you fucking bitch' while they jabbed me with a needle - in the arse. So they pulled down the back of my pants to inject me. I mean that's just...you know...you just cant get more personal. I became a very, very angry, violent, uncontrollable person because of the closeness of men in my life there. Especially being in ICU. The more I was in ICU the more angry I got.

**Diane:** Total lack of dignity?

**Siobhan:** Total. Totally, yeah. I mean I was there for a long time so there's probably a lot of stories but on the whole...yeah. It was pretty



bad...

**Diane:** So that's the male nurses. What about the male patients? Any specific incidents that come to mind?

**Siobhan:** Yeah. It didn't involve me but it scared the daylights out of me. There was one big guy [Maori guy] he was coming on to a lot of the female patients and three times he crawled into women's beds in the middle of the night with them and started fondling them and three times he wasn't prosecuted and three times he wasn't put into ICU. And we were told to handle it. That he was sick.

**Diane:** How did you get to hear about what he had done?

**Siobhan:** One of the women it happened to was a friend. A really good friend.

**Diane:** And did she complain to the staff?

**Siobhan:** Yeah.

**Diane:** And was told to handle it?

**Siobhan:** Was told that he was really sick and they'd move him. They'd move his room away from her. But he just did it to someone else so...you know, it got rid of her problem but...one of the major reasons why a lot of women I know have been in hospital with me feel unsafe is we used to get up in the middle of the night...can't sleep you know how it is. And, there's usually two nurses on and often they're asleep at the desk and when we complain about...well I know that I've talked to my nurses when I was up in the wing about not feeling comfortable with men around the wing, I was told that we were completely safe because there was two nurses on at night always looking after us. But they were asleep so how would they



know if anything happened?

**Diane:** So you have men sleeping in the room next door to you, and nurses asleep?

**Siobhan:** To me, that was just a set up for women to be abused.

**Diane:** From the nurses station...could the nurses see all the bedrooms

**Siobhan:** No. Not at all. They could probably see three bedrooms....I think that even if they just had half a wing for women I think the women would have felt safer.

Sue felt that for herself there were two inherent dangers of being in a mixed-sex ward.

**Sue:** One was the likelihood, or what I perceived as the likelihood of there being violence against myself and I felt fearful about that because there was a lot of raised voices etc. And...but the other thing was that at certain stages of my illness I was highly promiscuous and receptive to any sort of sexual advances and totally lacked any inhibitions, and then afterwards when I was starting to feel well again, it was a huge blow to me psychologically knowing what I'd done and who it was and the hows which unfortunately seemed to stay quite vivid, just I could never understand why. And then I would be incredibly embarrassed and so it was another trauma to have to deal with and that feeling that I had a total inability to control my sexuality and feeling sort of confused about that and not really...I don't think that it was ever discussed...like for me, being attracted to both males and females, I found that very confusing and didn't understand that and I was still relatively young I suppose. And never having that explained to me in any regard at all, it just compounded, it just made me feel that I was less in control of myself and I was going to be



basically a slave to these kind of urges and god knows what kind of a mess I would get myself into. And so feeling that the only way I could really do it would be to exclude myself completely from the community, was the only way that I actually had to keep myself away and I...for me, it meant I kept myself locked in my house for 18 years. That's what I did.

One of the ex-patient participants also worked in mental health with service consumers. In her (name withheld for confidentiality) work, the area she found most problematic in relation to mixed-sex psychiatric wards were those that housed the geriatric population:

...one of the issues that came up really quickly when I was on the ward was that the women felt really unsafe with the males. And they wouldn't actually say to staff 'I feel really unsafe with the males', they would talk...because I talked to people in a very...much more informal....you know 'hello how are you, this is what I do you know dah, dah, dah'. And I probably spent more time trying to cultivate relationships with clients to a degree....The difference sometimes with older people is that there is nowhere else for them to go...so you do get some people in for reasonable amounts of time and it came up really quick, and it was constant, was that the females did not want to be near the males. They found them loud, they found them intrusive, they found that they got more attention, they found it distressing when men would walk around in their pyjamas and they had all their private parts hanging around, you know these women had not seen even their husbands naked you know and they found the whole thing very distressing. And they quite often would just put themselves in their rooms to try and get away from them and the men would just walk in and out.

Whilst hearing how these women felt about mixed sex wards, she was not able to take it very much further:



...none of the older women would make a complaint or they'd say to me...because I said you know I'd take it through to the quality meetings and sort of say what could be done about this, but definitely didn't want to be named, didn't want to be seen as a troublemaker, you know felt they were being a bit silly dah de dah, you know, very much you know, we should be grateful that we're here anyway and the doctors have got so much on their plate you know. It's just very much a generational thing that you don't complain. So whilst they would allow me to take it in a very general way back to meetings and back to the unit manager etc, etc,...I was never able to get one of the women to actually make a complaint about the males. Even when they did go in their room etc, and the staff I might add were fairly diligent in that regard because they were aware of the distress but...limited staff, can't watch all the time so it was still occurring you know, men going into the rooms at night and hoping into bed with the women. And when you have got people who are dementing, I mean, they actually forget. You know, where they are. Like I'm saying a lot of the time there was actually no malice or anything but.....having some stranger hop into bed with you.

Three of the four women felt that if they had a choice they would be in an all woman ward. (One I forgot to ask). And two would have preferred that ward to be staffed wholly or mainly by women.

## **On being lesbian**

**Julie:** I think that things I've seen, that I've noticed are things like racism amongst the staff. That's a real big one. Dealing with fundamentalist Christian patients...who you know just make your life a misery basically. Like I mean there is no way you can come out to them.



**Diane:** I didn't at all when I was there.

**Julie:** No. Well I did right from day one with the staff and that was interesting...yeah and this...not being able to be away from men who were...not serious harassment but just being there all the time.

**Diane:** That underlying feeling?

**Julie:** Yeah.

**Diane:** Of fear actually. I found.

**Julie:** Yeah.

**Diane:** So did the patients, like any time you've been in there have the patients known that you're lesbian?

**Julie:** One time one of them did but that's because she was as well.

**Diane:** Right. Would it have felt unsafe for you for them to...

**Julie:** Yeah.

**Diane:** Especially the men, finding out?

**Julie:** Not so much the men because I didn't care so much about the men, what the men thought. And I could avoid the men most of the time. But I don't know what it would be like these days...the new way the wards have been redesigned...some of the women who get totally out of it and find god...can be really uncomfortable I would imagine and I've heard from other people who have been in the ward at different times that they've found it really difficult.

**Diane:** Right. But you didn't feel that if the men found out you'd be in physical danger or anything?



**Julie:** I guess I would have been but there was no way I would have told them...



## Chapter Six

### Women and Mental Health

In the conclusion to chapter two, I noted that the international and local literature showed that often women patients were not being believed when they complained of a sexual assault. Their claims were dismissed as being *part of their illness*. This emerged again with the staff and ex-patient transcripts making this a strong theme for me. In addition however, the transcripts showed how men often had their abusive behaviour excused because it was all part of *their illness*.

So what causes this gender bias, where female patients are not being believed while male patients are having their behaviour excused? In an attempt to answer this question I will, in this chapter first provide an overview of women's vulnerability to sexual abuse and rape in general, then, within mixed-sex psychiatric wards. Following this I will discuss, from a feminist perspective, how women are perceived to be in relation to their mental health. Within and amidst this, I will suggest some explanations as to why women are not being believed.

#### Some Facts about Sexual Assaults on Women

In their endeavour to develop a therapeutic environment, psychiatric hospitals have essentially created 'mini communities'. Claybury Hospital in the United Kingdom was attempting to create the therapeutic community as early as the 1950s and introduced their first mixed-sex wards in 1958 (Martin, 1962:79). But a 'mini community' is merely a smaller version of the original and most probably contains all the elements of the larger community, including violence. And in the larger community, men sexually and physically abuse women.



The real rate of abuse on women by men is hard to establish as many rapes and/or physical and/or sexual assaults go unreported. According to the Rape Crisis Centre however, most sources predict that a quarter of all women will experience rape or sexual abuse in their lifetime (Rape Crisis Centre, 1997:9). Rape and sexual abuse statistics compiled from 26 Rape Crisis Centres in Aotearoa New Zealand between 1992 and 1996 showed that:

- "Of the 25,331 telephone, face-to-face and mail contacts logged, 10,901 (43.0%) of the contacts were by or about rape and sexual abuse survivors.
- Statistics collected show that 96.0% of clients contacting Rape Crisis are female.
- Rape or sexual abuse was disclosed by more than three-quarters of the survivors (77.5%).
- More than half the survivors (53.0%) were raped or sexually abused when they were children, almost as many (42.3%) when adults, and more than one-third (34.8%) were raped or sexually abused during adolescence. Of these, almost one-quarter (24.2%) disclosed multiple incidences of rape or sexual abuse.
- Survivors own homes were the most commonly reported location of abuse (70.0%), then the offender's homes (29%).
- The vast majority of survivors (92.6%) knew the sexual offender(s) when the rape or sexual abuse began" (Rape Crisis Centre, 1997:9-10).

The New Zealand National Survey of Crime Victims (1996) also refers to the



fact that women are exposed to a greater risk of sexual violence than men and that women were more likely to be assaulted by those they knew well (Young *et al* 1997:32-33).

### **Mixed-sex wards: Increasing the risk?**

The research indicates that being female means that you have a higher chance of being sexually assaulted or raped. The research also shows that people with developmental, physical or psychiatric disabilities may be more vulnerable to sexual assaults (Mullins, J.B, 1986). For instance, a 1986 study by Hard cited in Nibert *et al* (1986:342) shows that out of 95 participants with developmental disabilities, 32% of the men and 83% of the women had been sexually abused. Further studies indicate that the incidence of sexual abuse for people with hearing impairments might be as high as 50%, and that as many as 100,000 people who have disabilities were raped in the United States in 1981, and even more were sexually assaulted in ways other than rape (*ibid*).

Being admitted to a mixed-sex psychiatric ward increases that likelihood even more (Nibert *et al*, 1986, Crossmaker, 1991). Nibert *et al* (1986) carried out a study on 58 (30 female and 28 male) psychiatric patients in the United States. This showed that whilst resident in a psychiatric facility 38% reported that they had been sexually assaulted and that of those, 55% said that this assault was carried out by other residents the most often and 27% named institutional staff as the person who assaulted them most often (*ibid*:345). Unfortunately, once again, these results were not broken down into female and male complainants.

Phyllis Chesler (1997) has also written on the incidence of institutional sexual abuse and notes, 'Over the years, there have been numerous newspaper accounts of the prostitution, rape, and impregnation of female mental patients by the professional and non-professional staff, and by male inmates' (*ibid*:77).



Maureen Crossmaker (1991:205) argues that the dynamics of institutions and of sexual abuse are similar, making the probability that institutional sexual abuse will occur a high one. The institution, acting as a self-sustaining microcosm of a hierarchical structure will mean that (according to organizational theory) client need will be superseded by institutional need.

'Sexual abuse can run rampant in such an isolated atmosphere. The people on the lowest rung of the institutional ladder - the residents - are reinforced for compliant behaviour, economically, physically and psychologically dependent, isolated and lacking in credibility; all factors increasing vulnerability to sexual abuse' (ibid).

Goffman (1961) also referred to the effects of institutionalisation. Earlier in this thesis I quoted Goffman and his reference to psychiatric hospitals as just one of what he referred to as 'total institutions', and how within these institutions people lost their sense of self. This loss he argued was brought about by the institutional culture itself, which was characterised by compliance to strictly adhered-to rules. Patients cease to be self-determining beings and instead become a 'patient'. The result he points out, is that one begins to feel powerless and ultimately damaged in terms of their self-esteem. Nibert *et al* (1986:343) argue that it is precisely these reasons, the effect of depersonalisation that makes sexual assaults on people with disabilities more likely to occur in a psychiatric hospital.

With all these indicators alerting us to the likelihood that women will be sexually assaulted and raped in a mixed-sex ward, it is hard to see why they have so frequently been disbelieved when they complained of such assaults. Crossmaker (1991) notes that staff frequently fail to believe reports of sexual abuse and adds that ignoring, disbelieving or minimising sexual abuse histories



is also common. She argues that both sexual abuse and mental illness have been medicalized pointing to the literature, which demonstrates a response to abuse with 'minimization, neglect, denial, victim blame, and psychiatric diagnosis or institutionalization' (ibid:206).

Crossmaker (1991) quotes Stark and Flitcraft (1988) who say 'traditional mental health views violence as symptomatic of [victims'] underlying psychiatric or behavioural problems' (Crossmaker,1991:206). Such an approach Crossmaker argues, pathologises the situation and ultimately 'can collude in further violence if professionals view victims as willing participants in, or responsible for, the sexual abuse' (ibid). Thus abuse and institutionalisation can reinforce each other.

'Abuse victims often have a sense of worthlessness, a belief that other's sense of reality is more valid than their own, feel little control over their body or environment and are disconnected from their feelings. As problems for institutionalised citizens as well, these can become even more insurmountable for the many residents with abuse histories and those who will experience sexual abuse in facilities' (ibid:208).

In addition to having their worthlessness and helplessness confirmed by being institutionalised, female patients who have a history of suffering abuse are exposed to the possibility of further abuse by virtue of the length of time spent as an inmate. An American study by Mills *et al* (1985) used medical records to examine the hospital experiences of 188 adult and adolescent patients (123 females and 65 males). The data showed that female residents who have physical and/or sexual abuse histories have longer admissions than those who have not been abused, and within this, sexually abused women have longer stays than physically abused women.

The risk is heightened even more for women patients with a history of abuse as they are more likely to have higher levels of sedation. An American study by



Bryer *et al* (1987) on 66 female patients of a private psychiatric hospital showed that 48 (72%) reported a history of abuse. Within this 14 (21%) reported sexual abuse only, 12 (18%) physical abuse only, and 22 (33%) reported both sexual and physical abuse. Their study showed that abused women patients differ from non-abused woman patients in that the former have more severe symptoms of psychiatric illness and are 'given pharmacological treatment more often' (ibid:1429).

It seems from the data gathered then that being a woman means you are vulnerable to sexual abuse and rape. It also appears that being in a mixed-sex psychiatric institution means you are even more vulnerable. Certainly the links between being female, being abused and being a patient is what this thesis is about. But it doesn't explain *why* women are often *disbelieved* when complaining of a sexual assault. I argue that the same gender dynamics operate within a mixed-sex psychiatric ward as occur in our wider patriarchal society. Perhaps they are even intensified in the ward setting. A feminist analysis of women and mental health may provide more insight.

## **A Feminist Perspective of Women and Mental Health**

Feminism is a complex idea which functions on a political, social, psychological and philosophical level, and which seek to be resolute on the existence and experiences of women (Jebali, 1995:138). Feminist theory argues that society is basically a male construct controlled by men for the advantage of men. Within this, women's experiences and realities are seen to be of less significance to men's, and the roles they are prescribed, are trivialised and devalued (ibid). Despite being persecuted, women for many years prior to the advent of psychiatry had functioned well as healers themselves.

'Women have always been healers. They were the unlicensed doctors and anatomists of western history. They were abortionists, nurses and counsellors.



They were pharmacists, cultivating healing herbs and exchanging the secrets of their uses. They were midwives, travelling from home to home and village to village. For centuries women were doctors without degrees, barred from books and lectures, learning from each other, and passing on experience from neighbour to neighbour and mother to daughter. They were called "wise women" by the people, witches or charlatans by the authorities. Medicine is part of our heritage as women, our history, our birthright.' (Ehrenreich & English, 1973:3).

As men took over, and institutionalised the medical profession, women were not only denied access to healing, but those who practiced it were deemed as sick. Women healers who had in the middle ages been burnt as witches, were now redefined as mentally ill and sent to languish for a lifetime with the rest of the insane (Callaghan & O'Carroll, 1993:28).

Feminist scholars have claimed that the Victorian era saw a change in the relationship between women and mental health (Ussher, 1992, Chesler, 1997, Showalter, 1985). It was at this time that madness came to be seen (and treated medically) as mental illness. It was also at this time that "madness became synonymous with womanhood" (Ussher, 1992:64).

'While the name of the symbolic female disorder may change from one historical period to the next, the gender asymmetry of the representational tradition remains constant. Thus madness, even when experienced by men is metaphorically and symbolically represented as feminine: a female malady'. (Showalter, 1985:4).

Showalter (1985) argues that as early as the seventeenth century women composed the majority of psychiatric cases (ibid:3). Others have argued that assertion (Wright and Owen, 2001), however the evidence shows clearly that women have predominated in statistics of the insane since the mid nineteenth century (Ussher, 1991:71). Certainly in the 1800s asylums in the United Kingdom modelled their building design on the assumption that there would always be more female than male patients (Showalter, 1985:55).



According to Showalter (1985), there are two main schools of thought, which seek to explain the statistical prevalence of women among the insane. Firstly, there is the argument that women have been 'socialised' into the role of being mentally unwell. That is, their social location and corresponding confining roles as daughters, wives and mothers (ibid:3). The dominant view she argues however, is one which contemporary feminists and scholars have espoused and which draws a underlying coalition between 'woman' and 'madness', showing how women are '...typically situated on the side of irrationality, silence, nature, and body, while men are situated on the side of reason, discourse, culture and mind' (ibid:4).

There was during the 19<sup>th</sup> century an emphasis on the biological and emotional differences between men and women. The implication was that women were not only different to men, but also inferior to them. To the Victorian physician, statistics confirmed their suspicions that women were more prone to insanity due to their physiology, or more specifically, their reproductive systems, which '...interfered with their sexual, emotional, and rational control' (ibid:55). Ussher (1992:71), agrees that it was the association between female sexuality and deviancy on which the association of madness with femininity was based. This was also the position of Foucault (1967) who wrote:

'[In the eighteenth century] the female body was analysed - qualified and disqualified - as being thoroughly saturated with sexuality; whereby it was integrated into the sphere of medical practices by reason of a pathology intrinsic to it'. (Foucault, quoted in Ussher, 1992:71).

Treatment for the female malady was often brutal. An English physician named Dr. Isaac Brown who became convinced that female madness was caused by masturbation, performed surgery in his private London clinic on his female



clients between 1859 and 1866. Symptoms of illness included, wanting to work outside the home, wanting to take advantage of the new Divorce Act and nymphomania. His surgical solution was to remove the women's clitoris, and as the years passed and he got more confident, their labia also. Brown, who was most pleased with his 100% cure of the nymphomaniac patients (Showalter, 1985:75-76), was eventually expelled from the Obstetric Society in 1867 mainly because of complaints by patients that they had been tricked into the operation, not because his methods were necessarily abhorred. (ibid:77).

Feminists have of course seen these operations as a means of controlling women but focus also on the more subtle form of social control intrinsic to the moral management of women occurring in the asylums of the 19<sup>th</sup> Century. '...It expressed the power of male psychiatrists over definitions of femininity and insanity. Instead of the surgeon's knife, moral management looked to the physical design and domestic routine of the asylums to regulate even the most deviant behaviours' (Showalter, 1985:78).

For instance, Ussher (1992) argues that often women who were strong, outspoken or suffering from 'hysteria', and who protested were given the 'rest cure' in which isolation and complete absence of mental activities were prescribed (ibid:75-76). British physician Silas Weir Mitchell who in 1874 was at the peak of his career promoted the rest cure, and at first glance, this treatment looks harmless enough. But Ussher (1992) draws a parallel between the rest cure and solitary confinement and sensory deprivation used on political prisoners today. 'Mitchell's guiding philosophy was that the hysteric should be broken, almost like a wild horse, which will eventually be cowed and tamed' (ibid:76).

The 'hysteria' to which Mitchell refers can be traced back to Ancient Greece where the word meant 'uterus', and where medical writings dating from 1900



B.C. referred to recommended treatments for hysterical disorders. Such disorders it was thought at the time were caused by the movement of the uterus throughout the body (Bernheim & Kahane, 1985:2). Women in the 19<sup>th</sup> century were being increasingly treated for this 'wandering womb', and it has been widely discussed in the feminist literature (Ussher, 1989; Showalter, 1987). Women's biological processes of menstruation, pregnancy and menopause were linked closely to their madness. 'The womb itself was deemed to wander throughout the body, acting as an enormous sponge which sucked the life-energy or intellect from vulnerable women' (Ussher, 1992:74). Women were almost fated to suffer from this malady given their constitution.

What was perceived as mental illness in women in the Victorian era was interesting. Symptoms included; wanting to work outside the home, wanting to leave your husband, speaking out, being sexual, being strong, and another not mentioned previously, was campaigning for the right to higher education (Busfield 1996). Indeed, anything that was seen to be 'unfeminine'. A predisposition for this insanity was having a womb.

Freud wrote at length on hysteria and women and in doing so related sexual assault and trauma with mental illness. In 1896 he delivered a paper to the Society for Psychiatry and Neurology in Vienna entitled 'The Aetiology of Hysteria' in which he linked hysteria to the patient's history of childhood sexual abuse. This belief was not well received by his peers who were not ready to accept the possibility of widespread sexual abuse of their children. He was urged never to publish this paper unless he wanted to ruin his reputation (Masson, 1985). Indeed, according to Juanita Williams (1987:48) he was, for a time, a pariah until he later changed his mind about sexual abuse being the cause of hysteria. Instead Freud argued that rather than being a reality of his women patients' experience, sexual abuse was simply a fantasy. Masson (1985), in his controversial book *The Assault on Truth: Freud's Suppression of*



*the Seduction Theory*, argues that this modified position did not threaten the social order and: 'Therapists could thus remain on the side of the successful and the powerful, rather than of the miserable victims of family violence' (ibid:xxix).

Feminists writing on contemporary issues of women and mental illness draw repeatedly from and refer to, the above material. These herstories have been important in demonstrating how patriarchal and sexist beliefs and practices have impacted on the perception of women and their mental health/illness. Jebali (1995) argues that psychiatry today exhibits many similarities to the 19<sup>th</sup> century expectations of women. Women are still expected to fulfil a particular social role, which is believed to stem from their biology. 'The primary role for women continues to be that of wife and mother' (ibid:138). But this job, Jebali argues, is not one which gets any returns leaving the worker feeling unimportant, a characteristic of all victims of oppression. Within this, the female role is often reinforced for women patients by offering therapies such as knitting, shopping and cooking (ibid). But one would not expect psychiatry to be anything but firmly entrenched in conventional patriarchal ideology. It too places limits on both men and women's behaviour and what is or is not acceptable.

In reviewing the literature on feminist conceptualisations of women's madness, United Kingdom authors Nicola Wright and Sara Owen (2001) assert that discrimination and gender stereotyping remains intrinsic to welfare policies and provisions (ibid:143). They also point out that although feminists agree that psychiatry serves to oppress women more than it does men, there is some disagreement in the literature (ibid:144). Showalter (1985) for instance has argued that through using misogynistic practices men have used the construction of madness as a (recent) means of controlling women, and that this was clearly demonstrated in the growth of asylums during the 19<sup>th</sup> century (Wright & Owen, 2001:144).



Wright & Owen cite Busfield (Wright & Owen, 2001) who argues that there is a danger of distorting the understanding of women's madness by focusing solely on one sex. She argues instead that some forms of madness were likened to men and masculinity and that it is gender relations that are important (Wright and Owen, 2001:146). In addition, she acknowledges that images of madness during the 19<sup>th</sup> century depicted women, but argues that '...male representations were equally powerful. Images such as the mad genius and the criminal lunatic portray men's madness as a 'malfunction' of masculine rather than feminine traits' (ibid). Yes perhaps these images are as powerful but they are not as prevalent. Constructions of madness and deviance have been distinctively 'gendered' with a specific female image of madness used diagnostically to make assumptions about women's bodies and about their 'proper' roles.

Phyllis Chesler (1997) has taken another approach. She has argued that men and women's behaviour has been regulated to conform to normal expectations through the use of labels of mental disorders. Intrinsic to this is the fact that the male role is more highly valued and, that women who are both *close to* and *'stray' from* their prescribed roles are likely to attract a diagnoses of mental illness (Wright & Owen, 2001:144).

'Women who fully act out the conditioned female role are clinically viewed as neurotic or psychotic. When and if they are hospitalised, it is for predominantly female behaviours such as depression, suicide attempts, anxiety neuroses, paranoia or promiscuity. Women who reject or are ambivalent about the female role frighten both themselves and society so much that their ostracism and self-destructiveness probably begin very early. Such women are assured of a psychiatric label and if they are hospitalised, it is for less female behaviours such as schizophrenia, lesbianism or promiscuity' (Chesler, 1972:56 cited in Wright & Owen 2001).

This view suggests that once a women is labelled as disturbed, she will be treated unfavourably compared to men. She is more likely to be given drugs, to be sexually abused by her therapist and to be hospitalised (ibid). Constructions of madness and deviance have been distinctively 'gendered' and a specific



feminine image of madness has arisen often employing prejudicial assumptions about women's bodies and about their 'proper' social roles.

Jenni Williams and Jill Watson (1996) argue that while it is sometimes social inequalities that bring many women to mental health services, they are met by institutional structural inequalities once there (ibid:242). Jenni Williams met with a group of users and ex-users of mental health services in England. These women named (among other things) incidents of sexual, physical and emotional abuse, which they felt had brought them to mental health services in the first place. They also spoke of sexual and physical abuse occurring once in the mental health services (ibid:243) where women often find themselves after being diagnosed as having severe mental illness, a major factor of which may have been sexual and/or physical abuse (ibid:245).

The social control of women through psychiatry has also been called the medicalization of unhappiness. It is argued that more often emotional and social problems are being interpreted and treated within a psychiatric framework (Wright & Owen, 2001:147). Feminists commonly refer to unipolar depression because it is, in Western societies, seen as a female rather than male disorder. According to the American Psychiatric Association (1994) and printed in the DSM IV, Major Depressive Disorder is '...twice as common in adolescent and adult females as in adolescent and adult males' (p.341). The feminist literature focusing on this issue generally tries to explain why women get depressed and three aspects have been identified repeatedly, helplessness, loss and trauma (Wright & Owen, 2001). Helplessness, loss and trauma are also the after-effects of sexual assault/rape and, as noted earlier in this section, abuse can be seen as symptomatic of a psychiatric problem.

How women are viewed in comparison to men is significant in psychiatric



diagnosis and treatment. Studies show that stereotyping between the sexes favours men. 'Indeed when a man and a woman exhibit exactly the same behaviours, the man's performance is usually rated more favourably than the woman's' (Callahan & O'Carrol, 1993:28).

Ironically, this influence by gender stereotyping occurs with both male and female clinicians. This was clearly demonstrated in the well-known study by Broverman *et al* (1970). In this study, a number of clinicians were divided into three groups. Using gender stereotypic statements about behaviour, the first group was asked to indicate which statements corresponded to a healthy adult male. The second group was asked to do the same for a healthy adult female. The third group repeated this process but for a healthy adult - sex unspecified. The study showed that not only was the clinician's concept of a healthy adult female vastly different from a healthy adult male, the healthy male was rated the same as the healthy adult - sex unspecified.

This study shows that clinicians view women's behaviour differently (less favourably) than men's. Expectations of patient behaviour differ with women needing to exhibit less 'adult' behaviour than men to be deemed 'normal'. Such expectations can become internalised and women may come to believe they are less valued, inferior and at times, powerless. These factors may work against women patients when they complain of sexual assault on the ward. Male patients on the other hand, being deemed more 'adult', are more likely to have their explanations accepted and/or their behaviour excused.

Relegating allegations to the realms of 'it's all part of *her* illness' and defences to 'it's all part of *his* illness' may very well be loaded with unconscious stereotypical assumptions on who is providing the more valid (adult) explanation.



## Conclusion

I have argued in this chapter that the same gender dynamics that exist in the wider western society operate within the community of a mixed-sex ward. I also suggest that such dynamics may be magnified given the wide mixture of peoples within a relatively confined physical space. For women patients, this has meant that whilst seeking asylum in a psychiatric ward, they have at times been physically and sexually abused by male patients and staff.

I discussed how some have argued that women psychiatric patients have been treated in a different, less favourable way than men in the mental health system since at least the Victorian era. Treatment often focused on ensuring that the women's behaviour conformed to the 'female role'. Indeed, identification of mental illness was partly based on deviance from this role, and genital mutilation was sometimes used as a cure of mental illness in women.

Mental health and sexual 'difference' has played a part in the treatment of male and female psychiatric patients. And it is perhaps this 'different' treatment that sees some women patients not being believed when they complain of sexual assault, while male patients who carry out these assaults, are at times excused.

But this issue is not the only one to evolve from this study. The (concluding) chapter outlines a number of main points that I find significant. I conclude with a recommendation and suggest possible further studies.



## Chapter Seven

### Concluding Discussion

#### **Normalisation and the creation of an abnormal environment.**

My original motivation for writing this thesis was to investigate whether sexually integrated acute psychiatric wards are the safest environments to facilitate the healing process for female patients.

I began by discussing how the change from single-sex wards to sexually integrated wards was driven by the well intentioned desire to normalise the living environment for all psychiatric patients.

In this final chapter I argue that not only are sexually-integrated psychiatric wards often unsafe for female patients, but that it is precisely the promotion of a so called 'normal' living environment that creates this level of unsafety, and thus, once attained, the situation becomes 'abnormal'.

The process of normalisation aims to recreate the circumstances of life outside the psychiatric ward as much as possible. This begins by bringing male and female patients together in the one living environment. Sometimes sleeping quarters and bathroom facilities are separate, sometimes they are not. Structurally, the level of integration varies from ward to ward. Essentially however, men and women who are usually strangers, live together, eat together and share most, if not all of their waking moments together. They see each other at their best, their worst, and often in various states of undress including bathrobes and nightwear.



Already, this situation is not 'normal' for most people, but the experience of abnormality that 'normalisation' offers differs depending on whether you are male or female. I noted earlier that studies have suggested that male patients respond positively to being in a mixed-sex environment. Some say that male patients in this setting require less medication to keep themselves well, others that the men are less physically and verbally violent. Certainly I have not come across any evidence which found that male patients in a mixed-sex psychiatric ward suffer any negative consequences from having women patients living with them.

I believe the situation is quite different for some women patients however and that the reality of living in close proximity to an increased number of unwell male strangers offers no obvious benefits for women in their quest for asylum. Indeed, such a situation presents women with an increased risk of being harmed and thus creates an environment which is non-therapeutic.

This increased risk is noticeable when compared to women's experiences outside the confinement of the sexually integrated psychiatric ward. On the 'outside', women are, to an extent, able to avoid certain situations which may be unsafe for them.

Essentially, sharing one's living environment with members of the opposite sex who are strangers is hardly 'normal'. Neither is the state of being unwell. By bringing men and women together when they are acutely unwell, the institution *itself* may have become 'normalised', but the patient experience, at least for women, has not.

Perhaps the best way to demonstrate this is to use a quote (cited on page 47 above) from a female patient who, when complaining of having her privacy invaded by male patients said: 'No matter how mad I get, or how psychotic I am, I never ever wander into the men's toilets. No matter how disorientated, no matter what is going on for me, I never mistake the men's toilets for the



women's'.

If there is a genuine confusion amongst mentally ill men in regards to the difference between men's and women's sleeping quarters, toilets and bathrooms, then surely they must be housed separately. If this confusion is *not* genuine, then there is even more reason for separation.

The following points are based on the findings of this study and are significant to the conclusion of this thesis:

- To assume that what equates to a therapeutic in-patient treatment service for men is also therapeutic for women demonstrates an underlying gendered and sexist ideology within the process of mental health policy development.
- The physical and sexual safety of disturbed women needs to be of paramount concern whilst they are either forcibly or voluntarily admitted to an acute psychiatric ward.
- Placing women in an environment where they are vulnerable to sexual attacks can at the least be seen as risky, and at the most be seen as unethical.
- These ethics are particularly strained when patients that staff know are sex offenders are placed with patients who are victims of sexual abuse.
- Patients are in an acute psychiatric setting for such a short period of time that being separate from members of the opposite sex would seem unlikely to cause any psychological harm.
- The argument that 'consensual' sexual relationships should be allowed between patients, or between patients and ex-patients while in acute care is problematic given the vulnerability of the mentally unwell and the fact that sexual desire can be a symptom of illness.



A realistic view must be taken when considering the best possible health care for vulnerable mentally unwell people. It is predominantly men who sexually abuse women not the other way around. This is a 'statistically predictable' trend. It happens all over the world, from society to society. That it should occur in sexually-integrated psychiatric wards is perhaps no great surprise. Shouldn't we do all that is in our power to prevent this abuse happening to our acutely unwell female patients? Shouldn't we be creating the most therapeutic environment possible?

### ***Recommendation***

Economic expediency has not been examined in this study. However, informal comments made to me during the research period of this thesis leads me to believe that the increased cost of financing single-sex wards *may* be used as an argument for keeping mixed-sex wards.

In addition, participants in this research have expressed that services and facilities needs to be planned and developed with both the individual *and* collective needs of women in mind. Therefore, this recommendation is for a service that combines the options of both the single-sex and mixed-sex wards.

In such a setting, facilities will be designed with separate living/sleeping/eating spaces for women and men. A communal area could be located in between the men's and women's areas. This area would be observable from the nurses station and could be used by men and women who wished to socialise with each other. This way, women would have a choice as to whether or not they spend time with male patients, and if they choose to do so, such time would be observed by staff and therefore 'safe'.



### ***Further research***

There are a number of questions that remain unanswered and further research needs to be carried out on the topic of the safety of female patients in sexually-integrated psychiatric wards. Future areas of research could include:

- A larger study than this one to ascertain the extent of the problem for female ex-psychiatric patients in Aotearoa New Zealand. It would also include:
- A study of ward preference conducted *after* the women have left hospital.

This larger study could examine various mixed-sex psychiatric wards and ascertain:

- Policies and procedures regarding the review of allegations of sexual assault.
- Steps in place to follow through sexual assault charges on women who are seen as too unwell to be able to testify.
- Ways of identifying and safely managing those patients who have a history of either sexual abuse or sexual offending.
- The policies and procedures in place to protect vulnerable patients in wards where staff believe that patients, as adults, are able to engage in sexual acts if they choose.



Appendix A  
**MIXED-SEX WARDS STUDY**  
**MENTAL HEALTH SERVICE USER INTERVIEW SCHEDULE**

**SECTION A**

What name would you like to use for this study? \_\_\_\_\_

**1. How old are you?**

- |          |                          |               |                          |
|----------|--------------------------|---------------|--------------------------|
| 18-19yrs | <input type="checkbox"/> | 45-49yrs      | <input type="checkbox"/> |
| 20-24yrs | <input type="checkbox"/> | 50-54yrs      | <input type="checkbox"/> |
| 25-29yrs | <input type="checkbox"/> | 55-59yrs      | <input type="checkbox"/> |
| 30-34yrs | <input type="checkbox"/> | 60-64yrs      | <input type="checkbox"/> |
| 35-39yrs | <input type="checkbox"/> | 65-69yrs      | <input type="checkbox"/> |
| 40-44yrs | <input type="checkbox"/> | 70 y or older | <input type="checkbox"/> |

**2. What ethnic group do you identify as?**

- |          |                          |         |                          |
|----------|--------------------------|---------|--------------------------|
| Pakeha   | <input type="checkbox"/> | Niuean  | <input type="checkbox"/> |
| European | <input type="checkbox"/> | Cook Is | <input type="checkbox"/> |
| Maori    | <input type="checkbox"/> | Tongan  | <input type="checkbox"/> |
| Samoan   | <input type="checkbox"/> | Other   | <input type="checkbox"/> |

**3. Do you identify as:**

- |              |                          |           |                          |
|--------------|--------------------------|-----------|--------------------------|
| Heterosexual | <input type="checkbox"/> | Bi-sexual | <input type="checkbox"/> |
| Lesbian      | <input type="checkbox"/> | Gay male  | <input type="checkbox"/> |
| Other        | <input type="checkbox"/> |           |                          |

**4. When was your *first* admission to a psychiatric ward?**

- |                                |                          |
|--------------------------------|--------------------------|
| a) More than thirty years ago  | <input type="checkbox"/> |
| b) Between 25 and 30 years ago | <input type="checkbox"/> |
| c) Between 20 and 25 years ago | <input type="checkbox"/> |
| d) Between 15 and 20 years ago | <input type="checkbox"/> |
| e) Between 10 and 15 years ago | <input type="checkbox"/> |
| f) Between 5 and 10 years ago  | <input type="checkbox"/> |
| g) Less than 5 years ago       | <input type="checkbox"/> |



5. What hospital was that? \_\_\_\_\_

6. What country was that hospital in? \_\_\_\_\_

7. Was the ward Single-sex ☐

Mixed-sex ☐

8. When was your *last* admission to a psychiatric ward?

a) More than thirty years ago ☐

b) Between 25 and 30 years ago ☐

c) Between 20 and 25 years ago ☐

d) Between 15 and 20 years ago ☐

e) Between 10 and 15 years ago ☐

f) Between 5 and 10 years ago ☐

g) Less than five years ago ☐

9. What hospital was that? \_\_\_\_\_

10. What country was that? \_\_\_\_\_

11. Was the ward Single-sex ☐

Mixed-sex ☐

---

**SECTION B1 (for those who have been in a mixed-sex ward only)**

1. Before you were admitted to hospital for your first admission, were you informed that the ward you were going into was mixed-sex?

2. Did you have any particular feelings about this?

3. In relation to privacy, how did you find the ward design.

4. Were there any incidents during this first or subsequent stays when you felt uncomfortable or unsafe being in a mixed-sex ward? (If no, go to q8).

5. Did you report this incident/feeling or incidents/feelings to staff?

6. What was the response?



7. Was this response to your satisfaction?

8. Would you like to tell me in your own words some of your experiences in wards that contain both men and women?

## **SECTION B2**

**(For those who have experienced both single and mixed-sex wards)**

1. Having experienced both single and mixed-sex wards, which do you prefer?

2. Why?

3. Tell me about the differences that you experienced between the two environments (mixed-sex vs single-sex).

4. In relation to privacy, how did you find the ward design in mixed-sex wards.

5. Were there any incidents during any of your stays in a mixed-sex ward when you felt uncomfortable or unsafe?

6. Did you report this incident/feeling or incidents/feelings to staff?

7. What was the response?

8. Was this response to your satisfaction?

9. Would you like to tell me in your own words some of your experiences in wards that contain both men and women?

---



Appendix B  
MIXED-SEX WARDS STUDY  
MENTAL HEALTH SERVICE WORKER INTERVIEW SCHEDULE

**1. How old are you?**

- |          |                          |               |                          |
|----------|--------------------------|---------------|--------------------------|
| 18-19yrs | <input type="checkbox"/> | 45-49yrs      | <input type="checkbox"/> |
| 20-24yrs | <input type="checkbox"/> | 50-54yrs      | <input type="checkbox"/> |
| 25-29yrs | <input type="checkbox"/> | 55-59yrs      | <input type="checkbox"/> |
| 30-34yrs | <input type="checkbox"/> | 60-64yrs      | <input type="checkbox"/> |
| 35-39yrs | <input type="checkbox"/> | 65-69yrs      | <input type="checkbox"/> |
| 40-44yrs | <input type="checkbox"/> | 70 y or older | <input type="checkbox"/> |

**2. What ethnic group do you identify as?**

- |          |                          |         |                          |
|----------|--------------------------|---------|--------------------------|
| Pakeha   | <input type="checkbox"/> | Niuean  | <input type="checkbox"/> |
| European | <input type="checkbox"/> | Cook Is | <input type="checkbox"/> |
| Maori    | <input type="checkbox"/> | Tongan  | <input type="checkbox"/> |
| Samoan   | <input type="checkbox"/> | Other   | <input type="checkbox"/> |

**3. Are you:**

- Male ☐
- Female ☐

**4. Do you identify as:**

- |              |                          |           |                          |
|--------------|--------------------------|-----------|--------------------------|
| Heterosexual | <input type="checkbox"/> | Bi-sexual | <input type="checkbox"/> |
| Lesbian      | <input type="checkbox"/> | Gay male  | <input type="checkbox"/> |
| Other        | <input type="checkbox"/> |           |                          |

**5. In Aotearoa New Zealand, have you worked in:**

- Mixed-sex wards only ☐
- Both single and mixed-sex wards ☐

**6. Which hospital/s** \_\_\_\_\_

\_\_\_\_\_



**SECTION B1**

**(for those who have worked in both mixed-sex and single-sex wards)**

1. Were you working in mental health when psychiatric wards were changing from single-sex to mixed-sex wards? (if no, go to q3).
  2. If yes, what was your position?
  3. What was your initial reaction to the change from single-sex to mixed-sex wards? For instance, did you see the integration of male and female patients to be a factor in the creation of a therapeutic environment?
  4. Has your opinion changed since then?
  5. Why? What do you consider a therapeutic environment to contain?
  6. What difficulties, if any, have you encountered with mixed sex wards?
  7. How were these difficulties dealt with?
  8. Was this to your satisfaction?
  9. What are the main aspects of single or mixed-sex wards that you see as being significant?
-



**SECTION B2**

**(for those who have worked in mixed-sex wards only)**

1. What position do you, or did you hold in Mental Health Services?
  2. Was there anything about mixed-sex wards that stood out for you initially?
  3. Did you see the integration of male and female patients to be a factor in the creation of a therapeutic environment?
  4. Has your opinion changed since then?
  5. Why?
  6. What difficulties, if any, have you encountered with mixed-sex wards?
  7. How were these difficulties dealt with?
  8. Was this to your satisfaction?
  9. What are the main aspects of single or mixed-sex wards that you see as being significant?
-



Appendix C  
(Massey University Letterhead)  
**MIXED-SEX WARDS STUDY**  
**MENTAL HEALTH WORKER INFORMATION SHEET**

My name is Diane Hewitt. I am a Post Graduate student researching Social Policy at Massey University Albany campus. I have also worked in the field of Mental Health for approximately five years before becoming hospitalised in a psychiatric ward myself in 1999. This experience has influenced my desire to conduct the following study.

I am examining the ways in which psychiatric wards moved from being single-sex to mixed-sex and the impact that this has had on female service users (patients). I am asking women who have been patients in both single and mixed-sex wards, and people who have worked, or are currently working in Mental Health Services to help me with this study. It is hoped that this will give me a better picture about how mixed-sex wards are working for women patients, and, whether there are things that need to be done differently.

Within this, I am interested in ensuring that the experiences of both heterosexual and lesbian women are included in this study.

As someone who works/has worked in Mental Health Services, you may be interested in participating in this research.

If you agree to take part, we could meet at a time and place that suits you. The interview will last for about one to one and a half hours. Your information will provide me with a unique perspective of how mixed-sex wards in psychiatric hospitals are/not working.

The results of this study will be used for a Master of Arts thesis and possibly as a tool for influencing policy. If you wish, I will provide you with the important findings once I have finished. No one will be able to identify you from the information you have given me.

If you decide to take part and then change your mind, you are free to withdraw from the study within two calendar months of the interview without having to give a reason. If you still want to be part of the study, but wish to refuse to answer any particular question or would like to have some of the information taken out, you are also able to do that.

If there is anything else you need to know in order to help you make up your mind please contact me at home by phoning 0800..... My supervisors, Cindy Kiro (09) 4439666 and Carole Adamson (09)4439771 are available at the School of Social Policy and Social Work, Massey University Albany Campus if you have any complaints or concerns.

In the unlikely event that you suffer injury as a result of your participation in this study, you will not be eligible for cover by the Accident Rehabilitation and Compensation Insurance Corporation.

Diane Hewitt



Appendix D  
(Massey University Letterhead)  
**MIXED-SEX WARDS STUDY**  
**MENTAL HEALTH SERVICE CONSUMER INFORMATION SHEET**  
**AUCKLAND REGION**

My name is Diane Hewitt. I am a Post Graduate student researching Social Policy at Massey University Albany campus. I have also been hospitalised in a psychiatric ward myself and this experience has influenced my desire to conduct the following study.

I am examining the ways in which psychiatric wards moved from being single-sex (segregated) to mixed-sex (de-segregated) and the impact that this has had on female service users (patients). I am asking women who have been patients in both single and mixed-sex wards, and people who have worked, or are currently working in Mental Health Services to help me with this study. It is hoped that this will give me a better picture about how mixed-sex wards are working for women patients, and, whether there are things that need to be done differently.

Within this, I am interested in ensuring that the experiences of both heterosexual and lesbian women are included in this study.

If you agree to take part, we would have a talk in your own home or wherever it suited you. If you would like to have a friend, family member, or your key worker (if you have one) present, this can easily be arranged. The interview might last for about one to one and a half hours. Your information will give a better idea of how mixed-sex wards in psychiatric hospitals are working for you and other women.

The results will be used for a Master of Arts thesis and possibly as a tool for influencing mental health policy. If you wish, I will provide you with the important findings once I have finished. No one will be able to identify you from the information you have given me.

If you decide to take part and then change your mind, you are free to withdraw from the study within two calendar months following our interview without having to give a reason. If you still want to be part of the study, but wish to refuse to answer particular questions or would like to have some of the information taken out, you are also able to do that.

If there is anything else you need to know in order to help you make up your mind please contact me by phoning 0800..... by..... My supervisors, Cindy Kiro (09) 4439666 and Carole Adamson (09) 4439771 are available at the School of Social Work and Social Policy, Massey University, Albany Campus if you have any complaints or concerns.

In the unlikely event that you suffer injury as a result of your participation in this study, you will not be eligible for cover by the Accident Rehabilitation and Compensation Insurance Corporation.

If you have any queries or concerns regarding your rights as a participant in this research you may contact the Health Advocates Trust, phone 0800 205 555. Thank you for taking time out to consider my request.

Diane Hewitt



Appendix E  
(Massey University Letterhead)  
**MIXED-SEX WARDS STUDY**  
**MENTAL HEALTH SERVICE CONSUMER INFORMATION SHEET**  
**WELLINGTON REGION**

My name is Diane Hewitt. I am a Post Graduate student researching Social Policy at Massey University Albany campus. I have also been hospitalised in a psychiatric ward myself and this experience has influenced my desire to conduct the following study.

I am examining the ways in which psychiatric wards moved from being single-sex (segregated) to mixed-sex (de-segregated) and the impact that this has had on female service users (patients). I am asking women who have been patients in both single and mixed-sex wards, and people who have worked, or are currently working in Mental Health Services to help me with this study. It is hoped that this will give me a better picture about how mixed-sex wards are working for women patients, and, whether there are things that need to be done differently.

Within this, I am interested in ensuring that the experiences of both heterosexual and lesbian women are included in this study.

If you agree to take part, we would have a talk in your own home or wherever it suited you. If you would like to have a friend, family member, or your key worker (if you have one) present, this can easily be arranged. The interview might last for about one to one and a half hours. Your information will give a better idea of how mixed-sex wards in psychiatric hospitals are working for you and other women.

The results will be used for a Master of Arts thesis and possibly as a tool for influencing mental health policy. If you wish, I will provide you with the important findings once I have finished. No one will be able to identify you from the information you have given me.

If you decide to take part and then change your mind, you are free to withdraw from the study within two calendar months following our interview without having to give a reason. If you still want to be part of the study, but wish to refuse to answer particular questions or would like to have some of the information taken out, you are also able to do that.

If there is anything else you need to know in order to help you make up your mind please contact me by phoning 0800..... by \_\_\_\_\_. My supervisors, Cindy Kiro (09) 4439666 and Carole Adamson (09) 4439771 are available at the School of Social Work and Social Policy, Massey University, Albany Campus if you have any complaints or concerns.

In the unlikely event that you suffer injury as a result of your participation in this study, you will not be eligible for cover by the Accident Rehabilitation and Compensation Insurance Corporation.

If you have any queries or concerns regarding your rights as a participant in this research you may contact the Advocacy Network Services Trust, phone 0800 423 638. Thank you for taking time out to consider my request.

Diane Hewitt



Appendix F  
**MIXED-SEX WARDS STUDY**  
**Confirmation of Meeting**

Dear \_\_\_\_\_,

Thank you for your response of interest to take part in my study on mixed-sex psychiatric wards.

As per our discussion on \_\_\_\_\_, I would like to confirm that our meeting will be at \_\_\_\_\_, on \_\_\_\_\_ at \_\_\_\_\_.

Please find enclosed an information sheet that provides an outline of the study.

If after reading this information sheet you still wish to participate, you have the right to change your mind and withdraw from this study two calendar months following our meeting. In your case this will be by \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

Should you indicate that you would like to receive a transcript of our meeting, I will ensure that this is received by you for approval or amendment before your withdrawal from study date.

Should you wish to contact me again before our meeting, please refer to the contact number on the information sheet.

Once again, thank you for agreeing to participate in this study. I look forward to meeting with you.

Diane Hewitt



**Appendix G**  
**(Massey University Letterhead)**  
**MIXED-SEX WARDS STUDY**  
**CONSENT FORM**

English:	I wish to have an interpreter	Yes	No
Maori:	E hiahia ana ahau ki tetahi tangata hei korero Maori ki ahau	Ae	Kao
Samoan:	Oute mana'o e iai se fa'amatala upu	Io	Leai
Tongan:	'Oku fiema'u ha fakatonnnulea	Io	Ikai
Cook Is:	Ka inangaro au I tetai tangata uri reo	Ae	Kare
Niuean:	Fia manako au ke fakaaoga e tagata fakahokohoko vagahau	E	Nakai

I have read the Information Sheet and have understood what is being asked of me. I have had an opportunity to ask questions and have them answered to my satisfaction. I understand that I may ask further questions at any time.

I agree to participate and I understand I have the right to withdraw from the study in the two months following the interview, and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that I will not be able to be identified.

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audiotape to be turned off at any time during the interview.

I wish to see a copy of what I have said at my interview.                      yes ☐                      No ☐

I understand that if any person other than the researcher transcribes my tape, they will have signed a confidentiality agreement.

I have adequate support systems in place and will access them if needed.

I have given my consent freely and with understanding.

**Signed:**.....

**Name:**.....

**Support person (if applicable)** .....

**Witness:** .....

**Date:**.....



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