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ABSTRACT

This study explores the psychiatric inpatient experiences of lesbian and gay service users in relation to their intimate relationship needs, and how these experiences affected their mental health recovery. Semi-structured interviews were conducted with three gay men and three lesbians who had been resident on public sector psychiatric wards in the United Kingdom. The data were analyzed using Interpretative Phenomenological Analysis (IPA). Five master themes emerged: the conceptualization of intimacy; the relationship between intimate relationships and recovery; experiences of the ward; experiences of prejudice and discrimination in services; and a loss of power and personal identity as a service user.

Keywords: lesbian, gay, mental health, recovery, severe mental illness, intimate relationships, sexuality, inpatient, psychiatric services, recovery, National Health Service (NHS), United Kingdom

INTRODUCTION

Researchers (Laurenceau, Rivera, Schaffer, & Pietromonaco, 2004; Reis & Patrick, 1996) and laypeople (Marston, Hecht, Manke, McDaniel, & Reeder, 1998; Monsour, 1992; Parks & Floyd, 1996) agree that partners in intimate relationships differ from those in more casual associations in six ways: they have “extensive personal, often confidential, *knowledge* about one another” (Miller, Perlman, & Brehm, 2007, p.4); *care* about each other (*op. cit.*); have *interdependent* lives (Berscheid, Snyder, & Omoto, 2004); exhibit a high degree of *mutuality*, recognizing the overlap between their lives and thinking of themselves as “us” rather than “me and him/her” (Fitzsimmons & Kay, 2004); *trust* one another (Holmes, 1991); and are *committed* to one another (Miller et al., 2007).

Such conceptualizations of intimate relationships may be problematic; for example, authors have suggested that not all of the above components are required for intimacy to occur and that each may exist when the others are absent (Goodwin & Cramer, 2002; Haslam & Fiske, 1999). In addition, no reference is given to the time needed to develop intimacy, with whom one might become intimate, or the roles of sex, romance or love. Definitions of intimate relationships have also historically been developed using heterosexual or presumed heterosexual populations where monogamy was assumed, and therefore may not apply to other intimate relationship experiences in other populations.

In the present study, the researchers adopted a broad and open conceptualization of intimacy and invited lesbian, gay and bisexual (LGB) people to discuss their experiences of intimate relationships.

The intimate relationships of LGB people

Intimate relationship experiences may be more similar than different across heterosexual and LGB groups (Kurdek, 2005); for example, levels of relationship satisfaction and quality reported by gay men and lesbians are at least equal to that reported by spouses from married heterosexual couples (Kurdek, 2001, 2004), and for each type of couple, self-reported relationship quality is relatively high at the start of the relationship but decreases over time (Kurdek, 1998). Nonetheless, same-sex intimate relationship experiences may also differ from their heterosexual counterparts: for example, in relation to the assignment of household labor (Patterson, 2000); conflict resolution (Gottman et al., 2003; Kurdek, 2004); and support from family members and friends (Kurdek, 2004). Klinkenberg and Rose (1994) also found that gay male dating “scripts” were more sexually oriented and less intimacy-focused than those of lesbians; this may account for findings that gay men are more likely to be in couples that allow extra-dyadic sex than are lesbian couples (Bryant & Demian, 1994).

Same-sex partners may also face challenges not experienced in heterosexual intimate relationships. In the United Kingdom, the *Civil Partnership Act* (CPA) (HMSO, 2004) gives same-sex couples identical rights and responsibilities to civil marriage, and *The Marriage (Same Sex Couples) Act* (HMSO, 2013) has legalized marriage between same-sex partners. Nevertheless, same-sex partners have not had equal access to the normative union formation and commitment models of heterosexual relationships (Reczek, Elliott & Umberson, 2009), and must forge and maintain their relationships in social climates that often marginalize and devalue same-sex intimate relationships (Mohr & Fassinger, 2006). Thus, the intimate relationship experiences of LGB groups should not be assumed to mirror those of heterosexual populations, and should be explored in their own right.

Intimate relationships and psychiatric inpatients

In the United Kingdom, National Health Service (NHS) (public sector) inpatient services are part of a planned and integrated whole-system approach to acute mental health care and are delivered in conjunction with NHS community services. The purpose of inpatient services is, “to provide a high standard of humane treatment and care in a safe and therapeutic setting for service users in the most acute and vulnerable stage of their illness” (Department of Health, 2002a, p.5).

Studies indicate that inpatient sexual activity is common (Civic, Walsh, & McBride, 1993; Cournos et al., 1994; Warner et al., 2004). However, the intimate relationship experiences of inpatients are largely unknown (McCann, 2003); research remains confined to quantitative investigations regarding ‘risky’ sexual behaviors and rates of sexual activity, and does not include the perspectives of service users themselves. The risk-avoidance stance of this literature may perpetuate ideas that service users are asexual (Vandereycken, 1993) or that their sexuality is inappropriate or even dangerous (Weinhardt, Carey, & Carey, 1998).

There may be challenges for inpatients and staff alike in negotiating intimate relationship needs within residential mental health settings. For service users, conjugal rights may be denied, questions may be raised over capacity to consent to sexual activity, activity off the ward may be restricted, and issues of privacy may be raised (Fairbank, 2011). There may also be barriers to discussing intimate relationship needs with staff that include professionals’ attitudes towards sexuality and opinions about professional roles (Kautz, Dickey & Stevens, 1990), as well as staff members’ lack of time, fear of causing distress to the client, and fear of encouraging promiscuity (Cort, Attenborough, & Watson, 2001; Shield, Fairbrother, & Obmann, 2005). Mental health professionals may also struggle to balance the rights of clients

and concerns regarding their capacity to consent to sexual activity, unsafe sexual practices, and the trading of sex for money and drugs (Buckley & Hyde, 1997).

Both service users and researchers have argued the need for clear and comprehensive policies regarding sex and romance in psychiatric hospitals (Deegan, 1999; Buckley, Hogan, Svendsen, & Gintoli, 1999). However, there is currently no clear national guidance on sexual behavior for people who are subject to conditions under the Mental Health Act (MHA) (HMSO, 2007). In the absence of any clear written policy, there may be a greater likelihood of arbitrary responses by ward staff (Bowers, Ross, Cutting, & Stewart, 2014; Davison, 1999), which could lead to discriminatory practice. The intimate relationship needs of LGB service users may therefore be at greater risk of being neglected or ignored in inpatient services than those of presumed heterosexual service users.

Intimate relationships and LGB psychiatric inpatients

People of sexual minority identity report elevated levels of mental health difficulties and service usage compared with the heterosexual population (Chakraborty, McManus, Brugha, Bebbington & King, 2011; Fergusson, Horwood, Ridder & Beautrais, 2005; King et al., 2008). The minority stress model asserts that this is a result of LGB-related stigma (Meyers, 2003); for example, social prejudice, isolation and marginalization, stigma, experiences or fear or discrimination and rejection, homophobic bullying and internalized negative feelings (Carr, 2010).

A legacy of homophobia within psychiatry may make it especially hard for LGB people and their partners to access mental health services, and to discuss their intimate relationship

needs with staff. 'Homosexuality' was classified as a psychiatric disorder by the APA until 1973, and treatments to help 'homosexuals' achieve heterosexuality were administered up until the early 1970s (King & Bartlett, 1999), causing lasting emotional distress to patients (Smith, Bartlett, & King, 2004).

Initiatives have emerged to improve health services for sexual minority populations; for example, *Capabilities for inclusive practice* (National Social Inclusion Programme, 2007), *Reducing health inequalities for lesbian, gay, bisexual and trans people* (Department of Health, 2007), and *Sexual Orientation: A practical guide for the NHS* (Department of Health, 2009). The British Psychological Society (BPS) (2012) has also published guidance for psychologists working with sexual minority clients, and therapeutic approaches have been developed which seek to affirm LGB identities as equally positive human experiences and expressions to heterosexual identity (Davies & Neal, 1996).

Nevertheless, the needs of LGB service users continue to be neglected within mental health settings (Hellman, Sudderth, & Avery, 2002; Kidd, Veltman, Gately, Chan, & Cohen, 2011), and many LGB people experience mental health facilities as homophobic and heterosexist (Lucksted, 2004). King and McKeown (2003) found that up to 36% of gay men, 26% of bisexual men, 42% of lesbians and 61% of bisexual women experienced negative or mixed reactions from mental health professionals when disclosing their sexual orientation. Similarly, the Department of Health (2007) found that gay men, bisexual men and lesbians experienced negative or mixed reactions from mental health professionals when they disclosed their sexual orientation, and that mental health professionals made causal links between their sexual orientation and their mental health problem. Bartlett, Smith and King (2009) explored the views of mental health professionals on the use of therapy to change same-sex desires.

17 per cent (222 respondents) reported that they had attempted to help LGB clients reduce or change their same-sex feelings if they were distressed or confused by these; and of those 222, 79 per cent (159 respondents) believed that counselling services should be available for clients who want to change their sexual orientation.

To the researchers' knowledge, only one study has explored the inpatient experiences of LGB people within psychiatric residential facilities in the United Kingdom; McFarlane (1998) interviewed 35 LGB people who reported having experienced: fears about safety, being pathologized, negatively judged or stigmatized; worries about confidentiality; and lack of acknowledgement of sexual identities other than heterosexual whilst on inpatient wards. The diagnosis, treatment and care of LGB people were found to be variable and dependent on the prejudices of individual workers.

The present study sought to explore the intimate relationship experiences of LGB people whilst resident on psychiatric inpatient units.

The intimate relationships of LGB service users and recovery

Recovery is a complex, individual and self-defined process concerned with regaining hope and independence after an experience of mental health difficulties (Turner-Crowson & Wallcraft, 2002). Anthony (1993, p. 15) describes it as, "a deeply personal, unique process of changing one's attitudes, values, feelings, goals and/or roles." A number of recovery models have been developed (e.g. the 'Tidal Model', Barker & Buchanan-Barker, 2005; the 'Wellness Recovery Action Plan (WRAP)', Copeland, 1997; the 'Mental Health Recovery Star', Mental Health Providers Forum, 2008), and government policies have supported the implementation and

development of recovery-focused mental health initiatives in Britain (e.g. *The journey to recovery* (Department of Health, 2001) and *Making recovery a reality* (Shepherd, Boardman, & Slade, 2008)).

Although personal accounts (e.g. Deegan, 1988; Leete, 1989), empirical research (e.g. Corrigan & Phelan, 2004; Hendryx, Green, & Perrin, 2009; Topor, Borg, Di Girolamo, & Davidson, 2011), recovery frameworks (e.g. Mental Health Providers Forum, 2008; Barker & Buchanan-Barker, 2005; Repper & Perkins, 2003) and evidence-based guidance (NICE, 2007; 2009a; 2009b; 2011) have attested to the interpersonal nature of recovery, research has ignored the potential role of intimate relationships. This role may be of particular significance for LGB service users; lesbians and gay men report higher levels of connection to ex-intimate partners than do heterosexuals (Harkless & Fowers, 2005), and intimate relationships may be especially important for those LGB service users who are not able to count on the 'safety net' of family members due to familial conflict or rejection regarding their sexual orientation (Lucksted, 2004). Indeed, previous authors have highlighted the importance of 'families of choice' for LGB people; that is, the construction of elaborate support networks to compensate for a lack of supportive family ties (Cody & Welch, 1997).

To promote recovery, Repper and Perkins (2003) suggest that mental health workers consider three central and inter-related processes: (1) facilitating personal adaptation through helping the person to reach an understanding of what has happened, mobilize internal resources for recovery and gain control over the mental health difficulties and his/her life; (2) promoting access and inclusion through helping the person to access material resources and access and maintain the roles, relationships, activities and resources necessary for recovery; and (3) creating hope-inspiring relationships through valuing the person for who he/she is, believing

in the person, listening to the person, believing in the authenticity of the person's experience, accepting and exploring the person's experiences, tolerating uncertainty about the future and seeing problems and set-back as part of the recovery process. According to this model, intimate relationships could affect the mental health recovery of LGB service users through promoting or impeding these processes.

The current investigation sought to explore how the intimate relationship experiences of LGB inpatients influenced their mental health recovery whilst resident on psychiatric wards.

METHOD

Ethical approval for the study was obtained from three ethics committees (two within the NHS and one within Royal Holloway, University of London). Equality and Diversity Leads for an NHS Foundation Trust and a gay service user were consulted to inform the design of the study. In addition, participants were asked for feedback on the data analysis to obtain respondent validity.

Procedure

The study was advertised via the e-newsletters, Twitter accounts and websites of 15 LGB, HIV and mental health organizations. Participants were given an information sheet about the investigation and encouraged to share this information with acquaintances; this led to participants obtaining further contacts in a 'snowball' fashion. The investigation required that individuals self-identified as lesbian, gay or bisexual. The study also required participants to have been adult inpatients on an NHS mental health ward within the last five years. Individuals were excluded if they were intoxicated or experiencing severe mental distress at the time of interview; none met these criteria. The researcher obtained written and verbal consent to participate from each participant.

Participants

Nine people enquired about the study, of whom six agreed to participate. Participants were three gay men and three lesbians, aged between 31 and 57 years (mean age = 45 years). No bisexual people participated. All participants had experience of intimate relationships during

their inpatient stay(s). Two participants identified as White-British, one as White-Scottish, and three as mixed heritage. Five participants had degrees at either a Bachelor or a Masters level. All participants had paid or voluntary occupations, five of which were in mental health and/or equality and diversity. Four participants were single, one was in a long-term relationship and one was in a civil partnership. Four participants lived alone. All participants had received psychiatric diagnoses and some multiple diagnoses including schizophrenia, bipolar affective disorder and personality disorders. All participants had received psychoactive medication and had engaged in psychological interventions. The range of number of ward admissions was between one and 20 (mean = 6). The length of time since participants' last admission ranged between one to 256 weeks (mean = 115 weeks). The length of participants' last admission was between two and six weeks (mean = three weeks). Five participants had been hospitalized in England (four in London) and one in Scotland.

Data collection and analysis

The investigation utilized semi-structured interviews. A schedule was developed by the research team in collaboration with a consultant psychiatrist, the Service User and Equality and Diversity Leads for an NHS Foundation Trust, and a gay service user, all of whom had experience of working or receiving care on inpatient wards and/or working with LGB service users. Interviews (range = 44-144 minutes, mean = 82 minutes) were conducted by the main researcher in an Outpatient Psychology department in London.

All interviews were transcribed verbatim and any identifiable information was removed. They were then analyzed using Interpretative Phenomenological Analysis (IPA) (Smith, 1994, 1996). IPA was chosen as it allowed the authors to 'give voice' to a marginalized group that is

infrequently studied, is concerned with examining individuals' lived experiences and how they make sense of them, privileges the participant as an expert of their experiences, and is suited to addressing sensitive matters (Smith, Flowers & Larkin, 2009). It also considers contextual factors that may play a part in the meaning-making process (Shaw, 2001); this was important as narratives about service users and sexual minority groups may have influenced participants' experiences of intimate relationships, mental health services and recovery (Ellison & Gunstone, 2009; Shaw, Butler & Marriott, 2008). The data analysis followed the steps recommended by Smith and colleagues (2009). The final analysis was emailed to participants who were asked for feedback on its validity; four responded and described the analysis as "accurate", "authentic" and "truthful". The other two participants did not provide detailed feedback but reported that they were satisfied with the analysis when contacted at follow-up. Throughout the research process, the main researcher noted down their thoughts in a reflective journal in order to "bracket off" their interpretations and assumptions (Holloway & Jefferson, 2005).

RESULTS

Five master themes emerged from the data analysis and encompassed: how participants conceptualized intimacy; the reciprocal relationship between intimate relationships and recovery; participants' experiences of the ward environment; participants' experiences of prejudice and discrimination in services; and the loss of power and personal identity experienced as a service user. All are discussed in relation to experiences of intimate relationships and recovery. All names provided are pseudonyms.

Master theme one. Redefining intimate relationships.

Intimacy was experienced in relationships where participants felt accepted, supported and understood. These factors were beneficial to recovery and were especially important for participants who felt marginalized and misunderstood on the basis of their sexual identity and mental health difficulties. However, all participants differentiated intimate relationships from other experienced relationships in that they featured sex. Thus, intimacy was experienced in a wide range of relationships (e.g. friends and family), but intimate relationships were conceptualized as those where both intimacy and sex were present. Furthermore, intimacy was not necessarily a feature of sexual relationships; some participants valued sex with strangers, ex-partners, "shag buddies" and "friends with benefits".

...those women helped me a lot because they, they were all dykes and they, they, they just seemed to accept me the way I was (Fareiba)

...it would be better to have purely sexual relationships, um, because then I'd only need what... (laughs) you know...I don't need the, the, the emotional stuff you get from relationships (Fareiba)

All male participants spoke of non-monogamy as important; this may have been important to them as men or as gay men. One female participant reported that it was not acceptable for women, lesbian or heterosexual, to have multiple sexual partners, and no female participants reported having more than one concurrent sexual relationship.

...sometimes there might have been lap over between different relationships (Michael)

Master theme two. A reciprocal relationship in recovery: intimate relationships and mental health.

Intimate relationships could be both a resource and an obstacle to recovery, and the mental health of participants could be both an asset and a source of conflict in intimate relationships. Being single was experienced as having “failed” in the eyes of society; intimate relationships therefore allowed participants to feel “normal” and access a sense of social inclusion, which facilitated recovery. This was important to those who felt stigmatized by their mental health difficulties, and was especially helpful in inpatient services where participants felt de-personalized and de-humanized.

...you've got to be in a relationship, you know, and, and if you're, you're not or you don't want to be then there's something wrong with you (Fareiba)

...she did come and see me and we went out to the park and, um, we went for walks and things like that, we went for something to eat, um...(later on in transcript) it just felt like I had some normal, a bit of, that it wasn't, the normal...the normality (Caroline)

... [Intimate relationships give] the sense of being, the sense of achievement, the sense of being someone, in, in...a mental health system being more (Michael)

Some partners were able to assess participants' mental health and support them in accessing services; this support and understanding was particularly useful to participants who felt isolated and alienated within services.

...if he [partner] spots it [symptoms of mania] I'll, I'll look at myself and think, "OK I need to do something here because this might be building" (Edward)

I think what was more helpful being in the relationship was that I didn't feel alone...and I felt, I felt totally alone in my last, um, admission...um...although I felt like the, you know, I was in a black hole I had, you know, I had someone saying, "I'm not, I'm not letting you go" (Rachida)

Some participants reported that they decided to seek relationships with those with experience of mental health difficulties as this enabled more "honest" and "open" relationships in which partners could share experiences without fear of rejection.

...the fact that I said, "I've got bipolar and I've gone through this" means that she, made her open, be more open about her issues and that's actually, she said that's the

first time she has opened up because she felt I would understand, that I wouldn't judge her (Rachida)

However, all participants had experienced conflict in intimate relationships related to their experience of mental health difficulties. Some reported feeling pressurized to involve partners in their care when this was not always what they wanted whilst others spoke of the pressures their partners faced to ensure their recovery.

...you're under a pressure, um, a lot of the time when you're in a relationship to get well (Fareiba)

...there's a lot of pressure for him [ex-partner] probably not to, a lot of pressure for him to not have any needs for himself...a lot of pressure for him not to be able to say "this is too much" ...'cause then he's not caring then he's not supportive (Michael)

Furthermore, all participants spoke of feeling stigmatized by partners because of their mental health difficulties, leading to feelings of shame and guilt as well as a reluctance to enter intimate relationships again or to involve partners in their care, which was sometimes detrimental to recovery. Others felt a sense of guilt over the impact of their mental health difficulties on partners.

It has tainted my view of relationships because it, because it ended so badly in my, in my first admission and, um, it kind of put me off getting close to people again (Caroline)

...the biggest barrier to recovery is actually getting over what you've done [to your partner] (nervous laughter) when you were unwell. Um....um...I think that was very hard (Michael)

Sexual dysfunction as a result of mental health problems and/or psychoactive medications also created difficulties for all participants and their partners, and led to feelings of guilt. Some participants had managed this by stopping their medication whilst others had decided to end their relationships; this had implications for their recovery and intimate relationships.

...I'm off the medication now, it wasn't the only reason but it was one of the reasons because it, my poor partner, then partner, would be ex- (laughs), ex-, at the point of exhaustion because it would take, take so long [to achieve orgasm] (Rachida)

Master theme three. The ward environment: A barrier to forming and maintaining same-sex intimate relationships.

Inadequate resources, under-staffed wards and a lack of cleanliness dissuaded partners from visiting on the ward and led to feelings of being devalued and unimportant to services, both of which were detrimental to participants' recovery.

Researcher: What wasn't nice about it [the ward]?

Oh, just dirty and stained and smelly from the guy who usually sat there and because it was at the end of the corridor it was dark and dingy and it was never cleaned...um, not exactly conducive to spending any kind of decent time with someone (Solomon)

A lack of private space on the ward also interrupted intimacy between partners and was especially difficult for those participants and partners for whom it felt dangerous to be 'out' as gay or lesbian, or to experience intimacy on the ward. Restrictions on the ward such as visiting hours and limited internet and phone access were also obstacles to achieving a sense of normality as a couple.

...everyone else could come and just sit down beside you or the staff can just wander past and listen in...so there, there is a real lack of private space ...[later in transcript] there is never any real sense of you being able to have...the relationship (Solomon)

Fear of physical and sexual violence from other service users made the ward a threatening place in which to be and was especially difficult for participants who feared homophobic violence from others; at least one participant had been subjected to a homophobic sexual assault whilst on the ward. Participants also feared violence in the form of restraint and forced injection from staff members; this interrupted the development of rapport and trust between participants and staff, a relationship which was already damaged by previous negative experiences of services.

...he pushed me against the wall and felt me up basically, um...and I forget what he said, something, I kind of blanked it out a little bit, I think he said something along the lines of, "That's what you're missing" or something and I actually reported that to the nurse...and nothing happened. (Rachida)

Master theme four. Attitudes within services: prejudice and discrimination as barriers to service users forming and maintaining intimate relationships.

Negative attitudes towards service users were experienced by all participants and added to a sense of stigmatization which was detrimental to their recovery. All participants reported that they anticipated homophobia from others, and were vigilant for 'cues' that sexual minority identities would be treated equally to their heterosexual counterparts. An absence of such indicators and a lack of specific services for sexual minority people caused the ward to feel threatening and perpetuated a sense of being 'invisible' as a minority population.

...it is literally, you know, walking into a field full of landmines...you don't know who is safe to talk to on your ward, you don't, you don't talk [about your sexual identity]
(Rachida)

Participants experienced homophobia in staff attitudes, differential treatment to presumed heterosexual service users, and the pathologization of sexual minority identities. Heterosexism was experienced in conversations with staff and the portrayal of families on the ward; these experiences were alienating for both participants and their partners, and hindered participants' recovery. Interestingly, all participants were aware of staff members whom they assumed to be LGB and who seemed afraid to be 'out' on the ward; this fostered participants' sense of alienation.

... [The psychiatrist said] that my, my, my problems were emotional and that being lesbian or gay was, was a contributory factor to my, to my mental health (Caroline)

...and the assumption is...because that, they know I have children so the assumption is that you're straight (Fareiba)

...I know that there are lots of LGBT staff...um...but I know that none of them are out (Michael)

It is important to note that although participants expected homophobic attitudes from staff, this did not always happen; instances were described where same-sex intimate relationships were supported by staff. These experiences were beneficial to participants and partners, who felt welcomed and accepted on the wards, and therefore able to spend more time together.

...staff welcomed X [partner] onto the ward and were happy to see him and so it was easy for him to come in, um, made it more pleasant for him to be there, um, that...meant he was quite happy to come as much as he wanted to come and see me and that was obviously good for me (Solomon)

Some participants experienced racism; this added to a sense of “intolerance” on the ward which was threatening for participants and dissuaded partners from visiting the ward. The ethnicity of staff was also mentioned by participants; there were perceptions that ethnic minority staff were more likely to be evangelical Christians with homophobic attitudes and that some white staff were seen as racist.

...a particular group of African evangelical care assistants who were rampantly homophobic...um....I mean they'd be telling me and another guy who were...gay and

another couple of lesbians that we were going to he-hell and we'd, we'd burn for all eternity and this was why we'd got mental health problems (Solomon)

Master theme five. Being a service user: The loss of power and personal identity as barriers to forming and maintaining intimate relationships.

Participants reported that neither they nor their partners experienced good communication with services and that they were often not involved in decisions regarding their care. This was experienced as disempowering and was damaging to participants' recovery and their relationship with services. It may have also resonated with previous experiences of disempowerment through belonging to sexual minority groups. Participants experienced sectioning (committing someone compulsorily to a psychiatric hospital in accordance with a section of the Mental Health Act (2007)) as particularly anxiety-provoking and disempowering; they likened the process to being worse than prison.

...in a way going to prison can be better than, than if you're on a section because...um...you're given a, a, a sentence and you know what the maximum's going to be...whereas if you're on a section you, yeah, each section has a time limit but then that section can be changed you know...so in a way it's better to go to prison than to go to...the nuthouse (speaks quietly) (Fareiba)

Participants and their partners were able to regain some control over their care through utilizing existing contacts within services and communicating their needs with services; here

the ability to be assertive or having an assertive partner were paramount, and important tools in recovery.

...you have to be quite blunt and say, "This is, this is the situation. This is what I want to happen. These are the expectations" and not everybody who has been taken onto the ward can do that and not everybody's partner can do that (Solomon)

A sense of being stripped of any human or personal identity was amplified through a purely medical approach to care, in which non-biological factors were not considered and all participants were treated the same. Failure to consider service users as individuals may have echoed with experiences of being stereotyped on the basis of sexual identity.

...they are just looking at things from, some psychiatrists not all, from a biochemical viewpoint and that your brain is broken, we'll fix your brain with some medication and there, you know, there is no, you know, your social and personal life has very little to do with your, your madness you know (Rachida)

The sexuality of participants was also rendered 'invisible' through the failure of services to ask about participants' intimate relationships needs, or to involve partners in participants' care. This felt dismissive for both participants and partners, and for some participants was experienced as a denial of their sexual identity. Where participants attempted to talk about intimate relationships, they were met with silence and embarrassment or were ignored. Some participants believed that staff felt it was "taboo" for service users to have sexualities; this

may have added to experiences of internalized homophobia. Others felt that staff did not feel comfortable or skilled in talking about intimate relationships.

...it was like the elephant in the room...The white elephant...nobody discussed it [sexual identity] (Michael)

I had a male doctor and he, when I brought that up the subject [sexual dysfunction] he just went red, (laughs), really, really, red. Really red. He said, "OK I'll note it" and that was all was said about it (Rachida)

DISCUSSION

The current study suggests that inpatient psychiatric services can be difficult environments in which to be a lesbian or gay (LG) service user or pursue a same-sex relationship; inadequate resources create a poor and restrictive environment in which it is hard to enjoy intimacy, and where both LG service users and their partners may be subject to violence. This supports a national survey of 343 former inpatients which found that 56% of service users felt that the ward was a non-therapeutic environment (Baker, 2000), and adds to evidence that service users experience physical threats, violence and sexual harassment while on psychiatric wards (Mental Health Act Commission, 2005; MIND, 2004; National Patient Safety Agency, 2006; Royal College of Psychiatrists, 2005). According to Meyer (2003), LG service users and their partners may be particularly alert to the potential for violence as a result of past experiences of homophobic hate crimes.

Clinical practice on wards may also be detrimental to the ability of LG service users to form and/or maintain intimate relationships. For example, negative staff attitudes towards service users may negatively impact service users' self-esteem (Link, Struening, Neese-Tood, Asmussen, & Phelan, 2001), and impede their forming of social relationships (Verhaeghe, Bracke, & Bruynooghe, 2008). This may be particularly damaging for LG service users who experience 'double discrimination' as LG people and service users (Hellman, 1996; Mizock, Harrison & Russinova, 2014), or multiple forms of cultural difference, e.g. as people from black or minority ethnic groups (Hellman, 2012); numerous studies have attested to the damaging effects of homophobia and heterosexism on mental health in these populations (e.g. Mays & Cochran, 2001), as well as on same-sex intimate relationships (e.g. Balsam & Syzmanski, 2005).

Homophobic and heterosexist practices support previous findings (e.g. Lucksted, 2004). Such practices and the perceived reluctance of staff to be 'out' on the ward may disrupt LG service users' intimate relationships through contributing to any internalized homophobia. Internalized homophobia is associated with greater intimate relationship conflict in LG relationships (Balsam & Syzmanski, 2005; Meyer & Dean, 1998; Mohr & Fassinger, 2006), and may negatively impact sexual intimacy; higher levels of internalized homophobia are associated with greater sexual depression, sexual anxiety, and sexual image concern, and lower levels of sexual esteem and satisfaction in gay men (Dupras, 1994; Meyer, 1995), and have been implicated in sexual problems among lesbians (Nichols, 2004).

An impersonal and purely medical model of care may make inpatient services especially inaccessible for LG service users and their partners as it does not allow for the consideration of social, psychological or behavioral factors and neglects diversity among individuals (McIntyre, Daley, Rutherford, & Ross, 2011). The failure of services to discuss participants' intimate relationship concerns created challenges for service users in managing their intimate relationship needs. The treatment of service user sexuality as unimportant, pathological and even taboo supports previous findings (Buckley & Hyde, 1997; Lucksted, 2004), and may have echoed with participants' previous experiences of homophobia and added to feelings of stigmatization and disempowerment.

Participants reported that intimate relationships were instrumental to their recovery, supporting personal accounts (e.g. Deegan, 1988; Leete, 1989; Wallcraft, 2002), literature (e.g. Corrigan & Phelan, 2004; Hendryx et al., 2009; Topor et al., 2011), and models (e.g. Barker & Buchanan-Barker, 2005; Mental Health Providers Forum, 2008; Repper & Perkins, 2003) that argue for recovery occurring within an interpersonal context. Service users have

stated that they want to discuss intimate relationship concerns with staff (McCann, 2000; Volman & Landeen, 2007); including intimate partners and/or intimate relationship needs when developing care plans, consulting with service users, and planning inpatient activities, including psychological therapy, could therefore be beneficial to service users.

According to Repper and Perkins (2003), feeling understood, valued, listened to, believed and accepted by intimate partners may have aided personal adaptation for participants, especially those who experienced rejection on the basis of their sexual identity or mental health difficulties. This would support evidence that gaining support from other LGB people has been found to be beneficial to the self-esteem of sexual minority individuals and their abilities to cope with homo-negative experiences (Mayfield, 2001; Nesmith, Burton, & Cosgrove, 1999; Rowen & Malcolm, 2002).

Intimate partners may have increased participants' access to services by being able to identify their distress and help them to seek support. A heightened sense of social inclusion for participants may have also been facilitated by the "normality" provided by being in intimate relationships. Personal accounts have attested to the importance of striving for normalcy in recovery from mental health difficulties (Wisdom, Bruce, Saedi, Weis, & Green, 2008). From a social constructionist perspective (Burr, 2003), in being able to identify as someone's "partner" participants may have been able to escape the stigmatized identity of "service user", which may be particularly salient within an inpatient setting.

On the other hand, forming and maintaining intimate relationships may be difficult for LG service users due to the impact of their mental health difficulties and/or psychiatric medication, and/or stigmatization from partners. Indeed, Thornicroft, Brohan, Rose, Sartorius and Leese (2009) found that 63% of 700 people with severe mental health problems reported

having stopped themselves from trying to initiate new close personal relationships as a result of relationship difficulties due to their mental health experiences. The current study suggests that partners may also experience difficulties in intimate relationships as a result of caring for a LG service user; this may be particularly difficult where there is limited support for LG service users and their support networks. Thus, it may be beneficial to develop support for intimate partners of LG service users whilst resident in psychiatric facilities.

CONCLUSION

This study suggests that intimate relationships can have important roles in recovery and should be considered by practitioners when working with LG service users. Lucksted (2004, p.37) proposes that, “when a mental health program is knowledgeable about, comfortable with, and sensitive to LGBT clients’ needs, clients feel safer and more at ease, thereby facilitating trust in therapeutic relationships, engagement in treatment and openness on the client’s part”.

Service-level interventions are beyond the scope of this study. However, a number of ideas for improved clinical practice with LG clients are suggested, including: the provision of holistic, client-centered care; the development of gay affirmative practice (Davies & Neal, 1996; Hellman, 2012); the provision of programs for LGB inpatients or LGB people living with severe and enduring mental health problems (e.g. Hellman, 2012; Hellman, Klein, Huygen, Chew & Uttaro, 2010); involving partners, friends and family in care planning and therapeutic activities; providing non-medical (e.g. psychological) interventions on the ward and/or establishing referral pathways to appropriate services; addressing sexual functioning and intimate relationship needs; and providing support for intimate partners. Discussion of how

to negotiate conflicting cultural and religious beliefs whilst providing non-discriminatory care by staff is also essential.

Organizational change may also need to occur, for example: increased training for staff regarding working with sexual and ethnic minority populations; support for staff from sexual minority groups; increased staff from sexual minority and gay affirmative groups; training in discussing intimate relationship needs with service users and partners (e.g. Bradbury & Lavner, 2012; Wright & Pugnaire-Gros, 2010); the development of clear pathways to LGB resources; and the development of clear policies regarding the negotiation of service users' intimate relationships in wards. The ward environment may also need to improve, for example by: having a comfortable physical environment for service users; providing at least one room for meeting with others in private and a range of semi-private and public spaces; providing visual indicators that people from sexual minorities would be welcomed and accepted on the ward (e.g. signs, rainbow pins for staff) and removing heterosexist references; providing numerous recreational and physical activities on the ward; and addressing sexual harassment and violence.

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