

Women who use Secure Services: Applying the literature to women with learning disabilities.

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Abstract

Purpose: This paper reviews research of relevance to women with learning disabilities, focusing in particular on literature which is applicable to women with learning disabilities who use forensic services.

Approach: Research involving women with learning disabilities over the past 30 years was sought out and reviewed, and literature relating to women living in locked wards (including those without learning disabilities) was focused upon. Related themes such as the BPD diagnosis, self injury, and aggression are explored.

Findings: The author found very little research relating to women with learning disabilities who use secure services, particularly which included quotes from the women themselves.

Research implications: The author recommends that more research in this area is needed, primarily research which includes the voices of women service users themselves.

Value: This paper will be relevant to all staff who work with women in secure services.

Introduction

Considering the relatively large amount of published literature and personal accounts detailing women's experiences of residential psychiatric services in the UK and USA (see for example Pembroke, 1996), the scarcity of work which includes women with learning disabilities who use services is notable. Perhaps due to the heterogeneity and medicalisation of the population of adults who have been diagnosed with the label 'learning disabled', historically research has concentrated on medical syndromes and service provision (Aspis, 2000) and has, with little exception, been presented in a gender-neutral way (Atkinson et al., 2000).

This paper will introduce research that looks at the experiences of women with learning disabilities who use secure services. Relevant research concerning women who use secure mental health services will also be included, as these women are described as having similar experiences and needs (James and Warner, 2005). Specific themes which arise in the literature, such as the 'borderline personality disorder' diagnosis, self-harm and sexual abuse will be discussed; these themes apply to many women who are detained regardless of the labels that have been applied to them.

Voices of women with learning disabilities in research

Until recently, women with learning disabilities have not been provided with the opportunity to fully participate in both private and public aspects of society. As Traustadottir and Johnson (2000) argue:

'In the past many have been excluded from their families during childhood and have been prohibited from forming adult relationships or families of their own. They have often been excluded from work or community involvement or their participation has been voluntary or unacknowledged.' (2000: 16).

Women with learning disabilities have had very little representation or influence in the feminist or the disability movements (Aspis, 1997), and their circumstances have been hidden or overlooked (see Traustadottir and Johnson, 2000). There is a small but growing literature that has looked at the experiences of women with learning disabilities; however there is very little

research with women who use services (Allen et al., 2001; Crawford, 2001; Taggart et al., 2008). Brown (1996) suggests that the reason for this is that learning disability services have traditionally hidden behind a 'gender blind' approach (also see Scior, 2003).

Traustadottir and Johnson (2000) write about their involvement with learning disabled women, and report that they felt:

'outraged by the failure of those around them to recognise them as women or to take into account their concerns and desires...their stated desires and needs were ignored by families and service providers while their gender (when it was acknowledged) was constructed as a problem and a threat' (2000:11).

Authors looking at the history of learning disability claim that historically women with learning disabilities have been treated as a threat to society because of the combination of their gender and their impairment, and that this belief is still held in society today (see for example Phillips, 2007; Carlson, 2009).

Historical perspectives - Institutionalisation

The construction of women with learning disabilities as a problem and a threat dates back in history to the European eugenic movement in the early 20th Century and the emerging philosophy of institutional medicine at that time. The focus on women tended to be in terms of the possible social threat they posed through their capacity to have children. The Mental Deficiency Acts of 1913 and 1927 reinforced the ideology of this era by creating a legal framework by which to label and detain people on the grounds of their 'handicap' or 'moral defectiveness'. This framework was gender specific, targetting unmarried mothers and disabled women. These 'feeble-minded women' were considered to be promiscuous, carriers of disease and highly fertile (see Phillips, 2007). Engwall relates that 'Feeble-minded men were seen as problematic due to their assumed tendency to turn into criminals, feeble-minded women were threatening society through their sexuality' (ibid, 2004:78).

For most of the 20th Century, people with learning disabilities were detained in large institutions, placed in sex-segregated wards and denied access to the workplace, family life and parenthood. Thomson (1992) shows that the Mental Deficiency Act (1913) targeted girls as a sexual problem and that once they were institutionalised they often stayed for life. The Act led to the separation of many thousands of people from their families in an attempt to curb what was seen as a threat to society, particularly by women who were widely regarded as the likely bearers of defective offspring (Carlson, 2001).

Women entered the institutions as children, young women or later in life when caring relatives had died (Phillips, 2007). Kristina Engwall, in her study of 481 medical records detailing the daily lives of women in institutions in early 20th Century Sweden, found that women were encouraged not to put too much emphasis on an attractive appearance, but rather on hard work, obedience and being on time. Prohibition of marriage and sterilisation ‘excluded women from sexuality and fertility’ (Engwall, 2004:83), and staff encouraged women into ‘helping’ roles. Despite this, Atkinson and Walmesley (1995) present accounts of women who remember gaining satisfaction from their enforced roles as carers for less able patients in the institution, and they also found ways to have forbidden relationships: ‘These accounts remind us that even in such outwardly unpropitious circumstances women can still retain a sense of themselves as more than just victims. They are capable of resistance because, it seems, they possess a personal identity which is at variance with the label others have placed on them’ (Atkinson and Walmsley, 1995:223). It is comforting to know that women were clearly not passive recipients of the social norms and values at that time, any more than they are today (for example see Barron, 2002).

At this time of institutionalization, medical discourses which showed interest in issues affecting women with learning disabilities were restricted to a consideration of how identified ‘syndromes’ and ‘disabilities’ expressed themselves differently in men and women and how they affected women’s sexuality. Traustadottir and Johnson (2000) believe that the fact that women were portrayed in this way allowed professionals to dehumanise and objectify them.

The principle of normalization (Wolfensberger et al., 1972) advanced awareness of the disadvantages of institutionalization, and supported a community-based living approach for people with learning disabilities. However, normalisation has been criticized as reinforcing traditional gender roles which serve to maintain a woman's place as being in the home or in low paid work (Brown and Smith, 1992). Women living in community care are often forced to live with other people; including men; that they have not chosen to live with, are placed in situations which mimic 'family life' and encouraged to fulfill normative roles of domesticity taking on the bulk of the housework.

Research with women with learning disabilities in the Community

Three notable books stand out in the work of feminist research with women with learning disabilities. In a 'landmark' book detailing women's narratives by Atkinson et al. (2000), the experiences and life stories of women with learning disabilities are presented. The women relate their experiences of what matters to them - employment, relationships and family. Although some of the accounts are positive, there is an overriding theme which touches all accounts – a theme where the women convey that their needs are being ignored in some way. Traustadottir and Johnson (2000) also present narrative accounts of women with learning disabilities, but in this book the women are from eight different countries. The theory and approach used in both books is that of allowing women to speak for themselves about what they consider to be important.

The third study by McCarthy (1999) presents a profound insight into the sexuality of women with learning disabilities. Her writing does not present women's narratives, but quotes from exceptionally in-depth interviews from the 17 women who were taking part in a sex education group with McCarthy. The women described themselves as having very little choice or control over their sexual experiences, and experiencing little or no enjoyment. This was the case with women living in the community as well as in residential services.

More recent research includes a paper by Phillips (2005), who recounts the narratives of eight older women with learning disabilities, demonstrating how they reflect on how their bodies were central to their notions of self and, at times, their collective identities:

‘Contemporary debate within Disability Studies has focused on the role of ‘the body’ in a social model understanding of disability and impairment. In this context, disability refers to the environmental and discriminatory barriers imposed by cultural and social situations, while the body is neglected and medicalised in relation to one’s biological impairment. For people socially and medically labelled as having a ‘learning disability’ the reverse situation applies, whereby a perceived impairment of mind or intellectual ability extends to a perceived impairment of the body. Consequently for people with learning difficulties the body is a site of regulation by a range of welfare, educational and medical discourses and controlled by carers, parents and professionals.’ (Phillips, 2007:503)

Even though these women lived in the community, Phillips described them as feeling contained, organised and policed through a system of institutionalised discourses. Welfare and educational services decided where women should be housed, medical professionals and social workers surveyed and recorded every action: ‘Case notes, daily logbook accounts, personal programme plans and reviews all document patterns of behaviour and personal bodily functions. Visits to the doctor, dentist, chiropodist, times of hair washing sessions, baths and personal hygiene recommendations are all noted’ (ibid, 2007:511). Weight, diet and food were high on the agenda in day centres, where women were weighed on weekly basis, which Phillips interprets as centralizing the female body form in the public arena. The women all felt that they had experienced a lack of choice over their dress and appearance, which was experienced as a form of control over their identity.

Women with learning disabilities in forensic services

The Reed Report comments that: ‘In male dominated environments, women’s needs including their more personal female needs are liable to be overlooked...Services need to be responsive and proactive in order to counteract these problems in order that women receive appropriate care, treatment, accommodation and rehabilitation with proper attention to their personal dignity’ (Reed Report, Vol 6. 1994). Ifill (1998:14) agrees with this, and states that ‘female patients in a

predominantly male setting do not always receive services that are geared to their needs...most provision is set up for the majority, in this case men’.

Women are a minority in almost all medium secure units in England, with the exception of a few units specifically accommodating women (Byrt et al., 2001). Many women have been admitted compulsorily for behaviours that were not classed as offences, or caused by mental disorders, but which opposed society’s expectations of how women should behave, such as aggression or self-harm (Byrt et al., 2001). Other women are admitted through the CJS diversion schemes, however these have been described as under-resourced and lacking in proactive screening, and particularly inadequate with regard to links with learning disability services (Hunter et al., 2008). The Lord Bradley report calls for more consistent implementation of diversion policy in the CJS, better identification and assessment and for learning disability to be seen separately to mental illness (Bradley, 2009).

Most of the research about secure units has focused on the special hospital system. Bartlett and Hassel (2001) report that it would be difficult to know the extent to which findings in other parts of the health service would generalise to these units. They suggest that women may be subjected to high levels of restriction not because of their problems but because of the type of people who share the service with them:

‘In small units, women may have no way of avoiding sexualised social contact with men who have a history of sexual and physical violence towards women...The reluctance of some medium secure units to deal with women patients because of unsafe environments... may create further difficulty.’ (Bartlett and Hassell 2001:306)

According to Stafford (in a 1999 WISH publication), women in secure hospitals are more likely to be classified as having a personality disorder, are more likely to have experienced sexual and/or physical abuse (also see Lindsay et al., 2004), and are more likely to stay longer than men in secure care. Research indicates that women are involved in more incidents of aggression than men (Sequeira and Halstead, 2001; Alexander et al., 2006), are more likely to self-harm (Maden, 1996) and are construed by staff as more ‘volatile’ than men (Crawford, 2001). It is suggested

that the institutional response to these complexities is to place women in services of higher security than needed (Berber and Boer, 2004), and women are problematised and pathologised without any recognition of the trauma that their pasts might have caused them (Aitken and Noble, 2001).

In her literature review about women offenders with learning disability, Hayes (2007) suggests that adequate diversity and local proximity of services for women is lacking. She recognises that despite some active interventions of those advocating on behalf of women, the justice system tends to remain male focused and male dominated. Hayes recommends that further research to aid policy development is urgently needed, addressing the dearth of information in this area, and enabling the voice of women offenders with a learning disability to be heard: 'Female offenders are a small, neglected and devalued group within the criminal justice system; the even smaller minority group with a learning disability have little in the way of specific resources, services or advocacy' (Hayes, 2007:190).

Crawford (2001) interviewed ten women with mild or borderline learning disabilities and their care staff in two secure units. The women were admitted to medium security as the result of damage to property, self injurious behaviour and aggressive behaviour displayed towards staff within less secure facilities. Seven of the women she interviewed had a diagnosis of personality disorder, five of whom had three or more diagnoses, including paranoid schizophrenia and 'emotional instability'. She reports that during admission 'all women had cut their bodies' (Crawford, 2001:6), and that 80% of women had attacked their carers and 70% had attacked their peers in the last year. She interpreted that the women used self harm as a way to bring revenge upon their carers or to punish themselves, as well as (more commonly) releasing tension at the time of the behaviour. She describes the women as having developed a 'hierarchy' of self-harm; where the most dangerous acts would generate more response from staff; and she interprets this as the women ensuring she is not 'forgotten'. These conclusions differ from other research (Harker-Longton and Fish, 2002; Duperouzel and Fish, 2010) where women described self-harm as a coping mechanism and a realisation of taking control over their own body.

With reference to gender identity, Crawford (2001) refers to an 'invisible gender' in secure services, which allows the service to ignore any potential differences between services offered to men and women. However, their gender may become 'visible' due to her difficult behaviour, when the behaviour is blamed on her being a woman and a problem. She reports one patient identifying her fears of losing her self-identity as a woman, due to the oppression of women caused by the presence of male sex offenders, for example the service was limiting her leisure activities and the way she was allowed to dress.

Crawford concludes that 'current personality disorder diagnoses form the institutional perceptions of women as a group of 'disorderly women', using women's distress and behaviour as evidence of further madness; and perpetuating the institutional mythology of 'difficult' women' (Crawford, 2001 :5). Crawford proposes that the 'borderline' diagnosis renders women as categorized on the edge of diagnosis, intelligence and womanhood; and asks whether experiences of abuse or trauma can be quantified into this single diagnostic category.

Crawford's paper points to discrete topics for potential research, but does not offer any quotes from the transcripts to illustrate her interpretation. The evidence she provides seems to paint a picture of services not having the means to recognize gender differences until they become a problem; this problem is then talked about as existing within the group of women, rather than situational. The discourse or language used about a person can affect their care, for example some studies suggest that women are described and believed to be 'mad' rather than 'bad', signifying that behaviour which does not lie within expectations is considered to be a sign of some pathology of the mind. Labels such as this can be used by staff when talking about a person, and reinforced through case notes over long periods of time (Johnson and Webb, 1995).

There is a good case to be made that women in secure facilities may present different clinical challenges than men due to their previous experiences and different reasons for entering the service (Bartlett and Hassell, 2001; Sarkar and di Lustro, 2011), and as the literature suggests, it is possible that secure units are not meeting the needs of women as they represent a minority, or even putting their safety at risk (Berber and Boer, 2004).

Kelley Johnson's ethnographic study looked at women with learning disability who lived on a locked unit in Australia (Johnson, 1998). In this study gender discourses at the unit were described as influencing the women's exclusion from their families and communities in the past. Johnson observed that the women's subjectivity and identity was not something held by the women and imparted to others, but was constituted by the staff. She noticed that the sexuality of the women on the unit was either ignored, or talked about by staff in terms of either the threat of pregnancy or exploitation, rather than as an expression of desire (also see Barron, 2002). Staff saw themselves as primarily there to care for the women physically and though all of the staff commented that they took pride in caring for the women, they resented having to do so many household tasks rather than developing treatment programmes for them. Due to this perceived shortage of time, Johnson reports that special attention was given to some individuals while others missed out. Staff made efforts to understand the women's 'challenging behaviour', sometimes seeing it as frustration over their living environment, and other times as 'attention seeking' or copying from the disruptive behaviour of other service users. Controlling aggression was seen by the staff as one of their most important functions or skills, but staff disliked the custodial nature of their relationships with the women.

As well as the clients, the staff were also described as being locked in. That is, there were few opportunities to go outside other than with a group of women for whom they were responsible. Johnson observed that the women were always under the surveillance of the staff and the staff were always watched by the women, something she refers to as a 'mutual gaze' which she describes as complex and ambivalent. Not surprisingly, these factors contributed to the fact that relationships with the women were intimate, complex and inescapable, both within the group of staff and with the women who lived on the unit.

Johnson's findings reflect the struggle for control that staff experience with the women in their care, whilst themselves being subjected to controlling mechanisms and surveillance from the organization. The staff wanted to have more time and scope to develop therapeutic relationships with the clients, but saw their roles as mainly custodial and (physical) health related. Areas which could have been explored with the women, for example sexuality, were avoided or construed as problematic.

The institutional response to women in secure care

‘It has been noted for many years that mental health services are no different from other social institutions in having rules and practices that serve the interest of privilege. Hence, services are frequently responsible for compounding the past experiences of disempowerment of many service users rather than providing opportunities of acknowledgement, understanding and change.’ (Williams et al., 2004: 32)

Research has found that women in residential secure services are prescribed more psychoactive drugs than men, and in the case of sedatives and anti-depressants, five times more (Bartlett and Hassell, 2001; Powell, 2001). Women are often believed to contribute to staff stress and burnout due to more frequent incidents of aggression and self harm (Fish, 2000). Research within secure units (Harker-Longton and Fish, 2002; Fish and Culshaw, 2005; James and Warner, 2005; Duperouzel and Fish, 2008; Duperouzel and Fish, 2010) suggests that staff and organisational responses to these types of incident are further distressing to women and viewed as punishments, for example the use of physical restraint and confiscation of belongings to control self-harm. Women’s behaviour is being controlled through drugs and extreme reactions from staff because it is preconceived as being problematic.

According to Scior (2003), learning disability literature and services come across as ‘gender blind’, but for women with learning disabilities, gender and disability cannot be separated. Instead they may be faced with contradictions and dilemmas when they try to position themselves within dominant discourses of gender and disability.

Aitken points out that this sense of ‘unsafe uncertainty’ is increased by the discourse surrounding women in secure care:

‘For example, women patients become constructed as having particularly complex needs, being particularly challenging, and especially vulnerable to overt forms of abuse (all of course relative to men). Women are also constructed as ‘too fragile’ to be allowed to risk

trying out therapies which explore the emotional and relational aspects of being, even at a woman's request. In effect, women are constructed as differently dangerous but more so than men – to services and to themselves. The consequence is that a culture of suppression of rage, anger, frustration, and fear is maintained, as is the communication of women's sense of vulnerability and powerlessness. Women are 'done to' rather than 'being with' (Aitken, 2006:727).

Owen and colleagues studied residential services for women with long term mental health needs. Their research found that staff felt that they knew what was best for the women, particularly around the care and treatment offered, as well as their sexuality and fertility. Frequent judgments were made concerning their behaviour, particularly if this behaviour did not conform to socially acceptable standards (Owen et al., 1998:286).

Kristansen discusses the paternalism of services, in terms of an imposed form of 'diminished credibility' (p380) where women are not believed or trusted, and everything they do or say becomes interpreted as due to their impairment, or 'only to be expected' (p380).

Issues relevant to women in secure services

Literature from research with women in mental health secure services as well as learning disability services conveys a number of themes that are particularly relevant to women who use services. A short overview of each theme will be given in the following sections:

Mad rather than Bad?

Authors have suggested that women are overrepresented in secure care (in comparison with prison) because of their gender: 'Because we feel differently about women committing crime, we go to great lengths to avoid defining them as criminal, preferring the idea that they have emotional problems; they are mad rather than bad' (Probyn, 1990 cited in Warner, 1996:113). Therefore, gender discourse and expectations play a crucial role in the labelling of female offending (Powell, 2001).

Allen (1987) found that women appearing before court are twice as likely as men to be dealt with by psychiatric means in that they are more likely to be referred for psychiatric report, more likely to be found insane or of diminished responsibility and if convicted, more likely to be placed in a special hospital in place of a penal sentence. Allen claimed that these findings cannot be explained by differences in the mental health of offenders. Some writers seem to suggest that this situation is no accident:

‘Instead of special hospitals appealing to women as a source of help and support they consistently fail to offer constructive treatment and the fact that a convicted woman once admitted to a special hospital loses her release date and can be detained indefinitely causes women to fear transfer no matter how bad her prison experience is. In this context there appears to be considerable confusion throughout the criminal justice system about what to do about female deviance’ (Powell, 2001:2)

Powell goes on to point out the sex differences in the diagnosis of ‘psychopath’. For women, behaviours such as fighting, thefts and sexual promiscuity are taken into account whereas diagnosis for men only concerns violent behaviour.

Williams (2004), drawing on interviews with staff in a secure mental health unit, proposes;

‘It is inappropriate to conceptualise women’s mental health problems in terms of individual pathology. It is both more accurate and more useful to conceptualise women’s mental health problems as responses to, and sometimes as creative ways of coping with, damaging experiences that are rooted in their lived experiences of inequality and abuses of power.’ (Williams et al., 2004: 32)

They go on to say that ‘Psychiatric labels supplemented with ward-based jargon are the raw material of women’s reputations. This information, together with details of their index offence, precedes them into all settings’ (ibid: 37).

It seems that even at the point of admission, women are predetermined to be a problem, and therefore are at a disadvantage within this system. The worrying fact is that their release date is dependent on the opinions of the very professionals who admit them to the service.

Control or therapy?

Authors writing about secure care recognise the contradictions that apply when working with the client group. Owen (1998) found that service providers appeared to experience a conflict between protecting the women from their perceived vulnerabilities, and respecting their rights, including the right to safety, privacy, choice, support, independence and care services.

Wilkins and Warner (1996) discuss this conflict which they say exists between positioning the patients as vulnerable children and at the same time as adults responsible for their actions. Therefore, a conflict arises regarding the treatment and security: security is demanded by society but treatment is essential in defining a hospital as an institution. It is suggested that the hospital then becomes anti-therapeutic, as conflicts emerge between control and therapy. Powell asks: 'how can a woman patient trust the person they are talking to/ being treated by when part of their job is to report on her and be her jailer?' (Powell, 2001:5)

Research at secure units reveals that the conflict between 'duty of care' and therapeutic risk is a significant concern for staff (Fish, 2000; Duperouzel and Fish, 2008; Fish and Duperouzel, 2008; Fish et al., in press), and this conflict can affect and characterize relationships between staff and service users. As would be expected in a closed unit, relationships with staff were very important to service users (Harker-Longton and Fish, 2002; Fish and Duperouzel, 2008; Clarkson et al., 2009), however these relationships can be difficult to develop and are often frustrated by staff moves, high levels of long-term sickness and ward changes. 'In order to facilitate and maintain a secure base for patients, staff also require a secure base. Time for reflection and formal emotional support, should be an essential daily aspect of the role of clinical staff, rather than in times of crisis' (Wilkins and Warner, 2003:36)

Self-injury

Self injury in secure units has been found to be prevalent for both men and women (Burrow, 1992) and individuals who repeatedly self injure have been described as one of the most challenging groups of patients (Huband and Tantam, 2000). Self injury in the non learning disabled population is primarily defined as intentional harm to one's own body without conscious suicidal intent and may involve cutting, self poisoning, ingesting objects, self neglect, burning, breaking bones amongst many others. These forms of self injury have been described for people diagnosed with mild/moderate learning disabilities who describe self injury in terms of a way of coping, a symptom or disclosure of distress, a physical release from frustration, or a form of self-punishment (Harker-Longton and Fish, 2002; James and Warner, 2005).

All the participants in a 2010 study at a learning disability secure unit felt that their self injurious behaviour was helpful to them at times of emotional strain. They did not feel they should be prevented from hurting themselves, and described how this organisational response was in fact contributing to their distress and ultimately maintaining their self injury (Duperouzel and Fish, 2010).

Intentional damage to the body seems to be an extremely difficult form of expression for health professionals to process (Babiker and Arnold, 1997). This may be because nursing staff can experience working with people who self injure to be challenging and draining, becoming frustrated when they don't see a decrease in self injurious behaviour (Fish, 2000).

Warner and Wilkins propose that women use self injury as a coping behaviour in the absence of any alternative:

'Turning rage and depression inwards may have less to do with women's biological inadequacies and more to do with their social marginalisation and subjugation. We should be careful, therefore, not to pathologise individuals for what might be better understood as being the result of social inequality and restricted choice.' (Warner and Wilkins, 2004:267)

A small number of studies have looked at experiences of self harm from the point of view of women service users with learning disabilities. James and Warner's (2005) study concluded that judging women against inappropriate male standards would be to additionally penalize them for their self harming behaviour. The patients and staff in their research described self harm as a coping strategy to deal with past traumatic experiences, current relationships and issues around privation and security.

The incorporation of self harm into an individual's life can be a gradual process which increases in meaning to the person over time (Lovell, 2008). Harker-Longton and Fish's (2002) in depth case study about Catherine, one woman with learning disability who self harms, found that this behaviour can provide many meanings and functions even for the same person, such as feelings of euphoria, release of frustration and self punishment. The scars were described as emblems of past distress. The service's response to the woman's self harm was prevention, and sometimes seclusion, which served to make Catherine feel punished. Catherine was insistent about preferring female staff who cared and understood about self harm.

Functions described by Catherine such as self punishment, communication of frustration and rebellion are recognised by Burstow (2004) who also acknowledges the addictive high experienced by people who self-injure. Liebling et al (1997) and McCarthy (1998) discuss the struggle for control and power for women using services, which was also present in Catherine's account.

Sexual Abuse

Women with learning disabilities have been described as facing double oppression at the 'intersection of gender and disability', which makes them particularly vulnerable to sexual violence and exploitation (Brown 2004). Early attempts to communicate abuse are often not believed, and even when abuse is disclosed in adulthood this can be ignored by services (Wilkins and Warner, 2003). Often, when women are offered support it is not the right kind (Atkinson, McCarthy et al., 2000; Traustadóttir and Johnson, 2000).

Adshead (1994) looked at women's referrals to a forensic service. She found that 81% reported childhood sexual abuse, mainly by perpetrators known to the patient, and a further 56% had experienced sexual assault during adulthood. The most common diagnosis was personality disorder (66%), a further 44% specified as having borderline personality disorder, and all women had committed at least one act of self harm with 87% regularly harming themselves.

Mansell et al. (1998) propose that the experience of having been a victim of sexual or physical violence is an important factor in the development of later offending behaviour on the part of the individual. They report that both learning disabled and non-learning disabled children who have been the victim of abuse exhibit aggressive and dominant behaviours, low self-esteem and inappropriate anger –which may be associated with offending later in life.

Borderline Personality Disorder is a very common diagnosis for women who use services, particularly secure mental health or learning disability services and is characterized by impulsive actions, unstable mood and chaotic relationships. Wilkins and Warner (2003) explored the connection between childhood abuse and this diagnosis. They concluded from interviews with staff that staff 'perceive relationships as an internalised difficulty for these women' (p33), and point out that 'problems are associated with abuse, abuse is internalised as a problem for women, therefore women and problems becomes connected – women are then condemned as essentially problematic' (Warner, 1996:34). Warner proposes that services construct these past difficulties as part of personality, rather than socially situated and relational.

Aggression

Sequeira and Halstead (2001) found that women with learning disabilities in a residential service were involved in a disproportionately high number of aggressive incidents that had resulted in seclusion, restraint or tranquilization. They also found that women had a significantly higher probability of being given rapid tranquilization following a violent incident and that seclusion was more likely to be used with men.

Fish and Culshaw (2005) interviewed staff and service users at a medium secure unit about their experiences of aggressive incidents. Women service users reported that physical restraint; the

most commonly used intervention at the unit; could trigger feelings of retraumatisation from abuse they had suffered in the past, particularly if a male staff member was involved in the restraint. Some of the service users felt that physical restraint was being used as a punishment rather than as a 'last resort' measure, and all of the participants (including staff) gave negative comments about the use of physical restraint at the service.

Conclusion

The above literature suggests that the treatment and needs of women who reside in secure learning disability services are complex and may be different to those of men due to their life experiences (Sarkar and di Lustro, 2011). It has been suggested by many sources that women are not being placed appropriately in services which are designed for male offenders, and that the level of security in these services is inappropriately high for many women who should be treated more therapeutically in smaller community-based units (see for example Lindsay and Taylor, 2005; Benton and Roy, 2008; Wootton and Maden, 2010; Sarkar and di Lustro, 2011). This type of unit (WEMSS) is currently being piloted in some areas of the UK (Wootton and Maden, 2010) and their remit is to provide more accessible locally based services, with high levels of therapy in a non-oppressive environment.

When women are incarcerated within secure services, a lack of awareness of the women's needs can contribute to the development of challenging behaviour and to difficulties in identifying the needs expressed through these behaviours (Clements et al., 1995). Women in medium secure services who repeatedly act out are subject to pejorative labels such as 'attention seeker', and these kinds of descriptions can endure for long periods of time. The literature describes services trying to dominate, judge and control women for whom power, violence and gender are likely to have been historically connected (Bartlett and Hassell, 2001). The social and interpersonal context of individual behaviours is ignored, and therefore diagnostic systems disguise the way that so called mental disorders are products of their particular time or place (Marecek, 2006).

Institutions have been described as rationalising the degree of surveillance of women by labelling them as vulnerable, further emphasising their dependency on others for care and

protection (Crawford, 2001). Despite this, there is evidence that service users are not safe from harm and have suffered sexual violence from men who share their unit.

Within secure services, staff assume instructional or controlling roles (Barron, 2002) which neither they nor the women find effective for therapeutic care and relationships. Often, services encourage independence and self-sufficiency, rather than inter-dependence and supportive relationships which are valued by many women (Clements, Clare et al. 1995). More worryingly, service users can perceive organizational responses such as physical restraint and seclusion as punishment or even retraumatisation (Sequeira and Halstead, 2002; Fish and Culshaw, 2005).

Encouragingly, however, much of the literature which includes voices of women with learning disabilities shows the resilience and resistance of women albeit on an individual rather than collective level. Women are not passively accepting the roles and restrictive identities offered to them, and make attempts to show that they are also in control.

Recommendations for Practice

- Safety of women who share forensic services with men should be paramount.
- Policies and organizational discourses about women should be examined.
- Organizations should provide time for staff / client relationship building and more recognition should be given for positive therapeutic relationships with staff and other service users.
- Women only 'speak out' groups should be made available in forensic services.
- Organisational responses such as physical restraint procedures should be looked at on an individual basis, taking into account the client's past history.

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