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‘They’ve said I’m vulnerable with men’: Doing sexuality on locked wards

Abstract

In intellectual disability services, women’s sexuality has long been considered a problem, with women being removed from their residences and segregated from men as a form of protection. This paper draws on ethnographic research based on a secure unit for people with intellectual disabilities in England. It suggests that staff and clients are concerned about the client mix on the unit, and that staff feel protective towards women service-users. Physical contact on the wards is highly regulated and all spaces are described as ‘public’, therefore women are not afforded privacy to explore their sexuality. During interviews, many of the women disclosed experiences of childhood sexual abuse and some were unsure about their sexual orientation. This paper argues that life on the locked ward positions intellectually disabled women as both sexually vulnerable and as fundamentally asexual. This prevents women from learning the skills needed to make informed choices about sexual partners.

Key words: Sexuality, forensic services, intellectual disability.

‘They’re saying I’m vulnerable with men’: Women, sexuality and the locked ward

Introduction

This paper is based on an ethnographic research with women service users at a medium secure unit for people with intellectual disabilities in the North of England. Women are placed within such units if they are labelled as intellectually disabled and they have committed an offence, or if their behaviour is considered a risk to themselves or others, leading to a breakdown of a previous community placement. Importantly, women are a minority in this service but are able to interact with men intermittently throughout the day. The wards I am going to talk about are single sex and contain between 5 and 8 women at any one time.

The objective of the research was to observe the daily life of the women and staff, with the aim of recommending improvements to such services. It is accepted in policy that as women are a minority in services such as this, they are ‘fitting in’ to a structure which is more suited to men who have offended (e.g. Corston and Britain, 2007). It is argued that because women are placed in these units with men who have offended, they are subjected to greater measures of security and surveillance than they might need (Bartlett and Hassell, 2001). Although the focus of my research was not on sexuality, it did emerge as a major theme during the field work and analysis.

The unit has comprehensive policies that provide guidance on safeguarding vulnerable people and supporting personal relationships. These make reference to and are a reflection of national policy, however national guidance on safeguarding, such as the Department of Health document '*No Secrets*' (Dunn et al., 2000) has been criticised for emphasising the vulnerability of people rather than recognising and encouraging their strengths and capabilities. This can result in staff focussing on 'protection' rather than 'choice' (Braye et al., 2010). This study contributes to the discussion about the extent to which individual needs are taken into account (Dein and Williams, 2008, Fyson and Kitson, 2010).

Contextualising the literature

Sexuality and women with learning disabilities

Previous research has found that people with intellectual disabilities are assumed to be uninterested in sexual relationships by their carers (Heyman, 1995). They may be actively discouraged by family and staff from embarking on relationships (Grieve et al., 2009, Clements et al., 1995, Rushbrooke et al., 2014a). The attitudes of family and staff can be extremely influential (Healy et al., 2009), which can result in people being excluded from support or education about sexuality (Abberley, 1987, Hollomotz, 2011, Rogers, 2009). When asked, people with intellectual disabilities describe their intimate relationships as very important, allowing opportunities for increasing self-esteem and independence as well as providing comfort and support (Lafferty et al., 2013). Yet it was found in an interview study with support staff that some service users were assumed to be unable to understand them sufficiently due to their perceived 'social impairment' (Yool et al., 2003). Heyman (1995) found that service users

were actively discouraged from awarding themselves a licence to practice sexual relationships. Their informal carers felt, variously, that the adult was not interested in

sexual relationships, not able to understand them, not capable of acting responsibly, at risk of exploitation or a danger to other people (Heyman, 1995:195).

Indeed research with 17 intellectually disabled women aged between 19 and 55 found they had very little control or choice over their sexual experiences (McCarthy, 1999). Participants who lived in long-stay hospitals had the most negative experiences and 82% of women had experienced sexual violence over the course of their lives, including sexual abuse as children. Barron's research in Sweden suggested that women with intellectual disabilities did not see themselves as sexual beings, largely because they considered themselves to be sexually 'unavailable' (2002:69). Barron explains this is a result of the women having internalised views of themselves from others (parents and professionals), due to the fact that there was much 'time and effort spent on training women with learning difficulties to behave in ways defined by others as proper and right for them to behave' (Barron, 2002:59).

Women with intellectual disabilities, in particular those who live in inpatient services may encounter negative and controlling attitudes towards any form of sexual expression (Yool et al., 2003, Williams and Nind, 1999), with staff and families often regarding women's sexuality as a problem which needs to be managed. It is assumed that intellectually disabled people are sexually promiscuous and dangerous when their sexuality is awakened, and therefore must be kept 'innocent' and asexual by shielding them from knowledge. This type of protection can be harmful because it can lead to the belief that sexual expression can either be ignored or must be suppressed (Hollomotz, 2011, McCarthy, 1993).

Women labelled intellectually disabled were portrayed as a sexual problem in operationalising the Mental Deficiency Act of 1913, and Walmsley (2000) argues that the

regulation of sexuality was a key motivating factor in the institutionalisation of women under this act, with women framed as either dangerous, oversexed beings or innocent children (Carlson, 2001, Block, 2000).

Björnsdóttir and Traustadóttir (2010) propose that the portrayal of people with intellectual disabilities is due to the way disability intersects with other social factors such as gender and religion. Importantly, however, they also point out that people challenge and resist society's disabling mechanisms and find a way to construct themselves in an alternative way, as will become clear in the study reported here.

Sexuality, vulnerability and the locked ward

Hollomotz (2009) interviewed people with intellectual disabilities living in the community, and found that women were often described as 'vulnerable' by their support staff – a label that 'assumes that a certain set of personal attributes and low self-defence skills combined, create risk.' (*ibid*: 109-110). She suggests that people need to have knowledge in order to make decisions about sexual approaches and skills to resist unwanted ones. These skills include having knowledge about sex and sexuality, the vocabulary needed to report sexual violence, awareness of one's rights to resist sexual contact, and self-esteem needed to resist unwanted sexual approaches.

Johnson (Johnson, 1998:148) argues that the label of vulnerability can be used as a reason to control behaviour and can result in greater regulation and less positive risk taking (c.f. Rushbrooke et al., 2014b).

For women who use secure services, the notion of vulnerability is mixed with conceptions of dangerousness. In Johnson's study staff members rarely discussed gender unless sexuality was an issue.

When sexuality became a problem, this was talked about in relation to their impairment, what disability scholars would call an impairment effect (Thomas, 1999). This became a reason for increased regulation, for example by 'isolating them from contact with others, containing their dangerousness and establishing strict measures of control over their behaviour' (Johnson, 1998:67). Two of the women in Johnson's study were confined to the locked ward in part *because* of their sexual activity. (Johnson, 1998:66). Johnson concludes that women on the unit were considered to be sexually 'dangerous' (Johnson, 1998:66) and this, combined with their vulnerability, enabled strict governance and control over their behaviour.

There is an overwhelming picture of how women with intellectual disabilities are not expected to want sexual relationships, and when they show signs of sexual feelings, they are not given support or information to make choices. This phenomenon is exacerbated by the closed institutional lifestyle on locked wards. This paper explores experiences in a contemporary institution, a neglected area of research, and includes the voices of both the women service users and staff. The theoretical framework draws on ideas in Disability Studies associated with the social model of disability and feminist methodology, which privileges accessing the voices of women and marginalised groups.

Methods and approach

Introduction

This paper is drawn from my ethnographic research with intellectually disabled women in locked wards. Ethnographic researchers are concerned with the meanings people attach to things in their lives Bogdan and Taylor (1998). By observing people in context during their everyday lives, researchers are able to develop concepts from the data rather than testing preconceived models or theories. Many researchers in the intellectual disability field have used observational methods in their research with some exploring the experiences of people in locked wards (Johnson, 1998, Hubert and Hollins, 2006, Owen et al., 2008). Using ethnographic methods enables service users who are less articulate to participate in research (e.g. Booth and Booth, 1996). My observations included daily life on three of the wards where the women lived, over a period of nine months. I subsequently interviewed 16 clients (as residents of the unit are referred to) and 12 staff. The wards that I observed were designated to me by the ward manager for reasons I was not party to. Two of the wards were classified as low secure (wards are locked but clients are able to access other areas of the unit) and one was part of the medium secure unit (wards are locked and clients must stay within the two-storey enclosure at all times).

Doing ethnography enabled me to really get to know the women and also talk about my reasons for carrying out the research. It also facilitated a trusting two way relationship. Of course I was well aware of inequalities in the research relationship as described by researchers such as Stacey (1988), but my aims were to make recommendations which might improve the lives of women on the unit.

Access, Consent and Ethics

Prior to the study, I had been a reasonably well-known member of staff on the unit and part of the Women's Action Group (a service user support group) for 12 months so I knew many of the women and staff beforehand. This is not to suggest that I was a true 'insider' (Mercer, 2007) as I was not one of the direct care staff and had not visited the wards prior to the research. Despite my status as a staff member, gaining access to the wards was still difficult and time consuming, largely due to the physical procedures of getting on and off the wards, which involved obtaining a belt and special pouch, keys and a personal alarm system. The research was negotiated with management prior to commencement and at the time I was employed as a part-time researcher on the unit. Importantly managers were in favour of research with such an open remit being carried out. However, during these early phases of the study, the management structure changed considerably and the new managers asked for a more focussed remit. For example, they required the research to find out how women experienced incidents of physical intervention, special observation and seclusion. This meant that the focus of the study changed slightly and the interview schedule became more prescriptive than I had originally planned. I agreed to give feedback to the unit management and the Women's Action Group when analysis had finished. All other themes of analysis emerged from the observation and interview data, including the theme of sexuality.

I spent over 120 hours observing life on the wards at different times of the day, over a period of nine months. This involved much sitting and talking, with many of the women saying they were happy to have someone to talk to who did not have the duties of other staff. I was called upon to help out occasionally, for example to escort people to work or stay outside with them whilst they smoked. I purposefully did not spend too much time talking with staff, so that the women would not consider me to have a supervisory role. I do believe that my

presence did change what happened on the wards, for example there was very little conflict between the women whilst I was there despite this being a significant theme in the interviews. The fact that conflict was reduced during my time on the wards may reflect my status as a partial 'outsider'.

My research was given ethical approval from the National Health Service (NHS) Local Research Ethics Committee. One of the prerequisites of approval was that I had to gain written consent from all the people involved, to write about any observation. This was a lengthy and difficult process, but it nevertheless enabled me to discuss the research in-depth with people in the unit. The women who participated in the research were all labelled as having mild/moderate intellectual disabilities and were judged by their case managers to be able to give consent. They were informed that the information that they gave would be anonymous and that their name would not be written down anywhere. Pseudonyms were given during the transcription process and I have excluded any information that could identify participants (Rogers and Ludhra, 2012, Ellis and Bochner, 2000).

Ethical adherence followed the guidance of Perry (2004). Case managers were consulted before requesting consent, and those women who were not considered able to give consent at the time were not approached, nor were any field-notes taken about situations that they were involved in. Separate consent forms were completed by staff and clients, and for participation in the observation and interviews. Verbal checks were performed with clients to make sure they had understood the process of the research. Any participant who disclosed that they had been subject to abuse were referred for counselling if the issue had not been already dealt with.

Carrying out the interviews

All participants in the observation phase of the research were invited to be interviewed, and although some declined, twelve staff and sixteen clients agreed to be involved. All were white British and between the ages of 18 and 60. My observations produced field-notes, which I arranged into themes and used these to develop interview questions. I carried out in-depth interviews with both staff and service users. Many of the questions were open ended and general, such as, ‘How do you feel about living here?’ and ‘How do you think services for women could be improved?’

Many of the things I was told as a researcher were distressing and difficult to hear, and I felt privileged to be in the trusted situation that allowed this, but also conscious that I was using this trust as a way to get a PhD and advance my own career. Disengaging myself from these relationships that had been built up was difficult (Rogers, 2003) but was made easier by my leaving to go on maternity leave. I plan to provide staff and client briefs about the research for the organisation and participants. In the following section I discuss four emergent themes – sexual violence, regulated behaviour, resistance, and same sex relationships.

Analysing the data

Experiences and effects of sexual violence

More than half of the service users I interviewed disclosed experiences of abuse as children, or sexual violence as adults, even though I did not question them directly about this, for example, Bonnie told me: *‘I mean me and my mum have never had a good relationship.*

From the age of 2 till I was 8 I was in and out of care, then when I was 8 I had to give evidence against my brother, my uncle, my dad and my next door neighbour in court, about abusing me.’ and Kate said ‘I was um, I was very very very disturbed (pause) because of all the sexual abuse from my dad and that, I was really really, I was disturbed in the head, I guess you could say I was a psycho back in them days. Because I actually set fire to my own house, whilst a member of staff were upstairs and I didn’t even know I done it.’

Another service user, Ellie recalled the sexual violence she experienced in a home she lived in previously. She told me *‘It’s still in my head at night.’* She went on to say, *‘But I’ve never talked about it because I was too scared to tell anyone, but it’s all coming in my mind and I want to get it off my mind.’* She described the impacts of abuse on her current relationships, *‘I won’t even give my dad a hug because I’m too scared to hug anyone, but I’m trying to build that confidence up between me and my dad to hug him, because I used to hug dad before [this experience], but I won’t hug him now’.*

In my interview data there were a number of stories about sexual violence within services. Ellie’s story concerned a staff member in a previous service, while other women described sexual assaults by other service users, male and female, showing that women are not always safe when living in an inpatient service (Mezey et al., 2005). Karen experienced sexual violence when living in an inpatient service; and described how she felt when she was raped:

R: Were you scared? Did you not scream?

Kate: Yes I did but I couldn’t move because in a way I was paralysed so I couldn’t move but after it happened I come back, didn’t say anything for a couple of days and

staff knew sommat were up and they said 'Has sommat happened?' And I just burst into tears and told them what happened

Kate went on to have a pregnancy test, swabs, and internal examination, as a result of this assault. Recounting the event, she said

The worst thing, the worst thing about it was, I was raped by a male in [service] whilst I'm supposed to be safe but it was my own fault because I did say I was [at work] when I weren't. But then when I went for my swab, there was a man doing it because there was no female available. And they said 'You can come back at a later date if you want a female but chances are the evidence won't be there so we need to get it while it's fresh.' So I just bit my tongue and let him get it.

Clearly service users are not always safe even within services, and police treatment of women with intellectual disabilities who have been raped can be inappropriate and ill conceived (Petersilia, 2000).

Interviews with staff members indicated that staff did understand that women had experienced sexual violence in their past, and many of them pointed out that they saw the challenging behaviour of the women in terms of past experiences of abuse. For example, Iona said

It was all so obvious when you sit and listen to people's stories this is why people behave this way, um some very light-bulb moments in my head. If you've never experienced abuse, you've never experienced abuse. Not just abuse as a woman but abuse as a vulnerable woman, no matter how gobby [outspoken] and confident they seem, they are all very very vulnerable. From very poor backgrounds a lot of them,

starved of support and love really.'

However, describing women as 'vulnerable' can result in the focus of analysis being on the woman and her personal history rather than her current circumstances (Hollomotz, 2011).

Regulated behaviour

Although the unit forbids sexual activity with the rationale that all spaces are public, my observations established that intimate relationships were played out on the unit. Indeed there were attempts to control behaviour on the single sex wards, as can be seen from my field notes,

On the (Perspex covered) noticeboard there is an A4 sheet named 'Conduct on the ward.' It has a list of things that clients are allowed to do, for example 'Clients can sit with one hand on another client's knee. Clients can greet each other with a peck on the cheek.' The last item is 'No swearing.' When I ask a member of staff if they are able to have physical contact with others in the privacy of their room, I am told that because it is a secure unit, all spaces are classed as public, so this is not possible (Field-notes.)

Men and women were not allowed in each other's living accommodation, though they encountered each other during day services, in the grounds, and sometimes during social activities in the evening. In these spaces they were able to play pool, listen to music, buy snacks from a vending machine and so on. Staff concerns focussed on women mixing with men who had offended against women. For example Karen told me that,

They're just told that relationships are not allowed. They're not allowed. But again these women that say they're going out with someone, they're not told the history or the index offence and it's very difficult that because if they knew, then. . . Mind you

some of them if they knew anyway it wouldn't make any difference because that's what they've grown up with isn't it? And some of these women will always end up with [that type of man] they will bless them, they will. Because that's all they know and they're so vulnerable, they're targeted aren't they.

Karen's comment reflects the popular discourse that some women tend to repeat patterns from their past by choosing partners similar to those who have violated them (Van der Kolk, 1989, Marx et al., 2005). She suggests that women are not able to make informed decisions about prospective partners because they are not party to the same knowledge as staff about the person's offence. Jackie, however, acknowledged the role of the organisation in this type of situation when she said,

But then there's also something about not putting them in the situations that maybe reenact situations that they've been in in the past in terms of abuse or being at risk of men. Or perhaps in terms of their behaviour when around men they put themselves at risk for all sorts of reasons.

Jackie's narrative suggests that women put themselves at risk, emphasising as Karen did, that women ultimately end up recreating abusive situations from the past by being attracted to the same sort of person in the present. Although this discourse points to areas where therapy and education are needed, it situates the burden of responsibility with the victim (Warner, 1996).

The lack of information given to women about sexual relationships can be seen as a symptom of the lack of consideration given to women's sexuality, as illustrated in my field-notes,

There was some discussion about the male clients and their medication, apparently there have been complaints about medication ruining their 'sex lives'. I enquire whether they are allowed a sex life in the unit. The staff member says, 'Yes, with

themselves.’ This causes me to think afterwards that I have heard talk about men’s sexual needs, but no such talk about women. The lack of privacy offered to certain women who are subjected to ‘special observations’, where staff members have to watch them constantly in case they try to self-harm, should highlight these concerns.
(Field-notes)

Though the women were not considered as ‘needing’ sexual gratification, if they did want to participate in sexual activity they were described as promiscuous. My reflections highlight that here:

Linda tells me about a client, who in the past has inserted items into her vagina. She tells me that once she was caught having sex with a male service user in the laundry room, they’d managed to initiate penetrative sex in the very short time before the member of staff entered the room. Linda tells me that the client is ‘very promiscuous’
(Field-notes).

These two examples suggest that sometimes women are not expected to want or need sexual experiences. Although women service users were encouraged to see male staff as positive role models, there was an overriding regulation of women’s sexuality that was related to the perceived risk posed by male offenders residing at the unit.

Resistance

Due to the nature of client mix in the service it was very difficult for people to meet potential partners. This was seen by the women as very important. Although women who were married were supported to accept visits from their partners, service users were often unsure what behaviour was ‘allowed’ within sexual relationships. Despite this, there were many efforts to remain in contact with potential partners. For example, Helen told me:

It is difficult, but there is someone that I like on the ward next door. But because we're not allowed to write, well someone said we're allowed to write letters and they sometimes say we're not and that's why it's not got any further because we don't know where we stand - if we're allowed to write letters or if we're not. So we need to talk to our case managers or our key workers and get it checked to see what we're allowed to do.

The service had segregated some of the women and men based on individual risk assessment due to an incident that happened prior to my fieldwork. Only certain people were allowed to socialise on a 'mixed' basis. Women were not clear what the reason for this was, believing that it was because some people were having sex and this was somehow 'dangerous.' We can see this played out here in an interview with Kate:

Kate: Yes because if we're on group, day services bring us back, day staff drop us off and day services staff bring us back. But they've split the sessions haven't they? Strictly female, strictly male or mixed. And the ones that can't be mixed, they're saying that on the way back we're not allowed to talk to any of the lads or the lads aren't allowed to talk to any of the women on the way back and if we do try to say hello, they sort of like separate us! And it's not right, it shouldn't be happening because it makes us feel like we've done something wrong that we haven't - it's all because of four different clients. All this has changed because of four clients having sex in the toilets at the club, the poly tunnels in the gardens. This is all because of four clients this. No-one else has done anything, it's all because of them four clients.

R: Is that what happened?

Kate: Yes it is because of four clients. One set were boyfriend and girlfriend and the other set were boyfriend and girlfriend and um, they were basically going into the

club toilets whenever they could having sex or the poly tunnels whenever they could and they got caught on all the occasions. And it was actually the Valentines party that got cancelled first because of it. The staff felt it wasn't enough time to safeguard everybody because the party only got cancelled three days before it was due to start. So there weren't enough time to figure out who was dangerous and who weren't. So they had to stop it completely. And I did see him for a couple of weeks after that at the club, and then it just went.

R: Can you write letters to each other?

Kate: Yes but we don't really like doing that because it's not right. We shouldn't have to just write letters we should be able to see each other. And he's getting upset about it, I'm getting upset about it [sigh].

Many of the women pointed out that this did not equate to community life, as Teresa said *'It's not normal though is it? Just women, you wouldn't have that in the community would you? How are you supposed to get to the community when they're doing this? [...] 'It's not normal life that'*. Indeed, Teresa felt that the segregation was punitive and prison-like.

Despite this type of regulation on the unit, women managed to establish relationships with potential partners as Katrina told me:

R: OK, I know you've got a boyfriend here, how often do you get to see him?

Katrina: Every other Thursday, at the canteen. We're engaged. [shows me her engagement ring.] He gave it me last Thursday. He said will I marry him and I said yes.

R: When are you going to get married?

Katrina: When we get out of here.

Rather than having to rely on the club to see her boyfriend, Katrina was able to see him at the canteen, but this situation was dependent on staffing. Regulations were interpreted in different ways. For example, as Lorna said, *'We're not meant to hold hands but I do hold hands with him.'*

If the rules were broken expulsion was often a result. Kate for example, had been sexually active at a previous unit, and was moved to another unit. She was particularly distressed that *she* was the one who had to move. She said that she would still like to be able to have a sexual relationship with her current boyfriend but their contact had been reduced due to the segregation. A lengthy but illuminating extract from the interview follows:

R: You can't have sexual intercourse here then?

Kate: No we're not allowed, it's one of the hospital rules.

R: What do you think about that?

Kate: Well it would be alright if we were allowed at least once a month (laugh).

R: do you have a boyfriend or.. here?

Kate: Yes, yes.

R: Do you ever get to see him?

Kate: No not at the minute because um, I used to see him all the time at the club you know before it got changed. Me and him were a bit cheesed off to tell you the truth.

R: I can imagine.

Kate: Because they're saying I'm vulnerable with men but what we did is we spoke to [staff] who runs the club, and we said to [staff], 'Has there ever been a problem with us being sat together and talking and that?' and she said, 'No, but I'll have to admit this to you,' and I said, 'What?' She said 'I've been told to watch you especially,' and I said 'Why' and she said 'Because of your vulnerability.' So she says 'I've been keeping an eye on you over any of the other clients.'

R: And how do you feel about that?

Kate: It made me feel better actually knowing that she could truly say that there was nothing happening because she had been watching me, and knowing that if something had happened she would have reported it straight away and separated us. But I spoke to [psychiatrist] and I've asked him to make me go to mixed clubs because my fella's leaving in August and he's really upset, he were crying the other day because he can't see me often. And it upsets me to see him crying.

It is clear from these narratives that when women were perceived as vulnerable, they were 'watched' (Hollomotz, 2009, Hollomotz, 2011). Certain relationships caused problems for the day-to-day running of the wards, for example, Louise kept running away because of issues related to her relationship with her boyfriend. When relationships became problematic, women needed extra support (McConkey and Ryan, 2001). Perhaps they did not request this because sexual relationships were prohibited and therefore dialogue on this subject was difficult.

Same sex relationships

Some of the service users had previously had relationships with women. Despite the fact that there was a popular lesbian, gay, bisexual and transsexual (LGBT) support group and club at the unit, it seemed as though support and guidance for some of the women was lacking. Lorna she told me that her girlfriend had just finished with her and that now she was going out with a boy. She went onto say that *'I don't want another girlfriend, I've been there, done that, worn the tee-shirt and never going back. Staying with lads now. They're not as difficult, but saying that, they are'*. When I asked if she had spoken to her therapist Lorna told me *'Yes she's talked to me about it but she's said she's not the right person to deal with that so she'll transfer me to another therapist because she couldn't deal with the things that I was talking about.'* Lorna's experience illustrates the potential consequences of disclosing issues of a sexual nature; her bisexuality is treated as a specialist issue, which requires treatment by a particular therapist.

Andie told me that she was unsure about her sexuality, but her questioning was treated as disgusting by other clients as we can see here: *'I didn't want to tell my friends in case I'm a freak, kind of way and that's why I didn't tell them last night. I once said 'I don't fancy lads.'* *A girl went 'Ew!' and I said 'What? It's nature. Different. Some lads are gay in here. I asked her if she has been offered the option to go to the LGBT club but she said she was told by staff that it was not appropriate because of her age (she was 19). She said 'I'd like to go and talk to them and see what it's like being gay... 'I'm 20 this year I think I'll be honest, I am gay, kind of thing but I do need some help with it.'*

Staff members sometimes framed their concerns about gay relationships for the women as symptomatic of their past experiences, or again in terms of vulnerability, for example Adele told me:

'Some [women] have either chosen - not chosen to be gay - but decided that being gay is safer, that perhaps they weren't pre-disposed from an early age to be gay, but through circumstances have felt that it's safer to be with another woman and then there's others I think are just naturally and would have been gay no matter what. [...]but then we get issues with vulnerability, like we've two women at the moment on the same ward who've been having a relationship, but one's more predatory than the other, so there's been a duty to keep the other one safe, so we've had to say 'no, you can't sit together', which sounds really punitive, but it's to keep one of them safe.'

Some staff discussed service users and their sexuality using a 'predatory/vulnerable' binary, possibly due to the common discourse around sexuality on the unit and its focus on risk. This has similarities with research focussing on teenage sexuality, for example Elliott (2010) who talks about the risks perceived by parents when their child embarks on a sexual relationship. The emphasis in these narratives is that of protection from risk (Hollomotz, 2013). It was unclear whether staff were encouraging self-defence skills and healthy decision-making in the women or if it was simply controlling behaviour (Löfgren-Mårtenson, 2004, McCarthy, 1998).

Conclusions

What is not explored sufficiently in forensic [secure] settings is the meaning of 'normal' sexual relationships for people who have experienced considerable

childhood trauma and deprivation, and who are detained in long-term residential settings that are both custodial and therapeutic (Adshead, 2004:83).

The women in my research were highly regulated when it came to sexual behaviour and relationships. The concept of 'vulnerability' was used as a rationale for this regulation, and linked to the women's intellectual disability or history, rather than being connected to the presence of male offenders at the unit. Stories of sexual violence and child abuse were very common with half of all interviewed service users disclosing such experiences, without being prompted. Some staff proposed that the women had issues with repeating patterns of abuse. Despite these experiences of abuse, and the potential problems of extra regulation related to the presence of male offenders, and in accordance with Mezey et al. (2005), the majority of the women did not want to be segregated from the men.

When women shared the secure service with men who have offended, concerns about them mixing came to the fore, (Warner and Wilkins, 2004, Yool et al., 2003), but same sex relationships were also being regulated. Previous research has suggested that women with intellectual disabilities have little knowledge of same sex relationships due to lack of information, role models and sex education, and some have very strong negative views about homosexuality (Hollomotz, 2011, Burns and Davies, 2011). Although my study shows that some women are interested in exploring their sexual identity, this was avoided by staff who, as in Yool *et al.*'s study, did not think it was appropriate to discuss homosexuality with service users (Yool et al., 2003).

Two of the women that I interviewed did not convey interest in sexual relationships, giving their negative past experiences as reasons. However, contrary to some research about women

with intellectual disabilities (such as McCarthy, 1993, Fitzgerald and Withers, 2011), the other participants did want a sexual relationship, despite the sexual abuse and violence in their pasts. In the face of high levels of regulation they found ways to experience these intimate relationships. As Carol Thomas (1999) notes, disabled people, like all people are both determined and determining.

My study suggests that the ability to have sexual relationships is important to women with intellectual disabilities who live on a locked ward. Women tend to stay in this kind of service for long periods of time, and services should consider how to balance protection and risk. Rogers (2009) throws light on the dilemma between protection and freedom from the point of view of the mother of a young woman and it is through her auto-ethnographic account that we can see that issues of consent and self-defence become paramount:

we are forced into thinking about who has the right (and abilities) to be sexually and intimately active, to mother, and ultimately to make decisions about their own body.

These cases underline the need to understand intimacy, sexuality and learning disability in the transition to adulthood in everyday life (Rogers, 2009:273).

What is encouraging about my study is that women are managing to find ways to express themselves sexually, even though sexual relationships are regulated by the service. Individual staff 'allow' some sexual expression in controlled ways (Christian et al., 2001), and policies and guidelines are individualised depending on risk factors. A reassuring point is that staff recognise the past experiences of the women as contributing to their challenging behaviour, rather than related to personality or impairments. However these experiences elicit feelings of protection in staff (Hollomotz, 2013). who become concerned about the balance between risk and protection.

This positioning of women between risk and protection is helpfully articulated as an intersection of intellectual disability and gender, where issues of protection and paternalism proliferate (Björnsdóttir and Traustadóttir, 2010), but also of female offending, where agency is discounted (Adshead, 2011). Ultimately, this can work against women's chances of rehabilitation and resilience. Nevertheless, as Bernert points out:

Equality and protection do not have to be an either/or priority if they are approached as an integrated process to enhance the sexual health and development of women with intellectual disabilities (Bernert, 2011:140)

There is clearly a way forward from this. If it is unrealistic to enable women to experience sexual relationships in this setting where they may reside for a large part of their lives, then clear policies and procedures informed by service users must be introduced (Rushbrooke et al., 2014a) which have the scope to be individualised. Further research might focus on the development of policies which could be developed in collaboration with service users and communicated openly to them in order to promote self-determination and allow people to make informed choices about relationships in the future (Bernert, 2011).

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