Voices Unheard

Exploring the Experiences of Women Overcoming Sexual Violence in Mental Health Settings

By

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This book first published 2025

Ethics International Press Ltd, UK

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

Print Book ISBN: 978-1-83711-019-3

eBook ISBN: 978-1-83711-020-9

Kintsugi

Kintsugi is the Japanese ‘art of scars’. When something precious is broken, the Japanese do not throw it away, they mend it to make it stronger; so it is less likely to break a second time. They create something enduring from the initial damage.

Kintsugi can be likened to a pivotal moment in our lives, where we break apart from the pressure of reaching our limits of endurance. If we can remain strong in the face of that damage, the thing that broke us is just another aspect of our journey. Kintsugi is therefore a metaphor for healing and resilience.

Contents

Glossary of Terms and Abbreviations

- BMA: British Medical Association.
- CQC: Care Quality Commission.
- COHSE: Confederation of Health Service Employees.
- ECHR: European Convention on Human Rights 1950.
- ECtHR: European Court of Human Rights.
- GMC: General Medical Council.
- ICU: Intensive Care Unit.
- MHA: Mental Health Act 1983.
- NHS: National Health Service.
- NPSA: National Patient Safety Agency.
- OT: Occupational Therapy.
- PTSD: Post traumatic stress disorder.
- Sexual trauma: trauma resulting from experiencing non-consensual sexual acts or exposure, which can cause significant and lasting physical and psychological harm.
- Sexual violence: Unwanted sexual behaviour, sexual harassment and abuse, in addition to sexual assault and rape. Acts of a sexual nature carried out against a person's will, through the use of physical force, intimidation or coercion, or any attempts to do this.
- Trauma: a personal experience that is deeply distressing and/or disturbing. This may cause the person to feel severe shock or emotional distress.
- Retraumatization: the reliving of stress reactions to a past traumatic event when a person is exposed to a similar incident at a later time. Retraumatization involves a new event or situation that causes someone to re-experience the

intense emotions and physical responses of the original trauma, making it feel as if the trauma is reoccurring.

- Trauma site: a location associated with a traumatic event.

Acknowledgments

My sincere thanks to Dr Louise Hide for granting me permission to quote extensively from her work: 'In Plain Sight: Open Doors, Mixed-sex Wards and Sexual Abuse in English Psychiatric Hospitals, 1950s—Early 1990s' in Social History of Medicine [Nov 2018] Volume 31, Issue 4, 732–753, and Gender and Class in English asylums, 1890-1914 (Basingstoke, Palgrave Macmillan, 2014)

With thanks to my friend and colleague Jason Lowther for his help and support in securing the research sabbatical that allowed me the time to write this book.

With thanks to the women who told their stories, without them this book would not be; and to Passy for everything she has taught me.

Authors note: The term 'survivor' is used throughout this book to describe women who have survived sexual violence. It is intended to counteract the sense of powerlessness that the word 'victim' implies.

Foreword

Kim Jewell, Team Leader, Independent Sexual Violence Advisor Service

In my role as an Independent Sexual Violence Advisor (ISVA), I have witnessed examples of the best and worst of humanity. I have seen how acts of sexual violence, be it recent or non-recent, can destroy and steer the course of people's lives. It can create a wall of silence which freezes and isolates a survivor into a never-ending loop of fear, shame and anxiety. It is left to them to rebuild everything they once knew. From their sense of security and personal boundaries to their very identity; extending to how they function as a parent, a member of the workforce, and in any other roles expected of them by society. I have also seen how it affects the people in their lives, causing breakdowns even in once very intimate and strong relationships. Where people were husbands, wives, sons, and daughters, they are now the survivors' mental health workers and/or sole providers.

That's without taking into consideration how much the act of sexual violence and resulting trauma puts pressure on services such as our medical, Criminal Justice, and benefits system. Currently I support survivors with trial dates two to three years in the future after they have reported. This is far from the notion of 'swift and effective justice', an idea coined during the creation of the Criminal Justice System. Instead, should victims/survivors report the offence, they are expected to continue with their lives whilst they wait for what is a broken criminal justice system to deal with their case. They often have to rely on the support of

underfunded and beyond capacity services. Many excellent non-statutory services face closures due to lack of funds and/or continue to block their waiting lists intermittently to cope with the ever-growing demand for support. Services who support the most vulnerable, all have common theme. Workers are underpaid, overworked, and are impacted continuously by vicarious trauma. The traumatised are ultimately being supported by the traumatised. This can directly impact the quality of support provided due to absence from sickness and poor staff retention.

The strength and resilience of a survivor, however, continues to amaze me. Despite their trauma, I have witnessed my clients rebuild their lives and even go on to support people who had similar experiences. The determination of workers in this sector inspires me every day. In the face of adversity, they continue to fight daily for their clients. That is the humanity that keeps me and many others in this crucial role.

Make no mistake, acts of sexual violence permeate all aspects of everything it encounters, from the individual to the wider society. Once engrained it cripples the host until nothing, but a figment is left in its standing, a shell of its former self. It is a long-standing, silenced pandemic that no one wishes to address, for fear that our society may not be as civil as it believes itself to be. Where the issue remains all but denied, education and financial support around the topic of sexual violence is more crucial than ever.

That is why Lisa's book is instrumental. Any research that brings to light the impact of sexual violence and trauma is significant in its contribution to changing the way society views sexual violence, prevents it, and supports those impacted. This book is important

because it recognises and gives voice to people who are unable to necessarily speak for themselves, those who are the most vulnerable in our society; those with mental health needs.

Kim Jewell
26 August 2025

Introduction: The Background

"One message is the importance of listening to people who use mental health services. Nothing can compare with the power of individual testimony".[1]

This book explores sexual violence towards women in inpatient mental health settings. It advances existing research, which reports that sexual safety is a common problem for women who are involved with mental health services;[2] whilst disclosures of sexual violence are at risk of being minimised and inadequately addressed by mental health professionals.[3] Here I build on the work of the Care Quality Commission,[4] Bowers et al[5] and Ashmore et al, all which demonstrate that impatient mental health settings are now widely acknowledged as sexual violence "high-risk sites",[6] particularly for women. Betterly's research concluded that "sexual assault in the inpatient psychiatric setting presents a

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[1] Jeremy Laurance, *Pure Madness: How Fear Drives the Mental Health System*, (Routledge 2003) 134

[2] Elisabeth Hughes, Michael Lucock, Charlie Brooker, 'Sexual Violence and Mental Health Services: a call to action' in Epidemiology and Psychiatric Sciences [2019] 28, 594-597

[3] Toni Ashmore, Jo Spangaro, Lorna McNamara, 'I was Raped by Santa Claus: Responding to disclosures of sexual assault in mental health inpatient facilities' in International Journal of Mental Health Nursing [2015] 24, 139-148

[4] Care Quality Commission, Sexual Safety on Mental Health Wards, Report (Sept 2018) https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards#:~:text=What%20we%20found,the%20person%20who%20is%20affected

[5] L Bowers, J Ross, P Cutting, D Stewart, 'Sexual behaviours on acute inpatient psychiatric units' in Journal of Psychiatry and Mental Health Nursing [2014] 21,3, 271

[6] Ashmore et al (2015) 139

host of problems for providers". [7] Sexual violence in this environment does not exist in a vacuum; it creates medical, ethical, and legal implications. Medical problems include sexually transmitted infection, unintended pregnancy from rape, physical and psychological trauma. Ethical concerns include reports made by patients who are suffering from symptoms of mental illness, the responses to these reports, their dignity and privacy. Legal challenges may arise in the form of civil liability and criminal litigation which may run concurrently with an internal investigation.

Societal incuriousness towards this problem has its foundations in the disregard of the rights and voices of people who suffer from mental health problems. The number of sexual violence incidents still occurring in mental health settings is unacceptable and must be urgently addressed. O'Dwyer et al point out that that sexual violence predisposes and maintains mental illness and mental illness then increases the risk that a women will experience sexual violence. [8] This manifests as an accumulation of negative experiences that feel relentless and overwhelming to an individual.

In the early 1990s, researchers placed the problem of rape and sexual assault of vulnerable psychiatric patients in the spotlight;

[7] Holly Betterly, Meghan Musselman, Renee Sorentino, 'Sexual assault in the inpatient psychiatric setting' in General Hospital Psychiatry (May-June 2003) Volume 82, 7-13

[8] Carol O'Dwyer, Laura Tarzia, Sabin Fernbacher, Kelsey Hegarty, 'Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units' in BMC Health Serv Res [Nov 2019] 14, 19, 1, 839

calling for urgent measures to address it.[9] Extant studies report equal, if not worse, sexual safety risks.[10] Research carried out in recent years demonstrate that inadequate internal and external reporting policies and a lack of training for staff are key drivers behind the continuing problem.[11] Better training for professionals, therapeutic responses to disclosures, along with a more robust reporting policy are key to improving sexual safety. However, I discovered from my conversations with survivors that the stigmatising of women with mental health problems remains a culture within mental health settings that obstruct effective responses to sexual violence disclosures. There is enduring evidence that institutional bias is supported by the ideology that women inpatients who report sexual violence have no credence.[12] As a mental health nurse once offhandedly commented to me, "all women [in mental hospitals] are either mad, bad, sad or a combination of all three". When women are stereotyped in this manner, they are divorced from their individuality and their right to be heard. They are ultimately deprived of a voice.

With that in mind, this work highlights the perspectives and voices of women survivors of sexual violence; women who are seldom the focus in leading discourses of professional practice in this area.

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[9] C Thomas, A Bartlett, G,C Mezey, 'The extent and effects of violence among psychiatric in-patients' in Psychiatric Bulletin [1995] 19,10, 600-604

[10] CQC (2018)

[11] Tara Lawn, Elizabeth McDonald', Sexual Assault on Psychiatric Inpatient Wards' in Psychiatric Bulletin [2009] 33,108-111. See also Care Quality Commission Report (2018) and Michelle Cleary, Razelle Warren, 'An Exploratory Investigation into Women's Experiences in a Mixed Sex Psychiatric Admissions Unit' in Australian and New Zealand Journal of Mental Health Nursing' [1998] 7, 33-40, 34

[12] Lawn et al (2009)

My work moves some way towards equalising this disparity by acknowledging their experiences and arguing that what they say should be listened to. The findings of this study demonstrate the tenuous interrelationship between mental health, sexual offences and ethical issues such as the sexual dignity of detained women.

This work does more than consider the impact of sexual violence on women. By incorporating the whole story of the survivors, it explores the 'before' and the 'after', thus providing a broader scope of the repercussions of institutional failings in sexual safety incidents. I have not avoided conveying the indignity, powerlessness, anger and sadness of the women who told me their stories. The intention is to ensure that those who read this work can appreciate and understand the vulnerability of women when they were physically and emotionally harmed by perpetrators; then victimised within a system that should protect them, not enable their abuse.

Conceptual aspects of the study

In this book I frequently refer to the term 'sexual violence'. This encompasses unwanted sexual behaviour, sexual harassment and abuse, in addition to sexual assault and rape. I was also informed by the helpful definition of Ashmore et al who use the term 'sexual violence' to define "acts of a sexual nature carried out against a person's will, through the use of physical force, intimidation or coercion, or any attempts to do this". [13] This study involves discussions about people's mental health. People with mental illness and mental health diagnoses are vulnerable to being

[13] Ashmore et al (2015)

stigmatised and discriminated against.[14] Words used to describe them can reinforce their 'otherness'.[15] I have used neutral terms such as 'service users' and a 'person with a mental health issue' or a 'mental health problem'. I have avoided labelling or using definitions that are no longer acceptable. These are included only where the literature or the participants refer to such definitions or they are necessary to convey something of importance.

This book is about the lived experiences of individual women. Due to the methodological approach, it reveals personal details about them. To protect their identities, they have pseudonyms in place of their real names, and some other identifiable information has been altered or changed. Although I have shared information about symptoms the women were experiencing in the past, I have not included any diagnoses they may have been given. All of the women had recovered from mental health problems at the time I met with them, none had been involved with mental health services for several years. They provided informed consent to participate and approved the final draft of their story.

Research driven by personal experience

Across the global research community, academic research is regularly motivated by personal experience. I carried out research into the impact of sexual violence on women in mental health

[14] Mind, 'Half of UK adults believe there is still a great deal of shame associated with mental health conditions' (*Mind*, March 2024) https://www.mind.org.uk/news-campaigns/news/half-of-uk-adults-believe-there-is-still-a-great-deal-of-shame-associated-with-mental-health-conditions/#_ftn1

[15] Treating people as inferior or unfairly because they have a mental health condition

settings because it has personal significance for me. Between 2002 and 2008, I worked directly with women inpatients in five different mental health institutions, including privately funded and NHS. Most of the wards I worked on were occupied by mixed gender patients, many of whom were detained compulsorily under the Mental Health Act 1983 (MHA). In those six years, I witnessed first-hand, or learned of, many incidents of sexual violence, ranging from sexual harassment to rape.[16] The situation in some hospitals was unmanageable with primarily male (but sometimes female) patients, behaving in ways that compromised the sexual safety of other patients. The staff rarely intervened unless circumstances spilled over into a situation that disrupted the ward environment. This is reminiscent of a report published by the mental health charity Mind, who were generally critical of psychiatric hospital staff, noting, "staff do not seem interested in their jobs; patients are left to wander around in an unsafe environment".[17] This is supported by Laurance whose research found,

> "People were bored and frustrated on the wards. 40% were involved in no social or recreational activity so they took it out on the staff or on each other. They played music too loud, drank, took drugs, got into fights. Many patients felt unsafe, especially women".[18]

[16] Ashmore et al (2015) found that sexual violence is significantly higher in mental health settings than in the general population.
[17] Mind, 'Ward Watch: Mind's campaign to improve hospital conditions for mental health patients: Report Summary' (*Mind*, 2004) http://news.bbc.co.uk/nol/shared/bsp/hi/pdfs/07_09_04_mindsummary.pdf
[18] Laurance (2003) 99

Laurance argues that this problem is primarily fuelled by the attitudes of clinical staff,

> "There's the inability of ward staff to have any meaningful interaction with patients. Nurses preferred the environment of the office to any of the rooms where the patients sat. They talked to each other not the clients who were left to fend for themselves unless something serious occurred".[19]

Disengagement of staff increases sexual safety risks. In its report, Mind observed that "one in five respondents reported sexual harassment whilst five per cent of respondents reported a sexual assault".[20] I worked on an acute ward where a male patient sexually touched every female patient or staff member who walked past him, but he continued to be left unsupervised in communal areas, and no action was taken to stop him.

That is not to say that all sexual violence in mental health settings is perpetrated by men against women. It is acknowledged that all genders may experience sexual violence and it may be perpetrated by people of any gender. However, in a scoping review of existing literature, Betterly et al found that 90% of allegations were made against male patients and male staff members, and 71% of all allegations of sexual violence were made by females.[21] This is supported by Thomas et al and by Abel and Newbigging who report that female patients are significantly more likely to be victims of sexual violence and sexual trauma.[22]

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[19] Ibid
[20] Mind (2004)
[21] Betterly et al (2003)
[22] Thomas et al (1995)

During my time on wards, when non-consensual sexual behaviour or sexual violence was suspected, reported or witnessed, it was too often tolerated, ignored, minimised and/or written into the victim's pathology as a characteristic of their illness.[23] Rarely was it properly investigated, either at management level or by external authorities. It seemed that in the mental health setting, sexual violence was something that could happen; if it did, that was unfortunate, but that was the nature of such places. Sexually abusive patients were sometimes transferred away from mixed wards but not always; male staff who were reported were commonly exonerated without further investigation.[24] The trauma suffered by the victim was largely ignored, yet research finds that women in mental health settings are more likely to have suffered sexual abuse as children and/or as adults. [25] They can be profoundly retraumatised by further sexual violence.[26]

When attempting to communicate with senior clinical staff about patient disclosures of sexual violence, I discovered that official procedures designed to report and address it were opaque and overly complex. It was a subjective process where only some incidents were logged with the hospital management reporting system. This was often based on the consensus that reports were not read, therefore there was no point in wasting time completing one. In addition to a system that lacked efficient recording, there was inadequate training to support staff in dealing with or

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Kathryn M Abel, Karen Newbigging, Addressing Unmet Needs in Women's Mental Health, British Medical Association (2018)

[23] Ashmore et al (2015), Cleary, Warren (2018) 38

[24] Ashmore et al (2015) identified specific challenges for staff dealing with disclosures of sexual violence involving male staff members

[25] Cleary, Warren (2018) 38

[26] Bowers (2014) Abel Newbigging (2018)

responding to sexual violence. McLindon and Harm's research concluded that, "many mental health professionals report lacking skills and confidence to respond to patient disclosures of sexual assault in the inpatient environment, even those that are coherent and supported by evidence".[27]

Furthermore, what tends to miss the research agenda is the toxic culture of victim blaming that existed in some of the institutions I worked in. Discussions about sexual violence allegations focused on the victim, not the perpetrator. It was often accepted that victims of sexual violence were delusional, intentionally falsely disclosing, behaving in a way that encouraged sexual violence, regretting choices made about their sexual activity or failing to protect themselves. But even delusional or false reports are made for a reason, for example, triggered disclosures of past sexual violence,[28] but this was rarely recognised by practitioners. This was detrimental to the wellbeing of victims. According to Ashmore "whether the patient's allegation is believed in the first instance, harm is done by reacting with disbelief or dismissal".[29]

The patients making disclosures were vulnerable; they were psychologically distressed, unable to leave the ward where they had suffered harm, and their freedom of choice was restricted. Refusals to address disclosure may have been a defensive tactic because staff possessed neither the confidence nor the skills to

[27] Elizabeth McLindon, Louise Harms, 'Listening to mental health workers' experiences: Factors influencing their work with women who disclose sexual assault' in International Journal of Mental Health Nursing [2011] 20, 2–11

[28] Ashmore et al (2015) 146

[29] Ibid 149

respond appropriately to incidents or reports of sexual violence.[30] However, there exists a duty of care to keep patients safe from harm and abuse as well as obligations under the European Convention on Human Rights. [31] The consequence of a misogynistic attitude towards sexual violence means that perpetrators have more freedom to act on their intentions. Sexual violence thrives in this environment. In its report 'Promoting Sexual Safety through Empowerment' the CQC stated that,

> "Stakeholders told us sex is often treated as a taboo subject. Providers, staff and families can be reluctant to raise issues. This can affect people's wellbeing. It also means predatory behaviour can be missed or normalized".[32]

At the risk of sounding overly critical, it should be noted that within the institutions I worked in there were committed people who practiced exemplary care and compassion towards their patients; but there was also a significant amount of distancing and disregard, where staff confined themselves to the ward office, barely communicating with patients unless they were dispensing medication or de-escalating aggression. This detachment was in some cases a reaction to staff shortages coupled with overcrowded wards. It is the case, as Laurance points out, "that many mental

[30] Ibid 149

[31] ECHR Art 3 public bodies must not allow a person to be treated in an inhuman or degrading way, taking reasonable steps to protect a person when public officials know (or should know) there is a risk of inhuman or degrading treatment. Public bodies should investigate where there may have been inhuman or degrading treatment which occurred when a person is in the care of public services

[32] Care Quality Commission, Promoting sexual safety through empowerment (Feb 2020) https://www.cqc.org.uk/publications/major-report/promoting-sexual-safety-through-empowerment

health staff are skilled, caring and committed but continue to be constrained by the lack of resources to maintain a high enough standard of care to patients".[33] This can create a culture within a system, where there is a dynamic of defensiveness by staff towards patients. In this environment, women are vulnerable to sexual violence because the staff are unaware of grooming or other potential risks posed by dangerous patients. In one unit I worked in the hospital managers implemented a scheme called 'protected time'. This was a period each day when visitors were not allowed, and nurses each had a patient allocated to them to sit with for one hour to discuss anything important or sensitive. This was with the intention of encouraging nurses to spend quality time with patients.[34] In the year that I worked there, I did not see a single nurse engage with protected time. A study published in the Nursing Times found that protected time was inconsistently implemented for various reasons, but primarily through nurses prioritising other matters such as staffing levels and difficult patients.[35] Protected time is also incompatible with the hierarchal relationship that often exists between patients and staff. This professional distancing has been argued to be an exercise in self-preservation for mental health professionals and was defined in 1985 by Warner,

> "Nurses adhere to the cultural definition of madness as something to be shunned. They know not all their patients behave in a mad way but the fact that patients have being diagnosed means they can all be legitimately defined as mad.

[33] Laurance (2002) xviii
[34] Nursing Times, 'Evaluating protected time in mental health acute care' (4 Sept 2008)
[35] Ibid

> Since nurses cannot get away from madness physically, they get away emotionally, they develop a relationship that locates insanity in the patients and sanity in themselves, with a barrier to prevent contamination. This arrangement allows nurses to stay in the situation without feeling that their minds are being damaged".[36]

This argument is problematic, because whilst staff need to protect their own mental health, patients should not be left alone without supervision. More than ever before mental health wards accommodate some extremely dangerous and unpredictable people[37] who must be carefully monitored to preserve the safety of other vulnerable patients.

Aims and objectives of the study

In the era of 'Me too', a global movement against sexual violence, and 'Times up', a campaign which aims to combat sexual harassment; sexual violence in hospitals tends to miss the agenda. Barnett writes on this subject,

> "In the wake of the #MeToo movement, significant strides have been made in addressing sexual violence within society. Extending these efforts to the isolated worlds of psychiatric facilities is a logical next step".[38]

This argument is supported by Hide, "while child abuse is subject to a growing body of scholarship, less attention has been paid to

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[36] Richard Warner, *Recovery from Schizophrenia* (Routledge, 2004) 80-81
[37] Laurance (2002)
[38] Brian Barnett, Addressing Sexual Violence in Psychiatric Facilities in Psychiatric Services [Sept 2020) 71, 9, 959

adult care in long-term psychiatric institutions". [39] Similarly, Bowers notes, "[Sexual Violence] is largely ignored by hospital policies and by academic literature".[40] Whilst Thomas et al point out, "little attention has been paid to the sexual victimization of psychiatric inpatients".[41]The invisibility of this problem, and my own experiences of working in adult mental health inspired me to research and write this book. As Glenda Russell observes, "good research springs from the researcher's values, passions and preoccupations". [42] My research interests include gender-based violence and social justice. I chose to work solely with women within a feminist methodology because rape and sexual violence are seen as key crimes against women within the feminist agenda. [43] Furthermore, prioritising women's discourses in research is suited to a feminist theoretical approach. [44] Feminist scholars in the field of women and mental health have argued that the high level of mental illness in women is a consequence of the oppression they face. [45] Being detained in a hospital is not a solution to this social construct if women then suffer further oppression and inequality in the form of sexual violence.

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[39] Louise Hide, 'In Plain Sight: Open Doors, Mixed-sex Wards and Sexual Abuse in English Psychiatric Hospitals, 1950s—Early 1990s' in Social History of Medicine [Nov 2018] Volume 31, Issue 4, 732–753, 734

[40] Bowers (2014) 271

[41] Thomas et al (1995) 600

[42] Glenda Russell, Nancy Kelly, 'Research as an Interactive dialogic processes: Implications for Reflexivity' in Forum Qualitative Social Research [2002] 3:3

[43] Maria Bevacqua, *Rape on The Public Agenda: Feminism and the Politics of Sexual Assault*, (Northeastern University Press, 2000)

[44] Sandra Harding, *Feminism and Methodology*, (Indiana University Press 1987) 6

[45] Joan Busfield, 'Mental illness as social product or social construct: a contradiction in feminists' arguments?' in Sociology of Health & Illness [1988] 10: 521-542

I work with respect to the feminist way of holding the belief that there is more than one correct form of knowledge. This embraces the idea that there are many versions of reality which are dependent upon and relational to context they are happening in.[46] I wanted to ensure that the voices of women who experienced sexual violence whilst detained in hospital were prioritised in this study. I therefore avoided a scientific theoretical stance. I was privileged to work with four women who survived sexual violence, and who were willing to share their stories. Using methodologies of phenomenology and narrative analysis ensures that each woman's story is given the context, meaning and significance it deserves.[47]

The objective of this book is to widen the scope of discussion about sexual violence in mental health settings. It aims to address the central problem not just in an administrative or managerial sense, but one places centrally the voices of those with lived experience and illustrates the individual and the collective effect of such violence. Through the spectrum of contemporary debate about the problem of sexual violence, we need to identify the essence of the challenge that confronts mental health policy, then work towards finding solutions that prevent it from happening, rather than ruminating on the aftermath. Women who are detained for care and treatment of mental illness deserve to be safe; it is their human right not to experience abuse and inhumane treatment. It is not admissible to accept the risk that they will suffer harm, or consider their sexual safety as unimportant. It is hoped that this research continues to raise awareness about the impact sexual violence has

[46] Virginia Braun, Victoria Clarke, *Successful Qualitative Research: A Practical Guide* (Sage 2013) 4

[47] See chapter 10 Methodology

on female inpatients. Increased awareness can be a motivation to improve safety for women in mental health settings.

The overreaching aim of mental health care in the UK is to improve services, prevent mental illness, and reduce inequalities. [48] If women are detained compulsorily, having their freedom of movement and choices taken from them, sometimes for years, it is imperative that they are not placed at risk of sexual abuse or violence. Many of these women are already veterans of sexual violence and abuse, it may have played a major role in their illness. Therefore, to be exposed to further violence in what should be a place of safety contradicts the aims of mental health care and feeds into a culture of inequality and institutional abuse. Women who experience sexual violence leave hospital not walking towards recovery, but re-traumatised by new harms. I will argue that attitudes have barely evolved since the 1950s; in particular, the refusal of personnel to acknowledge reports of sexual safety breaches, the inability to address incidents effectively and the minimising of sexual violence.

Chapters one and two explore the history of mental health care from the Victorian asylums with their strict gender segregation, to the open doors and mixed gender wards of post war hospitals. Although Victorian physicians held the firm belief that a women's reproductive cycle and sexuality were the primary cause of mental illness, very little information was documented about sexual violence in asylums. Institutional rape and sexual assaults were abstract concepts, barely acknowledged until the 1970s when feminists influenced professional understanding of women as

[48] NHS England, Crisis and Acute Mental Health Services (*NHS*, 2024)

victims of sexual violence. Chapter three focuses on the modern mental health setting and the prevalence of sexual violence. We consider why this is still such a significant problem according to victim testimonies, official inquires and contemporary research findings. Here we explore the legal concepts of human rights and sexual offences and their interrelationship with the ethical values of dignity and respect. Chapters four, five, six and seven present the experiences of four women, all who are survivors of the sexual violence they suffered whilst detained in hospital under the Mental Health Act 1983. These narratives are presented as in-depth and subjective narratives which provide deeply personal accounts of each woman's journey from being detained, to working towards empowerment and overcoming the sexual violence they suffered. Chapter eight explores the themes that emerged from the women's experiences, including unsafe wards in the context of sexual safety, barriers to reporting sexual violence, victim blaming, and (re)traumatisation. Additional themes of disempowerment and compromised (sexual) dignity are also explored. The final chapter considers the recommendations for mental health care to become more gender informed, women friendly and the concepts of 'investigative' and 'therapeutic' responses by staff to disclosures of sexual violence. Ashmore et al argue that both are crucial aspects of duty of care to patients,[49] if services are going to ensure the security, safety and dignity of women using mental health services. Finally, 'trauma informed care' is well established in many services who work with sexual violence survivors, yet it seems to be lacking in mental health where it should be

[49] Ashmore (2015) 148

implemented and followed by all those who work with vulnerable women on wards and in the community.

This book would not have been possible without the testimonies of the women who agreed to share their experiences. These stories undoubtably make for difficult and distressing reading at times, but I believe they are crucial if we are going to recognise and acknowledge the trauma that sexual violence in mental health settings causes to some of our most vulnerable members of society.

Chapter One
Women and Mental Health Care in the 19th Century

"Not conforming to the norm risks the label of deviance or madness

It is sometimes attended by confinement".[1]

The 19th Century: The growth of the asylum

The Victorian Era saw the mass institutionalisation of people who were considered to have mental illnesses or learning disabilities, facilitated by the building of 'lunatic' asylums during this time period [2] The word 'asylum' derives from the rudimentary institutions which provided safe refuge to the mentally ill; [3] asylums being the historical counterparts of the modern psychiatric hospital. Before asylums were established, the insane or those who were simply unable to cope in society remained with their families or were accommodated in private institutions. If they were poor and destitute, they were likely to be sent to the

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[1] Lisa Appignanesi, *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present* (Virago, 2008) 7

[2] Andrew Scull, *The Most Solitary of Afflictions: madness and society in Britain, 1700–1900* (Yale University Press, 1993)

[3] Usually religious in nature. See, A Victorian Mental Asylum *(Science Museum*, June 2018) https://www.sciencemuseum.org.uk/objects-and-stories/medicine/victorian-mental-asylum#:~:text=Before%20asylums%2C%20people%20with%20mental,up%20in%20workhouses%20or%20prisons