

Between Normalization and Protection: A Qualitative Multi-Stakeholder Study of Gender Composition in Psychiatric Wards

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Abstract

Background: The organization of psychiatric inpatient wards by gender remains contested, framed as a trade-off between safety and recovery-oriented care. Existing research has typically examined these tensions from a single stakeholder perspective.

Methods: This qualitative study explored perceptions of ward gender composition across four groups: current inpatients (n = 74), former inpatients (n = 60), family members (n = 37), and mental health staff (n = 62). Data were collected through open-ended written responses and analyzed using reflexive thematic analysis.

Results: Seven themes emerged: safety and the risk of sexual harm; social connection and therapeutic benefit; behavioral regulation and ward dynamics; normalization and reflection of real-world life; privacy and bodily integrity; religious, cultural, and individual identity; and the complexity of preference and the call for individualized solutions. No single position was universally endorsed. Safety concerns predominated among female inpatients, former inpatients, and family members; the social and therapeutic value of mixed environments was most strongly articulated by male patients and those without trauma histories. Participants differentiated between closed acute and open rehabilitation wards as warranting different compositional arrangements. An integrative theoretical model – *The Gendered Safety-Connection Tension Model* – is proposed to capture how individual background variables, dialectical tensions, and clinical context moderators interact to produce individualized ward preferences.

Conclusions: Gender composition in psychiatric inpatient settings is best understood as a dynamic, multi-level negotiation shaped by individual history, clinical context, and ward type. Findings highlight the need for tiered, trauma-informed, and identity-sensitive approaches that move beyond uniform policy toward individualized placement decisions.

Introduction

The organization of psychiatric inpatient wards along gender lines remains a contested issue in contemporary mental health care, situated at the intersection of clinical practice, patient safety, and ethical responsibility. While some systems have moved toward mixed-gender environments in the interest of normalization and deinstitutionalization, others continue to advocate for gender-segregated spaces, particularly in response to concerns regarding safety, privacy, and vulnerability. This ongoing debate reflects broader tensions within psychiatry between containment and recovery, protection and autonomy, and institutional control versus everyday social life.

Despite a growing body of research on gender, safety, and inpatient care, existing studies have rarely examined how current inpatients, former inpatients, family members, and clinical staff may conceptualize and prioritize these concerns in distinct ways, and the field lacks an integrative understanding of how perspectives grounded in lived experience, anticipatory concern, and professional judgment converge and diverge.

The present study addresses this gap, exploring perceptions of gender composition in psychiatric inpatient settings across four stakeholder groups: current inpatients, former inpatients, family members, and mental health staff. The study asks: (1) How do different stakeholder groups perceive mixed versus single-gender wards? (2) What considerations underlie their preferences? and (3) How are these shaped by lived experience, contextual conditions, and position within the mental health system?

Background

Concerns regarding safety in mixed-gender psychiatric wards have been widely documented, particularly in relation to women's vulnerability to harassment, boundary violations, and sexual assault [1, 2, 3]. Women in inpatient settings may experience fear, discomfort, and a lack of privacy, especially where supervision is limited or where patients' judgment is impaired [4]. Such concerns are further compounded by the ethical complexity of consent in psychiatric contexts, where acute symptoms may affect decision-making capacity. As a result, calls have been made for gender-sensitive services, including single-gender wards or women-only spaces, as a means of enhancing safety and dignity.

At the same time, an exclusive focus on risk and protection has been increasingly challenged by recovery-oriented approaches to mental health care. These frameworks emphasize autonomy, social participation, and engagement with environments that resemble "real life," suggesting that overly restrictive or segregated settings may undermine rehabilitation and reinforce institutionalization [5]. From this perspective, mixed-gender wards may offer opportunities for social interaction, relational development, and a sense of normalcy central to recovery processes. Qualitative research has indicated that some patients value mixed environments for their capacity to reduce isolation, foster connection, and create a more humane ward atmosphere [6].

The tension between safety and normalization is further intensified by the high prevalence of trauma among psychiatric populations: a substantial proportion of inpatients, particularly women, have histories of sexual violence, raising concerns that mixed-gender environments may reintroduce vulnerability or trigger traumatic responses [7, 5]. Translating trauma-informed principles into concrete ward structure decisions remains complex, as safety-enhancing interventions may inadvertently foreclose meaningful social engagement.

Method

Participants

The study included four distinct participant groups, whose characteristics are detailed in Table 1. *Current inpatients* ($n = 74$; 35 women; age 19–57, $M = 34.3$, $SD = 10.29$) were recruited from five wards in two Israeli mental health centers: Hospital A (a large mental health center, mixed-gender wards) and Hospital B (a mid-sized mental health center, single-gender wards). A trained research assistant invited voluntary

participation in each ward's occupational therapy room; patients under legal guardianship were excluded.

Table 1
Participant Characteristics by Group (N = 233)

Gender	Category	Current Patients (n = 74)	Former Patients (n = 60)	Family Members (n = 37)	Staff (n = 62)	Total
	Female	35 (47.3%)	39 (65.0%)	34 (91.9%)	36 (58.1%)	144 (61.8%)
	Male	39 (52.7%)	21 (35.0%)	3 (8.1%)	26 (41.9%)	89 (38.2%)
Age M(SD)		34.3 (10.29)	39.48 (11.06)	61.73 (9.69)	44.39 (11.26)	
Marital Status	Single	54 (73.0%)	36 (60.0%)	0	6 (9.7%)	96 (41.2%)
	Married	7(9.5%)	14 (23.3%)	26 (70.3%)	48 (77.4%)	95 (40.8%)
	Divorced	11 (14.9%)	10 (16.7%)	8 (21.6%)	8 (12.9%)	37 (15.9%)
	Widowed	2 (2.7%)	0	3 (8.1%)	0	5 (2.1%)
Religion	Jewish	57 (77.0%)	51 (85.0%)	37 (100%)	40 (64.5%)	185 (79.4%)
	Muslim	9 (12.2%)	1 (1.7%)	0	16 (25.8%)	26 (11.2%)
	Christian	2 (2.7%)	1 (1.7%)	0	2 (3.2%)	5 (2.1%)
	Other	6 (8.1%)	7 (11.7%)	0	4 (6.5%)	17 (7.3%)
Religiosity	Secular	29 (39.2%)	35 (58.3%)	20 (54.1%)	36 (58.1%)	120 (51.5%)
	Traditional	24 (32.4%)	15 (25.0%)	7 (18.9%)	18 (29%)	64 (27.5%)
	Religious	10 (13.5%)	5 (8.3%)	9 (24.3%)	5 (8.1%)	29 (12.4%)
	Ultra-Orthodox	3 (4.1%)	2 (3.3%)	1 (2.7%)	0	6 (2.6%)
	Other	8 (10.8%)	3 (5.0%)	0	3 (4.8%)	14 (6%)
Experience	Mixed	59 (79.7%)	45 (75.0%)	27 (73.0%)	48 (77.4%)	179 (76.8%)
	Single	47 (63.5%)	25 (41.7%)	15 (40.5%)	29 (46.8%)	116 (49.8%)

Former inpatients ($n = 60$; 39 women; age 21–68, $M = 39.48$, $SD = 11.06$) were recruited through social media outreach and nonprofit email lists, and reported prior hospitalizations across psychiatric and general hospitals throughout Israel.

Family members of current or former inpatients ($n = 37$; 34 women; age 39–85, $M = 61.73$, $SD = 9.69$; primarily mothers, $n = 29$) were recruited through community organizations and social media; they were not matched with the inpatient groups.

Staff members ($n = 62$; 36 women; age 26–66, $M = 44.39$, $SD = 11.26$; seniority 2–44 years, $M = 17.72$, $SD = 12.17$) from both centers included predominantly nurses ($n = 46$), plus psychologists (5), psychiatrists (4), orderlies (3), social workers (2), and occupational therapists (2).

The quantitative component of this mixed-methods study has been published separately [10]. The present paper reports on the qualitative findings.

Measures

Four questionnaires were developed specifically for this study. All questionnaires included questions about demographic characteristics and psychiatric characteristics (each questionnaire included specific questions relevant to each respective group). All participants were asked about their preferences regarding ward type (mixed-gender vs. single-gender), as well as an open-ended question about their explanation for this preference. Participants were also invited to provide additional comments via an open-ended question (“Do you have any additional comments on this topic?”). The first question was worded identically for all groups, with minor differences depending on relevance to the group (e.g., inpatients were asked about the type of ward they would prefer to be hospitalized in, while staff members were asked about the type of ward they would prefer to work in). The second and third questions were worded identically for all.

Procedure

The study was approved by the IRBs of the [Hospital A] and [Hospital B]. Questionnaires for current inpatients were administered in person by the research team and a trained research assistant, who visited the inpatient wards, recruited participants, and administered questionnaires. Participation was voluntary and followed a full explanation of the study, including assurances of confidentiality and anonymity, as well as the signing of informed consent forms. The research assistant was a clinical criminologist with professional experience in mental health settings and trained specifically for this study.

Questionnaires for former inpatients and family members were administered electronically in Google Forms via email and WhatsApp groups. Participation included provision of informed consent, and anonymity was emphasized. Recruitment was conducted through relevant community organizations

(including mental health consumer and family organizations), family support centers, and social media platforms.

Staff questionnaires were administered either in paper format or electronically (via Google Forms), according to participants' preference. Questionnaires were completed independently and included an informed consent section. Participants were assured of anonymity.

Questionnaires were administered in Hebrew; for the purposes of this article, all questions and participant quotes were translated into English by the researchers, using the back-translation method.

Data Analysis

Although data were collected through open-ended written responses rather than in-depth interviews, the richness and volume of the data enabled a qualitative thematic analysis. A qualitative approach allowed for the inclusion of a relatively large and diverse sample, while still capturing meaningful patterns of experience across participants.

Data were analyzed using reflexive thematic analysis, following the approach outlined by Braun and Clarke [8, 9]. This method was selected as it enables a systematic yet flexible identification and interpretation of patterns of meaning across qualitative data, while remaining sensitive to context and participants' lived experiences. The analysis proceeded through several iterative phases, including familiarization with the data through repeated reading of answers, initial generation of codes capturing meaningful units of text, and the development of candidate themes through the grouping of related codes. Themes were subsequently reviewed, refined, and defined in an ongoing process that involved moving back and forth between the data and emerging interpretations. Particular attention was paid to both semantic and latent meanings, allowing the analysis to capture not only explicit accounts but also underlying assumptions and tensions reflected in participants' narratives. Two ambiguous responses were excluded, as the anonymous format of questionnaires precluded follow-up clarification. The analytic process was inductive in orientation, while also informed by the study's focus on safety, relational engagement, and gendered experiences within psychiatric inpatient settings. No software was used for data analysis. Reporting of this study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist [11].

Positionality and Reflexivity

Both researchers are women with professional experience in psychiatric inpatient settings. The first author has a background in clinical criminology and has worked in a men-only ward; the second author is a mental health nurse with experience in a mixed-gender ward – backgrounds that provided complementary perspectives on the phenomenon under study, while also introducing distinct positional lenses. Both researchers brought prior familiarity with the complexities of psychiatric hospitalization, including its gendered dimensions, from both professional practice and the existing literature.

As women, both researchers may have brought heightened sensitivity to safety concerns, particularly those affecting female patients. Awareness of this potential bias informed the analytic process throughout: the full dataset, including all participant groups and genders, was read multiple times with deliberate attention to the full range of voices, including those of male inpatients whose accounts might otherwise receive less analytic weight. The thematic analysis was conducted by the first author and subsequently reviewed by the second author.

Results

The distribution of preferences in each of the groups is presented in Table 2. There was no clear preference for one type of ward. The study examined the considerations that underpinned these preferences.

Table 2
Ward Type Preferences Across Participant Groups (N = 233)

	Category	Mixed (%)	Single (%)	None (%)
Current Patients	Overall	52.7	33.8	13.5
	Male	69.2	12.8	17.9
	Female	34.3	57.1	8.6
Former Patients	Overall	40.0	40.0	20.0
	Male	61.9	4.8	33.3
	Female	28.2	59.0	12.8
Family Members - Own Preference	Overall	40.5	43.2	16.2
	Male patient	50.0	30.8	19.2
	Female patient	18.2	72.7	9.1
Family Members - Patient Preference	Overall	56.8	35.1	8.1
	Male patient	69.2	19.2	11.5
	Female patient	27.3	72.7	0
Staff	Overall	38.7	43.6	17.7
	Male	33.3	Men's ward – 54.2	8.3
			Women's ward – 4.2	
	Female	45.7	Men's ward – 25.7	17.1
			Women's ward – 11.4	

[Table near here]

Overview of Findings

The thematic analysis yielded seven overarching themes with distinct sub-themes: (1) Safety, Vulnerability, and the Risk of Sexual Harm; (2) Social Connection, Emotional Support, and Therapeutic Benefit; (3) Behavioral Regulation and Ward Dynamics; (4) Normalization, Recovery, and Reflection of Real-World Life; (5) Privacy, Bodily Integrity, and Personal Comfort; (6) Religious, Cultural, and Individual Identity; and (7) The Complexity of Preference and the Call for Individualized Care, a cross-cutting meta-theme reflecting the ambivalence expressed across all groups.

Theme 1: Safety, Vulnerability, and the Risk of Sexual Harm

The most frequently and urgently expressed theme across the dataset concerned safety, specifically the perception that mixed-gender wards created unacceptable risks of sexual harassment, exploitation, and assault. This concern was voiced most intensely by female current inpatients, female former inpatients, family members of female patients, and clinical staff working in acute closed wards. Critically, this theme was not merely theoretical: multiple participants described direct experiences of sexual harassment or assault in mixed settings.

1.1 Lived Experience of Sexual Harassment and Assault

A substantial number of participants disclosed first-hand encounters with sexual harassment or assault in mixed psychiatric wards or referenced witnessing such incidents. These accounts represent not abstract risk but concrete harm:

"I was raped in a mixed ward." (Former inpatient, female).

"I do not like boys, I was raped and that is why I am here. There is no sense of safety with boys and they bother me." (Current inpatient, female).

"I almost did not feel safe when I was there. I woke up and felt someone leaning over me, apparently looking for cigarettes in my bag. I screamed. The nurse who was supposed to supervise me simply wasn't paying attention." (Former inpatient, female).

"For women with post-trauma, to be near naked, violent men with heightened sexual impulses and no protection from staff, this is life-threatening." (Former inpatient, female).

Family members corroborated these accounts, several referencing cases among their social networks or within their own family's hospitalization:

"She almost got raped." (Family member of female).

"No discretion, a 50-year-old woman had sex with him, a bad experience for the patient, lack of hygiene. A person without discretion will not be able to decide to have sex either." (Family member of young male).

"I have also heard about rapes. People in crisis must focus on their recovery without attention to sexual matters. Bipolar patients in a manic episode may engage in uninhibited sexual behavior." (Family member of female).

1.2 Heightened Vulnerability Due to Psychiatric State

Participants across groups recognized the specific risk created by acute psychiatric states – mania, psychosis, dissociation – which impair reality-testing and the capacity for meaningful consent:

"In [hospital C], when I was previously in a mixed ward, men followed me around. I was in mania and had sexual relations out of mania and took the morning-after pill. If I had been in a women's ward, I would not have had sex with anyone, even in a manic state." (Current inpatient, female).

"There are people who arrive at hospitalization, particularly in closed wards, in a state of disinhibition. I encountered not a few instances of undressing in public spaces, of patients entering rooms that were not theirs and even getting into beds where someone lay sleeping, as well as men exploiting women whose judgment and reality-testing were impaired." (Former inpatient, female).

"When women with trauma arrive in a mixed ward in a manic or psychotic state, this puts them at considerable risk" (Staff member).

"In conditions of psychosis or mania, sexual tension in a mixed ward, together with uninhibited sexual behavior between patients, seriously damages the recovery and rehabilitation process." (Staff member).

1.3 The Argument for Separation as Protective Policy

This view, framing separation as a structural safeguard and ethical imperative, recurred across multiple participant groups.

"The time has come to separate all the wards in the country." (Former inpatient, female).

"Please, I beg you, implement gender separation in closed wards." (Former inpatient, female).

"Separation also prevents criminal acts of sexual harassment of patients who are in difficult states and insufficiently aware of reality." (Family member of female).

"In my view, psychiatric wards, especially acute ones, need to be separated." (Staff member).

Theme 2: Social Connection, Emotional Support, and Therapeutic Benefit

Countering the safety narrative, a substantial portion of participants – particularly male inpatients, some female inpatients, and a segment of clinical staff – articulated the view that mixed-gender environments offer meaningful social, emotional, and even therapeutic advantages. The presence of the other gender was described as enriching interpersonal life on the ward, providing motivation, mutual support, and a sense of vitality in what could otherwise feel like an isolating environment.

2.1 Social Enrichment and Companionship

For many male current inpatients, the prospect of interaction with women was framed as a source of vitality and social engagement:

"Women are more sociable; there is someone to talk to." (Current inpatient, male).

"There is more fun, it's not boring. I can do creative activities with women, for example, it warms the heart. Do you want to see people locked up here all day with medications?" (Current inpatient, male).

"Because women are compassionate, kind-hearted, and you can talk to them. The heart opens and one can find peace and tranquility, friendship!" (Current inpatient, male).

"It is nice that there are also women and men, a situation like outside, normal." (Current inpatient, male).

Female patients who preferred mixed wards similarly emphasized the interpersonal richness of such environments:

"A diversity of opinions, to speak and hear the other side." (Current inpatient, female).

"Men help women with cigarettes, with food, they sit with us. There are arguments but people have compassion for one another. Men encourage women when they are in a bad mood and women do the same for men; there is sensitivity and mutual support in the mixed ward." (Current inpatient, female).

2.2 Mutual Emotional Support and Shared Humanity

Several participants described a quality of mutual recognition and empathy that transcended gender, emphasizing the shared experience of mental distress as a basis for connection:

"We shared objective difficulties across both genders." (Former inpatient, female).

"One can find comfort, identification, help, and a listening ear from both genders." (Former inpatient, female).

"Much more human." (Former inpatient, male).

"Sometimes it is also pleasant to speak with women, to see what she is going through, whether she is experiencing what I am going through too." (Current inpatient, male).

2.3 Family Members and Staff on Social Benefit

Family members emphasized the social isolation that can characterize hospitalization:

"Patients are quite lonely and struggle to form connections; even interaction at a communicative level with women can sometimes calm them and contribute to behavioral balance." (Family member of male).

Staff similarly observed therapeutic dimensions of mixed-ward interaction:

"It seems to me that the mixing assists in treatment and does not allow comparison with prison conditions." (Staff member).

"A better reflection of community life for inpatients." (Staff member).

Theme 3: Behavioral Regulation and Ward Dynamics

A third major theme concerned the perceived effect of gender composition on behavioral dynamics within the ward, specifically aggression, violence, and overall atmosphere. Interestingly, perspectives on this theme were internally contradictory: proponents of mixed wards argued that the presence of women reduces male aggression, while proponents of single-gender wards argued that mixed environments generate additional tensions and require greater staff vigilance.

3.1 Women as a Calming Influence on Male Aggression

Multiple male patients, family members, and clinical staff held the view that women's presence moderates male aggressive behavior:

"Men are less violent when women are present; women calm them. A man who tries to impress a woman will be less violent." (Current inpatient, male).

"The girls provide a balance of calm, they create balance in the ward, a woman calms an angry man." (Current inpatient, male).

"This is not a prison, why would men cause trouble without women? With women they calm down." (Current inpatient, male).

"The presence of women in the ward reduces violence. There is a good influence of the genders on one another which reduces the level of violence." (Staff member).

"The presence of women moderates men's aggression." (Staff member).

3.2 All-Female Wards as Sites of Conflict

Several female patients and staff members challenged the assumption that single-gender female wards are inherently peaceful, noting specific forms of conflict and aggression:

"A man balances the situation that arises among women; he can put a woman in her place when she is screaming. Men help more. Women are not calm, they are constantly screaming and swearing. There is violence in women's wards. Once someone stabbed me with scissors." (Current inpatient, female).

"Women are dangerous, jealous, they hit each other, and it does not suit me to see that. With men it is different, they do not hit." (Current inpatient, female).

"From my experience, women are more violent than men." (Staff member).

"In single-gender wards there is more pressure and violence." (Staff member).

3.3 Mixed Wards as Generating Additional Staff Burden

Clinical staff who preferred single-gender settings often cited the additional supervisory and protective burden that mixed environments impose:

"In a mixed ward you cannot control it; there are many complaints about sexual harassment, unusual incidents, and complaints to the police." (Staff member).

"In a separated ward I do not encounter problems of the kind where patients 'compete' over a particular female patient, something which sometimes leads to violence." (Staff member).

Theme 4: Normalization, Recovery, and Reflection of Real-World Life

A fourth theme, voiced particularly by male patients, some female patients, former inpatients, family members, and clinical staff who preferred mixed settings, concerned the relationship between the ward environment and recovery. The core argument was that mixed-gender settings better approximate the social world outside the hospital, thereby facilitating reintegration, reducing stigma, and fostering recovery.

4.1 The Ward as a Mirror of Society

Participants in this group rejected single-gender wards as artificial, institutional, and even stigmatizing:

"It is important to be aware that we continue to behave as in society." (Former inpatient, male).

"Hospitalization in a separated ward does not represent the reality of life." (Former inpatient, male).

"Mixed [gender ward] - because that is how it should be; there is someone to impress and something to talk about." (Current inpatient, male).

"It seems obvious that it is preferable to be hospitalized in a mixed ward, so that there is a better reflection of the population." (Former inpatient, male).

"I do not understand why, as a secular woman, I need to be separated from men. I also do not understand what my emotional state has to do with my need to be in the company of men. Men do me good and heal me, even just their presence." (Former inpatient, female).

4.2 The Ward as Practice Ground for Social Skills

For some patients, the mixed setting was framed explicitly as a therapeutic arena for practicing social competencies:

"Like the normal world – to practice all the tools that cause me triggers; that helps me." (Current inpatient, female).

"The rehabilitation ward needs to be similar to life, with all its challenges, emotional encounters, communication skills, relationships with women as friends and potentially as romantic partners. The ward should be an interface with life, including 50% women." (Family member of male).

"Gender separation is dangerous for the harmony that nurtures patients' souls." (Current inpatient, female).

4.3 Institutionalization and the Prison Analogy

A notable sub-theme was the explicit comparison drawn between single-gender wards and carceral environments:

"This is a hospital, not a prison." (Current inpatient, male).

"In [hospital D], they tied me down with violence many times. The closed ward for men alone felt like a prison and the overall feeling was of a continuous violation of the soul. In [hospital E], by contrast, I was hospitalized in a closed mixed ward and the atmosphere was much better and more pleasant by comparison." (Former inpatient, male).

Theme 5: Privacy, Bodily Integrity, and Personal Comfort

A fifth theme concerned the relationship between gender composition and bodily privacy, particularly in the context of shared facilities such as bathrooms, showers, and dormitory spaces. This theme was more prominent among female patients and family members.

5.1 Shared Facilities and Physical Vulnerability

Participants described concrete situations in which shared or inadequately secured facilities in mixed wards created distress:

"More comfortable also in the showers. Men are more sexual; they can touch us, rape us, it is not pleasant. There are serious confrontations between women and men." (Current inpatient, female).

"Men enter my private space, they enter the bathroom when I am there, and fight with blows." (Current inpatient, female).

"She was afraid to shower because someone might enter the bathroom since there was no way to lock the door." (Family member of female).

"It is unpleasant when men sometimes walk around half-naked." (Former inpatient, female).

"It is unpleasant to be in shared bathrooms and toilets." (Former inpatient, female).

5.2 Privacy and Feminine Space

Some female participants described the value of single-gender environments in terms of the freedom and authenticity they afford:

"More female privacy; one can connect with women without men making moves on you, women's affirmation without interference from men. When there are no men, women connect more with one another." (Current inpatient, female).

"More comfort and authenticity in being only women." (Current inpatient, female).

"There is more privacy; fewer thoughts about sex." (Current inpatient, female).

"I feel more at ease in a women-only environment." (Former inpatient, female).

5.3 Staff Perspectives on Privacy and Gender-Sensitive Care

Clinical staff also articulated a privacy rationale for separated wards, often linked to the quality of gender-specific care:

"In separate wards, dignity can better be maintained in the face of difficult situations of impaired judgment. The patients' sense of safety is higher." (Staff member).

"The separation is very good for all parties at the basic level of gender-adapted care, even if not formally, the ways of relating, speaking, and treating differ, and the accumulated experience in those wards is adapted to that gender population." (Staff member).

Theme 6: Religious, Cultural, and Individual Identity

A sixth theme concerned the role of religious observance, cultural background, and individual life history in shaping preferences. Although this theme was less prevalent than others, it emerged distinctly and warrants attention given the diversity of Israel's population.

6.1 Religious Observance as a Determinant of Preference

A number of participants, both inpatients and their family members, grounded their preference for single-gender wards explicitly in religious norms:

"I am ultra-Orthodox." (Current inpatient, male; Current inpatient, female; Family member of male).

"For religious reasons." (Current inpatient, male).

"I have a partner; modesty." (Current inpatient, female).

Conversely, one secular female former inpatient challenged the implicit imposition of religiously coded gender norms within the secular healthcare system:

"I also do not understand why as a secular woman I need to be in separation from men. I do not understand why my emotional state is connected to my need to be in the company of men." (Former inpatient, female).

6.2 Personal History with Trauma as a Shaping Factor

Multiple participants explicitly connected their preference for single-gender settings to personal histories of sexual trauma, illustrating the intersection of identity, biography, and clinical need:

"I would never be hospitalized in a mixed ward as a survivor of sexual assault and domestic violence. I know there are harassments in mixed wards and I cannot bear it; it is a trigger." (Former inpatient, female).

"I have trauma from male violence – spitting, coarseness. I had almost no communication with them in the mixed ward I was in previously; I prefer to distance myself from them." (Current inpatient, female).

"My daughter suffers from sexual PTSD... so I assume she would prefer a separated ward." (Family member of female).

Theme 7: The Complexity of Preference and the Call for Individualized, Contextual Solutions

Across all four participant groups, a cross-cutting meta-theme emerged: preferences are heterogeneous, context-dependent, and cannot be reduced to a single policy position. Many participants explicitly resisted binary framing, advocating for individualized care and contextual flexibility.

7.1 The Open/Closed Ward Distinction

A particularly recurrent and clinically significant distinction was between open (voluntary/rehabilitation) wards and closed (involuntary/acute) wards. Participants frequently qualified their preferences according to ward type:

"If we are talking about a closed ward (where the situation is severe), a separated ward is a necessity. In an open ward it depends on the situation, and in any case one must provide a separated wing and at least separate rooms." (Family member of female).

"In closed wards it is vital that it be separated; otherwise, I would feel threatened and also the lack of privacy there would be more palpable. In a day-hospital setting it is less critical because one does not sleep in the same place and everyone returns home, but I still connect more with women and feel more comfortable in a women-only environment." (Former inpatient, female).

"I prefer closed wards with separation and chronic mixed wards." (Staff member).

"I am against mixed wards for people under the age of 60." (Staff member).

7.2 Individual Variability and the Limits of One-Size-Fits-All Policy

Many participants argued that decisions about ward type should be individualized, accounting for diagnosis, history, and personal preference:

"In my view, every illness and every patient is different and requires a different kind of treatment. I also believe that if a dedicated place for PTSD were to open, things would be much better and easier for

everyone." (Current inpatient, female).

"I have no PTSD of a sexual nature and have never been seriously attacked or harassed during a psychiatric hospitalization. Had I had such a history, my view might have been different." (Former inpatient, female).

7.3 The Ambivalence of Family Members

Family members frequently articulated a tension between their protective instincts – favoring separation – and their awareness of the patient's own preferences and social needs:

"On the one hand, out of worry for her I would say separation, so that she is not exploited during hospitalization when she arrives at the height of a manic episode accompanied by a psychotic episode and is more attracted to men. On the other hand, it seems this is her preference." (Family member of female).

"My motivation is patient safety. Were it possible to achieve a sufficient level of security, my position would change." (Family member of female).

7.4 Staff Recognition of Complexity

Clinical staff most consistently articulated the conditional and contextual nature of preferences, drawing on direct professional experience:

"The whole matter depends on age, in my view. Young age is somewhat problematic; more supervision is needed. In the current older ward it is pleasant to see them talking and sharing together." (Staff member).

"When women who are trauma survivors arrive in a mixed ward, it makes things harder for them. There were also cases where intimate relationships developed between patients, they become preoccupied with the relationship and not with the treatment." (Staff member).

"It sometimes creates difficulties characteristic of working with a mixed population, for instance, the occurrence of sexual relations; on the other hand, a mixed ward serves as a mirror for social systems outside the ward." (Staff member).

Summary of Thematic Findings

Across all four participant groups, the thematic analysis revealed seven themes shaping perceptions of ward gender composition: safety, vulnerability, and the risk of sexual harm; social connection, emotional support, and therapeutic benefit; behavioral regulation and ward dynamics; normalization, recovery, and reflection of real-world life; privacy, bodily integrity, and personal comfort; religious, cultural, and individual identity; and, as a cross-cutting meta-theme, the complexity of preference and the call for individualized, contextual solutions. No single position emerged as universally endorsed across groups. Instead, the data document a landscape of co-existing and often competing needs – safety and social connectedness, protection and normalization, trauma-sensitive containment and relational engagement

– whose relative weight varied systematically by participant group, gender, clinical context, and personal history.

Several structural patterns were consistent across the dataset. Safety concerns, grounded in first-person accounts of sexual harm rather than abstract risk, were most prominent among female inpatients and former inpatients, family members, and staff in acute closed settings. The social and therapeutic value of mixed environments was most strongly articulated by male patients and those without trauma histories. Across groups, participants consistently distinguished between closed acute and open rehabilitation wards as warranting different compositional arrangements. These patterns are elaborated in the Discussion.

Discussion

This study examined perceptions of gender composition in psychiatric inpatient settings across four stakeholder groups – current inpatients, former inpatients, family members, and clinical staff – yielding a seven-theme account of how mixed-gender and single-gender ward environments are experienced, evaluated, and negotiated. The richness and internal contradictions of these findings resist any simple policy prescription. Instead, they point toward a reconceptualization of ward composition as a dynamic, multi-level, and individually variable phenomenon.

Beyond the Binary: A Multi-Dimensional Reconceptualization

Prior debates on gender composition in psychiatric wards have frequently been organized around a binary trade-off between safety and normalization, with single-gender wards positioned as protective and mixed-gender wards as more recovery-oriented [2, 3]. The present findings substantially complicate this framing. Participants' accounts were not organized around a simple either/or preference; rather, they articulated a cluster of intersecting concerns – safety, connection, identity, behavioral dynamics, bodily integrity, and clinical context – that cannot be reduced to any single dimension.

This multi-dimensionality is captured in *The Gendered Safety–Connection Tension Model* (Fig. 1), which proposes that ward-type preference is the outcome of an interaction between four levels: (1) individual background variables (gender, trauma history, religious and cultural identity, and prior hospitalization experience); (2) a core dialectical tension between the Safety Pole and the Connection Pole; (3) clinical context moderators (ward type, clinical acuity, diagnosis, and staffing/supervision level); and (4) an individualized preference that is neither fixed nor universal. A feedback loop depicts how lived hospitalization experience recursively reshapes future preferences.

The model's key contribution is its insistence that both poles are simultaneously valid: normalization without safety is exposure to harm; safety without connection is restriction and institutionalization. This extends recovery-oriented frameworks [5, 12] while challenging approaches premised on safety alone.

[Figure 1 near here]

Safety, Trauma, and the Limits of Structural Solutions

The prominence of first-person disclosures of sexual harm reinforces concerns long documented in the literature regarding women's vulnerability in mixed psychiatric settings [2, 3, 4, 7].

However, participants repeatedly linked risk not to ward composition in isolation but to institutional conditions – inadequate supervision, unclear boundaries, and staff inattention. This aligns with the model's specification that staffing and supervision are *moderating variables*: the same composition may be safe in a well-resourced setting and unsafe in an under-staffed one. Structural composition and institutional practice are co-determinants of safety, not substitutes for each other [13].

Acute psychiatric states – mania, psychosis, and dissociation – create particular vulnerability by impairing reality-testing and the capacity for meaningful consent. The model captures this through the *clinical acuity* moderator at Level 3: the same patient who navigates a mixed ward safely when stable may be acutely at risk during a crisis episode.

Critically, the findings demonstrate that trauma does not simply increase the need for protection in a quantitative sense, but fundamentally reshapes how normalization *itself* is experienced. For survivors of sexual violence, a mixed-gender ward does not offer normalizing social engagement; it reintroduces conditions of vulnerability and may trigger re-traumatization [7, 14, 5]. This underscores the importance of trauma-informed care frameworks, which must be operationalized not only at the level of clinical interaction but at the structural level of ward composition and physical environment.

Social Connection, Normalization, and the Anti-Institutional Imperative

The social and therapeutic value of mixed-gender settings is equally compelling. For a substantial proportion of participants, the mixed ward was a primary therapeutic resource: reducing isolation, moderating aggression, and creating normalcy essential to recovery [5, 6]. Explicit comparisons with carceral environments suggest that segregation is experienced by many patients as punitive rather than protective. At the same time, data from Theme 3.2 challenge the idealization of all-female wards as inherently peaceful, with female inpatients and staff reporting distinctive patterns of conflict in single-gender settings.

Behavioral Regulation, Institutional Dynamics, and the Staff Perspective

Staff accounts highlighted the supervisory and protective burden of mixed settings, including the management of sexual incidents and romantic entanglements that displace therapeutic focus [15]. At the same time, staff registered the therapeutic complexity of mixed wards as a resource: richer clinical

demands and opportunities for professional learning, consistent with Morton et al.'s [16] arguments that gendered dimensions of inpatient care require sustained attention to ward culture and staff training.

Identity, Religion, and the Particularity of Preference

Theme 6, which concerns the role of religious observance, cultural identity, and personal biography in shaping ward-type preferences, introduces a dimension of the debate that has received insufficient theoretical attention. In the context of Israel's religiously and culturally diverse population, preferences grounded in Orthodox or ultra-Orthodox religious (halakhic) norms represent not merely individual choices, but commitments embedded in systems of meaning that are non-negotiable for their adherents. A ward composition policy that treats secular norms of social mixing as a default implicitly imposes a culturally specific framework on a heterogeneous patient population.

The *Gendered Safety–Connection Tension Model* incorporates religious and cultural identity as a Level 1 variable to make this analytically visible – applicable across diverse healthcare contexts internationally.

The Open/Closed Ward Distinction and the Case for Tiered Policy

The most consistent finding across groups was the distinction between open (voluntary/rehabilitation) and closed (involuntary/acute) wards as contexts warranting different compositional policies – the primary moderating variable at Level 3 of the model. In acute closed settings, involuntary admission, shared sleeping quarters, acute psychiatric states, and reduced supervision create conditions in which safety risks are highest and patients' protective capacity most constrained. In open and rehabilitation settings, greater stability and recovery-oriented activity shift the balance toward the Connection Pole. These observations support tiered or differentiated ward composition policies, consistent with trauma-informed, person-centered principles [5, 14].

Divergent Stakeholder Perspectives and the Construction of Knowledge

Current inpatients, particularly women, articulated a simultaneous experience of benefits and risks that destabilizes simple preference categorization. Former inpatients brought reflective distance, some offering accounts of harm, others articulating preferences for mixed settings grounded in the recovery-oriented meaning they attributed to hospitalization.

Family members' accounts were most consistently protective, reflecting their advocacy role and access to information about adverse incidents. Staff perspectives were characterized by the most consistent ambivalence, reflecting the practical demands of managing competing clinical imperatives within resource-constrained environments [15]. These differences confirm that preferences emerge from role, experience, and institutional position, making multi-stakeholder integration an epistemic necessity.

Implications for Practice and Policy

Three evidence-based implications follow from these findings. First, ward composition decisions should be calibrated to clinical context rather than uniform institutional policy. Tiered frameworks distinguishing at minimum between acute closed and open rehabilitation settings are warranted, with further differentiation by clinical acuity and supervisory capacity.

Second, intake assessments should incorporate a gender-sensitivity screen covering trauma history, religious and cultural identity, and prior hospitalization experience, to inform individualized placement decisions.

Third, trauma-informed principles must be operationalized structurally. Patients with histories of sexual or gender-based violence should have access to single-gender or women-only spaces as a default rather than an exceptional accommodation, and staffing levels should be treated as a co-determinant of ward safety, not merely a background condition.

Limitations

Several limitations of this study warrant acknowledgment. Data were collected through open-ended written responses rather than in-depth interviews, which may have constrained the depth of individual accounts and precluded probing for clarification. The study was conducted in Israel, and while it encompasses a diverse range of hospital settings and recruitment channels, the findings cannot be straightforwardly generalized to healthcare systems with different structural, cultural, or demographic characteristics. In particular, the sample does not adequately represent Arab participants – a significant population whose perspectives may be shaped by distinct cultural and religious frameworks.

Underrepresentation was most pronounced among family members and former inpatients (the latter included no Arab participants), both recruited via social media and advocacy networks. This may reflect lower engagement in formal mental health consumer organizations, a pattern warranting separate scholarly attention.

Finally, the proposed theoretical model – *The Gendered Safety–Connection Tension Model* – is derived from qualitative thematic analysis and should be understood as a conceptual framework rather than a formally validated instrument. Empirical testing of the model's predictive and clinical utility in prospective research would be a valuable direction for future work.

Directions for Future Research

Several directions follow from these findings. Longitudinal in-depth interviews with matched current and former inpatients would test the model's feedback mechanism – whether hospitalization experience recursively reshapes future preferences. Observational studies in matched mixed and single-gender wards would provide implementation-level evidence for the Level 3 moderators, examining how staffing patterns, supervisory culture, and ward architecture shape the enactment of safety and relational engagement in practice. Research specifically examining whether women's presence moderates male aggression – currently resting on participant self-report – would provide important empirical grounding.

Finally, comparative studies across healthcare systems with different ward composition frameworks would identify structural and cultural factors supporting or hindering the integration of safety and normalization.

Conclusion

This study reconceptualizes gender composition in psychiatric inpatient settings as a dynamic, multi-level, and individually variable phenomenon, rather than a binary organizational choice between competing goods. Through a seven-theme qualitative analysis spanning four stakeholder groups, it demonstrates that the safety-connection tension at the heart of the ward composition debate cannot be resolved through universal policy but must be navigated contextually, with sustained attention to the clinical situation, the individual patient's history and identity, and the institutional conditions within which the ward operates.

The Gendered Safety–Connection Tension Model (Fig. 1) provides a theoretically grounded framework for this navigation, offering both an explanatory account of the findings and a practical basis for clinical decision-making – advancing beyond the binary terms in which this debate has too often been conducted.

The voices of participants in this study are the most powerful argument against categorical solutions. They call for inpatient environments that are genuinely responsive to human complexity: places where safety and connection, protection and normalization, are understood not as competing values but as mutually constitutive conditions of therapeutic care.

Findings point to several immediate clinical implications. First, a structured gender-sensitivity inquiry at admission – covering trauma history, religious and cultural identity, and prior hospitalization experience – safe would enable more individualized and responsive placement decisions. Second, staffing and supervision levels must be treated as direct determinants of ward safety, not merely background operational conditions: adequate supervision can expand the feasibility of mixed arrangements, while insufficient staffing should preclude them. Third, patients with trauma histories related to sexual violence should have access to single-gender or women-only spaces as a default rather than an exceptional accommodation.

Abbreviations

Not applicable.

Declarations

Ethics approval and consent to participate

The study was approved by the Institutional Review Board (IRB) of both participating mental health centers (full details will be provided upon acceptance), and was conducted in accordance with the principles of the Declaration of Helsinki. All participants provided informed consent to participate in the study.

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analyzed during this study are not publicly available due to ethical and privacy restrictions but are available from the corresponding author on reasonable request.

Authors' contributions

Anat Yaron Antar: Conceptualization, Methodology, Investigation, Data Curation, Formal Analysis, Visualization, Writing – Original Draft, Project Administration.

Sagit Dahan: Methodology, Investigation, Writing – Review & Editing.

Competing interests

There are no competing interests.

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During the preparation of this work, the authors used Claude (Anthropic) to assist with manuscript drafting, linguistic editing and editorial revisions. The authors reviewed and edited the output as needed and take full responsibility for the content of the published article.

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Figures

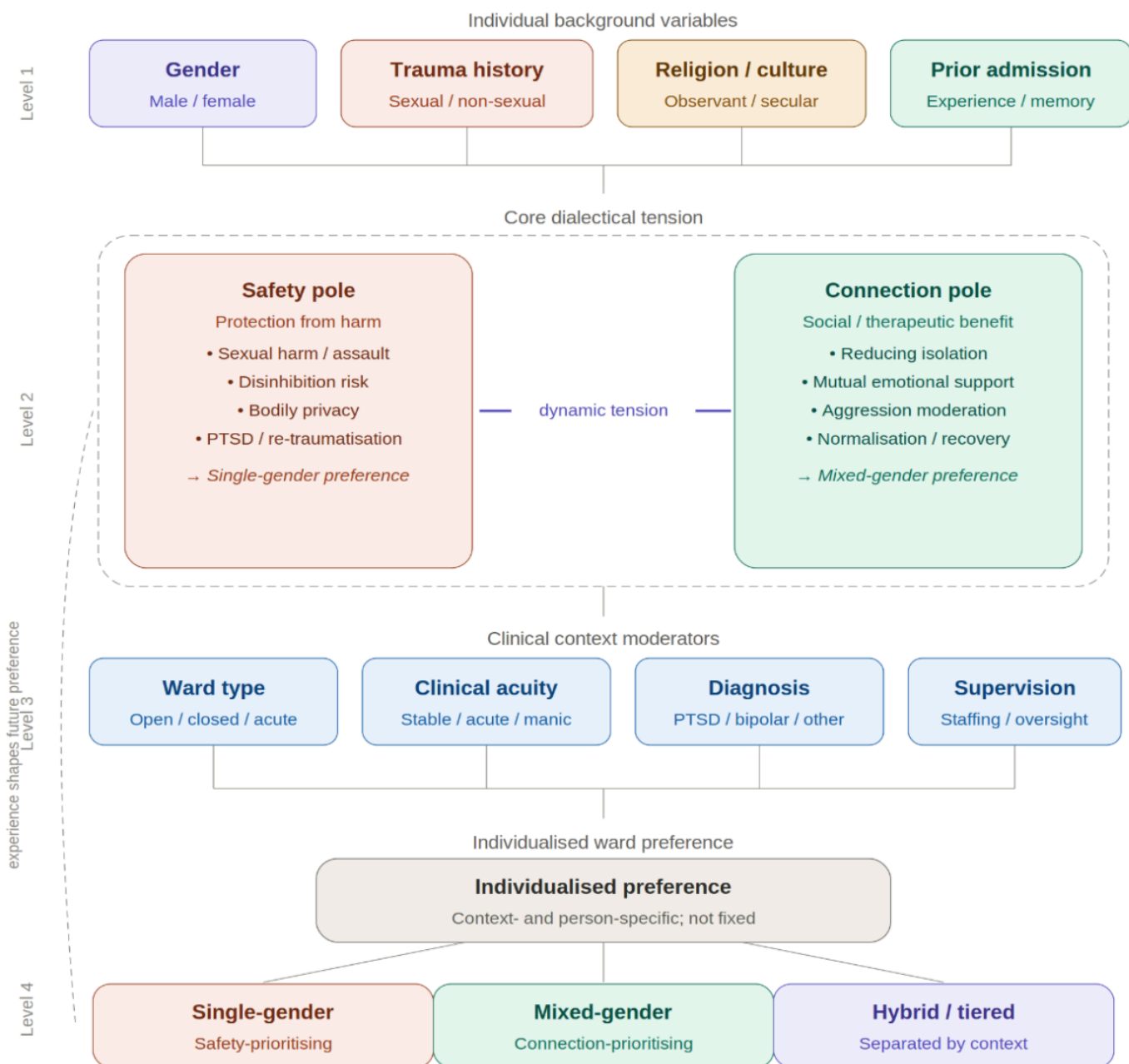


Figure 1

The Gendered Safety-Connection Tension Model: Determinants of ward-type preference in psychiatric inpatient settings.

Note. The model depicts preference as a dynamic outcome of four interacting levels: individual background variables (Level 1) activate the core safety-connection tension (Level 2), moderated by

clinical context (Level 3) to produce an individualized ward preference (Level 4). The dashed feedback arrow indicates that lived hospitalization experience recursively shapes future preferences. No single outcome is universally optimal; preference is person- and context-specific. Coral = safety-aligned constructs; teal = connection-aligned constructs; blue = clinical moderators; purple = person-level variables and hybrid outcomes; gray = integrative output node.