

Schizophrenia, Sexuality, and Recovery

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ABSTRACT

Sexuality in persons with schizophrenia has been a neglected topic in both research and clinical management. Contrary to stereotypes, people with schizophrenia can engage in healthy sexual activity. The illness itself can interfere with normal expression of sexuality though. In addition, antipsychotic medications cause sexual dysfunction in several domains. There have been relatively recent efforts to standardize assessments of sexual dysfunction and sexuality as an aspect of life satisfaction in research. Rather than just viewing sexuality and intimacy through traditional psychiatric perspectives of psychopathology and psychopharmacology, recovery based approaches focus on self-determination, social inclusion, and reclaiming a meaningful life.

Key Words: schizophrenia; sexuality; sexual dysfunction; recovery; ethics

Sexuality as a Neglected Topic

Schizophrenia is a complicated illness that has facets that by definition interfere with human interactions, including relationships and sexuality. Sexual desire or libido may be decreased by the very nature of the illness. Negative symptoms such as avolition (i.e., lack of motivation), anhedonia (i.e., lack of pleasure), and social withdrawal impair relational capacity. Psychosis associated with schizophrenia can interfere with perceptions of human interactions including verbal and nonverbal communication. Estrangement from friends and family is a common occurrence. Decreased capacity to deal with expressed emotions distorts development

of relationships that may result in normal sexual expression and relations. Antipsychotic treatment is itself associated with a high incidence of sexual dysfunction including decreased libido, erectile dysfunction, decreased vaginal lubrication, and delayed ejaculation among other side effects. There are societal barriers that interfere with the appropriate screening for sexual dysfunction, that affect even mental health professionals. A discussion of the sexuality of people with schizophrenia should naturally fall into the purview of their experiences as human beings with needs and desires that have largely been deemphasized in traditional psychiatric care. This article is an overview of the complexity of sexuality in people with schizophrenia.

The Myth of Persons with Schizophrenia as Asexual

The enduring impression that persons with schizophrenia were either asexual or practiced aberrant sexual activities was supported by earlier studies showing a very low rate of sexual activity ranging from 1.5-3%. Not only were people with schizophrenia thought to be incapable of meaningful relationships, it was thought that sexual activity could even exacerbate their psychosis (Buckley, 1999). Contrary to previous assumptions, people with schizophrenia do engage in sexual activity. With the increased focus on risk factors associated with HIV infection (which increased screening) several studies show that 50-60% of people engage in some sort of sexual activity. The presence of sexual activity (anal or vaginal intercourse) among people with serious mental illness has been estimated at between 44% and 80%. Approximately 80% of stabilized psychotic patients, and over 75% of men, have masturbatory activity (Bobes et al., 2003).

Sexuality and Psychotic Symptoms

Several studies have examined the association of symptomology associated with schizophrenia with sexual function and dysfunction. The Positive and Negative Symptom Scale (PANSS) measures total psychopathology, positive symptoms, and negative symptoms with higher scores indicating increased symptoms or level of psychopathology. In men, a high PANSS general psychopathology score was associated with an increased risk of erectile, ejaculatory, and orgasmic dysfunction. Higher PANSS positive subscale scores predicted increased libido, which decreased over time with symptom improvement. In female patients a high PANSS negative subscore also predicted decreased libido (Malik et al., 2011). Harley et al. (2010) examined the prevalence of sexual dysfunction in a community based population of people with chronic, relapsing schizophrenia. They found that patients had a higher incidence of sexual dysfunction as compared to the general population, with 74% of males with schizophrenia versus 34.8% in the general population, and 82% of female patients versus 53.8% in the general population. Interestingly the type and range of sexual dysfunctions was similar in both populations.

Medications' Impact in Reducing Sexuality

Antipsychotic induced sexual dysfunction is multifactorial, including effects on prolactin levels, and antagonism of α -adrenergic, dopaminergic, histaminic, and muscarinic receptors (Haddad & Sharma, 2007). Sexual dysfunction may involve one or more of the three areas of the sexual-response cycle: sexual interest (libido), arousal (vaginal lubrication or erectile function), or orgasm (Cutler, 2003). There is evidence that persons with schizophrenia often have diminished interest including sexual thoughts and urges. Antipsychotic drugs may restore interest, but subsequently impair performance because of side effects. Several proposed mechanisms for antipsychotic induced sexual dysfunction exist. Antipsychotics bind several central and peripheral receptor systems that lead to both their efficacy and side effect profiles. Sexual dysfunction during antipsychotic therapy can be attributed to several mechanisms: central non-specific effects (sedation), central specific effects, peripheral effects, and hormonal effects (Peuskens, Sienaert & De Hert, 1998). Table 1 summarizes antipsychotic induced sexual dysfunction (Baggaley, 2008; Haddad & Sharma, 2007; Peuskens, Sienaert & De Hert, 1998).

Assessment of Sexual Dysfunction in Research

Many studies that address sexuality rely on self-report or subjective clinician impression, rather than structured assessment. Designing structured interviews eliciting accurate information from persons with schizophrenia regarding their sexuality is challenging. While structured assessments lead to heightening reported sexual dysfunction, there is also wide variability among types of structured interviews utilized.

TABLE 1:
ANTIPSYCHOTIC INDUCED SEXUAL DYSFUNCTION

Libido	Dopamine antagonism	Impairment of motivation and reward cycle and therefore decreased libido
	Elevated prolactin	Antidopaminergic activity is associated with hyperprolactinemia and decreased libido
Arousal	Histamine antagonism	Sedation leading to impaired arousal
	Dopamine antagonism	Impairment of motivation and reward cycle and therefore decreased arousal
	Prolactin elevation	Antidopaminergic activity is associated with hyperprolactinemia and decreased arousal
Erection and Vaginal Lubrication	Muscarinic antagonism	Cholinergic blockade causes reduced peripheral vasodilation and hence erectile dysfunction
	Alpha adrenergic antagonism	Causes reduced peripheral vasodilation and therefore erectile dysfunction and decreased vaginal lubrication
Orgasm	Muscarinic antagonism	Delayed orgasm in females
	Prolactin elevation	Antidopaminergic activity is associated with hyperprolactinemia and impaired orgasm
Ejaculation	Alpha adrenergic antagonism	Failure of the internal sphincter of the bladder neck to close; blockage of alpha adrenergic actions on the vas deferens, seminal vesicles, and ejaculatory ducts
Priapism	Alpha adrenergic antagonism	Inhibition of sympathetically controlled detumescence

The Arizona Sexual Experiences Scale (ASEX) is one preferred and empirically validated assessment of anti-psychotic related sexual dysfunction (Byerley et al., 2006; McGahuey et al., 2000). The ASEX has five items assessing sex drive, arousal, vaginal lubrication/penile erection, ability to reach orgasm, and satisfaction from orgasm. The ASEX was administered as a measure of sexual functioning in the Schizophrenia Trial of Aripiprazole (STAR) study—a community-based comparison of aripiprazole with Standard of Care (SOC) olanzapine, quetiapine, or risperidone treatment. The STAR study randomly assigned 555 participants with schizophrenia to either the aripiprazole or SOC group.

While both treatment groups exhibited improvements in sexual function at 8 weeks, the aripiprazole group exhibited significantly greater improvement in sexual functioning than the SOC group. In the SOC group, participants who took olanzapine and quetiapine demonstrated better improvements in sexual functioning than participants on risperidone (Hanssens et al., 2008). Similar findings were obtained in the Intercontinental Schizophrenia Outpatient Health Outcomes (IC-SOHO) study, a 3-year, prospective, observational study comparing olanzapine (n=2638), risperidone (n=860), quetiapine (n=142), or haloperidol (n=188) (Dossenbach et al., 2006). This study used a modified version of the Udvalg for Kliniske Undersøgelser (UKU) Side Effect Rating Scale focusing on items related to sexual function (loss of libido,

amenorrhea, gynecomastia, impotence/sexual dysfunction, and galactorrhea).

The rate of participants reporting sexual dysfunction during the 12-month treatment period was highest for haloperidol (71.1%), followed by risperidone (67.8%), quetiapine (60.2%), and olanzapine (55.7%). Participants who were treated for up to 12 months with olanzapine or quetiapine had significantly lower odds of experiencing loss of libido, impotence/sexual dysfunction, and amenorrhea or menstrual disturbances, when compared to patients treated with either risperidone or haloperidol. Of note, there was significant discrepancy between patient and psychiatrist perception of the presence of adverse events related to sexual dysfunction. At 12 months, 40% of patients reporting sexual dysfunction were assessed by a psychiatrist as without impotence/sexual dysfunction. Further, the emergence of sexual dysfunction in persons who did not have this difficulty at baseline was less likely with olanzapine than risperidone or haloperidol.

Case Studies

Case 1. Ms M. is a married, middle class woman with a happy marriage and two kids in high school. She carries a diagnosis of bipolar disorder and was hospitalized due to a manic episode. During the manic episode she became hypersexual, told her husband she wanted a divorce and sexually propositioned a male nurse in front of her kids during a family visit. Later that night she was found in a male patient's room disrobed.

Case 2. Two 30-something persons with schizophrenia living in an assisted living facility start dating and develop a relationship. They decide to combine their disability checks and get their own apartment. Their case managers try to discourage them from doing this. He does not like taking his antipsychotic medication because it interferes with his ability to form an erection. He is subsequently hospitalized twice because of medication non-adherence.

These cases highlight some of the complexities of sexuality in persons with mental illness. The first demonstrates the association of psychiatric symptoms of some conditions with sexual behavior and the need for appropriate intervention from mental health care professionals. The second demonstrates normal expression of human sexuality and relationships, possible insensitivity of clinicians to this expression and how debilitating side effects can contribute to instability

Recovery and Sexuality

A consideration of sexuality in persons with schizophrenia and other severe mental illnesses should view sexuality not only through the traditional lens of psychiatric practice—psychopathology (i.e., problematic sexual behavior, diminished capacity due to psychopathology) and psychopharmacology (i.e., medication side effects). Rather it must encompass sexuality and intimacy as fundamental and personal expressions of humanity that have implications for self-determination, social inclusion, and reclaiming a meaningful life.

In psychiatric institutions, people with mental illnesses are discouraged and/or prohibited from engaging in sexual relationships with institutionalized and non-institutionalized individuals (Miller, 1997). Expressions of sexuality—such as flirting, kissing, masturbating, dating, and intercourse—are often adjudged as clinical problems indicative of active psychosis, manic hyperactivation, or behavior dysregulation (Buckley & Hyde, 1997). The propensity of mental health professions to label the sexual behavior of persons with severe mental illness as pathological may stem from their own held stereotypes, fear, and stigma about consumers shared with mainstream society (Collins, 2001). The prevailing view among mental health professionals is that such individuals are unable to provide consent to engage in a sexual relationship and are vulnerable to being coerced, manipulated, or abused sexually (Carey et al., 2004 & 1997; Dickerson et al., 2004). Thus, practitioners are often inclined to “protect” them from sexual interactions with other individuals receiving psychiatric services and members of the general population as reflected in organizational policies that restrict, prohibit, or ignore sexual activity (Buckley & Robben, 2000).

Individuals with severe mental illnesses have deemed the conventional approach to addressing their sexuality unsatisfactory. In Campbell and colleagues' landmark survey (1989) of over 300 people receiving mental health services, 51% of those surveyed rated their sex life as unsatisfactory, 47% rated their social life as unsatisfactory, and 40% reported that they lacked intimacy. Deegan (1999) obtained the perspective of individuals diagnosed with schizophrenia and other severe mental illnesses about the treatment of their sexuality by conventional care practices. Those interviewed expressed dissatisfaction with the propensity of traditional care to pathologize their expression of sexuality and devalue their need to be sexual in medication management. They also bemoaned the mixed messages transmitted by some programs about sexuality such as prohibiting sex yet providing contraceptives. Mixed messages regarding sexuality may be however stressful and frustrating for persons with schizophrenia, possibly adding to risk of symptom exacerbation.

Social skills deficits often impeded the ability of individuals with schizophrenia to initiate dating and romantic relationships (Pinkham et al., 2007). The experience of stigma and rejection may subsequently lead them to become disinclined to interacting with others in a sexual way due to fears of real or imagined rejection (Wright & Gayman, 2005). This sociological dimension of the experience of severe psychiatric symptoms and its impact on the sexual life of people with schizophrenia is an opportunity for practitioners to develop treatment objectives that address life challenges and enhance quality of life.

The recovery model suggests that individuals with psychiatric disabilities can experience recovery from severe mental illnesses — recovery in this sense occurs when an individual with a psychiatric disability is able to live a full and meaningful life in a community of his or her own choosing despite limitations imposed by psychiatric illness (Davidson et al., 2005). This model has ramifications for how practitioners address issues of sexuality for people with schizophrenia. The first is a fundamental change in how sexuality is viewed. The recovery model espouses the principle of self-determination — that people with severe mental illnesses have a right to determine their own life paths, goals, and aspirations.

In this regard, recovery-oriented care would afford individuals opportunities to make choices related to sexuality and intimacy and engage in “responsible risk taking” regardless of positive or negative outcomes or a practitioner’s evaluation of such decisions (Noordsy et al., 2000).

Rather than being prohibitive, recovery-oriented practitioners assist persons with severe mental illnesses to clarify their sex and intimacy needs and the effect of their choices on their quality of life. Such discussions may include a cost-benefit analysis of alternative choices and strategies for decreasing risk of unwanted pregnancies or sexually transmitted diseases. Practitioners are indeed faced with a dilemma when an individual’s behavior poses a potential safety or liability risk. It is, however, necessary to distinguish between such situations and occasions when the practitioners own stereotypes, fears, and stigma sets ceiling that may impede the individual’s personal growth.

The person-centered and individualized nature of recovery allows sexuality and intimacy to be addressed in treatment. Sexuality and intimacy goals may include dating, courting, establishing intimate relationships, carrying out or maintaining the role of a husband, wife, partner, lover, or companion despite the limitations that may be imposed by psychiatric symptoms. It may be useful to address issues related to sexual orientation in treatment planning for persons with severe mental illnesses who are also sexual minorities—such as the experience of homophobia, heterosexism, and stigma in the community and in treatment settings (Cook, 2000).

Practitioners can work with persons with schizophrenia to improve their overall social competence through skills training. Social skills training focuses on mitigating social dysfunction that impacts an individual’s performance in most social situations by improving conversational skills, interactive behaviors, social intelligence/perception, assertiveness, and dating/relationship skills (Bellack et al., 2004). It allows individuals to rehearse scenarios that are relevant to dating and relationships such as starting and keeping a conversation going, asking someone out on a date, expressing positive feelings, and asking your partner to use protection. Rehearsing such scenarios increases the likelihood that social skills germane to sexuality are assimilated and effectively implemented in real-world situations. Harper (2011) evaluated the benefit of a 12-week social skills group designed to enhance dating behaviors for young men who had experienced their first psychotic episode within a five-year period. Participants reported decreased anxiety and increased confidence in meeting people but the study did not report if participants subsequently dated.

Conclusion

Sexuality is a normal expression of humanity. Instead of ignoring this important aspect of a satisfactory life, clinicians should incorporate assessment of a person’s functioning and dysfunction into treatment planning and provision of care. Psychopharmacologists can aid an individual’s wish for a sexual life by minimizing sexual side effects common with many antipsychotics and antidepressants such as erectile dysfunction and inorgasmia. This may involve (1) switching or adjusting medication dosages and/or frequencies

so that they minimally interfere with sexual desire and activity; (2) frequently evaluating the need for medications that produce sexual side effects; (3) prescribing flexible regimens whenever possible that allow consumers to factor their daily sexual needs into administration time and frequency; and (4) providing treatment for sexual dysfunction due to psychiatric medications.

At a systems level, policies that forbid consensual intimate relationships are inconsistent with the recovery model. We encourage systems to replace such policies with those that allow individuals to pursue sexual interests while safeguarding from coercion and rape. People with severe mental illnesses may also benefit from system-sponsored sex education that may increase their knowledge about sex, sexual health, pregnancy, sexually transmitted diseases, and correct use of contraceptives. Inpatient settings can further encourage sexuality by fostering more privacy within hospital units and providing frequent opportunities to visit home as this would allow married people to spend time with their spouses, lovers, or partners so that their work in treatment minimally interferes with their intimate relationships.

Finally, we encourage practitioners to combat stigma and discrimination against individuals with psychiatric disabilities that largely impact their sexual lives in their own practice and society in general. This can be accomplished by supporting sexual self-determination and individuality, challenging personal biases and misattributions about people with severe mental illnesses, and engaging in advocacy and educational activities in the community to reduce stigma.

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