3 Sexuality and Sexual Health

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Introduction

Practitioners in inpatient psychiatric settings are periodically faced with the question of how to address issues of sexuality and sexual health among inpatient psychiatric patients. The question—should hospitalized patients be allowed to express themselves sexually in socially acceptable ways?—is one that elicits knee-jerk responses among practitioners, patients, and consumer advocates. Whereas, many providers in inpatient settings may not be inclined to allow patients to engage in intercourse, there may be less resistance to other forms of sexual expression. In contrast, patients and consumer advocates have argued that restrictions inpatient settings place on the expression of sexual interest and behavior of patients reflect a general propensity of traditional care settings to limit the rights of hospitalized patients. They argue that the normal expression of sexuality is a civil rights issue.

Deegan (1999) best encapsulated the consumer and consumer advocate view when she wrote, "Like all people, we [people with mental illness] experience the need for love, companionship, solitude, and intimacy. Like all people, we want to feel loved, valued, and desired by others…" (p. 21). Of course, for practitioners, allowing the free expression of sexuality may raise issues of risk, liability, and even practicality. Where does a practitioner draw the line between what represents culturally acceptable sexual expression versus clinically significant sexual behavior? If patients are allowed to have sex on the unit, what challenges does that place on the unit in terms of accommodations for privacy, consent, sexual health, and birth control?

The convention has been for mental health practitioners to ignore issues of sexuality among hospitalized psychiatric patients (Barr 1912; Brown et al. 2014; Collins 2001; Quinn et al. 2011). This has been to the peril of the mental health system as it contributes to evidence that traditional care is poorly responsive to the wishes of patients. The sexuality of psychiatric patients, whether one believes it should be ignored as a potential distraction to treatment (a view

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espoused by many care providers) or embraced as part of holistic approach to treatment, remains an important yet divisive topic within the psychiatric inpatient literature (Perlin et al. 2009).

A Clash of Perspectives

The following case vignettes provide a snapshot of the tensions that exist between the practitioner and patient perspectives on sexual expression on the inpatient unit.

Case Vignette #1

Patient A is a 55-year-old, married, Caucasian male who was admitted to the Chronic Mental Health Unit of SMI Psychiatric Hospital 22 months ago. He had first been admitted to the Acute Unit of the hospital 24 months ago after he attempted suicide by overdosing on over-the-counter medication during a depressive episode. Patient A was first diagnosed with Schizoaffective Disorder when he was in his early 20s, and he has a longstanding history of psychiatric readmissions due to his medication nonadherence. Over the past two weeks, nursing staff have caught him twice pretending to take his prescribed medication (i.e. cheeking his medications). During his weekly individual psychotherapy session, the patient revealed that he and his wife are planning on having sexual relations during their next visit in two weeks. In preparation for this visit, the patient reported that he has stopped taking his antidepressant medication for the last two days, as one of the side effects of this medication is his difficulty achieving and maintaining an erection.

The patient's interdisciplinary treatment team is informed of the patient's medication nonadherence and intent to have sexual relations with his wife during their private visit. As a result, the treatment team informs the patient that he will not be allowed to meet with his wife privately for the next several visits, as the hospital has a firm policy restricting patient's sexual activity, regardless of the marital status of the patient. In addition, the patient will now have to take his antidepressant medication in front of nursing staff in order to prevent him from not adhering to his medication regimen. Nursing staff will check under his tongue and in his cheeks to ensure that he is not "cheeking" his medication. If patient continues to not adhere to his medication, he will be given intramuscular (IM) injections of Oral Dispersible Tablets (ODT) alternatives to ensure his treatment adherence.

Case Vignette #2

Patient B is a 23-year-old, reportedly engaged, African-American female who was admitted to the Acute Unit of the SMI Psychiatric Hospital three weeks ago after she walked into the middle of a busy highway. When queried about why she had engaged in this dangerous behavior, Patient B reported that she had been attempting to use her superhuman powers to "stop cars in the highway by looking at them directly." Following a comprehensive psychiatric evaluation, Patient B was diagnosed with schizophrenia. During the course of her admission, Patient B attended psychoeducational and group psychotherapy classes at the hospital's day treatment center. After two weeks of consistent medication adherence, nursing staff alerted the patient's interdisciplinary team when Patient B refused to take her prescribed antipsychotic medication for two consecutive days. Patient B informed the treatment team that an angel had told her in a dream that antipsychotic medications would harm her fetus, and she stated that she had decided not to take her medication since she and her fiancé were actively trying to start a family. Her treatment team is uncertain about her reality testing capacity and some staff members question whether she really has a fiancé. Despite the treatment team's recommendation that Patient B

focus on her recovery before starting a family, the patient stated that she would not willingly take psychotropic medication until the birth of her first child.

Case Vignette #3

When Dr. Allen took over the administrative responsibilities of a state hospital, he envisioned a program that would be informed by the recovery model and sensitive to the civil rights of patients. After consulting with his state Department of Behavioral Health, relevant state laws and statues, lawyers, and several colleagues, he developed a plan to reform the hospital's policy with regard to patients and sexual expression. He also restructured his hospital units to allow patients to schedule and have conjugal visits. Dating and relationships was now allowed among patients and consensual sex among patients was allowed under a set of conditions—documentation of consent by parties involved, psychoeducation about sexual behavior and communication, and safe sex.

Dr. Allen ensured that training was provided to staff with regard to the implementation of the new policy. On the hospital units, greater accommodation was provided to patients to allow them to have more privacy. Patients generally received the policy shift gladly, whereas many staff members were very concerned about the risks involved in the policy shift and the challenges of protecting vulnerable patients from sexual coercion. At one year, following the implementation of the hospital's new policy, it was clear that patient satisfaction was increased. Some staff members also felt that some patients benefited with regard to increased opportunities to work on their social and interpersonal skills. Several challenges were, however, apparent. Staff members often grappled with the issue of whether particular patients should be "allowed" to consent and many suggested that such issues should be reviewed by the treatment team. There were concerns that certain dating/relationship contexts such as breakups often affected the progress of treatment for some patients. Many psychiatrists continued to raise issues of liability, particularly with a few situations in which vulnerable patients were involved. Some staff members expressed concerns that some patients were not practicing safe sex and were at increased risk of sexually transmitted diseases. Others noted that many patients often demanded to be taken of medications so they could have sex regardless off its impact on their psychiatric symptoms.

It is clear from all three vignettes that there exist tensions between practitioner goals for patients and what patients deem as important. Whereas, practitioners underscore the need for the patient to remain fairly compensated through medication and treatment adherence, patients' interests and degree of treatment adherence may be influenced by non-clinical factors (Deegan and Drake 2006). Criteria such as their desire to engage in valued social roles such as a parent, husband, wife, or sexual partner, may drive patient's own decision to engage in sexual relationships. The third case vignette is an illustration of some of the challenges of a more open and responsive approach to sexuality in inpatient settings.

This chapter will cover the history of sexuality within the context of the psychiatric unit and legislation and current rulings pertinent to sexual health on the inpatient unit. Existing tensions between staff attitudes toward inpatient sexuality, current hospital policies, and risks associated with sexual autonomy on the inpatient unit will be discussed. We will highlight several issues germane to sexual expression in people with mental illnesses. These include normal expressions of human sexuality and the impact of psychiatric symptoms, substance use, and psychotropic medication on sexuality. Within the discussion of normal sexual expression among people with serious mental illnesses, the chapter will highlight the psychosocial aspects of sexuality, sexual and reproductive health, and family planning in individuals admitted to an inpatient unit.

Historical Background and Relevant Legislation

Until relatively recently, sexuality has been viewed as a cause of symptoms of psychopathy (Deegan 1999). As such, the sexuality of patients on the psychiatric inpatient unit or ward has been considered either as a potential sign of "deviancy" that requires close monitoring and restrictive parameters, or a topic to be ignored in its entirety unless forced by circumstances (Brown et al. 2013; Doak 2000; Quinn et al. 2011). A historical turning point occurred with the 1972 Wyatt v. Stickney case, which subsequently led to the District Court of Alabama mandating minimum standards of care for individuals with mental illness and mental retardation (Perlin 2008). A full listing of "The Wyatt Standards" can be viewed in Table 3.1. The Wyatt Standards underscored a range of civil rights for psychiatric patients including adequate care and provisions that guaranteed heterosocial interactions. The Wyatt standards informed the subsequent patient bill of rights that many states adopted. Although, many states adopted the Wyatt Standards but few actually adopted the provision relevant to heterosocial interactions. Rather, many state hospitals operate with gender-segregated units.

Several other litigations were filed related to the sexual rights of people with psychiatric disabilities since the landmark Wyatt case, but a review of litigation history is beyond the scope of this section. A 1983 landmark case, however, warrants comment. Foy v. Greenblott, involved a former psychiatrically hospitalized patient in California who sued her former care provider for not preventing her from having sex while she was hospitalized. The plaintiff had gotten pregnant and gave birth during her hospital tenure. She claimed that her care provider failed to provide adequate supervision to prevent her from having sex and failed to provide her with contraceptives and reproductive education. The California court in this case ruled against the former patient. The court opined that as a patient, she had a right to engage in voluntary sexual relationships:

> A conservatee or other institutionalized mental health patient enjoys the "same rights and responsibilities guaranteed all other persons" except those which are specifically denied by law (medically contraindicated) or court order (declaration *of* lack of capacity to consent). Every institutionalized person *is* entitled to individualized treatment under the "least restrictive" conditions feasible – the institution should minimize interference with a patient's individual autonomy, including her" "personal privacy" and "social interaction", which includes the freedom to engage in consensual sexual relations." Foy v. Greenblott (1983) 141 Cal.App.3d

The court invoked the provision of "least restrictive condition" as necessary to provide

Table 3.1 The Wyatt standards

Category
Physical living environment and custodial care
Personal liberties
Treatment and record keeping
Medical care
Use and administration of psychotropic medications
Protection from harm and physical safety
Adequate staffing and staff supervision
High risk or unusually restrictive treatment
Seclusion and restraint
Treatment in the least restrictive environment appropriate and transitional services
Children's services

ample opportunities for mental health patients to engage in heterosocial interactions. The court also underscored that contrary to the plaintiff's claim of "wrongful birth," her child had not been affected because mental health patients do not give birth to inferior children. The court, however, opined that the defendant denied the patient's right of reproductive choice by not providing contraception and sex-related counseling.

Given the absence of laws or litigation that protects the rights of people with physical and psychiatric disabilities in many countries, the United Nations recently convened the Convention on the Rights of Persons with Disabilities. The mandate of the convention was to collaborate with representatives from all of the countries represented at the convention to define the rights of people with disabilities and develop a plan to seek legislation and reform that is responsive to those rights. The United Nations Convention on the Rights of Persons with Disabilities proposed in Article 25 of its 39-point articles of convention adopted on December 13, 2006 that "nations provide persons with disabilities with the same range, quality, standard of free or affordable health care and programs as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes" (UN General Assembly 2007, p. 18).

In summary, existing legal precedent appears to favor hospital decisions/policies that allow psychiatric inpatients to exercise their autonomy and preference with regard to their sexuality. It also appears that legally, fostering an environment that supports the free exercise of sexual preference requires that certain accommodations and protections be put in place in the treatment milieu. These legal precedents have thus far done little to change the current practices in inpatient settings as units that allow sexual relationships among hospitalized patients are very rare. Several other pressures appear to exert more of an effect on the expression of sexuality among inpatients.

Staff Attitudes Toward the Sexual Autonomy of Patients

Practitioners' and other staff members' own attitudes about people with mental illness may influence the degree to which patients' expression of sexuality is encouraged. Evidence suggests that negative attitudes about people with mental illnesses are prevalent among mental health practitioners although in degrees lower than that of the general population (Stuber et al. 2014). Such attitudes include beliefs about the competence and dangerousness of mental health patients and desires for social distance from mental health patients. To the degree that staff members view psychiatric patients as incompetent, they may be less inclined to support policies that encourage sexual autonomy. Similarly, some staff members' fears about the possibility of sexual coercion may be fueled by exaggerated notions about the dangerousness of many psychiatric patients. Staff members' attitudes and resistance to the possibility of sexual autonomy on the psychiatric unit may be similarly consolidated by isolated incidents of challenging sexual behavior that they have witnessed on the unit. Interestingly, these isolated or anecdotal reports of sexual discretion often form the bases for broad generalizations about the sexuality of others with mental illnesses.

As illustrated in the third case vignette, practitioners and other unit staff members do harbor concerns about the clinical implications and potential logistical challenges posed as a result of sexual interactions between patients. A number of studies have documented such concerns including—questions about the decisional capacity of some patients to consent to sexual activity and the potential risk of transmission of sexually transmitted diseases (Brown et al. 2014; Carey et al. 1997; Cole et al. 2003; Mandarelli et al. 2010; Mossman et al. 1997). Decisional capacity in the context of sexual consent remains to be standardized or operationalized; as such, it remains in the purview and discretion of hospital staff members to express their own impressions.

Treatment teams on psychiatric units have differing perspectives about the level of sexual autonomy that should be allowed on a unit. Whereas, some staff members may believe that the potential liability issues that may arise overrides the petition for patient sexual autonomy presents; other staff members subscribe to a level of "responsible risk taking" (McCann 2000). It is our impression that whereas many in the medical disciplines may be inclined to err on the side of safety, many of the rehabilitative disciplines (e.g., social work, peer support) may be more likely to view the expression of sexuality in the context of the individual's aspirations, valued social roles, and recovery context.

In a qualitative study of 14 psychiatric nurses, Quinn et al. (2011) identified four themes around which mental health nurses viewed the sexual health of their patients and their job roles. Specifically, mental health nurses indicated that despite the acknowledgment of the importance of sexuality: (1) discussions of sexuality were avoided unless the patient indicated that they were experiencing a sexual problem; (2) nurses felt that talking about sexuality was not a part of their job description; (3) some nurses felt that sexuality was not a priority for mental health services; and (4) some nurses felt that sexuality of patients was poorly addressed by other mental health practitioners. Earlier research studies similarly suggested that other mental health professionals might incorrectly assume that individuals with diagnoses such as schizophrenia are asexual, are incapable of maintaining meaningful relationships, or that sexual activity would worsen their symptoms (Buckley 1999).

The clinical repercussions of the active avoidance of discourse around issues of sexuality are unclear. In the absence of a discussion about the patient's own sex/relationship goals, practitioners lose an opportunity to give due consideration to how medication effects (including sexual dysfunction, weight gain) may impact those sex/relationship goals. Moreover, such discussions may have provided an opportunity for the provider to elicit the patient's "buy-in" through negotiation and shared decision-making. Thus, the high prevalence of treatment disengagement including medication nonadherence among psychiatric patients (Kreyenbuhl et al. 2009) may be at least partly understood in the context of care providers who are unresponsive to the patient perspective.

Mental health professionals may not be solely responsible for this silence. Maurice and Yule (2010) postulate that the absence of frank discussions with patients about their sexual health results from the "conspiracy of silence" (p. 470) between the professional and patient. This conspiracy of silence refers to the mutual decision between professional and patient to not broach a sensitive topic such as sexuality and sexual health. The conspiracy of silence appears to be particularly prominent in patients without recognized partners, as mental health professionals may not believe that the topic of sexuality is relevant for such patients. Brown et al. (2014) suggested that the absence of frank discussions with patients about their sexual health coupled with the lack of sexual autonomy experienced by patients on the inpatient unit results in a new type of "amputated sexuality" (p. 250). Amputating the sexuality of psychiatric inpatients is convenient for the unit staff striving to maintain order on the unit. On discharge, however, amputating sexuality may attenuate the degree to which patients are able to form intimate relationships after discharge.

Hospital Policies

Current hospital policies play a large role in the management of sexual expression on the inpatient unit in the United States and abroad. In 1996, the Royal College of Psychiatrists recommended that psychiatric facilities in the United Kingdom develop policies about sexual expression and recommended that these policies have an individualized approach for each institution (Bartlett et al. 2010). More specifically, the Royal College of Psychiatrists (1996) reported, "sexuality and sexual issues are considered a part of individual care plans" (p. 2). Despite the recommendation that psychiatric facilities use an individualized approach to hospital policies

about sexuality and emotional relationships, Bartlett et al. (2010) found that most hospitals in the United Kingdom prohibited or actively discouraged the expression of sexuality.

Although most institutions in the UK are prohibitive toward sexual expression, actual written policies varied widely among psychiatric institutions with regard to conjugal visits, expressions of affection, and contraception. For example, some facilities viewed conjugal visits as permissible with the consent of the multidisciplinary team, while other facilities disallowed even physical expressions of affection such as handholding or hugging (Bartlett et al. 2010). Likewise, some facilities allowed patients to obtain condoms with the approval of the treating practitioner, while other facilities viewed condoms as contraband. For the most part, longer term units tended to be more open to patient intimacy than acute units (Apfel and Handel 1993).

One of the first policies ever adopted in the attempt to balance the sexual rights of patients with the logistical and clinical concerns of sexual autonomy was the revised policy of the Riverview Hospital in British Columbia (Welch and Clements 1993). The stated mission of this policy was to equitably balance patients' rights with the duties of the hospital. As such, the policy is broken down into different emphases to help maintain this balance. The first and fourth parts of the policy underscore patients' right to sexual intimacy in a private and dignified setting. These include access to private suites for masturbation or sexual intimacy, sexual health education, counseling, birth control, protection, and erotic materials. The second and third parts of the policy delineate the infrastructure necessary to implement the aforementioned parts of the policy (e.g., privacy suites, access to condoms) and the orientation, treatment, assessment, and treatment protocol for patients experiencing sexual issues (Welch and Clements 1993).

The outcome of this new hospital policy was reviewed following its implementation (Welch et al. 1999). This review identified steps that could be helpful to future hospitals in implementing a similar policy, as well as strategies that would help improve the current policy at Riverview Hospital. Specifically, the strategies suggest that staff should be provided with information about the policy and its implementation in order to reduce resistance from staff. This information dissemination would explicitly explain how the policy would prevent harm to patients by providing safe areas for sexual relations and the assessment of the sexual needs of each patient, and utilizing behavioral techniques (i.e., reinforcement) to be motivated to attend sex education classes (1999).

Although the Riverview Hospital policy was one of the first sexually "less restrictive" policies of its kind to be implemented, the pursuit of sexual autonomy for psychiatric inpatients goes back about four decades. In the 1970s, there were sexual training workshops created to help guide rather than restrict sexuality in inpatients. Research was geared to guide policy formation on the management of sexual relationships between adults with mental illness in residential care were in vogue (Wilson and Baldwin 1976; Torkelson and Dobal 1999). Other policies that have been developed, but not implemented, bear striking similarities to the policy implemented at Riverview Hospital in British Columbia. All of these policies share overarching principles that include: (1) a summary of patient rights; (2) the capacity to provide consent; (3) provision of sex education; (4) specific logistical considerations for masturbation; and (5) the rights of privacy and dignity within consensual sexual relations (Mossman et al. 1997).

The subculture of an institution may have as great an impact on sexual activity on an inpatient unit as the restrictiveness or permissiveness of hospital policies (Buckley et al. 1999). The subculture of each hospital is affected not only by the official hospital policy, but also by factors such as the acuteness and types of mental illness on the unit. Specifically, acute units are more likely to prohibit sexual expression as compared to longer term units. The overall type of unit also appears to have a significant effect on the sexual expression seen on a unit. For example, sexual intercourse between males is most often seen on all male units and masturbation is the most

common form of sexual expression on geriatric units (1999). One commonality among all units is the propensity for sexual bartering by patients for items such as food or cigarettes (Buckley et al. 1999).

Risks Related to Sexual Autonomy on the Inpatient Unit

Common to all of these aforementioned policies is the need to balance patient's rights with the duties of the hospital. Hospitals must balance patients' right to sexual autonomy with the increased risk for sexually transmitted diseases (Carey et al. 1997; Henning et al. 2012), the risk of sexual assault (Barlow and Wolfson 1997; Cole et al. 2003), the ability to consent to sexual activity (Mandarelli et al. 2014), and the clinical impact of sexual activity on an inpatient unit (Bartlett et al. 2010). A summary table of the risks related to sexual autonomy can be seen in Table 3.2.

Unfortunately, individuals with severe and persistent mental illness are at greater risk for sexually transmitted diseases than individuals without psychiatric diagnoses (Lagios and Deane 2007). As with all sexual activity, the potential for the transmission of sexually transmitted diseases remains an area of great concern on an inpatient psychiatric unit. Infection with the human immunodeficiency virus (HIV) in individuals with severe and persistent mental illness has been found to be 10–76 times greater than rates found in the general population (Carey et al. 1997). In addition, syphilis, which may cause or aggravate symptoms of psychiatric disorders, has well-established comorbidity with HIV (Henning et al. 2012). Both the potential for sexual assault and the aforementioned life-changing diseases can further exacerbate psychiatric symptoms, as well as leave the hospital vulnerable to possible litigation if the assault or infection occurs within the inpatient hospital (Farago v. Sacred Heart General Hospital 1989).

The prospects of sexual assault within inpatient psychiatric units, is also perceived by many staff members to potentially increase with the allowance of consensual sexual relationships on an inpatient unit. For example, Cole et al. (2003) surveyed nursing and medical staff members of an adult psychiatric hospital with regard to their perceptions and concerns about sexually active inpatients. Results from this study indicated that 16.7 % of doctors and 28.2 % of nurses were concerned that they would possibly be blamed for an assault. Moreover, there remains the possibility that female patients who form sexual relationships on the unit would be vulnerable to abuse and exploitation (Cole et al. 2003). Of course concerns about sexual assault, abuse, or exploitation are well founded. For example, Barlow and Woflson (1997) found that approximately 56 % of female inpatients surveyed had been sexually harassed or assaulted during their psychiatric hospitalization. Given that the survey had been completed in one hospital in the UK, it is unclear how much unit-specific characteristics, such as staffing levels and unit structure, might have contributed to the rates reported. Moreover, there was no evidence that the program had specific policies regarding sexuality. Notwithstanding the generalizability of the study findings, any loosening of restrictions among patients on psychiatric units should include protections against assault, abuse, and exploitation.

Table 3.2 Risks related to sexual autonomy on the inpatient unit

Type of risk	Supporting research
Increased risk for sexually transmitted disease	Carey et al. (1997), Henning et al. (2012)
Increased risk of sexual assault	Cole et al. (2003), Barlow and Wolfson (1997)
Concern about the ability to consent to sexual activity	Mandarelli et al. (2014)
Clinical impact of sexual activity on the inpatient unit	Bartlett et al. (2010)

One protection against the risk of sexual exploitation and abuse is the development of executable guidelines for determining if prospective sexual partners have capacity to consent. Unfortunately, there is no consensus definition or criteria established to determine competence to consent to sexual activity (Mandarelli et al. 2014). Existing capacity determination guidelines have focused on determining capacity to consent to treatment or participate in research. With little emphasis on sexual activity competency determination, no validated instruments have been developed to aid sexual consent capacity determination in psychiatric inpatient settings (Mandarelli et al. 2014). Similar to capacity determination for research and treatment, one may conjecture that factors such as the severity of psychopathology or neurocognitive impairments may be contributors to impaired capacity.

A related question relates to the putative components or areas of consent capacity, which should arguably extend beyond the ability to consent to sexual relations. For example, Noffsinger (1999) indicated that five areas of competencies and consent must be evaluated regarding the patient's capacity: (1) to participate in sexual activity; (2) to give consent for birth control; (3) to consent for abortion; (4) to be considered competent as a parent; and (5) to be considered competent to relinquish parental rights. To our knowledge, there are no established standards or criteria to ascertain the absence of sex-related decisional impairment in inpatients. Should possible contributors like severity of psychiatric symptoms and degree of neurocognitive impairments factor into the positive ascertainment of decisional capacity? Further, should decisional competence for sex be a clinical decision or legal adjudication?

Last, some mental health professionals hold reservations about sexual relationships and other forms of sexual expression on psychiatric units due to therapeutic concerns (Bartlett et al. 2010). Providers may, for example, be concerned that some patients with histories of sexual abuse may be revictimized or possibly become perpetrators of abuse should there be less restrictions on sexual activity on the unit. Some providers may also be concerned that allowing sexual relationships between patients might be counter-therapeutic if such relationships become a source of psychosocial stress (e.g., a break-up, heartache). Such concerns may be founded in some cases, but providing adequate psychotherapy/counseling, psychoeducation, and decision support services may be potential safeguards in sexual decision-making. Moreover, consumers and consumer advocates have criticized such benevolent paternalism as fostering of dependence and disability. From the consumer perspective (e.g., Deegan 1996), people with psychiatric illnesses should be afforded the "dignity of risk" and "the right to fail" much like adults without mental illness, many of whom have engaged in high-risk sexual behaviors, one night stands, experienced heartache, or made decisions about their sexuality and relationships they later regretted.

Sexuality and Serious Mental Illness

Research focused upon sexuality and mental illness has identified the need for the inclusion of sexuality into the case conceptualization and overall treatment for psychiatric patients, particularly for individuals diagnosed with certain disorders such as anorexia nervosa, schizophrenia, and posttraumatic stress disorder (PTSD) (Garte 1989; Kelly and Conley 2004; Leon et al. 1985). Within the past 10–15 years, some researchers have begun to focus upon the limited expression of sexuality within the inpatient unit and the repercussions of this restriction (i.e. limited relationship skills) following discharge as a result of the paucity of research upon this topic (Brown et al. 2014; McCann 1999; Quinn et al. 2011). In a study conducted with 58 outpatients diagnosed with schizophrenia, 63.3 % of these individuals considered sexuality to be an important aspect of their life (Martin et al. 2003). Moreover, psychiatric patients were found to have sexual experiences close to the general population, except for a higher engagement in riskier sexual behavior, such as decreased

condom usage and higher rates of sexually transmitted diseases (Gonzalez-Torres et al. 2010).

Leon et al. (1985) suggested that sexuality and concerns related to interpersonal relationships might be an important aspect of treatment for individuals diagnosed with anorexia nervosa. In addition to overall treatment, sex education and other programs focused upon sexual health may be relevant to such patients due to the changes in body image that may result for treatment-induced weight gain. Moreover, other sex-related changes such as the potential for pregnancy even without the resumption of menstruation may be necessary to cover in sex-related psychoeducation (Balakrishna and Crisp 1998).

A similar emphasis on the inclusion of sexual health programs and treatment options is relevant to the care of people with PTSD. For example, Garte (1989) developed a treatment protocol for Vietnam veterans diagnosed with PTSD that addresses sexual health and intimacy during treatment. The author's rationale was that a core aspect of psychopathology in veterans with PTSD may be incomplete resolution of the Eriksonian psychosocial stage of intimacy versus isolation. Moreover, the author determined that veterans were experiencing significantly more difficulties with sexuality and intimacy than the comparison group. A more recent research study conducted by Sautter et al. (2011) introduced the treatment approach of Structured Approach Therapy, which the researchers conceptualized as a couples-based treatment for PTSD that underscores empathic communication training, stress inoculation procedures, and an overall return to intimacy for OEF/OIF veterans and their partners.

Studies suggest that patients with other psychiatric disorders would similarly benefit from holistic treatment plans that address sexual health (McCandless and Sladen 2003; Ostman and Bjorkman 2013). Although some individuals with schizophrenia may exhibit diminished sexual desire as a result of symptoms of the illness or side effects of medication, individuals with schizophrenia are not sexless as previously thought (Van Sant et al. 2012). Regrettably, some symptoms of schizophrenia do adversely affect both sexuality and intimacy. Positive symptoms of schizophrenia can contribute to difficulty forming intimate relationships due to problems in communicating or interpreting interactions with other people (Hirschberg 1985). Negative symptoms may also affect an individual's relational ability as a result of symptoms such as avolition, social anhedonia, poverty of speech, or isolation (Chapman and Chapman 1973).

Despite these barriers, in a study conducted with individuals diagnosed with schizophrenia, the majority of participants indicated that they were prepared to discuss sexual issues and wanted to engage in counseling that focused upon intimate relationships (Kelly and Conley 2004). Not only does it appear that individuals diagnosed with schizophrenia want psychosocial aspects of their health to be incorporated into their treatment, but approximately 50 % of participants reported that they never or infrequently spoke about their sexual functioning with a mental health provider (Rosenberg et al. 2003).

There is a clear need to address the sexual health of people with schizophrenia and other serious mental illnesses. People diagnosed with serious mental illnesses demonstrate suboptimal sexual health due to a history of sexual abuse, long-term sexual abstinence, poor communication with their mental health provider, and a lack of awareness about sexual health (Matevosyan 2010). They also demonstrate high rates of sexual dysfunction with rates as high as 50 % in men and women with schizophrenia (Dossenbach et al. 2005). Interestingly, there appears to be great discordance between patient and psychiatrist estimations of the prevalence of sexual dysfunction. Psychiatrists overall tend to underestimate the prevalence of sexual dysfunction among schizophrenia patients.

Specific impairments in sexual functioning appear to be associated with the type of mental illness experienced by the individual. Women diagnosed with schizophrenia, depression, and anxiety were likely to endorse low satisfaction from sex, while women with depression reported that they experienced symptoms such as

decreased pleasure from the sexual experience and difficulty achieving orgasm (Avellanet et al. 2008). Incidents of physical symptoms associated with sexual dysfunction such as dyspareunia, vaginal dryness, and bleeding after intercourse were most highly rated by women diagnosed with PTSD (Schnurr et al. 2009). For all women with serious mental illness, body mass index appears to partly mediate the effect of psychopathology on impaired sexual functioning. This is because women with serious mental illness are more likely to be overweight or obese than individuals in the general population (Matevosyan 2010).

Sexual Health and Substance Use

The impact of substance use upon sexual health and sexuality is an important facet of the inpatient care of individuals with serious mental illness. Substance use is particularly problematic, as the rates of substance use are higher in individuals with serious mental illness than individuals in the general population (Bahorik et al. 2013). Moreover, for people with mental illness, substance use is associated with a worsening of their mental health, relapse, and an overall poorer recovery (Bahorik et al. 2013).

The use of alcohol and illicit substances has been linked to sexual dysfunction including inhibited orgasm and painful sexual experiences in general population samples (Johnson et al. 2004; Smith et al. 1984). The rates of illicit substance use-related sexual dysfunction have yet to be, however, documented in mental health populations. One would expect higher rates of substance-related sexual dysfunction in mental health samples relative to the general population given their higher rates of illicit substance use. In a community sample, Johnson et al. (2004) found that 37 % of respondents had used illicit substances or heavily used alcohol, and 26 % of participants reported experiencing sexual dysfunction. These rates may be considered lower limits for rates in mental health samples.

Both individuals in the general population and in the psychiatric population are affected differently based upon the type of substance used. Although alcohol is often perceived by users to be an effective aphrodisiac and sexual facilitator, alcohol actually impairs sexual response (e.g., achieving and maintaining an erection, delayed orgasm). Chronic use of alcohol is associated with testicular atrophy and inhibition of testosterone production and spermatogenesis in men, as well as menstrual irregularities and dyspareunia in women (Pacheco and Esteves 2008; Shamloul and Ghanem 2013).

Much like alcohol, cannabis is perceived by users to have beneficial effects on sex as seen in the perceived increase of sexual pleasure and enhanced orgasm; however, inhibited orgasm is related to the use of cannabis (Smith et al. 2010). Likewise, opioid use has the perceived benefits of delayed ejaculation, but episodes of hypersexuality and premature ejaculation are often observed during opioid withdrawal. In addition, sexual side effects such as delayed ejaculation in men and delayed orgasm in women tend to occur with amphetamine and ecstasy use (Bang-Ping 2009; Peugh and Belenko 2001).

In addition to the effects of substances upon functioning, the sexual health and intimate relationships of individuals who abuse drugs are also affected by substance use. Women who use drugs are more likely to have a sexual partner who also uses drugs, although this same relationship is not seen in men (Pacheco and Esteves 2008). Risky sexual behavior, such as prostitution and decreased condom usage with new sexual partners, occur in higher rates in individuals who use substances (Loxley 1998; Mugisha and Zulu 2004). The use of substances by people with psychiatric illnesses impacts their sexual health and their intimate relationships. Moreover, substance users may demonstrate deficits in social skills necessary to build and maintain positive relationships (Pacheco and Esteves 2008).

In addition to their difficulty in maintaining social relationships and the greater tendency to engage in risky sexual behaviors, individuals who use substances are at greater risk for sexual victimization. Women in particular are at particular risk for sexual victimization, as research indicates that 54–60 % of women seeking

substance abuse treatment report having been raped at some point in their lifetime (Dansky et al. 1995). This percentage of victimization is significantly higher than seen in adult women in the general population, as the National Survey of Violence Against Women indicates that approximately 18 % of women in the general population report having experiencing rape at some point in their life (Tjaden and Thoennes 2000).

Women are not the only ones at risk for sexual victimization, as men who use substances are also at greater risk. Specifically, while there is a prevalence rate of male sexual victimization between 3 and 7 % in the general population, research indicates that approximately 16 % of male substance users in an inpatient sample had experienced sexual assault during their lifetime (Bullock and Beckson 2011). Moreover, the risk behaviors of illicit drug use and sexual activity have been found to lead to higher rates of HIV infection in individuals who use substances. Both women and men who use substances are more likely to engage in HIV risk behaviors and to use substances following a diagnosis of HIV (Baum et al. 2009; Keen et al. 2014).

Sexual Health and Psychotropic Medication

Unfortunately, substance use is not the only factor that impacts the sexual health of individuals with serious mental illness. For many psychiatric patients, their sexual health is negatively affected by both their disorder and the very medication prescribed to treat this disorder (Cutler 2003; Rosenberg et al. 2003). Research has focused heavily upon the role of psychotropic medication and sexual dysfunction due to its association with medication noncompliance, potential reproductive concerns, and overall impact on quality of life (Cutler 2003; Hellewell 2000; McCandless and Sladen 2003; Rosenberg et al. 2003). Sexual dysfunction from medication, whether negatively impacting an individual in one or multiple areas (i.e. libido, arousal, and orgasm), can impair quality of life, cause stigma, poor adherence to medication, physical morbidity, and possibly fatal consequences (Haddad and Sharma 2007).

In particular, many patients taking antipsychotic medications report symptoms associated with sexual dysfunction. Antipsychotics like risperidone act at D2 receptors and their blocking action at these receptors induces hyperprolactinemia. This increased prolactin expression in men subsequently causes decreased libido, erectile dysfunction, and potentially galactorrhea. In women, risperidone may also contribute to sexual dysfunction, infertility, and gynecomastia. Indirectly related to sexual dysfunction, patients taking risperidone are at a greater risk for acute extrapyramidal symptoms, and patients compliant with clozapine and olanzapine are at greater risk for weight gain (Haddad and Sharma 2007).

The awareness of potential side effects of psychotropic medication is important for reducing the rate of medication noncompliance, given that sexual dysfunction occurs as a side effect of treatment with conventional antipsychotics in approximately 50 % of patients diagnosed with schizophrenia (Kelly and Conley 2004). Sexual dysfunction is also one of most commonly cited reasons for medication noncompliance. Rosenberg et al. (2003) found that 43 % of participants diagnosed with schizophrenia reported that they had considered stopping their medication due to sexual dysfunction, while 27.5 % of participants actually had stopped taking their prescribed medication due to perceived sexual side effects. Therefore, patients diagnosed with schizophrenia may not be adherent with their medication regimen despite the effectiveness of atypical antipsychotics in acute schizophrenia and in preventing relapse (Gibson et al. 2013; Haddad and Sharma 2007). Unfortunately, it appears that many mental health nurses and other mental health professionals infrequently inquire about possibly medication-induced sexual dysfunction. This may be due to concerns that the patient would be embarrassed talking about sexual problems or concerns that the knowledge itself of the association between psychotropic medications and sexual dysfunctions may cause medication noncompliance (Haddad and Sharma 2007).

Much like conventional and atypical antipsychotic medications, antidepressants have also been shown to have sexual side effects, with estimates of prevalence of sexual dysfunction in depression ranging from 30–50 % in patients prescribed antidepressant medications (Schweitzer and Chee 2009). The percentages may underestimate the actual proportion of patients who experience antidepressant-induced sexual dysfunction. Selective serotonin reuptake inhibitors (SSRIs) may differ with regard to the degree of sexual dysfunction. For example, paroxetine is more likely to be associated with sexual dysfunction, while fluvoxamine is less likely to be associated with sexual dysfunction (Montejo-Gonzalez et al. 1997; Westenburg and Sandner 2006).

Mood stabilizers and anticonvulsants are commonly used in the treatment of manic episodes and depressive polarity without the exacerbation of other mood episodes (Freeman and Gelenberg 2005). During manic episodes, people with bipolar disorder may be at increased risk for sexual health problems due to impulsivity which drives increased sexual risk taking. High-risk sexual behavior during such episodes could pose potentially devastating consequences on the physical and emotional health of these individuals (McCandless and Sladen 2003). Freeman and Gelenberg (2005) postulated that the rates of unplanned pregnancy may be higher in women diagnosed with bipolar disorder than the rest of the general population. This issue is further complicated by the risk all mood stabilizers carry with pregnancy and delivery, such as the risk of fetal malformation, perinatal complications, and poorer long-term child developmental outcomes (Galbally et al. 2010).

Influence of Sexual Orientation and Gender in Individuals with Severe and Persistent Mental Illness

Identity plays an important role in the recovery and community reintegration of individuals with severe and persistent mental illnesses after discharge (Martin et al. 2011). Many identities of an individual (i.e. sexual orientation, ethnicity) may influence the treatment received in an inpatient setting as well as the social support received upon reintegration into the community. Salient identities such as being diagnosed with a mental illness, being a member of an ethnic minority group, being of a non-heterosexual orientation, or being a women may elicit stigma that may impact the overall well-being of psychiatric patients (Collins et al. 2008).

Studies with sexual minorities—individuals who self-identify as being of a sexual orientation other than heterosexual— suggest that they may face barriers to treatment or recovery as a result of their sexual identity (Hall 2013; Singer 2004). The first is the limited availability of gay-affirmative mental health services (Singer 2004). This finding is particularly disconcerting as there are high rates of homosexual activity among people with serious mental illness (Perry and Wright 2006). There is indeed a need for more affirmative programs due to the particular vulnerabilities faced by Lesbian/Gay/Bisexual/Transsexual/Questioning (LGBTQ) patients such as harassment or homophobia. Further, treatment should address the interaction between their minority status and mental illness in order to achieve more integrated care (Singer 2004). Many patients choose not to disclose their sexual identity for fear of experiencing rejection or discrimination from staff and/or other patients. Some have suggested that full mental health recovery may be elusive in the absence of a safe environment for the full disclosure of sexual identity (Hall 2013). Transgender patients in particular, face additional barriers to treatment and recovery from serious mental illness due to potential encounters with transphobia during treatment, lack of access to health insurance, and increased rates of suicide, self-harm, and trauma (Mizock and Fleming 2011).

In addition to sexual orientation, other identities may also influence psychiatric patients' full engagement in treatment and their overall recovery. In research conducted with married women on an inpatient unit, participants identified that their marital relationship was strained by stress from sexual difficulties (Martin et al. 2011). Moreover, sexual difficulties experienced

by married women was also associated with hostility from friends and family, which may further decrease the social support that plays such a significant role in a successful recovery.

An individual's identity as a woman is also associated with risks and vulnerabilities that are not associated with men (Lyon and Parker 2003). Risks for women with serious and persistent mental illness include a higher risk for assault and sexual trauma. In particular, women with severe mental illness are more likely than women in the general population to have experienced sexual abuse, as rates in the former population range from 34–51 % (Harris 1997). In a study of female inpatients, women with a history of abuse were more likely than women without a history of abuse to exhibit psychotic symptoms, to be diagnosed with borderline personality disorder, and to experience suicidal ideation (Harris 1997).

Intimacy and Family Life

From the recovery perspective, people with severe mental illnesses are entitled to the pursuit of intimacy, family life, and other valued social roles (Ahmed et al. 2011, 2016). The domains of sexuality and intimacy are often rated by patients to be the lowest in satisfaction of all life domains, listed below work, finance, social relations, leisure, living situation, security, family relations, psychological well-being, and general life satisfaction (Ostman 2014). Psychiatric patients tend to face significant difficulty in finding and maintaining an intimate partner relationship due to poor access to sexual partners, sexual dysfunction, social skills deficits, social anhedonia, dysfunctional attitudes, and difficulty forming relationships (Wright et al. 2007). Although studies have shown that cohabitation is positively associated with satisfaction with sexual relationships; most of the relationships that people with severe mental illness form tend to not lead to either cohabitation or marriage (Eklund and Ostman 2009; Perry and Wright 2006). The relationships of people with serious mental illness are usually considered to be less intimate, in addition to having less commitment (Perry and Wright 2006). Partners of individuals diagnosed with a severe mental illness often take on more responsibility within the relationship and face potential conflicts regarding hospitalization and the acceptance of the presence of a mental illness by their diagnosed partner (Crowe 2004). As such, Crowe recommended that within the mental health community, practitioners address the needs of partners of individuals with mental illness and consider the stability of the relationship as part of the treatment plan.

The stress of mental illness on the partner or family of the individual diagnosed with schizophrenia can influence the patient's prognosis and outcome. In a study conducted with the family members of individuals diagnosed with schizophrenia, approximately 52 % of the families were categorized as having High Expressed Emotion (EE; Miura et al. 2004). High Expressed Emotion in families has been associated with a patient's risk for relapse, as approximately 48 % of patients with schizophrenia who reside within high EE families will relapse as opposed to 21 % of patients in families with low EE (Kavanagh et al. 1997). Therefore, treatment that focuses on assisting family members or partners of individuals diagnosed with schizophrenia is beneficial to both the family and the diagnosed individual.

Most of the services and treatments offered on sexuality for psychiatric patients have focused on risk management as opposed to teaching patients how to work toward positive sexual relationships and emotional intimacy. For example, most sexuality-related interventions have focused upon providing information about prevention regarding sexually transmitted diseases and different contraception methods (Kopelowicz et al. 1999). In other words, treatments have tended to emphasize the behavioral and biological aspects of sexuality rather than the psychosocial aspects of a patient's sexual needs. Perry and Wright (2006) have called for a paradigm shift in how mental health providers view the sexuality of people with serious mental illness by practitioners providing

psychosocial rehabilitation to help patients gain skills for both platonic and romantic relationships.

Modern psychosocial treatment interventions provide the opportunity to rehabilitate social skills deficits that are germane to sexual behavior in individuals diagnosed with severe mental illness. These include modules with specific emphasis upon the establishment and maintenance of romantic relationships and intimacy. The UCLA Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation modules help patients learn social and independent living skills (Kopelowicz et al. 1999). The friendship, dating, and sexuality module is particularly salient in its focus on providing individuals with knowledge about sexuality and sexual decision-making. The module targets sexual communication skills such as sharing information with a partner about sexuality, verbal and nonverbal communication before sexual activity, communication after sexual activity, and talking about sexual problems. Similarly, Bellack et al.'s (2004) social skills training manual includes modules for the acquisition and performance of dating skills including asking someone for a date, giving or receiving compliments, refusing unwanted sexual advances, and assertively communicating the need for safe sex. These modules are examples of how sexual health and intimacy can be incorporated into treatment at an inpatient psychiatric hospital by providing practical tools and skills for learning about sexuality and intimacy.

Reproductive Health and Family Planning

Reproductive health, pregnancy, and family planning are of particular importance in the lives of some patients diagnosed with psychiatric illnesses and their experience of recovery. People with psychiatric illness, however, experience challenges that detract from their reproductive goals. Women with psychiatric illnesses are more likely to experience obstetric complications and other negative obstetrics characteristics during pregnancy, such as a higher rate of unwanted pregnancies, abortions, and miscarriages (Howard et al. 2002). Within mental illnesses, the prevalence of these problems tends to vary based upon the type of disorder. For example, the prevalence of abortions tends to be highest in individuals diagnosed with schizophrenia rather than individuals diagnosed with bipolar disorders, while individuals with bipolar disorder are more likely to have an unplanned pregnancy than individuals with schizophrenia (Ozcan et al. 2014). Women with schizophrenia and other disorders may also experience higher rates of obstetric complications due to lower socioeconomic status (Miller 1997). Perinatal risks have also been identified that are related to lifestyle factors such as illicit drug use, smoking, and alcohol use during pregnancy (Hauck et al. 2008). During pregnancy, patients and their treating physicians must weigh the risk of withholding medication with the risk of prescribing medication during pregnancy. Following delivery, there is an increased risk of an exacerbation of psychotic symptoms in women with schizophrenia during the postpartum period (Green et al. 2008; Miller 1997).

Compared to the general population, people with schizophrenia and other mental illnesses are less likely to be married. Marriage rates among men with schizophrenia are even lower compared to those of women with schizophrenia (Apfel and Handel 1993; Tang et al. 2007). Women with schizophrenia are more likely to be childless than the general population and men with schizophrenia have even higher rates of childlessness (Harley et al. 2010; Haverkamp et al. 1982). Men and women with mental illness may lack dating and relationship skills are necessary to attract prospective sexual partners and negotiate the complexities of sexual relationships. Pregnant women on an inpatient psychiatric unit not only have to deal with these barriers, but may also have to contend with staff perceptions of their pregnancy. For instance, a pregnant woman may be reproached by staff members who hold the view that she should not be a mother, or that her baby should automatically be taken away from her upon birth (Apfel and Handel 1993).

From a comprehensive literature review on the reproductive health of women with serious mental illnesses, Matevosyan (2009) concluded that patients with schizophrenia and mood disorders were more likely to experience reduced fertility and have more lifetime sexual partners. They were also more likely to elicit risky sexual behaviors such as lower rates of contraceptive usage, parenting difficulties, have unwanted pregnancies and abortions, and be at greater risk for the loss of child custody. Higher rates of unwanted pregnancies and abortions seem to be linked to the lower rate of contraceptive usage, as women with serious mental illness tend to experience difficulties using barrier (e.g., condom) and hormonal (e.g., synthetic estrogen and progestins) contraception methods. Due to the lack of compliance and improper use of some contraceptive devices, it has been suggested that implants and long-acting progestins may be the most effective forms of contraception for women with severe mental illness (Matevosyan 2009).

A meta-analysis of the literature on motherhood for women with severe mental illness identified several prominent themes related to their illness, their identity/role, and their child (Dolman et al. 2013). Several themes emerged from the meta-analysis: stigma of being a parent diagnosed with a mental illness, fear of custody loss, and concern over the impact of the mother's mental illness on the child (i.e., genetic risk, environmental, and secondary stigma). Moreover, the research literature identified themes of feelings of isolation, coping with dual identities, and the centrality of motherhood within mothers diagnosed with severe mental illness. From this meta-analysis, it was recommended that there was an increased need for education for mothers about their psychiatric disorder as well as general parenting education. Furthermore, integrated services were seen as necessary for the optimal care of both mother and child in order to address the concerns identified in the aforementioned themes (Dolman et al. 2013).

Pregnancy and motherhood are not the only considerations during the treatment of a woman of reproductive age on an inpatient unit. Studies have examined the effects of the female reproductive cycle upon chronic mental illness and found differences regarding the prevalence of menstrual irregularities, as well as differences in symptom severity based upon the stage of the menstrual cycle (Apfel and Handel 1993; Lande and Karamchadani 2002; Sit et al. 2011). One type of menstrual irregularity, amenorrhea, is thought to be strongly affected by psychosis as approximately 27 % of psychiatric patients experience this condition as compared to approximately 5 % of women in the general population (Apfel and Handel 1993). This menstrual abnormality was found to be higher in women with psychosis prior to the introduction of antipsychotic medication (Bargiota et al. 2013).

The menstrual cycle appears to also influence the mental health of women with severe mental illness. For example, some women may experience more severe psychotic symptoms during certain stages of their menstrual cycle, and their menstrual cycle in general may be affected by electroconvulsive therapy and psychotropic medications (Apfel and Handel 1993). Regular menstruation in a female who had previously experienced an irregular menstrual cycle during her admission on an inpatient unit may be an indicator of potential improvement in her overall symptomology. Postmenopausal women may also require higher doses of antipsychotic medication, as medication levels can vary based upon the menstrual phases or the lack of menstruation (Apfel and Handel 1993). Overall, recovery-based inpatient psychiatric care must be sensitive to issues of gender identity, as well as the desires of the patient for parenthood.

Conclusion

Human sexuality and sexual health are fundamental rights of all individuals regardless of physical or mental disability. This is the view espoused by proponents of the recovery model. With the advancement of the recovery perspective, there is a need to reexamine current psychiatric practices, which have traditionally been prohibitive of sexual contact among patients.

Recent court rulings and legislation lend credence to a recovery-focused perspective and provide legal precedents to adopt less restrictive policies (Hungerford and Kench 2013).

The adoption of less restrictive policies would signal a shift in focus from pathology and risk management to recovery and patient's rights. However, complications and barriers to sexual autonomy for patients remain a prominent concern. The absolute prohibition of sexuality or physical intimacy mainly appears to occur due to concerns about liability, the risk to patients and staff, logistical concerns about the implementation of a new policy, and therapeutic concerns about the effect of consensual sex upon the hospital milieu (Brown et al. 2014; Carey et al. 1997; Cole et al. 2003; Mandarelli et al. 2010). However, progressive ventures into sexual autonomy have occurred, as seen through less restrictive hospital policies (e.g., Riverside Hospital) and more comprehensive sexual education programs focused on personal sexuality, intimacy, and relationships (e.g., UCLA Friendship, Dating, and Sexuality Module). Once less restrictive policies are in place, hospitals should provide education on sexual health on the inpatient unit as part of a program of psychosocial rehabilitation. Such efforts should include teaching patients about the prevention of sexually transmitted diseases, contraception, family planning, and education about mental health and pregnancy.

Future studies may help to frame better understanding of the impact of severe mental illness on reproductive health. These research studies should be on a larger scale and provide more detailed information through the use of control groups and male patients (Bowers et al. 2014; Ozcan et al. 2013). In addition, more information about how mental health professionals discuss sexuality with their patients will help to further identify barriers and hindrances to the provision of holistic care (Quinn et al. 2011).

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