

# Sexuality, Intimacy, Mental Illness and Quality of Life

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# **PART 1- Sexuality and Mental Illness**

The greatest and most healing service that can be offered to people with psychiatric disabilities is to treat them with respect and honour them as human beings. This means honouring us in our full humanity, including our sexuality and our desire to love and be loved.

(Deegan, 2001, p.2)

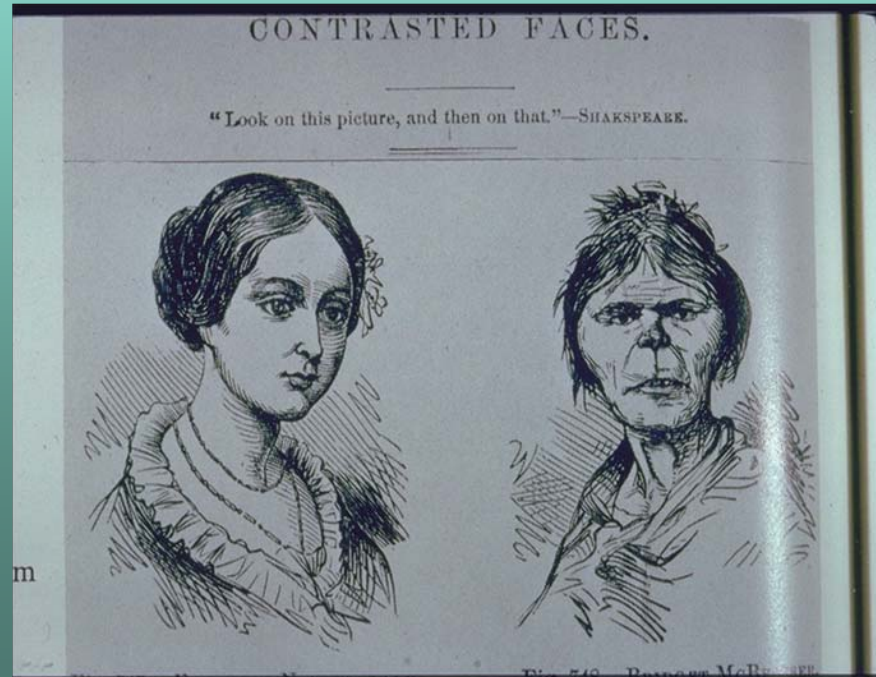
# Benefits of Sexual Activity

- Provides pleasure
- Creates and maintains intimate connection
- Part of personal identity
- Builds self esteem
- Health benefits: improves mood (oxytocin), sleep, reduces anxiety and stress, improves circulation
- Keeps you fit

# 1. The History of Sex and Mental Illness: Stigma and Taboo

Historically sexuality has been reduced to either the cause of mental illness or a symptom of psychopathology.

- Masturbation  
(see Handout)
- Eugenics
- Homosexuality



## 2. Myths and Misconceptions: Why Clinicians Don't Like to Talk About Sex

The client:

- Asexuality myth: people with a mental illness do not have sex
- Older people are asexual
- Heterosexuality assumption
- Talking about sex will increase the likelihood of sexual disinhibition
- It will embarrass/distress the client and aggravate symptoms

## The clinician:

- Not confident to talk about sex due to lack of training
- Open a Pandora's Box and not know what to do with the information
- CBT interventions are too hard for individuals with a serious mental illness and sexuality problems
- Silence reinforces taboo/stigma around mental illness and sexuality

### 3. Incorporating Sexuality into the Recovery Plan: Why Clinicians Need to Talk About Sex

- **HIV/AIDS:** there are numerous pathways for the association between mental illness and sexual risk behaviour: e.g. AOD, “survival sex”
- Non-compliance: sexual dysfunction as a result of medication e.g. desire, arousal and orgasm problems
- Quality of Life: first person accounts of individuals with mental illness are pervaded by themes of loss, alienation, and a desire for intimacy and companionship. **Inverse relationship between Quality of Life and sexual dysfunction**

## 4. How to Talk About Sex

- Engagement, engagement, engagement
- Ask the question (asking increases reporting)-  
“Many people find that their sex lives are affected by .....
- Be clear, concise, and use simple terms
- Explain what you mean
- Look for and respond to non-verbal cues that suggest discomfort
- Convey a sense of trust and confidentiality
- Normalisation and education
- Sense of humour

## 5. Medication and Sexual and Reproductive Function

### **Barriers for clients:**

**Stigma**: poor self image and confidence, limited self care and poor hygiene, histories of abuse and trauma, lack of privacy, poverty etc.

**Medications**: Sexual dysfunction a serious and common symptom in mood disorders.

Medications have non-specific effects such as weight gain and sedation.

**Antidepressants**- Older antidepressants: weight gain, sedation,

- Newer antidepressants (SSRIs, SNRIs): Sexual desire improves but males more likely to experience ejaculatory dysfunction; females decreased sexual desire and orgasmic dysfunction
- Fewer sexual side effects: Pristiq, duloxetine (Cymbalta), mirtazapine (Avanza). More sexual side effects: citalopram (Cipramil), fluoxetine (Prozac), paroxetine (Aropax), sertraline (Zoloft)

- **Mood stabilisers:** loss of interest in sex
- **Typical antipsychotics:** elevated prolactin levels (weight gain, infertility, erectile dysfunction)
- **Atypical antipsychotics:** are less likely to cause adverse side effects than traditional:
- Fewer sexual side effects- aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel).  
More sexual side effects- clozapine (Clozaril), risperidone (Risperdal)

# 6. Interventions

1. **Biological Interventions:** dosage (reduce but must balance with relapse), change,

2. **Address physical problems:**

- Gynaecologist, urologist, GP etc.
- Pain control
- Physical aids (dilators, vibrators, penile collars, pumps)
- Lubrication, lubrication, and more lubrication
- Topical oestrogen

3. **Psychosocial model:**

- Sexual education:
- Sexual counselling: Assessment and strategies to expand sexual repertoire, CBT, sensate focus exercises (exposure therapy), relaxation techniques
- Couples work: **communicate, communicate**