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The Sexuality of Individuals with Mental Illness

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ABSTRACT

Background: Stigma and stereotypes often go together with mental illness, especially regarding the sexuality of those living with mental illness. There exists a lack of awareness of the topic of psychiatric patients' sexuality and sexual relationships. **Purpose:** The purpose of this review was to explore the sexuality of individuals with mental illness, their obstacles, stigmas, and treatment, and how each relates to the other. **Method:** This was a thorough review of the literature. Each topic was outlined specifically looking at case studies and literature review. **Findings:** Although patients with mental illness are interested in maintaining an active sex life, many obstacles hinder that fulfillment. **Conclusion:** Sexuality is an integral part of the quality of life and should be treated as such.

INTRODUCTION

Patients with mental illness already suffer from harmful stigmas and stereotypes, but their sexuality can also be part of those obstacles (see Figure 1). The American Nurses Associations (ANA) and the Center for Disease Control and Prevention (CDC) have a plethora of information on sexual health and mental illness but no information that addresses both. All the articles in this review discussed stigmas, obstacles, treatment, and how they relate to each other in the care of patients with mental illness. The goal is to explore the literature on these topics and bring awareness to these issues to enhance treatment regimens in the future.

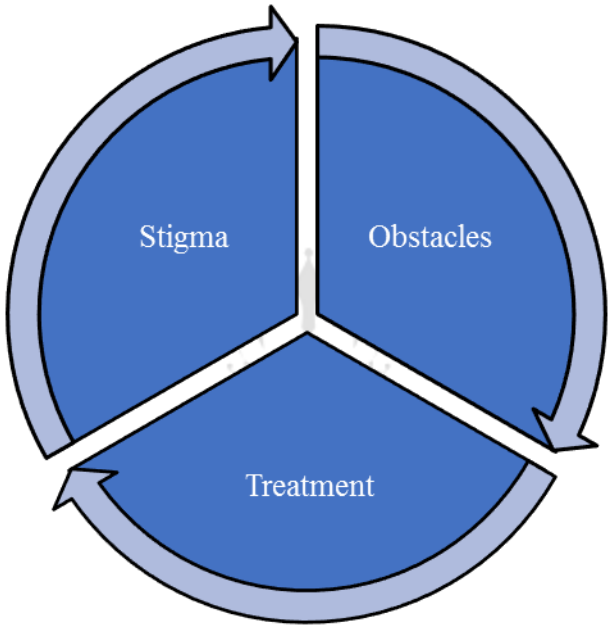


Figure No. 1: The sexuality of individuals with mental illness and its relationship.

CASE STUDY

In general, individuals with mental illnesses are more likely to suffer negative physical health outcomes, have difficulty accessing adequate services, and experience stigma and discrimination that take on many forms. Stigmatizing beliefs towards individuals with mental illnesses are deeply rooted in cultural attitudes rather than facts, and are associated with negative impacts, including low self-esteem, decreased self-efficacy, and decreased willingness to seek medical treatment. The subpopulation of women with mental illnesses occupies a specific social position

in which their experiences are impacted by stigmatization, institutionalization, and gendered dimensions of trauma and power that leave them vulnerable to victimization and rejection [1]. One study included 55 interviews with women in psychiatric units across the United States, investigating how women perceive sexuality and masculinity, focusing on gendered experiences of trauma, stigma, and attitudes about sexuality [1]. After the interview process was completed, some common themes arose regarding how women with mental illnesses perceive sexuality and how their experiences influence that perception. The following vignette will provide an example of the characteristics, symptoms, and behaviors present in a hospitalized woman living with mental illness.

Martha is a 43-year-old woman admitted to the inpatient psychiatric unit for suicidal ideation following the divorce from her husband. Martha has a history of major depressive disorder and sexual trauma. Since her admission, she has isolated herself to her room and has not interacted with other patients or staff, aside from the female nurses. It is now time for Martha to meet with a provider to discuss her sexuality and sexual health needs. She is apprehensive but attempts to answer questions reluctantly. When asked how she views herself in terms of her sexuality, Martha responds, “I see myself as not wanted and broken. No wonder why he left me. I did not think I’d be a good wife anyways. I feel empty." When asked to speak more about herself not feeling wanted, Martha added, "I should have known he wouldn't have wanted to be with someone with a mental illness. Who would want to have sex with someone who's depressed and miserable all the time?" When asked about the current desire for sexual relationships, Martha concluded, "At this point, Nah. This ruined it for me, and my body's dirty anyways after the years of abuse. I’m sure he never found me attractive after finding that out. Anyways, I see men coming down the hall, and I really don't need them hearing about this too…" Martha abruptly stood up and wandered back to her room for the evening.

This vignette demonstrates some of the characteristics, attitudes, and behaviors that a hospitalized woman living with a mental illness may showcase (see Figure 2). Individuals with mental illnesses often isolate themselves to cope with the stigma and rejection they endure. Individuals with a history of trauma are often reluctant to open themselves up to discussion regarding sexuality [1], which was demonstrated by Martha’s apprehension in the vignette. Her responses to the provider’s questions signaled the common themes women with mental illnesses

face regarding their sexuality, such as feelings of low self-esteem, self-blame for mental illness, and viewing themselves as undesirable and an inadequate partner. Women with a history of trauma often view their bodies as "tainted" or "dirty" [1], which was demonstrated in Martha's response to her current desire for sexual relationships. The vignette closed with Martha abruptly, ceasing the conversation due to male patients walking past her, which illustrates her discomfort with male patients. According to Frieh [1]85% of women reported feeling unsafe in mixed-gender wards and expressed fear of violence while being hospitalized. To combat the high rates of victimization women with mental illnesses experience on psychiatric units, it is important to consider the sexual experiences and stigmas of these patients and listen to their concerns. Future implications may involve implementing trauma-informed interventions and single-sex wards to counter the revictimization patients endure while hospitalized [1].

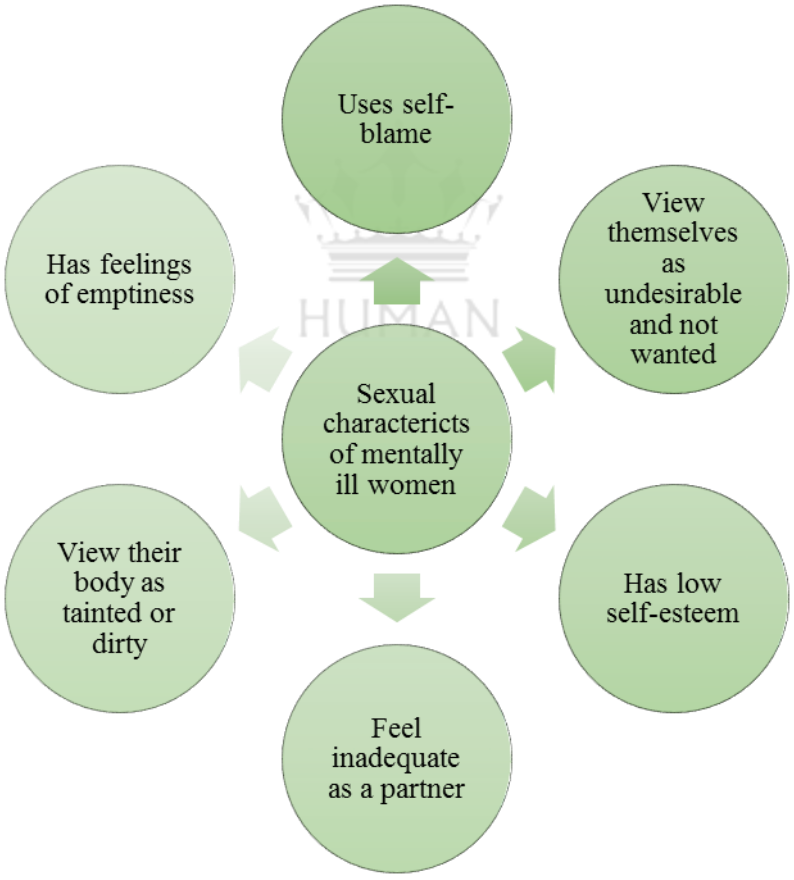


Figure No. 2: Sexual characteristics of hospitalized mentally ill women.

LITERATURE REVIEW

Mentally ill patients experience a range of factors that inhibit their ability to comply with treatment regimens while sustaining passionate physical and emotional relationships throughout their lives. Sexual relations in mentally ill patients often go undiscussed, and the topic, in general, is under-researched. Bringing attention to each issue's data is important to serve this patient population adequately, improve patient-centered care, and improve treatment regimens. Studies utilized include articles from 2008-2020. There were a limited number of published studies on the subject and overall understudy of sexual dysfunctions in mentally ill patients. To find appropriate studies key words such as sexual dysfunction, sexuality, mentally ill, schizophrenia, depression, anxiety, marriage, sexual relationships, stigmas, and sexual norms were used utilizing PubMed and the cumulative index to nursing and allied health databases.

Stigma Surrounding Sexuality

Individuals with mental illnesses face stigmas regarding their sexuality, and the ability to form sexual relationships is a global phenomenon. Limited progress has been made in support of individuals with mental and intellectual disabilities to form intimate relationships. McConkey *et al.* [2] found that a critical factor that has been seldomly researched is the attitude of the public towards the sexuality and reproductive rights of mentally ill individuals and the implications these views hold. Based upon the results of three national surveys conducted in Ireland over 10 years by the National Disability Authority, in which 1000 respondents were asked to rate their agreement that individuals with various disabilities (intellectual, mental, and physical) had the right to fulfillment through sexual relationships and bearing children, the percentage of agreement was highest for physical disabilities and lowest for mental disabilities. Furthermore, certain demographic characteristics of the respondents, such as those being more comfortable with individuals with mental illnesses living in their neighborhood, single individuals, and those with larger social networks, increased the agreement rate of individuals with mental disabilities having the right to have sexual relations and bear children.

The respondents of the Ireland survey also answered open-ended questions about why they believe or do not believe mentally ill individuals have the right to sex and bear children. Among the reasons, most respondents who thought individuals with mental disabilities do not have the

right to sex felt so due to a belief that mentally ill individuals are not capable of making decisions and could be vulnerable to abuse. The primary reason respondents disagreed with mentally ill individuals bearing children was the concern for the child's emotional and physical wellbeing [2]. The findings of this study demonstrate the societal stigma that prevails regarding the sexuality and reproductive rights of individuals with mental disabilities and suggest that this stigma extends worldwide.

The stigma surrounding sexuality with mental illnesses face can manifest at various levels. Elkington *et al.* [3] examined the role of mental illness-related stigma on romantic or sexual relationships and behavior among the youth population living with a mental illness. Of the 20-youth interviewed, half of the participants felt a societal stigma. They perceived that individuals without a mental illness would not want to be in a relationship with them and view them as "not dependable" or "a burden." Individual stigma was also prevalent in youth who had previous direct experiences with rejection. For example, after a female adolescent shared with a sexual partner that she had bipolar disorder, he responded with, "you better not start flipping out on me" [3]. Stigma can also be internalized, whereas adolescents living with mental illnesses have expectations of rejection, although rejection may not have occurred. This internalized stigma can lead to feelings of low self-worth, fear of opening-up to someone, lack of control related to intimate relationships and partner options, or avoidance of relationships entirely due to the perception of there being "no options" [3].

Sexuality and Women Enduring Mental Illness

Davison and Huntington [4] aim to explore women's experiences with mental illness, specifically relating to sexuality, and ways of improving health providers' practice concerning the issue. Most of the research on the topic only examines mixed gender. These mixed-gendered studies entirely disregard the influence that gender has on sexuality. Sexuality is a gendered experience, so both sexuality and gender must be researched separately as well. The study starts by giving background information on sexuality and the integral role sexuality plays in a person's health and wellbeing. It also gives a clear definition of sexuality and explains how it is more than just the act of sexual activity and reproduction. Women with mental illness are seen to engage in riskier sexual intercourse, have multiple partners, sexual coercion, and have higher rates of sexually

transmitted infections and HIV. Most of the research on this subject only focuses on their behavior and not the contextual factors that may lead them to behave this way. Some of these factors include socioeconomic status, mental illness, staff attitudes, sexual health education, abuse, and sexual coercion/gender power imbalances. Women with mental illness are often living in poverty from limited employment and dependence on government financial help. Other factors listed include sexual abuse in adulthood and childhood, lack of sexual health education, and providers not asking questions about sexuality in general [4].

The phrase "out of sight, out of mind" is referenced due to its relevance to the study. It relates to this study because sexuality is often a very personal matter and somewhat "out of sight." The term "out of mind" refers to women's sexual experiences being layered with their mental illness experiences. When asked about the stigma they face, a few women stated that they enjoyed being with someone who also had a mental illness because they did not possess the stigma of mental illness, making them feel safer and more accepted. Others said that they simply did not tell their partner about their mental illness because they were too shameful and did not want it to affect the relationship negatively. Lastly, heteronormativity is discussed and how harmful it can be to those of another sexual orientation. Many women found it hard to be “openly out” due to the social dominance of heteronormativity. When they did come out, people wanted to blame their sexuality for their mental illness. One woman even stated that a health care provider told her to go to therapy and get a boyfriend, despite being a lesbian [4].

Compounded Stigma in LGBTQ Community

One study focused on the relationship between mental illness, substance abuse, sexual minority status, and trauma in the LGBTQ community [5]. Behavioral health stigma being the stigma one internalizes as a negative view of themselves due to societal pressures, willpower, personal control, decision making, responsibility, and normalcy. The literature uses a four-circle Venn diagram to visualize how mental illness, substance abuse, sexual minority status, and trauma interact. The authors determined that substance abuse is more prevalent in the LGBTQ community, but many were self-medicating for psychiatric illnesses. The authors report that this possibly happens due to compounded stigma, meaning the stigma they face due to their sexual minority group and psychiatric disorder makes them less likely to seek care for their mental

illness (see Figure 3). The authors discuss the prevalence of personality disorders in the LGBTQ community, which is thought to be linked to adverse childhood events, which is also another factor in the role of self-medicating. The authors make a full circle coming back to compounded stigma by stating how much impact it has on sexual minorities and mental illness. Compounded stigma also causes decreased action in seeking help and is reinforced by negative experiences in the clinical setting due to heterosexism, homophobia, and general discrimination [5].

Figure No. 3: Compounded stigma due to sexual minority status and psychiatric disorder makes the mentally ill less likely to seek care.

Obstacles Relating to Sexual Health

Individuals living with a mental illness experience countless obstacles relating to their sexual life and sexual health. Despite conceptions, individuals who suffer from mental illnesses are interested in maintaining an active sex life, yet they experience rejection, prejudice, and other barriers that prevent them from sexual fulfillment. As illustrated in Figure 4, one obstacle that impedes the sexuality of individuals living with mental illnesses is the complications of the disease itself. Some mental illnesses can increase suspicion of others' motives or cause individuals to misinterpret non-verbal behaviors, which can make forming intimate relationships difficult. Some pharmaceutical drugs that patients take to treat mental illnesses can also have adverse effects on their sex lives, experiencing loss of libido, erectile dysfunction, and anorgasmia, leading to worry and frustration surrounding intimate relationships. Along with frustration, feelings of loneliness and isolation were also evident in individuals living with a mental illness, based on a meta-analysis of sexuality in individuals living with mental illnesses [6]. This loneliness was connected to feelings of disconnection from the rest of society,

preventing individuals living with mental illnesses from establishing new social relationships or hindering them from maintaining existing ones.

Sexual complications related to mental illness may include	Suspiciousness of others' motives
	Misinterpretations of non-verbal behaviors
	Some psychiatric medications decrease sex drive
	Possibility of erectile dysfunction for men
	Lack of sexual orgasm

Figure No. 4: Sexual complications related to mental illness.

Another obstacle that patients living with mental illnesses face regarding sexual health involves the increased risk of unsafe sex practices and contracting sexually transmitted diseases (STDs), especially within the youth population. Elkington *et al.* [3] noted that adolescents with mental illnesses are at greater risk of contracting the human immunodeficiency virus (HIV) than their counterparts without a mental illness. This heightened risk is associated with an attempt to manage a stigmatized identity. In contrast, adolescents may engage in behaviors that directly or indirectly increase the risk of getting HIV or a sexually transmitted disease, such as failing to request condom use or purposefully attempting to get someone pregnant in hopes the person would stay. Additionally, adolescents with a mental illness reported an earlier age of sexual debut, more inconsistent condom use, and a greater likelihood of having multiple sex partners than the general population. Despite this knowledge, the relationship between mental illness and high-risk sexual behaviors is not well understood [3].

Sexuality and Intimacy

McCann et al. [7] explored the obstacles individuals with serious mental illness (SMI) face when expressing sexuality and other ways their SMI negatively (and sometimes positively) impacted their lives. Some barriers found were the attitudes of mental health personnel, exclusion and not asking about sexuality issues, not enough privacy, and side effects of medications. Even the mention of sex was taboo and not encouraged within the units. Others said no one asked them about their sexuality, so they never mentioned it to anyone, but they felt tremendously better once they did. Talking about sexual issues and interventions is integral to recovery and

psychosocial wellbeing. These patients want to talk about their sexuality but are not given a chance. For some, being in the psychiatric setting puts a pause button on their sexuality, while sexuality remains throughout their stay for others [7].

Sexual Barriers in Relation to Depression and Anxiety

Laurent and Simons [8] examine many disorders about sexual dysfunction but focus primarily on anxiety and depression and their relation to sexual dysfunctions. This study reviews literature from other published articles to support the need for a further investigation surrounding sexual desire, relationships, and performance in individuals with depression and anxiety to improve the Diagnostic and Statistical Manual of Mental Health (DSM) criteria. This study was critical concerning mentally ill patients and their sexual experiences because it explains what research exists to support these patients' barriers and obstacles regarding sexual functioning. For example, loss of libido is perhaps the most common aspect of sexual functioning affected by depression or depressive symptoms. Patients with a history of major depression were almost twice as likely to experience low sexual desire [8]. When assessing a depressed patient's perception of self, it is negatively connotated. The loss of sexual drive can inhibit a patient's ability to perceive themselves in a more positive light, which is an essential aspect of treatment.

Furthermore, studies indicate that up to 50% of men who have erectile dysfunction are depressed or show depressive symptoms and that depression is 2-3 times more likely in men with erectile dysfunction than men with no sexual arousal disorder [8]. This illustrates the importance of showing the opposite relationship of sexual dysfunction as a physical disorder that can cause mental disorders such as depression. Most of the time, studies focus on the psychological disorder being the cause of the physiological effect, which is not always the case. Individuals who cannot perform sexually can suffer from anxiety and depression due to the negative self-image associated with the lack of intimacy or satisfaction they can provide their partner or themselves. Laurent and Simons [8] further discuss how this dimensional approach to sexual dysfunction and mental illness addresses the whole picture, from healthy function to dysfunction, by encompassing healthy sexual functioning as a major part of the human experience. Without acknowledging the spectrum of how sexual dysfunction, as an obstacle, can be a cause or effect of mental illness, centering care around the mentally ill patient continues to be problematic.

Marriage and Relationships

Marriage is another prevalent barrier for mentally ill patients who struggle with intimacy and sexual relationships. Teitlerand and Reichman [9] elaborate on other obstacles mentally ill mothers face, leading to them being less likely to marry and have intimate partner relationships than mothers who are not mentally ill. For example, Mothers with mental illness were much more likely than mothers without mental illness to have suboptimal physical health (17% vs. 8%) and low levels of education (e.g., 53% of mothers with mental illness had less than high school education, compared to 40% of those without mental illness). They were less likely to have been employed (69% vs. 77%), more likely to have been covered by Medicaid for the birth (85% vs. 75%), more likely to have received welfare or food stamps at baseline (57% vs. 44%), and more likely to have lived in a poor neighborhood (28% vs. 23%). They were less likely to have cohabited with the father at baseline (41% vs. 49%) and more likely to have had children with another father (51% vs. 40%) [9].

These statistics are important when examining the intimate dynamic of mentally ill patients' relationships. Because they are less likely to marry, adequate education and interventions need to be established surrounding lifestyle modifications for mentally ill patients, especially pregnant women. Recognizing that these women have lower levels of education, employment, socioeconomic status, and father support will provide an accurate framework for psychiatrists to use when evaluating patient goals, outcomes, and treatment plans. This data also helps health care providers assess mentally ill mothers by addressing possible barriers instead of ignoring them, giving the patient time to ask questions and attain proper education on what resources are available and how to take advantage of them [9].

Treatment for Traumatized Individuals

Regarding the treatments and resources available for individuals with mental illnesses struggling with their sexuality and sexual health, future research and greater consideration and awareness of sexuality struggles individuals with mental illnesses experience is critical. McConkey *et al.* [2] propose that interventions that promote coping and individual resilience among mental health patients may be more productive than countering the stigmas these patients face, considering the societal stigmas are so widespread. Hortal-mas *et al.* [6] add that structured social skills training

programs may be a treatment option that could simultaneously improve individuals with mental disabilities and decrease the stigma surrounding the sexuality of mentally ill patients. In patients who have experienced trauma or sexual assault, trauma-informed interventions are crucial to stop the cycle of traumatization and promote treatment adherence [1].

Effective sexuality and sexual health treatment for patients with mental illnesses also require attention to the specific populations and experiences that individuals in those populations endure and tailor treatment to meet their needs. Frieh [1] wondered if single-sex-wards should be implemented in psychiatric units to avoid the traumatization of women who have a history of trauma experience in hospital settings and remove the perceived threat. A single-sex ward is an example of a treatment modification that we can implement to meet patients' needs. Additionally, when working with the youth population of the mentally ill, clinicians should be inclined to discuss sexual relationships and safe sex practices while also addressing the stigmas youth face and explore the behaviors used to cope with treating these individuals better [3].

Sexual Dysfunction and Drug Treatment

Liu-Seifert et al. [10] examine the sexual effects of using conventional antipsychotics and risperidone (an atypical antipsychotic) as a treatment for schizophrenia. The patients in the study needed to meet the American Psychiatric Association criteria for schizophrenia, schizoaffective disorder, or schizophreniform disorder. Participants also only qualified if receiving conventional antipsychotic or risperidone treatment for at least three months before participating.

The data presented in this study revealed 60% of mentally ill subjects tested experienced sexual dysfunction associated with elevated prolactin levels caused by conventional antipsychotics and risperidone [10]. The high prevalence of sexual dysfunction in patients taking conventional antipsychotics is associated with the patient's elevation in serum prolactin caused by the drugs' acute and chronic dopamine blocking effect. These medications are often the go-to when treating patients with schizophrenia and are associated with low compliance for many reasons, one being the negative sexual symptoms that occur with use, such as impaired libido, orgasmic dysfunction, erectile dysfunction, and ejaculation impairment [10]. This is a quality-of-life barrier for these patients and is particularly understudied. The first step to individualizing patient

care while addressing sexual health problems begins with psychiatrists' assessments of their patients' sexual relationships and sexuality while on antipsychotic medications.

Prolactin elevations in males accounted for lower levels of testosterone, leading to reductions in orgasm and ejaculation, as well as impaired sexual interest in postmenopausal women [10]. Many men and women who suffer from mental disorders are put on a plethora of medications. Lie-Siefert *et al.* [10] indicate that further investigation and sexual assessments need to be conducted if physicians want patients to remain compliant with treatment while also sustaining physical and emotional relationships. Having intimate relationships is a vital aspect of mental health, as well, because it is human nature. This locates specific problems in the current treatment regimens for schizophrenic patients. This is an obstacle that, with further attention, can be addressed in future treatments to improve adherence to treatment and overall quality of life in mentally ill patients.

Sexual Functioning and Schizophrenia

Boer *et al.* [11] examined literature surrounding all aspects of sexual functioning relevant to clinicians when treating patients with psychiatric disorders, focusing mainly on schizophrenia. It is crucial to bring all the evidence supporting sexual dysfunction in patients with psychiatric disorders full circle to tackle current treatment issues accurately. When addressed directly by the physician, most patients are willing and relieved to discuss sexual problems; even those who are treatment-resistant wish to talk about this, while clinicians do not ask and underestimate the rates of sexual dysfunctions in these patients [11]. The biggest obstacle to treatment, in many cases, is clinicians simply not discussing sexual satisfaction and sexual experiences with patients. Studies using structured interviews or self-report questionnaires tend to report a prevalence rate of 30-60% for adverse sexual side effects related to antipsychotic treatment [11]. This demonstrates a need for direct questioning during patient assessment surrounding antipsychotic therapy in patients with schizophrenia and related disorders.

Alternatives to traditional treatment include lowering the dosage, switching to an antipsychotic with less detrimental effects on sexual function, or using combined therapies with dopamine agonists, aripiprazole, or phosphodiesterase-5-inhibitors [11]. Collaboration with the patient using trial and error methods to identify what works best for the individual would work best

when providing care for these patients. It is also increasingly important to guide the patient with scheduling follow-up visits, addressing psychosocial and financial concerns, and providing proper education on which medications have less effect on social function, using the evidence from studies such as these.

Women and Sexual Dysfunction

Basson and Gilks [12] reviewed the most prevalent sexual dysfunctions associated with mental illness, as well as pharmacological induced sexual dysfunctions. The authors start by stating mental illness and sexual dysfunction are related but not well understood. Research does not explain if the sexual dysfunction precipitates the mental illness or if the mental illness precipitates the sexual dysfunction. The most likely explanation is that both are a result of an underlying vulnerability. Previous research on this topic also looks at men when more women with mental illness are affected by sexual dysfunction. Medications and stigma are also cited as contributing factors. One study reported that only 17% of providers inquire about sexual functions and concerns. The prevalence of these disorders is unknown due to the lack of valid questionnaires for diagnosing [12].

Patients with depression experience high rates of risky sexual behaviors due to the adverse effects of the disorder. Anxiety disorders are risk factors for low sexual desire, orgasmic difficulties, and sexual pain. Women with anxiety have "anxious arousal," characterized by muscle tension, increased temperature, shortness of breath, and palpitations. Sexual and nonsexual worries can distract the patient from relaxing and enjoying her sexual experience. These act as a vicious cycle, for one's anxiety increases pain, and the pain can cause more anxiety. Psychotic illness can lead to low sexual activity, decreased sexual satisfaction, and impaired arousal. This area has also been researched but mostly only on men. The differences in male and female sexuality show that these factors play a larger role in women's dysfunctions. Medications for all these disorders can cause sexual dysfunction causing them to discontinue taking them [12].

Some management and treatment therapies are introduced that have been found to have a positive impact on women's sexual function. Cognitive-behavioral therapy (CBT) and mindfulness-based cognitive therapy (MBCT) are shown to benefit women with depression and

anxiety by increasing arousal and desire. CBT specifically helps by teaching relaxation skills, addressing avoidance behaviors, target self-critical thoughts, and restore sexual function. MCBT has been shown to decrease pain related to sexual experiences, hypervigilance, and sexual distress. Sex therapy is also discussed but is focused on women who have sexual partners [12]. Figure 5 lists the interventions and treatments for mentally ill individuals with sexual issues.

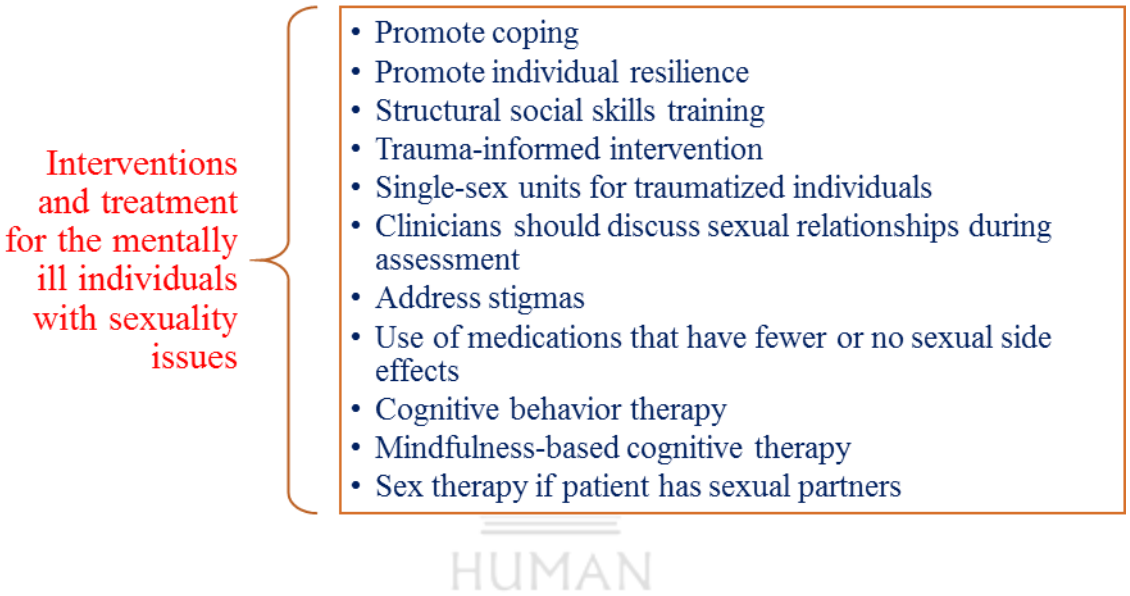


Figure No. 5: Interventions and treatments for mentally ill individuals with sexual issues.

DISCUSSION

After examining stigmas contributing to lack of attention toward sexual experience for the mentally ill, it was evident that clinicians do not view sexual fulfillment as an important aspect of the care received, and patients do not feel intimacy is a priority aspect of their treatment. This was mainly due to beliefs that mentally ill individuals cannot make sexual decisions and are vulnerable to abuse. Adolescents with mental illness also internalize feelings of being rejected due to inadequacy caused by their mental illness. Women feel more comfortable with similar mentally ill partners, as they do not feel judged and do not risk outside relationships because of the harmful stigmas surrounding mentally ill women's sexual experiences and lifestyles. Heteronormativity and compounded stigmas for the LGBTQ community also decrease sexual

satisfaction for mentally ill individuals as they suffer from stigmas and discrimination based on mental illness and sexuality together [4].

The mental illness pathology itself is a significant contributor due to suspicions of others and misinterpret non-verbal behavior. Major obstacles lie in the treatments for psychiatric disorders. Pharmacologically, it was determined that most sexual dysfunction in mentally ill individuals is attributed to increased prolactin levels from conventional antipsychotics and risperidone [10]. The largest obstacle to addressing sexual relationships and the needs of psychiatric patients is the lack of discussion from clinicians surrounding the subject of sex and sexuality. If providers took the time to have the conversation during assessment and center care around the patient's sexual needs, there would be increased compliance with treatment regimens and overall quality of life in the mentally ill population. The final factor that inhibits improvements in this area is the lack of study surrounding the topic. There is still little information and conclusive evidence regarding specific sexual problems and their causes in the mentally ill population. Almost every study concluded further investigation is needed to support evidence surrounding causal factors.

CONCLUSION

A thorough review of studies and articles, the stigmas, obstacles, and treatments for psychiatric patients' sexual functioning, sexual/intimate relationships, and overall sexual experience were examined. Limited progress has been made in supporting mentally ill patient's ability to form and maintain sexual and intimate relationships. Although patients with mental illness are interested in maintaining an active sex life, many obstacles hinder that fulfillment. There is much work to be done to address obstacles and avoid associated stigmas. It has been determined that efforts being put toward implementing interventions in the pharmacological treatment and assessing sexual factors in patients' lives will decrease the stigmas and obstacles discussed while increasing patient satisfaction with treatment regimens and the quality of life for mentally ill individuals.

REFERENCES

1. Frieh, Emma C. (2020). Stigma, trauma, and sexuality: The experiences of women hospitalised with serious mental illness. *Sociology of Health & Illness,42*(3), 526-543. DOI: 10.1111/1467-9566.13034
2. McConkey, Roy, & Leavey, Gerry. (2013). Irish attitudes to sexual relationships and people with intellectual disability. *British Journal of Learning Disabilities,41*(3), 181-188. DOI: 10.1111/bld.12036

3. Elkington, Katherine S, Hackler, Dusty, Walsh, Tracy A, Latack, Jessica A, McKinnon, Karen, Borges, Cristiane, . . . Wainberg, Milton L. (2013). Perceived mental illness stigma, intimate relationships, and sexual risk behavior in youth with mental illness. *Journal of Adolescent Research,28*(3), 378-404. DOI: 10.1177/0743558412467686

4. Davison, J., & Huntington, A. (2010). "Out of Sight": Sexuality and women enduring mental illness. *International Journal of Mental Health Nursing*, 19, 240-249. DOI: 10.1111/j.1447-0349.2010.00676.x

5. Rojas, J. I, Leckie, R., Hawks, E. M., Holster, J., del Carmen Trapp, M., & Ostermeyer, B. K. (2019). Compounded stigma in LGBTQ+ people: A framework for understanding the relationship between substance use disorders, mental illness, trauma, and sexual minority status. *Psychiatric Annals*, 49(10), 446-452. doi:10.3928/00485713-20190912-01

6. Hortal-Mas, R., Moreno-Poyato, A. R., Granel-Gimenez, N., Roviralta-Viella, M., Aguayo-Gonzalez, M. P., Gimenez, D., Bernabeu-Tamayo, M. D., & Leyva-Moral, J. M. (2020). Sexuality in people living with a serious mental illness: A meta-synthesis of qualitative evidence. *Journal of Psychiatric and Mental Health Nursing*, Journal of psychiatric and mental health nursing, 2020-10-12. DOI: 10.1111/jpm.12700

7. McCann, E., Donohue, G., de Jager, J., Nugter, A., Stewart, J., & Eustace-Cook, J. (2018). Sexuality and intimacy among people with serious mental illness: A qualitative systematic review. *JBI Database of Systematic Reviews and Implementation Reports*, 17(1), 74-125. DOI: 10.11124/JBISRIR-2017-003824

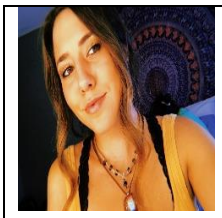
8. Laurent, M., & Simons A. (2009). Sexual dysfunction in depression and anxiety: Conceptualizing sexual dysfunction as a part of an internalizing dimension. *Clinical Psychology Review, (29)*, 573-585. DOI: 10.1016/j.cpr.2009.06.007

9. Teitler, J. & Reichman, N. (2008). Mental illness as a barrier to marriage among unmarried mothers. *Journal of Marriage and Family, 70*(3), 772-782. DOI: 10.1111/j.1741-3737.2008.00520.x

10. Liu-Seifert, H., Kinon, B., Tennant, C., Sniadecki, J., &Volavka, J. (2019). Sexual dysfunction in patients with schizophrenia treated with conventional antipsychotics or risperidone. *Neuropsychiatric Disease and Treatment, 2009*(5), 47-54. DOI: 10.2147/NDT.S4766

11. Boer, M., Castelein, S., Wiersma, D., Schoevers, R., &Knegtering, H. (2015). The facts about sexual (dys) function in schizophrenia: An overview of clinically relevant findings. *Schizophrenia Bulletin, 41*(3), 674-686. DOI: 10.1093/schbul/sbv001

12. Basson, R., &; Gilks, T. (2018). Women's sexual dysfunction associated with psychiatric disorders and their treatment. Women's Health, 14, doi:10.1177/1745506518762664

	**Gabriela L. Frabotta** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
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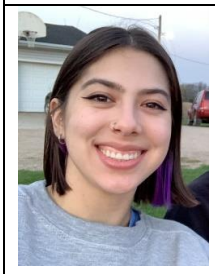	**Zoe T. Zuehlke** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
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