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1 **Sexuality and intimacy among people with serious mental illness: a**
2 **systematic review of qualitative research**

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49 **Abstract**

50 **Objective:** The aim of this systematic review was to synthesize the best available qualitative evidence
51 on the experiences and support needs of people with serious mental illness (SMI) regarding sexuality
52 and intimacy within hospital and community settings. The objectives were to explore intimate
53 relationship experiences of people with SMI, to uncover potential obstacles to the expression of
54 sexuality and to present recommendations for mental health policy, education, research and practice.

55
56 **Background:** Mental health services worldwide have seen major transformations in recent years
57 through deinstitutionalization programmes and more enlightened ways of organizing and providing
58 mental health care. However, in terms of social and emotional well-being, issues persist for people with
59 SMI, particularly related to intimacy and the expression of sexuality. This systematic review may assist
60 service providers to determine ways that they may better support people in establishing and maintaining
61 satisfying intimate relationships and the full expression of their sexuality.

62
63 **Inclusion criteria:** This review explored the intimacy and sexuality experiences, perceptions and
64 concerns of people over the age of 18 years who were living with a serious mental illness in hospital or
65 community settings.

66 **Types of studies:** This review considered studies that focused on qualitative data including, but not
67 limited to, designs such as phenomenology, grounded theory, ethnography, action research and
68 feminist research.

69
70 **Methods:** The databases MEDLINE, CINAHL, PsycINFO and Embase and Web of Science were
71 utilised in the review. The search included studies published from 1995 up to and including February 6,
72 2018 and were limited to those in the English language. Each paper was assessed by two independent
73 reviewers for methodological quality using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist
74 for Qualitative Research. Any disagreements that arose between the reviewers were resolved through
75 discussion. Data extraction was conducted by two independent reviewers using the
76 standardized qualitative data extraction tool from JBI. The qualitative research findings were pooled
77 using JBI methodology. The JBI process of meta-aggregation was used to identify categories and
78 synthesized findings.

79
80 **Results:** Based on the thematic findings from the 21 studies, three synthesized findings were extracted
81 from 10 categories and 83 findings: (1) the complexity of individual sexual experiences, (2) the clinical
82 constructs of sexuality and (3) family and partner involvement.

83
84 **Conclusions:** Having fulfilling and satisfying sexual and relationship experiences is a fundamental
85 human right that can enhance an individual's quality of life. Being aware of the potential stresses and
86 challenges that having a serious mental illness can have on a relationship and involving partners in the
87 treatment, may help to promote intimacy and recovery. Practitioners can use these findings to guide
88 future policy, education and developments in practice. Further research is required to develop and

89 evaluate interventions that target the identified barriers and help people with SMI to fulfil their unmet
90 sexuality and intimacy needs.

91

92 **Keywords**

93 Sexuality; intimacy; serious mental illness; systematic review; qualitative

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<p>Review Title: Sexuality and intimacy issues among people with serious mental illness: a systematic review of qualitative research</p> <p>Population: People aged over 18 years who have been diagnosed by a clinician with serious mental illness</p> <p>Phenomena of Interest: Intimacy and sexuality experiences, perceptions and concerns of people who are living with a serious mental illness.</p> <p>Context: Studies that have been conducted among people with SMI in hospital or community settings.</p>					
Synthesized finding	Type of research	Dependability	Credibility	ConQual score	Comments
<p>The complexity of individual sexual experiences</p> <p>Living with a serious mental illness is a difficult and lifelong journey, beset with experiences often involving loss, trauma and victimization. In the midst of these multi-faceted challenges, the question of sexuality is one that is often neglected by mental health clinicians and by individuals themselves. For those individuals with SMI who identify outside of heteronormative relationships, this has led to what is described as a double stigma, with difficulties of alienation and identity. For others, the effects of self-stigma have acted as a barrier to intimacy, a difficulty in acceptance of self and feelings of inadequacy.</p>	Qualitative	High	Downgrade one level	Moderate	Downgraded one level as there was a mix of unequivocal and credible findings
<p>The clinical constructs of sexuality</p> <p>The clinical constructs of sexuality include clinical attitudes, communication and environmental issues. The expression and experience of sexuality is highly influenced by the context it arises in. The setting of a mental health institution poses several challenges for both caregivers and consumers when it comes to the expression of sexuality, disclosures of (past) sexual experiences and the risks related to these issues.</p>	Qualitative	High	Downgrade one level	Moderate	Downgraded one level as there was a mix of unequivocal and credible findings
<p>Family and partner involvement</p> <p>Family and partner involvement is significant in terms of supporting the individual with SMI. The psychosocial needs of families are often unrecognised and the necessary supports are usually lacking.</p>	Qualitative	High	Downgrade one level	Moderate	Downgraded one level as there was a mix of unequivocal and credible findings

148
 149 The final synthesized findings were graded according to the ConQual approach for establishing confidence in the output of
 150 qualitative research synthesis and presented in the Summary of Findings table.⁴⁶ The Summary of Findings table includes the
 151 major elements of the review and details how the ConQual score was developed. Included in the table is the title, population,
 152 phenomena of interest and context for the specific review. Each synthesized finding from the review is presented along with the
 153 type of research informing it, a score for dependability, credibility, and the overall ConQual score. Despite low percentages noted

154 for the collective responses to Q6 and Q7 (Table 1), at an individual level, all papers scored highly across other criteria and
155 therefore the level 'high' remains for Dependability on the ConQual Summary of Findings.

156 **Review question/objective**

157 The aim of this systematic review was to synthesize the best available qualitative evidence on the
158 experiences and support needs of people with serious mental illness (SMI) regarding sexuality and
159 intimacy issues within hospital and community settings. The objectives of the present study were:

- 160 • to explore intimate relationship experiences of people with SMI
- 161 • to highlight specific issues related to sexuality that are important to people with SMI
- 162 • to uncover potential obstacles to the expression of sexuality and
- 163 • to present recommendations for mental health policy, education, research and practice.

164

165 **Introduction**

166

167 Mental health services worldwide have seen major transformations in recent years through
168 deinstitutionalization programmes and more enlightened ways of organizing and providing mental
169 health care, particularly in relation to rights-based, empowering and service user-led policy initiatives.¹⁻

170 ⁴ However, in terms of social and emotional well-being, issues persist for people with SMI, particularly
171 with concerns related to intimacy and the expression of sexuality. The definition of serious mental
172 illness, with the widest consensus, is that of the US National Institute of Mental Health (NIMH) and is
173 based on diagnosis, duration and disability. People who experience serious mental illness have
174 conditions such as schizophrenia or bipolar disorder that can result in serious functional impairment
175 which substantially interferes with or limits one or more major life activities.⁵

176 A recognised working definition of sexuality is:

177 ...a central aspect of being human throughout life encompasses sex, gender identities and
178 roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is
179 experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values,
180 behaviours, practices, roles and relationships. While sexuality can include all of these
181 dimensions, not all of them are always experienced or expressed. Sexuality is influenced
182 by the interaction of biological, psychological, social, economic, political, cultural, legal,
183 historical, religious and spiritual factors (p.5).⁶

184

185 In terms of potential psychosocial supports, the area of human sexuality continues to present
186 challenges to practitioners within the mental health professions.^{7,8} Several studies have highlighted
187 issues around unmet needs regarding intimate and sexual relationships among people diagnosed with
188 SMI.⁹⁻¹⁰ Where challenges in issues around sexuality and forming intimate relationships exist, some
189 basic psychological needs may also remain unfulfilled.

190 A recent study has identified key issues related to the experience of sexuality in people with
191 psychosis.¹¹ Some of the main concerns highlighted in the paper were around sexual needs, satisfaction
192 and desires. Other issues concerned sexual risk and behaviour, sexual dysfunctions, stigma, sexual

193 fantasies and sexual trauma. The study findings identified a noticeable large representation of evidence
194 focusing on biological aspects of sexuality and intimacy such as psychotropic side-effects, sexual risks
195 and sexually transmitted infections (STIs).¹¹ Practice and research focusing on psychosocial aspects
196 of sexuality is therefore necessary to address the often unmet but reported needs regarding sexuality
197 and intimacy in people with SMI.¹² In appreciating an intimate relationship as a fundamental part of a
198 person's environment, it becomes increasingly evident that this area of life should not be ignored when
199 trying to support recovery and the enhancement of the lives of people with a mental illness.¹³ This has
200 clear implications for policy, research, education and practice developments.

201 With the emergence of the recovery model in mental health, views on the possibility of recovery in
202 people with serious mental illness (SMI) and ways of supporting people in the process are evolving.¹⁴
203 The recovery ethos prioritizes the person instead of the condition and strives towards a satisfactory
204 existence regardless of the presence of mental health issues. This approach was driven by service user
205 movements and arose as a criticism of mental health care, dominated by purely biomedical
206 processes.¹⁵⁻¹⁷ With this increasing focus on recovery-oriented approaches, there is more emphasis on
207 connecting care to the individual needs of people with SMI in different domains of living.¹⁸ Despite these
208 positive changes, some activities of living have received relatively little attention in mental health care.
209 One of those domains is the expression of sexuality and intimacy and all that this entails. Sexuality,
210 intimacy and relationships play a major role in the lives of almost every human being. Since early
211 childhood, people gravitate towards physical affection and intimacy. Sexuality and intimacy are
212 therefore fundamental contributory elements of general well-being and quality of life.

213 However, sexuality and intimacy are not self-evident for everyone. About 15% of the general
214 population is dissatisfied with his or her sex life and this percentage is significantly higher in people with
215 mental health problems.¹⁹ Several national and international studies have highlighted the significant
216 gaps and unmet needs in intimate and sexual relationships especially among people with SMI.^{20-22, 9,11}
217 Significantly, the findings from one study revealed that more than two thirds of all people with a
218 psychiatric disorder experienced sexual problems.²³ However, other researchers discovered this figure
219 to increase to 78 percent in people with depression.²⁴ Sexual problems also occur in people with post-
220 traumatic stress disorders (PTSD)²⁵ and anxiety disorders.²⁶ However, the prevalence of sexual
221 dysfunction among people with psychosis seems to be the highest where investigators concluded, in
222 their research on people with schizophrenia, that 86-96% of the study population experienced sexual
223 problems.²⁷ One other study found a figure of 64.1% among people who experience psychosis.²⁸ Even
224 though some people report decreased needs in the field of sexuality and intimacy due to mental health
225 problems, most people have the same requirements as the general population.^{22,11} In terms of intimate
226 relationships, people with SMI are more often single and /or divorced when compared with the general
227 population.²⁹⁻³³ In addition, partner relationships are often characterized by less intimacy and
228 satisfaction within the relationship.²⁹⁻³¹ This is noteworthy, because research has shown that
229 relationship status in people with SMI is correlated with well-being, quality of life and the development
230 and course of psychiatric disorder.³⁴⁻³⁷

231 These studies have demonstrated the unmet needs that exist regarding sexuality and intimacy in
232 people with SMI and highlights the requirement for more attention in clinical practice. While there has

233 been some research on the more biological aspects of sexuality, such as sexual health and
234 psychotropic side-effects, studies on psychological and social aspects of sexuality in people with SMI
235 are underrepresented. Also, compared to sexuality, intimacy and relationships have received far less
236 attention in research.^{9,11,22} Within recovery-oriented care, attention to this area of life is growing and an
237 overview on what is known so far is lacking or absent altogether. With the current review study, we aim
238 to explore what is known about the needs and problems in the field of intimacy, sexuality and
239 relationships among people with SMI and what factors might underlie individual reported unmet needs.
240 Increased knowledge and awareness of sexuality and intimacy needs in people with SMI should help
241 in bringing more attention to this important area of living in order to promote recovery. Therefore, this
242 review has the capacity to provide opportunities for multidisciplinary collaboration in developing shared
243 insights and potential responses to the subjective experiences of people with SMI around sexuality and
244 intimacy concerns. This holistic approach to recognizing and supporting intimacy and the expression of
245 sexuality cannot only enhance our knowledge and understanding of the individual needs and concerns
246 but also help support people in a more empowering, fulfilling and recovery-oriented way.¹³

247 In order to address the research objectives, this systematic review of evidence generated by
248 qualitative research was conducted. To confirm that no other systematic reviews existed about sexuality
249 and intimacy experiences in relation to people who have serious mental illness a preliminary exploration
250 of the literature was conducted. A search of the *Joanna Briggs Institute Database of Systematic*
251 *Reviews and Implementations Reports*, the Cochrane Library, PROSPERO, CINAHL, PubMed and
252 Scopus databases did not find any current or planned systematic reviews on this topic. This current
253 review was carried out in accordance with an *a priori* published protocol.³⁸

254 **Inclusion Criteria**

256 *Participants*

257 This qualitative review includes studies involving people aged over 18 years who have been diagnosed
258 by a clinician with serious mental illness of sufficient duration to meet diagnostic criteria specified within
259 the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V)³⁹ or the 10th
260 revision of the International Classification of Diseases (ICD-10).⁴⁰ Years of living with SMI is not
261 identified as a requirement for inclusion in this review once the diagnostic criteria, as stated above,
262 have been met.

264 *Phenomena of interest*

265 This qualitative systematic review investigated intimacy and sexuality experiences, perceptions and
266 concerns of people over the age of 18 years who are living with a serious mental illness. The review
267 highlights pertinent issues and identifies specific needs in relation to sexuality and intimacy. Also,
268 barriers to sexual expression have been elucidated.

269

270 *Context*

271 This review considers studies that have been conducted among people with SMI in mental health
272 hospital or community settings.

273

274 *Types of studies*

275 This review considered studies that addressed intimacy and sexuality experiences of people living with
276 a SMI. The focus was on qualitative data including, but not limited to, designs such as phenomenology,
277 grounded theory, ethnography, action research and feminist research.

278

279 **Methods**

280 *Search strategy*

281 The comprehensive search strategy involved a three-phase process: i) a search of academic databases
282 for published studies, ii) a search of sources of gray literature for unpublished studies, and iii) a hand
283 search of reference lists for studies unidentified in the other two searches. Initial scoping searches using
284 the database thesauri were run in MEDLINE, CINAHL, PsycINFO and Embase. These searches
285 provided a list of synonyms using MeSH terms, CINAHL subject headings, PsycINFO descriptors and
286 Emtree headings. This was then followed by an analysis of the keywords contained in the title and
287 abstract, and of the index terms used to describe the articles retrieved during the search. A double
288 strand search strategy was applied running the thesauri terms first and then keywords. These two
289 searches were then combined using the OR operator. This method was repeated for each concept and
290 at the end these four different concepts were combined together using AND: Concept 1 AND Concept
291 2 AND Concept 3 AND Concept 4 were combined to yield the results. This strategy was initially created
292 within MEDLINE, and then adapted for all other databases searched using keywords and database-
293 specific subject headings where applicable. The searches were conducted on 6th February 2018. All
294 results were filtered for adults over 18 years of age as per the exclusion criteria. A date range of 1st
295 January 1995 to 6th February 2018 was applied to coincide with the increasing emphasis and public
296 discourse on recovery and related concepts involving people living with a serious mental illness.⁴¹ The
297 reviewers only included studies published in English. Five databases were selected for searching,
298 MEDLINE (1965 -), CINAHL Complete (1937-), PsycINFO (1990-), Embase (1990-) and Web of
299 Science (1945-). This database spectrum ensured wide coverage of the literature ranging from journal
300 articles to conference proceedings and monographs. The search for unpublished or grey literature
301 included ProQuest Dissertations and Theses, relevant key journals which report on conference
302 proceedings, and the websites of relevant mental health organizations. The reference lists of all
303 included studies were reviewed for additional relevant studies.

304 Four key concepts were defined for searching and beneath each is a sampler of the thesauri terms
305 searched. A fully mapped search strategy for each database is located in Appendix I.

306 Concept 1: Serious Mental Illness

307 MEDLINE: (MH "Personality Disorders+") OR (MH "Schizophrenia Spectrum and Other Psychotic
308 Disorders+") OR (MH "Bipolar and Related Disorders+") OR (MH "Schizophrenia+") OR (MH "Psychotic
309 Disorders+")

310 Concept 2: Sex or Intimacy

311 MEDLINE: (MH "Sexuality+") OR (MH "Sexual Behavior+") OR (MH "Paraphilic Disorders"+)

312 Concept 3: Experiences

313 MEDLINE Keyword search only including experience OR experiences OR experienced OR view OR
314 views OR viewpoint OR viewpoints OR perception ...

315 Concept 4: Study Type

316 MEDLINE: (MH "Empirical Research") OR (MH "Grounded Theory") OR (MH "Qualitative Research+")
317 OR (MH "Hermeneutics") OR (MH "Focus Groups") OR (MH "Anthropology, Cultural+")

318 The subject librarian, involved in the review, carried out the searches of the academic databases and
319 the gray literature. The hand-search of the reference lists of records that has been retrieved for inclusion
320 eligibility was completed concurrently by two of the reviewers. Figure 1 contains a diagrammatic
321 representation of the search strategy that is based on the Preferred Reporting Items for Systematic
322 Reviews and Meta-Analyses (PRISMA) method.⁴² The final list of unique articles was then exported into
323 an online systematic review program *Covidence* for screening.⁴³

324

325 *Assessment of methodological quality*

326 After the removal of duplicates from the search, two reviewers scrutinised citation titles and abstracts
327 using the defined inclusion and exclusion criteria. Qualitative papers selected for retrieval were
328 assessed by two independent reviewers for methodological validity prior to inclusion in the review using
329 the JBI Critical Appraisal Checklist for Qualitative Research⁴⁴; a standardized critical appraisal
330 instrument from the *Joanna Briggs Institute System for the Unified Management, Assessment and*
331 *Review of Information* (JBI-SUMARI).⁴⁵ Studies were excluded on the basis of not meeting the pre-
332 defined eligibility criteria. Any disagreements that arose between the reviewers were resolved through
333 discussion, or with a third reviewer. The studies that remained were the final number included in this
334 systematic review.

335 *Data extraction*

336 Qualitative data were extracted from the papers included in the review using the standardized data
337 extraction tool from JBI-SUMARI⁴⁵ by two independent reviewers. The data extracted included specific
338 details about the country, phenomena of interest, participants, methods, methodology and the main
339 results of each study. The extracted findings, and the accompanying illustrations from each paper, were
340 evaluated for agreement and congruency by the primary and the secondary reviewers. Individual
341 findings were appraised and could achieve one of three outcomes: unequivocal (well-illustrated and
342 beyond reasonable doubt); credible (contains illustrations that may be challenged); or unsupported
343 (findings not supported by data) (Appendix III).

344

345 *Data synthesis*

346 Qualitative research findings have been pooled, where possible, using JBI-SUMARI with the meta-
347 aggregation approach.⁴⁵ This involved the aggregation or synthesis of findings to generate a set of
348 statements that represent that aggregation, through assembling the findings and categorizing these
349 findings on the basis of similarity in meaning. These categories have been subjected to a synthesis in
350 order to produce a single comprehensive set of synthesized findings that can be used as a basis for
351 evidence-based practice.

352

353 **Results**

354 The comprehensive literature search was conducted and 3,773 potential papers were identified:
355 CINAHL (N=554), Embase (N=410), Medline (N=940), PsycINFO (N=1085), and Web of Science
356 (N=742). A further 42 articles were discovered through searching the available gray literature. Following
357 the removal of duplicates (N=834), using the inclusion criteria, two reviewers assessed the titles and
358 abstracts of the remaining papers (N=2981). A further 2892 papers were excluded from the review. A
359 total of 89 papers were assessed for eligibility and 68 papers were excluded (Appendix V). Two
360 reviewers appraised the remaining papers (N=21) for methodological quality. No papers were excluded
361 following quality appraisal. Finally, a total of 21 papers published between 1995 and 2018 were included
362 in the review.⁴⁷⁻⁶⁷

363

364 *****Insert Figure 1*****

365

366 *Methodological quality*

367 Table 1 contains the quality appraisal of all studies. The results for each study ranged from a moderate
368 score of six out of ten (n=4) to a high score of seven and above out of 10 (n=17). Seven of the ten
369 quality appraisal questions achieved a high proportion of 'yes' ratings; however, questions 1, 6 and 7
370 had a significantly lower proportion of 'yes' ratings. For question 1, more than half of the studies (62%)
371 contained details of the philosophical approach adopted or were unclear about their methodology. A
372 total of 43% of the studies had a statement locating the researcher culturally or theoretically (question
373 6) and 43% had a statement indicating the influence of the researcher on the research (question 7).
374 Despite this, all key criteria were met across the 21 studies and therefore no study was excluded on
375 the basis of this quality appraisal process.

376

377 *****Insert Table 1*****

378

379 *Characteristics of included studies*

380 The characteristics of the studies are provided in tabular form (Appendix II). A majority of the studies
381 were published after 2010 (n=12) indicating a greater interest in the topic of intimacy, sexuality and
382 mental health. The geographical locations and the number of studies conducted were: UK
383 (n=5),^{50,57,60,62,65} USA (n=4),^{49,52,55,59} Australia (n=4),^{47,48,61,64} Canada (n=2),^{58,67} India (n=1),⁵¹ Israel
384 (n=1),⁵⁶ Netherlands (n=1),⁵⁴ New Zealand (n=1),⁵³ Slovenia (n=1),⁶⁶ and Sweden (n=1).⁶³ The
385 methodologies used included qualitative description,^{50-53,57,60,62-64} multiple case study,⁴⁷ single case
386 study,^{55,59} participatory action research,⁴⁸ phenomenology,^{49,61,65,66} and grounded theory.^{54,56,58,67}
387 Sample sizes ranged from one to 146 participants. Most studies used individual interviews for data
388 collection. Two used observation^{47,55} and direct-therapist interactions.⁵⁹ One study used case notes⁵⁷
389 and another utilized focus groups.⁵³ The data analysis techniques used were thematic
390 analysis,^{48,50,52,53,57,62-64} content analysis,^{51,60} case study analysis,^{47,55,59} constant comparison
391 analysis^{54,56,58,67} and phenomenological analysis.^{49,61,65,66}

392 **Findings**

393 All twenty-one studies included in the review addressed the views and opinions of people with serious
394 mental illness around intimacy and their sexual expression. The review objectives were considered fully
395 to enable the construction of a meta-synthesis (Tables 2,3,4). The analysis yielded a total of 83 research
396 findings of which 37% (n=31) were assessed as unequivocal and 63% (n=52) as credible. See Appendix
397 III for the findings from each study. The 83 findings were grouped into ten categories that were
398 aggregated into three synthesized findings. The first synthesized finding had four categories and 36
399 findings, 56% of which were unequivocal and 44% credible. The second synthesized finding had four
400 categories and 38 findings, 18% of which were unequivocal and 82% credible. The third synthesised
401 finding had two categories and nine findings, of which 56% were reported unequivocal and 44%
402 credible. No findings received a rating of unsupported. The ConQual process was used to realise the
403 level of confidence or trust that exists in the value and level of evidence of each synthesised finding
404 (Summary of Findings).

405 For synthesized finding 1 (the complexity of individual sexual experiences), the majority of the studies
406 received four to five 'yes' responses on the ConQual identified criteria for dependability; therefore, the
407 level of confidence remained unchanged. The findings were a mix of unequivocal and equivocal
408 (credible) ratings, thus necessitating the downgrading by an additional level, resulting in a ConQual
409 score of moderate.

410 For synthesized finding 2 (the clinical constructs of sexuality), the majority of the studies also received
411 four to five 'yes' responses on the ConQual identified criteria for dependability; therefore, the level of
412 confidence remained unchanged. The findings were a mix of unequivocal and equivocal (credible)
413 ratings, thus necessitating the downgrading by an additional level, resulting in a ConQual score of
414 moderate.

415 For synthesized finding 3 (family and partner supports), the majority of the studies also received four to
416 five 'yes' responses on the ConQual identified criteria for dependability; therefore, the level of
417 confidence remained unchanged. The findings were a mix of unequivocal and equivocal (credible)
418 ratings, thus necessitating the downgrading by an additional level, resulting in a ConQual score of
419 moderate.

420

421 **Synthesized Finding One: The complexity of individual sexual experiences**

422

423 *****Insert Table 2*****

424

425

426 **Synthesized Finding One: The complexity of individual sexual experiences**

427 Living with a serious mental illness is a difficult and lifelong journey, beset with experiences often
428 involving loss, trauma and victimization. In the midst of these multi-faceted challenges, the question of
429 sexuality is one that is often neglected by mental health practitioners and sometimes by individuals
430 themselves. For those individuals with SMI who identify outside of heteronormative relationships, this
431 has led to what is described as a double stigma, with difficulties of alienation and identity. For others,
432 the effects of self-stigma have acted as a barrier to intimacy, a difficulty in acceptance of self and
433 feelings of inadequacy. The emotional toll of this has led to experiences of 'abnormality' amongst this

434 population; feelings of guilt and poor self-confidence for some, and for others, personal struggles in
435 managing and maintaining close and intimate relationships. Whilst it is long established that supportive
436 relationships with friends, family and community are beneficial to the mental health of all individuals,
437 the experience of intimacy in this population contained personal narratives of loss, the dimensions of
438 which are far reaching and include, family, community and sexual intimacy. This synthesized finding
439 was derived out of thirty-six findings which were divided into four categories. Within these ten
440 categories, there were thirty-six findings.

441

442 **Category 1.1: Stigma experiences**

443 Despite increased attention to the human rights of this population, people with mental illness continue
444 to be stigmatized, leading to serious obstacles in the recovery trajectory for the individual.^{51,54,55,61}
445 Though mental illness stigma has been described as a contributor to social and sexual isolation, recent
446 evidence suggests that it also may increase sexual risk behaviors.⁵⁸ LGBT+ people must confront
447 stigma and prejudice based on their sexual orientation or gender identity while also dealing with the
448 societal bias against mental illness. The effects of this double or stigma can be particularly harmful,
449 especially when someone seeks treatment.^{55, 58}

450 M returned to the concern of having “a double stigma” because of her psychiatric diagnosis and
451 transgender status. Because she had rarely discussed her psychiatric illness in previous
452 sessions, this comment seemed almost incongruent with the trend of recent thoughts. M now
453 denied psychosis, and focused on depressive symptoms, but rationalized these as the result
454 of other people’s behavior toward her. ^{55 (p.134)}

455 They had to call an ambulance for me. It was interesting because when I told the ambulance
456 attendants about the Huntington’s, they were very interested. But when they found out I have
457 a mental illness, they stopped talking to me. I couldn’t win no matter which way. If I go with
458 Huntington’s somebody might not know what it is and stop talking. If I go with mental illness,
459 people back off. If I go with gay, people back off. It is like a triple-header. I couldn’t win no
460 matter which way. ^{58 (p.25)}

461 The word psychosis will not come out of my mouth. If I were in a happy relationship, perhaps I
462 would tell her at some point. If she would be very easy to talk to, I would tell her (Divorced,
463 male, 42 years). ^{54 (p.6)}

464

465 **Category 1.2: Making sense of individual sexual experiences**

466 Research on the sexuality of people with serious mental illness most often focuses on dysfunction and
467 the side-effects of medication ^{50,54,60,62}. When looking at the qualitative studies of this review, it was
468 found that when asked, participants were happy to disclose both their desires for meaningful sexual
469 expression alongside the uncertainty that long periods of isolation away from significant others may
470 elicit^{54,60,63,65,67}.

471 I’d love to be in a relationship again. (...) I can hardly even imagine what it would be like. It
472 seems like a dream. (...) If you’re single for 10 years, then you’re just really lonely. That’s just
473 what it is (Single, male, 38 years). ^{54 (p.4)}

474 I'd really like to have children, but maybe it's too late now. We're trapped in this place. I'd like
475 us both to live together in a flat in London. Could we have children? I don't know...^{62 (p.254)}
476 The narratives of patients often included worries about being unable to lead a life in which
477 healthy sexuality played a part. They wondered whether they still had the capacity for sexual
478 activity and could give their partner satisfaction in a sexual relationship.^{63 (p.22)}
479 I guess I get my strength from my friends and from the few members of my family who support
480 me and love me...I am lucky to have a relationship with my dad...I know a lot of people with
481 mental illness who don't have that kind of family connection, never mind being gay.^{58 (p.28)}
482 The experience of schizophrenia affected the person's relationality, or how the person
483 experienced relationships with others, including family members, friends, and mental health
484 nurses. The data show that the embodiment of schizophrenia had a paradoxical effect on social
485 relationships, sometimes eliciting support while at other times damaging relationships.^{61 (p.789)}
486 I had become 'mental' at that time. I could not understand anything. I would go anywhere I liked
487 and roam around. During that time many people have 'spoil' me. Some would take me to the
488 grove and would talk to me until it was dark and then would rape me and go away. They would
489 get me eatables and take me to movies. I used to feel very happy. These kinds of things
490 happened many times. I do not even know who they were and what they did. I was very crazy
491 about clothes, eatables, and movies. If anybody got me those I would go with them (28-year-
492 old, bipolar disorder, mania with psychotic symptoms).^{51 (p.329)}
493

494 **Category 1.3: Significance of loss**

495 Narratives of loss were implicit across the findings of this review, although the dimensions of these loss
496 experiences were multi-faceted and dependent on individual experiences.^{48,50,53,58,62} Mental health
497 problems alter existing relationships that can result in a lack of interest in sex and intimacy. On the other
498 side, the stress of having a spouse with a serious mental illness can often be overwhelming leading to
499 relationship rupture.^{52,54,56,61} This has far reaching consequences, not just in maintaining healthy
500 romantic relationships, but also in managing healthy relationships with family and the wider
501 community.⁴⁸

502 I lost my husband. He dropped me off and said he didn't want anything to do with me.... he
503 couldn't take care of me anymore because of my mental illness, which means I lost my whole
504 life, everything.^{48 (p.98)}

505 Sometimes my own mental illness caused a great deal of loss with the church when I started
506 thinking that they're the devils in my house...I had religious delusions but the church couldn't
507 see it as religious delusions.^{48 (p.98)}

508 I would say this place has amputated my sexuality. Definitely, it's – it's not my home, it's not –
509 it's not a free environment and ... it's a – it's so anti-life. I just don't even think about sexuality
510 in here and I grieve over that quite a lot. And ... I try and cope with this place on its own terms,
511 you know and whatever it has to offer me I will engage with. So and try to make it a reality, its
512 own reality but I still can't feel human enough to be a sexual being in this environment.^{50 (p.250)}
513

514 **Category 1.4: Emotional impact**

515 Sexuality is an integral and crucial part of any individual's personal identity. When a person experiences
516 a serious mental illness, the impact can be catastrophic and prolonged treatment can result in a further
517 sense of alienation from both oneself and previous close relationships.^{50,53,58,60,66} Mental health settings
518 themselves can inadvertently place barriers in terms of an expression of these needs and as a result,
519 sexuality can become a casualty for individuals with participants of this review expressing feelings of
520 loneliness, guilt and despair in relation to this aspect of their identity.^{53,58,64,66}

521 One of the general characteristics of the sexual life of psychotic patients with other people is
522 that it is absent for different reasons. The common denominator is difficulties in regulating
523 closeness. Patients attribute to themselves and feel responsible for everything that they lack
524 and cannot achieve. They feel inadequate both as sexual performers and partners as well as
525 guilty for this inadequacy.^{66 (p.113)}

526 I could have cut somebody's head off, which went against myself as the "nice guy." But I knew
527 it was there.... I stared at myself in the mirror thinking that I am really crazy. And that solidifies
528 that I can no longer repress or pretend that I was somebody that I wasn't because it was just
529 making me too hostile.... I am still thinking that it [maintaining sobriety] is going to take me a lot
530 of effort after 40 years of drinking. That was my best friend in the loneliness of knowing you are
531 different from everybody else.^{58 (p.26)}

532
533 **Synthesized Finding Two: Clinical Constructs of Sexuality**

534
535 *****Insert Table 3*****

536
537
538 **Synthesized Finding Two: Clinical Constructs of Sexuality**

539 The expression and experience of sexuality is highly influenced by the situation it arises in. The context
540 of a mental health institution poses several challenges for both caregivers and consumers when it
541 comes to the expression of sexuality, disclosures of (past) sexual experiences and the risks related to
542 these issues. This synthesized finding was derived out of thirty-eight findings which were merged into
543 four categories: safety, risk and vulnerability; mental health practitioners and therapeutic involvement;
544 communication and disclosures; and the clinical setting.

545
546 **Category 2.1: Safety, Risk and Vulnerability**

547 Clients expressed specific challenges such as abuse in different situations including hospital and
548 community settings.^{52,54,57,62} Talking about and caring for safe and healthy sexual expression is difficult
549 for all people. Different phenomena and barriers towards openness are presented and considered in
550 the findings. It was found that impulsive sexual acts are not very frequent, but they make a strong
551 impact.^{47,50,51,64,66} Patients may inappropriately touch sexual organs of other patients or of the staff
552 members, they can behave promiscuously, or can attempt sexual intercourse in public or covert places.
553 ^{51,54,64}

554

555 Sex is an organized act that two people come together and do – and they're going to do it
556 wherever that is, you know, under a tree, at the end of a tunnel, they're still going to do it. Like,
557 there's an old corridor. And there was a place where you hang your coats, where you can't see
558 people when they looked down there. So I walked in and went to put my coat round there and
559 they (two male patients) were having sex in the corner ... and it's not the first time they'd done
560 that actually, they'd done it somewhere else as well. ^{50 (p.248)}

561 Three years ago I was in my sister's house for a few days. My brother-in-law is not all right. He
562 is very crazy about women. I think even my sister is aware of this, but she keeps quiet. She
563 has two children and has to bring them up. She does not work and that is why I think she is
564 scared. He had an eye on me also. But I never realized. One day I was alone at home. My
565 brother-in-law came. That day he got an opportunity. He did not care, however much I
566 requested. He raped me (22 years old, psychosis). ^{51 (p.328)}

567 Case 8 followed some girls and then indecently assaulted another girl he had just met, after
568 which he followed her home and waited for her outside. His explanation was he was looking for
569 love and he felt that he loved his victim and 'she was nice'. ^{66 (p.113)}

570 There is always the risk of sexual assault, especially given the offending histories of our
571 patients... Sometimes they might get involved above their capabilities and out of their comfort
572 zone and be pressured into having sex. ^{64 (p.671)}

573 Like STDs. How do you explain this without getting your arse kicked? And if you ask for a
574 condom, you're breaking the rules, so how do you explain that? You don't have access to
575 condoms. Puts you at risk. They have condoms here, but you have to ask for them and then
576 you're self-incriminating yourself because the next question is, "What do you need that for?"
577 There is a condom machine but it is never full so you have to ask staff for them. It's a very
578 awkward situation. ^{64 (p.672)}

579 Qualitative analysis suggested broad gender differences in emergent themes, with some
580 overlap among youth. Themes among males were - Feeling abnormal or "broken" - Focus on
581 "going crazy" - Fantasy and escapism in video gaming - Alienation and despair, but with desire
582 for relationships. Themes among women were; - Psychotic illness in family members - Personal
583 trauma with more than half spontaneously brought up a history of trauma, including neglect,
584 abuse, parental separation, and witnessing violence. There was also personal struggles with
585 intimate relationships, personal development and self-esteem. ^{49 (p.3-4)}

586

587 **Category 2.2: Mental Health Practitioners and Therapeutic Involvement**

588 For some, the onset of schizophrenia intensified social relationships but for others, a decline
589 occurred.^{52,55-56,61} Within the context of a romantic relationship, clients struggled with their sexuality in
590 relation to being mentally ill.^{60,63,65,67} Some participants blamed their medication, while others are
591 affected by negative (sexual) experiences. Nevertheless, these topics are rarely discussed.⁶⁰ Proper
592 education as well as assessment of or sensitivity towards specific issues such as transgender
593 processes or autoerotic asphyxiation appears to be lacking.^{59,62,66} The first step in remedying the
594 situation is to increase the awareness of mental health professionals in this regard, something that can

595 be accomplished by more staff training in sexual matters and greater personal supervision of those
596 providing supports and treatments.

597 I think they feel uncomfortable talking in any, any depth about my sexuality. I don't think they've
598 been trained to – I don't think that they, they have the insight. I'm sure we could have a very
599 sensitive discussion with them about it, but for some reason, there's a barrier and I can't
600 understand why. ^{50 (p.246)}

601 No one has ever asked me these questions earlier, so I have never told anyone. Now I feel OK
602 and don't feel distressed about these experiences." (42-year-old, obsessive-compulsive
603 disorder). ^{51 (p.329)}

604 It started off with us being taught about the human body, biology . . . male and female, to say
605 we received sexual education – no not really. Oh no, nothing in the hospital, it was never
606 discussed. ^{62 (p.254)}

607 In some cases an erotic transference from client towards his or her therapist occurs, which can
608 assume a form of erotic delusions. ^{66 (p.113)}

609 Psychotic people are so desperate for basic human relatedness and for hope that someone
610 can relieve their misery that they are apt to be deferential and grateful to any therapist who
611 does more than classify and medicate them. Understanding M, and not merely classifying her
612 as a psychotic patient, had significant positive implications in her treatment. ^{55 (p.135)}

613 Some staff did make me feel like a real person, a whole human being, and made it OK for me
614 to talk about anything, including my girlfriend at the time." One participant also spoke about the
615 impact of having a provider tell her that she was a lesbian herself.....I felt it was nice that she
616 did that. It made me feel less ashamed. It was because she is a nurse and she is gay and there
617 is nothing wrong with that. ^{58 (p.31)}

618 **Category 2.3: Communication and Disclosures**

619 Communication about sexual matters is lacking in clinical practice and is rarely initiated by mental health
620 professionals. ^{56,62,63} However, the evidence would suggest that most patients are very willing and able
621 to do so. ⁶² The fear of triggering unwanted responses appears unjust and it appears perfectly safe to
622 talk about these issues within mental health care contexts. Based on the findings, talking about sexual
623 issues and contemplating potential interventions are significant in terms of supports and psychosocial
624 wellbeing. Responses to a variety of sexuality related disclosures are presented. Participants in existing
625 studies appeared to respond well to the interviews. In fact, many seemed pleased to be asked about
626 concerns regarding something as fundamental as sex and relationship issues. ^{47,60,66} There were no
627 patient reports of distress or staff complaints about deleterious effects following interview sessions. No
628 interview had to be prematurely terminated.

629 We found that patients and partners do not regularly communicate with each other about issues
630 related to their sexual relationship. However, some patients have said that they do speak with
631 close friends and relatives about their sex life and their feelings of dysfunctionality. ^{63 (p.22)}

632 Patients with psychosis are willing, ready and even thankful if they are given the opportunity to
633 talk about their sexuality. They have no problem discussing their wishes and fantasies,

634 regardless whether they are heterosexual, homosexual or 'unusual', and their overt sexual
635 activities, be it masturbatory or with others.^{66 (p.112)}

636 Some people are made feel inadequate and this may be due to age and lack of experience.
637 The thing is nobody ever said, you're single, what do you do about it? How do you go about
638 being single? I mean obviously you talk to somebody these days off the road ... they start
639 walking away from you, get intimidated by you, you know. You get all ... you feel upset.^{65 (p.163)}

640 After spending 2 weeks in an acute inpatient unit in a psychotic state, Jay had been moved to
641 sub-acute care, as she began to stabilize. Several days later, Jay returned to the unit after
642 walking in the hospital grounds in a distressed state and told the nurses she had been 'raped
643 by Santa Claus'. Staff assumed this was a regression of her psychosis, and initially dismissed
644 her account. Following further investigation, eye witnesses reported seeing Jay with a grounds
645 man who had a long white beard like Santa Claus. He was also recalled as wearing a red shirt
646 that day. When confronted with this information, the grounds man admitted to having sex with
647 Jay.^{47 (p.143)}

648 This patient brought up that he might be gay and didn't want anyone else to know because he
649 didn't want to be picked on, ridiculed, or raped.....And then there is the issue of what happens
650 if one of our guys are picked up on a gay beat? Imagine the headlines and imagine the
651 implications for this place.^{64 (p.673)}

652

653 **Category 2.4. The Clinical Setting**

654 Being hospitalized is a significant life event. For some, the reason for hospitalization inhibits sexual
655 needs temporarily. For others, sexuality remains an important aspect of life, throughout the admission
656 and particularly for protracted stays.^{49,50,57,62-63,69} There can be barriers and obstacles to the expression
657 of sexuality such as a lack of privacy. Much depended on the type of setting and context.⁶² Some of the
658 study participants were in a forensic unit and others were in supported accommodation in the
659 community.^{64,66} These, and other related topics are considered.

660

661 Judging by the responses in some of the studies, a majority would like more opportunities to
662 meet people and develop social skills away from the institution.^{60 (p.134)}

663 Because of the environment, they have been indulging in homosexual activity. Which I possibly
664 think is not the way they are orientated, but is due to the 'abnormal' environment.....My
665 understanding is that the guys who are gay aren't really gay. It's just that they can't get into bed
666 with a woman. They get frustrated and turn gay because there are no women around . . . that's
667 why a lot of them turn gay in prison. It's their only option.^{64 (p.674)}

668 There is no privacy around here. There's not much chance to have sex. We're under the staff.
669 Staff just come into the room, they don't bother to knock. I have no one to talk to about this stuff
670 and I get worried that I may harm her.^{62 (p.254)}

671 Sex relations had stopped for three-quarters of respondents since being hospitalized. When
672 asked why sexual relations had stopped, the following reasons were given: illness of self (four);
673 lost interest myself (four); lack of opportunity (five); no privacy (three); in hospital (six).^{60 (p.135)}

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Synthesized Finding Three: Family and Partner Involvement

Insert Table 4

Synthesized Finding Three: Family and Partner Involvement

681 This finding relates to family and partner experiences and support needs. Living with SMI presents a
682 variety of stresses and challenges to both the person with the disorder and those who live with and care
683 for them. This included partners who were learning to cope with the many challenges that the illness
684 presented. In the last twenty years, the socio-political landscape in Europe has supported
685 deinstitutionalisation, hospital closure programmes and the locus of mental healthcare being situated
686 in the community. As a result, this often necessitates families, including partners, facing the challenges
687 and shouldering the burden involved in providing care and support to their family member. Families
688 become a crucial element in fulfilling the person's health and social care requirements. Inevitably,
689 families had become unpaid and unrecognised 'silent' carers. In terms of sexual and relationship
690 aspirations, studies have supported the idea that people with SMI are able to have satisfying and
691 fulfilling intimate relationships. Despite the willingness and ability to be sexually active, challenges exist
692 around establishing, sustaining and maintaining relationships. The necessary supports may include
693 information and education, skills training, coping strategy enhancement and access to talking therapies.
694 This synthesized finding was derived out of nine findings which were merged into two categories.

695

Category 3.1: Family needs and supports

697 Families would often provide examples of the emotional and practical input that was given
698 unconditionally, 'no matter what.' However, the statutory supports available to families remained limited
699 and this often led to increased anxiety, frustration and stress for family members.^{48,52,56,60}

700 Gender has been ignored in the treatment and support needs of people with SMI. Many family
701 members, particularly mothers, had made significant sacrifices necessary to enable the
702 provision of psychosocial supports to allow the person with SMI to lead a more satisfying,
703 fulfilling and meaningful life. One mother felt services were failing her and her son stating that
704 'they are abusing my child emotionally. They planned on taking my kid away immediately after
705 he was born without even discussing it with me.'^{52 (p.148)}

706 Mental health-related stigma was an obstacle to maintaining custody of children. Other issues included
707 emotional abuse within the relationships, sexual abuse, locating information and supports around
708 contraception, pregnancy and sexually transmitted infections.^{51, 52, 62-64}

709

Category 3.2: The experiences and needs of partners

711 People with SMI can face challenges in the forming and maintaining relationships. However, people are
712 willing and able to talk about intimacy experiences. There are higher rates of divorce and separation
713 issues in people with SMI are two to three times more than in the general population.^{48,53,56,61,65} The risk
714 of suicide can be as high as 20%.⁴¹ The formation and maintenance of intimate relationships was
715 important to many participants and was revealed in the studies included in the review.^{52,63} People were

716 able and willing to articulate their experiences, the strengths and the challenges they face and how they
717 might cope with these. Research has shown the negative impact that SMI can have upon partners and
718 potential distress and the strain on interpersonal and intimate relationships.⁵⁶

719 Spouses would try to 'stay on top' of possible relapses of their partner's condition. Some study
720 participants described feeling 'resentful' and of being 'unappreciated' in the work they were
721 doing. Difficulties were compounded if the partner with SMI had trouble accepting their
722 diagnosis and treatments. ^{56 (p.195)}

723 Stigma associated with SMI was also an issue for some participants where people thought they
724 may be unfairly judged and forced to only choose potential partners who had similar mental
725 health experiences. ^{53 (p.245)}

726 One partner described the impact SMI can have upon their relationship...I ask myself, is she
727 escalating? I watch her carefully for a day or two until I find she's not, then I can relax again.'
728 How can you live with this? It is so scary.'^{56 (p.196)}

729 Although many interpersonal challenges existed, there were some positive outcomes for the
730 relationship. Partners noted that the bipolar disorder experiences strengthened their
731 relationship by deepening their bond and increasing trust. For the spouses, trust had to do with
732 the belief that their partner would remain stable and comply with treatment so that they would
733 not have a recurrent episode. There was also evidence of increased empathy and compassion
734 towards others through experiencing the challenges associated with the mental health
735 condition. Spouses talked about developing resilience through facing adversity and
736 appreciating new perspectives on 'what is important in life.'^{56 (p.194)}

737

738 **Discussion**

739 The purpose of conducting this systematic review of the literature was to synthesize the best available
740 evidence regarding people with a serious mental illness and their sexuality and intimacy experiences.
741 A comprehensive search of the literature produced 21 studies that met the inclusion criteria and
742 addressed the aim and objectives of the systematic review. There was some international
743 representation with most studies conducted in the UK, USA and Australia that produced qualitative
744 descriptive data through various appropriate designs. Following the appraisal process, all studies were
745 included in the review as they addressed the review objectives highlighting sexual and relationship
746 experiences, issues and concerns. The voice of participants and their views and opinions were
747 imperative in informing and shaping the review.

748 The 21 included studies resulted in 83 unequivocal or credible findings that were grouped into 10
749 categories. Finally, three synthesized findings emerged from the data: 1) The complexity of individual
750 sexual experiences, 2) Clinical constructs of sexuality, and 3) Family and partner involvement. The
751 expression of sexuality and the drive to form fulfilling intimate relationships is a fundamental part of
752 being human.⁶⁷ In terms of SMI and psychosocial aspects of recovery, holistic assessments of need
753 should include intimate relationships and address individual desires and wishes around forming and
754 maintaining meaningful relationships. ^{69, 70} However, challenges remain as evidenced through this
755 systematic review of the available literature.

756 *Discussion points related to finding one*

757 The complexity of individualized experiences in relation to sexuality was a significant finding in relation
758 to individuals with a diagnosis of serious mental illness. When provided with an opportunity to express
759 their thoughts on this topic, many individuals documented the stigma experiences held both internally,
760 in the form of self-stigma, and externally, through interactions with people in their communities. These
761 experiences can present barriers and inhibit people from forming intimate or meaningful relationships.⁷¹⁻
762 ⁷³ People outside of heteronormative relationships can experience a double stigma that can often lead
763 to an even heavier burden.⁷⁴ Given the already difficult experience of living with a serious mental illness,
764 it is important for mental health practitioners to be aware of the impact of these stigma experiences on
765 the individual and not to perpetuate them through their own internalised stigmatising behaviours.

766 *Discussion points related to finding two*

767 The question of sexual vulnerability and sexual coercion in the SMI group was identified in some of the
768 reviewed studies.^{47,51,54,57} These phenomena can take different forms and may be experienced in
769 different contexts. For some, the identified events pose a lifelong barrier to their expression of sexuality.
770 However, it is important to be aware that disclosures and perceptions of sexual experiences may be
771 altered due to the person's state of mind.⁷⁵ In psychosis, sexuality may be experienced differently,
772 which makes it important to listen carefully and for practitioners to ensure that they do not dismiss
773 unclear or ambiguous expressions as purely psychotic or 'delusional' experiences.⁷⁶ Potential barriers
774 to the expression of sexuality for patients may be experienced because caregivers rarely enquire about
775 sexuality and intimacy issues proactively. Therefore, important vulnerability and sometimes challenging
776 issues remain hidden, which can lead to sexual risks. Issues of autonomy and responsibility can add
777 complexity to the topic.⁷⁷ One of the most important outcomes is that several studies have shown that
778 people with serious mental health problems are willing and able to talk about sexuality and intimacy
779 and that doing so, is often constructive, informative and safe.^{54,55,60-65}

780

781 *Discussion points related to finding three*

782 Having fulfilling and satisfying sexual and relationship experiences is a fundamental human right that
783 can enhance an individual's quality of life.⁷⁻¹¹ However, this review has indicated that, despite people
784 with SMI possessing the will and desire to be intimate, potential obstacles exist.^{35,36} The SMI experience
785 can have a profound effect on family members, including partners and spouses.⁶²⁻⁶⁴ Challenges remain
786 around the supports and services available to significant people in the person's life. Being aware of the
787 potential stresses and challenges to the relationship and involving partners in the treatment may help
788 to promote intimacy and recovery.¹⁻⁴

789

790 *Strengths and limitations*

791 The aim of the review was to examine sexuality and intimacy issues for people who experience SMI.
792 The review offers deep insights into the unique experiences of people with SMI and gives significant
793 perspectives on the needs of individuals, partners and spouses. Because of the non-experimental
794 design and explorative nature of most included studies in this review, the exact nature of the relationship
795 between the different concepts such as SMI and sexual expression cannot be established. Although

796 this review offers extensive insights into issues regarding intimacy and sexual expression, further
797 research is needed to explore the found topics, in depth. Another opportunity exists to conduct research
798 in different cultural contexts including non-English speaking countries.

799

800 **Conclusion**

801 This review has identified a range of key concerns that exist in relation to the experiences and needs
802 of people who have a SMI regarding their sexual and relationship requirements. The findings from this
803 review highlight areas requiring attention in terms of practice, education and future research
804 developments.

805 *Implications for Practice*

806 On the strength of the ConQual summary of findings, it is recommended and encouraged that policy
807 makers in mental health settings make clear and explicit their policies on sexuality issues. These
808 considerations should include issues such as privacy during admission, assessment of sexual risks
809 such as sexually transmitted infections (STI's), unwanted pregnancies and the use of contraception.
810 These formalisations offer the preconditions to translate these policy implications to direct patient care.

- 811 1. Practitioners need to engage with people and routinely enquire about sexuality and intimacy
812 issues. There should be an increased dialogue around 'sensitive' issues. This may require them
813 reflecting upon their own attitudes and beliefs around the topic. (Grade A)
- 814 2. Appropriate and adequate assessment and care planning should include sexuality and intimacy
815 issues. (Grade A)
- 816 3. There needs to be a greater awareness and responsiveness of practitioners around sexual
817 abuse issues, sexual risks and vulnerabilities. (Grade A)
- 818 4. There needs to be more availability of and access to talking therapies such as individual and
819 couple counselling and psychosexual therapy. (Grade A)
- 820 5. There should be time dedicated to exploring thoughts, emotions and meaning around sexuality
821 experiences including the implications of stigma, confidence and self-image. (Grade A)
- 822 6. Policies related to sexuality issues in healthcare settings need to be examined and reviewed.
823 (Grade A)

824

825 *Implications for Education*

826 Education and training have emerged as key concerns in developing knowledge and skills necessary
827 to address issues in relation to the expression of intimacy and sexuality. Specifically, these relate to
828 psychosocial experiences such as the impact of loss and isolation, discrimination and stigma,
829 oppression and social exclusion. Educational input should highlight the sensitivity in dealing with
830 specific issues such as transgender experiences or autoerotic asphyxiation. The review has
831 demonstrated that practitioners often have had limited previous educational and practice development
832 opportunities.

833

- 834 1. The development of practitioner knowledge and skills that relate to the key issues highlighted
835 in this review.

- 836 2. Inclusion of sexuality and intimacy issues within the undergraduate curriculum for all health and
837 social care students.
- 838 3. Provision of sexual health education around family planning, contraception and safe sex
839 strategies should be available for all stakeholders.
- 840 4. Training for caregivers in asking about sexuality and (sexual) trauma and sexual health
841 counselling.
- 842 5. There should be opportunities for skills training and educational sessions in the formation and
843 maintenance of intimate relationships.
- 844 6. Continuing professional development (CPD) opportunities to include innovative teaching and
845 learning approaches in order to build and develop confidence in addressing key sexuality
846 issues and concerns.

847

848 *Implications for Research*

849 This review highlights the need for a detailed focus on sexuality and intimacy issues among people with
850 SMI to better understand their needs, effective supports, interventions and service responses. There is
851 a significant opportunity to make a shift away from purely exploring sexuality and intimacy issues among
852 people with SMI through the lens of perceived risk and vulnerability, towards developing and evaluating
853 interventions that target the identified barriers and help people with SMI to fulfil their unmet needs. Due
854 to the significant health and social care needs of people who experience SMI, there is an increased
855 opportunity to research the effectiveness of supports, treatments and psychosocial interventions. Future
856 research therefore, should address the following concerns:

- 857 1. Policy evaluation
- 858 2. Education and training evaluation
- 859 3. Sexuality and quality of life studies
- 860 4. Intervention studies
- 861 5. Multi-centre national and international studies
- 862 6. Service user and family involvement

863

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865 None

866

867 **Conflicts of interest**

868 The authors declare no conflict of interest

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1078 **Appendix I: Search Strategy Examples**

1079 **1.1 Medline Search Strategy**

1080 Concept 1: Serious Mental Illness

1081 Medline: (MH "Personality Disorders+") OR (MH "Schizophrenia Spectrum and Other Psychotic
1082 Disorders+") OR (MH "Bipolar and Related Disorders+") OR (MH "Schizophrenia+") OR (MH
1083 "Psychotic Disorders+")

1084 Keywords: Schizophrenia OR Schizophrenic OR schizoaffective OR schizoid OR paranoid OR
1085 paranoia OR psychosis OR psychoses OR psychotic OR bi-polar OR bipolar OR manic OR mania OR
1086 manias OR "treatment resistant depression" OR Manic-Depressive OR "Manic Depressive" OR
1087 "Personality Disorder" OR "personality disorders" OR "serious mental illness"

1088

1089 Concept 2: Sexuality & Intimacy

1090 Medline: (MH "Sexuality+") OR (MH "Sexual Behavior+") OR (MH "Paraphilic Disorders"+)

1091 Keywords: sex* OR sexual* OR sexy* OR sexuality* OR "Sexual Behavior" OR "Sexual Behaviour"
1092 OR "Sexual Activities" OR "Sexual Activity" OR "Sex Behavior" OR "Sex Behaviour" OR "Oral Sex"
1093 OR "Sexual Orientation" OR "Sex Orientation" OR "Anal Sex" OR "sexual intercourse" OR coitus OR
1094 courtship OR masturbation OR intercourse OR intimacy OR intimate OR attraction OR attracted OR
1095 Bisexual* OR Heterosexual* OR Homosexual* OR Transsexual* OR Bi-sexual* OR Hetero-sexual*
1096 OR Homo-sexual* OR Trans-sexual* OR exhibitionism OR Fetishis* OR Masochism* OR "Sexual
1097 Masochism" OR Paedophil* OR Pedophil* OR Sadism OR Transvestism OR Voyeurism OR
1098 Paraphilias OR Paraphilia OR "Sex Deviations" OR "sex Deviation" or "deviant sex"

1099

1100 Concept 3: Experience

1101 Medline: keywords only

1102 Keywords: experience OR experiences OR experienced OR view OR views OR viewpoint OR
1103 viewpoints OR perception OR perceptions OR perceive OR perceived OR attitude OR attitudes OR
1104 belief OR beliefs OR perspective OR perspectives OR opinion OR opinions OR concept OR concepts
1105 OR thought OR thoughts OR awareness OR value OR values

1106 Concept 4: Study Type

1107 Medline: (MH "Empirical Research") OR (MH "Grounded Theory") OR (MH "Qualitative Research+")
1108 OR (MH "Hermeneutics") OR (MH "Focus Groups") OR (MH "Anthropology, Cultural+")

1109 Keywords: "Empirical Research" OR "qualitative research" OR "Grounded Theory" OR Hermeneutics
1110 OR "focus groups" OR "focus group" OR "observational studies" OR "observational study" OR
1111 "comparative study" OR ethnography OR phenomenology OR "action research" OR "feminist
1112 research" OR "narrative research" OR "narrative analysis" OR "descriptive study" OR "descriptive
1113 studies" OR "qualitative descriptive research" OR "exploratory study" OR "exploratory studies" OR
1114 "systematic review" OR "literature review" OR "qualitative study" OR "qualitative studies" OR
1115 "qualitative research design" OR "qualitative descriptive design" OR "qualitative research" OR
1116 "interpretative analysis" OR "case study" OR "case studies" OR survey OR "structured interview" OR

1117 "semi-structured interview" OR "unstructured interview" OR "open interview" OR "content analysis"
1118 OR "thematic analysis" OR "thematic coding" OR "open-ended interviews" OR "qualitative descriptive"

1119 **1.2 CINAHL Search Strategy**

1120 Concept 1: Serious Mental Illness

1121 CINAHL: (MH "Bipolar Disorder+") OR (MH "Schizophrenia+") OR (MH "Psychotic Disorders+") OR
1122 (MH "Personality Disorders+")

1123 Keywords: Schizophrenia OR Schizophrenic OR schizoaffective OR schizoid OR paranoid OR
1124 paranoia OR psychosis OR psychoses OR psychotic OR bi-polar OR bipolar OR manic OR mania OR
1125 manias OR "treatment resistant depression" OR Manic-Depressive OR "Manic Depressive" OR
1126 "Personality Disorder" OR "personality disorders" OR "serious mental illness"

1127

1128 Concept 2: Sexuality & Intimacy

1129 CINAHL: (MH "Psychosexual Disorders+") OR (MH "Sexuality+") OR (MH "Intimacy")

1130 Keywords: sex* OR sexual* OR sexy* OR sexuality* OR "Sexual Behavior" OR "Sexual Behaviour"
1131 OR "Sexual Activities" OR "Sexual Activity" OR "Sex Behavior" OR "Sex Behaviour" OR "Oral Sex"
1132 OR "Sexual Orientation" OR "Sex Orientation" OR "Anal Sex" OR "sexual intercourse" OR coitus OR
1133 courtship OR masturbation OR intercourse OR intimacy OR intimate OR attraction OR attracted OR
1134 Bisexual* OR Heterosexual* OR Homosexual* OR Transsexual* OR Bi-sexual* OR Hetero-sexual*
1135 OR Homo-sexual* OR Trans-sexual* OR exhibitionism OR Fetishis* OR Masochism* OR "Sexual
1136 Masochism" OR Paedophil* OR Pedophil* OR Sadism OR Transvestism OR Voyeurism OR
1137 Paraphilias OR Paraphilia OR "Sex Deviations" OR "sex Deviation" or "deviant sex"

1138

1139 Concept 3: Experience

1140 CINAHL: keywords only

1141 Keywords: experience OR experiences OR experienced OR view OR views OR viewpoint OR
1142 viewpoints OR perception OR perceptions OR perceive OR perceived OR attitude OR attitudes OR
1143 belief OR beliefs OR perspective OR perspectives OR opinion OR opinions OR concept OR concepts
1144 OR thought OR thoughts OR awareness OR value OR values

1145 Concept 4: Study Type

1146 CINAHL: (MH "Focus Groups") OR (MH "Interviews+") OR (MH "Qualitative Studies+") OR (MH
1147 "Empirical Research")

1148 Keywords: "Empirical Research" OR "qualitative research" OR "Grounded Theory" OR Hermeneutics
1149 OR "focus groups" OR "focus group" OR "observational studies" OR "observational study" OR
1150 "comparative study" OR ethnography OR phenomenology OR "action research" OR "feminist
1151 research" OR "narrative research" OR "narrative analysis" OR "descriptive study" OR "descriptive
1152 studies" OR "qualitative descriptive research" OR "exploratory study" OR "exploratory studies" OR
1153 "systematic review" OR "literature review" OR "qualitative study" OR "qualitative studies" OR
1154 "qualitative research design" OR "qualitative descriptive design" OR "qualitative research" OR
1155 "interpretative analysis" OR "case study" OR "case studies" OR survey OR "structured interview" OR

1156 "semi-structured interview" OR "unstructured interview" OR "open interview" OR "content analysis"
1157 OR "thematic analysis" OR "thematic coding" OR "open-ended interviews" OR "qualitative descriptive"

1158 **1.3 PsycINFO Search Strategy**

1159 Concept 1: Serious Mental Illness

1160 PsycINFO: (DE "Schizophrenia") OR (DE "Psychosis") OR (DE "Mania") OR (DE "Bipolar
1161 Disorder") OR (DE "Treatment Resistant Depression") OR (DE "Personality Disorders")

1162 Keywords: Schizophrenia OR Schizophrenic OR schizoaffective OR schizoid OR paranoid OR
1163 paranoia OR psychosis OR psychoses OR psychotic OR bi-polar OR bipolar OR manic OR mania OR
1164 manias OR "treatment resistant depression" OR Manic-Depressive OR "Manic Depressive" OR
1165 "Personality Disorder" OR "personality disorders" OR "serious mental illness"

1166

1167 Concept 2: Sexuality & Intimacy

1168 PsycINFO: (DE "Sexuality" OR DE "Intimacy" OR DE "Paraphilias")

1169 Keywords: sex* OR sexual* OR sexy* OR sexuality* OR "Sexual Behavior" OR "Sexual Behaviour"
1170 OR "Sexual Activities" OR "Sexual Activity" OR "Sex Behavior" OR "Sex Behaviour" OR "Oral Sex"
1171 OR "Sexual Orientation" OR "Sex Orientation" OR "Anal Sex" OR "sexual intercourse" OR coitus OR
1172 courtship OR masturbation OR intercourse OR intimacy OR intimate OR attraction OR attracted OR
1173 Bisexual* OR Heterosexual* OR Homosexual* OR Transsexual* OR Bi-sexual* OR Hetero-sexual*
1174 OR Homo-sexual* OR Trans-sexual* OR exhibitionism OR Fetishis* OR Masochism* OR "Sexual
1175 Masochism" OR Paedophil* OR Pedophil* OR Sadism OR Transvestism OR Voyeurism OR
1176 Paraphilias OR Paraphilia OR "Sex Deviations" OR "sex Deviation" or "deviant sex"

1177

1178 Concept 3: Experience

1179 PsycINFO: keywords only

1180 Keywords: experience OR experiences OR experienced OR view OR views OR viewpoint OR
1181 viewpoints OR perception OR perceptions OR perceive OR perceived OR attitude OR attitudes OR
1182 belief OR beliefs OR perspective OR perspectives OR opinion OR opinions OR concept OR concepts
1183 OR thought OR thoughts OR awareness OR value OR values

1184 Concept 4: Study Type

1185 PsycINFO: (DE "Qualitative Research" OR DE "Empirical Methods" OR DE "Grounded Theory" OR
1186 DE "Interviews" OR DE "Observation Methods") OR (DE "Action Research")

1187 Keywords: "Empirical Research" OR "qualitative research" OR "Grounded Theory" OR Hermeneutics
1188 OR "focus groups" OR "focus group" OR "observational studies" OR "observational study" OR
1189 "comparative study" OR ethnography OR phenomenology OR "action research" OR "feminist
1190 research" OR "narrative research" OR "narrative analysis" OR "descriptive study" OR "descriptive
1191 studies" OR "qualitative descriptive research" OR "exploratory study" OR "exploratory studies" OR
1192 "systematic review" OR "literature review" OR "qualitative study" OR "qualitative studies" OR
1193 "qualitative research design" OR "qualitative descriptive design" OR "qualitative research" OR
1194 "interpretative analysis" OR "case study" OR "case studies" OR survey OR "structured interview" OR

1195 “semi-structured interview” OR “unstructured interview” OR “open interview” OR “content analysis”
1196 OR “thematic analysis” OR “thematic coding” OR “open-ended interviews” OR “qualitative descriptive”

1197 **1.4 Embase Search Strategy**

1198 Concept 1: Serious Mental Illness

1199 Emtree: 'schizophrenia'/exp OR 'psychosis'/exp OR 'personality disorder'/exp OR 'mania'/exp

1200 Keywords: Schizophrenia OR Schizophrenic OR schizoaffective OR schizoid OR paranoid OR

1201 paranoia OR psychosis OR psychoses OR psychotic OR bi-polar OR bipolar OR manic OR mania OR

1202 manias OR “treatment resistant depression” OR Manic-Depressive OR “Manic Depressive” OR

1203 “Personality Disorder” OR “personality disorders” OR “serious mental illness”

1204

1205 Concept 2: Sexuality & Intimacy

1206 Emtree: 'sexuality'/exp OR 'sex'/exp OR 'intimacy'/exp OR 'sexual behavior'/exp

1207 Keywords: sex* OR sexual* OR sexy* OR sexuality* OR "Sexual Behavior" OR "Sexual Behaviour"

1208 OR “Sexual Activities” OR “Sexual Activity” OR “Sex Behavior” OR “Sex Behaviour” OR “Oral Sex”

1209 OR “Sexual Orientation” OR “Sex Orientation” OR “Anal Sex” OR “sexual intercourse” OR coitus OR

1210 courtship OR masturbation OR intercourse OR intimacy OR intimate OR attraction OR attracted OR

1211 Bisexual* OR Heterosexual* OR Homosexual* OR Transsexual* OR Bi-sexual* OR Hetero-sexual*

1212 OR Homo-sexual* OR Trans-sexual* OR exhibitionism OR Fetishis* OR Masochism* OR “Sexual

1213 Masochism” OR Paedophil* OR Pedophil* OR Sadism OR Transvestism OR Voyeurism OR

1214 Paraphilias OR Paraphilia OR “Sex Deviations” OR “sex Deviation” or “deviant sex”

1215

1216 Concept 3: Experience

1217 Emtree: keywords only

1218 Keywords: experience OR experiences OR experienced OR view OR views OR viewpoint OR

1219 viewpoints OR perception OR perceptions OR perceive OR perceived OR attitude OR attitudes OR

1220 belief OR beliefs OR perspective OR perspectives OR opinion OR opinions OR concept OR concepts

1221 OR thought OR thoughts OR awareness OR value OR values

1222

1223 Concept 4: Study Type

1224 Emtree: 'qualitative research'/exp OR 'hermeneutics'/exp OR 'interview'/exp

1225 Keywords: “Empirical Research” OR “qualitative research” OR “Grounded Theory” OR Hermeneutics

1226 OR “focus groups” OR “focus group” OR “observational studies” OR “observational study” OR

1227 “comparative study” OR ethnography OR phenomenology OR “action research” OR “feminist

1228 research” OR “narrative research” OR “narrative analysis” OR “descriptive study” OR “descriptive

1229 studies” OR “qualitative descriptive research” OR “exploratory study” OR “exploratory studies” OR

1230 “systematic review” OR “literature review” OR “qualitative study” OR “qualitative studies” OR

1231 “qualitative research design” OR “qualitative descriptive design” OR “qualitative research” OR

1232 “interpretative analysis” OR “case study” OR “case studies” OR survey OR “structured interview” OR

1233 “semi-structured interview” OR “unstructured interview” OR “open interview” OR “content analysis”

1234 OR “thematic analysis” OR “thematic coding” OR “open-ended interviews” OR “qualitative descriptive”

1235 **1.5 Web of Science Search Strategy (keyword only searches)**

1236 Concept 1: Serious Mental Illness

1237 Keywords: Schizophrenia OR Schizophrenic OR schizoaffective OR schizoid OR paranoid OR
1238 paranoia OR psychosis OR psychoses OR psychotic OR bi-polar OR bipolar OR manic OR mania OR
1239 manias OR "treatment resistant depression" OR Manic-Depressive OR "Manic Depressive" OR
1240 "Personality Disorder" OR "personality disorders" OR "serious mental illness"

1241

1242 Concept 2: Sexuality & Intimacy

1243 Keywords: sex* OR sexual* OR sexy* OR sexuality* OR "Sexual Behavior" OR "Sexual Behaviour"
1244 OR "Sexual Activities" OR "Sexual Activity" OR "Sex Behavior" OR "Sex Behaviour" OR "Oral Sex"
1245 OR "Sexual Orientation" OR "Sex Orientation" OR "Anal Sex" OR "sexual intercourse" OR coitus OR
1246 courtship OR masturbation OR intercourse OR intimacy OR intimate OR attraction OR attracted OR
1247 Bisexual* OR Heterosexual* OR Homosexual* OR Transsexual* OR Bi-sexual* OR Hetero-sexual*
1248 OR Homo-sexual* OR Trans-sexual* OR exhibitionism OR Fetishis* OR Masochism* OR "Sexual
1249 Masochism" OR Paedophil* OR Pedophil* OR Sadism OR Transvestism OR Voyeurism OR
1250 Paraphilias OR Paraphilia OR "Sex Deviations" OR "sex Deviation" or "deviant sex"

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1252 Concept 3: Experience

1253 Keywords: experience OR experiences OR experienced OR view OR views OR viewpoint OR
1254 viewpoints OR perception OR perceptions OR perceive OR perceived OR attitude OR attitudes OR
1255 belief OR beliefs OR perspective OR perspectives OR opinion OR opinions OR concept OR concepts
1256 OR thought OR thoughts OR awareness OR value OR values

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1258 Concept 4: Study Type

1259 Keywords: "Empirical Research" OR "qualitative research" OR "Grounded Theory" OR Hermeneutics
1260 OR "focus groups" OR "focus group" OR "observational studies" OR "observational study" OR
1261 "comparative study" OR ethnography OR phenomenology OR "action research" OR "feminist
1262 research" OR "narrative research" OR "narrative analysis" OR "descriptive study" OR "descriptive
1263 studies" OR "qualitative descriptive research" OR "exploratory study" OR "exploratory studies" OR
1264 "systematic review" OR "literature review" OR "qualitative study" OR "qualitative studies" OR
1265 "qualitative research design" OR "qualitative descriptive design" OR "qualitative research" OR
1266 "interpretative analysis" OR "case study" OR "case studies" OR survey OR "structured interview" OR
1267 "semi-structured interview" OR "unstructured interview" OR "open interview" OR "content analysis"
1268 OR "thematic analysis" OR "thematic coding" OR "open-ended interviews" OR "qualitative descriptive"

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Appendix II: Characteristics of included Studies (SUMARI)

Reference and Country	Phenomena of interest	Participants	Methods	Methodology	Main results
Ashmore et al. (2015) ⁴⁷ Australia	Examine incidences of sexual assault on inpatient units	People with serious mental illness (SMI) (n=5)	Observation and case notes Case study analysis	Case study	Model for disclosure were provided. Case studies demonstrating different disclosure scenarios. Therapeutic or investigative responses were given. The importance of effective communication and safety in responding to distress is elucidated. There needs to be more rigorous assessment and care planning. Review of policies required. Service capacity building and staff education and support discussed.
Baker and Proctor (2015) ⁴⁸ Australia	Examine relationships, loss and mental illness	People with SMI (n=16): female (n=11), male (n=5)	Semi structured interviews Thematic analysis	Participatory action research	Lost relationships were significant and impacted upon a person's illness trajectory. Participants viewed these losses as contributing to the onset of their illness including the loss of intimate relationships (partners, family, children or friends). The challenges of forming and maintaining intimate relationships are discussed. Practitioners need to be aware of the relevant factors that impact upon adequate and responsive care and supports.
Ben-David et al. (2014) ⁴⁹ USA	Explore the experiences of at-risk youths, ethnically diverse males and females who were participants in a prodromal	Youth with SMI (n=24): Male (n=12), female (n=12). Aged 16-27 years	Individual interviews Phenomenological analysis	Phenomenology	Emergent themes were largely different for males and females. Males described alienation and despair, feeling broken, and a fear of going "crazy." They desired relationships but

	research program				instead they were alone, escaping into fantasy. They had a vague hopefulness that things might improve in the future, but no real plan for going forward. By contrast, the females described being in 'the thick of things', managing relationships and building careers, while dealing with the sadness of ill family members and past trauma.
Brown et al. (2014) ⁵⁰ UK	Examine the expression of sexuality in forensic mental health settings	Forensic mental health inpatients with SMI (n=20): male (n=15), female (n=5). Aged 20-55 years	Semi structured interviews Thematic analysis	Qualitative description	Personal and sexual relationships were seen as problematic. The study revealed a transformation of people and their sexual identity. The emergent themes included: exclusion, territorialisation (strict regimes), and amputation (disconnection).
Chandra et al. (2003) ⁵¹ India	Explore sexual coercion in women with SMI on a mental health unit	Women with SMI (n=146) screened for sexual coercion (n=50)	Semi structured interviews Content analysis	Qualitative description	A total of 48% of participants reported their spouse as the perpetrator; 26% friend; and 20% uncle or cousin. Most coercion took place in the woman's home. Significantly, 60% had not told anyone and felt fearful, anxious and vulnerable. Their experiences remain invisible, hidden and unacknowledged. Further research is needed around vulnerability factors, help-seeking behaviors and supports.
Cogan (1998) ⁵² USA	Identify intimate relationship needs for women with SMI	Women with SMI (n=25). Aged 18-65 years	Structured interviews	Qualitative description	A majority of participants (80%) had emotional abuse needs, 56-68% had sexual abuse issues,

			Thematic analysis		60% had sexual health needs (STIs, contraception, family planning). A significant number (77%) of mothers had child custody concerns. Stigma was an obstacle to keeping children. Staff were often reluctant to deal with sexual abuse issues.
Davison and Huntington (2010) ⁵³ New Zealand	Explore the sexuality experiences of women with SMI	Women with SMI (n=8)	Individual interviews and focus group Thematic analysis	Qualitative description	Sexuality was seen as an important part of identity. There were challenges to expressing sexuality where participants were seen as 'other' and invisible or hidden. Sexuality perceived as fundamental to care, supports and recovery. It is necessary to create cultures of support towards sexual expression in clinical practice. Sexuality is often controlled and influenced by systems and organisations such as the biomedicine, and psychiatry and societal responses that include stigma and heteronormativity.
de Jager et al. (2017) ⁵⁴ Netherlands	Explore intimacy experiences among people with psychosis	People with diagnosis of psychosis (n=28)	Semi structured interviews Constant comparison analysis	Grounded theory	Five factors emerged that impacted upon intimate relationships that were: medication side-effects, illness symptoms, stigma, sexual abuse and social skills. Health practitioners need to effectively engage with people around sexuality issues in order to establish pertinent psychosocial needs and to provide necessary interventions and supports.

Garrett (2004) ⁵⁵ USA	Describe the treatment experiences of a transgender client with schizophrenia	Male to female (MTF) trans person aged 48 years diagnosed with schizophrenia	Observation, direct patient-therapist interactions Case study analysis	Case study	An individual case presentation that addresses the role of gender identity in the clinical treatment of a person identifying as transgender in provided. The main issues were around appropriate assessment and treatment opportunities in mental health settings. LGBT people may be resistant to 'coming out' for fear of rejection, abandonment and being viewed as sexually deviant that can have a detrimental effect on people accessing and using relevant support services.
Granek et al. (2016) ⁵⁶ Israel	Explore the impact of bipolar disorder on individuals, spouses and intimate relationships	People with a diagnosis of bipolar disorder (n=11). Spouses (n=10)	Individual interviews Constant comparison analysis	Grounded theory	The impact of bipolar disorder on spouses included self-sacrifice, caregiving burden, the emotional impact and related challenges. The experiences of patients related to emotional issues, self-care responsibilities, and social struggles. The impact on the relationship included volatility, ambiguity and family planning issues. Given the high rates of divorce and relationship problems, relevant healthcare professionals can provide practical and emotional support to patients and spouses both individually and as couples.
Greenall and Jellicoe-Jones (2007) ⁵⁷ UK	Explore the factors other than mental disorder relevant to sexual violence	Men with a history of sexual offences and a diagnosis of	Case notes Content analysis	Qualitative description	Troubled childhoods, abuse in the home, unemployment issues and mental health problems were relevant factors in sexual violence.

	in mentally ill sex offenders	schizophrenia (n=11). Aged 23-72 years.			Sexual violence was driven by anger, psychosis, sexual disinhibition and paedophilia. Medication was used as the main treatment. There is a need to consider a range of psychosocial interventions in the treatment of sex offenders.
Kidd et al. (2011) ⁵⁸ Canada	Examine LGT people's experiences of stigma and connectedness	People with SMI (n=11): lesbian (n=6), gay men (n=3), transwomen (n=2)	Individual interviews Constant comparison analysis	Grounded theory	The study revealed the interactions between stigma and sexual and gender identity and the challenges people endure in mental health settings. Individual experiences of connection and community had positive effects on wellness and resilience. Mental health practitioners need access to knowledge and skills training to provide appropriate and responsive supports and care to this group.
Martz (2003) ⁵⁹ USA	Examine the treatment of a patient engaging in auto-asphyxiation	College student aged 22 years with SMI	Observation, direct patient-therapist interactions Case study analysis	Case study	The autoerotic asphyxiation was treated with the use of cognitive behavioural therapy. The study suggests that the described behavior succumbs to behavioral contingencies similar to any 'normal' sexual behavior. Use of exposure techniques can be used to extinguish the power of such a taboo and forbidden behavior so as to render it impotent.
McCann (2000) ⁶⁰ UK	Explore past and present sexual and relationship experiences;	Inpatients diagnosed with schizophrenia (n=15):	Semi-structured interviews	Qualitative description	The patients appeared to respond well to the interviews. Many seemed pleased to be asked about concerns regarding something

	hopes for the future	male (n=7), female (n=4)	Content analysis		as fundamental as sex and relationship issues. A significant number (eight) had no sexual relations at the present time. Just under half the respondents reported that they had enjoyed sexual relations before hospitalization. More than half reported having strong sexual feelings before admission to hospital. Just under half said they had sexual feelings at the present time. The reasons sexual activity stopped were: illness of self; lost interest myself; lack of opportunity; no privacy; or in hospital. A majority would like more opportunities to meet people and develop social skills away from the institution.
McCann and Clark (2004) ⁶¹ Australia	Examine how young people with schizophrenia experience their illness as an embodied phenomenon and find meaning in the illness.	Young adults with diagnosis of schizophrenia (n=9): male (n=5), female (n=4)	Individual interviews Phenomenological analysis	Phenomenology	Three themes emerged from the data about how the participants embodied the experience of schizophrenia. - “Embodied temporality: illness seen as a catastrophic experience” illustrated how the illness affected the person’s perception of present circumstances and future events. - “Embodied relationality: illness perceived as a mediator of social relationships” showed how the illness affected their relationship with others. - “Embodied treatment: medications side effects experienced as burdensome.” This

					highlighted how the side effects of antipsychotic medications distorted the individual's perception of his or her body, and the individual's ability to engage in sexual relationships.
McCann (2010) ⁶² UK	Explore the sexuality experiences of people with psychosis living in the community	People with diagnosis of schizophrenia (n=30): male (n=15), female (n=15)	Individual interviews Thematic analysis	Qualitative description	The findings illustrate a range of issues and concerns that are important to people with schizophrenia in the field of intimacy and sexuality. The respondents provided poignant accounts of their experiences and were willing and able to do so. The key themes that emerged were: stigma, sexual side effects of medications, family planning and sexual risks. Practitioners need to be more aware of sexuality needs and address pertinent issues
Östman and Björkman (2013) ⁶³ Sweden	Examine the effect of schizophrenia on intimacy and sexuality experiences	People with a diagnosis of schizophrenia (n=5): female (n=3), male (n=2). Partners (n=3)	Individual interviews Thematic analysis	Qualitative description	People with schizophrenia diagnosis were willing and able to discuss intimacy and sexuality issues. Main areas for concern were: intimacy in the relationship; uncertainties about capacity; sexual fantasies, desire and sexual satisfaction; and communication and psychosexual supports. Practitioners need to provide opportunities for people to discuss relevant sex and relationship concerns that may guide the development of responsive and appropriate interventions and supports. Need further

					research to evaluate potential treatments and therapeutic interventions.
Quinn and Happell (2015) ⁶⁴ Australia	Explore sexual risks and the views of patients and nurses	Forensic patients with SMI (n=10): male (n=6), female (n=4). Aged 25-48 years. Nurses (n=12)	Individual interviews Thematic analysis	Qualitative description	Sexual risk was a major theme arising from the interviews. Subthemes from nurse participants included sexual safety, sexual vulnerability, unplanned pregnancies, and male sexuality issues. Subthemes from patients included risks associated with sexual activity, access to information and sexual health care, unplanned pregnancies, vulnerability, and male sexuality issues. Information and assistance were considered by patients to be less than satisfactory in improving their knowledge or in providing the support they considered important to reduce sexual risks.
Redmond et al. (2010) ⁶⁵ UK	Explore the meaning of romantic relationships for youth with psychosis	Youth with diagnosis of psychosis (n=8)	Semi-structured interviews Interpretative phenomenological analysis (IPA)	Phenomenology	Five key themes around relationships emerged from the study: illness as a barrier; relationships as positive; relationships as 'high risk'; developing trust and confidence; and lack of experience and resources. Strategies for addressing the challenges and barriers are presented and discussed. Practitioners are in a good position to support young people in their intimate relationships. Interventions may include programmes that incorporate

					education and skills training around dating experiences. Supported employment schemes and continuing education can increase access to financial resources and to expanding social networks.
Škodlar and Žunter Nagy (2009) ⁶⁶ Slovenia	Examine sexuality experiences among people with psychosis psychodynamically	Unclear	Multiple discussions and case reports Phenomenological analysis	Phenomenology	Patients with psychosis are willing, ready and even thankful if given the opportunity to talk about their sexuality experiences. Participants would rarely bring up the topic spontaneously. Sexual disorders, except for the sexual dysfunctions accompanying neuroleptic treatment, are not specific by their frequency or form. Sexual activity is often limited. Masturbation was seen as a replacement for sexual activity and as a means of reducing tension and anxiety. Impulsive sexual acts were not very frequent, but they can have as strong impact. In some cases an erotic transference from client towards his or her therapist occurs, which can assume a form of erotic delusions.
Volman and Landeen (2007) ⁶⁷ Canada	Examine how people with schizophrenia perceive and experience their sexuality	People with a diagnosis of schizophrenia (n=10): Male (n=5); female (n=5)	Individual interviews Constant comparison analysis	Grounded theory	People may integrate sexuality into a sense of self. Some people were able to maintain satisfying sexual relationships and to construct their own meaning of sexuality and articulate key issues and concerns. Implications for

					effective recovery are presented and 'opening the door' to discussions of sexuality. There is a need to integrate sexuality and intimacy into holistic care programs through rigorous psychosocial assessments and recovery plans. There needs to be a full evaluation of the interventions and the processes involved.
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Appendix III: Findings extracted from the included studies with illustrations

Ashmore T, Spangaro J, McNamara L. 'I was raped by Santa Claus': Responding to disclosures of sexual assault in mental health inpatient facilities. Int J Ment Health Nurs. 2015; 24(2):139-48.⁴⁷	
Finding	<i>Psychotic coloring of sexual abuse disclosure (C)</i>
Illustration	After spending 2 weeks in an acute inpatient unit in a psychotic state, Jay had been moved to subacute care, as she began to stabilize. Several days later, Jay returned to the unit after walking in the hospital grounds in a distressed

	state and told the nurses she had been 'raped by Santa Claus'. Staff assumed this was a regression of her psychosis, and initially dismissed her account. Following further investigation, eye witnesses reported seeing Jay with a groundsman who had a long white beard like Santa Claus. He was also recalled as wearing a red shirt that day. When confronted with this information, the groundsman admitted to having sex with Jay. (p.143)
Finding	<i>Delusional disclosures (C)</i>
Illustration	Cecily, 84 years old, was admitted to a general hospital after falling and breaking her hip. Following surgery, she reported that she had been abducted from her hospital bed and raped by men wearing masks. An investigation of staff, patients, and visitors present in the unit at the time was undertaken to ensure there were no times that abuse might have occurred. Clinicians spoke with Cecily about her fears and implemented actions to increase her sense of safety. Having excluded the possibility that sexual violence had occurred at that time, and taking into account age, prior mental state, and other manifested symptoms, post-general anaesthetic dementia was diagnosed. (p.143)
Baker AE, Procter NG. 'You Just Lose the People You Know': Relationship Loss and Mental Illness. Arch Psychiatr Nurs. 2015; 29(2):96-101.⁴⁸	
Finding	<i>Loss of intimate relationship (U)</i>
Illustration	...to do with loss of husband, marriage...everything I'd worked for...that all coincides with my illness because that was the cause of it.... (p.98)
Finding	<i>Loss of spouse or partner (U)</i>
Illustration	I lost my husband. He dropped me off and said he didn't want anything to do with me...he couldn't take care of me anymore because of my mental illness, which means I lost my whole hoke, everything. (p.98)
Finding	<i>Loss of children and parenthood (U)</i>
Illustration	...I lost him through death...but I lost a bit of time and freedom I had with him because I was put in a mother and baby home because people...didn't think I could care for him. (p.98)
Finding	Loss of family (C)
Illustration	I lost my sister-in-law's respect. She...couldn't handle the fact that I'd been in a psychiatric hospital...that nearly killed me...my sister-in-law's attitude. (p.98)
Finding	Loss of friends (C)
Illustration	Not only were they not...coming and seeing me, I stopped going and seeing them because I felt so depressed. (p.98)
Finding	Loss of people in the community (C)
Illustration	Sometimes my own mental illness caused a great deal of ...loss with the church when I started thinking that they're the devils in my house...I had religious delusions but the church couldn't see it as religious delusions. (p.98)
Ben-David S, Birnbaum ML, Eilenberg ME, DeVylder JE, Gill KE, Schienle J, Azimov N, Lukens EP, Davidson L, Corcoran CM. The subjective experience of youths at clinically high risk of psychosis: a qualitative study. Psychiatr Serv. 2014; 65(12):1499-501.⁴⁹	
Finding	<i>Gender differences and vulnerability of youth present clinical high risk (U)</i>
Illustration	Themes among males were - Feeling abnormal or "broken" - Focus on "going crazy" - Fantasy and escapism in video gaming - Alienation and despair, but with desire for relationships. Themes among women were; - Psychotic illness in family members - Personal trauma with more than half spontaneously

	brought up a history of trauma, including neglect, abuse, parental separation, and witnessing violence." - Struggle with intimate relationships - Career and personal development.
Brown SD, Reavey P, Kanyeredzi A, Batty R. Transformations of self and sexuality: psychologically modified experiences in the context of forensic mental health. Health. 2014;18(3):240-60.⁵⁰	
Finding	<i>Exclusion and not asking about sexuality issues (C)</i>
Illustration	"I think they feel uncomfortable talking in any, any depth about my sexuality. I don't think they've been trained to – I don't think that they, they have the erm.. the insight. I'm sure we could have a very sensitive discussion with them about it, but for some reason, there's a barrier and I can't understand why" (p.246)
Finding	<i>Territorialisation: Vulnerability and predation discourse (C)</i>
Illustration	"Sex is an organised act that two people come together and do – and they're going to do it wherever that is, you know, under a tree, at the end of a tunnel, they're still going to do it. Like, there's an old corridor. And there was a place where you hang your coats, where you can't see people when they looked down there. So I walked in and went to put my coat round there and they (two male patients) were having sex in the corner ... and it's not the first time they'd done that actually, they'd done it somewhere else as well". (p.248)
Finding	<i>Amputation- losing one's sexuality (C)</i>
Illustration	"I would say this place has amputated my sexuality. Definitely, it's – it's not my home, it's not – it's not a free environment and ... it's a – it's so anti-life. I just don't even think about sexuality in here and I grieve over that quite a lot. And ... I try and cope with this place on its own terms, you know and whatever it has to offer me I will engage with. So and try to make it a reality, its own reality but I still can't feel human enough to be a sexual being in this environment". (p.250)
Chandra PS, Deepthivarma S, Carey MP, Carey KB, Shalinianant MP. A cry from the darkness: women with severe mental illness in India reveal their experiences with sexual coercion. Psychiatry. 2003; 66(4):323-34.⁵¹	
Finding	<i>Adult sexual abuse (C)</i>
Illustration	"Three years ago I was in my sister's house for a few days. My brother-in-law is not all right. He is very crazy about women. I think even my sister is aware of this, but she keeps quiet. She has two children and has to bring them up. She does not work and that is why I think she is scared. He had an eye on me also. But I never realized. One day I was alone at home. My brother-in-law came. That day he got an opportunity. He did not care, however much I requested. He raped me." (22-year-old, psychosis) (p.328)
Finding	<i>Childhood sexual abuse (C)</i>
Illustration	"When I was 8 to 9 years old, my cousin came to our house. He was an adult at that time. He came behind me to a room where I went. It was dark there. He tried to grab me from behind. I just pushed him away and ran away from there. I found it bad, he was doing it with sexual feelings ... another incident I remember was when I was 4 to 5 years old, and a boy in the neighborhood used to come to my house. He was 10 to 12 years old. One day he said 'hold my penis and you will feel better.' I did not know what to do. I just held it and then left it and ran away." (42-year-old, obsessive-compulsive disorder) (p.328)
Finding	<i>Perpetrator of sexual abuse (C)</i>
Illustration	"Even in my mother's house my elder brother beat me up, asking me why I came here leaving my husband. I have bruises all over my body. Even when I

	was a kid be would bit me and sometimes when no one was there at home be would do thing like touching my breasts, vagina and make me touch his genitals and so on. I did not know anything at that time. I was scared of him. Hence I would keep quiet." (20-year-old, severe depression) (p.328)
Finding	<i>Context of sexual abuse (C)</i>
Illustration	"I bad become 'mental' at that time. I could not understand anything. I would go anywhere I liked and roam around. During that time many people have 'spoilt' me. Some would take me to the grove and would talk to me until it was dark and then would rape me and go away. They would get me eatables and take me to movies. I used to feel very happy. These kinds of things happened many times. I do not even know who they were and what they did. I was very crazy about clothes, eatables, and movies. If anybody got me those I would go with them." (28-year-old, bipolar disorder, mania with psychotic symptoms) (p.329)
Finding	<i>Reactions to coercive sex (U)</i>
Illustration	"My husband is a very strict man. I have to listen to him. Whenever he wants [sex], I have to agree, otherwise he will beat me up. I am scared that he may go to other women. What to do? Men can do anything. We women will have to do what they say. That is our fate. Sometimes I would cry and other times I would get angry. Now I have got used to all this." (30-year-old, bipolar, disorder with mania and psychotic symptoms) (p.329)
Cogan JC. The consumer as expert: Women with serious mental illness and their relationship-based needs. Psychiatr Rehabil J. 1998; 22(2):142.⁵²	
Finding	<i>Abuse within relationships (C)</i>
Illustration	"I have been threatened by men, but because they don't live with me I can't get a restraining order or relief from abuse. So they can basically do what they want." (p.147)
Finding	<i>Sex related issues (C)</i>
Illustration	"A lot of lesbian women are there [at a community mental health social club]. There's a lot of homophobia among the other clients and some of the staff." (p.147)
Finding	<i>Needs of mothers (U)</i>
Illustration	"Dealing with SRS [Social Rehabilitation Services] and the lies they tell you. My son is in SRS custody. My son's father threatened to kill me and my son. They turned it around and said that I threatened to kill him. They are abusing my child emotionally. They planned on taking my kid away immediately after he was born without even discussing it with me". (p.148)
Finding	<i>Mental illness as stigma: mothers on trial (C)</i>
Illustration	"If you are labeled mentally ill you can't take care of your kid. My son is not thriving in any foster home. He's lost weight. SRS has put a restraining order on me. I can't see my kid. I'm in legal stuff. I'm on my third judge and fifth lawyer. I need my son back. I am smart enough to know if I could take care of my son. If I couldn't I would put him up for adoption. I know how to take care of kids". (p.148)
Davison J, Huntington A. "Out of sight": Sexuality and women with enduring mental illness. Int J Ment Health Nurs. 2010; 19(4):240-9.⁵³	
Finding	<i>The effects of female socialization (C)</i>
Illustration	"Well, one of my biggest stumbling blocks was feeling like I always needed permission, permission to be a woman, and not validating myself, not feeling good about myself, to have a say . . . and feeling threatened. I always felt

	threatened that something was going to happen to me, I was gonna get the bash, or something like that". (p.244)
Finding	<i>The effects of stigma (C)</i>
Illustration	"I kind of had like a rule for myself that it wasn't something that I'd just tell anyone, but it wasn't a secret either. I felt when beginning a relationship, it was really important really early on to let the person know, and when I didn't feel they were going to run away because of it" (p.245)
Finding	<i>The effects of heteronormativity (C)</i>
Illustration	"Some of us we actually hid it, our sexual orientation, by trying to conform to what society wanted, by trying to be seen as having a partner of the opposite gender". (p.245)
de Jager J, Cirakoglu B, Nugter A, van Os J. Intimacy and its barriers: A qualitative exploration of intimacy and related struggles among people diagnosed with psychosis. Psychosis. 2017 Jun 1:1-9.⁵⁴	
Finding	<i>Relationship needs & intimacy (C)</i>
Illustration	"I'd love to be in a relationship again. (...) I can hardly even imagine what it would be like. It seems like a dream. (...) If you're single for 10 years, then you're just really lonely. That's just what it is". (Single, male, 38 years) (p.4)
Finding	<i>Self-stigma (C)</i>
Illustration	"The word psychosis will not come out of my mouth. If I were in a happy relationship, perhaps I would tell her at some point. If she would be very easy to talk to, I would tell her" (Divorced, male, 42 years). (p.6)
Finding	<i>Social skills and deficits (C)</i>
Illustration	"When I was younger, I let people walk over me. Or I would keep pushing my own boundaries. Especially with boys, I found it hard to say no. I kept wanting to please the other". (Single, female, 34 years) (p.6)
Finding	<i>Sexual abuse (C)</i>
Illustration	"I have been divorced for 28 years from my first husband but I have lain in bed with fear for 23 years." (Married, female, 57 years). (p.6)
Garrett NR. Treatment of a transgender client with schizophrenia in a public psychiatric milieu: A case study by a student therapist. J Gay Lesbian Ment Health. 2004; 8(3-4):127-41.⁵⁵	
Finding	<i>Double stigma (U)</i>
Illustration	M returned to the concern of having 'a double stigma' because of her psychiatric diagnosis and transgender status. Because she had rarely discussed her psychiatric illness in previous sessions, this comment seemed almost incongruent with the trend of recent thoughts. M now denied psychosis, and focused on depressive symptoms, but rationalized these as the result of other people's behavior toward her. (p.134)
Finding	<i>Importance of providing an understanding space (C)</i>
Illustration	"Psychotic people are so desperate for basic human relatedness and for hope that someone can relieve their misery that they are apt to be deferential and grateful to any therapist who does more than classify and medicate them." Understanding M, and not merely classifying her as a psychotic patient, had significant positive implications in her treatment". (p.135)
Finding	<i>Difficulty understanding the transgender process (U)</i>
Illustration	Possibly the most difficult area in M's treatment was understanding her identification as a male-to-female transgender person. Her understanding

	appeared concrete and immature, incomplete in some meaningful way. p137 When the therapist's anxiety regarding the disparity between M's transgender and mental illness concerns was confronted, a primary goal of treatment emerged. M wanted to be understood by others, and this appeared to be a projection of her need to understand herself. (p.137)
Granek L, Danan D, Bersudsky Y, Osher Y. Living with bipolar disorder: the impact on patients, spouses, and their marital relationship. Bipolar Disord. 2016; 18(2):192-9.⁵⁶	
Finding	<i>Emotional impact of SMI on spouses (U)</i>
Illustration	Throughout the interviews, both partners described dealing with symptoms of the disorder such as aggressiveness, impulsivity, compromised memory, psychotic incidents, personality changes, and severe episodes of depression and mania that included extreme hyperactivity and intense feelings of sorrow, sadness, and anxiety. (p.193). "I have to have my antennae out. And most of the time everything is fine... but every once in a while, I ask myself, is she escalating? And I watch her carefully for a day or two until I find that she's not, and then I relax again'. 'How can you live with this? It's so scary. You don't want to live like this... when he was hospitalized, I saw people here who are elders and you think to yourself, it's scary, very scary". (p.196)
Finding	<i>Self-sacrifice (U)</i>
Illustration	For spouses, sacrifices included giving up on having more children because of the patient's inability to participate fully in child raising; being chronically sleep deprived; giving up on their own pleasures in life (i.e., going out with friends, having hobbies, going to movies or dancing); and feeling as if they had no time or energy to think about themselves, or their own needs and wishes. (p.194)
Finding	<i>Caregiver burden (U)</i>
Illustration	Spouses described responsibilities that sometimes included the 'full-time job' of caring for the patient (i.e., medical appointments, ensuring treatment compliance, caring for the patient while hospitalized, etc.), occasionally being the sole financial provider in a context where medical care added expenses, and taking full responsibility for care of the house and children. Spouses reported other impacts including helplessness to assist the patient in the face of bipolar disorder; loneliness in coping with the effects of the disorder; embarrassment and shame at the partner's condition; anxiety and hypervigilance that the patient would relapse (p.194)
Finding	<i>Personal evolution (C)</i>
Illustration	Spouses described positive impacts including increased empathy and compassion towards others, a sense of resilience in dealing with life's hardships, and a sense of perspective on what is important in life. (p194)
Finding	<i>Difficulty accepting diagnosis (U)</i>
Illustration	Spouses described the difficulty of the patient in accepting the diagnosis and the subsequent changes that come with the condition, including treatment compliance and lifestyle changes to prevent relapses. (p194)
Greenall PV, Jellicoe-Jones L. Themes and risk of sexual violence among the mentally ill: implications for understanding and treatment. Sex Relation Ther. 2007; 22(3):323-37.⁵⁷	
Finding	<i>Anger or violence (C)</i>
Illustration	'Case 2 was hearing voices and thought he radio was talking to him. He was angry, irritable and hostile, and spoke of violent intentions towards others. He could not remember sexually assaulting two girls on public transport, but recalls drinking heavily beforehand' (p.329)

Finding	<i>Psychotic drive (C)</i>
Illustration	'Case 7 sat in a car armed with knives waiting for a particular type of woman to rape and murder. He has been acting like this for several weeks. This behaviour was apparently driven by voices in his head that instructed him to find rape and kill a woman. The thought of this excited him and had become incorporated into his sexual fantasies'. (p.330)
Finding	<i>Sexual disinhibition (C)</i>
Illustration	'Case 8 followed some girls and then indecently assaulted another girl he had just met, after which he followed her home and waited for her outside. His explanation was he was looking for love and he felt that he loved his victim and she was nice'. (p.330)
Finding	<i>Childhood sexual abuse (C)</i>
Illustration	'Case 11 indecently assaulted three children over several years. These assaults were reportedly related to periods of depression, low self-esteem and self-pity, deviant sexual fantasies of grooming and being alone with children, plus powerful rationalization that his actions would not harm his victims'. (p.331)
Kidd SA, Veltman A, Gately C, Chan KJ, Cohen JN. Lesbian, gay, and transgender persons with severe mental illness: Negotiating wellness in the context of multiple sources of stigma. Am J Psychiatr Rehabil. 2011; 14(1):13-39.⁵⁸	
Finding	<i>The emergence of stigma (U)</i>
Illustration	"People started to make fun of me. I started to get beat up sometimes...I think that people knew I was gay before I really knew myself."(p.23)
Finding	<i>Multiple sources of stigma (C)</i>
Illustration	"They had to call an ambulance for me. It was interesting because when I told the ambulance attendants about the Huntington's, they were very interested. But when they found out I have a mental illness, they stopped talking to me. I couldn't win no matter which way. If I go with Huntington's somebody might not know what it is and stop talking. If I go with mental illness, people back off. If I go with gay, people back off. It is like a triple-header. I couldn't win no matter which way". (p.25)
Finding	<i>Interactions between identities and mental illness (U)</i>
Illustration	"I could have cut somebody's head off, which went against myself as the "nice guy." But I knew it was there.... I stared at myself in the mirror thinking that I am really crazy. And that solidifies that I can no longer repress or pretend that I was somebody that I wasn't because it was just making me too hostile.... I am still thinking that it [maintaining sobriety] is going to take me a lot of effort after 40 years of drinking. That was my best friend in the loneliness of knowing you are different from everybody else". (p.26)
Finding	<i>Family as sources of strength (U)</i>
Illustration	"I guess I get my strength from my friends and from the few members of my family who support me and love me." "I am lucky to have a relationship with my dad...I know a lot of people with mental illness who don't have that kind of family connection, never mind being gay." (p.28)
Finding	<i>Psychiatric service settings and challenges (C)</i>
Illustration	"When you go into the unit you're already sick enough, you wouldn't be going into a unit if you weren't. You don't want to have to educate everybody...you're probably suicidal, you probably wish you were dead, and then you have to explain yourself all over again". (p.29)

Finding	<i>Psychiatric service settings and positives (C)</i>
Illustration	“Some staff did make me feel like a real person, a whole human being, and made it OK for me to talk about anything, including my girlfriend at the time.” One participant also spoke about the impact of having a provider tell her that she was a lesbian herself. “I felt it was nice that she did that. It made me feel less ashamed. It was because she is a nurse and she is gay and there is nothing wrong with that.” (p.31)
Martz D. Behavioral treatment for a female engaging in autoerotic asphyxiation. Clin Case Stud. 2003; 2(3):236-42.⁵⁹	
Finding	<i>Autoerotic asphyxiation occurs in women too and can be treated with exposure techniques (C)</i>
Illustration	“This case study presents a 22-year-old college female with comorbid depression and avoidant personality disorder complaining of the use of autoerotic asphyxiation during masturbation.” (p.236) “After the 10 exposure sessions, Sue reported that the fantasy was diminished during masturbation and consequently she had ceased use of asphyxiation.” “It suggests that this behavior succumbs to behavioral contingencies much like any normal sexual behavior. Use of an exposure technique can be used to extinguish the power of such a taboo and forbidden behavior so as to render it impotent.” (p.240)
Finding	<i>Screening for auto asphyxiation and safety procedures (C)</i>
Illustration	“Due to the life-threatening nature of this behavior, psychotherapists should regularly screen for this practice in their clients. Furthermore, if a client is performing such a behavior, the therapist should ensure that he/she has designed the ligature in a failsafe manner until the behavior is extinguished.” (p.241)
McCann E. The expression of sexuality in people with psychosis: breaking the taboos. J Adv Nurs. 2000; 32(1):132-8.⁶⁰	
Finding	<i>Need for social skills training for clients leaving hospital (C)</i>
Illustration	‘Judging by the responses, a majority would like more opportunities to meet people and develop social skills away from the institution’. (p.135)
Finding	<i>Decline in sexual activity to do with being in hospital (C)</i>
Illustration	Sex relations had stopped for three-quarters of respondents since being hospitalized. When asked why sexual relations had stopped, the following reasons were given: illness of self (four); lost interest myself (four); lack of opportunity (five); no privacy (three); in hospital (six). (p.135)
McCann E. Investigating mental health service user views regarding sexual and relationship issues. J Psychiatr Ment Health Nurs. 2010; 17(3):251-9.⁶²	
Finding	<i>People are able and willing to talk about intimacy (U)</i>
Illustration	‘Nevertheless, all of the participants were able to articulate their views of intimacy and mentioned aspects such as love, closeness and caring’. (p.253)
Finding	<i>The formation of relationships is challenging but important for most (U)</i>
Illustration	“Of the 30 participants, only one respondent said he had never been in a relationship. Three men and nine women were currently in a relationship. People were able to expand on their experiences and some of the challenges they face in forming and maintaining relationships. (p.253)
Finding	<i>Privacy often lacking in mental health settings (C)</i>

Illustration	"There is no privacy around here. There's not much chance to have sex. We're under the staff. Staff just come into the room, they don't bother to knock. I have no one to talk to about this stuff and I get worried that I may harm her."
Finding	<i>Self-stigma is a barrier in the formation of intimacy (C)</i>
Illustration	"I am reluctant [to approach women] because I'm afraid they all know that I am not well. I am very reluctant to go next to my own Kurdish people because of the shame I feel." (p.254)
Finding	<i>SMI can lead to insecurities about family planning (U)</i>
Illustration	"I'd really like to have children, but maybe it's too late now. We're trapped in this place. I'd like us both to live together in a flat in London. Could we have children? I don't know" (p.254)
Finding	<i>Sexual side effects of medication can be a barrier in sexual expression (C)</i>
Illustration	"It sometimes stopped me from having sex because I cannot relax to do sexual movements. I get stiffness in my arms and legs. Slowness too, and it does something to the muscles, I was like with myself the other day and couldn't make it hard, like a few days ago like I could swear it can stop you sex life completely." (p.254)
McCann TV, Clark E. Embodiment of severe and enduring mental illness: Finding meaning in schizophrenia. Issues Ment Health Nurs. 2004; 25(8):783-98.⁶¹	
Finding	Living with SMI challenging (U)
Illustration	"For many participants, schizophrenia was a devastating experience that made the future even more unpredictable. They felt alarmed because they could see no future beyond their immediate illness experience." (p.788)
Finding	<i>Feelings of guilt, embarrassment and poor self-confidence during acute episode of psychosis (U)</i>
Illustration	"For example, Martin limited his social activities because of his embarrassment about the illness: "When it was my friend's 21st birthday party last Saturday....I had to tell him I couldn't go." (p.788)
Finding	<i>Relationships as problematic (C)</i>
Illustration	"The data show that the embodiment of schizophrenia had a paradoxical effect on social relationships, sometimes eliciting support while at other times damaging relationships." (p.789)
Finding	<i>Spirituality as an important support (C)</i>
Illustration	"Spirituality provided a means of support in striving to cope with the experience of schizophrenia." (p.789)
Östman M, Björkman AC. Schizophrenia and relationships: the effect of mental illness on sexuality. Clin Schizophr Relat Psychoses. 2013; 7(1):20-4.⁶³	
Finding	<i>Relationships outweigh sexuality (U)</i>
Illustration	The patients' narratives told of bad or non-existent sexual relationships, with some patients and partners having experienced no sexual intercourse at all. Some reported no sexual activity in their relationship for 8 months, 2 years, and even 7 years. Both patients and partners indicated that they had had a much healthier sex life before the onset of the illness. Some patients related with delight how they had experienced sexuality earlier and actively partook in it. (p.22)
Finding	<i>Uncertainties about one's capacity (U)</i>
Illustration	The narratives of patients often included worries about being unable to lead a life in which healthy sexuality played a part. They wondered whether they still

	had the capacity for sexual activity and could give their partner satisfaction in a sexual relationship. (p.22)
Finding	<i>Sexual fantasies, feelings of desire and satisfaction (C)</i>
Illustration	The patients we interviewed experienced a failure to achieve satisfaction during sexual intercourse. Some longed for the ability to achieve orgasm. Others claimed that they were incapable of feeling anything at all: neither desire nor satisfaction, whether they were aroused or not. One patient, who had been sexually abused as a child, told of how those experiences had impacted her thoughts and behavior, leaving her with feelings of inappropriateness, dirtiness, and embarrassment about sexual matters. (p.22)
Finding	<i>Need to talk about support in sexual matters (C)</i>
Illustration	We found that patients and partners do not regularly communicate with each other about issues related to their sexual relationship. However, patients have said that they do speak with close friends and relatives about their sex life and their feelings of dysfunctionality (p.23)
Finding	<i>The attitude of mental health medical personnel (U)</i>
Illustration	The first step in remedying the situation is to increase the awareness of mental health professionals in this regard, something that can be accomplished by more staff training in sexual matters and greater personal supervision of those providing treatment. (p.23)
Quinn C, Happell B. Exploring sexual risks in a forensic mental health hospital: Perspectives from patients and nurses. Issues Ment Health Nurs. 2015; 36(9):669-77.⁶⁴	
Finding	<i>Sexual safety problematic for forensic group due to specific problems (C)</i>
Illustration	“There is always the risk of sexual assault, especially given the offending histories of our patients. . . . Sometimes they might get involved above their capabilities and out of their comfort zone and be pressured into having sex” (p. 671) “Some patients need protecting, some are sick you know” (p.673) “I know some blokes will force themselves on some of the females. I’ve heard that blokes stand over the girls and I’ve heard that male patients give the female patients money for sex” (p.674)
Finding	<i>The assessment of sexual abuse by nurses is insufficient (C)</i>
Illustration	It’s possible that the abuser might be so dominant that the victim might be too afraid to identify the abuse out of fear from the abuser or lack of belief from staff. Distrust from staff occurs, and so why would you identify abuse occurring if you’re simply not heard. We have a lot of female patients here who have trauma histories and we don’t want to open old wounds because they are too frightened to speak out and say I really didn’t want that to happen. So that’s something we do not do. (p. 672)
Finding	<i>Female patients encouraged to take contraception as precaution (C)</i>
Illustration	“If someone was to become pregnant, the whole trauma of having a child, childbirth, the whole aspect of this would just be totally unmanageable. . . . We get them to see the GP and we start them on the pill. They don’t have any choice in it. It’s for the best” (p.672) “Physically and chemically it would be a major concern because genetically two people with schizophrenia having a baby together there is a very high probability that that baby is going to have schizophrenia” (p.673)
Finding	<i>Male patients in hospital may have sex with other males without being gay (C)</i>

Illustration	<p>“Because of the environment, they have been indulging in homosexual activity. Which I possibly think is not the way they are orientated, but is due to the abnormal environment “(p.672)</p> <p>“My understanding is that the guys who are gay aren’t really gay. It’s just that they can’t get into bed with a woman. They get frustrated and turn gay because there are no women around . . . that’s why a lot of them turn gay in prison. It’s their only option” (p.674).</p>
Finding	<i>Coming out as gay risky in hospital context (C)</i>
Illustration	<p>“This patient brought up that he might be gay, and didn’t want anyone else to know because he didn’t want to be picked on, ridiculed, or raped”. (p. 673)</p> <p>“And then there is the issue of what happens if one of our guys are picked up on a gay beat? Imagine the headlines and imagine the implications for this place” (p.673).</p>
Redmond C, Larkin M, Harrop C. The personal meaning of romantic relationships for young people with psychosis. Clin Child Psychol Psychiatry. 2010; 15(2):151-70.⁶⁵	
Finding	<i>Illness as incompatible with sexuality (U)</i>
Illustration	<p>“It’s really difficult as a mentally ill person to actually meet people who I feel/ ’cos mental illness is ... don’t know if this is right but a lot of people my age haven’t had any kind of ... so I feel quite isolated in that respect” (p.158)</p>
Finding	<i>Relationships as normalizing (C)</i>
Illustration	<p>“I think they’d be pleased for me ’cos I found someone ... I’m not just hiding behind my mental health problems ... I’m getting on with life and doing things just like any other young woman” (p159)</p>
Finding	<i>Lack of experience and resources (C)</i>
Illustration	<p>“The thing is nobody ever said, you’re single, how do you? What do you do about it? How do you go about being/ I mean obviously you talk to somebody these days off the road ... they start walking away from you, get intimidated by you, you know....You get all ... you feel upset” (Ali) (p163)</p>
Škodlar B, Žunter Nagy M. Sexuality and psychosis. Psychiatr Danub. 2009; 21(1):111-6.⁶⁶	
Finding	<i>People with psychosis are willing and able to talk about their sexuality and it’s safe to do so</i>
Illustration	<p>“Patients with psychosis are willing, ready and even thankful if they are given the opportunity to talk about their sexuality. They have no problem discussing their wishes and fantasies, regardless whether they are heterosexual, homosexual or unusual, and their overt sexual activities, be it masturbatory or with others” (p.112)</p>
Finding	<i>Non-specificity of sexual disorders in psychotic patients (C)</i>
Illustration	<p>“Sexual disorders, except for the sexual dysfunctions accompanying neuroleptic treatment, are not specific by their frequency or forms.” “However as already stated their frequency does not exceed the frequency of sexual problems of other patients” (p.112)</p>
Finding	<i>Difficulties in establishing a stable sexual identity and questioning one’s own sexual orientation (C)</i>
Illustration	<p>“They feel themselves as being changeable in behavior, speech and gesture through associating with different people. They can feel also empty of a sense of self or inner hold and they cannot assume a firm stance about anything. So, in the same way sexual attraction and sexual identity are at stake as well.</p>

	Patients can feel attracted to both sexes or even to people of different age-groups, and they can be confused in this respect" (p.112)
Finding	<i>Feelings of guilt (C)</i>
Illustration	"One of the general characteristics of the sexual life of psychotic patients with other people is that it is absent for different reasons. The common denominator is difficulties in regulating closeness." "Patients attribute to themselves and feel responsible for everything which they lack and cannot achieve. They feel inadequate both as sexual performers and partners as well as guilty for this inadequacy" (p.113)
Finding	<i>Masturbation as stress relief (C)</i>
Illustration	"Masturbation may represent a central sexual activity of a patient as it serves as a replacement for sexual activity with another and as a means of reducing tension and anxiety" (p.113)
Finding	<i>Erotic transference from client to therapist can occur (C)</i>
Illustration	In some cases an erotic transference from client towards his or her therapist occurs, which can assume a form of erotic delusions" (p.113)
Finding	<i>Impulsive sex acts can happen (C)</i>
Illustration	"Impulsive sexual acts are not very frequent, but they make a strong impact. Patients can grab sexual organs of other patients or of the staff members, they can behave promiscuously, or can enter sexual intercourse in public or not hidden places" (p.113)
Volman L, Landeen J. Uncovering the sexual self in people with schizophrenia. J Psychiatr Ment Health Nurs. 2007; 14(4):411-7.⁶⁷	
Finding	<i>Personal definitions, seeking satisfaction, searching for meaning (U)</i>
Illustration	"It's all about relationships- loving relationships, companionship, and trust". (p.413)
Finding	<i>My sexuality and my illness; struggling self-image, adjusting to changes in sexual function, wanting intimacy, not feeling like a whole person (U)</i>
Illustration	"He tells me that he loves me, and that I'm a good person. [He also tells me] that I am beautiful and that I have a good soul. My friends tell me that too. It makes me feel alright, but the voices tell me different" (p.414)
Finding	<i>Managing the impact; regaining control, testing boundaries, perspective, opportunities and reclaiming a positive self-image (U)</i>
Illustration	"[The illness affected my sexuality] in a negative way, of course. But it takes faith to have the full experience of life even if you have something working against you. You can live with things that are negative and somehow those negative things work out eventually" (p.415)

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1320 **Appendix IV: JBI definitions of levels of credibility**

1321 Unequivocal (U): findings accompanied by an illustration that is beyond reasonable doubt and
1322 therefore not open to challenge.

1323 Credible (C): findings accompanied by an illustration lacking clear association with it and therefore
1324 open to challenge.

1325 Unsupported (Un): findings not supported by data. (JBI, 2014, p.40)⁴⁶

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1359 **Appendix V: Excluded studies**

1360 The following studies did not meet the predefined inclusion criteria and were excluded from the final
1361 review.

1362
1363 à Campo J, Nijman H, Merckelbach HL, Evers C. Psychiatric comorbidity of gender identity disorders:
1364 a survey among Dutch psychiatrists. *Am J Psychiatry*. 2003; 160(7):1332-6.

1365 *Reason for exclusion: Wrong study design*

1366

1367 Acuña MJ, Martín JC, Graciani M, Cruces A, Gotor F. A comparative study of the sexual function of
1368 institutionalized patients with schizophrenia. *J Sex Med*. 2010; 7(10):3414-23.

1369 *Reason for exclusion: Wrong study design*

1370

1371 Aizenberg D, Zemishlany Z, Dorfman-Etrog P, Weizman A. Sexual dysfunction in male schizophrenic
1372 patients. *J Clin Psychiatry*. 1995; 56(4):137-141.

1373 *Reason for exclusion: Non-retrievable*

1374

1375 Allen DJ. The role of personality and defense mechanisms in the adjustment to a homosexual identity.
1376 *J Homosex*. 2002; 42(2):45-62.

1377 *Reason for exclusion: Wrong patient population*

1378

1379 Amoo G. Zoophilic recidivism in schizophrenia: a case report. *Afr J Psychiatry*. 2012;15(4):223-225

1380 *Reason for exclusion: Wrong study design*

1381

1382 Apantaku-Olajide T, Gibbons P, Higgins A. Drug-induced sexual dysfunction and mental health
1383 patients' attitude to psychotropic medications. *Sex Relation Ther*. 2011; 26(2):145-55.

1384 *Reason for exclusion: Wrong study design*

1385

1386 Azariah S, Coverdale J. How sexual health clinics address the needs of patients with major mental
1387 disorders: an Australasian survey. *Venereology*. 2001;14(3):105.

1388 *Reason for exclusion: Wrong study design*

1389

1390 Bai YM, Huang Y, Lin CC, Chen JY. Emerging homosexual conduct during hospitalization among
1391 chronic schizophrenia patients. *Acta Psychiatr Scand*. 2000; 102(5):350-353.

1392 *Reason for exclusion: Wrong study design*

1393

1394 Biaggio M, Rodes LA, Staffelbach D, Cardinali J, Duffy R. Clinical evaluations: Impact of sexual
1395 orientation, gender, and gender role. *J Appl Soc Psychol*. 2000; 30(8):1657-1669.

1396 *Reason for exclusion: Wrong phenomena*

1397

1398 Bitzer J, Platano G, Tschudin S, Alder J. Education: Sexual Counseling for Women in the Context of
1399 Physical Diseases—A Teaching Model for Physicians. *J Sex Med*. 2007; 4(1):29-37.

1400 *Reason for exclusion: Wrong phenomena*
1401
1402 Black DW, Kehrberg LL, Flumerfelt DL, Schlosser SS. Characteristics of 36 subjects reporting
1403 compulsive sexual behavior. Am J Psychiatry. 1997; 154(2):243.
1404 *Reason for exclusion: Wrong patient population*
1405
1406 Bonfils KA, Firmin RL, Salyers MP, Wright ER. Sexuality and intimacy among people living with
1407 serious mental illnesses: Factors contributing to sexual activity. Psychiatr Rehabil J. 2015; 38(3):249.
1408 *Reason for exclusion: Wrong study design*
1409
1410 Bouchard S, Godbout N, Sabourin S. Sexual attitudes and activities in women with borderline
1411 personality disorder involved in romantic relationships. J Sex Marital Ther. 2009; 35(2):106-21.
1412 *Reason for exclusion: Wrong study design*
1413
1414 Boyda D, McFeeters D, Shevlin M. Intimate partner violence, sexual abuse, and the mediating role of
1415 loneliness on psychosis. Psychosis. 2015; 7(1):1-3.
1416 *Reason for exclusion: Wrong study design*
1417
1418 Brotto LA, Knudson G, Inskip J, Rhodes K, Erskine Y. Asexuality: A mixed-methods approach. Arch
1419 Sex Behav. 2010; 39(3):599-618.
1420 *Reason for exclusion: Wrong study design*
1421
1422 Brown A, Lubman DI, Paxton S. Sexual risk behaviour in young people with first episode psychosis.
1423 Early Interv Psychiatry. 2010; 4(3):234-42.
1424 *Reason for exclusion: Wrong phenomena*
1425
1426 Brown AP, Lubman DI, Paxton SJ. Psychosocial risk factors for inconsistent condom use in young
1427 people with first episode psychosis. Community Ment Health J. 2011; 47(6):679-87.
1428 *Reason for exclusion: Wrong study design*
1429
1430 Brown A, Lubman DI, Paxton SJ. Reducing sexually-transmitted infection risk in young people with
1431 first-episode psychosis. Int J Ment Health Nurs. 2011; 20(1):12-20.
1432 *Reason for exclusion: Wrong study design*
1433
1434 Chanen A, Jovev M, Betts J, Nyathi Y, Smith A, Pitts M, Stabolidis A, Thompson K. The sexual health
1435 and relationships of young people with borderline personality pathology. Early Interv Psychiatry 2016;
1436 10:83-83.
1437 *Reason for exclusion: Wrong study design*
1438

1439 Coverdale JH, Turbott SH, Roberts H. Family planning needs and STD risk behaviours of female
1440 psychiatric out-patients. BJ Psychiatry. 1997;171(1):69-72.
1441 *Reason for exclusion: Wrong study design*
1442

1443 Coverdale JH, Turbott SH. Risk behaviors for sexually transmitted infections among men with mental
1444 disorders. Psychiatr Serv. 2000; 51(2):234-8.
1445 *Reason for exclusion: Wrong study design*
1446

1447 Cummings SM, Cassie KM. Perceptions of biopsychosocial services needs among older adults with
1448 severe mental illness: Met and unmet needs. Health Soc Work. 2008;33(2):133-43.
1449 *Reason for exclusion: Wrong patient population*
1450

1451 Dardennes R, Al Anbar N, Rouillon F. Episodic sexual addiction in a depressed woman treated with
1452 Cyproterone Acetate. J Clin Psychopharmacol. 2013; 33(2):274-6.
1453 *Reason for exclusion: Wrong phenomena*
1454

1455 de Boer MK, Castelein S, Wiersma D, Schoevers RA, Knegtering H. A systematic review of
1456 instruments to measure sexual functioning in patients using antipsychotics. J Sex Res. 2014;
1457 51(4):383-9.
1458 *Reason for exclusion: Wrong study design*
1459

1460 Dein KE, Williams PS, Volkonskaia I, Kanyeredzi A, Reavey P, Leavey G. Examining professionals'
1461 perspectives on sexuality for service users of a forensic psychiatry unit. Int J of Law Psychiatry. 2016;
1462 44:15-23.
1463 *Reason for exclusion: Wrong patient population*
1464

1465 De Luca M, Chenivresse P. Psychosis and Fetishist relationships: a case study. Evolution
1466 Psychiatrique. 2003; 68(4):551-62.
1467 *Reason for exclusion: Wrong language*
1468

1469 Dickerson FB, Brown CH, Kreyenbuhl J, Goldberg RW, Fang LJ, Dixon LB. Sexual and reproductive
1470 behaviors among persons with mental illness. Psychiatr Serv. 2004; 55(11):1299-301.
1471 *Reason for exclusion: Wrong study design*
1472

1473 Elkington KS, McKinnon K, Mann CG, Collins PY, Leu CS, Wainberg ML. Perceived mental illness
1474 stigma and HIV risk behaviors among adult psychiatric outpatients in Rio de Janeiro, Brazil.
1475 Community Ment Health J. 2010; 46(1):56-64.
1476 *Reason for exclusion: Wrong study design*
1477

1478 Eklund M, Östman M. Belonging and doing: important factors for satisfaction with sexual relations as
1479 perceived by people with persistent mental illness. *Int J Soc Psychiatry*. 2010; 56(4):336-47.
1480 *Reason for exclusion: Wrong study design*
1481

1482 Fuoco M, Cox L, Kinahan T. Penile amputation and successful reattachment and the role of winter
1483 shunt in postoperative viability: A case report and literature review. *Can Urol Assoc J*. 2015; 9(5-
1484 6):E297.
1485 *Reason for exclusion: Wrong phenomena*
1486

1487 Gonzalez-Torres MA, Salazar MA, Inchausti L, Ibañez B, Pastor J, Gonzalez G, Carvajal MJ,
1488 Fernandez-Rivas A, Madrazo A, Ruiz E, Basterreche E. Lifetime sexual behavior of psychiatric
1489 inpatients. *J Sex Med*. 2010; 7(9):3045-56.
1490 *Reason for exclusion: Wrong study design*
1491

1492 Goodman LA, Rosenberg SD, Mueser KT, Drake RE. Physical and sexual assault history in women
1493 with serious mental illness: prevalence, correlates, treatment, and future research directions.
1494 *Schizophr Bull*. 1997; 23(4):685.
1495 *Reason for exclusion: Wrong study design*
1496

1497 Granstein J, Strimbu K, Francois D, Kahn DA. An Unusual Case of Erotomania and Delusional
1498 Misidentification Syndrome. *J Psychiatr Pract*. 2015;21(4):306-12.
1499 *Reason for exclusion: Wrong phenomena*
1500

1501 Hariri AG, Karadag F, Gurol DT, Aksoy UM, Tezcan AE. Sexual problems in a sample of the Turkish
1502 psychiatric population. *Compr psychiatry*. 2009; 50(4):353-60.
1503 *Reason for exclusion: Wrong study design*
1504

1505 Harley EW, Boardman J, Craig T. Sexual problems in schizophrenia: prevalence and characteristics.
1506 A cross sectional survey. *Soc Psychiatry Psychiatr Epidemiol*. 2010;45(7):759-66.
1507 *Reason for exclusion: Wrong study design*
1508

1509 Higgins A, Barker P, Begley CM. Iatrogenic sexual dysfunction and the protective withholding of
1510 information: in whose best interest? *J Psychiatr Ment Health Nurs*. 2006; 13(4):437-46.
1511 *Reason for exclusion: Wrong patient population*
1512

1513 Hui CL, Poon VW, Ko WT, Miao HY, Chang WC, Lee EH, Chan SK, Lin J, Chen EY. Risk factors for
1514 antipsychotic medication non-adherence behaviors and attitudes in adult-onset psychosis. *Schizophr*
1515 *Res*. 2016; 174(1):144-9.
1516 *Reason for exclusion: Wrong study design*
1517

1518 Incedere A, Küçük L. Sexual life and associated factors in psychiatric patients. *Sex Disabil.* 2017;
1519 35(1):89-106.
1520 *Reason for exclusion: Wrong study design*
1521

1522 Jensen HM, Poulsen HD. Auto-vampirism in schizophrenia. *Nord J Psychiatry.* 2002; 56(1):47-8.
1523 *Reason for exclusion: Wrong phenomena*
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% 'yes' responses	48	90	100	95	100	38	38	86	90	100
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Y = yes; N = no; U = unclear

Y=yes, indicates a clear statement appears in the paper which directly answers the question;
N=no, indicates the question has been directly answered in the negative in the paper;
U= unclear, indicates there is no clear statement in the paper that answers the question or there is ambiguous information presented in the paper; N/A = not applicable, indicating that the question did not apply to the study being assessed.

Critical appraisal questions for comparable qualitative studies were as follows:

1. Is there congruity between the stated philosophical perspective and the research methodology?
2. Is there congruity between the research methodology and the research question or objectives?
3. Is there congruity between the research methodology and the methods used to collect data?
4. Is there congruity between the research methodology and the representation and analysis of data?
5. Is there congruity between the research methodology and the interpretation of results?
6. Is there a statement locating the researcher culturally or theoretically?
7. Is the influence of the researcher on the research, and vice- versa, addressed?
8. Are participants, and their voices, adequately represented?
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?