Exploring sexual and relationship possibilities for people with psychosis – a review of the literature

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Abstract

This review examines the literature on sex and relationship issues in the context of serious and persistent mental health problems. It identifies gaps in the research and high- lights key issues needing further investigation. The available published documents have been identified, which contain information, ideas, data and evidence on the topic. A critical analysis of the subject, through the examination of the various documents, is pro- vided. The main themes that emerged included HIV/AIDS, medication and sexual dysfunction, sexuality needs, intimate relationships, family planning, policies and sex education. Several subthemes are discussed and include needs assessment, stigma and loneliness. The key findings highlight the lack of systematic studies in the UK, especially regarding the subjective views of patients in determining need and the subsequent devel- opment of appropriate plans of care. The author argues that future mental health research needs to go beyond investigating perceived 'risky' behaviours and should include potential therapeutic responses in all areas of sexuality. Further recommendations are made in terms of nurse education particularly the inclusion of psychosexual aspects in future pre- and postregistration curricula. This paper may be of interest to ser- vice users, mental health practitioners working alongside people with serious and persistent mental health problems as well as educators, researchers and policy makers.

Keywords: HIV/ AIDS, psychosis, relationships, schizophrenia, sexuality

Introduction

There is a lack of published literature regarding sexual and relationship need

and serious mental illness. This is despite the fact that 1% of the population worldwide suffers from schizophrenia (Kaplan 1992), an illness which can have a devastating effect on interpersonal and social relationships, as well as on libido (Bancroft 1989). Twelve per cent of the entire National Health Service budget in the UK is spent on the provision of mental health services including services for people suffering from psychosis (Sheppard 1995). It is unclear how much of this is allocated to sexual disorders, needs, problems and difficulties in intimate relationships. The number of papers in journals does not suggest that this topic has a high priority (Carr 1996, Earle 2001).

Since the introduction of the *NHS and Community Care Act* (Department of Health 1990a) and the *Care Pro- gramme Approach* (Department of Health 1990b) in the UK, more attention has been paid to detailed and holistic assessments of the needs of all individuals suffering from severe and enduring mental illnesses. Priorities include housing, occupation, medical and psychiatric care, social- ization and risk assessment. The intimate sexual and inter- personal needs of affected individuals have only recently emerged as a legitimate concern for carers (Lewis & Scott 1997). *The Health of the Nation* (Department of Health 1992) targets compartmentalized sexual health and mental health as separate and distinct entities. The former concen- trated on teenage pregnancies and sexually transmitted dis- eases and the latter aimed to reduce suicides (Adler 1997). While these targets seem laudable for the whole UK pop- ulation, the sexual needs of individuals with psychosis appear to have been marginalized. In the UK, the *National Survey of Sexual Attitudes and Lifestyles* (Wellings *et al*. 1994), one of the largest sexual studies since the *Kinsey Report* (Kinsey *et al*. 1948), only referred to physical health. More recent publications have outlined government strategies which aim to tackle issues pertinent to users, car- ers, and significant others regarding mental health provi- sion through the *National Service Frameworks* and *Our Healthier Nation* (Department of Health 1999a,b). Addi- tionally, the government has published a national strategy for sexual health and HIV (Department of Health 2001). However, despite these initiatives, plans of care do not nor- mally include an assessment of sex and relationship need. Psychosexual interventions are not usually offered and in light of the emergence of a younger group of people with quite different expectations around sex and relationship issues; this poses new challenges for mental health profes- sionals. Many of these individuals are striving for a 'nor- mal' life in the community (d'Ardenne & McCann 1997). Nevertheless, public perception of schizophrenia reveals widespread ignorance and prejudice (Rowlands 1995). Some would argue that many cultural taboos remain in addressing sexuality with vulnerable people, and where cli- nicians do wish to help deal with intimate need, they may be reluctant to publish their views or findings (di Mauro 1995).

The agenda remains large and relatively unexplored. In relation to sexual and relationship issues, examples in everyday practice include: limited social access and social skill; low self image and confidence; poor self care, includ- ing hygiene and

health; poverty and its links past and present with prostitution and exploitation; sexual abuse in childhood and adulthood; the sexual content of hallucina- tions and delusions; sexual disinhibition and risk to self and others; the effects of psychotropic medications on libido; the secondary effects of medication – including extrapyramidal symptoms; hospital policies and the expression of sexual need in institutional semi-public set- tings; the lack of privacy – even in supported community hostels and housing; education and consent; safe-sex and contraception (Birley & Hudson 1991, McCulloch *et al*. 1992, Miller & Finnerty 1996, Attenborough & Watson1997, Coverdale *et al*. 1997, McFarlane 1997, Walkup *et al*. 1999).

Method

The literature considered in the review was accessed using Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsycLIT and Medline databases.

1. *CINAHL* (1982–2000) The application of keywords sex$ or intimacy and schizophrenia or psychosis revealed 100 hits.
2. *PsycLIT* (1991–2000) The use of keywords sex$ or inti- macy and schizophrenia or psychosis revealed 1183 records. A language and data limit was used to further reduce the search, for example, human, English only, journal articles, 18 years and older. This was gradually reduced to 35 records.
3. *Medline* (1966–2000) Keyword inputs of sex$ or inti- macy revealed 11 744 hits and schizophrenia or psycho- sis gave 11 055 hits. Combining the two produced 111 papers. The language and data limit procedure used in PsycLIT was applied and revealed 46 articles.

Results from the various electronic searches totalled 181. These were checked and duplicate articles identified and excluded. The remaining 156 articles that addressed sexuality issues and psychosis were logged and classified. An indexed bibliography of all the articles is available from the author. The review process was guided by methods used in the research literature (Gould 1994). A critical analysis of each paper involved a visual search for themes that were categorized. A total of eight key themes and a number of subthemes emerged from the review of the identified papers and are illustrated in Fig. 1. These themes are used as a framework to discuss the content of the published papers.

HIV/AIDS and serious mental illness

Recent studies, mainly in the USA, have examined the prev- alence of HIV-risk behaviours among chronic mentally ill adults. The impetus behind the studies was recognition of the potential for the rapid spread of HIV among psychiatric populations (Goisman *et al*. 1991, Kelly *et al*. 1992, Cournos *et*

al. 1993, Kalichman *et al*. 1994, Grassi *et al*. 1999).

HIV-risk behaviours and psychiatric patients

Most of the papers located (*n* □ 43) concerned studies undertaken in the USA. There were no available data from the UK. Twenty studies examined HIV-risk behaviours and seropositivity in people with mental health problems, pre- dominately people with schizophrenia. A growing number of studies, particularly in the USA, have shown an increased risk of HIV infection in psychiatric patients in both community and inpatient settings (McKinnon *et al*. 1993, Herman *et al*. 1994, McDermott *et al*. 1994, Got- tesman & Groome 1997). Furthermore, HIV seropreva- lence rates have been shown to be significantly higher in those with serious mental illness compared to the general population (Susser *et al*. 1993, Volvka *et al*. 1991). Grassi (1996) suggests that people with mental illness have been neglected as potential 'victims of HIV infection'. According to Checkley *et al*. (1996), by far the greatest risk of infec- tion would appear to be illicit drug use and unprotected sexual activity. Perhaps not surprising, as these are impor- tant risk factors within the general population also. According to Buckley *et al*. (1996), the closure of psychi- atric hospitals and the drive towards community living may increase the vulnerability factors associated with HIV/ AIDS including mixing with high-risk populations. As such, the mentally ill may then be viewed as a high-risk group. With reference to risk studies, most interest would appear to be from a public health viewpoint (di Mauro 1995). However, health professionals may need to exercise caution in their exploration of this topic. It involves dealing with a group of people who are not only generally per- ceived as forgotten, disenfranchized and marginalized, but also stigmatized, vulnerable and socially disadvantaged (Grassi *et al*. 1999). It could be argued that care should be taken to avoid further discrimination on the grounds of perceived 'threat' to the general public. The burning issue is whether this vulnerable section of society is at greater risk of infection than the general pop- ulation and whether there is a need to operationalize early detection, risk reduction, education, counselling, preven- tion and intervention strategies (Knox *et al*. 1994, Sacks *et al*. 1994, McKinnon *et al*. 1996).

Knowledge about HIV/AIDS

Some studies demonstrated that patients wanted more information about HIV/AIDS and the potential risks involved in sexual activity (Katz *et al*. 1994, Sacks *et al*. 1994). Katz *et al*. (1996) looked at needs around AIDS education and training and recognized shortfalls in knowl- edge regarding risk. In this particular study, psychoeduca- tion, including sexual risk, was effective in increasing knowledge and the recognition of increased risky situa- tions. Kalichman *et al*. (1994) evaluated a four-session HIV/AIDS prevention project. The programme included risk education,

sexual assertiveness techniques, condom use and behavioural self-management. The interventions proved effective in reducing unprotected sexual intercourse in the sample. Furthermore, Seeman *et al*. (1990) have argued for comprehensive preventative education pro- grammes that are flexible and responsive to individuals needs. The authors proposed that any therapeutic interven- tions should be provided within an assertive community treatment framework. Grassi (1996) recognized the need for an evaluation of high-risk behaviour in psychiatric pop- ulations and called for the use of structured interviews to elicit factors related to sexuality and sexual behaviour (e.g. condom use, multiple partners, substance abuse). The author recommended routinely testing psychiatric patients for antibodies but identified ethical and clinical dilemmas that include potential psychological damage and increased discrimination against patients. This, he argued, must be weighed against potential benefits such as initiating preven- tative measures, early detection, counselling and treatment.

Sexual problems

Medication

Schizophrenia is normally treated with neuroleptic drugs and although 70% of patients show improvement in psy- chotic symptomatology, many still experience distressing and recurrent symptoms (Curson *et al*. 1988). In a com- munity survey by Harrow & Silverstein (1977), 47% of patients continued to experience persistent psychotic symp- toms despite conventional neuroleptic drugs. As a result, patients may be reluctant to accept drug treatments and some may even wish to cease taking medications altogether (Kemp *et al*. 1996). Several studies have shown that sexual problems related to traditional psychotropic medications are extremely common (Verhulst & Schneidman 1981, Lyketsos *et al*. 1983, Bhui & Puffett 1994, Burke *et al*. 1994, Aisenberg *et al*. 1995). Less is known about the impact of newer atypical drugs on sexual functioning (Bhui *et al*. 1997). The rates of sexual dysfunction in those people with major mental illness vary between 18% and 67% (Spector & Carey 1990).

Impaired sexual intercourse has been identified as a result of tardive dyskinesia (Yassa & Samarthji 1985). Moreover, anticholinergenic effects of psychotropic drugs may cause loss of desire, inability/delay in orgasm and reduced libido (Kockott & Pfeiffer 1996). Aisenberg *et al*. (1995) examined three groups, which included drug free schizophrenics, people with schizophrenia on neuroleptics and healthy volunteers. The findings for the group taking neuroleptics suggested decreased libido, poor sexual per- formance, less sexual desire, premature ejaculation, erectile problems, decreased satisfaction with sex and less pleasure at orgasm. In one study, the question was raised about which symptoms may be drug related and which were

related to the illness itself. Usually, when drugs were stopped, sexual functioning improved (Gerlach & Peacock 1995).

Surprisingly few studies investigated women only. Kathleen Degen, a New York Professor of Psychiatry, explored the literature on desire, excitement and orgasm in women, and argued that studies generally focused on male sexual performance (Degen 1982). High levels of orgasmic dysfunction were seen in women taking Fluphenazine depot injections. Ninety-one per cent of the same sample reported alterations in menstruation (Ghadirian *et al*. 1982). The imbalance in studies related to male–female sexual concerns may be due to male researcher bias (O'Connell Davidson & Layder 1994). This neglect is con- cerning as, some would claim, women have traditionally had poor treatment within psychiatric systems (Showalter 1987).

Newer drugs

Some studies address the effects of traditional psychotropic medications in relation to sexual problems. Less has been published about the newer 'atypical' neuroleptics and rela- tionship and social needs. The newer 'atypical' antipsy- chotic medications (e.g. Olanzapine, Risperidone) appear to cause fewer extrapyramidal symptoms (Gerlach & Pea- cock 1995). However, they still carry the risk of unwanted effects such as sedation, dysphoria, sexual dysfunction, weight gain, endocrine effects, autonomic and cardiovas- cular effects, anticholonergic effects and seizures, as well as some extrapyramidal problems (Barnes & McPhillips 1999). Clarke & Yaeger (1994) postulated that a decrease in extrapyramidal side-effects along with an improvement in negative symptoms would inevitably lead to the person with schizophrenia transforming from a withdrawn indi-vidual to a 'social animal'.

Sexuality needs

Nursing is in a unique position to provide for the sexual health care needs of clients. This care is important to the goals of health promotion in nursing. It allows nurses to function as advocates, and enables them to meet the grow- ing demand for informed, responsible patient care. Wein- berg (1982) described further attributes such as: giving patients information; listening to patients' views and con- cerns; ensuring their need for confidentiality and privacy; and involving patients in decisions about their care. In some areas, plans of care use the activities of living model (Roper *et al*. 1981). However, in the author's experience, the category entitled 'expressing sexuality' tended to be underused or even ignored by nurses. This is despite the fact that clear guidelines were introduced by the Royal Col- lege of Nursing (1996) pertaining specifically to the sexual health needs of people with mental health

problems. Webb (1985) felt that nurses' responses could be due to a lack of understanding of the complexities of sexuality or of diffi- culty in deciding how to collect and record information. To enable nurses to fulfil this role confidently and competently, they need to be knowledgeable about the biological, psy- chological and social aspects of sexuality.

Assessment

Rigorous holistic assessments would normally take account of every aspect of individual need. However, the area of human sexuality is generally neglected in mental health care (Young 1987, Merrill *et al*. 1990, Earle 2001).

Dilloway & Hildyard (1998) explored the sexual health needs of women in East London with a view to designing a training initiative for general practitioners. Most respon- dents said they would prefer talking to a nurse rather than a doctor about sexual issues. They saw it as less intimidat- ing. A significant number thought the demeanour and per- sonality of the health practitioner was more important than gender. Many found clinical/medical jargon off-putting. In addition, Bor & Watts (1993) looked at methods of talking to patients about sexual matters. The areas of health related to dying, terminal illness, relationships and sexual issues were seen as challenging. However, undeveloped counselling and interpersonal skills were perceived as obstacles to gathering accurate information as part of the assessment process. Other impeding factors for patients were identified and included: inhibitions; assuming the partner's gender; feeling judged or ridiculed; and assump- tions regarding sexual activity, e.g. older people or people with schizophrenia as somehow 'asexual'. The most com- mon barrier to nurses discussing sexuality with patients was the fear of 'causing the patients anxiety' (Kautz *et al*. 1990).

Park Dorsay & Forchuk (1994) surveyed nurses, patients and audited charts in order to establish nursing attitudes, client sexuality needs and assessment strategies. Patients concerns included sexual abuse issues, marital rape, sexual dysfunctions, sexually transmitted diseases and relationship events. Sadly, findings showed that most of the staff don't ask about sex issues, feel uncomfortable with the subject and generally ignore the sexual domain in assessments. According to Jacobs & Bobek (1991), a thor- ough sexual history should include the physical, emotional, intellectual, social and spiritual spheres. This forms the basis of the formulation of problems, goals and needs. Therapeutic interventions would then be planned from the data.

Sexual behaviour

Verhulst & Schneidman (1981) conducted an inpatient sur- vey involving 20 people with schizophrenia. Patients were asked about sexual dysfunctions, sexual norms, relation- ship patterns and drug-related sexual side-effects. The study showed that

there was little evidence of sexual prob- lems other than that attributed to medication including premature ejaculation, anorgasmia and vaginismus. Inci- dentally, the investigators claimed that reliability seemed to be enhanced because they were the primary inpatient psy- chiatrists and were familiar to the patients. Outpatients, who had never met the researchers, refused to participate in the study.

The effects of the institution on sexual behaviour has received far less attention than the ways psychotropic medications impact sexual functioning and sex drive (Kotin *et al*. 1976, Teuch *et al*. 1995). Primary disabilities may be compounded by life in an institution and by the opinions of professionals. There was a general assumption that people with schizophrenia were somehow asexual (Weinhardt *et al*. 1997). Furthermore, the authors asserted that addressing the subject would perhaps be seen as actively encouraging widespread institutional promiscuity. Despite the inclusion of social skills training in rehabilita- tion programmes, sexual education was rarely a compo- nent (Civic *et al*. 1993, Katz *et al*. 1996, Lewis & Scott 1997).

Intimate relationships

There is a range of possibilities for intimate relationships including same sex, heterosexual and bisexual. People have very diverse expectations of what constitutes a 'normal' life in the community for people with mental illness. Therapeu- tic responses in clinical practice were varied (McFarlane 1997, Wells 1997, King & Bartlett 1999). In a study exam- ining the attitudes of nurses in relation to same sex part- nerships, 77% of Registered Mental Nurses gave homophobic responses (Smith 1992). In another survey, 43% of student nurses opposed homosexuality (Syno- ground & Kellmer-Langan 1991). Compounding the issue, family and social support networks may be scant or non- existent. Baucom *et al*. (1998) discussed the notion of enlisting families of people with schizophrenia as support- ive agents to assist with the formation and maintenance of intimate relationships. However, there are no empirical studies to date, which look specifically at this subject.

The family (in its broadest sense) can be seen as an important factor in the prognosis of schizophrenia (De Jesus Mari & Streiner 1994; Pharaoh *et al.* 2001). Family management programmes promote the adoption of the stress vulnerability – family coping skills model for improv- ing outcomes (Mueser & Glynn 1995). Schizophrenia family work involves helping the family look at coping strategies, problem solving, psychoeducation, improving communication and expanding social networks (Leff 1997). Sex and relationship issues are not generally covered in the family work sessions. There may be scope to inte- grate these important concerns into present cognitive- behavioural family interventions.

Historically, the notion that people with severe mental health problems might marry each other has been met with disapproval. Freud (1917)

cautioned, ‘we urgently advise our male patients not to marry any girl who has had ner- vous trouble before marriage.’ Shanks & Atkins (1985) conducted a survey involving 22 married couples who had at least 5 years contact with psychiatric services. Half of the sample had been advised against marriage by families and professionals because of concerns about the deleterious effects on the patients’ mental health. The findings suggest that couples had less hospital contact and increased satis- faction within their relationships. This may be due to the mutual support found in shared disability (Craft & Craft 1981).

Loneliness

An important aspect when examining the lived experiences of people with enduring mental illness is perceived alien- ation. DeNiro (1995) used social skills interviews to anal-yse relationships, closeness, separation, loneliness, social isolation and sense of belonging. People with schizophrenia perceived themselves as different. They felt stigmatized and experienced social distance. This led to accentuated feelings of despair and distress. People described feeling out of place and poorly understood. More than half of the respon- dents felt more isolated because of negative family attitudes and reactions to their illness. Contributory factors included diminished social networks, poverty, withdrawal, poor self-care, inadequate role functioning and bad general health. Most respondents lacked even the anticipation of enjoyment or satisfaction with life. Nearly half expressed the desire to share their thoughts and feelings with others, given the opportunity. This need to ventilate hopes and aspirations around issues of intimacy is borne out in the lit- erature (McCann 2000). Further, collaborative alliances with mental health nurses can foster hope within the inter- personal relationship. The family and significant others may also be seen as crucial in helping the person with schizophrenia achieve their goals (Tarrier & Birchwood 1995).

Stigma and mental illness

The result of having a diagnosis of schizophrenia com- pounded by misconceptions of society can lead to ostra- cism and alienation and may affect the formation and maintenance of intimate relationships. Furthermore, the ways that people in society perceive people with mental health problems and the ensuing responses can have a pro- found effect on the individual. Bacharach (1992) provides a poignant example from a former patient:

> Sadly, in addition to handicaps imposed by our illnesses, the mentally disabled must constantly deal with barriers erected by society as well. Of these there is none more devastating, discrediting and disabling to an individual recovering from mental illness than stigma. We are denied jobs, unwanted in our

communities. We are seen as unattractive, lazy, stupid, unpredictable and danger- ous.

Prejudice, descrimination, oppression and negative atti- tudes towards those with schizophrenia can only have a detrimental effect on self-esteem and personal develop- ment, including sexual and relationship possibilities. In addition, according to some, societal disapproval and fear regarding the production of offspring could possibly affect the potential for relationship formation (Rowlands 1995).

Family planning

Family planning needs in respect of risk behaviours have been described (Coverdale *et al*. 1997). The capacity to make decisions or judgements was weighed against vulner- ability factors. Mental health practitioners were warned against paternalistic responses and administering contra- ceptives without consent (e.g. Depo-provera). Constructive interventions were recommended and included: giving information and support; counselling on how to decrease risk; skills training in contraceptive use (male and female); and communication and assertiveness skills. Early interven- tion strategies were explored as well as integrating services such as family planning, general practice and psychiatry. Seeman & Cohen (1998) eloquently described a pioneering service for women with schizophrenia in Toronto, Canada. The clinic offered initial patient and family assessment, rec- ommendations to General Practitioners and short-term treatment options. Treatments generally lasted from 6 months to 1 year and were provided by nurses, occupa- tional therapists, social workers and psychiatrists. The comprehensive programme consisted of: individual coun- selling; drug therapy; case management; cognitive- behavioural interventions; programmes for first episode psychosis; family interventions; psychoeducation; leisure/ activity groups; work readiness programmes; stress reduc- tion groups; as well as sex and relationship groups.

Policies

Institutional responses to sexual expression have been var- ied but generally sex and relationship needs are ignored (d'Ardenne & McCann 1997). Sociocultural barriers, par- ticularly in institutions such as hospitals and hostels, need to be recognized. Some critics may regard these environ- ments as primitive, repressive, regressive and exploitative (Bell *et al*. 1993, Keitner & Groff 1981). Research has shown the importance of a positive therapeutic environ- ment such as ward size, ward structure and staff attitudes (Holbrook 1989). Another study (Welch *et al*. 1991) chal- lenged the notion of providing education alone. Most peo- ple in their study were sexually active and in hospital, but had no opportunity to practise

responsible sex in a digni- fied atmosphere. It was not uncommon for patients to have sex in bushes in the hospital grounds in exchange for money or cigarettes. Civic *et al*. (1993) investigated staff perspectives of behaviours such as public displays of affec- tion and sexual risk. They discovered that hospital staff were uncomfortable about discussing these issues with patients. Sexual expression was discouraged although com- monplace, usually involving clandestine meetings in the grounds of the hospital. A programme was designed to address communication strategies. Moreover, policies and guidelines were examined and recommendations made.

In the USA, Buckley & Hyde (1997) canvassed 86 psy- chiatric hospital directors about service priority issues. Most respondents (88%) expressed concerns about inpa- tient sexual behaviours. Surprisingly, a majority of hospi- tals had sex policies. This contrasts with 1981 statistics where only one hospital had guidelines regarding sexual behaviour (Verhulst & Schneidman 1981).

Sex education

There has been some admirable work carried out among people with learning disabilities and people with cancer concerning sexual dysfunction and relationship support (Craft & Craft 1981, Brown 1992, McCarthy 1996).

Some early work looked at sex education in mental hos- pitals. Much of the content of the sessions seemed rather prescriptive. Patients were not generally canvassed about what they may need to know to enable them to make choices and decisions around sexuality concerns. Topics covered included: anatomy and physiology; sexual rights in hospital; privacy; relationship stress; staff attitudes; hospi- tal policies; and family planning (Wolfe & Menninger 1973, Shaul & Morrey 1980, Wasow 1980, Pepper 1988). Very few studies have examined the experience of those with schizophrenia living in the community and their sex education requirements. Lukoff *et al*. (1986) were con- cerned about: high levels of sexual dysfunction and non- compliance with medications; social isolation as a risk factor in relapse; social and sexual functioning declining in the absence of interventions; inappropriate sexual behav- iours as obstacles to community integration; rising repro- ductive rates in schizophrenia; and sexual abuse of women. A sex education programme was designed consisting of eight biweekly sessions lasting 1 hour. An additional ses- sion covered intimacy skills. Lukoff and colleagues recom- mended the use of sexual surrogates who offered specialist training in sexual functioning. It was common in San Fran- cisco to see advertisements in local papers requesting sex- ual surrogates for people with physical disabilities. It was often viewed in the context of rehabilitation (Tapley 1985). Here in the UK, there is no such

service available to people with disabilities. The viability of such a resource and the potential benefits to people with schizophrenia would be worthy of further exploration. One study actually asked people with schizophrenia living in the community what they perceived their sexual education needs were (Lewis & Scott 1997). Client's descriptions of needs varied greatly from those inferred by the investigators. Seven issues for discussion were identified including: the effects of medica- tion on sexual functioning; the effects of illness on sexual functioning; how to maintain long-term relationships; how and where to meet people; clarification of values; prevent- ing unwanted sexual advances; and sexual relationship preferences. A majority of respondents (76%) thought it would be helpful to discuss issues around sexuality. This is the only study that asked for clients' preferences around topic inclusion. It may be an important consideration when planning services, that therapeutic interventions are designed around the expressed interests of the clients involved which would encompass hopes and aspirations for the future.

Conclusions and implications for psychiatric nursing

One of the most dramatic findings from this review of the literature is the paucity of published data on sexuality, especially in the UK, which may indicate a lack of interest in the field of human sexuality. Another contributing factor could be the apparent constraints within the health service, financial and otherwise, with clinicians viewing this area as low priority. Possibly, nurses' own feelings and attitudes regarding sexuality may act as a barrier to the exploration of sexual issues with patients. Before nurses can assist oth- ers with sex and relationship needs, they may need to examine their own attitudes, values, fears and beliefs. There should be a conscious drive towards facilitating communication about sexuality, correcting myths and misinformation, providing education and encouraging exploration of the patients' feelings and resources. However, being supportive of a patient's sexuality should not be defined simply as permitting or condoning intercourse among clients. There is a broad continuum of therapeutic approaches to sexual matters: from answering clients' concerns with calm, informed responses to providing a private space and other opportunities for sexual intimacy. Moreover, practitioners have often had to rely on their own common sense and clinical judgement in their drive to maintain order and propriety and still remain sensitive to the psychological, emotional and sexual needs of patients.

Through this review of the literature, the potential frustrations and obstacles to developing enthusiasm and sup- port in this important area of human experience become apparent. Within the social sciences, the primary force for behavioural

research in sexuality is a preventive health agenda that appears to prioritize sexuality as a social problem and behavioural risk. In biomedicine, this definition translates to a disease-prevention focus encompassing med- ically defined categories of analysis, epidemiological assessments and/or pharmaceutical interventions. Within both the social sciences and in biomedicine, it is these approaches that appear to dictate the funding for sexuality research. Whilst some sexuality research should aim to pre- vent social problems and/or disease, particularly in light of the HIV/AIDS pandemic, the ramifications of a limited, preventive approach are significant. First, the research questions are focused primarily on identifying high-risk sexual behaviours and/or motivating behavioural change, and second, sexuality is conceptualized within an extremely negative and problematic context. This, it could be argued, narrows the research and therapeutic possibili- ties. In addition, some reservations may be held regarding enquiring about 'sensitive' issues. Although some studies have shown that patients are willing to participate in what is traditionally seen as a 'taboo' subject (McCann 2000).

In terms of education and sexuality, the biomedical model appears to dominate in steering curriculum content, consisting mainly of genito-urinary and gynaecological concerns. Arguably, there is scope for greater integration of sexuality into both pre- and postregistration courses, which may address the biopsychosocial aspects of sexuality. This may be facilitated by way of enhanced teaching methods such as microteaching with video feedback, case discussions, experiential workshops and seminars. Personal and professional attitudes, values and beliefs could then be explored in a safe and nonjudgemental environment. This teaching may be delivered on site with follow-up clinical supervision to support practitioners.

If mental health professionals are to be truly responsive to the needs of people with serious and persistent mental health problems and their carers, they have an obligation to ask about sexual and relationship issues. They need to enquire about subjective experiences and a person's hopes, feelings, beliefs and aspirations regarding sexual and relationship fulfilment. Furthermore, great care must be taken in ensuring that no further escalation exists in the discrimination, marginalization and suffering of this already vulnerable group in our society.

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