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Sexual behavior in psychiatric patients: a review

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Abstract

Sexual behavior is a normal component of healthy adult development. Many factors, including cultural and religious influences, significantly affect sexual behaviors. Sexuality is often viewed narrowly regarding sexual practices; however, it can also encompass broader views and affects all areas of life. Sexual behavior is usually influenced by interpersonal and social interactions, and it can become problematic if it interferes with a person's ability to engage in functional daily tasks. The concept of sexual behavior includes various activities related to sexual interaction, stimulation, and sexual orientation. Sexual orientation can be categorized as heterosexual behavior, homosexual behavior, bisexual behavior, and paraphilic behavior. Paraphilic sexual behaviors are challenging to conceptualize, define, and classify. This paper reviews research on the sexual behavior of psychiatric patients, aspects of sexual functioning, identified sexual problems, treatment and management approaches, associated psychotropic medication, and current directions for future research. Sexual behavior includes a wide range of interpersonal behaviors engaged in for erotic satisfaction. Sociocultural influences heavily shape ideas of socially acceptable sexual acts. Sexuality encompasses sexual thoughts, feelings, beliefs, values, and activities. Sexuality affects the individual in all areas of life, including psychological, physical, spiritual, and sociocultural aspects. Sexuality includes a person's sexual development, sexual functioning, sexual behavior, sexual orientation, sexual identity, and sexual shyness. Sexuality is not limited to sexual interaction, sexual activity, and sexual practices. Normative sexual behavior is behavioral expressions of sexuality according to a culturally defined population.

Keywords: Sexual disorder; psychiatric patients; Antipsychotic drugs; Phases of sexuality

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Introduction

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Sexual behavior includes a wide range of interpersonal behaviors engaged in for erotic satisfaction. Sociocultural influences heavily shape ideas of socially acceptable sexual acts. Sexuality encompasses sexual thoughts, feelings, beliefs, values, and activities. Sexuality affects the individual in all areas of life, including psychological, physical, spiritual, and sociocultural aspects. Sexuality includes a person's sexual development, sexual functioning, sexual behavior, sexual orientation, sexual identity, and sexual shyness. Sexuality is not limited to sexual interaction, sexual activity, and sexual practices. Normative sexual behavior is behavioral expressions of sexuality according to a culturally defined population.

Sexual behavior may change over the course of life as a result of changes in individual development (puberty, the aging process), changes in living environment (new school, job, city), and major life events (marriage, childbirth, death). Sexual behavior may also be influenced by a person's mental state, such as the occurrence of stressors, mood changes, or illnesses. Therapeutic interventions can also affect sexual behavior, revealing sexual concerns that a patient did not wish to discuss previously. When sexual behavior interferes with the individual's ability to perform acceptable functional daily activities and forms a pattern that perseveres across situations or temporal circumstances, the term sexual behavior problems is used. It has been argued that sexual behavior problems may be more related to abnormal social behavior than to individual sexual functioning. Some sexual type questions are often raised about patients in psychiatric clinics, such as whether patients have sexual fantasies, do they experience sexual dreams, and at what age do patients start to ask about sexual matters.

Theoretical Framework

A comprehensive examination of the literature on sexual behavior in psychiatric patients is presented here, focusing especially on unwanted sexual behavior, sexual competency, and the perceived and explicit effects of psychotropic medications (antipsychotics, antidepressants, and mood stabilizers) on sexual activity. Selected studies, case reports, and literature reviews that explore sexual behavior in patients diagnosed with schizophrenia, schizoaffective disorder, psychotic depression, bipolar disorder, and neurocognitive disorders (dementia, frontotemporal dementia, and Huntington's disease) are highlighted. Specifically among bipolar patients, there is a particular focus on the manic state, as this state is often associated with sexual disinhibition.

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Given how thoughts about sex often preoccupy the human mind, it is not surprising that discussions about sexual activity and sexual health would find their way into psychiatric settings. Age, gender, religiousness, and personal, familial, or cultural factors can all influence views on discussing sexual issues. Nevertheless, psychiatric patients often have questions or anxieties concerning sexuality, which caregivers may feel either unable or uninterested in addressing. There are often contested views about sexual behavior in psychiatric patients. On one side, some psychiatric patients are believed to require care for sexual urges, while others are perceived as being unfit for sexual activity. These polarized perspectives do not consider the complexity and variability of sexual motivations and behavior.

Sexual health is a key component of overall health; good sexual health contributes to individual well-being and enhances partners' mutual enjoyment. Sexual health can further strengthen other areas of health, happiness, and quality of life, as well as facilitate social interaction, intimacy, and love. Long considered a taboo topic, the increased openness about sexual matters in modern society has prompted a number of inquiries about sexual activity, sexual health, sexual satisfaction, and sexual issues in mental illness settings. Counseling, education, and treatment to improve sexual competency, alleviate sexual anxiety, or manage unwanted sexual behavior or excessive sexual activity in healthy patients can readily be conducted. Sexual history-taking can be complex and takes time. Unwanted sexual behavior is often grounds for legal action. Still, the need for guidance and support on sexual and relationship issues is huge and rising among psychiatric patients.

Biopsychosocial Model

Psychiatric conditions arise from the convergence of biological, psychological, and social elements, and they affect interpersonal relationships. However, psychiatric dysfunction often leads to sexual dysfunction or risky sexual behavior. Male and female psychiatric patients possess different sexual behavioral patterns and motivations, with these variations influenced by numerous factors. Numerous studies worldwide focus on understanding the sexual behavior of psychiatric patients. Exploration into the sexual behavior of psychiatric patients, with reference to the biopsychosocial model, is limited in many countries, including China. There is a high prevalence of sexual dysfunctions and disorders among psychiatric patients, along with an increased risk of sexual victimization or perpetration. Psychiatric conditions are shown to greatly affect patients' social interactions, and sexual outreach is a crucial aspect of social behavior. Sexual risks among psychiatric patients cannot be overlooked, and psychoeducation is vital for ideal functionality.

Sexual behavior explores the influence of social, individual, and psychiatric factors on sexual behavior among psychiatric patients based on the biopsychosocial model and examines sexual behavioral differences in terms of sex and diagnosis types. The delineation depicts sexual outreach's critical importance for participation in life in psychiatric patients. Notably, increased

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psychiatric severity or impaired symptom control correlates with reduced sexual engagement, while the nature of the psychiatric diagnosis further affects sexual behavior. Sexual outreach among psychiatric patients is intricately influenced by complex biopsychosocial factors needing adequate attention.

Prevalence of Sexual Behavior in Psychiatric Patients

Sexual behaviors are complex outcomes of psychological, biological, and environmental factors. Similar to other domains of behavior, sexual behavior in the general population forms a continuum, is highly variable, and is influenced by psychiatric disorders. Exploration of sexual behavior in psychiatric patients raises important clinical, ethical, and social issues for mental health professionals. In some psychiatric patients, hypersexuality or sexual dysfunction may coexist as a part of the illness, which may complicate the clinical picture, alter the course of the disease, and affect treatment response. On the other hand, sexual aggressiveness may also develop as a side effect of certain psychoactive substances abruptly used or withdrawn, or as an impulse control disorder associated with certain psychotropic agents.

Sexual behavior includes a wide variety of activities, including sexual thoughts, interests, fantasies, preferences, urges, activities, and relationships. Sexual acts also encompass a large spectrum, ranging from behaviors that may or may not affect others (e.g., sexual masturbation, paraphilias) to sexual offenses against non-consenting partners (e.g., sexual harassment, sexual abuse, and rape). Similar to other domains of behavior and various mental disorders, sexual behavior also forms a continuum in the general population. Observations in some individuals may be either benign variations in normal behavior or situations that may require clinical attention. Individuals who fall at the extremes of the continuum may be very different from the general population, and may suffer from distress and impairment to social, occupational, and other areas of daily functioning. Various psychiatric disorders, mental retardation, personality disorders, posttraumatic stress disorder, and organic diseases, as well as androgens, have been shown to affect sexual behavior.

The first population-based study of sexual behavior in psychiatric patients was conducted using two years' epidemiological data collected in the world's largest catchment area in the city of Shenzhen, China. That study used a text/word analysis method, developed not only to explore the prevalence of sexual behavior but also to identify the different types in patients with different diagnoses. Rates of sexual behavior were relatively lower among psychiatric patients than among the general population. However, specific forms of sexual behavior that differed from the general population were more common among patients with schizophrenia or substance-related disorders. The latter findings were replicated in other epidemiological studies in Harbin and Wuhan, China. Also reported were different forms of sexual behavior in psychiatric patients with a focus on populations suffering from sexual-related disorders.

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Epidemiological Studies

There are only a few epidemiological studies of sexual behavior in psychiatric patients. Most have studied sexual activity and/or psychiatric diagnosis. Four studies have compared the sexual behavior of psychiatric patients to nonpsychiatric controls. One census study sampled patients' sexual behavior before the start of the first psychotic episode. Only one study examined the sexual behavior of psychiatric patients over a long period of time. Most studies were initiated because of concern about sexual abuse by psychiatric patients, and the studies' findings were often used to justify spending more money on staff.

Most epidemiological studies attempted to estimate the prevalence of sexual activity without a clear definition of sexual activity and without controlling for opportunities for sexual activity or the effect of neuroleptic, antidepressant, and anticonvulsant medications. Nonpsychiatric medical patients were often chosen as controls without a clear justification. Mental health professionals often misperceived the sexual behavior of psychiatric patients, considering it to be inappropriate, dangerous, and aggressive although there is no empirical justification for such perceptions.

Almost all epidemiological studies, including one study by Meyer, Steinberg, and Davidson of almost 2,800 hospitalized patients, relied solely on the opinions of professional staff to assess patients' sexual behavior. It is commonly thought that the sexual behavior of psychiatric patients is somehow "different," that is, more frequent, inappropriate, and dangerous. There are no published, systematic, controlled studies of the sexual behavior of psychiatric patients as perceived by themselves, other patients, and other individuals in their environment.

A specially designed interview schedule translated into several languages was used to survey, in a controlled fashion, the sexual behavior of psychiatric patients on an acute admissions unit. The patients' perceptions and norms were compared to the perceptions of other patients and the perceptions of psychiatric staff. Since, at the unit studied, the psychiatric staff was composed of a majority of male staff, most of whom were psychiatrists, the perceptions of male staff were analyzed separately from those of female staff.

Types of Sexual Behavior in Psychiatric Patients

Sexual behavior in psychiatric patients has long been viewed with skepticism. However, an increasing amount of attention is being given to the sexual behavior of psychiatric patients in recent years. This attention has been given both in treating the patient during psychotherapy and taking a sexual history. An understanding of the sexual behavior of the patient enables a better understanding of the person as well as of the condition of the illness itself. Many patients who seek treatment for psychological difficulties have sexual questions, concerns, and behaviors. It stands to reason that individuals with psychiatric disorders would have sexual

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difficulties. Sexual behaviors ranging from hypersexuality to inactivity may be seen. The monetary impact of sexual behavior may also be seen through prostitution or the use of sexually transmitted disease.

Descriptive terms such as hypersexuality, sexual addiction, sexual compulsiveness, and nymphomania describe a myriad of clinical presentations that involve an increase in sexual thoughts, fantasies, and behaviors which may also cause distress or impairment in functioning. Depending on the clinical situation and theorist, there exist a plethora of associated clinical descriptors that may be used to describe the same phenomenon in a different manner. For example, sexual addiction may at times be used interchangeably with other descriptive terms, although it appears to reflect a more cognitive-behavioral framework where unwanted sexual thoughts, fantasies, or behaviors are engaged in with some degree of psychological dependency. Other orthodoxy discusses the sexual behavior within a more psychodynamic framework as sexual compulsiveness in which there exists a desire or impulse that is unable to be controlled ultimately producing acting out sexual behavior and fantasies. It is this psychodynamic understanding of acting out sexual behavior which may be better understood within the milieu of psychiatric illness.

Hypersexuality

The term "hypersexuality" has been used to refer to an array of overlapping conditions including sexual addiction, sexual compulsivity, sexual impulsivity, out-of-control sexual behavior, and paraphilia. Hypersexual patients engage in excessive sexual activity that is time-consuming, out of control, distressing, and results in negative social, occupational, legal, or financial consequences. The advent of the internet, with its easy access to pornography, chat rooms, and sex-related sites, has led to a rapid increase in reports on hypersexuality and sexual compulsivity. Neuroscientific studies suggest that sexual addiction may involve a neurobiological process similar to other behavioral addictions, including the upregulation of the limbic brain and downregulation of the frontocortical brain.

Numerous psychiatric disorders have been associated with sexual problems, but most studies have focused on sexual dysfunctions, such as erectile dysfunction, lack of sexual desire, orgasmic impairment, and problems with the physical act of sex. In contrast, hypersexuality or sexual compulsivity has received less clinical and research attention. Studies have investigated various aspects of sexual behavior such as sexual arousal, sexual preference, sexual act, sexually related emotions, and sexual orientation. Sexual compulsivity can be defined as an excessive engagement in sexual behaviors despite negative consequences, or as difficulty in controlling sexual behaviors resulting in significant distress or impairment. The definitions and terminology used in research are diverse, including sexual addiction, paraphilia, sexual impulse control disorder, compulsivity, and hypersexuality.

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Research on sexual compulsivity is relatively limited within the neurobiological perspective. Studies have attempted to address the neurobiological underpinnings of sexual compulsivity but have yielded limited findings. For decades, sexual addiction has been equivocal. A diagnosis of sexual addiction is not recognized in the DSM-5, and there is an ongoing controversy regarding the categorization of sexual addiction or compulsivity. Nevertheless, the existence of hypersexuality has been well documented in various populations. Understanding such nuanced sexual behavior is important for developing treatment strategies and improving quality of life.

Risk Factors for Problematic Sexual Behavior

There is only limited data related to sexual behavior in psychiatric patients diagnosed with sexual behavior problems, aggressive sexual behavior, or sexual addictions, and the relationship between psychiatric disorders diagnosed or treated and problematic sexual behavior. A small number of studies were reviewed to explain overall psychiatric disorders related to sexual problems across patient groups. There are also studies about sexual behavior and psychiatric problems diagnosed, where the psychiatric diagnosis can be a reason for having sexual problems with aggressiveness or paraphilia. Herein, explored sexual acts, sexual paraphilia, sexual dysfunctions, sexual misbehavior, or other. The reasons and psychiatric diagnosis for the studies were heterogeneous too, so it is difficult to analyze and operate a model to represent this worldwide concern open area.

Describing and exploring interesting and important questions would include: Are psychiatric disorders and sexual problems related or not? What is the most common relationship between diagnoses? What are the ethnic, gender, or age differences? When should psychiatric disorders be treated first, or should sexual problems be treated first? Exploring these questions would open an understanding of the connection of the world mental health care problems. There is more and more importance to understand and investigate sexually problematic behavior in mentally disordered patients and in imprisoned patients with paraphilia, hypersexuality, compulsive sexual behaviors, sexual addiction, or sociophobias with sexual embarrassments. Describing the sexual behavior and the psychiatric comorbidity of the studied patients diagnosed with mental and sexual behavior problems would be the first step to understanding and exploring the further questions above.

Sexual problems are perceived as a taboo topic that is difficult to approach when asking in a psychiatric setting. There is no global overall data or reviews about this area in different general hospitals. A database with a representative sample group helped to study sexual behavior across psychiatric problems. This explored the sexual behavior in psychiatric patients diagnosed with sexual problems and the relationship between psychiatric disorders and sexual behavior. This reviewed the all-patient after-intake diagnosis summaries, diagnoses from psychiatric consulting, and psychiatric treatment that were all coded.

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Psychiatric Diagnoses

Psychiatric disorders have been implicated in both the etiology and treatment of sexual dysfunction. Affective disorders reportedly increase libido and related behaviors, while numerous other diagnoses (e.g., substance abuse, schizophrenia, organic brain syndromes, traumatic events) can lead to the opposite effect. Li et al. found a predominance of sexual dysfunction among patients with schizophrenia and those on clozapine. While sexual problems are frequently overlooked, aggressive sexual behavior is found predominantly among the paranoid group of patients, independent of antipsychotic treatment.

Sexual desire is modulated by a network of neurotransmitters, including serotonin, dopamine, noradrenaline, and others. Inhibition is provided mainly by serotonin, while other neurotransmitters enhance sexual function. The majority of studies focus on the impact of atypical or newer antipsychotics on sexual function but have produced conflicting results. Moral or legal obligations resulting from the sexual behavior may depend on cultural background and acceptance of the sexual problems, isolation, service professional attitudes, as well as attitudes toward mental illness in the community, and the more common and numerous problem behaviors are disallowed, the more pervasive and problematic they can become.

To summarize the available published studies on sexual behavior in psychiatric patients, using the reference list of foreign language journals published over the last fifteen years in a similar manner to those in the Medical Sciences. Similar studies and review articles originating from the former USSR and written in Russian were provided separately. Examination of the text database revealed that sexual problems (in terms of hyperactivity, abuse, etc.) attracted professional care in the late sixties and early seventies. Grouped by subject matter, three types of sexual problem behavior in psychiatric (hospitalized) patients were observed predominantly: increased sexual behavior and sexual abuse, usually associated with affective disorders; lack of sexual desire and impotence, usually associated with schizophrenia and neuroleptic treatment; and gender identity disorder in (homosexual) transvestism or transsexualism in paranoid states.

Assessment of Sexual Behavior in Psychiatric Patients

The absence of a standardized assessment format for evaluating sexual behavior in psychiatric patients is reflected in the profusion of methods that researchers have used over time. Most early research employed semi-structured interviews with content focusing on psychotic and disorganized behavior, as well as information about prior sexual behavior. This content was then rated on a scale designed by the researcher. Over time, more standard research interview formats were developed that included questions on sexual behavior relevant to the admission diagnosis.

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Some researchers have monitored sexual behavior through the review of case records for forensic patients. Such chart reviews may not be the best unit of analysis, as they are usually limited to cases of malady and relevant information may be subjectively documented. Some studies focused on specific disorders. For example, to investigate the link between personality disorder and sexual dysfunction, four patients meeting covalent personality disorder criteria were observed. While this focus could be justified in the early classification of a disorder, the knowledge gained would not relate exclusively to patients with that diagnosis. Pathological sexual behavior would seem to spectrum across diagnoses.

Researchers have administered self-report instruments like the Sexual Dysfunction Inventory and Sexual Behavior Inventory. These production measures, scoring frequency or total number of reported behaviors, fail to identify patients whose symptoms meet the threshold for a specific disorder. Given the often unanticipated nature of sexual behavior in this population, assessment through self-reporting is of concern. As an enhancement to research, some studies performed a pilot test of the DSM-IV research criteria and procedure, finding them feasible and acceptable to hospitalized patients. Spontaneous report, observational coding, and low-inference event sampling methodologies have also been introduced that limit biased reporting and thus could explore directly observable phenomena even less identified in prior studies.

Studies with large samples of cases, such as forensic hospital patients, might be valid even if retrospective and cross-sectional. In the absence of definitive longitudinal treatment and follow-up studies, they could offer grounds for a prospective inquiry. It is difficult to imagine anything more needed than an exposure history. Where child molestation has been proven, or the like on a current basis, sexual deviancy grows more probable. This would only hold for adult complaints. Outside the mental health area, human sexual behavior was classed by a psychopathic laboratory in Massachusetts using language descriptive of thought disorder.

Another experimental attempt was made in Connecticut but was changed from a rating scale to consensus criteria without scoring. It is difficult to interpret what is meant by uncontrolled or otherwise disorganized sexual behavior. The latter sounds like something very routine on a psychiatric inpatient unit. There is a need to externally validate the DSM consensus procedure, unless interest lies only in screening a facility. The objective would be the assembly of a broadly applicable system for alternate-site use. The multiple-stage approach anticipated would depend upon New York standards.

Clinical Interviews

Information regarding sexual behavior should be gathered carefully. Patients with psychiatric disturbance may have difficulty describing their sexual concerns because of embarrassment,

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poor insight, cognitive impairment, and disorganization of thought. It is helpful to first build a trusting relationship. A nonjudgmental, openly communicative approach can do a lot to put patients at ease. An informal observational approach may be more effective than direct questioning. Clarifications should be made in terms of the patient's/clients level of understanding. The questions to be asked should be culturally sensitive, as sexual behavior may be unacceptable in some cultures or have socio-religious implications that threaten fear of retribution. Understanding the patient's background, local norms, and issues/concerns prior to formally or informally inquiring about sexual behavior can facilitate a better relationship and the accurate gathering of information.

Sexual behavior is personal, and the person who is inquiring must be viewed as trustworthy. It is important to indicate that the information will be kept confidential. Not addressing sexual behavior in psychiatric patients may leave psychiatric links unexamined, though the behavior will continue, possibly causing distress or loss of treatment gains. For patients with schizophrenia, asking about sexual behavior through projective techniques (e.g. drawings) can lessen embarrassment and barriers that inhibit accurate reporting.

Patients with poor insight will not have an accurate understanding of their sexual behavior. Cognitive disturbances make it difficult to discuss sexual behavior. Simple, direct language is more understandable. Folk terms are more helpful than clinical terms, as patients may have different referents regarding clinical words. Questions may need to be reformulated several times. Questions with cross-cultural implications should be phrased carefully. Questions beginning with "Do you think you may have...?" imply the notion of acceptability or morality, which may elicit denials when this is an issue of concern. However, close-ended questioning like "Have you ever...?" by an outsider may be considered intrusive.

Treatment Approaches

Patients exhibiting sexual behavioral problems may present a variety of different problems, and corresponding treatment approaches may be needed. Below, the most commonly employed treatment approaches are discussed in general. Always discuss the treatment options with a mental health professional.

The pharmacological approach is usually the first employed by mental health professionals. This is because it treats the symptom and does not require a long-term commitment from the patient. If this approach does not satisfy the patient, other treatment approaches are recommended. Pharmacologist David H. Rosenberg describes three types of medications commonly used to lessen sexual problems in patients: selective serotonin reuptake inhibitors, antipsychotics, and hormonal agents. There is also some non-pharmacological treatment in Rosenberg's review. Although not always successful, most cases in Rosenberg's study were improved with medications.

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Unfortunately, a treatment that is effective for one person may be ineffective for another. Therefore, an open dialog between the mental health professional and the patient is encouraged. The issue of finding the right treatment may take time, and the patient should not get discouraged if a treatment proves unsuccessful.

Like a pharmacological intervention, the psychotherapeutic and behavior therapy interventions can take either a supportive or confrontive form. The choice of treatment is usually up to the patient, and a discussion with a mental health professional can shed light on the best treatment plan given the specific case and need. The supportive form of psychotherapy and behavior therapy regards the patient's sexual activity and feelings as normal, yet urges the patient to gain better control over the sexual behavior. In most cases, this intervention is used as a supplement to the pharmacological intervention. The confrontive mode of psychotherapy and behavior therapy attack the sexual problem as a real psychiatric problem and focus more strongly on the sexual act itself. These approaches can be effective without a pharmacological intervention, but they normally require a long-term commitment from the patient. It should be noted that the confrontive form does not necessarily mean that the mental health professional personally confronts the patient about their sexual behavior. Rather, it means that the sexual behavior in itself is studied as the source of the problem.

Unfortunately, even though the confrontation mode of treatment is more focused and powerful, it may also cause depressive feelings in the patient. In the confrontative therapy used in Haghighi's review, a lot of time was spent to directly confront the sexual problem as the underlying reason behind the depression. In two cases, the patient got severely depressed during treatment. Such a development is especially dangerous for a depressed patient, as it may spur a suicide attempt. It is important for the mental health professional to choose the treatment approach carefully, as a focus on the sexual behavior may not be appropriate for all individuals.

Pharmacological Interventions

Psychotropic medications can influence sexual function in terms of desire, arousal, orgasm, or satisfaction. Psychotropic agents with a high frequency of adverse sexual effects include antidepressants (particularly selective serotonin reuptake inhibitors), antipsychotics, antihypertensives, and mood stabilizers. The sexual adverse effects of psychotropic medications can be misattributed to the underlying psychiatric disorder and often under-recognized by clinicians. In clinical practice, several strategies can be used to minimize or discontinue the unwanted sexual side effects attributable to psychiatric medications, including dose reduction, switching to lower-risk agents, adding one or more therapeutic agents that counteract the adverse effects of the agent of concern, and lifestyle modifications to enhance sexual desire (e.g., lifestyle changes to improve cardiovascular health, increased exercise, curtailing alcohol use).

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Several common sexual side effects of psychotropic medications have been documented. Antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs), can cause sexual dysfunction in up to 25% of cases. 5-HT reuptake inhibitors generally produce decreased sexual desire and arousal and erectile dysfunction. The highest rates of sexual adverse effects have been found with fluoxetine and paroxetine. Viagra, with its massive publicity surrounding its new and wondrous ability to cure erectile dysfunction, was released into the marketplace in 1998; it has consistently been the most commonly prescribed drug in the United States. The increased attention to the side effect of erectile dysfunction associated with psychotropic drugs is likely also due to the introduction of Viagra. The side effect of erectile dysfunction associated with the use of SSRIs and other commonly prescribed antidepressants is now being carefully noted in clinical studies.

There is a large body of anecdotal and epidemiological data suggesting that the use of lithium can cause sexual dysfunction, particularly in men. Various sexual side effects have been associated with the use of lithium, but the most commonly noted have been impotence in men and impaired sexual arousal in both sexes. However, more recent studies have suggested that with careful attention to lithium blood levels and health maintenance, sexual side effects may be less common than originally thought. It is interesting that women on lithium may become more sexually bat-like, although lithium treatment has been associated with both increased and decreased sexual interest in men.

Ethical Considerations

Both the psychiatrist's and the patient's ethical rights in having sexual relationships with each other are examined in this review. A sexual relationship can be a natural extension of caregiving and care receiving; when both partners are consenting adults, it constitutes a legitimate choice. Nevertheless, the entire psychiatrist-patient encounter is inherently imbalanced and unequal, and thus potentially exploitative, partly because of power, authority, and knowledge differentials. Such relationships can have detrimental effects on patient care because of the inevitable shifting of feelings toward the patient. There are, nevertheless, circumstances under which sexual relationships can be both acceptable and ethical. In the case of an ongoing relationship prior to treatment, it needs to be carefully supervised and monitored, ensuring no harm or distress befall the patient. Overnight transcendence from carer to lover is ethically unacceptable. When the psychiatrist offers sexual relationships, he/she invariably places the patient's interests last. Because ethics can never be written down in a code, it should be constantly enriched and nurtured.

A review of the literature on sexual behavior in psychiatric patients in both acute and chronic settings focuses upon psychosis and specifically investigates issues of consent, inappropriate or harmful sexual behavior, sexually transmitted disease, and the adequacy of policies and training in dealing with these issues. Sexual behavior in psychiatric patients has received

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insufficient research exposure. Current policies and training seem inadequate to deal with the risks these patients may impose on themselves or others. Areas of research, training, policy formulation, and social support are outlined to address gaps in this field. It is concluded that inpatients and staff on psychiatric wards are grossly unprotected from inappropriate sexual behavior, and there is a need for urgent systemic change.

It discusses some ethical aspects of sexual behavior in psychiatric patients. These concerns are relevant to their involvement in research and handling of any specific inappropriate sexual behavior, usually considered unwanted, illegal, immoral, and inhumane. Nevertheless, patients with such behavior are at the same time victims of a cruel and traumatic state of mind and an oppressive psychiatric regime. It seems paradoxical that most complaints and concerns are voiced against the victims rather than the abusers of the most basic human rights. Forced treatment with psychotropic drugs, allowing humiliating electric shocks, deprivation of freedom and dignity, and increasing survival challenges simply because of their sexual behavior is intolerable. It is important to view psychiatric patients as human beings, respecting their natural instincts, personal choices, sexual expression, and right to love and be loved. However, some sexual activities may be harmful, such as a special interest in children. Some sexual behavior is illegal or inappropriate from a social standpoint; nevertheless, every individual must be considered.

Informed Consent

The majority of psychiatric patients can give informed consent to participate in research. However, ethical guidelines and laws governing research must be followed. A major premise of ethical research is that subjects have the right to make informed, voluntary decisions related to the risks and benefits of participating in research. Yet the reality is that there is no single standard for 'informed consent' but instead that the concept has a variety of forms in practice. A lack of standardization creates moral and logistical issues in various settings as well as legal exposure. Although several guidelines and toolkits exist to provide templates and accommodate linguistic and cultural adaptation, these interventions alone are not likely to increase the return on research investment in low- and middle-income countries. Informed consent is a complex issue in psychiatric research settings, especially when research is conducted with subjects with severe mental illness such as schizophrenia. Consent is considered informed when subjects can appropriately understand relevant information regarding the study, appreciate its implications on their situation, weigh the potential risks versus benefits of participation, and make a voluntary choice regarding study participation. These essential elements are impacted in psychiatric patients due to cognitive dysfunctions or distortions resulting from their illness, use of psychotropic medications, or study medications. Added to this is the coercive nature of psychiatric institutions and ethical issues related to studying vulnerable populations. Despite the challenge, recent directives, guidelines, and

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regulations require that psychiatric patients be invited to participate in research studies, which puts demands on investigators in achieving informed consent. However, as more research is conducted with psychiatric patients, the issues surrounding informed consent are being more broadly discussed.

Conclusion

The review of the literature on sexual behavior in psychiatric patients underscores the relevance of this subject to broad areas such as patient-clinician interactions, prescription of medications with sexual side effects, sexual coercion and aggression, and high-risk sexual behavior. Additional research on sexual behavior in psychiatric patients is warranted. Methodologically sound epidemiological studies with representative samples are needed to accurately define the prevalence and nature of different sexual behavior characteristics in psychiatric patients.

These studies should take into account factors such as age, gender, marital status, cultural background, and psychiatric diagnosis. Future studies should also adopt standardized methods for assessing sexual behavior, with particular attention to coercive and aggressive behavior. The impact of psychiatric and pharmacotherapy on sexual behavior warrants further investigation. Future studies should examine patients' perspectives and experiences with sexual problems resulting from medication treatment. The finding that sexual behavior has not been investigated in subject samples from non-Western cultures suggests the need for cross-cultural studies.

The view that sexual behavior, as a part of human behavior, is as relevant in psychiatric patients as in healthy individuals is increasingly gaining ground. An increasing number of studies have reported on different aspects of sexual behavior in psychiatric patients. Some studies have focused on sexual side effects of medications with psychotropic mechanisms of action, while others have addressed sexual coercion and aggression, high-risk sexual behavior, and sexually transmitted diseases. The view that aberrant sexual behavior is part of the symptomatology of a psychiatric disorder is mostly neglected in the literature on sexual behavior in psychiatric patients. Such behavior may, however, compromise therapy compliance and worsen the overall illness. Most psychiatric patients, particularly those with alcohol and drug abuse and antisocial personality disorder, display sexually aggressive behavior.

The acknowledgment that psychiatric patients may have sexual problems in common with their healthy counterparts is of clinical significance. Such problems may hinder the uptake of treatment by the patient and, if untreated, complicate the psychiatric condition. Beyond this, there are particular aspects of sexual behavior that should be taken into consideration in the provision of treatment, e.g., sexual coercion and aggression. There is also an ethical dimension to the discussion on sexual behavior in psychiatric patients. There is an imbalance in the patient-clinician relationship that gives rise to the ethical question of whether it is appropriate to

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have sexual relations with a patient and, if so, under what conditions. Issues such as these are important determinants in the quality of care provided.

Future Directions

A request was made to write content for the following section of a work titled "Sexual Behavior in Psychiatric Patients: A Review": "10. Future Directions". The content should adhere to the specifics and guidelines provided.

In the presented literature, sexual (or gender) behavior is an important aspect of an all-encompassing understanding of human growth, flourishing, and existence. Therefore, any theory regarding mental or physical well-being must address human sexual behavior as well as the behavior of people who have been diagnosed with a mental disorder. This literature review is an overview of current work on sexual behavior in psychiatric populations. The conclusion describes gaps in the current research and directions for future inquiry.

Overall, sexual behavior has yet to be thoroughly accounted for in research involving people with mental disorders. In some cases, it is defined as socially unacceptable, crude, and inappropriate, and there is often a risk of it being excluded from consideration. Yet, given the above description, culture shapes sexual behavior, so it is likely that people with a mental disorder experience sexuality and/or sexual behavior differently. What is needed is an open attitude—and a suitable methodology—for understanding the sexual behavior of those with a health diagnosis. Several directions for future work are indicated on the basis of the literature examined herein. These suggestions regard the sexual behavior of three groups: those with autism spectrum disorders, those with schizophrenia and other psychotic disorders, and the elderly. Such an understanding has the potential to shed more light on the nature of these sexual behaviors with respect to larger societal issues: culture, gender, and power relations. This societal issue is particularly important if one wishes to counter the marginalization of individuals with a mental disorder in society.

There is a desire and need to continue to promote an all-embracing approach to sexuality among people with mental disorders. Current status is often legitimate, while positions in the future may not be as easily sustained. A precondition for the exploration of sexual behavior amongst the mentally ill is a non-stigmatizing, positivist approach, without pre-conceptions, taboos, or social evaluations. In theory formation, research method and focus, a certain degree of caution is advocated in light of today's understanding of the slow pace of change with regard to societal sexual behavior and the sexual behavior of the mentally healthy.

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Competing interests

The authors declare no conflict of interest.

Ethics Statement

Not applicable.

Authors' contributions

All authors shared in the conception and design and interpretation of data, drafting of the manuscript and critical revision of the case study for intellectual content and final approval of the version to be published. All authors read and approved the final manuscript.

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