American Journal of BioMedicine
AJBM 2015;3(2): 378–388
Research Article doi: 10.18081/2333-5106/015-02/378–388

Sexual behavior in psychiatric patients: a review

Van J Heaton[1], Asselin H Bancroft[*]

Abstract

Sexuality is a natural component of human behavior, and the nature of sexual behavior in the normal population has been well addressed. Further interplay of multiple facets, including anatomical, physiological, psychological, developmental, cultural, and relational factors. Sexual dysfunction is common in people with Psychiatric disorder e.g. schizophrenia and other psychotic disorders, and it are known to affect all domains of sexual function including desire, arousal, erection, ejaculation and orgasm. Furthermore, antipsychotic drugs are associated with sexual dysfunction with unclear mechanisms. This article will review the literatures on the psychiatric sexual behavior in focusing on prevalence, etiology, and treatment.

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

[*]Corresponding author email: AsselinH@Yahoo.com
[1]Department of Psychiatry, Cleveland, USA
Received 02 January 2015; accepted March; 07, 2015, Published April 14, 2015

Substance Use and Abuse

Psychoactive substance use and abuse have consistently been found to be associated with sexual risk behavior and the acquisition or transmission of STDs/HIV among men and women [1]. Most of these studies assessed frequency and amount of use of alcohol and illicit substances and did not assess the presence or absence of substance use disorders. Substances that were most often cited as being related to sexual risk behavior include alcohol, marijuana, crack, cocaine, methamphetamines and other recreational drugs. Among adolescents, alcohol and marijuana use were substantially more common among sexually experienced adolescents than the national average [2]. It has been shown that cigarette, alcohol and marijuana use are significant predictors of risky sexual behavior.

Mood and Psychiatric Distress

Numerous studies have reported an association between negative affective states and increased sexual risk behavior in both adolescents and adults [4]. This association has been seen across a wide range of populations, including adult men and women [5], men who have sex with men [6], opioid users, young gay and bisexual men and adolescents [8]. Most of these studies assessed severity of psychiatric distress (i.e., depression, anxiety, hostility) without

Research Article doi: 10.18081/2333-5106/015-02/378–388

diagnostic assessments of psychiatric disorders. However, a few studies have found an association between mood disorders and posttraumatic stress disorder and increased sexual risk behavior [9].

Unfortunately, systematic comparisons have not yet been conducted regarding the associations of different types of mood disorders with sexual risk behaviors. According to the DSM-IV, one of the main features of a manic episode is often hypersexuality. However, unipolar depression is much more pervasive than bipolar disorder. Although many people with relatively severe unipolar disorders do have reduced libido, there are many other people with depression who have fluctuating levels of libido that may often be high enough to lead to risky sexual behavior [10]. Furthermore, unipolar depression increases risk for suicidal and self-destructive behavior. People who are self-destructive are perhaps less likely to inhibit their sexual impulses, because if they do not care about life itself, they may reason that there is no reason to care whether they acquire an STD.

In a large cross-sectional birth cohort study, young adults diagnosed with substance dependence, schizophrenia spectrum, depressive, manic and antisocial disorders were more likely to engage in risky sexual intercourse, contract sexually transmitted diseases and have sexual intercourse at an early age (younger than 16) [11].

Furthermore, the likelihood of risky behavior was increased by psychiatric comorbidity. This study was one of the first to establish strong links between a wide range of psychiatric disorders and sexual risk behavior. More specifically, they found that compared to people without psychiatric disorders, those with anxiety disorders were more likely to report STDs; those with depressive, substance dependence and antisocial disorders were more likely to engage in sexual risk behaviors, report STDs and were younger at first sexual intercourse; those with mania were more likely to have engaged in risky sexual behavior and to report STDs; and those with symptoms in the schizophrenia spectrum were more likely to engage in sexual risk, report STDs and were younger at first sexual intercourse [12].

The strongest association of risky sexual behavior was with disorders characterized by disinhibition or a pattern of impulsive behavior and comorbid psychiatric conditions. In particular, depression, substance dependence and antisocial disorders showed stronger associations with risky behavior compared with any single psychiatric disorder [13].

While many studies have found that sexual risk taking was associated with the presence of negative mood states and Axis I disorder, there have been studies that failed to find such an association. No association between depression scores and sexual risk among sexually active gay men [14]. Positive self-esteem to be associated with greater sexual risk behavior and an association between sexual risk and lower levels of psychological distress [15]. Found depressed ideation was associated with a reduced likelihood to engage in sexual risk behavior [16]. Two patterns of association between depressive disorders and sex behavior. Major depression was associated with reduced sexual activity, while dysthymic disorder was associated with an increased likelihood of unprotected sex [17].

Research Article doi: 10.18081/2333-5106/015-02/378–388

Disruptive Behavior Disorders

Youth with externalizing disorders (e.g., attention-deficit disorder, conduct disorder, oppositional defiant disorder) are likely to be at elevated risk for unsafe sexual behavior for a number of reasons. Such youth may have difficulty attending to or absorbing information about the health risks of having multiple unsafe sexual partners [18]. As described in the DSM-IV, individuals with these disorders are, in many cases, impulsive and prone to engage in a wide variety of sensation-seeking or risky experiences. They may associate with youth who encourage them to behave in an antisocial manner. In addition, they may resist the recommendations of adult authority figures [19]. Many youths with disruptive behavior problems receive inadequate adult supervision and have more opportunities than other young people to engage in sexual behavior with several partners. As a result, youth with disruptive behavior disorders may tend to have a high number of lifetime unsafe sexual partners and be at elevated risk for STDs [20].

Personality Disorders, Traits

Numerous studies have indicated that personality disorders and maladaptive personality traits contribute to increased risk for sexual risk behavior. Research has indicated that traits characteristic of personality disorders, such as impulsivity, lack of empathy, failure to appreciate risks and egocentrism, are associated with sexual risk taking among adolescents [21]. Adolescents with elevated personality disorder symptom levels have been found to be more likely than adolescents without elevated personality disorder symptom levels to report a high number of sexual partners [2]. Elevated antisocial, dependent and paranoid personality disorder symptom levels and certain specific antisocial, borderline, dependent, histrionic, narcissistic, obsessive-compulsive, paranoid and schizotypal personality disorder traits were independently associated with high-risk sexual behavior.

The DSM-IV Cluster B (antisocial, borderline, histrionic, narcissistic) personality disorders may be particularly associated with high-risk sexual behavior. Research has suggested that individuals with borderline personality disorder may be at elevated risk for unsafe sexual behavior and that this may be partially attributable to the co-occurrence of borderline personality disorder with substance use disorders and other mental disorders [3]. Individuals with antisocial, histrionic and narcissistic personality disorders may be likely to engage in unsafe sexual behavior because they often tend to be impulsive, self-centered or have a lack of concern for the well-being of their sexual partners [4].

Other Psychiatric Disorders

In addition to the above disorders, a variety of other psychiatric disorders may also be associated with sexual risk behavior. For example, several studies have documented high levels of sexual risk behaviors and HIV prevalence among men and women with severe and persistent chronic mental illness, including those with psychotic symptoms [9].

Research Article doi: 10.18081/2333-5106/015-02/378–388

Causal Explanations

It is widely known that negative mood such as depression and anxiety is usually associated with a decrease in sexual interest and behavior [9]. However, it seems that in some individuals there is evidence for increased sexual interest and responsiveness among people with affective disorders [7]. For them the tendency may be to use sex as a mood regulator. Forth explanations within a framework in which sexual response depends on a balance of excitatory and inhibitory mechanisms in the brain [18].

Thus, in the presence of anxiety or depression, the negative state of arousal can either lead to distraction from sexual activity with a focus on the mood-provoking stimuli or to sexual release as a means of reducing the negative arousal. In depression, there appear to be additional mediating mechanisms such as the need for validation through intimate contact versus a need to avoid intimate contact, depending on individual personality traits [5]. Similarly, other researchers have hypothesized that some individuals with a depressive disorder are more likely to take sexual (and other) risks because they care less about potential negative consequences [3].

Several reports have sought to explain the association between psychopathology and sexual risk behavior as being primarily related to vulnerability, especially in the context of psychosocial comorbidities [7] In many of the populations studied there are multiple factors that are likely to contribute to the relatively high levels of HIV and STD risk behaviors.

These include poverty, history of violence and childhood abuse (including sexual abuse), family substance use, history of incarceration, comorbid psychiatric conditions, poor access to quality health care, and stigma associated with minority status (i.e., racial and ethnic, sexual orientation, psychiatric illness). It is the combination of any of these factors or conditions that is hypothesized to make such groups vulnerable to risk, including risk for HIV and STDs.

In the absence of longitudinal studies with designs appropriated for systematic hypothesis testing, causal direction for the association between sexual risk behavior and psychopathology is unknown [19]. For example, it may be that individuals with depression engage in risky sexual behavior and substance abuse secondary to feelings of hopelessness and worthlessness or as a means of self-medication. However, it is also possible that negative consequences from risky sexual scenarios may precipitate psychiatric distress or a depressive episode.

Clinical Implications

Whatever the precise causal pathway, the bottom line for all health care professionals is that there is substantial evidence that points to the greater likelihood of sexual risk behavior among populations of people who have elevated psychiatric symptomatology and/or psychiatric illness (Axis I and/or Axis II conditions) [8].

This sexual risk includes risk to self as well as risk to sex partners. This review is brief and not comprehensive; there are likely to be associations between sexual risk behavior and psychiatric conditions other than those covered here.

Research Article doi: 10.18081/2333-5106/015-02/378–388

Additional systematic research is needed in this broad domain, along with in-depth analyses of possible causal pathways, including longitudinal studies of the phenomenon [7].

Sexual desire and behavior are normal aspects in the lives of most adolescents and adults, including those with chronic and persistent mental illness. It is important for primary care providers to address the mental health needs of their patients, with appropriated diagnosis and referral for treatment, and for all health care providers to address the sexual lives of their patients without shame, embarrassment or judgment [12].

People who are vulnerable to engaging in risky sex behaviors can benefit from targeted counseling that increases risk perception, motivation for change, the acquisition of protective behavioral skills, and self-efficacy for enacting and maintaining healthy behaviors. Referrals for mental health supportive services are often necessary. Providers can play an important role in empowering their patients to reduce behaviors that carry with them significant risk for HIV and other STDs and to normalize the pursuit of satisfying and healthy sexual gratification [16].

Prevention

Because the cause of compulsive sexual behavior isn't known, it's not clear how it might be prevented, but a few things may help keep this type of behavior in check:

- Get help early for problems with sexual behavior. Identifying and treating early symptoms may help prevent compulsive sexual behavior from getting worse over time or escalating into a downward spiral of shame, relationship problems and harmful acts.
- Seek treatment early for mental health disorders. Compulsive sexual behavior may be worsened by depression or anxiety.
- Identify and seek help for alcohol and drug abuse problems. Substance abuse can cause a loss of control and unhappiness that can lead to poor judgment and may push you toward unhealthy sexual behaviors.
- Avoid risky situations. Don't jeopardize your health or that of others by putting yourself into situations where you'll be tempted to engage in risky sexual practices.

Associated Procedures

- Cognitive behavioral therapy
- Family therapy
- Marriage counseling

Compulsive sexual behavior

- Symptoms & causes
- Diagnosis & treatment
- Doctors & departments

Treatment

Treatment for compulsive sexual behavior typically involves psychotherapy, medications and self-help groups. A primary goal of treatment is to help you manage urges and reduce excessive behaviors while maintaining healthy sexual activities 19.

If you have compulsive sexual behavior, you may also need treatment for another mental health condition. People with compulsive sexual behavior often have alcohol or drug abuse problems or other mental health problems, such as anxiety or depression, which need treatment.

People with other addictions or severe mental health problems or who pose a danger to others may benefit from inpatient treatment initially. Whether inpatient or outpatient, treatment may be intense at first. And you may find periodic, ongoing treatment through the years helpful to prevent relapses [6].

Psychotherapy

Psychotherapy, also called talk therapy, can help you learn how to manage your compulsive sexual behavior. Types of psychotherapy include:

- Cognitive behavioral therapy (CBT), which helps you identify unhealthy, negative beliefs and behaviors and replace them with more adaptive ways of coping. You learn strategies to make these behaviors less private and interfere with being able to access sexual content so easily.
- Acceptance and commitment therapy, which is a form of CBT that emphasizes acceptance of thoughts and urges and a commitment to strategies to choose actions that are more consistent with important values.
- Psychodynamic psychotherapy, which is therapy that focuses on increasing your awareness of unconscious thoughts and behaviors, developing new insights into your motivations, and resolving conflicts.

Medications

In addition to psychotherapy, certain medications may help because they act on brain chemicals linked to obsessive thoughts and behaviors, reduce the chemical "rewards" these behaviors provide when you act on them, or reduce sexual urges [20]. Which medication or medications are best for you depend on your situation and other mental health conditions you may have [21].

Medications used to treat compulsive sexual behavior are often prescribed primarily for other conditions. Examples include:

- Antidepressants. Certain types of antidepressants used to treat depression, anxiety or obsessive-compulsive disorder may help with compulsive sexual behavior.
- Naltrexone. Naltrexone (Vivitrol) is generally used to treat alcohol and opiate dependence and blocks the part of your brain that feels pleasure with certain addictive

behaviors. It may help with behavioral addictions such as compulsive sexual behavior or gambling disorder [22].

- Mood stabilizers. These medications are generally used to treat bipolar disorder, but may reduce compulsive sexual urges.
- Anti-androgens. These medications reduce the biological effects of sex hormones (androgens) in men. Because they reduce sexual urges, anti-androgens are often used in men whose compulsive sexual behavior is dangerous to others.

Competing interests

The authors declare that they have no competing interests.

References

1. Ghadirian, A. M., Chouinard, G. & Annable, L. Sexual dysfunction and plasma prolactin levels in neuroleptic treated schizophrenic outpatients. Journal of Nervous and Mental Disease 1982;170: 463 -467. [Medline]
2. Kay S, Fishbein A, Opler LA. The positive and negative symptom scale (PANSS) for schizophrenia. Schizophrenia Bulletin 1987;13;261-275. [Abstract/FREE Full Text]
3. Lyketsos GC, Sakka P, Mailis A. The sexual adjustment of chronic schizophrenics: a preliminary study. British Journal of Psychiatry 1983;143: 376 -382. [Abstract/FREE Full Text]
4. Creadie RG. on behalf of the Scottish Comorbidity Study Group. Use of drugs, alcohol and tobacco by people with schizophrenia: case-control study. British Journal of Psychiatry 2002; 81: 321-325. [Abstract/FREE Full Text]
5. Mullen B, Brar JS, Vagnucci AH, et al. Frequency of sexual dysfunction in patients with schizophrenia on haloperidol, clozapine or risperidone. Schizophrenia Research 2001; 48: 155 -156. [CrossRefMedline]
6. Smith S, O'Keane V, Murray R. Sexual dysfunction in patients taking conventional antipsychotic medication. British Journal of Psychiatry 2002;181:49-55. [Abstract/FREE Full Text]
7. Coleman CC, King BR, Bolden-Watson C, et al. A placebo-controlled comparison of the effects on sexual functioning of bupropion sustained release and fluoxetine. Clin Ther 2001; 23: 104010–1058. [PubMed]
8. Laumann EO, Rosen RC. Sexual dysfunction in the United States: prevalence and predictors. JAMA 1999; 281: 537–544. [PubMed]
9. Abdallah RT, Simon JA. Testosterone therapy in women: its role in the management of hypoactive sexual desire disorder. Int J Impotence Res 2007; 19: 458–463. [PubMed]
10. Ponticas Y. Sexual aversion versus hypoactive sexual desire: a diagnostic challenge. Psychiatr Med 1992;10: 273–281. [PubMed]
11. Morales A, Heaton JP. Hormonal erectile dysfunction. Evaluation and management. Urol Clin North Am 2001; 28: 279–288. [PubMed]
12. Basson R. Androgen replacement for women. Can Fam Physician 1999; 45: 2100–2107. [PubMed]
13. Walsh KE, Berman JR. Sexual dysfunction in the older woman: an overview of the current understanding and management. Drugs Aging 2004; 21: 655–675. [PubMed]
14. O'Carroll R, Bancroft J. Testosterone therapy for low sexual interest and erectile dysfunction in men: a controlled study. Br J Psychiatry 1984; 145:146–151. [PubMed]
15. Montejo AL, Majadas S, Rico-Villademoros F, Llorca G, De La Gándara J, Franco M, et al. Frequency of sexual dysfunction in patients with a psychotic disorder receiving antipsychotics. J Sex Med 2010; 7: 3404–13. [CrossRefMedline]
16. Howes OD, Wheeler MJ, Pilowsky LS, Landau S, Murray RM, Smith S.Sexual function and gonadal hormones in patients taking antipsychotic treatment for schizophrenia or schizoaffective disorder. J Clin Psychiatry 2007; 68: 361–7. [Medline]
17. Cohen S, Kühn KU, Bender S, Erfurth A, Gastpar M, Murafi A, et al. Sexual impairment in psychiatric inpatients: focus on depression.Pharmacopsychiatry 2007; 40: 58–63. [CrossRefMedline]
18. Uçok A, Incesu C, Aker T, Erkoç S. Sexual dysfunction in patients with schizophrenia on antipsychotic medication. Eur Psychiatry 2007; 22:328–33. [Medline]

19. Aizenberg D, Zemishlany Z, Dorfman-Etrog P, Weizman A. Sexual dysfunction in male schizophrenic patients. J Clin Psychiatry 1995; 56:137–41. [Medline]
20. Clayton AH. Recognition and assessment of sexual dysfunction associated with depression. J Clin Psychiatry 2001; 62 (suppl 3): 5–9. [Search Google Scholar]
21. Bitter I, Basson BR, Dossenbach MR. Antipsychotic treatment and sexual functioning in first-time neuroleptic-treated schizophrenic patients. Int Clin Psychopharmacol 2005; 20: 19–21. [Medline]
22. Van Bruggen M, van Amelsvoort T, Wouters L, Dingemans P, de Haan L, Linszen D. Sexual dysfunction and hormonal changes in first episode psychosis patients on olanzapine or risperidone.Psychoneuroendocrinology 2009; 34: 989–95. [Medline]

American Journal of BioMedicine
Journal Abbreviation: AJBM
ISSN: 2333-5106 (Online)
DOI: 10.18081/issn.2333-5106
Publisher: BM-Publisher
Email: editor@ajbm.net