Orygen
The National Centre of Excellence in Youth Mental Health

Clinical practice in early psychosis

Promoting sexual health

Introduction

Adolescence is a key stage of physical, emotional and social development, when young people transition from childhood, mature physically, and begin to develop adult identities and behaviour. The key challenges of adolescence include more than just the physical changes of puberty; young people also begin in this stage to develop a sense independence, personal identity, healthy values and attitudes and a strong social support network. Sexual health, sexual identity and sexual behaviour are all key parts of every person's life and personal development.[1]

Early psychosis typically emerges in young adulthood, and thus can disrupt this crucial period of physical, social and psychological development. Sexual health and wellbeing is a particular area that can be affected by the onset of psychosis, at both the physical and emotional level. Although it can be a difficult subject for a clinician to broach, it is a crucial part of ongoing assessment in an early psychosis service and should be addressed regularly, with young people given ample opportunity to discuss their sexual health or sexuality.

Understanding sexual health

Sexual health is defined by the World Health Organization as 'a state of physical, mental and social wellbeing in relation to sexuality'. It requires a 'positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence'.[2]

Sexual health, adolescence and early psychosis

The period of adolescence and emerging adulthood (12–25 years of age) is the primary time in which foundations of sexuality develop and the scene is set for adult sexual health. During this time we explore both romantic relationships and sexual activity as well as begin to conceptualise our gender and sexual identity. Risk-taking behaviours increase in adolescence, including unsafe sexual activity, as young people start to challenge boundaries and experiment and explore their sexual identity.[2-5]

> "Definitely when you're young it needs to be discussed, relationships, consent, everything. Absolutely everything, because when you're young you do stupid shit … I don't want anyone to go through the things that I had to go through and learnt on my own.

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The onset of psychosis can affect a young person's sexual health in a number of domains. Firstly, young people who are at considered at ultra high risk of developing psychosis (UHR) and those who have experienced a first episode of psychosis are more likely to have sexual problems or dysfunction.[6] Furthermore, psychosis represents a significant disruption of the normal developmental trajectory. This disruption can greatly affect a person's sexual development, their formation of sexual health-related knowledge, attitudes, and beliefs, their sense of sexuality and body image, and their experiences of positive romantic relationships.[7-9] Young people with early psychosis as a group have experienced disproportionately more abuse and childhood trauma compared with the general population, which can also complicate exploration and expression of sexuality and intimacy.[10]

Other compounding concerns such as stigma, the impact on self-confidence and self-esteem, isolation, or sexual dysfunction related to medications, all lead to potential difficulties for young people in expressing their sexuality and maintaining their sexual health.

Sexual functioning

Sexual activity and sexual function

Sexual function is a complex process of psychological, social and physiological factors. Sexual dysfunction refers to disruption in one of the following areas or processes: sexual interest or libido, arousal, orgasm and ejaculation and resolution.[11,12]

Risk factors for sexual dysfunction in men and women include:[11]

- poor general health status
- diabetes mellitus
- cardiovascular disease
- other chronic diseases
- genitourinary disease
- psychiatric/psychological disorders
- socio-demographic conditions.

Gaining accurate statistics on the rates of sexual dysfunction in the general population is difficult.[13] However, up to 32% of men and around 35% of women have been reported to experience at least one sexual difficulty in a year.[14-16]

Sexual dysfunction in people with psychosis

Sexual dysfunction is common both among people with an established psychotic disorder and those who have experienced a first episode of psychosis.[6,17] It has also been shown to be prevalent in people identified as UHR, suggesting that sexual dysfunction can be a presenting feature of the disorder even before a young person begins taking medication (see later).[6]

This prevalence of sexual dysfunction among people with psychosis may be because, unfortunately, many of the risk factors for sexual dysfunction, such as cardiovascular disease and poor physical health, are also more prevalent in this group.[18,19] Sexual dysfunction can also be caused or exacerbated by side effects of medication (see below), or may be related to psychological issues or stigma stemming from the young person's diagnosis, such as low self-esteem, reduced self-confidence or relationship problems.[20]

Decreased libido is a common complaint reported in untreated individuals with schizophrenia.[21] Furthermore, compared with controls, men with schizophrenia report lower sexual desire, higher rates of erectile dysfunction, premature ejaculation and orgasmic dissatisfaction.[22] The negative symptoms of schizophrenia can negatively affect the ability to enjoy a sexual life. People can also face challenges establishing relationships as a consequence of recurrent psychotic episodes, obesity and low self-esteem.[7]

In studies of people with schizophrenia, poor quality of life is more strongly correlated with sexual dysfunction than with psychotic symptoms.[23] Despite this, young people rarely report sexual dysfunction of their own volition, which may explain why clinicians tend to underestimate the impact of sexual difficulties. One study into the frequency of sexual dysfunction among people with psychosis found that only 37% of participants with sexual dysfunction reported it spontaneously.[24] As such, clinicians are often unaware when treatment non-adherence is related specifically to sexual dysfunction.[25]

> "Look, I just miss being able to come, that's all I miss.
>
> Young person,
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Effects of antipsychotic medication on sexual functioning

There is a known link between sexual dysfunction and all types of antipsychotics. This can be an effect of their action on neurotransmitters and hormones that are known to be involved in sexual function, or can be a result of other side effects such as sedation or weight gain.[12]

By blocking neurotransmitter uptake, antipsychotics can directly affect sexual arousal. Blocking of the D2 dopamine receptor can also cause hyperprolactinaemia (increases in the hormone prolactin), which is associated with decreased libido, impaired arousal and impaired orgasm.[26,27] Almost a quarter of young people prescribed prolactin-raising antipsychotic medication report sexual side effects and diminished sexual performance.[28] Although a range of factors are involved in antipsychotic-induced sexual dysfunction, the strong correlation between raised prolactin levels and sexual dysfunction indicates that those antipsychotics that are less likely to increase prolactin may be less likely to cause sexual side effects.[27]

Sexual dysfunction side effects are also associated with other commonly prescribed psychotropic medications for depression and anxiety, which are common co-occurring conditions.[29-31]

> “I do believe a whole therapy session should be devoted to side effects and how they’re going to affect you, and how you feel about that ...
>
> Young person,
> Orygen Youth Health Clinical Program

Managing sexual side effects and sexual dysfunction

It is important to ask about a young person’s sexual functioning prior to their commencing on antipsychotic medication and to undertake an assessment of baseline sexual functioning. Clinicians should also discuss the possible sexual side effects and the importance of reporting any concerns. This will help the young person feel comfortable about broaching the subject later on, and may help reduce the chance of non-adherence because of problems with sexual functioning. However, it is important not to rely on the young person to bring up sexual side effects themselves at follow up appointments – clinicians should ensure that sexual side effects are routinely asked about in their appointments with young people (see Box 1 on page 4).

If it appears that a young person’s medication is affecting their sexual functioning, it should be discussed with the young person’s psychiatrist. Dose reduction[12] or a switch to an antipsychotic with a neutral effect on prolactin levels[32] may avoid the negative impact of medication on sexual functioning.

It is important to remember that medication is only one possible cause of sexual dysfunction. It is therefore essential that if a young person is having problems with sexual function, all possible causes are examined and addressed, including physical health concerns. Psychosocial interventions to address social skills, self-stigma or other psychological conditions may be indicated, as might sex education or relationship counselling.[20]

Box 1. Talking about sex

People experiencing psychosis want the opportunity to talk about sexuality in a meaningful and respectful way.[33] Young people often report that they want to engage in more diverse and comprehensive sexual education, but also emphasise the importance of talking 'with' rather than 'at' them.[1]

One systematic review of qualitative studies investigating barriers to UK health professionals' discussing sex and sexuality[34] identified a number of structural, organisational and personal barriers, including:

- fear of 'opening up a can of worms'
- lack of time, resources, and training
- concern about knowledge and abilities
- worry about causing offence
- personal discomfort
- a lack of awareness about sexual issues.

These barriers were particularly marked in relation to the sexuality of black and minority ethnic groups, people with intellectual disabilities, older patients, non-heterosexual service users, and people of the opposite sex.

Another study found that clinicians' ability to discuss sexual and relationship health with young people was influenced by their levels of knowledge and information, their personal beliefs, and the availability of private time and space.[35]

While clinicians may not feel young people are comfortable talking about their sexual health, they are in fact able and willing to discuss sexual and relationship concerns when prompted.[8,36] However, only asking if a young person is experiencing any medication side effects may not be enough to initiate a response – it is important to directly ask about sexual side effects. Structured interviews and self-report questionnaires can help young people explore and report their experiences of sexual dysfunction.[37] The therapeutic relationship is the key, as is ensuring that the most appropriate person in the team asks the questions required.

> "Ask questions. If you don't know, ask, because no one knows themselves better than the person. It's all anyone really wants, is to just [someone] to say 'Okay ... tell me more, go on, your voice, your experience, tell us.'

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Social functioning and sexual health

There are important core social functions that are involved in both sexual relationships and romantic relationships. For most people a healthy sexual relationship contributes to, and can be a crucial part of, wellbeing.

Difficulty with social functioning can also be present even in the UHR phase of early psychosis.[38] and social isolation can be more common.[39] This will impact on sexual development due to the social skills required to engage in sexual activity and developing relationships. However, it is also important to reflect that not all young people with psychosis will experience difficulty in this area of development.[40]

> "It is tough. It's also tough having to explain this to a partner – why you're not present

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Although some young people see the prospect of having a relationship as 'normalising', others may perceive relationships to be emotionally 'risky' or incompatible with psychosis.[8] Young people may therefore benefit from therapeutic interventions aimed at developing a secure sense of self, reframing their expectations of intimacy and reducing expectations of risk. Self-stigma is a pertinent issue for young people and can exacerbate feelings of isolation and promote self-imposed celibacy. Young people should therefore be informed that sexual difficulties are also common in the general population,[24] to normalise their experience and reduce self-stigma associated with early psychosis.

> You know, relationships are complicated, so complicated; and young people definitely need to know how to survive one

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TIP It is important to consider the social support that young people give each other in regard to discussing sex or sexuality.[1] If a young person has lost their social support networks because of their experience of psychosis, the young person could be given appropriate support or referred to an appropriate peer support group.[41]

Sexual identity and sexual attraction

Sexual attraction refers to the type of people that we are sexually attracted to. Sexual identity is how a person defines themselves. The terms homosexual and heterosexual are clinical terms, and many young people prefer to use the terms straight, lesbian, gay, straight, bisexual, transsexual, intersex, queer (LGBTIQ), or more recently, same-sex attracted.

Young people identifying as LGBTIQ experience higher rates of mental health issues and are more likely to experience trauma, self-harm and suicidality.[42] They may also have lower levels of parental support and experience higher rates of stigma, discrimination, homelessness and substance use.[43-45] There is some evidence that LGBTIQ people experience a higher incidence of psychotic symptoms compared with heterosexual people, and that this is partly caused by stress from bullying, discrimination and trauma related to LGBTIQ status.[42] When undertaking a mental health assessment, clinicians should therefore be mindful of, and identify, the circumstances and stressors common to LGBTIQ young people that are also risk factors for psychosis.

Young people who identify as same-sex-attracted or who are questioning their sexual identity must be offered a safe space to talk about their sexuality. However, a study investigating clinicians' experiences of providing sexual health services to young people found that many practices and attitudes within services assumed heterosexuality and cis-genderedness (identifying with your biological sex) to be the norm (e.g. having to define someone's biological sex as either male or female on case records).[46] Young people have also described avoiding health professionals because of 'the language they use, not feeling validated or listened to, or being consistently misgendered'.[47]

However, clinicians are well-placed to reduce social and structural barriers to high-quality care by appropriately engaging LGBTIQ young people and by being culturally competent in their practice.[46] It is therefore important that services and clinicians take the time to understand the competencies needed to work effectively with LGBTIQ young people (see Box 2).

Do we need labels?

Many people do not feel the need to have a label to express or explain their sexuality or gender identity. There is debate that sexuality and gender identity is not fixed, but malleable throughout life. We regularly work with diagnostic uncertainty within our mental health services, so let's refrain from labelling young people in terms of their sexuality and gender identity.

> Your sexuality is very personal. A label doesn't cover it, not even for a second.

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Box 2. Resources for working with LGBTIQ young people

The National LGBTI Health Alliance's Cultural Competency Implementation Framework supports mental health services to better serve LGBTIQ communities.

The Rainbow Network has a range of resources on their website for young people, families and clinicians, including 'Beyond Awkward', a resource developed by Orygen Youth Health Clinical Program to help mental health workers in their conversations with young people about sexuality, gender identity, sexual safety and sexual activity.

Safe sexual behaviour

Sexually transmitted infections

Unsafe sex is considered one the of the leading risk factors for morbidity in young people worldwide,[48] and young people are overrepresented in data on sexually transmitted infections. In Australian in 2013, three-quarters of reported cases of both chlamydia and gonorrhoea occurred in young people aged 15–34 years old.[49] Globally, studies suggest that up two thirds of sexually transmitted infections are from people under the age of 25.[50,51]

Young people with who have experienced a first episode of psychosis have been shown to be less likely to use condoms compared with young people with no clinical diagnosis.[52] However, they do not seem to have any worse knowledge about sexual health than young people in the general population.[53,54] There is suggestion that other psychosocial factors may be more likely the reason for poor condom use in young people with first episode psychosis, such as lacking confidence to discuss use of condom with partners, stigma associated with condom use, unemployment (which is higher among people with psychosis) and lack of support for condom use in young people's friendship circles.[52] Higher risk behaviour, including increased sexual risk-taking, increases during manic or hypomanic stages of bipolar disorder.[55,56] Common comorbid conditions such as substance use disorder and depression also have been shown to be indicative of increased sexual risk taking behaviours.[57,58]

> "I was in such a messed up place ... I think it's important to have a discussion like, 'Look, you know your value as a person isn't rooted in the slightest in how you can satisfy someone sexually'.

Young people should be encouraged to attend mainstream sexual health services, although as young people are less likely to engage with generic sexual health clinics, and psychosis may make this even more difficult, it may be necessary to ensure young people feel safe to access these services.[59]

Young people have stated that they would like more access to sex education from a range of sources in an ongoing integrated manner. Outside of school, many young people prefer to get sex and sexual health information from youth centres and youth health services[1]. McCann (2010) reported that although users of mental health services said they would talk about sexual health with a trusted mental health professional, most felt that clinicians were too busy to ask and that when it was asked it was only for risk assessment.[36] It is therefore crucial that clinicians make the time to talk to young people about sex and sexuality (see Box 1).

> "Having information available ... Here's where you can get birth control, here's where you can go for a test. You know, just having it out there, not being patronising, not being non-judgemental.

Young person,
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TIP

Text messages, email or websites are effective ways to deliver information to young people and increase STI knowledge.[60] But most young people say they prefer online information to augment sexual health education and not be the primary source[1].

Intimate partner violence

Intimate relationships can be an important and even protective factor for psychosis; however, they must be healthy and safe. Unhealthy relationships can impact young people's short term and long term development. Violence within adolescent intimate relationships can lead to increased risk of depression, suicidal ideation, anxiety, alcohol abuse, cigarette and drug use, unintended pregnancies and other sexual health risk behaviours.[61-63] Other negative effects include decreased self-esteem, poorer academic performance, disordered eating behaviours, substance dependence, and poor mental health measures.[64,65]

Many risk factors for intimate partner violence first appear in childhood, including witnessing or being a victim of violence, violence within family, lack of connectedness with adults, poor parenting practice, low education, belief that violence is tolerable, and early delinquent behaviours.[66] Therefore intervening early in life to minimise the impact of these risk factors may subsequently lower the risk of intimate partner violence.

Social skills development related to developing and maintaining healthy intimate relationships can be addressed through discussion or role play in therapy.[41,67]

> "When it comes to things like ... consent and power dynamics, those things absolutely need to be discussed, and [we] need a safe space for those things to be discussed.
>
> Young person,
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> "[Discuss] how to be able to say, 'I'm honestly not in the mood, I can't do this right now', instead of going through something that you might find painful or distressing because you feel pressured, 'cause you feel like you have to.
>
> Young person,
> Orygen Youth Health Clinical Program

Service considerations

Creating a safe space

All young people within a mental health service have the right feel safe in expressing their sexual identity and talking about any sexual issues. They also have the right to feel safe from acts that compromise or breach their sexual safety while in a mental health service environment.

Services are encouraged to develop their own local policies and protocols regarding sexual health, sexual safety, expression of sexual identity and behaviour. Young people should also be consulted about the sexual safety standards developed to govern appropriate behaviour within the service they are involved with.

TIP Have appropriate literature and posters around your services that let young people know they can talk to clinicians about their sexuality or gender confidentially and without judgement.

Education and training

Simply providing clinicians with education can both increase awareness of the importance of sexual health and make clinicians more likely to address sexual health concerns in their practice.[68] Education and training are therefore a core part of ensuring staff understand the needs of young people regarding their sexual health and sexuality, and are comfortable with broaching the topic.

> “Often as clinicians, we have our own understanding and prejudices from our personal experience, and this is why training is so important. It makes us question our assumptions, and ensures we have a base knowledge about how to approach the topic.
>
> Senior clinician, EPPIC,
> Orygen Youth Health Clinical Program

Service structure and culture

As discussed, sexuality and sexual health are core concepts that should be discussed as a routine part of mental health clinical practice. It is important to embed this in core practice within the service and to create a culture where all clinicians feel confident and comfortable to ask the questions about sexuality and sexual health.

The area of sexual health and sexuality is ever-changing, and to ensure that adequate processes are in place it is useful to have leaders in the services who will advocate in this area. It is also helpful for services to have a working group (including young people enrolled in the service) that can progress and discuss any changes in sexual health information or policies.

> “How wonderful would it be for a young person to come in and have a transgender therapist? That would be awesome … there’s someone who gets it, who know what’s at stake.
>
> Young person,
> Orygen Youth Health Clinical Program

Educate your organisation’s staff and youth about gender identity. Make sure that people understand that transgender youth want to use the restrooms that conform to their gender identity. If possible, designate gender-neutral restrooms (toilet facilities that anyone may use, irrespective of gender identity or gender expression).

What does this mean in practice?

Sexual health can be part of the functional recovery process, and therefore should be a key focus of treatment for early psychosis. Some practical ways to ensure you promote sexual health in your clinical practice include:

- Ask the young people you work with how much they are comfortable speaking about sexuality with you. They may be waiting for reassurance that it is ok to talk about it.
- Be aware of your limitations and own cultural beliefs; make sure you regularly get supervision and support.
- Engagement and psychoeducation about sexual health are an ongoing part of assessment and treatment. Consider keeping a checklist of any assessments or conversations you have with young people in regard to their sexual health and any screening tests that have been required. This will not only aid treatment but will save the young person being asked about sensitive issues twice.
- Sexual health screening should be routinely discussed; consider helping young people to access and attend services for sexual health screening.
- If a young person is taking sexual risks, use a non-judgemental motivational interviewing approach to try to change thoughts regarding risky behaviour.
- If appropriate, peer support can be helpful.
- Don’t presume to know a young person’s sexual identity, sexual attraction or gender identity. Always ask who they are attracted to, ask how they identity themselves and if appropriate, which pronouns they prefer. Most young people are happy to answer questions provided you tell them why you are asking. Give them the power to refuse to answer questions.
- Advocate for young people and explore what LGBTIQ support services or groups are available in your local community.

- Discuss confidentiality from the beginning. Ensure that the young person knows what is confidential and when you may have to break that confidence (e.g. if they or someone one else is at risk of sexual harm or exploitation).
- Cultural background must be considered when discussing sex or sexuality with young people.
- Give young people the opportunity to get supportive counselling with their sexual partners, either in your service or, if they prefer, through an external relationship service. Supporting people to keep their intimate relationships intact and healthy will have a flow on effect on their mental health.

Case study: Ben

Ben is a 20-year-old man who lives with his family in the western suburbs of Melbourne. He has been attending an early psychosis service for some time since he began to have trouble attending university and work due to experiencing a first episode of psychosis. His symptoms included fears that he has an 'intense smell' that made people avoid him, and hearing voices teasing him about his appearance.

Ben has few friends, and says he often declines invitations to socialise as he feels different to others and thinks that 'no one really likes me anyway because I smell so bad'. He also says he has never "kissed a girl or a boy, so I'm not sure who I like". However, he has started to feel attracted to a young man that stacks the shelves at the supermarket where he works part-time, though he is too scared to even approach him.

As Ben's perceptual experiences decrease with treatment, he begins to feel more comfortable talking to the young man at his work, who invites him out to a music gig. However, in his next session with his case manager, he reports considerable distress as he is no longer able to get an erection. He is also putting on weight and says he is convinced no one would ever be attracted to him.

Ben's case manager tells Ben that it's possible that both the weight gain and his not being able to get an erection might be caused by his medication, so perhaps they need to change his dose or type of medication. She schedules a medical review for him and then asks if he has any other concerns about his sexual health. At Ben's request, they also completed a session to talk more about his exploring his sexuality. His case manager provides further information about community and online LGBTIQ resources, and they decide to visit these together to find out more about the supports available. Ben says his other main concern is feeling unattractive. Together they develop a weight management plan that involves Ben attending a local gym and starting to row with his university team again, which he used to excel at. They also start having some of their sessions walking in a nearby park instead of the case manager's office. Ben's case manager also starts working with him to cognitively challenge some of his thoughts about 'not being good enough'.

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