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Sexual functioning and experiences in young people affected by mental health disorders

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ABSTRACT

The majority of mental disorders have their onset in late adolescence and early adulthood and this coincides with important stages of sexual development. Although sexual dysfunction is highly prevalent among people with mental health disorders, little is known about this topic among youth. This study aimed to evaluate the sexual functioning and subjective experience of sex in young people aged between 15 and 26 years attending a youth mental health service. One hundred and three participants were assessed with the Sexual Health Questionnaire, Sexual Functioning Questionnaire, Brief Psychiatric Rating Scale, Scale for the Assessment of Negative Symptoms and the Medication Adherence Rating Scale. There were 43 males, 52 females, and 8 transgender and gender diverse participants with a range of mental health disorders. Eighty (77.7%) had experienced consensual sexual intercourse. Ninety-nine (95.8%) endorsed at least one item of sexual dysfunction and clinical sexual dysfunction was present in 37 (38.9%) cases. Sexual dysfunction was associated with greater severity of general psychopathology, negative symptoms, antipsychotic use, lower antipsychotic medication adherence, and negative subjective experiences around sex. Addressing this sexual dysfunction in young people could lead to both an improvement in subjective experiences of sexual relationships and potentially improvement in adherence to treatment.

1. Introduction

The majority of mental disorders have their onset in late adolescence and early adulthood and the prevalence of mental health disorders rises rapidly post-puberty (McGorry et al., 2011). This timing coincides with the development of sexual identity and the transition to adult sexual role functioning at the appropriate ages (Impett et al., 2006). Sexual dysfunction is an umbrella term for one or more difficulties related to sexual desire, arousal, erectile response, genital or pelvic pain, orgasm and ejaculation (McCabe et al., 2016a) and it is a common and significant experience among people with mental health disorders that is often overlooked (Macdonald et al., 2003). In order to be classified as a sexual dysfunction disorder, symptoms are generally required to be present in at least 75% of sexual experiences, for at least three months, and to cause individual distress (McCabe et al., 2016a). In the general population, risk factors for sexual dysfunction include psychological stress, smoking, obesity and diabetes mellitus (McCabe et al., 2016b).

In addition to the above factors, young people with mental health disorders have additional risk factors for developing sexual dysfunction. The increased prevalence of sexual dysfunction in this population might be attributed in part to the use of psychotropic medications, which can interfere with sexual functioning (de Boer et al., 2015) and significantly affect quality of life (Finn et al., 1990). This, in turn, can affect future medication adherence (de Boer et al., 2015). However, sexual dysfunction has also been found to co-occur with mental health disorders irrespective of the type of medication prescribed (Montgomery et al., 2002; Macdonald et al., 2003), the length of time on medication (Malik et al., 2011) or indeed whether medication is used at all (Marques et al., 2012; Roy et al., 2015). This suggests that mental health disorders might directly influence sexual functioning, with associations observed between sexual dysfunction and the severity of psychopathology (Lourenco et al., 2011; Malik et al., 2011).

Sexual functioning can also be affected by factors that are common to a number of mental health disorders, including poor self-esteem, anhedonia and sleep disturbance (Macdonald et al., 2003; Kelly and

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Conley, 2004; Boin et al., 2014). Moreover, poor self-esteem can lead to social isolation and feelings of worthlessness in relation to sexual intimacy, which, in turn, may decrease opportunities for positive sexual engagement (de Jager and McCann, 2017).

Specific disorders can also have factors that increase the prevalence of sexual dysfunction. In psychotic disorders, negative symptoms such as affective blunting, social withdrawal and impairments in abstract thinking, have been associated with poorer sexual functioning (Macdonald et al., 2003). Another study found that half of young people identified as being at ultra-high risk for psychosis had sexual dysfunction and those affected were more likely to transition to a full threshold psychotic disorder, suggesting that sexual dysfunction may be a core component of a psychotic disorder (Marques et al., 2012). Studies in other diagnostic groups have tended to focus on older adult populations and they have demonstrated that sexual dysfunction is highly prevalent in individuals with bipolar affective disorder, borderline personality disorder, depression and anxiety disorders (Bancroft et al., 2003; Sansone et al., 2008; de Boer et al., 2015). The research to date has tended to focus on individual diagnostic groups, despite sexual dysfunction appearing to be a non-specific feature of mental health disorders.

Healthy sexual functioning is an important component of quality of life, yet people with mental health disorders are often reluctant to spontaneously discuss sexual issues with their clinicians, and clinicians frequently avoid enquiring about them (de Boer et al., 2015). This can lead to an underestimation of the prevalence of sexual dysfunction, unmanaged symptoms, and reduced adherence to treatment, especially if an individual attributes the cause of their dysfunction solely to medication (de Boer et al., 2015). Yet, few studies have focused on the subjective experience of people receiving mental healthcare with regard to their sexual relationships (Vucic-Peitl et al., 2011), and it has never been investigated whether the presence of sexual dysfunction might be associated with particular subjective experiences.

The present study aimed to evaluate the sexual functioning and subjective experiences of sex in young people with a range of mental health disorders. It aimed to determine the prevalence of sexual dysfunction, and whether the prevalence of sexual dysfunction was associated with demographic and clinical factors such as gender identity, diagnosis, medication, severity of psychopathology, previous trauma, or smoking status. Finally, it was hypothesised that the presence of sexual dysfunction would be associated with more negative subjective experiences of sex.

2. Methodology

2.1. Setting

The study took place at Orygen Youth Health (OYH), the State Government funded youth mental health service for young people residing in northwestern and western metropolitan Melbourne, Australia. OYH operates across four streams of care: First episode psychosis (Early Psychosis Prevention and Intervention Centre (EPPIC)) (McGorry et al., 1996), ultra-high risk for psychosis (Personal Assessment and Crisis Evaluation (PACE)) (Yung et al., 2007), borderline/severe personality disorder (Helping Young People Early (HYPE)) (Chanen, 2014), mood disorders (Youth Mood Clinic (YMC)).

2.2. Participants - Inclusion and exclusion criteria

All young people attending OYH were included, regardless of age or relationship status. Participants were aged between 15 and 26 years, and were recruited from both the outpatient and inpatient settings. Participants with insufficient fluency in English were excluded.

2.3. Instruments

Sexual health was measured using a questionnaire developed by the Australian Research Centre in Sex, Health & Society (ARCSHS) to evaluate the sexual health of secondary school students (Smith, 2009). This instrument has not been validated, however, the questions used in this measures provide a one-to-one mapping between responses on a single item and the outcome of interest (e.g., number of sexual partners) - rather than attempting to measure an underlying construct via multiple items. The instrument developed by ARCSHS was chosen for the current study because it had already been widely used in Australia to successfully gather meaningful data on the sexual behaviours and health of young people. This instrument was reviewed by two members of the research team (BO'D and AB) and the questions that were deemed relevant for young people with mental health disorders were included in the Sexual Health Questionnaire developed for this study (items D1, D4, D8, D10, D11, D13-D15, D18-D20; see Smith et al., 2009). Additionally, the questionnaire was reviewed by the Orygen Youth Health peer consultation group (known as Platform), in order to make the questionnaire acceptable to young people. The Sexual Functioning Questionnaire (SFQ) was used to assess sexual dysfunction and a cut-off score of eight corresponded to the presence of clinically relevant sexual dysfunction, as previously determined by the study by Smith et al. which was conducted in a clinical cohort of young people with a first episode of psychosis or at ultra-high risk for psychosis (Smith et al., 2002). The Brief Psychiatric Rating Scale (BPRS) was used to evaluate the severity of psychiatric symptoms (Overall, 1962), and the Scale for the Assessment of Negative Symptoms (SANS) was used to evaluate the severity of negative symptoms in the psychosis and ultra-high risk for psychosis for psychosis group only (Andreasen, 1983). The Medication Adherence Rating Scale (MARS) (Thompson et al., 2000) was used to determine adherence to medication and higher scores indicated more negative attitudes and lower adherence to medication. Doses of antipsychotic medications were converted to chlorpromazine equivalent doses using the conversion table by Woods (Woods, 2003). The diagnoses were taken from the clinical notes and these were made by the treating consultant psychiatrist.

2.4. Study design & statistical analysis

This was a cross-sectional study. To determine if differences existed between groups for continuous variables, *t*-tests were performed for parametric data and Mann Whitney *U* test was performed for non-parametric data. To determine if differences existed between groups for categorical variables, chi square tests were performed. Binary logistic regression was performed to establish odds ratios. Statistical analysis was conducted using SPSS v20.

2.5. Ethical approval

Ethical approval was granted by the Melbourne Health Human Research Ethics Committee and ethical approval was granted for young people aged between 15 and 17 to provide consent for themselves if they had decisional capacity and were demonstrated to be a 'mature minor'. This was in response to the feedback from the consumer consultation group who advised that young people would have been unlikely to participate if they had to obtain parental consent. Participants were reimbursed for any travel, or other inconvenience incurred due to their participation, with a voucher to the value of $20. A stipulation of the ethics approval was that the treating clinical team could exclude potential participants on a case-by-case basis if it was judged that an interview about their sexual health would be clinically contraindicated, for example in circumstances in which clients are known to become distressed when discussing sexual experiences. All participants provided informed written consent.

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