

## SEXUALITY AND PSYCHOSIS

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### SUMMARY

*Sexuality and sexual disorders of patients with psychoses are frequently neglected and under-investigated. The main purpose of the present study is to discuss the subjective experience of sexuality in patients with psychosis within the general psychodynamic and phenomenological understandings of psychotic states.*

*The authors, both psychotherapists, dealing with patients with psychoses, reflected experiences from their clinical work with the help of the conceptual frameworks of psychodynamic and phenomenological psychiatry.*

*Willingness and need of patients to talk about sexuality, non-specificity of frequencies and variety of sexual disorders in psychotic patients, difficulties in establishment of a stable (sexual) identity and the question of homosexuality, absence of sexual activities with others and feelings of guilt and inadequacy, masturbation with its functions, impulsive sexual acts or lack of sexual self-control, erotic delusions and erotic transference were the main findings, dominating the sexual sphere of these patients.*

*All these manifestations of sexuality in patients with psychosis can be seen - as exposed in discussion - as consequences of a basic self-disorder (phenomenological perspective) or of difficulties in regulating closeness and distance (psychodynamic perspective). Reasons of avoidance of treatment of sexuality by the therapists of psychotic patients are discussed as well.*

*Implications for dealing with sexuality issues in psychotherapy of patients with psychoses were drawn from the above findings in the last part of the article.*

**Key words:** *self-disorder – phenomenology - psychodynamic psychiatry – homosexuality - erotic delusions*

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### Introduction

Most of the authors, dealing with the psychotherapy of psychotic patients agree upon the fact, that the issue of sexuality is very neglected within it (Akhtar & Thomson 1980, Münch 2002). It is also under-investigated. There are many reasons for this. Münch (2002) writes, that in modern psychoanalysis as well as in psychotherapy in general the treatment of sexuality is less and less present. He suggests that theoreticians of psychotherapy of psychoses played a role in this process. They stressed predominantly the importance of non-sexual needs for the development of a child. In the mother and child relationship they focused on needs for adequate emotional responsiveness, mutual communication, and physical contact, which help the child to form self-identity. Meanwhile the psychosexual development was left behind. But we know from our

clinical work, that the diverse facets of psychological development, as mirrored in the theories of drives, object relations, ego psychology and self psychology, are strongly intertwined and that they cannot be treated separately.

Sexual dysfunctions, though being most probably one of the major factors contributing to noncompliance with antipsychotic medication, have also received relatively little attention within standard psychiatric care for psychotic patients (Kelly & Conley 2004).

We tried to investigate in the present article the reasons why it is so: to understand from a psychodynamic point of view, what occurs in a therapeutic process with a person with psychosis contributing to such a neglect and avoidance. Simultaneously we searched the access points to treat adequately sexual issues in the treatment of these patients.

## Procedures

Both authors are psychotherapists, working or having worked in the Unit for psychotherapy of psychoses of University Psychiatric Hospital Ljubljana. They were thus accompanying psychotic patients during their hospitalisations as well as through long-term out-patient individual and/or group psychotherapies.

For the present paper they recollected their clinical experiences and reflected on them with the help of the conceptual frameworks of psychodynamic and phenomenological psychiatry. Through multiple previous discussions and case reports they mapped basic categories of manifestations of sexuality within the psychotherapy process with potential complications and pitfalls. The whole procedure followed the general epistemological prerequisites of a qualitative phenomenological research.

In the last part of the paper they outlined the recommendations for adequate treatment of sexual issues in the psychiatric and psychotherapeutic care for these patients.

## Findings

### (1) *Willingness and need of patients to talk about sexuality*

Patients with psychosis are willing, ready and even thankful if they are given the opportunity to talk about their sexuality. They have no problem discussing their wishes and fantasies, regardless whether they are heterosexual, homosexual or unusual, and their overt sexual activities, be it masturbatory or with others.

They often talk about them in a more detached manner and with less emotional accompaniment. But they can report sexuality to be one of the most vivid topics in their lives and in the therapy. One of our patients said: "Whenever I talk about sex, I feel alive. It is one of the very few things, where I feel alive at all".

At the same time it is rarely that they would bring up the topic spontaneously. So, they need to be stimulated by tactful and timely questions about sexuality by their therapists.

### (2) *Non-specificity of frequencies and variety of sexual disorders in psychotic patients*

Sexual disorders, except for the sexual dysfunctions accompanying neuroleptic treatment, are not specific by their frequency or forms. Patients are sexually active in reality or in their fantasies, they may not have any sexual disorders,

or they report having problems with premature or retarded ejaculation, erectility problems, etc. However as already stated their frequency does not exceed the frequency of sexual problems of other patients.

### (3) *Difficulties in establishment of a stable (sexual) identity and the question of homosexuality*

Patients report difficulties in establishing a stable sense of self and a stable identity. They feel themselves as being changeable in behaviour, speech and gesture through associating with different people. They can feel also empty of a sense of self or inner hold and they cannot assume a firm stance about anything. So, in the same way sexual attraction and sexual identity are at stake as well.

Patients can feel attracted to both sexes or even to people of different age-groups, and they can be confused in this respect. One of our patients said: "I think I can become sexually attracted to anyone, with whom I am in an intense relationship, regardless of the sex or age." He, for example, having had for a short while a sexual relationship with a girl, spent a whole week-end with his roommate, and was confused after it by the strong sexual desire towards him.

Patients very often contemplate and ruminate around questions about homosexuality. In many cases the reason for these preoccupations lie not so much in a direct wish for a homosexual relationship, but more in a doubt springing from general doubts about their identity. Several of our patients suffering from psychosis talked about their paralysing preoccupations of being homosexual without any wish for a physical contact with a person of the same sex. They started in most of the cases from pleasant feelings or longings for close contacts with peers, triggering doubts in one's sexual orientation, followed by obsessional types of ruminations about it.

### (4) *Absence of sexual activities with others and feelings of guilt and inadequacy*

One of the general characteristics of the sexual life of psychotic patients with other people is that it is absent for different reasons. The common denominator is difficulties in regulating closeness. Patients feel overwhelmed, anxious and uneasy in the presence of other people, even more so in the presence of potential sexual partners. One of our male patients with schizotypal personality disorder felt every gaze of other people painful and

distressing: this was so with a neutral gaze, more so with an unpleasant gaze of another man, but the worst was a seducing gaze of an attractive woman. A "natural" consequence for him of these experiences was avoiding contacts with women. Similarly another of our patients with schizophrenia, who was for many years in love with a librarian, regularly visited the library once a week. He described in therapy his sexual fantasies, connected to her. But in reality he never approached her, even though she was showing also some signs of sympathy towards him.

Many times such avoidant behaviour, precluding the chances for close relationships together with a basic lack of initiative accompany feelings of guilt. Patients attribute to themselves and feel responsible for everything which they lack and cannot achieve. They feel inadequate both as sexual performers and partners as well as guilty for this inadequacy.

#### *(5) Masturbation with its functions*

Because of the mentioned absence of sexual activities with others, masturbation may represent a central sexual activity of a patient. So, it serves as a replacement for sexual activity with another person. It can be accompanied by fantasies, imagination and by usage of pornographic material.

Secondly, masturbation can serve as a means of reducing tension and anxiety. It may not be accompanied by any representation or image of a potential sexual partner. It may even assume a form of compulsory activity.

#### *(6) Impulsive sexual acts or lack of sexual self-control*

Impulsive sexual acts are not very frequent, but they make a strong impact. Patients can grab sexual organs of other patients or of the staff members, they can behave promiscuously, or can enter sexual intercourse in public or not hidden places.

These acts occur in acute psychotic phases as well as in some chronic courses of schizophrenia and represent both a diminished impulse control as well as weak contact with other people and the imperatives of common sense.

One of our female schizophrenia patients, who was withdrawn within the first two hospitalisations, started to engage in sexual relationships with several patients while being hospitalized for the third time.

#### *(7) Erotic delusions and erotic transference*

In some cases a patient can develop an erotic transference towards his or her therapist, which can assume a form of erotic delusions. One of our female patients with schizophrenia developed a delusion, that a therapist was in love with her, so he tried to hinder her treatment. He was trying, according to her, to keep her ill and thus to keep her dependent on him. Patients often do not express their erotic delusions to the therapist, who is their object, but to other therapists or team members. This can lead to a complex situation within a therapeutic setting.

Another patient, illustrating erotic transference, mentioned several times in the therapy, how he imagines his future girl-friend to be. She would be, he said, short, with short, blond hair and full lips...in one word: similar to his therapist. She would become his wife and he will have children with her.

#### **Discussion**

From our clinical experience we could observe, as mentioned above as our first finding, that patients are willing to talk about their sexuality without problems and are thankful for the opportunity to do it. This is similar to observations of some other authors (Wasow 1980). Sexuality is always present in the psychotherapy of patients with psychoses. It takes different forms. It can be manifested in the clinical picture of psychosis, i.e. in delusions, in fears and wishes, related to the object, in erotic transference etc. The beginning of psychosis takes time usually in adolescence, when the infantile drive conflicts are revived. This is not coincidental. It points to the great importance of this type of conflicts.

The patients only need to be encouraged by adequate questions and openings. Of course a therapist needs to do it tactfully and with a feeling for a good measure, otherwise some difficulties might appear. Rosenfeld (2005) warns, that a therapist should not act intrusively or seductively in order to avoid development of erotic transference or even transference psychosis, which should be all the time controlled for.

On the other hand a therapist should not be too reserved and scarce in asking about sexual problems so as not to hinder treatment of sexual difficulties of a patient: e.g. side-effects of neuroleptic treatment.

If we agree that the major psychodynamic dilemma in psychosis is regulation of closeness

and distance (Pao 1994), and the differentiation of a self and an object, then it is obvious how important sexuality is in the psychotherapy of such patients. A patient is constantly confronted with problems of rapprochement, emotional attachment and submission as well as of distance, separation, and loss.

Mentzos (2002) suggests to define first, what sexuality is, and then to search relevant connections of sexuality and psychosis. If we talk about sexuality in a strict sense of the word: that is about sexuality, originating in a biological drive, and about the needs streaming from it, then we find in psychotic patients no deviations in the frequency or variety of sexual disorders, which was our second finding. Patients are sexually active partially or genitally in fantasies or/and in reality.

It is different, if we take into consideration sexuality in a broader sense. In this case we are not limited only to the sexual drive, but also to the question of identity and to all related wishes, fears and conflicts. From a phenomenological point of view a patient with psychosis suffers from basic self-disorder, which impedes formation of identity (Parnas 2003, Sass & Parnas 2003). It results in the instability of identity with hyper-reflexivity, having its manifestation also in the sexual sphere, which was our third finding.

One of its manifestations is also preoccupation with the question of homosexuality (Lester 1975), springing from this same instability. This question raises also a dilemma of the connection between paranoid ideas and homosexuality, the former being reaction-formation and projection of threatening unconscious homosexual wishes (Chalus 1977). From Freud's famous interpretation of the Schreber case we find in the psychoanalytic literature a continuous line of understanding paranoid phenomena on the ground of unconscious homosexuality as their organizing principle (Frosch 1981). But we can understand homosexual preoccupation also from another angle: as being part of a search for a company of peers of the same sex or for a group of like-minded and like-bodied, with whom one is erotically linked (Rosenbaum 2005). Psychotic patients have general difficulties in establishing relationships with others: full of doubts, uncertainties and ambivalence with ruminations and hyperreflexivity (Sass 2000). Sexuality and especially fear of being homosexual are among the most common sources of such uncertainties.

Our fourth finding was that of an absence of sexual activities with others. A patient, having difficulties in regulating closeness and distance (Pao 1994) often does not dare to approach an object (partner) or quickly withdraws from a relationship. We can see such withdrawal from relationships with a natural consequence of absence of sexual activities within a broader framework of schizophrenic autism (Parnas et al. 2002).

Masturbation and impulsive sexual acts - our fifth and sixth finding - represent behavioural consequences of the above mentioned basic instability and insecurity in the whole structure of experiencing oneself. Control mechanisms, which a patient activates to cope with them, cannot hold the whole structure of the self together anymore - especially in acute phases and in severe chronic cases of schizophrenia - and impulsive acts ensue.

Some of patients with psychosis talk about sexuality extensively, without shame and without usual distance: e.g. about their sexual fantasies while masturbating. Mentzos (2002) understands this as a forced "sexualisation", with which a patient defensively covers deeper lying fears. Such an understanding may help a therapist, especially when dealing with erotic transference. Sometimes such forced and changed sexuality: e.g. obsessive masturbation without enjoyment, serves as prevention from threatening psychic disintegration (Ogden 1995).

Another important issue in psychotherapy of psychotic patients, as already mentioned as our seventh finding, is erotic transference, which is difficult to manage. Rosenfeld (2005) warned against too early interpretation of the erotic transference, since the patient can understand interpretation as therapist's seduction and react accordingly. It can develop into erotic delusions, which need intensive and longer treatment.

Why is there, in spite of such rich material on sexuality among patients with psychosis, such an evident lack of research and discussions on this topic? One of the reasons for the marginalisation of sexuality in patients with psychotic disorders are we, the therapists ourselves. We avoid it because of our fears. We can see this neglect as a therapists' selective inattention, as Yalom (1980) called the analogous inattention of existential concerns in psychotherapy.

Psychiatrists avoid sexual themes out of counter-transference and prejudices. They consider sexuality of psychotic patients to be bizarre,

inaccessible and uncontrollable. Or they think that their sexuality is non-existent, so they don't want to embarrass a patient with such questions. Therapists usually assume general convictions, that depression is connected with a sexual inactivity, mania with excessive sexual behaviour and schizophrenia with bizarre or perverse sexuality, asexuality or sexuality limited to masturbation. Successful genital sexuality of patients with psychoses is for them almost unimaginable.

### Implications for the therapy

How shall a therapist deal with sexuality within psychotherapy of patients with psychosis? A basic condition is the establishment of a trusting atmosphere and safe environment, in which a patient can openly talk about sexual issues. If a patient feels that he/she is being understood, it can lead him or her to further relaxation and lessening of fears.

But at the same time, as we already mentioned, a therapist should not be intrusive or even seductive. A neutral interest with open and direct questions about sexuality seems to be the most appropriate attitude to adopt.

Interpretations of transference phenomena should be predominantly based in object relation theories and self-psychology, meanwhile interpretations of conflicts can take their place much later in therapy. All the interpretations should be tactful and timely, following the patient's capacities of differentiation of a self and an object, of symbolisation and of maturity of other relevant ego functions.

At the same time psychotherapists should be attentive and become aware of problems stemming from counter-transference and the preformed prejudices on sexuality of patients with psychoses. Such endeavours enable a therapist to overcome "scotomes" for sexuality, which is, as we have seen, a vital part of therapy.

Another important implication, springing from the above exposition, is a precaution in interpreting sexual material in the therapy. It may and in many occasions it actually does hide in itself global changes and basic disorders of experiential structure of a patient (Parnas 2003). A therapist should have in mind that common sexual disorders or uncertainties of a patient can bear in themselves deeply rooted self- and identity-instability. A similar line of analysing sexual material stems from psychodynamic psychiatry. Oral problems are

wrapped in genital disguise: i.e. apparently genital material is symbolic of the more central earlier oral problems of survival of a patient. So, the so-called genital battles of people with psychosis, who have more difficulties in every domain of their life, should also have expression in their sexual area (Karon & VandenBos 2004).

### Conclusion

Sexuality of patients with psychosis is diverse and rich. It ranges from absence of overt sexual activities to erotic delusions, and from feelings of guilt and inadequacy to impulsive sexual acts. Sexual problems of our patients may not be different from sexual problems of other people in their manifestations and forms. But they can be very different in the basic experiential structure, from which they stem.

There are two main tasks of therapists, which can be deduced from the above discussions. First, we need to become aware of our prejudices and counter-transferential "scotomes", which hinder the assessment of sexuality of our patients. And secondly, we need to be cautious in interpreting the assessed material from a broader perspective of the experiential world of our patients.

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