Sex Education and Rehabilitation With Schizophrenic Male Outpatients

by David Lukoff, Debbie Gloia-Hasick, Greer Sullivan, Joshua S. Golden, and Keith H. Nuechterlein

Abstract

Research indicates that schizophrenic patients lack intimate relationships and show a high rate of sexual dysfunction. Despite increasing awareness of the rights of handicapped persons to sexual expression, the treatment of schizophrenic patients rarely addresses their sexuality. A sex education program for recent-onset male schizophrenic patients attending an outpatient clinic was developed in response to several incidents involving patients' inappropriate sexual behaviors. To enhance our understanding of the current sexual functioning and needs of these patients, sex histories were taken. Almost all of the 16 patients interviewed were sexually active, with autoerotic activity predominating. Sixty-three percent of the patients reported orgasmic and/or erectile dysfunctions. Other studies have linked sexual dysfunction to the side effects of antipsychotic medications. The objectives of the sex education program were: (1) to provide information; (2) to clarify values; (3) to overcome sexual dysfunction; and (4) to enhance intimacy skills. The authors used role playing, modeling, group exercises, and explicit sex therapy audiovisual material to improve patients' intimacy skills. Patients participated actively and used the group to explore sexual issues. No exacerbations of symptoms were observed among patients participating in the program.

Sexual functioning is a legitimate and important concern in a comprehensive rehabilitation program for schizophrenic patients. While many rehabilitation programs for physically disabled (Madorsky and Dixon 1983) and ill (Golden 1986) people now include sexual rehabilitation as part of comprehensive care, the sexual functioning of mentally ill people continues to be ignored (Wasow 1980; Friedman and Harrison 1984). The Sex Information and Education Council of the U.S. (1986), which operates a clearinghouse for sex education materials, recently noted:

Unfortunately . . . there are no sex education resources, such as curricula or booklets, at this time for either the mentally ill themselves or educators working with them. [p. 4]

No studies of the outcome of sex education with schizophrenic patients have been published, and there are only a handful of anecdotal accounts of sex education programs with the mentally ill reported in the literature.

Several factors contribute to this situation. Psychiatric staff members report discomfort when having to deal personally with patients about sexual concerns (Wolfe and Menninger 1973; Withersty 1976). This personal discomfort is compounded by the fear that psychiatric patients are not capable of responsibly handling their sexuality and that recognition of their sexuality might trigger inappropriate behavior (Sadow and Corman 1983).

Since at least the early 1900s, psychiatry has linked sexual activity and psychiatric illness. Von Krafft-Ebing in 1904 maintained that sexual excesses, particularly masturbation, caused insanity. Even as recently as 1972, a survey of 18 hospital-based psychiatrists in Boston found that "consultant and staff psychiatrists believed sexual activity might have been a contributory factor for all listings under anxiety and depression.

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and for two-thirds of those under schizophrenia" (Pinderhughes, Grace, and Reyna 1972, p. 98). Furthermore, those surveyed thought that sexual activity could retard recovery in one- to two-thirds of their schizophrenic patients. Although there is no empirical evidence to support these beliefs, they continue to influence the expectations and behavior of mental health professionals. In the same survey, for example, psychiatrists stated that they were much less likely to discuss sexual functioning with schizophrenic patients than with depressed or anxious patients.

Fears that sex education programs lead to increases in sexual acting out have been shown to be false in studies with high school students (Kirby 1985). With developmentally disabled patients, Demetral (1981) found that sex education did not worsen but improved patients' behaviors relating to sexuality, including appropriateness and hygiene. With a population of psychiatric inpatients, Wolfe and Menninger (1973) noted that after a sex education program, "no tendencies were seen toward eroticism, nor were there any additional major sexual experiences, such as intercourse or homosexuality noted on the ward" (p. 150). Patients in this and other programs were found to be eager for sex education and receptive to it (Axelrod, O'Brien, and Hines 1973; Mindek 1974; Wasow 1980).

Sexual Dysfunctions in Schizophrenic Patients

Investigators have studied the nature of sexual functioning in the normal population (Levine and Yost 1976) and a variety of acute and chronic illnesses (LoPiccolo and LoPiccolo 1980). The situation in psychiatric disorders is different:

Surprisingly, psychiatry, in contrast to other medical specialties, has generated little data about the sexual behavior of patients suffering from the various mental disorders. [Friedman and Harrison 1984, p. 555]

As a result, little is known about the "natural history" of sexual functioning in people with schizophrenia. A few studies of hospitalized chronic schizophrenic patients have been reported (Rozan, Tuchin, and Kurland 1971; Akhtar et al. 1977; Nestros, Lehman, and Ban 1981). These studies suggest that schizophrenic patients' sexual functioning is both qualitatively and quantitatively different from normals. Nestros, Lehman, and Ban (1981) found that schizophrenic patients were more likely, even premorbidly, to have autoerotic behavior as their primary sexual activity. With one exception (Lukianowicz 1963), these studies have reported that schizophrenic patients have less overall sexual activity of any type than do normals. Furthermore, Nestros, Lehman, and Ban (1981) found that while normal sexual activity peaked at ages 30-39 and then gradually dropped off, the schizophrenic patients' sexual activity dropped progressively after adolescence.

For a better understanding of the sexual functioning of our patients, we administered a 15-minute interview covering sexual history and current sexual behavior to 16 Caucasian male patients with schizophrenia at the UCLA Aftercare Clinic. One other patient in the clinic declined to answer the questions and another was too conceptually disorganized to provide useful information. The average age of the patients in the survey was 25.6 years and most came from social classes III-V. Since the Aftercare Clinic is linked to a longitudinal follow-through study of recent-onset DSM-III schizophrenic and schizophreniform patients, all patients in the group had been ill less than 2 years at entry into the clinic. These are the first published data on the sexual functioning of recent-onset male schizophrenic patients living in the community.

The data in table 1 show that recent-onset male schizophrenic patients are sexually active, with most of their sexual activity being autoerotic. Only 19 percent reported having a current sexual partner and the median number of sexual partners during their lifetime was three, considerably below average for a group of males in their twenties (Kinsey, Pomeroy, and Martin 1948). Nineteen percent reported never having had a sexual partner. Current homosexual contacts were reported by only one patient, and one other patient reported a homosexual experience in the past.

Sexual dysfunctions were reported by 63 percent of the patients. Five said they had difficulty achieving or maintaining erections when masturbating. During sexual intercourse, one reported difficulty with erections 25 percent of the time, two with premature ejaculation 25 percent of the time, and two with retarded ejaculations 25 percent of the time. Two patients reported more than one sexual dysfunction. Four did not answer these questions (including the three who had never had sexual intercourse). Thus, 3 of the 12 patients who responded to questions about sexual intercourse reported sexual dysfunction 25 percent of the time. Several of the patients who reported no dysfunction admitted during the interview that
Table 1. Frequency of sexual activity of recent-onset male schizophrenic patients (n = 16)

<table>
<thead>
<tr>
<th>Sexual activity</th>
<th>Everyday</th>
<th>Several times a week</th>
<th>Once a week</th>
<th>Once a month</th>
<th>Once every several months</th>
<th>Once a year</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masturbation</td>
<td>%</td>
<td>19</td>
<td>38</td>
<td>31</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>%</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

they had few experiences on which to base their report.

These rates are consistent with the high incidence of sexual dysfunction reported in the literature in medicated schizophrenic patients (Ghadirian, Chouinard, and Annable 1982). Studies in the general population have found the prevalence of orgasmic dysfunction to be somewhere between 15 and 25 percent and the prevalence of impotence, about 10 percent (Frank, Anderson, and Rubinstein 1978). Thus, the rates for schizophrenic patients are clearly elevated.

Many of these sexual dysfunctions are known to be related to antipsychotic medications including: total inhibition of ejaculation and retarded ejaculation (Blair and Simpson 1966); spontaneous ejaculation (Keitner and Selub 1983); difficulties in achieving and maintaining erections (Kotin et al. 1976); decreased sexual desire (Witton 1962); painful orgasms (Berger 1979); and priapism, a prolonged painful erection which frequently requires immediate surgical intervention (Moloney, Elliot, and Johnson 1976).

Sex Education for Schizophrenic Patients

There are ample reasons for including sexual functioning in rehabilitation programs:

1. Schizophrenic patients, like others, are sexual beings and the recognition and validation of their sexuality is an important "quality of life" issue. In our culture, sexual competence is a major component of self-esteem and well-being (Golden and Golden 1980).

2. The incidence of sexual dysfunction in schizophrenic patients is high. Studies, including our own, have found that 30-60 percent of patients have major dysfunctions (Nestros, Lehman, and Ban 1981). Worry and concern over having a sexual dysfunction can be a stressor. Within the vulnerability-stress-coping-competence model of the course of schizophrenia (Liberman et al. 1986), sexual dysfunction could be a contributing stress factor leading to the exacerbation of symptoms or relapse, as well as impairing coping and competence.

3. Noncompliance with medication among some patients has been attributed to complaints about medication-induced side effects of sexual dysfunction (Carlson and Sadoff 1971). Many studies on the causes of noncompliance have not considered this source, and it may be greatly underreported in the literature.

4. Training schizophrenic patients in intimacy skills and motivating them to develop sexual relationships could help them to overcome social isolation. In addition to being considered a negative symptom of schizophrenia, social isolation is also a risk factor in relapse (Sokolovsky et al. 1978). Both social and sexual functioning appear to deteriorate with time in the absence of intervention.

5. Inappropriate sexual behaviors, sexual fears, and delusions of some patients may be major obstacles to their integration into the community (Akhtar and Thompson 1980).

6. Reproductive rates of both male and female schizophrenic patients appear to be on the increase (Erlenmeyer-Kimling et al. 1969). Many of these pregnancies are unwanted and unplanned, suggesting that awareness and use of birth control are lacking (Abernethy et al. 1976). In addition, schizophrenic women seem to be at high risk for sexual abuse (Friedman and Harrison 1984).

Sex Education Program

At the UCLA Aftercare Clinic, an outpatients clinic for schizophrenic and schizophreniform patients, problems of sexual dysfunction, as well as problems linked to inappro-
appropriate sexual behaviors, led to our decision to introduce a sex education program. These incidents included: (1) two female receptionists complained to our staff that two male patients from the Aftercare Clinic were constantly asking them for dates and making inappropriate sexual remarks to them; (2) one male patient who had his first experience of sexual intercourse caused a disruption at his board-and-care residence by claiming that his girlfriend's baby was his and they should get married; (3) one patient had the delusion that little children were being placed in front of him to tempt him to molest them; (4) one female patient underwent a pregnancy scare which caused her great distress; and (5) one male patient was asked not to return to his health club because several of the women complained that he touched them and made sexual remarks to them in the jacuzzi. In addition, several patients complained during therapy sessions about their lack of an active sex life and guilt over masturbation.

Aftercare Clinic patients were invited to participate in a series of group sex education sessions. Since some of them came to the clinic on Mondays and others on Thursdays, two sections of the group were offered. Not only the patients specially nominated for the sex education group by the Aftercare Clinic team, but all 18 male patients coming to the clinic on these 2 days were offered the sessions. Although we would have preferred a coed group, our clinic is disproportionately composed of male patients. Since only one female patient was attending the clinic on either of these 2 days, we limited the group to male patients.

Objectives. Since no curricular materials for schizophrenic patients were available, the first two authors designed a program which incorporated the standard goals that have been established for sex education programs in general: (1) to increase participants' knowledge and comfort about their sexuality and the sexuality of others; (2) to help participants identify and clarify their values and attitudes about sexuality and; (3) to help participants acquire decision-making skills (George and Behrendt 1985).

However, schizophrenic patients have additional specific clinical needs such as overcoming sexual dysfunction, preventing deterioration of sexual functioning, and learning intimacy skills. The sex education materials available for students (McCary 1975) and developmentally disabled patients (de la Cruz and La Veck 1973) do not incorporate these goals. Programs for persons with major physical disabilities who are at risk for loss of sexual functioning do deal with sexual functioning graphically and explicitly (Madorsky and Dixon 1983).

To help us develop a sex education program, we consulted with the staff of the UCLA Human Sexuality Program who have experience working with physically ill and disabled patients. The result was a program that incorporated sexually explicit material usually used during sex therapy sessions—for example, the Sensate Focus films (Bozanian 1972) which show a couple engaging in and then discussing mutually pleasurable exercises.

After reviewing the results from our survey, we also included more rudimentary intimacy skills training than is typical for sex education programs—for example, role plays and discussions focused on finding appropriate sexual partners, initiating sexual encounters and communicating about sex with partners.

This curriculum would probably be considered too explicit for most sex education programs conducted in public educational settings.

Of the 16 patients who completed the sex history and functioning interview, 10 attended the sex education program regularly. Two groups of six and four patients met for eight biweekly 1-hour sessions. The groups were co-led by David Lukoff, Ph.D., and Debbie Gioia-Hasic, L.C.S.W. Joshua Golden, M.D., Director of the UCLA Human Sexuality Program, provided supervision for the groups. (See table 2 for an outline of the lesson plans used in the group education program.)

Results of the Program

Participation in the group started with an interview on sexual history and functioning. When the interview schedule was first presented at the Aftercare Clinic team meeting, there was a collective "gulp" at the explicitness of the questions. The mental health professionals described some discomfort at having patients respond to questions about age at first masturbation and first sexual intercourse, number of partners, and occurrence of sexual dysfunction. In contrast, the interviewers did not find that the schizophrenic patients showed signs of discomfort at being asked these questions.

Although we did not inquire into the reasons six patients chose not to participate in the group, it is possible that the interview served to forewarn and screen out patients who did not wish to explore further issues of their sexuality. Unfortunately, this included the patient who had delusions that children were being placed in front of him to tempt him sexually. However, he was being seen in individual therapy which addressed this symptom.
Table 2. Content of sex education sessions held with schizophrenic patients

**Session 1. Your sexual identity and self-esteem**  
Brief discussion on the importance of sex in everyone’s life.  
**Exercise:** Make a collage of your sexual identity. Magazines (*Playboy, Time, Sports Illustrated*, etc.), scissors, glue, crayons, and string were available for this exercise. Presentation and discussion by each person of the meaning of his drawing.

**Session 2. Thinking of your sexual partner as a person**  
**Exercise:** List and then share three characteristics of someone you would like to meet and go on a date with. Group brainstorming session of places where one might meet potential dating partners. Role plays of introducing yourself to someone at a party.

**Session 3. A. Male reproductive anatomy**  
B. Your strengths as a partner  
Slide show of male reproductive anatomy including information on the size and functioning of the penis.  
**Exercise:** Write a classified ad about yourself for a singles magazine. Discussion of each person’s assets as a potential partner in a relationship.

**Session 4. A. Female reproductive anatomy**  
B. Dating behavior  
Slide show of female reproductive anatomy including the relationship of menstruation and lubrication to sexual intercourse.  
**Exercise:** Share personal experiences of dates, e.g., who initiated the date and how; what did you do on the date; how did the date move into sexual intimacy; how did you feel during the different sexual phases?

**Session 5. Pleasure not performance as the focus in sex**  
Viewing of *Sensate Focus*, which shows a couple engaging in the Masters and Johnson sensate focus exercises. Discussion of the importance of communication between partners about what is pleasurable during sexual activities.  
**Exercise:** Each person was given a navel orange and asked to explore and report on the sensory processes of seeing, feeling, smelling, peeling, and eating the orange.

**Session 6. Birth control and the prevention of sexually transmitted diseases**  
Presentation from a Planned Parenthood educator on the alternative forms of birth control, their proper use, and rates of effectiveness. Discussion of which birth control techniques the members of the group had employed in the past, what their personal preferences were, and what plans they had for use of birth control in the future.

**Session 7. Open communication with sexual partners**  
Viewing of the movie *Active Partners* (Silverman and Lenz 1979) concerning a spinal injured male’s relationship with his girlfriend and their sexual activities. Discussion of the obstacles to living full and rewarding sexual lives experienced by the patients as the result of their schizophrenic illness, ways of overcoming them, and the diversity of possible sexual activities for achieving pleasure.

**Session 8. Human sexual response and sexual dysfunction**  
Presentation on the four phases of the sexual response cycle, the effects of neuroleptic medication on sexual functioning, types of dysfunction, how to tell whether the dysfunction might be medication-related, and steps to take if you suspect that the dysfunction is medication-related. Patients encouraged to ask questions.
During the group sessions, active verbal participation had to be solicited. As is typical of schizophrenic patients, most did not initiate interactions. To compensate for the passivity of the patients, the co-leaders introduced exercises to facilitate sharing of experiences and exploration of attitudes. In response to questions frequently asked of the participants to elicit their views and experiences, none showed reluctance to participate. Over the course of the program, the atmosphere in the group became lighter with appropriate joking, sharing of personal sexual frustrations, and asking of questions. One patient wanted advice on how to deal with parental disapproval of his sexual behavior. Another asked whether masturbation could cause mental illness, and another whether all orgasms were the same. A patient who expressed the fear that his medication might cause birth defects was reassured to be told that this issue had been investigated and no evidence found to link neuroleptic medication with an increase in birth defects.

The patients who attended were enthusiastic about the program. Since all patients in the Aftercare Clinic are assessed every 2 weeks for level of symptomatology on the Brief Psychiatric Rating Scale (Overall and Gorham 1962), it was possible to evaluate whether the sex education program might have stimulated improvements in sexual functioning produced by the alleviation of psychotic anxiety, thought disorganization, fear of physical intimacy with potential sexual partners, and other symptoms that can be expected to interfere with sexual functioning may be more significant and outweigh the detrimental effects of the drugs on sexual functioning. [Nestros, Lehman, and Ban 1981, p. 436]

However, many of the negative side effects of neuroleptics on sexual functioning are dose related (Ghadirian, Chounard, and Annable 1982). Recent findings indicate that most schizophrenic patients can be maintained on doses that are a fraction of the previously recommended levels (Marder et al. 1984). This offers hope that side effects, including sexual dysfunction, can be reduced. In addition, patients who experience sexual dysfunction on one of the neuroleptic medications may not on a different type. Thus, issues of medication-related sexual dysfunction can be addressed in rehabilitation programs without the fear that patients will discontinue their medications as a consequence of becoming better informed of their possible side effects.

Even patients who engage in autoerotic activity as their primary or sole sexual activity might be very disturbed by sexual dysfunctions during masturbation. Yet studies have found that patients usually do not bring up the subject of sexual dysfunction, even with their physicians. Mental health professionals need to become more aware of the potential side effects of antipsychotic medications on sexual functioning and routinely inquire about sexual dysfunction even in patients who are not interpersonally sexually active.

In view of the large percentage of schizophrenic patients who suffer from global deficits in sexual functioning, lectures on reproduction and birth control will not constitute effective intervention. To produce improvements in sexual functioning, many patients will require explicit information about sexual dysfunction as well as training in intimacy skills. The most effective methods of achieving these ends have yet to be determined.

For physically handicapped persons who do not have sexual partners, sexual surrogates offer specialized training in sexual functioning (Tapley 1985). Many magazines for people with physical disabilities routinely publish advertisements for sexual surrogates (e.g., the Westchester Advocate) who view their services in a rehabilitation context. While our program did not make use of sexual surrogates, there may be some schizophrenic patients who could benefit from the training services available from surrogates.

The question remains open as to which patients might be most likely to benefit from sex education and rehabilitation programs. Some mental health professionals have expressed the fear that the intensity of intimate sexual relationships—or orgasm itself—might precipitate exacerbation of symptoms (see Knoepfler 1982). Indeed, there are
case reports of decompensation during sex therapy with schizophrenic patients (Kaplan 1983). However, exacerbation of symptoms is a risk in all types of rehabilitation with schizophrenic patients. For example, Goldberg et al. (1977) found that their intensive vocational and sociotherapy rehabilitation program precipitated relapses among some patients. Little is known about contraindications for participation in sexual education and therapy by schizophrenic patients. While better information will become available as more attention is paid to this area of functioning, perhaps a good recommendation would be to conduct screening interviews to exclude patients who are highly symptomatic, particularly patients who are highly anxious. These were the patients who suffered the highest incidence of relapses in other rehabilitation programs (Goldberg et al. 1977). Patients who are recuperating from a recent decompensation should be excluded until their clinical condition stabilizes. Good premorbid patients who enjoyed relatively “normal” social and sexual functioning and had good intimacy skills before becoming ill would be particularly appropriate candidates for programs incorporating sexual education.

Of course, patients who show an exacerbation of symptoms during a sex rehabilitation program should also be evaluated immediately to determine whether the treatment should be postponed. Patients should be free to choose whether to participate. Some may have religious values that preclude open exploration of sexuality, and some may simply prefer an asexual existence.

Although this sex education program did not include women, studies have found that the sexual functioning of female schizophrenic patients is also frequently dysfunctional and can be impaired by antipsychotic medications (Ghadirian, Chouinard, and Annable 1982; Friedman and Harrison 1984; Raboch 1984). The most effective sex education might be achieved in groups where men and women jointly practice communication skills and explore sexual myths that interfere with their sexual functioning.

Improving the sexual functioning of schizophrenic patients is an important objective that requires sex education programs for both patients and staff members. To the detriment of their patients’ well-being, mental health professionals have generally ignored the area of sexual functioning. Yet we know from work with the developmentally and physically disabled that when professionals can communicate openly and provide information about sexual issues, their patients benefit.

References


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