



THE TEMPLE UNIVERSITY COLLABORATIVE ON
COMMUNITY INCLUSION
of Individuals with Psychiatric Disabilities

Addressing Sexuality and Intimacy Interests of Persons with Mental Health Conditions: Recommendations for Program Administrators

by Julie Tennille, Ph.D., MSW

West Chester University Graduate Department of Social Work
West Chester, Pennsylvania

Temple University

Collaborative on Community Inclusion

The contents of this publication were developed under a grant from the National Institute on Disability, Independent Living, and Rehabilitation Research (#90RT5021-02-00 NIDILRR; DHHS). NIDILRR is a Center within the Administration for Community Living (ACL), Department of Health and Human Services (HHS). The contents of this publication do not necessarily represent the policy of NIDILRR, ACL, HHS, and you should not assume endorsement by the Federal Government.

This document is a community inclusion monograph from the Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities.

September 2016

www.tucollaborative.org

Introduction

Forming intimate relationships and expressing sexuality can be particularly elusive aspirations for persons with mental health conditions. Beyond sexual side effects of many medications used to treat mental health conditions, people often encounter providers and service systems routinely ignoring their interests in sexuality and intimacy (Wright, Wright, Perry, & Foote-Ardah, 2007), rather than treating this aspect of adult life as valuable to recovery (Boucher, Groleau, & Whitley, 2016; Deegan, 2007; Slade, 2012; Tennille, Solomon, & Blank, 2010). Today, there is increased attention on developing more effective strategies to deliver comprehensive services that are inclusive of the sexuality and intimacy concerns of individuals with mental health conditions (Higgins, Barker, & Begley, 2008; Quinn & Brown, 2009; Quinn, Happell, & Welch, 2013; Tennille, Solomon, & Bohrman, 2014; Van Sant, Ahmed, & Buckley, 2012; Wright, McCabe, & Kooreman, 2012). It is likely in the years to come that providers, with technical support, will play a more deliberate role in incorporating these facets of life into person-centered care.

It should be noted that recipients of mental health services are interested in (McCann, 2000; Tennille, Solomon, & Blank, 2010) and should rightfully expect attention to this critical domain of their lives across all aspects of the policies, programs, and practices of providers. This monograph delineates specific opportunities to realize the intimacy and sexuality goals of service recipients within the context of a mental health system more in line with the recovery transformation. The monograph concludes with detailed recommendations for cultivating the skills of Motivational Interviewing (MI), a recovery oriented evidence-based practice (Torrey & Wyzik, 2000), within the mental health workforce as a means to address these concerns among service recipients.

The recovery framework as a starting point

There is international consensus on the importance of adopting a 'recovery' framework to inform and transform mental health policy and design systems of care for persons with mental health conditions (Slade, Adams, & O'Hagan, 2012). Though Slade and colleagues (2014) lament and systematically outline persistent misuses of the way in which 'recovery' is interpreted, the movement continues taking shape and taking hold around the world. The recovery framework promotes a move away from the myopic focus on mental health symptom reduction to a broader emphasis on reclaiming valued social roles that may not correspond directly to symptom reduction (Davidson & Roe, 2007). Specifically, recovery work entails an embrace of the innumerable roles individuals are in possession of or dream of pursuing in community life. A focus on illness is secondary and relevant only to the extent it has meaning to the individual in receipt of service. Since helping professions have historically neglected the value of being a sexual partner as one central aspect of recovery, there exists great potential for innovation in addressing these issues (Boucher, Groleau, & Whitley, 2016; Cook, 2000; Quinn, Happell, & Browne, 2011; Tennille, Solomon, & Bohrman, 2014).

Dr. Patricia Deegan, a forerunner of the recovery movement, described recovery like this:

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup again ... The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and *love* (emphasis added) in a community in which one makes a significant contribution [22, p.15].

Research on the benefits of intimacy and sexuality

Promisingly, research reveals many benefits to intimacy and sexuality. Dating back to 1975, the World Health Organization (WHO) proclaimed human sexuality as integral to an individual's overall physiological, psychological, and social well-being (WHO, 1975). Indeed, sexuality and intimacy foster development of new relationships and correlate with social integration (Lukoff, Sullivan, & Goisman 1992), increased quality of life (Eklund & Östman, 2009), improved treatment outcomes (Ailey, Marks, Crisp, & Hahn, 2003; Dobal & Torkelson, 2004; Shildrick, 2007; Welch, 1996), lower hospital readmission rates (Binder, 1985), and decreased mental illness stigma (Davison & Huntington, 2010; Shanks & Atkins, 1985). In addition, establishing a new standard of care that increases intentional conversations about sexuality and intimacy (Quinn, Happell, & Welch, 2013) may serve to improve therapeutic alliances and working relationships: Tennille and colleagues (2010), for example, found that when case managers were coached with clinical skill to introduce topics of sexuality and intimacy within conversations with their clients with mental health conditions, working alliances were either neutrally affected or improved.

Research on what gets in the way at the consumer level

While intimate relationships present challenges for everyone, people with mental health conditions report: having poor access to sexual partners; often experiencing profound problems with sexual performance; struggling to form relationships; and facing sexually restrictive treatment cultures (Wright, Gronfein, & Owens, 2000). Approximately 50% report unhappiness with their sex lives and describe their social lives as lacking in warmth, intimacy, and satisfaction (Cook, 2000). Some are able to find and maintain long-term relationships, but a variety of obstacles make intimacy and sexual expression difficult even within more enduring relationships. Side effects of medication taken to manage symptoms hover at the top of that list of obstacles, and are the leading reason for non-adherence to psychotropic medications (Deegan 2001; Kodesh et al. 2003).

One study distinguished male from female thinking and behavior related to effects of medication on sexual performance (Tennille, Solomon, Fishbein, & Blank, 2009). The research found that men were frustrated with their lack of physical desire, expressed difficulty getting and keeping an erection, worried about the fragility of their sexual response, and were willing to forgo using condoms to enhance performance. Of greater concern from this study was the finding that it was commonplace for many men to purchase sexual stimulants 'on the street' to counteract the side effects of medication. Rather

than consulting a physician, men chose to go it alone, risking complicating what, for many, are already fragile states of physical health, given that persons with mental health conditions have high rates of medical comorbidity (Colton & Mandersheid, 2006).

Women, on the other hand, expressed anger about their own lack of interest in sex, reported difficulty with lubrication, had problems achieving orgasm, and were generally frustrated with partners who shared struggles with sexual performance. Davis and Huntington (2010) conducted research that shed even greater light on the complex intersections of the experience of women coping with enduring mental health conditions. These researchers found that, for women, further exacerbating the challenge of sexual expression while coping with a mental health condition were issues of socialization to body size norms (e.g., women assessed themselves as either too thin or too heavy to be sexually attractive) and heteronormativity (e.g., gay women reported discomfort with the rare public expression of same-sex intimacy). These societal pressures further suppressed sexual identity and expression. Moreover, women's accounts of weight gain as a consequence of adhering to psychotropic medicines negatively affected their self-image and worsened a sense of mental illness stigma.

Research on what gets in the way at the provider level

Individuals with mental health conditions are often faced with silence or disapproval from service providers regarding sexual activity. For example, in a research study on sexuality in mental health settings (Wright, Wright, Perry, & Foote-Ardah, 2007), one woman stated, "It is common knowledge that at a group home you don't do anything (sexual)... They didn't say anything, but the point is obvious (3, p. 93)." This type of systemic discrimination perpetuates mental illness stigma: many providers continue to consider consumers asexual, exclusively heterosexual, or believe that consumers with psychiatric disabilities are simply too emotionally vulnerable and will get sick and require hospitalization if they date or become sexually active (Solomon et al., 2007). Consequently, providers often adopt a 'protective' role, advising against or, when possible, prohibiting sexual activity.

Additional provider fears have emerged, including that: provider discussions on sexuality and intimacy may be misinterpreted (Encandela et al., 2003); consumers might construe dialogues as a 'come on' from a provider; consumers would feel entitled to ask providers about their personal sexual lives; discussions might damage the therapeutic relationship; and providers fear they will not know how to talk about sex once the topic is raised. Mythic beliefs that providers have traditionally held include that only 'young' consumers are interested in sexual activity, that one 'can tell' if a consumer is LGBT, that only consumers who are 'promiscuous' want to talk about sexuality or intimacy, that medical professionals are exclusively equipped to have these conversations, or that medical personnel *are actively* having these conversations with their consumers (Tennille, Solomon, Fishbein, & Blank, 2009).

Even in the field of nursing, while diligently addressing sexuality for oncology and cardiac patients, studies have found that nurses often avoid raising sexual issues with consumers in receipt of mental health care. Research indicates that nurses also believe 'others' in healthcare should be addressing these issues (Quinn, Happell, & Brown, 2010). A fairly recent study (Quinn & Happell, 2012) with mental health nurses found that increased awareness and sensitivity along with practicing discussions of

sexuality made it progressively easier to transform old habits: merely discussing medications' possible sexual side-effects was helpful to begin dialogue, and conversing about sexuality and intimacy topics was easier when broken into steps.

If mental health providers (including social workers, nurses, mental health counselors, peer specialists, or other direct services staff) generally fail to assume responsibility for including conversations on issues of sexuality and intimacy, this subtly reinforces oppressive dominant discourses, suggesting that discussion of these topics is linked to privilege. The media supports these ideas by portraying sex primarily as a privilege of white, heterosexual, young, single, and non-disabled individuals (Tepper, 2000). In provider settings it is not uncommon to hear grave concerns about a consumer dating or engaging in a sexual relationship, thereby risking exacerbating symptoms of a mental illness: the assumption is that persons with mental health conditions must be 'ready' or somehow 'eligible,' for such experiences. The questions then become: what would be the criteria for readiness, and who is the arbiter of such decisions?

Research on what gets in the way at the policy and programmatic levels

In the past, this concept of 'readiness' has been applied to domains of work and housing, with disappointing results. A generation of research into the effectiveness of Supported Employment provides ample evidence that counselor assessments of 'readiness to work' are often inaccurate and that effective competitive employment programs that are inclusive of everyone who says they want to work are more likely to have heightened job placement and retention results (Bond, Becker, et.al., 2001). Housing First is an example of an intervention where, in the past, a Treatment First approach to housing required detoxification and sobriety as qualifiers for housing eligibility. Once that barrier was removed, outcomes improved. Research suggests that the removal of a 'readiness' qualifier could and perhaps should extend to dating and sexual relationships as well (Slade, 2012), suggesting that 'readiness' is an unhelpful, patriarchal, and provider-driven, as opposed to person-driven, approach of limited utility. Recovery movement proponents argue that there is essential 'dignity in risk and a right to failure' (Deegan, 1988) in all aspects of community life, one that should be extended to intimacy and sexuality.

Though it will require training efforts to assist providers in supporting the dating and intimacy interests of consumers, remaining silent on these topics is no longer acceptable. Indeed, silence can be construed as systemically sanctioned microaggressions - defined as the variety of both overt and subtle cues to marginalized groups, like those with mental health conditions, that there are parts of community life from which they should be legitimately excluded. Such microaggressions have been defined as "everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership" (Sue, 2010, p. 3). Sue et al. (2007) offered a preliminary set of themes focused on racial microaggressions, including "ascription of intelligence," "criminality/assumption of criminal status," and "second class citizen" and more recently the concept of

microaggressions has been expanded in consideration of harmful outcomes related to gender (Capodilupo et al., 2010), sexual orientation (Nadal et al., 2011; Shelton & Delgado-Romero, 2011), and ability status (Keller & Galgay, 2010). Limited research exists on the impact of microaggressions toward persons with mental health conditions (Gonzales, Davidoff, Nadal, & Yanos, 2015), but what is known is that persons with mental health conditions report general microaggression experiences that result in isolation, negative emotions, and treatment nonadherence. Gonzalez and colleagues (2015) warn that such experiences likely contribute to internalization of stigmatizing attitudes toward mental health conditions, quite the opposite of where the mental health field hoped to head by emphasizing the recovery transformation.

Recommendations at the policy and programmatic levels

Any provider organization undertaking a cultural shift in service that acknowledges service recipients' interests in intimacy and sexuality will need the humility to acknowledge that there is no 'quick fix' to becoming more inclusive in preparing to offer competent services on these previously often taboo topics. First, providers should consider beginning with an internal task force that includes a range of stakeholders (persons with mental health conditions, representatives of all health provider types, and administrators, etc.) as a first step toward engendering a more inclusive provider culture. Such a task force then can direct the providers' ongoing initiatives to alter the cultural environment.

Second, recognition of the importance of coherent and consistent policies is critical. In the absence of such policies, providers are more likely to arbitrarily respond to "sexual incidents" in ways that could demean and violate persons' liberty and dignity (Mossman, Perlin, & Dorfman, 1997). It will be useful to assess whether there are antiquated policies that do not reflect a recovery orientation or supportive responses to client sexuality, or whether there is just an absence of relevant policy altogether. Developing and articulating recovery-oriented policies on sexuality and intimacy is imperative. Of course, policy development will depend on provider context (outpatient, inpatient, residential and so forth), but having clear and more thoughtful responses to issues surrounding clients' sexual activities that reflect varied perspectives and contexts will be far more useful in preserving the dignity to which clients are fundamentally entitled.

Third, additional early work of the task group might involve not only careful examination of the presence, absence, and philosophy of coherent policies, but also a thoughtful review of the day-to-day workings of the agency with regard to intimacy and sexuality. Examining and modifying intake and other documentation that either avoids information about sexual behavior or interests or that may inadvertently be transphobic, homophobic, heterosexist, or otherwise stigmatizing and lacking person-first language of inclusion is a critically important, but relatively easy, step in the right direction. Examining visual alternatives or compliments to posters, paintings, and informational materials and working toward inclusive images of greater diversity of possible relationships - including gender non-conforming persons, a mother and child, two men or two women in an embrace - are indications of safer spaces for discussions about sexuality and intimacy. Cook (2000) also recommends that the leadership within the recovery movement concertedly incorporate sexual expression and intimacy goals

across its agenda, building in specific program elements to provide opportunities for service recipients to explore intimacy and sexuality themes in a supportive environment.

Our earlier [monograph](http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/relationships_family_friends_intimacy/intimacy.pdf) (Tennille & Wright, 2013, http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/relationships_family_friends_intimacy/intimacy.pdf) provides a detailed depiction of the systematic approach to conducting a three level stakeholder driven (system, provider, client) needs-assessment, a plan for next steps, and a plan for implementation evaluation of creating capacity to deliver competent services inclusive of intimacy and sexuality. At the system level, a needs assessment prompts policy makers and administrators to pinpoint implicit assumptions within policies, intake, or assessment documentation. Among other items, are there inherent assumptions related to gender, sexual orientation, or status as a parent? How do policies and physical plant characteristics support dignified spaces for clients for sexual expression and needs for intimacy? Likewise, at this needs assessment phase, we recommend that providers and clients reflect on ways personal biases and cultural views of sexual expression and intimacy may shape delivery or receipt of services. Taking stock of myths, fears, and assumptions are part of laying a strong foundation to plan for next steps. In the planning phase, policy makers and administrators ensure system policies assist clients in clarifying sex and intimacy needs while also distinguishing behaviors that may pose safety or liability risks, depending on context. Further, in this phase, a systematic means to regularly assess intake and other newly introduced documentation, identification of workforce training with evidence-based practices, and detail supporting all context-appropriate providers to develop proficiency in and adopt new and sustainable practices is outlined in this earlier monograph. Finally, the monograph outlines a plan for implementation evaluation that requires assessing fidelity to new provider practices along with collecting client satisfaction data.

Fourth, direct service personnel require training in how to address these topics. The remaining part of this monograph proposes developing workforce capacity, providing direct service personnel with the skills to use Motivational Interviewing as a way to initiate and sustain discussions about intimacy and sexuality. Motivational Interviewing (MI) helps personnel develop the clinical ability to engage in, “a collaborative conversation style for strengthening a person’s own motivation and commitment to change” (Miller & Rollnick, 2012, p. 12). Applying MI to the topic of sexuality and intimacy may also open up new avenues of discussion and growth in this previously difficult-to-manage topic area.

Recommendations at the practice level

After the scaffolding of policy creation and alterations to the physical plant have taken place, special consideration should be given to formal training of providers, including administrative decision makers and those employed in basic services, and, importantly, extending to the emerging mental health workforce of peer specialists. Buy-in and enhanced skill is necessary at all levels for a cultural shift in service to occur in any context, as there is much room for microaggressions.

Research has underscored that passive training strategies (e.g., training manual distribution, single session didactic workshop) can increase knowledge but are ineffective at producing behavior change (Davis & Davis, 2009; Powell, McMillen, Hawley, & Proctor, 2013). Effective approaches typically involve

dynamic multidimensional strategies addressing a wide range of learning styles (Davis & Davis, 2009) and are inclusive of: a treatment manual; multiple days of workshop training, ongoing expert consultation, review of audio or video practice sessions; supervisor trainings; and booster sessions (Herschell et al., 2010). Supervised behavioral rehearsal of new skills is fundamental to skill development and maintenance (Beidas, Cross, & Dorsey, 2013; Beidas & Kendall, 2010).

The design of such a training module should be informed by new research. In consultation with a community advisory board, the author of this monograph received IRB approval to adapt the Sexuality Attitudes and Beliefs Survey (SABS), previously used with nurses in hospital settings, to administer the adapted survey to listservs of behavioral health providers. Over 200 providers completed the online survey. Preliminary findings of this research indicate that the needle may have moved in recent years to reflect more receptivity to learning how to have conversations about sexuality and intimacy with persons with mental health conditions. This heartening snapshot of provider attitudes points to evidence at the $p < 0.05$ level suggesting that providers exposed to trainings on sexuality and intimacy are indeed more open to incorporating these discussions in their practice. This finding reaffirms the important research in nursing conducted by Quinn and Happell (2012).

A training program for providers would necessarily be highly experiential in nature, to increase knowledge while also infusing the skills needed for having conversations about sexuality and intimacy with clients living with mental health conditions. The training should contain recent study findings and include the literature on barriers and facilitators to sexuality and intimacy for persons with mental health conditions. The main focus of the training would be to address both informal agency culture and develop staff capacity for delivering evidence-based practice using the vehicle of Motivational Interviewing (MI), an evidence-based practice applicable in a great variety of settings for 'change conversations' about myriad health topics (Lundahl et. al., 2013). Furthermore, the training should extend to booster elements akin to Communities of Practice (CoPs) for sustaining new practice competencies.

Originally developed by William Miller, MI is an Evidence-Based Practice (EBP) utilized in a variety of settings where services are offered to individuals with mental health conditions. Aligned with values of collaboration, consumer self-determination, embracing a strengths-based perspective and harm reduction model approach to intervention, utilization of MI is increasing. The techniques of MI as applied to sexuality and intimacy do not presume a behavioral *problem* exists, but positions sexuality and intimacy goals as worthy foci of attention by support systems. Thus, considering the taboo nature of these topics and often clumsy manner in which they are approached, development of related practice proficiencies can be helpful.

William Miller and Stephen Rollnick describe the value of utilizing MI, particularly in sensitive conversations focused on change, explaining that,

MI involves attention to natural language about change, with implications for how to have more effective conversations about it, particularly in contexts where one person is acting as a helping professional for another. Our experience is that many such

conversations occur in a rather dysfunctional way, albeit with the best of intentions. MI is designed to find a constructive way through the challenges that often arise when a helper ventures into someone else's motivation for change [68, p.4].

Asking open-ended questions, a key skill in MI, despite being a fairly fundamental clinical skill, is often not natural to providers. Consider the question, "Do you experience sexual side effects from your medication?" This closed-ended question might result in a yes or no answer and not yield valuable content. Instead, we suggest beginning with the sensitizing statement, "Persons who take medicine to manage symptoms of mental illness often experience sexual side effects from medication." Then we recommend this statement be followed by an open-ended question, "what sexual side effects have you experienced?" With this type of open-ended question, there is an increased likelihood of a more expansive response rather than a yes or no response.

Providing authentic affirmations that are precise, and communicate the MI spirit is another fundamental skill crucial for practitioners. Noting that a consumer has courageously adhered to medication despite painful sexual side-effects is an example of such an affirmation.

Reflective listening is the dance of staying on the same page as a person with a mental health condition describes an experience of intimate relationships, sexuality, dating, and possible rejection. One of the impulses that persons in provider roles may have is to change the subject. This practice of reflective listening warrants staying on the topic that the person with a mental health condition has raised and involves the practitioner closely listening, paraphrasing what they have understood, and at times, involves slight guesses about a consumer's meaning. Reflections can encompass both thoughts and feelings that are being expressed during a conversation. For example, a man quietly mentions that he avoids sexual encounters for fear he will have difficulty maintaining an erection. The provider could choose to reflect on the content of the statement, or could choose to reflect on the underlying emotion such as embarrassment or both. While skilled providers can make reflective listening appear to be a very basic and intuitive skill, it requires extensive practice to become proficient.

An extensive multi-day training module blending spirit and skill of MI and discussions of intimacy and sexuality would be followed by ascertaining provider fidelity to MI practice and periodic evaluation and booster work in a Communities of Practice workgroup. The inserted table below provides a modular overview of a two-day training toolkit, currently under development at the Temple University Collaborative, inspired by the recent work of Miller and Rollnick (2012). All training information will be accompanied by "experiences" and behavioral rehearsal of skills related to having conversations about sexuality and intimacy.

Training Toolkit Using Motivational Interviewing (MI)

Topic	Exercise
What is Motivational Interviewing (MI) and the Spirit of MI	Musical Questions (1)
Review of Principles, Processes, and Micro Skills of MI	Guided Imagery Exercise (1)
	OARS (1)
	Practicing Open-Ended Questions Exercise (1)
	Stages of Change Exercise (1)
	Real Plays (1)
Engaging and Laying a Relational Foundation	Spot the Difference Exercise (1)
Focusing and Finding Strategic Direction	Gauging Interest Using Rulers Exercise (1)
	Values Exercise (1)
Evoking and Preparing for a Change	Make a Role Play Exercise (2)
	Agenda Mapping Exercise (2)
	Role Play Demonstration (2)
	Just right, pretty good, cold exercise (2)
Planning and Bridging to Change	3-Phase Role Play and Debrief Exercise (2)
	Fidelity to MI (2)
	Using the MITI Exercise (2)

Communities of Practice (CoPs) have received increased attention in healthcare as a means of creating informal community networks to support EBP skill development, maintenance, and implementation. Li and colleagues discuss several aspects of CoPs including interaction among novices and experts, an emphasis on learning and sharing knowledge, and investment to foster a sense of belonging among members. Recently, Piat and colleagues (2015) have noted the absence of research on the strategy of “communities of practice” for implementing evidence-based practices and call for research on factors supporting or hindering the success of CoPs. The purpose of incorporating the CoP into the module on MI and intimacy and sexuality is to address the problem of skill drift following training completion.

Conclusion

The international adoption of the recovery framework in mental health service delivery systems of care is a clear call to address this most recent frontier of inclusive practices related to topics of sexuality and intimacy. In policy, program and practice, we can lead in developing effective methods of intentionally infusing, with permission, discussions on sexuality and intimacy for persons with mental health conditions into everyday practice. There is research suggesting that brief education programs about sexual issues of consumers of mental health services can result in sustained practice change if clinical skills are integrated more deliberately across policy, programs, and practices to the extent that providers develop more confidence to skillfully engage in conversations about sexuality as part of holistic care (Quinn, Happell, & Welch, 2013). This monograph includes a recommendation to administrators to obtain the technical assistance necessary to incorporate MI across service contexts as a deliberate strategy to improve service delivery to persons with mental health conditions on topics of sexuality and intimacy with the added benefit that your workforce will be more equipped for clinical conversations of all sorts. The dignity in risk and pursuit of goals belongs exclusively to consumers who will determine, with our support, their unique 'readiness' for conversations about dating, sexuality, and intimacy.

For more information on this topic and the development of training programs on sexuality and intimacy, readers should contact the Temple Collaborative on Community Inclusion, at tucollab@temple.edu.

Helpful links:

[American Association for Marriage and Family Therapy \(AAMFT\)](#)

(<http://www.aamft.org/iMIS15/AAMFT/>)

[American Association of Sex Educators, Counselors, and Therapists \(AASECT\)](#)

(<https://www.aasect.org/>)

[Non-monogamous relationships](#)

(<https://uwm.edu/lgbtrc/wp-content/uploads/sites/162/2014/09/polyamory-101.pdf>)

[Asexual relationships FAQ](#)

(<http://www.asexuality.org/home/?q=relationship.html>)

[Planned Parenthood's Guide to Safer Sex](#)

(<https://www.plannedparenthood.org/learn/stds-hiv-safer-sex/safer-sex>)

Helpful LGBT links:

[Safer Sex for Lesbian and Bisexual Women](#)

(<http://lesbianlife.about.com/od/lesbiansex/a/FirstTimeSex.htm>)

[Gay Sex Advice](#)

(<http://gaylife.about.com/od/gaysexadvice/u/datingadvice.htm>)

[Trans Men and Sex](#)

(<https://ftmark.wordpress.com/2012/11/02/how-to-have-sex-with-a-transman/>)

[Trans Women and Sex](#)

(<http://early2bed.com/2014/02/05/trans-women-sex-awesome/>)

[MTV's Safer Sex Initiative \(LGBT inclusive information\)](#)

(<https://uwm.edu/lgbtrc/support/relationships-and-sex/>)

[LGBT Power and Control Wheel](#)

(<https://uwm.edu/lgbtrc/wp-content/uploads/sites/162/2014/09/lgbtq-power-and-control-wheel.pdf>)

[Gender pronouns FAQ](#)

(<https://uwm.edu/lgbtrc/support/gender-pronouns/>)

References

- Ailey, S. H., Marks, B. A., Crisp, C., & Hahn, J. E. (2003). Promoting sexuality across the life span for individuals with intellectual and developmental disabilities. *Nursing Clinics of North America*, *38*(2), 229-252.
- Beidas, R. S., Cross, W., & Dorsey, S. (2014). Show me, don't tell me: Behavioral rehearsal as a training and analogue fidelity tool. *Cognitive and Behavioral Practice*, *21*(1), 1-11.
- Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice: a critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice*, *17*(1), 1-30.
- Bond, G.R., Becker, D.R., Drake, R.E., Rapp, C.A., Meisler, N., Lehman, A.F., Bell, M.D. & Blyler, C.R. (2001). Implementing Supported Employment as an Evidence-Based Practice. *Psychiatric Services*, *52*, 313-322.
- Boucher, M. E., Groleau, D., & Whitley, R. (2016). Recovery and severe mental illness: The role of romantic relationships, intimacy, and sexuality. *Psychiatric rehabilitation journal*, *39*(2), 180.

- Binder, R. L. (1985). Sex between psychiatric inpatients. *Psychiatric Quarterly*, 57(2), 121-126.
- Capodilupo, Nadal, K. L., Corman, Hamit, Lyons, & Weinberg. (2010). The manifestation of gender microaggressions. *Microaggressions and marginality: Manifestation, dynamics, and impact*, 193-216.
- Colton, C. W., & Manderscheid, R. W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Prev Chronic Dis*, 3(2), A42.
- Cook, J. A. (2000). Sexuality and People with Psychiatric Disabilities. Conference presentation: Disability, sexuality, and culture: Societal and experiential perspectives on multiple identities. San Francisco State University, San Francisco, CA, March 17-18. [Cited 5 may 2008] [Document](http://www.psych.uic.edu/mhsrp/sexuality.htm) available from <http://www.psych.uic.edu/mhsrp/sexuality.htm>
- Davidson, L., Roe, D. (2007). Recovery from versus recovery in serious mental illness: one strategy for lessening confusion plaguing recovery. *Journal of Mental Health* 16(4), 459–470
- Davis & Davis. (2009). Educational interventions. In: Straus S, Tetroe J, Graham ID, editors. Knowledge translation in health care: Moving from evidence to practice. Oxford, UK: Wiley-Blackwell; 2009. pp. 113–123.
- Davison, J., & Huntington, A. (2010). “Out of sight”: Sexuality and women with enduring mental illness. *International Journal of Mental Health Nursing*, 19 (4), 240-249.
- Deegan, P. E. (2007). The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatric rehabilitation journal*, 31(1), 62.
- Deegan, P. E. (2001). Human sexuality and mental illness: Consumer viewpoints and recovery principles. In: P. Buckley (Ed.). *Sexuality and Serious Mental Illness*. (pp. 21–33). Amsterdam: Harwood academic publishers.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11.
- Dobal & Torkelson, (2004). Making decision about sexual rights in psychiatric facilities. *Arch. Psychiatric Nursing* 18(2), 68–74.
- Eklund, M., & Östman, M. (2009). Belonging and doing: important factors for satisfaction with sexual relations as perceived by people with persistent mental illness. *International Journal of Social Psychiatry*.
- Encandela, J., Korr, W., Hulton, K., Koeske, G., Klinkenberg, W.D., Otto-Salaj, L, Silvestre, A., Wright, W. (2003). Mental health case management as a locus for HIV prevention: Results from case-manager focus groups. *The Journal of Behavioral Health Services & Research*, 30, 418-432.
- Gonzales, L., Davidoff, K. C., Nadal, K. L., & Yanos, P. T. (2015). Microaggressions experienced by persons with mental illnesses: An exploratory study. *Psychiatric rehabilitation journal*, 38(3), 234.
- Herschell, A., Kolko, D., Baumann, B., & Davis, A. (2010). The role of therapist training in the implementation of psychosocial treatments: A review and critique with recommendations. *Clinical Psychology Review*. 30:448–466
- Higgins, A., Barker, P., & Begley, C. M. (2008). ‘Veiling sexualities’: a grounded theory of mental health nurses responses to issues of sexuality. *Journal of Advanced Nursing*, 62(3), 307-317.
- Keller, R. M., & Galgay, C. E. (2010). Microaggressive experiences of people with disabilities. *Microaggressions and marginality: Manifestation, dynamics, and impact*, 241-268.

- Kodesh, A., Weizman, A., Aizenberg, D., Hermesh, H., Gelkopf, M. & Zemishlany, Z. (2003). Selegline and sexual dysfunction in schizophrenia. *Clinical Neuropharmacology*, 26 (4), 193–195
- Lukoff, D., Sullivan, G., & Goisman, R. M. (1992). Sex and AIDS education. In R. P. Liberman (Ed.), *Handbook of psychiatric rehabilitation* (pp. 171-182). New York: MacMillan Publishing Co.
- Lundahl, B., Moleni, T., Burke, B. L., Butters, R., Tollefson, D., Butler, C., & Rollnick, S. (2013). Motivational interviewing in medical care settings: a systematic review and meta-analysis of randomized controlled trials. *Patient education and counseling*, 93(2), 157-168.
- McCann, E. (2000). The expression of sexuality in people with psychosis: Breaking the taboos. *Journal of Advanced Nursing*, 32 (1), 132–138.
- Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. Guilford press.
- Mossman, D., Perlin, M. L., & Dorfman, D. A. (1997). Sex on the wards: Conundra for clinicians. *Journal of the American Academy of Psychiatry and the Law Online*, 25(4), 441-460.
- Nadal, K. L. (2011). The Racial and Ethnic Microaggressions Scale (REMS): construction, reliability, and validity. *Journal of Counseling Psychology*, 58 (4), 470.
- Piat, M., Briand, C., Bates, E., & Labonté, L. (2015). Recovery communities of practice: An innovative strategy for mental health system transformation. *Psychiatric Services*, 67(1), 10-12.
- Powell, B. J., McMillen, J. C., Hawley, K. M., & Proctor, E. K. (2013). Mental health clinicians' motivation to invest in training: Results from a practice-based research network survey. *Psychiatric services*, 64(8), 816-818.
- Powell, B. J., Proctor, E. K., & Glass, J. E. (2013). A systematic review of strategies for implementing empirically supported mental health interventions. *Research on social work practice*, 1049731513505778.
- Quinn, C., & Browne, G. (2009). The sexuality of people living with a mental illness: A collaborative challenge for mental health nurses. *International Journal of Mental Health Nursing*, 18, 195–203.
- Quinn, C., & Happell, B. (2012). Getting BETTER: Breaking the ice and warming to the inclusion of sexuality in mental health nursing care. *International journal of mental health nursing*, 21(2), 154-162.
- Quinn, C., Happell, B., & Brown, G. (2010). Avoiding sexuality in our practice: Mental health nurses' views about discussing sexual health with consumers. *International journal of mental health nursing*, 20 (1) 21-28.
- Quinn, C., Happell, B., & Welch, A. (2013). Talking about sex as part of our role: Making and sustaining practice change. *International journal of mental health nursing*, 22(3), 231-240.
- Shanks, J., & Atkins, P. (1985). Psychiatric patients who marry each other. *Psychological medicine*, 15(02), 377-382.
- Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: the experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology*, 58(2), 210.
- Shildrick. (2007). Contested pleasure: the sociopolitical economy of disability and sexuality. *Sexuality Research & Social Policy*, 4(1), 53-66.
- Slade, M., Adams, N., & O'Hagan, M. (2012). Recovery: past progress and future challenges. *International Review of Psychiatry*, 24(1), 1-4.

- Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., ... & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13 (1), 12-20.
- Solomon, P. L., Tennille, J. A., Lipsitt, D., Plumb, E., Metzger, D., & Blank, M. B. (2007). Rapid assessment of existing HIV prevention programming in a community mental health center. *Journal of prevention & intervention in the community*, 33(1-2), 137-151.
- Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. John Wiley & Sons.
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: implications for clinical practice. *American psychologist*, 62(4), 271.
- Tepper, M.S. (2000): Sexuality and disability: the missing discourse of pleasure. *Sex. Disab.* 18(4), 283-290.
- Tennille, J., Solomon, P., & Blank, M. (2010). Case managers discovering what recovery means through an HIV prevention intervention. *Community Mental Health Journal*, 46, 486-493.
- Tennille, J., Solomon, P., & Bohrman, C. (2014). Using the FIELD model to prepare social work students and field instructors on sexuality and intimacy for persons with psychiatric disabilities. *Sexuality and Disability*, 32(4), 469-483.
- Tennille, J., Solomon, P., Fishbein, M., & Blank, M. (2009). Elicitation of cognitions related to HIV risk behaviors in persons with mental illnesses: implications for prevention. *Psychiatric Rehabilitation Journal*, 33:360–365.
- Tennille, J., Wright, E. (2013): Addressing the intimacy interests of people with mental health conditions: acknowledging consumer desires, provider discomforts, and system denial. Temple University collaborative on community inclusion of individuals with psychiatric disability.
- Torrey & Wyzik. (2000). Recovery vision as a service improvement guide for community mental health center providers. *Community Mental Health Journal*, 36(2), 209–216.
- Van Sant, S. P., Ahmed, A. O., & Buckley, P. F. (2012). Schizophrenia, Sexuality, and Recovery. *Journal of Ethics in Mental Health* 7
- Welch, S. J., & Clements, G. W. (1996). Development of a policy on sexuality for hospitalized chronic psychiatric patients. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 41(5), 273.
- World Health Organization (1975) Education and treatment in human sexuality: the training of health professionals, report of a WHO meeting [held in Geneva from 6 to 12 February 1974]
- Wright, McCabe, & Kooreman. (2012). Institutional capacity to respond to the ethical challenges of patient sexual expression in state psychiatric hospitals in the United States. *Journal of Ethics in Mental Health* 7
- Wright, E., Wright, D., Perry, B., & Foote-Ardah, C. (2007). Stigma and the Sexual Isolation of People with Serious Mental Illness. *Social Problems*, 54(1):78-98