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Gender and sexuality of people with mental disorders in Brazil

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Abstract: The goal of this study was to understand the ways of living and thinking about sexuality of people with mental disorders. Open interviews were conducted with men and women in public mental health services in Brazil. Transcripts were examined based on the proposal of sexual scripts. Major imbalances coming from conceptions of masculinity and femininity in society were identified in the sexual scripts experienced by these men and women. Interviewees have little pleasure in their sexual lives, with recurrent complaints of sexual abuse, even by steady partners; prejudice; and lack of affection in their relationships. Additionally, they were found to have few self-care skills concerning sexual health, in a context marked by social exclusion. The results showed the need to promote sexual health as a human right, and fight gender stereotypes, which cause so much damage to the sexual health of people with mental disorders.

Keywords: sexuality; people with mental disorders; sexually transmitted disease; gender; nursing

Género y sexualidad de las personas con trastornos mentales en Brasil

Resumen: El objetivo de este estudio fue comprender las formas de vivir y de pensar acerca de la sexualidad de las personas con trastornos mentales. Fueron realizadas entrevistas abiertas con hombres y mujeres en servicios públicos de salud mental en Brasil y las mismas fueron examinadas con base en la propuesta de *scripts* sexuales. En los *scripts* sexuales experimentados por hombres y mujeres fueron identificados los desequilibrios propios de los conceptos de masculinidad y feminidad de la sociedad. Las y los entrevistados tienen poco placer en sus vidas sexuales, con recurrentes denuncias de abuso sexual, inclusive por parte de sus parejas estables; prejuicios; y falta de afecto en sus relaciones. Además, fueron encontradas escasas habilidades de autocuidado relativas a la salud sexual, en un contexto marcado por la exclusión social. Los resultados mostraron la necesidad de promover la salud sexual como un derecho humano y combatir los estereotipos de género, que causan mucho daño a la salud sexual de las personas con trastornos mentales.

Palabras clave: sexualidad; personas con trastorno mental; infecciones de transmisión sexual; género; enfermería

Gênero e sexualidade das pessoas com transtornos mentais no Brasil

Resumo: O objetivo deste estudo foi compreender as formas de viver e de pensar a respeito da sexualidade das pessoas com transtornos mentais. Foram realizadas entrevistas abertas com homens e mulheres em serviços públicos de saúde mental no Brasil e elas foram examinadas com base na proposta de *scripts* sexuais. Nos *scripts* sexuais experimentados por homens e mulheres, foram identificados os desequilíbrios próprios dos conceitos de masculinidade e feminilidade da sociedade. As entrevistadas e os entrevistados têm pouco prazer em suas vidas sexuais, com recorrentes denúncias de abuso sexual, inclusive por parte de seus companheiros estáveis; prejuízos; e falta de afeto em suas relações. Além disso, foram encontradas escasas habilidades de autocuidado relativas à saúde sexual, em um contexto marcado pela exclusão social. Os resultados mostraram a necessidade de promover a saúde sexual como um direito humano e combater os estereótipos de gênero que causam muito dano à saúde sexual das pessoas com transtornos mentais.

Palavras-chave: sexualidade; pessoas com transtorno mental; infecções de transmissão sexual, gênero, enfermagem

Gender and sexuality of people with mental disorders in Brazil

Introduction

Sexuality is a fundamental component in the life of any human being, and everyone has the right to live it fully, pleasantly and healthily. However, when it comes to people with severe and persistent mental disorders, as well as people with some kind of disability (Giami & Veil, 2004), they are seen as asexual or as if they have an uncontrolled sexuality (Brito & Oliveira, 2009; Miranda, Furegato & Azevedo, 2008). The usual behavior of family, health professionals, and social acquaintances towards this population is essentially the repression of any manifestation of sexuality or complete denial of its existence, as if this would resolve this situation (Quinn, Happell & Brewé, 2011).

However, studies conducted in different countries have shown that this population has active sex lives (Devieux *et al.*, 2007; Mead, 2006; Mead; Sikkema, 2007; Perry & Wrigth, 2006). In Brazil, a research project conducted with over 2,400 people with severe and persistent mental disorders found that 87.6% had been sexually active, and sexual initiation occurred before 18 years of age for 67.0% of the respondents (Guimarães *et al.*, 2009).

Furthermore, an epidemiological study conducted in 2006/2007 (Guimarães *et al.*, 2009) confirmed the existence of risky sexual behavior, such as relations without condom and with multiple partners; and also high rates of sexual violence suffered by this population. In Brazil, 29.9% reported exchanging sex for money or drugs; 18.6% reported having suffered sexual violence; and, although more than 90% had heard about HIV/AIDS, the prevalence of unprotected sex along their lives was 80.3%; and 23% reported having had some STD. The rate of HIV/AIDS is 0.8%, that is, 0.6% higher than that of the general population in Brazil (Brazilian Health Ministry)

Therefore, epidemiological information points out the vulnerability of this group and gaps in actions of sexual health promotion for this population in the country. Likewise, only a few studies have investigated the psychosocial aspects involved in their ways of living and thinking sexuality of this population, and that is a fundamental aspect for further progress in actions of sexual health promotion for people with mental disorders. The existing literature focusing on this subject shows, above all, how difficult it is to talk about sex and to negotiate safe sex

among this population (Pinto, 2007; Wainberg *et al.*, 2007; 2008), as there is no further elaboration of their own points of view on how they live their sexuality.

Thus, this study had the purpose of interpreting narratives of men and women with severe and persistent mental disorders in order to understand how they represent their sexuality and how they live it, particularly in their life contexts.¹

The Theory of Social Representations (TRS) was the initial theoretical-methodological approach adopted in this study, for its contribution to the understanding of thought and social practices. Social representations (RS) are constructs of the research subject as social subject. For Giami (1997) “there is no rift between expressions and the individual and collective meanings of representations, but homology, which translates into an approach that considers the social as contained and observable in the individual discourse”. Thus, he argues for the term ‘representations’ rather than ‘social representations.’ This choice does not result in a retraction regarding the social dimension of representations, but rather an opening, aiming at the construction of other models of relationships between the individual and the collective, on the one hand, and the psychological and social welfare on the other.

Additionally, when the sexual experiences of respondents were identified, their analysis led to the use of the Theory of the Sexual Scripts (Gagnon, 2003), having been interviewed subjects of different age groups. Gagnon addresses sexuality and desire, as well as love, as social constructs and scripted behavior. Scripts are perceived as social, cultural and psychic benefits, built through the individuals’ life stories, which influence their choices and define the way they interact with other people. For the author, scripts make people choose their partners in a certain context and have relationships with them in a particular way, according to shared norms and conventions. Sexual scripts are formed on three intertwined levels. The first, called cultural settings, is linked to collective meanings of sexuality. The second, called interpersonal scripts, works on the level of social interaction and has an interface between cultural settings and psychic life, which makes it possible for individuals to give their own responses facing other people’s behavior with socially acceptable behavior rules. Acceptance and use of such scripts form the basis of continuous patterns of social behavior which are more or less acceptable. Thus, behaviors may be seen as choices including the expectations of other people, in

¹ This research was carried out by the Universidade Federal de Minas Gerais (Federal University of Minas Gerais) with technical and financial support of the Ministry of Health/Secretariat of Health Surveillance/Department of STD, AIDS and Viral Hepatitis through the Project of International Technical Cooperation 914/BRA/1101 between the Brazilian Government and the United Nations Educational, Scientific and Cultural Organization-UNESCO.

addition to their own desires, that are at the subsequent level. On the third level, there are intrapsychic scripts that explain the relationship between the development of individual characteristics of people's desire, and their life experiences. These scripts represent the content of mental life which, on the one hand, results from the content of cultural settings and from demands of interaction and, on the other, are not dependent on them.

According to Gagnon (2003), some individuals faithfully reproduce instructions from the cultural settings in their daily behavior, with enthusiasm and no discomfort. Others make few changes according to the needs of the context. This is when they turn from 'actors,' who read their context, into 'improvisers,' with certain 'dramatist' components. And others disagree with the instructions, with great resistance to cultural demands and to the demands of social roles. The latter are isolated, suffer from repression, which explains the script follow-up by most individuals. However, Gagnon highlights the possibility of script diversity and the fact this individual behavior is not guided by one single script, but results from social context variation.

Several researchers in this area, such as Bozon (2009) and Giami (2004; 2007), who share this theory, believe that sexual intercours do not make sense without the contribution of scripts, required to understand social practices in the everyday life of individuals.

Methods

A qualitative approach was chosen as appropriate for a project where subjectivity is the central research object, in this case regarding 'sexual culture.' This is understood as a system of meanings, knowledge and practices that structure and model sexuality in different ways (Parker, 2000). Note that the focus of this inquiry is not placed only on the incidence of certain attitudes and practices, but on the cultural and social contexts in which sexual activity is defined and performed. Thus, qualitative research is an important tool to meaningful access to the ways individuals and social groups think and act facing grievances and aspects which involve them, providing a grounded, systematic basis for the formulation of health policy. Note, however, that this approach does not focus on a kind of knowledge that may be universalized as a rule, but its strength rests, rather, on a close look at the peculiarities and singularities of the individuals' social experience.

For data collection, open, in-depth interviews were conducted, as one of the most appropriate resources to obtain textual materials, which provide access to participants' narratives with description of facts, explanations, justifications and

feelings (Demazière & Dubar, 1997; Bertaux, 2001; Norris *et al.*, 2005). Questions were raised regarding interviewees' sexuality experience, such as: what they think about sex, how they live their sexuality, who their partners are. Particular care was exercised to find a starting point and ways to return to questions that would make individuals express themselves without feeling embarrassed, which would block or limit their speech given the peculiarity of the subject. Objective data were also collected to characterize the individuals' social context.

Participants

Individuals were adults with severe and persistent mental disorders, found in public mental health services in Brazil. Inclusion criteria were as follows: not experiencing a crisis at the moment of the interview, and being able to maintain a dialogue with the interviewer. These criteria were confirmed by the health professional responsible for the patient at the mental health service, and having taken part in the quantitative epidemiological research of a project called PESSOAS (People) (Guimarães *et al.*, 2009). The interviews were conducted once the interviewee was aware of the scope of the research project and he or she has signed a Term Informed Consent. Participants were selected at random among all of those who met this criterion. Interviews were conducted in two psychiatric hospitals and in two outpatient mental health service units located in the states of Minas Gerais and Rio de Janeiro, Brazil, where the researchers had facilitated access. The number of participants was not defined *a priori*, but by data saturation.

At outpatient services that are sought voluntarily, patients spend the day and return to their homes at night, or to shelters where there is no family support. These services they are accompanied by multidisciplinary team that seeks to gradually prepare patients for life in society. Patients who were hospitalized, forwarded by family members, were more severe cases, with increased difficulty for the return to life in society. However, the current mental health policy in Brazil indicates to deinstitutionalize as soon as possible, and reference for follow-up in ambulatory health care services.

The project was approved by the participants of the health service units, by the Ethics Committee of Universidade Federal de Minas Gerais (Federal University of Minas Gerais) (COEP/UFMG), and by the National Ethics Research Committee (CONEP), by Report 592/2006, according to Acts 196/96 and 25/97 of the National Health Council. Participants were given the right to refuse to participate in the research without any prejudice to confidentiality and anonymity of information.

Data analysis

Interviews were analysed according to the guidelines of Structural Analysis of Narration (Demazière & Dubar, 1997), based on a Grounded Theory framework (Strauss & Corbin, 2008). The theory of sexual scripts (Gagnon, 2003) supported the theoretical analysis, as the basis to discuss sexuality with a focus on gender, after interview breakdown. This was carried out in three stages (Blanchet & Gotman, 1992). In the first stage, a vertical reading of each interview is carried out, searching for its global meaning. The second stage was of horizontal reading, where each speech object was numbered in sequences, which then were rearranged into groups according to the subjects addressed, transforming them into empirical categories (Demazière & Dubar, 1997). In the third stage, of transversal reading, a comparative analysis of the interviews was carried out, as well as the final categorization of the meanings, which were interpreted in the light of the literature and of the researchers' reflections, constituting the final or theoretical categories.

Results

Participant Characteristics and their Social Context

Twenty-two men and seventeen women, aged between 18 and 72 years old, were interviewed. Twenty were inpatients and 19 were outpatients. Ten were illiterate, eighteen studied for a maximum of four years and ten for a maximum of eight years. One had finished high school and had a college degree. Most of the respondents did not live by themselves. Three of them had already been homeless. Twenty-two had some sort of income which, in general, did not exceed minimum wage (at that time around 350 US dollars). The others lived with the help of family members or from the charity of others. Most had psychiatric diagnosis of severe psychosis. The others had been diagnosed with retardation, dementia or epilepsy.

Twenty participants had children, but six did not have any contact with them, which was explained by difficulties to interact. Respondents reported having few friends and almost no family or social support network. In all interviews we observed low self-esteem and feelings of inferiority regarding social prejudice regarding the respondent's state of mental disorder: *Nobody likes a mental patient.*

Use of illegal drugs was reported by 25% of the interviewees and of alcohol by 30%, which is justified by the anxieties and unhappiness they face in life. Substance abuse was also associated with the context of drug addiction: *I saw everyone using it and I wanted to use it too.*

The profile of the research group is similar to that found in an investigation carried out with 2,475 people with mental disorders in Brazil, in the quantitative Project “PESSOAS” (People), which showed that 79.7% of participants had fewer than five years of education, 51% had an income lower or equal to the minimum wage, 18% reported having been homeless, 64% reported using alcohol and 21.9% reported using illegal drugs (Guimarães *et al.*, 2009).

Women's sexual scripts

The women's sexual trajectories were characterized by few sexual partners throughout their lives, and their sexual life was connected to affection and to establishing a stable relationship: *Good sex is the one that comes with love.*

The first approach to sexual practices was reported as having occurred with partners who were older than the respondent. These sexual intercours were reported as being an initiative of the partners, which continued throughout their lives, highlighting the social script of women's passivity in their sexual experience. Partners were reported as people with previous sexual experience, which was accepted by these women: *He already had experience, as he has already been around, right?!* That also shows the belief in men's sexuality as instinctive.

Pregnancy reports in the beginning of the sexual experience were not rare, which points to evidence of sexual initiation having been unexpected and with no clear information. Several women reported they did not know anything about sex or how to prevent pregnancy and STDs when this experience occurred, and they also reported lack of knowledge of their own body: *I didn't know the difference between being a virgin or not.*

Five women reported having started their sexual life in a context of violence, which proved to be a cause of great suffering for them: *It is difficult to accept it!* Two of them were sexually assaulted by their fathers. They reported having told their mothers about what had happened and not having received any support from them, and then having to leave home to protect themselves. None of them complained about this violence to police authorities. They claimed they did not have this opportunity at the time, but some reported that they were afraid of suffering new aggressions if they did that. Sexual violence left negative impacts on their lives, such as unwanted pregnancies and distaste for sex: *I have never felt pleasure. I think it is because of the rape.*

In general, sexual initiation was reported as not very pleasant, with reports of pain and no pleasure, which continued throughout their lives.

Most female respondents had had a stable relationship, even if not formalized, living together with their partner. However, only three women were living with their partners at the time of the interview. They attributed the instability of

their relationships to the aggressiveness and unfaithfulness of their partners, their negligence towards the family, and the use of drugs and/or alcohol by themselves (women) or their partners. Three women reported having contracted an STD from their steady partners along their lives.

For the women interviewed by this study, men, their only sexual partners, are focused on sex, and it is the woman's role to sexually please a man in order to get married and to maintain a marital relationship, even if they do not want to have sex: *I thought it was my role to please him and do what he wanted me to do in order to be with him.* Because of this, female respondents felt as if they were objects of men's pleasure: *He just wanted to use me and thought I had to give him everything. That is enough! He uses me and then throws me away as if I were toilet paper!*

However, even if they were not pleased, women reported difficulties to end their relationships, and maintained them for a long time due to their financial dependence and the lack of social support to separate, as reported by one respondent: *My mother did not accept my separation. I had to stay with him.* Another interviewee reported: *I was raised to tolerate everything.*

Those who separated had great difficulties as they did not have any financial support from their partners to live and look after their children: *I had to live on the streets.* After separated, many respondents did not want any emotional or sexual involvement as worthless: *I don't want it anymore! I have already suffered a lot with men. I am happy like this.* A similar consideration was made by the only widow interviewed. Another interviewee justified her option of not getting sexually involved anymore: *Men just get us pregnant!* The incapacity to control fertility along respondents' lives was frequently reported.

In most cases among respondents who started a new marital relationship, the new relationships were also considered unsatisfying, with repeated reports of emotional negligence and unfaithfulness, as well as aggressiveness, on behalf of their partners.

But there is a representation of a happy marriage with pleasant sexuality in spite of the suffering, and the expectation of the 'right partner' to come along, with whom 'having a relationship is worthwhile.' This man would be a good, faithful and loving partner, who would help pay the bills, would look after his female partner, would not use drugs or alcohol and would not be aggressive. This is a fundamental and persistent representation, also common in the female imaginary of society at large. Some respondents claimed that in the attempt to find the 'right' partner that would like to establish a stable relationship with them, they had had sexual relationships with any men who would be interested in them, since there were not many. Extramarital affairs were not reported, thus showing these women

oppose to this behavior: *A married man wanted to have sex with me but I didn't want it. His wife would suffer a lot.*

Women reported only vaginal sex, since intercourse was the only meaning of sex for them. Self-masturbation was considered as something "to be ashamed of," and the only interviewee who reported masturbating her partner claimed it was because of her partner's sexual dysfunction. In addition, she said that her partner did not reciprocate, which points to his negligence towards his partner's sexual pleasure. Men's lack of care and attention towards the pleasure of their partners was repeatedly present in women's reports, as something 'normal to men', but wishing it would be different, which is a regularity in female sexual scripts.

Although most female respondents had already heard about the male condom, many of them had never had access to it. It is worth pointing out that the male condoms are distributed for free at Primary Health Care Units in the cities where this study was conducted, and are available in some mental health units in Brazil. In general, women claimed that their partners refused to use condoms. Others claimed that they did not have the courage to ask them to use condoms. There were also those who felt safe because they had only one sexual partner, seeing the condom as something that was not necessary: *I do not need it, because I only have sex with him!* They had never heard of the female condom. This is only distributed by some health care services.

There were some reports of sex for sale, with irregular or no use of condoms. Sex for money was justified as a way to earn a living or to buy drugs. This practice was considered as painful, but hard to stop because of the difficulties to pay the bills and to stop using drugs. One respondent was HIV positive, which she hid from her partners, but she said she used condoms in order to protect herself from new infections. However, this did not happen when under effects of drugs or alcohol: *I get totally crazy!* All respondents reported not being under risk of infection and not having risk behaviors, but they considered that men do have risk behaviors and that they are the ones who "bring" them sexually transmitted diseases.

Out of 17 women respondents, two reported never having had a sexual relationship, justified by not having a steady relationship and being afraid of getting pregnant. None of them reported having had sexual relationships inside mental health care service units, but they said that the sexual relationships are usually hidden in these places and there are rumors of interviewees having sex with their hospital partners.

It is difficult for them to talk about sexuality with anyone, including one's own partners or health care professionals, which was related to moral issues or to each person's intimacy: *This is something that is only ours! I am embarrassed to talk about this!* They also reported that sexuality and sexual health had never been approached as a discussion topic at home and or at the health care services.

The sexual scripts of men

Unlike women's, the sexual trajectory male respondents was characterized by a considerably greater diversity, of partners and of sexual practices, which they report with pride: *I have already had sex with more than twenty women!* For them, sex, which is also just focused on sexual intercourse, is practiced regardless whether there is affective involvement or not. Men are seen as protagonists in the initiation of sexual practices, which for most occurred with prostitutes, which is considered sexual learning.

Although they talked about sex in a positive way, usually stating that it was "very good," there were recurrent reports of difficulties in the sexual act, which was seen as a reason for great suffering for them. These difficulties were attributed to the lack of partners, which they related to both prejudice against mental patients and their poor physical appearance: *I don't have teeth! Nobody is interested in me!* Due to the difficulty in finding partners, they look for paid sex along their lives. Difficulties for the sexual act were also related to low libido and difficulties to maintain an erection, attributed to the use of medicines to treat the mental disorder, as well as to the lack of a private place to have sex at. However, none of them reported having talked about these difficulties to health care professionals.

Although they wished they had a stable relationship, only a few men reported having lived with a partner, and one respondent reported a stable relationship with a partner of the same sex. Out of those who reported having had a stable relationship, only two still had a marital relationship. Breakups were attributed to difficulties in living together, to the partner's unfaithfulness, or for having been abandoned. Although none of the men related their separations to extramarital sexual relationships they had, this was presented as a common and completely normal practice, mainly for older men.

Sex also represents risk, but mainly of STD and HIV/AIDS. However, the use of the male condom, which is known by all of them, was reported by just a few. The justification for not using condoms was that they chose partners they already knew and who were 'healthy,' thus, in their opinion, did not represent a risk. In addition, they thought diseases are visually perceived by the way the woman walks, her physical appearance and by her general weakness, in addition to the anecdotal belief that 'women who are very beautiful are the most dangerous,' because many men want them. In addition to the representation that 'nobody wants a man with mental disorder', male respondents also reported preference for 'ugly women' and sex workers, since they are 'clean' and have 'good appearance'. With them, the use of condom is also considered unnecessary: *Well, it is not necessary to use it with her. I know her and I know she doesn't have any disease!*

Self-masturbation is reported as a normal behavior and is practiced by most of them, but some considered it 'disgusting' and reported getting angry when another patient masturbated without preserving their intimacy at the health care service unit. However, the practice was justified by the lack of a partner for sexual practice, and not as pleasant and safe sex alternative.

Among the men, two interviewees reported having partners of the same sex, emphasizing they suffered a lot of prejudice due to their sexual preference. One of them, who had been under inpatient care for over 30 years, said he started his homosexual career at the mental institution, but it is not known whether that happened as an option or due to the lack of an option. There was one report of sex with animals by an interviewee who used to live in the rural area.

Among the interviewees, there were reports of exchanging sex for money to buy drugs, as well as reports of suffering sexual violence, even in their childhood. Abusers were of the same sex, as well as in cases of prostitution. Sexual violence suffered by men was predominant at the mental health services. Like the women, the men who suffered sexual violence did not report it to anyone, which is believed to have occurred because they felt embarrassed about it.

Only two 25-year-old men had never had a sexual relationship. One of them claimed that it was for religious reasons, since his religion objected to sex before marriage. The other reported that he tried to have sex with a sex worker, but he did not have an erection.

Discussion

The results show that sexuality is an important dimension in the life of people with severe and persistent mental disorders, and constitutive of their identity. They also show that people in that population have sex with little pleasure and little autonomy, often with suffering along their lives.

Great differences are seen between the sexual scripts followed by women and men. In women's scripts, values such as passivity and subordination predominate, and their sexuality is experienced with limits and repression. Sexual experience is not a source of pleasure, but is seen as the women's obligation towards their partners, which is clearly explained by the virtual insignificance for them of the practice of masturbation. But for the men, sexual scripts are strongly marked by the search for sex as a source of pleasure and as a way to show their masculinity. From this perspective, the need to number their sexual conquests is justified, in spite of the many barriers reported concerning a pleasant sexual experience. In the men's narratives, more freedom and diversity is observed in their sexual experience. These

differences, observed from sexual initiation throughout people's lives, take place, according to Gagnon (2003), and Simon & Gagnon (1986), because of the connection between sexual behavior and gender behavior, where gender scripts are learned before sexual scripts, and the latter usually partly derive from the former.

Differences between men and women in their ways of living and thinking their sexuality, similar to those identified in this study, were pointed out in studies carried out with other populational groups, including some from different cultures (Barbosa & Koyama, 2008; Brasil, 2009; D'Oliveira *et al*, 2009; Giami, 2007; Heilborn, 1999; Lindgren *et al*, 2011; Paiva, 2000; 2008). This allows us to state that, in spite of the specificities in sexual scripts in this population due to their context and cultural settings, meanings attributed to the sexual experience for people with mental disorders are very similar to those for the population in general.

The experience of sexuality is subordinated to the fulfillment of social and sexual roles expected for men and women in society. Those are values based on the anatomical and physiological dimension of the male and female bodies, where men are seen and see themselves with an innate sexual instinct, and women are seen and see their sexuality as essentially related to their reproductive function (Parker, 1997). These conceptions, which have remained unchanged over decades, promote and foster differences in the relationships between men and women, where the will of the former predominates, contributing to situations of sexual abuse.

Although dissatisfaction was observed when following these scripts, it was evident, mainly in the women's speech, that their ways of living and thinking their sexuality was repeated by the younger generations. This situation may be understood both for the need to obtain social acceptance, which is directly linked to the fulfillment of social roles (Gagnon, 2003), and for the difficulties to change values learned during childhood, given the complex cultural process originated in the patriarchal model (Giddens, 2000; Parker, 1997). In addition, sexuality continues to be a taboo, so it is not a subject of conversation, even with people that respondents consider reliable, which makes it difficult to change individual values, as well as the quality of the interactions established with partners.

Moreover, difficulties in changing sexual scripts have been related to factors concerning their social context which, for the studied group, is marked by prejudice, poverty, low level of education and autonomy, reflecting on their self-esteem and capacity to defend themselves. In a study carried out by Christensen *et al*. (2011), financial difficulties showed to have an impact in the pleasure of sexual experiences of those surveyed.

In spite of gender differences, and similarities in the ways sexuality is lived within each gender, specificities were verified in scripts lived by each interviewee. According to Gagnon (2003), this is due to the fact that there is only one script

guiding behaviors within the same gender, but there are differences due to context variations of. There were scripts with many sexual partners, others with single partners, and scripts with and without sex for sale. Differences were related to factors such as social support, partners' behavior, experiences respondents had, and individual values such as religion; that is, interpersonal and intrapsychic factors.

The results also show that sexual health is neglected by people with mental disorders, who have little knowledge and ability in selfcare to prevent sexually transmitted diseases, pregnancy control, to defend themselves from abuse, and to maintain relationships which are both respectful and pleasant. Interestingly, there reports by respondents of perception of themselves as individuals who have rights were inexistent, which seems to be closely related to their social context, marked by exclusion and abandonment; which determines several limitations, as in making healthier choices for their lives, for example.

The findings from this study clearly show the effects of patterns for social behavior regarding the way people with mental disorders live their sexuality, reflected on differentiated scripts for men and women, and similar to what happens for other populational groups. The cultural settings that constitute these scripts are full of useless stereotypes of gender, which prevent sexual satisfaction and contribute to violations of the human rights of this population.

The narratives constitute reliable evidence of the importance to recognize the sexuality of this group, since it lies in the essence of human life, considering their life contexts, whose singularity makes it difficult for them to have a healthy and pleasant sexual experience. It needs to be addressed not only as a problem to be solved, or only from the point of view of preventing STDs and HIV/AIDS, but also as a source of happiness, pleasure and fulfillment. It is important to find opportunities for these people to talk about their sexuality and to share experiences. It is important to teach them about their bodies and how to gain power over, and what to do with them. It is important to break the silence about the violence suffered by people with mental disorders. It is also important to go beyond defensive practices and develop strategies coherent with their social contexts, so that human rights may be achieved. In order to this, it is also fundamental for society to examine gender stereotypes, and not accepting them as established facts, which increase displeasure and vulnerability in sexual experience.

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