

**Lived Experiences and Psychosexual
Health Perspectives of Severely and/or
Chronically Mentally Ill People: A Qualitative
Study**

VERSÃO FINAL APÓS DEFESA

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Dissertação para obtenção do Grau de Mestre em

Psicologia Clínica e da Saúde

(2º ciclo de estudos)

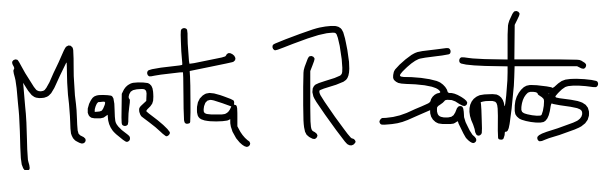
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Dezembro de 2025

Declaração de Integridade

Eu, Marta Rosário dos Santos, que abaixo assino, estudante com o número de inscrição M13184 do 2º Ciclo/Mestrado em Psicologia Clínica e da Saúde da Faculdade de Ciências Sociais e Humanas, declaro ter desenvolvido o presente trabalho e elaborado o presente texto em total consonância com o **Código de Integridade da Universidade da Beira Interior**.

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A handwritten signature in black ink that reads "Marta R Santos". The letters are cursive and connected, with a large 'M' and 'S'.

Universidade da Beira Interior, Covilhã 4/12/2025

Acknowledgments

I would like to express my sincere gratitude to Professor Henrique Pereira for his guidance and support throughout this process, and for granting me the opportunity to investigate a topic of considerable social relevance and significant impact on mental health.

I am deeply grateful to my family for their unwavering support throughout every stage of my academic and personal journey. Your belief in me, even in moments when I doubted myself, and your constant presence have been invaluable. Without your encouragement and love, this journey would not have carried the same meaning or significance.

I also wish to extend my heartfelt thanks to all those who, in various ways, contributed to this journey—colleagues, friends, and participants in this study. Every word of encouragement, gesture of support, and contribution has been essential in making this dissertation possible.

To all individuals living with severe mental illnesses who confront not only the challenges of their condition but also the weight of stigma and discrimination: it is my hope that this work serves as a meaningful contribution, amplifying your voices, fostering understanding, respect, and inclusion, and affirming that your dignity, identity, and worth transcend any diagnosis.

Finally, I acknowledge myself—for persevering through challenges, demonstrating resilience, and overcoming the obstacles encountered during what I consider the most demanding year of my life. This achievement is a testament to perseverance, dedication, and personal growth.

“Pedras no caminho? Guardo todas, um dia vou construir um castelo.”

- Fernando Pessoa

Resumo Alargado

A sexualidade constitui um elemento fundamental da identidade e do bem-estar humano, mas, no caso de pessoas com doença mental grave e/ou crónica, é frequentemente moldada por barreiras sociais, culturais e institucionais que comprometem a sua expressão de uma forma livre e íntegra. O presente estudo procurou explorar, através de uma abordagem qualitativa, as experiências vividas e as perspetivas psicosexuais de indivíduos com diagnóstico de doença mental grave e/ou crónica, analisando o papel do contexto social, do estigma e da discriminação na construção da sua sexualidade e na forma como esta se integra e influencia a sua saúde mental.

A investigação insere-se num enquadramento teórico que reconhece a interdependência entre saúde mental e saúde sexual, apoiando-se em conceitos como o estigma (Link & Phelan, 2001), o duplo estigma e o modelo do stress das minorias (Meyer, 2003). Estudos prévios têm demonstrado que as pessoas com doença mental grave e/ou crónica apresentam taxas elevadas de disfunção sexual e comportamentos sexuais de risco (Montejo et al., 2018), e que fatores como a ausência de apoio social, normas culturais conservadoras e patologização da sexualidade contribuem para isolamento e sofrimento psicológico (McCann et al., 2019).

A amostra foi constituída por 28 participantes (idade média de 31 anos, DP = 14; 71,43% mulheres; 46,42% pertencentes à comunidade LGBTQIA+), recrutados através de redes pessoais, profissionais e plataformas online. Os critérios de inclusão exigiam uma idade mínima de 18 anos e um diagnóstico de doença mental grave e/ou crónica. A recolha de dados foi realizada por entrevista eletrónica com questões abertas, explorando perceções sobre contexto social, expressão sexual, experiências de discriminação, impacto na saúde mental e fatores protetores. A análise seguiu o método de análise temática, com codificação colaborativa e identificação de temas recorrentes.

Da análise emergiram cinco temas principais e 19 subtemas: Contexto Social que incluiu experiências de ambientes positivos (acolhedores e inclusivos), negativos (marcados por machismo, LGBT-fobia e conservadorismo), apoio ou rejeição familiar, influência da religião, papel de amigos/pares, contexto laboral e diferenças geracionais; Discriminação incluindo violência interpessoal (verbal, física e social) e sexismo, frequentemente associado a desigualdade de género e insegurança; Estigma abrangendo LGBT-fobia e duplo estigma, levando à ocultação da identidade e à deterioração do bem-estar emocional; Expressão Sexual englobando vivências de estar “dentro” ou “fora do armário”, patologização da sexualidade e desvalorização da dimensão sexual, com impacto direto na

autoestima e na qualidade das relações; e Saúde Mental incluindo sintomas psicológicos agravados pelo estigma, fatores protetores como redes de apoio, presença de estigma sexual e preconceito internalizado.

Os resultados indicaram que o contexto social é determinante na experiência psicosexual das pessoas com doença mental grave e/ou crónica. Redes de apoio inclusivas, especialmente entre amigos, surgiram como um fator protetor, enquanto ambientes hostis amplificaram sentimentos de isolamento e inadequação. O duplo estigma foi identificado como barreira central à integração social, levando muitos participantes à ocultação da identidade sexual ou de género. A patologização da diversidade sexual e a negligência da sexualidade nos cuidados de saúde mental perpetuam barreiras e dificultam a promoção de um bem-estar integral.

A discussão relaciona estes resultados com a literatura, evidenciando a importância de abordagens integradas que reconheçam a sexualidade como parte do cuidado em saúde mental. Intervenções sugeridas incluem a formação de profissionais em diversidade sexual e de género, criação de espaços seguros, promoção de redes de apoio e políticas públicas inclusivas. É sublinhada a necessidade de modelos clínicos que integrem sexualidade e saúde mental no planeamento terapêutico, alinhados com o modelo de recuperação e o modelo biopsicossocial.

Entre as limitações, destaca-se a natureza auto-reportada dos diagnósticos, o uso de amostra de conveniência e a impossibilidade de validação posterior dos dados devido à recolha anónima e online. Apesar disso, o estudo contribui para a compreensão aprofundada de uma área ainda pouco investigada em Portugal e em contextos lusófonos, apontando para futuras investigações que considerem metodologias participativas e amostras mais diversas.

Em suma, este trabalho evidencia que promover o bem-estar psicosexual das pessoas com doença mental grave e/ou crónica exige a redução do estigma, o reforço das redes de apoio, a formação profissional culturalmente competente e a inclusão da sexualidade no acompanhamento clínico. Estas medidas poderão contribuir para uma melhoria significativa da qualidade de vida e da saúde mental desta população.

Palavras-chave

Saúde Mental; Psicosexualidade; Estigma; Apoio Social; Doença Mental Grave.

Abstract

This Dissertation focuses on how severe and/or chronic mental illness influences psychosexual perspectives and experiences, particularly in relation to social stigma, discrimination, and access to supportive environments. Given that this field remains academically underexplored, the present work aims to contribute to filling the gaps and limitations associated with the study of psychosexuality in people living with severe mental illness (PLSMI).

A qualitative design was employed, involving 28 participants, through online interviews that explored their lived experiences and personal perspectives on psychosexual expression and well-being. This research provided direct access to narratives that highlight both the challenges imposed by restrictive social norms, limited support, and internalized stigma, as well as the protective role of inclusive networks and positive relational contexts.

Thematic analysis of the responses resulted in several core themes, including the impact of social context, the influence of stigma and prejudice, limitations on intimacy and sexual expression, and the importance of supportive environments in fostering resilience and self-acceptance.

In addition to the qualitative study conducted, this Dissertation presents a critical reflection on the findings, contributions, and limitations, as well as future recommendations. These recommendations concern not only the need for further research to address the specific needs of this population but also the importance of mental health professionals adopting inclusive and holistic practices that safeguard the psychosexual rights of people living with severe mental illness.

Keywords

Psychosocial Health; Severe Mental Illness; Sexuality; Stigma; Social Support.

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List of Acronyms

SMI Severe Mental Illness

PLSMI People Living with a Severe Mental Illness

QoL Quality of Life

Introduction

This Dissertation was developed as a partial requirement for obtaining the Master's degree in Clinical and Health Psychology at the Faculty of Social and Human Sciences of the University of Beira Interior, and is part of the intersection between mental health and sexuality, seeking to contribute to the understanding of the psychosexual experiences of people living with severe and/or chronic mental illness.

The choice of this topic is justified by the growing international attention to mental health issues and the need to adopt a more holistic approach to studying the quality of life of these individuals. Literature has shown that sexuality constitutes an essential dimension of human well-being, but it remains frequently neglected in clinical and research contexts, especially when associated with the experience of severe mental illness (Montejo et al., 2018; McCann et al., 2019). The connection between these two dimensions is particularly relevant, since the experience of sexuality can be conditioned by multiple factors—individual, social, cultural, and institutional—that intertwine with the experience of illness and its respective psychosocial impacts.

The variables under study include: Severe and/or chronic mental illness (SMI) – understood as mental disorders that result in significant functional impairment; Psychosexual health – encompassing the perception of sexual well-being, identity, and expression of sexuality; Stigma and discrimination – social, cultural, and interpersonal manifestations that affect the experience of identity and relationships; Social support – as a protective or risk factor in mental and sexual health; Psychological well-being – reflecting symptoms, resilience strategies, and the overall impact of social integration or exclusion.

This document is presented in article format and is distributed in three chapters: I – Scientific Article: The empirical core of the work, presenting the objectives, theoretical framework, methodology, results, and discussion; II – General Discussion: That provides a more in-depth analysis of the results in light of existing literature, establishing critical connections between the empirical data and the theoretical framework, highlighting the clinical, social, and research implications, as well as the study's limitations; and III – Theoretical Appendix: That compiles and organizes the conceptual foundation supporting the research, exploring the variables under study in greater detail and offering a comprehensive review of the relevant literature.

Thus, this dissertation aims not only to give visibility to the experiences of often marginalized people but also to contribute to the construction of more inclusive,

informed clinical practices that are adjusted to the real needs of individuals with severe and/or chronic mental illness, recognizing sexuality as an integral part of their identity and overall well-being.

Chapter 1. Lived Experiences and Psychosexual Health Perspectives of Severely and/or Chronically Mentally Ill People

Abstract

Sexuality is a central aspect of human identity and well-being, yet people living with severe and/or chronic mental illness (PLSMI) often face barriers to expressing their psychosexuality. This study explored the lived experiences and psychosexual perspectives of PLSMI, focusing on the influence of social context, stigma, discrimination, and support networks. A qualitative, cross-sectional design was employed with 28 participants, using electronic interviews and thematic analysis to identify recurring patterns and themes. Five main categories emerged: Social Context, Discrimination, Stigma, Sexual Expression, and Mental Health. Results highlight the dual role of social environments, with inclusive networks fostering resilience, self-acceptance, and emotional support, while negative environments—characterized by prejudice, sexism, and LGBT-phobia—exacerbated isolation, internalized stigma, and mental health challenges. Participants also described the invisibility and pathologization of their sexuality, which further constrained authentic self-expression. Protective factors, particularly peer support and affirming relationships, mitigated these challenges. The findings underscore the need for integrated, holistic approaches in mental health care that recognize the interconnections between psychological and sexual well-being. Policies and interventions promoting inclusive, culturally competent care, public education, and targeted psychosocial support can enhance the quality of life and psychosexual health of PLSMI. This study contributes to a broader understanding of the intersection between mental health and sexuality, emphasizing the importance of addressing stigma, discrimination, and unmet sexual needs in this population.

Keywords:

Mental Disorders, Psychosexual Health, Severe/Chronic Illness.

Introduction

Mental health disorders are rising globally, making the topic increasingly relevant. According to the World Health Organization (2022), one in eight people worldwide—around 970 million individuals—live with a mental disorder. In 2024, statistics indicated that 5% of adults worldwide suffered from depression and 4% from anxiety disorders, making these the two most prevalent conditions (Huntington Psychological Services, 2024). The National Institute of Mental Health (2024) defines Severe Mental Illness (SMI) as “a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.” Importantly, this impairment extends to psychosexual health, which not only involves the absence of sexual problems but also the freedom to experience sexuality in alignment with sexual and reproductive rights, encompassing both physical and psychological well-being (Pereira, 2023).

Having fulfilling sexual and relational experiences is a fundamental human right that enhances quality of life. Yet numerous studies highlight persistent gaps and unmet needs in this area among people living with severe mental illness (PLSMI), who report higher prevalence of sexual problems and more frequent engagement in risky sexual behaviors compared to the general population (Montejo et al., 2018; McCann et al., 2019). Living with an SMI is a lifelong challenge, particularly regarding sexuality, which constitutes an integral aspect of identity and is profoundly shaped by context (McCann et al., 2019). As SMIs often emerge during adolescence—a critical period of sexual development—affected individuals may face disruptions in establishing sexual identity, gender role perception, and sexual attitudes (Brand et al., 2022). Evidence further suggests that many PLSMI experience detachment from their sexual selves (Wright et al., 2007).

Social support plays a central role in shaping health and well-being among PLSMI (Hansson, 2006). While positive support can enhance quality of life, stigmatizing or negative interactions often worsen it (Yanos et al., 2001). Cultural stereotypes portraying PLSMI as dangerous, unpredictable, or undesirable (Phelan et al., 2000) contribute to barriers in forming relationships, as many feel rejected after disclosing their condition (Hortal-Mas et al., 2020). Interestingly, Wainberg et al. (2016) found that individuals with non-SMI also reported similar levels of internalized sexual stigma, suggesting that expectations of rejection may be sufficient to alter behavior. Anticipating stigma, individuals may withdraw from sexual relationships altogether to avoid potential rejection (Link & Phelan, 2001).

Psychosexual health among PLSMI is shaped by complex interactions among psychological, social, and biomedical determinants, including the nature of the illness, social support, side effects of psychiatric medication, and stigma (Ma et al., 2018; Montejo et al., 2018; Hortal-Mas et al., 2020). For instance, sexual dysfunction is significantly more prevalent among those with bipolar disorder, depression, anxiety, personality disorders, and eating disorders, where symptoms directly affect desire, arousal, or satisfaction (Zemishlany & Weizman, 2008; Kopeykina et al., 2016; Montejo, 2018). PLSMI, particularly those with schizophrenia, major depression, or bipolar disorder, often struggle to find or sustain relationships due to rejection or shifting partner dynamics after disclosing a diagnosis (Wright et al., 2007; Elkington et al., 2012). Furthermore, a history of sexual abuse is strongly linked with chronic mental health conditions such as anxiety, depression, PTSD, eating disorders, and sleep disorders (Chen et al., 2010).

Regardless of diagnosis, PLSMI often internalize negative societal beliefs, perceiving themselves as devalued partners lacking desirable qualities (Wainberg et al., 2016; Wright et al., 2007). Many report feeling unworthy of intimacy, though some studies note that others are less affected by stigma in their relationships (Elkington et al., 2012). Still, comparative research shows that PLSMI experience more discrimination and receive less supportive attitudes from mental health professionals regarding sexual matters than their peers without SMI (Elkington et al., 2012; Wainberg et al., 2016). The frequent neglect of sexuality by both individuals and professionals perpetuates these barriers.

Although PLSMI are generally as sexually active and interested as the general population (Bahnsen et al., 2023), opportunities for sexual expression are often constrained by treatment settings and institutional cultures that impose structural discrimination (Wright et al., 2007). When given opportunities to share their experiences, many describe both internalized and external stigma (McCann et al., 2019). Recent research emphasizes the potential role of mental health professionals in supporting psychosexual well-being, including through sex education and creating safe spaces for sexual expression (Yang et al., 2023).

Against this backdrop, the present study aims to assess and describe the lived experiences and psychosexual perspectives of PLSMI through a qualitative approach. We focus on personal narratives concerning mental and sexual functioning, while accounting for the pervasive impact of stigma. Despite their importance, perspectives on the sexuality of PLSMI living in the community remain under-researched (Ostman, 2014).

Thus, our objective is to investigate how PLSMI articulate their psychosexual well-being and health, with particular attention to sexual identity, behavior, prejudice, and the implications for mental health.

Method

We conducted a qualitative, cross-sectional study to explore participants' perceptions and lived experiences of psychosexual health and well-being. Ethical principles of anonymity, confidentiality, and informed consent were strictly upheld throughout the research process. Approval was obtained from the Institutional Ethics Committee of the University of Beira Interior, Portugal (CE-UBI-Pj-2024-0105-ID2871). The study was carried out in accordance with the ethical standards outlined in the Declaration of Helsinki.

Participants

This study was conducted with a convenience sample of 28 valid participants. Eligibility criteria included being 18 years of age or older and having a diagnosis of a chronic and/or severe mental illness. Participants ranged in age from 18 to 70 years ($M = 31$, $SD = 14$). The sample was predominantly female (71.43%, $n = 20$), with males comprising 28.57% ($n = 8$). Regarding nationality, most participants were Portuguese (67.86%, $n = 19$), while the remainder were Brazilian (32.14%, $n = 9$).

Educational attainment was relatively high, with 57.14% ($n = 16$) having completed at least a university degree. Geographically, 42.86% ($n = 12$) resided in small towns, and 28.57% ($n = 8$) in rural areas. Regarding socioeconomic status, 39.29% ($n = 11$) identified as middle, 25% ($n = 7$) as middle-low, and 21.42% ($n = 6$) as middle-high.

With respect to sexual orientation, 53.57% ($n = 15$) identified as heterosexual, while 46.42% ($n = 13$) identified as part of the LGBTQIA+ community: bisexual (21.43%, $n = 6$), pansexual (10.71%, $n = 3$), gay (7.14%, $n = 2$), lesbian (3.57%, $n = 1$), and queer (3.57%, $n = 1$). Notably, only 28.57% ($n = 8$) of LGBTQIA+ participants reported being open about their sexual orientation or gender identity within their social contexts.

In terms of marital and relational status, most participants were single, with 46.43% currently in a relationship and 53.57% not in a relationship. Finally, when asked to rate their overall life satisfaction on a 0–5 scale, the average score was 3 ($SD = 1$). See Table 1 for further details.

Table 1. *Sociodemographic Data of the Participants (n=28)*

Variable	Categories	n	%
Gender	Man	8	28.57
	Women	19	67.86
	Trans Women	1	3.57
Sexual Orientation	Heterosexual	15	53.57
	Bisexual	6	21.43
	Pansexual	3	10.71
	Gay	2	7.14
	Lesbian	1	3.57
	Queer	1	3.57
Marital Status	Single not dating	13	46.43
	Single dating	11	39.29
	Married	2	7.14
	Divorced	2	7.14
Education	Bachelor's degree	12	42.86
	Up to 12 years of school	9	32.14
	Postgraduate or Master's Degree	4	14.29
	Other	3	10.71

Place of Residence	Small urban area	12	42.86
	Small rural area	8	28.57
	Large urban area	6	21.43
	Other	2	7.14
Socioeconomic Status	Middle	11	39.29
	Middle-low	7	25
	Middle-high	6	21.43
	Low	4	14.29

Table 2 presents the distribution of participants' self-reported diagnoses. The most frequently reported conditions were anxiety (53.6%) and depression (53.6%), followed by suicidal behavior (28.6%) and ADHD (25.0%). Other reported diagnoses included autism spectrum disorder (14.3%), obsessive-compulsive disorder (14.3%), bipolar disorder (10.7%), and borderline personality disorder (7.1%). Less commonly reported conditions were eating disorders, schizophrenia, and high skills/giftedness (each 3.6%).

Table 2. *Diagnosis* (n=28)

Self-Reported Diagnosis	Frequency	Percentage
Anxiety	15	53.5%
Attention Deficit Hyperactivity Disorder (ADHD)	7	25%
Autism	4	14.2%
Bipolar Disorder	3	10.7%

Borderline	2	4%
Depression	15	53.5%
Eating disorders	1	3.5%
High skills/giftedness	1	3.5%
Obsessive-Compulsive Disorder (OCD)	4	14.2%
Schizophrenia	1	3.5%
Suicidal behavior	8	28.5%

Design Analyses and Tools

Data were collected through electronic interviews administered via Microsoft Forms. On average, participants required approximately 25 minutes to complete the interview. The instrument consisted of two sections: the first gathered sociodemographic information (e.g., gender, sexual orientation, marital status, educational background, place of residence, and self-reported diagnosis), while the second included eight open-ended questions designed to explore the research topic in depth (see Table 3). Data collection took place between October and November 2024. Participants were recruited through personal and professional networks, mailing lists, social media platforms, and online forums, with over 400 individuals contacted during the process. Descriptive statistics were analyzed using Excel 365, and qualitative data were examined using thematic analysis in MAXQDA software.

A thematic analysis of interview responses was conducted following a codebook approach to identify themes and subthemes from recurring patterns and ideas (Braun & Clarke, 2024). Only topics that emerged at least three times were retained for analysis. This process yielded five themes and 19 subthemes. To ensure rigor, the research team collaboratively coded the first seven cases, resolving uncertainties regarding subtheme classification through discussion until consensus was achieved (Sabnis & Wolgemuth, 2023). Given the guarantees of confidentiality and anonymity, participants could not be recontacted to validate codes or interpretations. The study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007).

Representative participant quotations are presented throughout the results to enhance transparency and illustrate key findings.

Table 3. *Questionnaire*

Question 1	How do you describe the culture of the social context in which you live? What values are there? Is it sexist, collaborative, competitive, welcoming, encouraging, inclusive? Castrating, liberating, repressive, homophobic? Or not at all? It could be your family, network of friends, church/religion, support groups, interaction with the health system, etc. Please elaborate...
Question 2	Concerning the way you or someone you know expresses their sexuality (how they identify themselves, how they behave, how they talk about it, etc.), how do you describe the culture of the social context in which you are/were inserted? What values exist? Can you give any examples? Please elaborate...
Question 3	Do you know anyone who has revealed their sexual orientation or gender identity to someone in their current social context? Or who has come out, for example? If so, could you tell us a bit more about this experience? How did they react? If it applies to you personally, please elaborate on your experience.
Question 4	How does the culture that exists around the subject of sexualities and sexual and gender identities interfere with the way you express yourself and behave within your social context? (for example, concerning masculinity, femininity, <i>machismo</i> , sexism, heterosexism, etc.) Please elaborate...
Question 5	How does the culture that exists around the issue of sexualities and sexual and gender identities in your social context interfere with the mental health of its members? What are the implications for psychological well-being? Can you give any specific examples? Please elaborate...
Question 6	Have you ever suffered/seen someone suffer prejudice or discrimination in your social context because of their gender identity/sexual orientation? If so, how? If not, do you think that other people suffer prejudice or discrimination in their social context because of their gender identity/sexual orientation? Do you know of any cases? Please elaborate...
Question 7	What do you think a truly competent community would look like concerning the expression of its members' sexualities? Is there room for an inclusive vision of human diversity? Or do you think it's necessary to discriminate against people based on a profile considered optimal for membership in such a community? Please elaborate...
Question 8	Is there anything else I haven't mentioned on this topic that you'd like to add? If so, please elaborate...

Results

Analysis of the 28 interviews revealed five key categories and 19 subcategories, capturing the multifaceted dimensions of participants' lived experiences (see Table 4). To illustrate these findings, selected excerpts from the online interviews are provided, identified by case number, gender, age, self-identified sexual orientation, and self-reported diagnosis. These categories reflect the complex interplay between social context, personal identity, and psychosexual well-being. Social Context highlights how environmental and relational factors shape participants' experiences. Discrimination captures encounters with interpersonal violence, sexism, and other forms of mistreatment. Stigma encompasses social prejudices, LGBT-phobia, and the compounding effects of multiple stigmas, revealing how societal attitudes are internalized and affect self-perception. Expression of Sexuality explores the ways participants navigate self-disclosure, as well as experiences of pathologization and devaluation of their sexuality. Finally, Mental Health emphasizes psychological symptoms, protective factors, and the internalized impact of sexual stigmas and prejudices. Together, these categories provide a nuanced understanding of both the challenges and sources of resilience that shape the psychosexual lives of PLSMI. In the following sections, each category is presented in detail, supported by participants' own words to illustrate the lived realities underlying these themes.

Table 4. *Themes and subthemes*

Theme	Subtheme
Social Context	Positive Social Environment
	Negative Social Environment
	Family Support
	Religion
	Friends/Peers
	Workplace Environment
	Generationality
Discrimination	Interpersonal Violence
	Sexism

Stigma	LGBT-phobia
	Double Stigma
Sexual Expression	In the Closet
	Out of Closet
	Pathologization
	Lack of interest/Devaluation
Mental Health	Psychological Symptoms
	Protective Factors
	Sexual Stigma
	Internalized Prejudice

Note. C represents each participant who reported a particular category in the analysis of results.

Social Context

As anticipated, social context emerged as one of the most recurrent themes. Social support networks were identified as crucial by many participants, providing spaces of acceptance, understanding, and resilience. Research has shown that social support plays a central role in the well-being of people living with severe mental illness, influencing both objective and subjective quality of life. Positive social interactions can significantly enhance multiple aspects of life, while negative interactions—often characterized by stigmatization and rejection—can have profound effects, reducing life satisfaction and intensifying feelings of isolation and vulnerability (Yanos et al., 2001). Many participants emphasized that exclusion and prejudice contributed directly to mental health challenges, including anxiety and depression, illustrating the tangible impact of social and cultural factors on psychological well-being.

Positive Social Environments: Several participants described positive experiences within their social environments, noting that they felt welcomed, included, understood, and supported. These interactions occurred within contexts that fostered collaboration, tolerance, and respect for diversity, highlighting the protective role of affirming social networks in promoting resilience and psychosexual well-being.

“I currently find myself in a social context that is welcoming, inclusive, and supportive of diversity.” - (C9, Woman, 24 years old, bisexual, dg: Bipolar Disorder, Borderline, Depression, OCD).

“Fortunately, I've been able to grow in life and get involved in more diverse environments that are more tolerant of diversity.” - (C4, Woman, 32 years old, heterosexual, dg: Autism, ADHD, Anxiety, Depression).

Negative social environments emerged as a major challenge for participants, particularly in settings characterized by competitive, conservative attitudes, sexism, and LGBT-phobia. Such environments were frequently described as repressive, restrictive, and non-inclusive, amplifying feelings of exclusion, inadequacy, and social marginalization. Participants emphasized that these experiences not only undermined their sense of belonging but also had a tangible impact on their mental health and overall well-being, reinforcing internalized stigma and limiting opportunities for authentic self-expression.

“It's a macho, competitive, discouraging, castrating, repressive, homophobic environment” - (C8, Man, 31 years old, bisexual, dg: Depression, Anxiety, ADHD).

“It's sexist, uncooperative, competitive, castrating, repressive, and homophobic (...) so I've learned to have a rigid/mechanical posture in public, and I can only move to regulate myself when I'm completely alone” - (C2, Woman, 33 years old, pansexual, dg: ADHD, Autism).

“Sexist, not well-informed and understanding of my mental illness, not very inclusive, judgmental, and conservative” - (C21, Woman, 23 years old, pansexual, dg: ADHD).

These characteristics further reinforced social isolation and perpetuated stigma, particularly for participants who did not conform to heteronormative or traditional expectations. Negative social environments were often linked to interpersonal conflicts and a lack of community support, which heightened participants' vulnerability to mental health challenges and compounded feelings of exclusion, inadequacy, and marginalization.

“It has a negative effect, especially for those like me who have absolutely no one and no support” - (C8, Man, 31 years old, bisexual, dg: Depression, Anxiety, ADHD).

“The repressive social context causes severe depression, chronic anxiety and in my case even obsessive-compulsive disorder” - (C14, Man, undisclosed age, bisexual, dg: OCD, Depression, Anxiety).

Family support emerged as a crucial factor for participants’ psychosocial well-being, though experiences within this context were often complex and varied. Responses ranged from descriptions of welcoming, understanding, and supportive family environments to accounts of rejection, prejudice, and interpersonal conflict. These contrasting experiences highlight the significant influence of family dynamics on mental health, self-esteem, and the ability to navigate social and psychosexual challenges.

“In the family context, I'm part of a collaborative environment, although there is a certain competitiveness and machismo on the part of the men in my family.” - (C22, Woman, 22 years old, heterosexual, dg: Borderline).

“I was part of a welcoming family environment in which I felt supported at various times, but which was rigid and demanding, with extreme concern for appearance and some homophobic, racist, sexist, and moderately prejudiced influence concerning mental health.” - (C24, Woman, 22 years old, pansexual, dg: Bipolar Disorder type II, ADHD combined type).

However, most participants described their families as a source of challenge rather than support. Several reported conservative or homophobic family environments, which often limited emotional support, reinforced feelings of exclusion, and contributed to stress, anxiety, and diminished well-being. These experiences underscore the significant impact of family attitudes on the psychosocial and psychosexual development of people living with severe and/or chronic mental illness.

“Although some family members know what's going on, they don't really want to know and make things worse” - (C8, Man, 31 years old, bisexual, dg: Depression, Anxiety, ADHD).

“In my family, some relatives are closer and more welcoming, but most are not” - (C6, Man, 26 years old, bisexual, dg: Autism, High Skills, Depression, Anxiety).

“I grew up in a sexist and homophobic family” - (C4, Woman, 32 years old, heterosexual, dg: Autism, ADHD, Anxiety, Depression).

“In my family context, although it's possible to have conversations about it, it's not well received, it can cause arguments and even though I can express myself at my parents' house, there are certain things I have to suppress, for example, hanging an LGBT+ flag in my bedroom or bringing a same-sex romantic interest home...There is (discrimination) within my family when it comes to homosexuality” - (C9, Woman, 24 years old, bisexual, dg: Bipolar Disorder, Borderline, Depression, OCD).

Religion emerged as a significant factor influencing participants' psychosocial experiences. For many, religious beliefs and environments were associated with barriers to the acceptance and expression of sexual diversity, contributing to feelings of guilt, shame, and internalized stigma. These dynamics often shaped participants' ability to disclose their sexual orientation, engage in intimate relationships, and experience psychosexual well-being, highlighting the complex interplay between faith, identity, and mental health.

“Many people didn't want to accept my sexual orientation, mainly because I come from an evangelical family” - (C5, Woman, 21 years old, lesbian, dg: Depression, Anxiety).

In fact, many participants' narratives highlighted how specific religious doctrines and beliefs can perpetuate stigma and restrict social support. These experiences often reinforced feelings of marginalization, internalized shame, and fear of disclosure, further complicating participants' psychosocial and psychosexual well-being.

“In the religious context, I don't know anyone who has come out of the closet” - (C9, Woman, 24 years old, bisexual, dg: Bipolar Disorder, Borderline, Depression, OCD).

“One of my friends is gay (...) His parents are religious and think 'it's the devil” - (C6, Man, 26 years old, bisexual, dg: Autism, High Skills, Depression, Anxiety).

“(The Catholic Church) still has a very conservative vision (...) I feel that people with a sexual orientation different from heterosexuals can exist in the church, but that's all, to exist. They cannot participate in church life” - (C17, Woman, 31

years old, heterosexual, dg: Eating Disorder, Depression, OCD, Suicidal Behavior).

Hence, these narratives underscore how religion can function as a source of prejudice and exclusion. Notably, none of the participants reported positive experiences or acceptance within religious environments, suggesting that such contexts may pose challenges for individuals living with chronic mental illness or for those belonging to sexual minorities.

In contrast, *support from friends and peers* was frequently described as a positive counterbalance to experiences of prejudice in other social contexts. Many participants highlighted that their friendship networks were inclusive, affirming, and encouraging spaces, where they could express their sexuality and identity authentically, fostering resilience and psychosocial well-being.

“I express myself as a bisexual woman freely in my social context, especially among friends. (...) In my circle of friends, I know several people who have come out of the closet and have been welcomed with open arms. (...) There is no discrimination in my circle of friends” - (C9, Woman, 24 years old, bisexual, dg: Bipolar Disorder, Borderline, Depression, OCD).

“My close network of friends belongs to and/or supports the LGBTQIA+ community, we express our sexuality openly and have no problem talking about it or educating people about it when necessary” - (C24, Woman, 22 years old, pansexual, dg: Bipolar Disorder type II, ADHD combined type).

The importance of friends as sources of support also underscores gaps in other areas, such as family or religious environments. Inclusive friendships appeared to serve as protective mechanisms, helping participants cope with experiences of exclusion or prejudice and mitigating their negative effects on psychosocial and psychosexual well-being.

“In terms of friendships, everyone is inclusive, encouraging, liberating, and sensitive to the opinions of others” - (C22, Woman, 22 years old, heterosexual, dg: Borderline).

Our data suggest that friendship circles can serve as vital environments for acceptance, emotional support, and the enhancement of well-being among individuals living with chronic mental illness and those belonging to sexual minorities.

Workplace Environments also emerged as a context in which participants encounter challenges, particularly related to prejudice and discrimination. These experiences highlight how professional settings can impact both psychosocial and psychosexual well-being, shaping opportunities for inclusion, self-expression, and personal development.

“I have worked in sexist companies” - (C4, Woman, 32 years old, heterosexual, dg: Autism, ADHD, Anxiety, Depression).

“At work, there tends to be machismo, repression, and the prevalence of old ideas, usually expressed in joking tones” - (C6, Man, 26 years old, bisexual, dg: Autism, High Skills, Depression, Anxiety).

Participants highlighted *generational differences* as a significant factor shaping how sexuality and mental health are perceived and experienced. Age-related norms and cultural expectations influenced both social attitudes and personal experiences, affecting opportunities for self-expression, disclosure, and access to supportive environments.

“The context I’m in is made up of people my age who are more open to differences, but also older people who tend to be more conservative (...) I think that with friends my age there’s a lot of freedom to express one’s sexuality, but with family or people a bit older it’s not quite like that, I think there are still a lot of stereotypes and stigmas” - (C10, Woman, 23 years old, heterosexual, dg: Anxiety).

“Although some people in my circle of friends and family have more traditional views, I notice that there is a growing openness to issues related to sexual diversity, especially among the younger generations” - (C25, Man, 26 years old, heterosexual, dg: Anxiety).

The narratives indicated that younger generations generally demonstrated greater acceptance and openness toward sexual and gender diversity, whereas older generations often adhered to more conservative values, which were frequently linked to stereotypes and prejudices. Consistent with findings by Kalra et al. (2015), participants from rural areas reported experiencing discrimination more frequently than those from metropolitan regions (p. 464), highlighting the intersection of generational and geographic influences on the perception and experience of sexuality and mental health.

“I live in a small village with an aging population, so they prove to be more emasculating, sexist and homophobic” - (C22, Woman, 22 years old, heterosexual, dg: Borderline).

Discrimination

Discrimination has consistently been linked to poorer mental health outcomes. For example, Lozano-Verduzco et al. (2017) demonstrated a positive association between experiences of sexual discrimination and violence and the presence of depressive symptoms. Despite some cultural and legislative advances regarding the expression of sexuality, discrimination remains a pervasive reality. It manifests across multiple contexts, ranging from physical and verbal violence to social invisibility and exclusion, highlighting its cross-cutting impact on individuals' psychosocial and psychosexual well-being (Cabral & Pinto, 2023).

Interpersonal Violence: emerged as a critical dimension in the participants' experiences, manifesting itself in various forms, including verbal, physical, and social abuse:

“I've suffered prejudice in the street, people threatening to hit me” - (C5, Woman, 21 years old, lesbian, dg: Depression, Anxiety).

Verbal violence was reported by many, through offensive and derogatory comments, creating a hostile environment that damaged self-image and psychological well-being:

“I've suffered verbal abuse at home, at work, and at university because of my sexuality” - (C2, Woman, 33 years old, pansexual, dg: Autism, ADHD).

Physical violence was frequently mentioned by participants as both feared and, in some cases, as a directly experienced reality. These experiences contributed to heightened feelings of vulnerability, anxiety, and mistrust, further limiting opportunities for social engagement and authentic self-expression.

“I've witnessed family members being thrown out of their homes and suffering physical/verbal abuse, being socially excluded, or having their experiences invalidated.” - (C2, Woman, 33 years old, pansexual, dg: Autism, ADHD).

Sexism emerged as a significant form of discrimination reported by several participants. It was characterized by attitudes and practices that devalue individuals based on their gender, often limiting opportunities, undermining self-esteem, and reinforcing societal hierarchies. Participants described how these gendered prejudices intersected with other forms of stigma, further impacting their psychosocial and psychosexual well-being.

“The culture around sexualities and gender identities in my social context still bears traces of sexism and heteronormativity, which influences how people express themselves” - (C25, Man, 26 years old, heterosexual, dg: Anxiety).

This phenomenon was observed in both personal and professional environments, contributing to experiences of exclusion, marginalization, and inequality. Female participants, in particular, reported persistent experiences of machismo, describing how gendered expectations and biases limited their opportunities, constrained self-expression, and reinforced societal hierarchies.

“As for machismo and sexism, it's inevitable, as a woman, not to feel a hint of both every day, whether it's being afraid to walk alone at night, or catching people on public transport abusing my physical image, for example” - (C16, Woman, 18 years old, heterosexual, dg: Anxiety).

“Being a woman in the job market, it's inevitable to see the moments when the gender cut-off is necessary. There are many moments in my routine when I wonder if I would receive the same treatment if I were a man” - (C4, Female, 32 years old, heterosexual, dg: Anxiety, Autism, ADHD, Depression).

These experiences underscore how sexism constrains individual freedom and perpetuates gender inequality in everyday contexts. Participants' perceptions suggest that sexism not only has direct impacts on those affected but also shapes broader community attitudes, influencing how issues related to sexual and gender diversity are understood, addressed, and managed.

Stigma

Stigma was frequently described as a source of exclusion and discrimination, with negative impacts on participants' mental health and overall well-being. As anticipated, it was one of the most recurrent themes in the analysis. Two forms of stigma were particularly prominent: sexual minority stigma and double stigma. Stigma emerged as a

critical mediator that amplifies the harmful effects of social interactions, undermining self-esteem and diminishing individuals' sense of personal value (Yanos et al., 2001).

LGBT phobia was identified as a specific and persistent manifestation of stigma, exerting severe consequences on participants' emotional and social health. Experiences of prejudice, marginalization, and exclusion due to sexual orientation or gender identity contributed to heightened vulnerability, internalized shame, and reduced opportunities for authentic self-expression.

"People who have a different sexual orientation have to keep the truth hidden and repressed so as not to be despised or mocked" - (C8, Man, 31 years old, bisexual, dg: Depression, Anxiety, ADHD).

"I know people who have been put into conversion therapy" - (C6, Woman, 18 years old, queer, dg: Depression).

"I'd say that was the beginning of the development of my depression, realizing that I'll never be accepted by my family (...) the exclusion, violence, and disgust that people feel towards LGBT people can cause disturbances for them, such as depression, anxiety attacks, social phobia, among others, which can lead to suicide" - (C5, Woman, 21 years old, lesbian, dg: Depression, Anxiety).

This form of discrimination, targeting individuals with non-normative sexual orientations and gender identities, was reported across multiple contexts, including family settings, public spaces, and workplace environments. Participants described how these experiences of exclusion and prejudice not only limited social participation but also contributed to internalized stigma, emotional distress, and barriers to self-expression.

"I keep my bisexuality 'secret' because I know I would suffer prejudice from my own family, so I prefer to avoid it" - (C6, Man, 26 years old, bisexual, dg: Autism, High Skills, Depression, Anxiety).

"When I was in one of my same-sex relationships, I suffered prejudice and discrimination in the street from strangers with unpleasant comments" - (C9, Woman, 24 years old, bisexual, dg: Bipolar Disorder, Borderline, Depression, OCD).

"I've seen LGBTQIAPN+ friends suffer discrimination in the social context, especially in more conservative environments. These friends have faced

derogatory comments and exclusionary attitudes, both in social and academic spaces because they don't fit heteronormative standards.” - (C25, Man, 26 years old, heterosexual, dg: Anxiety).

“I've heard of people being fired because of their homosexuality” - (C3, Man, 42 years old, gay, dg: ADHD)

The narratives collected illustrate not only the prevalence of LGBT phobia but also its detrimental effects on participants' mental health and self-esteem. In response, participants emphasized the need for educational and community initiatives aimed at combating LGBT phobia and fostering inclusion, understanding, and respect.

Double stigma emerged as a critical theme in participants' accounts, reflecting the intersection of stigma related to mental illness with discrimination based on sexual orientation or gender identity. This overlapping of stigmas creates additional challenges for individuals belonging to minority groups, intensifying the negative effects on mental health and limiting opportunities to establish supportive social networks. As one participant remarked:

“There is a prejudice that people with a different sexual orientation have mental problems - when mental illness is probably generated by stigma and other elements” - (C8, Man, 31 years old, bisexual, dg: Depression, Anxiety, ADHD).

This sentiment was further reinforced by participants' accounts of how family and social rejection exacerbated mental health difficulties. Experiences of exclusion, lack of support, and interpersonal prejudice intensified feelings of isolation, lowered self-esteem, and created additional barriers to accessing supportive networks and resources.

“After I came out, there was a lot of estrangement from my parents... This affected my mental health” - (C9, Woman, 24 years old, bisexual, dg: Bipolar Disorder, Borderline, Depression, OCD).

Interestingly, even participants who do not identify as LGBTQIA+ acknowledged the challenges faced by sexual and gender minorities and recognized the impact that stigma and discrimination can have on mental health.

“The suffering that the LGBTQIA+ community goes through and how this affects, I suppose at an extremely negative level, their mental health, namely the

tendency towards mental disorders such as anxiety and especially depression”
- (C16, Woman, 18 years old, heterosexual, dg: Anxiety).

Expression of Sexuality

Sexual expression, understood as the ability to freely express one’s sexuality, was reported to vary considerably depending on social environments and interpersonal relationships. Some participants described positive experiences related to coming out, noting feelings of authenticity, acceptance, and personal empowerment. Conversely, others recounted negative experiences characterized by pathologization, demonization, prejudice, and discrimination, often accompanied by various forms of violence.

Participants who remained “*in the closet*” described choosing not to disclose their sexual orientation or gender identity due to fear of prejudice, social rejection, and potential violence. These experiences highlighted the protective but psychologically burdensome strategies individuals employ to navigate unsafe or non-affirming environments, revealing the complex interplay between self-expression, safety, and mental health.

“I don't express myself; I stay in the closet like almost everyone I know (...) I know (people who have come out) and they've all been removed from their social and family environment, that's why I don't do it” - (C14, Man, undisclosed age, bisexual, dg: OCD, Depression, Anxiety).

“The person hasn't revealed themselves yet because they're afraid of the family's reaction” - (C10, Woman, 23 years old, heterosexual, dg: Anxiety).

The implications of remaining in the closet extend beyond personal and psychological domains, impacting overall well-being and affecting other areas of life, including work, friendships, and social engagement.

Being Out of the Closet: This subtheme encompasses the experiences of individuals who have chosen to disclose their sexual orientation or gender identity across various social contexts. Participants often described these moments of visibility as positive, bringing feelings of relief, personal liberation, and acceptance. However, these experiences were frequently accompanied by challenges, including prejudice, rejection, and the ongoing negotiation of social and professional dynamics.

“It was absolutely normal, and no questions were asked. Acceptance and respect above all” - (C12, Woman, 21 years old, heterosexual, dg: Anxiety, OCD).

“When a friend of mine decided to reveal (his homosexuality), I showed him pride” (C18, Woman, 22 years old, heterosexual, dg: Depression, Anxiety)

“When I came out as a lesbian to my family, it wasn't easy” - (C5, Woman, 21 years old, lesbian, dg: Depression, Anxiety).

“From the moment someone finds out, if the people around them aren't willing to take them in, they can devalue themselves and trigger psychological problems” - (C11, Woman, 21 years old, heterosexual, dg: Anxiety, Depression).

Within our dataset, the majority of participants reported remaining in the closet due to fear of rejection or prejudice. Despite these challenges, coming out was frequently described as a crucial milestone for developing a more complete sense of identity and for building support networks grounded in authenticity and acceptance.

Pathologization refers to the perception that sexual and gender diversity is inherently pathological or morally wrong. Participants highlighted how this framing significantly affected their psychosocial experiences, contributing to feelings of shame, self-doubt, and heightened vulnerability, with tangible impacts on mental health and overall well-being.

“They consider all other genders and sexualities to be things of the 'devil' and repress them, thinking it's a mental problem” - (C14, Man, undisclosed age, bisexual, dg: OCD, Depression, Anxiety).

“An acquaintance of mine was taken to the psychologist for getting involved with women” - (C11, Woman, 21 years old, heterosexual, dg: Anxiety, Depression).

These experiences illustrate how the pathologization of sexual expression can exacerbate mental health symptoms, contributing to the development or intensification of conditions such as anxiety and depression.

Lack of Interest/Devaluation: This subtheme refers to how sexuality and sexual expression are frequently neglected, minimized, or devalued within the context of mental health care and the lived experiences of people with severe and/or chronic mental illness.

Participants emphasized that this neglect not only limits opportunities for fulfilling sexual and relational experiences but also reinforces feelings of marginalization and diminishes overall psychosocial well-being.

“I haven't had an active sex life for five years and I feel really good about it” - (C27, Woman, 52 years old, heterosexual, dg: Bipolar Disorder, Depression, Anxiety).

“I don't think sexuality is my biggest problem; there are symptoms of mental illness that are far more unpleasant than staying in the closet” - (C19, Man, 39 years old, gay, dg: Schizophrenia, Anxiety, Suicidal Behavior).

“Nobody cares (...) Live your own life and don't bother others” - (C1, Man, 32 years old, heterosexual, dg: ADHD).

These narratives highlight a significant gap in the psychosocial care of people living with severe and/or chronic mental illness, where sexuality is frequently overlooked or self-denied. This neglect contributes to a fragmented and potentially diminished psychosocial experience, limiting opportunities for authentic self-expression, relational fulfillment, and overall well-being.

Mental Health

This category captures the intrinsic relationship between mental health and the lived experiences of people with severe and/or chronic mental illness, with a focus on psychological symptoms, protective factors, sexual stigma, and the internalization of prejudice. Participants described how the symptoms of their mental health conditions adversely affected their overall well-being, interpersonal relationships, and psychosexual health, often expressing feelings of inadequacy and shame linked both to their sexual orientation and their mental health diagnoses.

Psychological Symptoms: Many participants reported that their mental health symptoms were exacerbated by daily experiences of prejudice and discrimination. These encounters contributed to heightened anxiety, depressive symptoms, and diminished self-esteem, underscoring the interplay between social stigma and psychological well-being.

“I have always been considered the odd one out, aggressive in childhood, unsocialized (...) My symptoms began to have a negative impact on my

relationship with my work team and on my well-being (...) I developed an inferiority complex, feelings of rejection and inadequacy, insecurity in relation to my physical well-being (fear of physical aggression), in relation to work (fear of dismissal) and others” - (C2, Woman, 33 years old, pansexual, dg: Autism, ADHD).

“The cultural context has a huge impact. Bullying, depression, and often harmful behavior such as self-mutilation” - (C17, Woman, 31 years old, heterosexual, dg: Eating Disorder, Depression, OCD, Suicidal Behavior).

“The conservative culture around sexualities and gender identities in my social context often generates repression and stigma, resulting in anxiety, depression, and feelings of inadequacy for those who don't fit the expected standards” - (C25, Man, 26 years old, heterosexual, dg: Anxiety).

“In terms of the social spectrum, anxiety has greatly limited my ability to speak freely with other people, as I have always tended to isolate myself rather than expose myself to certain topics” - (C16, Woman, 18 years old, heterosexual, dg: Anxiety).

Despite the challenges described, participants also identified *protective factors* that fostered resilience and supported their well-being. Many emphasized the crucial role of social support networks and peer acceptance in mitigating the adverse effects of mental health conditions. These supportive relationships provided emotional validation, opportunities for authentic self-expression, and a sense of belonging, helping participants cope with stigma, discrimination, and the psychological impact of their diagnoses.

“My social context is very welcoming in this sense, so I believe that the support we show each other is very positive in terms of mental health” - (C24, Woman, 22 years old, pansexual, dg: Bipolar Disorder type II, ADHD combined type).

“For the first time in all this time, I'm in control of my life and it's not my mental illness controlling it” - (C17, Woman, 31 years old, heterosexual, dg: Eating Disorder, Depression, OCD, Suicidal Behavior).

Sexual stigma emerged as a significant barrier to mental well-being. Participants reported that experiences of sexual stigma contributed to feelings of isolation, rejection, and diminished self-worth. These negative experiences often compounded existing

mental health challenges, limiting opportunities for social engagement and authentic sexual expression, and reinforcing internalized prejudices.

“I discovered my bisexuality at the age of 14. Because of the way I grew up, I didn't know this 'side' of the world, which brought up feelings that I had repressed for a long time, as well as confusion, and shame, and, after I came out, there was a great distancing from my parents who criticized me, didn't accept me and were homophobic towards me. This disrupted my mental health as I didn't feel like I belonged or was accepted and loved anywhere. It created a lot of isolation.” - (C9, Woman, 24 years old, bisexual, dg: Bipolar Disorder, Borderline, Depression, OCD).

“I'm sure it has an impact on the psychological well-being of many people, sometimes we want to fit into the 'drawers' we already know, and we stop being free, in a way” - (C10, Woman, 23 years old, heterosexual, dg: Anxiety).

“There is a prejudice that people who identify with a different sexual orientation are mentally ill - when mental illness is most likely generated by stigma and other elements.” - (C8, Man, 31 years old, bisexual, dg: Depression, Anxiety, ADHD).

“I think that when it comes to sexuality, society in general is much more receptive (...) but still holds a very conservative vision” - (C17, Woman, 31 years old, heterosexual, dg: Eating Disorder, Depression, OCD, Suicidal Behavior).

Internalized prejudice also emerged as a key factor contributing to psychological vulnerability. Participants described how absorbing societal stigmas—related to both mental illness and sexual or gender identity—led to self-criticism, shame, and diminished self-esteem. This internalization reinforced feelings of inadequacy and further compromised mental well-being, highlighting the deep interplay between social attitudes and personal psychological health.

“I have always found it difficult to accept myself as a whole since I was diagnosed.” - (C16, Woman, 18 years old, heterosexual, dg: Anxiety).

“If I tried to talk about my mental illness with people, I think I would be seen in a negative light.” - (C15, Woman, 25 years old, heterosexual, dg: Depression, Anxiety, Suicidal Behavior).

Such stigma also poses a substantial barrier to forming and maintaining relationships. People living with severe and/or chronic mental illness (PLSMI) frequently encounter societal rejection when disclosing their mental health condition, further reinforcing isolation and undermining opportunities for social and intimate connections (Hortal-Mas et al., 2020).

“I’m a bisexual but I have to keep it a secret, people are very homophobic and make jokes about it, I have to behave like them, act macho and homophobic so as not to arouse suspicion, otherwise I’ll be seen as something other than a person, much less of a man” - (C8, Man, 31 years old, bisexual, dg: Depression, Anxiety, ADHD).

This perception highlights how internalized prejudice can create additional obstacles to help-seeking and self-acceptance. Self-stigma appears to act as a barrier to intimacy, hinders the acceptance of one’s own identity, and reinforces feelings of inadequacy, further affecting psychosocial and psychosexual well-being.

Discussion

This study aimed to explore and describe the lived experiences and psychosexual perspectives of people living with severe and/or chronic mental illness through a qualitative approach. Specifically, it sought to examine individual narratives concerning mental and sexual functioning within the context of socially stigmatized environments. Overall, the findings indicate that social context plays a central role in shaping the psychosexual experiences of PLSMI.

The study identified both protective factors, such as inclusive support networks, and significant barriers, including internalized stigma, discrimination, and hostile social environments. Additionally, the data highlighted the frequent invisibility of sexuality within the context of mental health, which is often devalued or pathologized by close contacts, including family members. These findings are consistent with previous research demonstrating the complex interplay between stigma, mental health, and sexual expression, while also offering new insights into the cultural and social dynamics that shape these experiences. They suggest a need to revisit theoretical models that overlook the central role of sexuality in the overall well-being of PLSMI.

By amplifying the voices of a population often rendered invisible, this study contributes to a broader understanding of psychosexual needs and strategies for navigating challenges posed by social constraints and stigma. The results underscore the

importance of integrated approaches that recognize the interconnection between mental health and psychosocial experiences. Accordingly, mental health professionals should incorporate knowledge of sexual health and expression into their training, as many participants reported not discussing sexual issues with healthcare providers, reflecting a gap in appropriate counseling and support for sexual matters (Blalock & Wood, 2015; Bahnsen et al., 2023).

Social Context

Social context plays a central role in shaping the psychosexual experiences of people living with severe and/or chronic mental illness. Consistent with Cabral and Pinto (2023), social support can mitigate the effects of discrimination on internal shame, depression, and anxiety. Our findings, in line with previous studies (Kalra et al., 2015), highlight how individuals' sexual expression is deeply influenced by prevailing social attitudes. Societal norms and beliefs often link mental illness with a perceived lack of sexual autonomy, reinforcing stigma and discrimination. Such biases may lead to the suppression or pathologization of sexual expression, while limited social support and professional neglect further constrain opportunities for healthy psychosexual development.

Family support has traditionally been associated with greater resilience and better mental health outcomes (Cabral & Pinto, 2023). Conversely, lack of familial support is strongly linked to adverse outcomes, including mental health problems, suicidal behavior, substance use, and sexual risk behaviors (Ryan et al., 2010). Although prior research has shown that family and social support can benefit PLSMI (Hansson, 2006), our data indicate that many participants experienced rejection in family contexts. This may reflect specific cultural dynamics or a lack of emotional literacy within families (Bilač et al., 2024). Highlighting the importance of peer relationships, Parra et al. (2017) found that positive peer environments buffer against anxiety and depression in sexual minority young adults, even when family support is lacking. The divergence in support experiences between family and friends suggests a growing reliance on non-family networks as primary sources of acceptance, particularly when families struggle to address sexual health openly and informatively, further exacerbating the social isolation of PLSMI.

Positive social environments are essential for fostering resilience and promoting inclusivity, especially for individuals navigating challenges related to mental health and sexuality. Such environments counterbalance prejudice and exclusion while serving as

protective factors against the negative effects of discrimination and stigma. Our findings emphasize that inclusive support networks—particularly among friends and peers—contribute significantly to emotional and social resilience. Conversely, negative environments characterized by prejudice, sexism, and homophobia intensified feelings of isolation and inadequacy. These results align with previous studies demonstrating that positive social relationships enhance quality of life, including social satisfaction, frequency of interactions, engagement in leisure activities, and work outcomes (Yanos et al., 2002).

Generational and cultural influences were also evident in our data. Younger participants reported greater acceptance and openness, whereas older generations tended to perpetuate conservative and exclusionary values. While these findings reflect ongoing socio-cultural change, they also underscore the persistence of structural and attitudinal challenges that continue to affect the psychosexual and mental well-being of PLSMI.

Discrimination

Mental health is strongly influenced by social determinants, including discrimination and marginalization rooted in systemic oppression, such as heteronormativity (Lozano-Verduzco et al., 2017). Research indicates that discrimination contributes to higher rates of chronic disease, anxiety, depression, suicidal behavior, risky sexual practices, and substance use among LGBTQIA+ individuals (Cabral & Pinto, 2023). Our findings also highlight the intersection of discrimination based on sexuality and mental illness, with episodes of violence acting as catalysts for anxiety, depression, and social withdrawal. Beyond psychological consequences, discrimination manifests in structural barriers to healthcare, as stigma and bias among healthcare providers can discourage individuals from seeking medical or psychological support, exacerbating health disparities (Cabral & Pinto, 2023). These findings underscore the urgent need for social and institutional measures to protect vulnerable individuals, including inclusive healthcare policies, enforcement of anti-discrimination laws, and expansion of community-based mental health resources to foster safer and more supportive environments.

Stigma

Stigma emerged consistently across participants' narratives. The combined effects of mental illness stigma and prejudice against sexual minorities resulted in "double stigma," intensifying social isolation and hindering psychosexual well-being.

This aligns with existing literature identifying stigma as a primary obstacle to the health and well-being of PLSMI (Link & Phelan, 2001; Wright et al., 2007). LGBT-phobia, frequently reported as a form of intersectional discrimination, negatively affected mental health. Many LGBTQIA+ participants described concealing their sexual orientation as a protective strategy, which often generated loneliness and disconnection. This is consistent with Kalra et al. (2015), who note that the coming-out process is a critical period linked to heightened risk of substance use, unsafe sexual behaviors, self-harm, and suicidal tendencies, compounded by minority stress and both external and internalized stigma (Han et al., 2020). For PLSMI identifying outside heteronormative identities, this double stigma exacerbated challenges related to alienation and identity (McCann et al., 2019). These findings highlight the importance of educational interventions promoting diversity acceptance and self-acceptance programs to mitigate the harmful effects of internalized stigma.

Sexual Expression

Participants' experiences of sexual expression were often shaped by invisibility and pathologization. Many reported that their sexuality was devalued, and non-normative sexual orientations were frequently pathologized, intensifying anxiety and depression. The fear of pathologization can lead to underutilization of healthcare services, negatively impacting sexual and mental health and overall quality of life (Kalra et al., 2015). Concealing one's sexuality was sometimes used as a protective strategy but often led to feelings of loneliness and disconnection (Pachankis et al., 2020). These findings underscore the importance of inclusive and informed clinical practices (McCann et al., 2019). Conversely, positive experiences, such as coming out in safe contexts, were described as moments of relief, acceptance, and personal validation. Nonetheless, fear of rejection remains a significant barrier to authentic sexual self-expression for many participants.

Mental Health

The data revealed a close interplay between mental health symptoms and psychosexual well-being. Participants reported that anxiety and depression were exacerbated by social and internalized stigma, undermining self-esteem and the capacity to form intimate relationships, consistent with prior research (Cabral & Pinto, 2023). Protective factors, such as supportive social networks and acceptance from peers, mitigated the negative impacts of stigma and fostered resilience. These findings highlight the need to integrate sexual health into mental health care as part of a holistic, multidisciplinary approach. Emphasizing sexual health, providing affirmative therapy,

and implementing community interventions can break cycles of stigma, enhance overall well-being, and support the development of healthier, more fulfilling relationships (Vasconcelos et al., 2024).

Limitations

This study has several limitations that should be considered. First, participants' diagnoses were self-reported, and we did not have access to detailed clinical information or the course of their illnesses, which constrained the depth of analysis.

Sexuality and sexual relationships are deeply personal topics that some individuals may find difficult to discuss openly. Consequently, some participants may have withheld information as a protective mechanism, potentially affecting the depth and authenticity of the responses collected. Similarly, the analysis of experiences related to perceived stigma relied on self-reports, which are inherently subject to individual biases such as selective memory and subjective interpretation, potentially limiting the accuracy of the data.

The confidentiality and anonymity guaranteed to participants, combined with the nature of electronic interviews, prevented follow-up contact to validate coding and interpretation, imposing further constraints on the qualitative analysis. Additionally, our convenience sample—composed of individuals who opted to complete the online questionnaire—may not represent other populations, such as those receiving formal care or living in different contexts, limiting the generalizability of the findings.

Finally, individuals with severe and/or chronic mental illness living in the community are considered a hard-to-reach population and are often underrepresented in research, contributing to their continued marginalization and limited visibility in the literature. These factors highlight the need for caution in extrapolating the findings beyond the study sample.

Implications

Building on the limitations identified, future research should focus on developing tailored interventions that address the barriers faced by people with severe mental illness, helping them meet their unmet needs related to sexuality and intimacy. Examining the experiences of underrepresented populations, such as ethnic or religious minorities, could provide insights into additional intersections of stigma and exclusion.

Longitudinal studies would also be valuable to understand how sexuality and intimacy needs evolve over time, particularly in the context of ongoing treatment or support.

Further research should explore strategies to promote healthy sexuality and reduce risk behaviors in this population. Such studies should incorporate validated instruments and methodological approaches that enhance representativeness and, whenever feasible, include collaborative validation of qualitative data with participants to improve accuracy and authenticity.

Previous studies have emphasized the need for policies that ensure access to culturally competent mental health services and promote public awareness and education about mental health issues (Bilač et al., 2024). Mental health professionals would benefit from enhanced training on topics such as LGBT-phobia, internalized stigma, and minority stress, enabling more effective and sensitive interventions. Expanding research in this field can not only improve understanding of the specific needs of PLSMI but also guide the development of interventions that foster inclusion, well-being, and quality of life for individuals living with chronic mental illness.

Conclusion

This study highlights the complex interplay between mental health, social context, stigma, and psychosexual well-being among people living with severe and/or chronic mental illness. Our findings demonstrate that supportive social networks, inclusive peer relationships, and affirming environments serve as crucial protective factors, while internalized stigma, discrimination, and pathologization of sexual expression present significant barriers to well-being and authentic self-expression.

The results underscore the importance of integrating sexual health into mental health care, adopting a holistic approach that addresses both psychological and psychosexual needs. Mental health professionals must be equipped to provide culturally competent, inclusive, and affirmative care, particularly for individuals from sexual and gender minority groups.

By amplifying the voices of an often-invisible population, this study contributes to a deeper understanding of the specific challenges and needs of PLSMI. These insights can inform future research, guide the development of tailored interventions, and shape policies aimed at fostering inclusion, resilience, and improved quality of life for individuals living with chronic mental illness.

Acknowledgments

The authors would like to thank all participants in this study for their precious contribution.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest concerning this article's research, authorship, and/or publication.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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Chapter 2. General Discussion

The results of this study underscore the centrality of sexuality to the psychological well-being and quality of life of people living with severe and/or chronic mental illness (PLSMI). Sexuality is not merely a personal or private dimension of life but is deeply interwoven with social, cultural, and institutional factors that can act as both protective and risk determinants (Hortal-Mas et al., 2020; Montejo et al., 2018). Understanding how PLSMI experience their sexuality requires attention to these broader contexts, as social attitudes, cultural norms, and institutional practices profoundly shape opportunities for sexual expression, relationship building, and psychosocial development.

Protective and Risk Factors in Social Contexts

Inclusive, diverse, and supportive social environments emerged as critical protective factors in participants' narratives. Supportive networks, particularly among peers and friends, provided spaces for acceptance, validation, and resilience, mitigating the negative effects of stigma and discrimination. These findings align with prior research demonstrating that social support, especially from non-family networks, is essential in enhancing the well-being of vulnerable populations and buffering against the adverse effects of exclusion and prejudice (Yanos et al., 2001; Parra et al., 2017).

Conversely, social environments characterized by prejudice, sexism, and LGBT-phobia intensified feelings of isolation and inadequacy. Participants reported that these hostile contexts directly exacerbated psychological symptoms, particularly anxiety and depression (Cabral & Pinto, 2023; Lozano-Verduzco et al., 2017). Negative experiences in family, religious, and workplace environments highlighted the persistent influence of societal norms that devalue or pathologize mental illness and sexual diversity, reinforcing exclusion and social marginalization.

Double Stigma and Intersectional Challenges

A particularly salient finding was the experience of "double stigma," arising from the intersection of severe mental illness and belonging to a sexual or gender minority. This overlapping discrimination amplifies social and psychological vulnerabilities, creating additional barriers to integration and well-being. The compounding effects of stigma undermine self-esteem, prevent relationship formation, and restrict access to supportive networks, reinforcing cycles of exclusion and marginalization (McCann et al., 2019; Link & Phelan, 2001). Recognizing and addressing these intersectional challenges

is essential to developing interventions that are sensitive to the multiple layers of disadvantage experienced by PLSMI.

Sexual Expression and Pathologization

The expression of sexuality among participants was frequently constrained by invisibility and pathologization. Many reported experiences in which non-normative sexual orientations were interpreted as deviant or morally wrong, contributing to anxiety, depression, and social withdrawal. Concealment of sexual identity often served as a protective strategy to avoid rejection, yet this also led to feelings of loneliness, disconnection, and reduced opportunities for authentic relational experiences (Pachankis et al., 2020). While some participants described positive experiences of coming out in safe and supportive contexts—reporting feelings of relief, acceptance, and personal validation—the majority continued to navigate a pervasive fear of rejection. These findings emphasize the need for mental health services that are inclusive, informed, and supportive of diverse sexual identities, countering the ongoing pathologization and marginalization of sexual expression.

Sexuality in Mental Health Care

A notable finding is the limited attention to sexuality within mental health care. Participants reported that sexual issues are often neglected by professionals, contributing to myths, stigma, and a lack of tailored clinical strategies. Integrating sexuality into psychological assessment and intervention could significantly enhance holistic care, supporting the overall well-being and quality of life of PLSMI (Bahnsen et al., 2023; Blalock & Wood, 2015). Addressing sexuality in clinical practice not only validates this critical dimension of identity but also strengthens opportunities for meaningful interpersonal relationships, resilience, and self-acceptance.

Implications for Policy and Practice

These findings reinforce the need for public policies and clinical practices that recognize sexuality as a fundamental human right and an integral pillar of well-being. Interventions based on psychoeducation, affirmative therapies, and the development of professional cultural competence can reduce stigma, promote self-acceptance, and foster healthier interpersonal relationships. Mental health professionals should receive targeted training on topics such as LGBT-phobia, internalized stigma, and minority stress to enable informed, empathetic, and culturally sensitive interventions. Future

research should prioritize participatory methodologies that actively involve PLSMI in shaping interventions and developing solutions tailored to their lived experiences.

Professional Development and Skills Acquisition

Throughout the completion of this dissertation, I developed competencies aligned with the requirements of Decreto-Lei n.º 110/2017, which regulates the career path of Senior Technicians in Diagnosis and Therapy (TSDT), as well as the professional standards defined by EuroPsy. In particular, I strengthened my capacity for critical analysis of scientific information, planning and conducting methodologically rigorous research, and exercising technical-scientific autonomy by assuming responsibility for multiple stages of the project—including data collection, processing, and interpretation—under supervised practice. Additionally, I enhanced my scientific communication skills through writing, presenting, and discussing results in a manner informed by ethical reflection, thereby contributing to sustainable professional development in line with EuroPsy criteria.

Conclusion

In summary, this study emphasizes that sexuality is an essential aspect of identity and psychological well-being for PLSMI. Social context, stigma, and discrimination significantly influence the ability to express sexual identity, whereas inclusive and supportive environments foster resilience and self-acceptance. These findings underscore the importance of integrating sexual health into mental health care, developing public policies that protect and affirm the rights of PLSMI, and designing interventions that address both psychological and sexual well-being. By centering the voices of an often-invisible population, this study contributes to a deeper understanding of the intersection between mental health and sexuality and provides a foundation for advancing clinical practice, research, and policy in this field.

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Chapter 3. Theoretical Appendix

This appendix aims to synthesize relevant theories and models that help understand the psychosexual experiences of people with severe and/or chronic mental illness (PLSMI), as described in the study. The goal is to provide an integrative theoretical framework that supports data interpretation and informs clinical and policy recommendations.

1. Sexuality as a Central Theme of Well-Being and Quality of Life

As mentioned above, in the article, the World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental, and social well-being in relation to sexuality. This definition goes beyond the mere absence of dysfunction or disease, encompassing the possibility of experiencing sexuality in a safe and pleasurable way, free from coercion, discrimination, and violence (WHO, 2010). Sexuality is, therefore, widely regarded as a fundamental dimension of human experience, integrating physical, emotional, cognitive, and social aspects, and is recognized as a central element of well-being and quality of life (WHO, 2010).

In line with this perspective, the United Nations and the WHO emphasize that sexual and reproductive rights are universal human rights. These include access to accurate information, comprehensive sexuality education, the freedom to make decisions about one's own sexual and reproductive life, and protection from discrimination (United Nations [UN], 2014). The integration of sexual and reproductive health and rights into Transforming our world: the 2030 Agenda for Sustainable Development has reinforced sexual health as a global public health priority, aiming to improve overall health and quality of life throughout the lifespan (Vasconcelos et al., 2024).

Nowadays scientific evidence supports the strong link between sexual health and mental well-being, by way of example, a systematic review conducted by Vasconcelos and colleagues in 2024, found that almost all studies reported significant correlations between positive sexual health indicators and lower levels of depression and anxiety, as well as improved quality of life and greater life satisfaction. These findings suggest that emphasizing a positive and empowering approach to sexual health should be considered an integral part of strategies to promote overall health and well-being.

The recognition of sexuality as a component of quality of life is particularly relevant for vulnerable populations, such as individuals diagnosed with severe and/or chronic mental illness, whose sexual expression may be shaped by structural barriers, stigma, and limited access to appropriate care (Montejo, 2019). This research sought to highlight the lived experiences of these individuals and the central role of sexuality in their well-being, underscoring the urgent need to ensure that their sexual and reproductive rights are fully respected to promote both their health and dignity.

2. Context and Social Support

Context and Social Support were important topics in the conceptualization of our study, so we will now take a closer look at issues related to these topics. Over time, a variety of concepts and numerous typologies related to Social Support have emerged, making it difficult to agree on a single definition. In this section, we thought it would be useful to introduce part of the history of the development of Social Support Theories, presenting a brief chronological overview based on information provided in the article entitled “Social Support: Origins, Concepts, and Areas of Research” written by Professor José Ornelas in 1994.

The focus on Social Support Theories began in the 1970s, when Caplan (1974) introduced the term “Support System,” which encompasses not only the family and friends, but also informal neighborhood-based services and assistance provided by community service providers, relating the support provided to individuals to the provision of formal and informal services and highlighting the role that professionals can play in collaborating with community leaders in understanding human relationships and social needs. In the same year, John Cassei (1974) emphasized the importance of psychosocial processes in the etiology of diseases and, in particular, the role that social support can play in imbalances related to stressful situations. Two years later, Cobb (1976) referred to social support as essentially the information that the individual is loved, valued, and an integral part of a social network and reciprocal obligations, thus fulfilling the function of meeting social needs and protecting the individual from adverse consequences related to a crisis or stressful situation. He therefore considered social support to be a buffer against stress and concluded that it facilitates confrontation and adaptation in crises.

In the early 1980s, House (1981) proposed that Social Support was a set of interpersonal transactions involving (1) emotional concerns (sympathizing, liking, or loving), (2) instrumental help (goods and services), (3) information (about the

surrounding environment), and (4) recognition (information relevant to self-evaluation). A few years later, Cohen & Wills (1985) theorized about social support through two possible modes of action: the main effect model, which states that social relationships promote health and well-being regardless of the presence of stress, and the buffering hypothesis, which shows that social support mitigates the negative impact of stressful events on health, postulating that the presence of positive relationships acts as a protective factor, cushioning the impact of stressful events and promoting resilience.

A decade later, Vaux (1988), to systematize the diverse categories that were emerging, proposed a distinction between two complex and closely related concepts: Social Support activities, which consist of actions carried out by the individual, such as expressing concern, showing affection, sharing an activity, providing care, giving advice, making suggestions, or socializing, and Social Support functions, which do not relate to specific activities but to the consequences of these activities and the relationships in which they occur, examples can include intimate connections, a sense of belonging, and participation. In the mid-1990s, Ornelas (1994) presented a three-dimensional perspective of social support, viewing it as a complex transactional process, involving interaction between the individual and their support network, emphasizing that the most commonly used support measures could be divided into three categories: (1) the Networks dimension, which focuses on the individual's social integration into a group and their interconnections within the group context; (2) the Support Received dimension, which focuses on the support that the individual actually receives or considers to have received; and (3) the Perceived Support dimension, which focuses on the support that the individual believes to be available in case of need.

In the 2000s, Hansson (2006) conceptualized that social support remains an ambiguous concept and can be defined in various ways, having both a structural aspect that refers to the quantity of social relationships and a functional aspect that refers to more qualitative aspects, such as the type of interactions with other people and satisfaction with social and emotional relationships. Currently, there is a relatively stable consensus in scientific literature on the dimensions/domains of social support, although the nomenclature may vary slightly depending on the author or assessment tool used. The most recent models tend to integrate the initial proposals and subsequent studies, converging on three to five main dimensions: Emotional – expressions of empathy, love, and care; Instrumental – practical or material help; Informational – advice and guidance; and Evaluative – feedback that aids self-assessment.

Building on this theoretical foundation, contemporary research has explored the role of social support in specific populations, particularly in the contexts of severe mental illness and sexual minorities, with findings suggesting that Social Support may be decisive in promoting resilience and improving mental health outcomes for these populations (Parra et al., 2017; Cabral & Pinto, 2023). If we broaden our view to the social situation of people with SMI, there is generally a well-established link between social support and different aspects of health and wellbeing, as can be seen in a revision about “Determinants of quality of life in people with severe mental illness” done by Hansson (2006), where the studies have shown that more unmet needs are associated with poorer subjective quality of life, while satisfaction with social networks or relations correlates with better quality of life. Similarly, Yanos et al. (2001) showed that negative social interactions, especially when perceived as stigmatizing, are related to lower quality of life.

In the context of sexual minorities, social support plays a decisive role in legitimizing identity and sexual expression, acting as a mediator between stigma experiences and health outcomes (Cabral & Pinto, 2023). Parra et al. (2017) demonstrated that Social Support can protect mental health by increasing self-esteem and reducing the impact of discrimination on internal shame, depression, and anxiety in LGBTQIA+ individuals. Specifically, peer Social Support moderated the relationship between negative family attitudes and anxiety, as well as between family victimization and depression. These findings highlight that supportive peer groups can be especially protective for young LGB adults lacking family support, with inclusive networks, particularly among peers and LGBTQIA+ communities, mitigating isolation, fostering intimate relationships, and compensating for gaps in family or institutional support. Although peer support does not fully replace the role of the family of origin, it can constitute a meaningful support system, capable of reducing some of the negative effects imposed by this lack of support (Parra et al., 2017).

3. Stigma

Many people with severe mental illness face challenges in two ways: coping with the symptoms and disabilities associated with their condition and, at the same time, experiencing discrimination and prejudice rooted in stigmas and misconceptions about mental illness (Corrigan & Watson, 2002). Link and Phelan (2001) conceptualize stigma as a process composed of labeling, stereotyping, separation, loss of status, and discrimination, sustained by power relations. Applied to PLSMI, the model explains how the label of "mentally ill" can lead to devaluation as a sexual partner and social exclusion,

contributing to isolation and reduced self-esteem, phenomena repeatedly mentioned in the study's narratives.

Stigma can take multiple forms, but in this work, the focus is on internalized and double stigma, given its marked prevalence in the results. Internalized stigma, or self-stigma, refers to the assimilation of socially shared beliefs, stereotypes, and prejudices about one's condition, and it is very common among people with SMI, who sometimes abandon previously held or desired identities and adopt stigmatizing self-views (Corrigan & Watson, 2002; Yanos et al., 2008). This process undermines self-esteem, self-efficacy, perceived personal worth, hope, and social functioning, often resulting in isolation, avoidance of exposure, and reluctance to seek help, contributing to poorer mental health (Yanos et al., 2008).

In sexuality, internalized stigma may manifest as denial or concealment of sexual orientation or gender identity, reduced sexual desire or satisfaction, and the maintenance of unsatisfactory relationships due to fear of rejection (Pachankis et al., 2020). For individuals with SMI, these dynamics can be exacerbated by double stigma, where the person faces discrimination related to both their Mental Illness and their sexual or gender minority status (McCann et al., 2019). This intersectionality amplifies barriers to social integration, access to care, and the exercise of human rights, increasing vulnerability to depression, suicidal ideation, isolation, and risky behaviors (Kalra et al., 2015; Wainberg et al., 2016). Qualitative studies show that many people with SMI in the LGBTQIA+ community choose to conceal one or both aspects of their identity to avoid discrimination, paradoxically increasing psychological distress (Pachankis et al., 2020).

Within this intersectional framework, internalized homophobia and internal shame emerge as interconnected processes that reinforce and amplify one another. Internal shame, operating largely outside of conscious awareness, often originates in early experiences of shame and rejection. It is shaped by emotional socialization processes within primary relationships, where caregivers' responses to shame typically reflect prevailing social and cultural norms, imprinting stigma early in life (Cabral & Pinto, 2023). Functioning at a deeper, less consciously accessible level than self-esteem or internalized homonegativity, internal shame can have a lasting impact on self-directed affect, bypassing rational appreciations of personal worth and the right to a non-conforming identity (Cabral & Pinto, 2023). Empirical evidence indicates that it mediates the relationship between discrimination and adverse mental health outcomes, particularly depression and anxiety (Cabral & Pinto, 2023).

Recognition of double stigma underscores the need for clinical and policy responses that address these layered vulnerabilities simultaneously. Interventions should aim to promote self-acceptance, reconstruct positive identity narratives, and create inclusive environments that counter both mental illness stigma and sexual minority discrimination, thereby fostering resilience and improving quality of life.

4. Intersectional Theory

Intersectionality theory offers a particularly pertinent framework for understanding the experience of sexuality in PLSMI. These populations face not only the stigma associated with psychiatric diagnosis, but often other axes of marginalization, such as gender, sexual orientation, gender identity, social class, or ethnicity. As Crenshaw (1991) argues, different systems of oppression do not act in isolation, but interact and overlap, producing unique experiences of exclusion. In this sense, the notion of double stigmatization can be understood as a concrete expression of intersectional logic. Sexual marginalization and the pathologization of mental illness do not simply add up; they combine, multiplying barriers to psychosocial well-being and access to sensitive and inclusive health care (Crenshaw, 1991).

Adopting an intersectional perspective thus allows us not only to problematize the invisibility of sexuality in mental health care but also to highlight the need for public policies and clinical practices that recognize the complexity of these experiences, valuing the uniqueness of each person and combating the cumulative effects of different forms of discrimination.

5. Minority Stress Model

The Minority Stress Model, proposed by Meyer (2003), explains the relationship between belonging to minority groups and poorer health outcomes. It distinguishes between distal stressors - external events such as discrimination, violence, or exclusion and proximal stressors - internal processes such as expectations of rejection, identity concealment, and internalized stigma (Meyer, 2003). Among sexual minorities with SMI, these factors accumulate, generating chronic stress that affects mental, physical, and sexual health (Pachankis et al., 2020). According to this theory, mental health problems in LGBTQI+ individuals stem from the accumulation of general stressors (e.g., loss of a family member, illness, unemployment) and specific stressors linked to nonconforming sexual or gender identities including: (i) direct discrimination and violence; (ii) anticipation of rejection; (iii) pressure to conceal one's identity; and (iv)

internalization of society's negative attitudes and beliefs, such as internalized homonegativity (Cabral & Pinto, 2023).

The model is based on the premise that prejudice and stigma create unique stressors that adversely affect mental and physical health (Meyer, 2015). However, these factors, often present throughout an individual's life, can be mitigated by coping mechanisms and social support. This is where resilience plays a key role, understood as the ability to adapt positively in the face of adversity. Resilience can be individual, involving personal characteristics such as locus of control, optimism, or hardiness, or community-based, encompassing collective resources such as community centers, protective laws, support networks, and the positive redefinition of values and goals (Meyer, 2015).

Meyer (2015) warns that focusing solely on individual resilience can obscure the need for structural changes, fostering a "blame the victim" mentality. Therefore, the model argues that interventions should not only strengthen individual capacities but also transform the social environment by reducing stressors associated with stigma and inequality through safe environments, inclusive policies, culturally competent psychosocial support, and the promotion of supportive networks (Meyer, 2015).

6. The Role of Health Professionals and Organizations in Combating Sexual Stigma and Promoting Healthy Sexuality

Health professionals and institutions play a fundamental role in promoting sexual health and combating stigma, especially for people with SMI, whose sexuality, as mentioned previously, is often devalued in clinical settings (Blalock & Wood, 2015). The lack of specific training and the presence of implicit biases contribute to this invisibility, restricting access to counseling and the integration of sexual health into treatment plans (Hortal-Mas et al., 2020). Best practices include training in cultural skills and sexual sensitivity, the implementation of inclusive clinical protocols, and ensuring equitable access to sexual and reproductive health care (WHO, 2010). We now know that institutional policies that favor interdisciplinary and person-centered approaches are effective in improving quality of life, reducing stigma, and promoting more satisfying intimate relationships (Montejo et al., 2018).

Despite the growing scientific interest in sexuality, there remains a shortage of adequately trained professionals in the field, particularly in the field of mental health. Sexuality often remains a taboo topic and, therefore, is absent from basic clinical

training, even though psychiatric disorders often include symptoms that affect sexual desire, arousal, and satisfaction. Failure to address these aspects, including the prevention of iatrogenic sexual dysfunctions, can seriously compromise quality of life and lead to non-adherence to treatment (Montejo, 2019). It is therefore essential to adopt a comprehensive approach that recognizes sexuality as an integral part of holistic health care, emphasizing its role in well-being, adaptation to chronic illness, and identity development (Vasconcelos et al., 2024).

Combating stigma also plays a central role, not only by reducing discriminatory attitudes but also by empowering people to improve their quality of life (Hansson, 2006). Research has highlighted the importance of social support, especially from informal networks, in preventing and coping with physical and psychological health problems (Ornelas, 1994). For LGBTQI+ people, interventions should focus on reducing internalized stigma, addressing experiences of unconscious shame, and strengthening supportive relationships (Cabral & Pinto, 2023). Creating and maintaining support networks is crucial to promoting resilience and mental health, particularly considering the intersectional impact of gender, sexual orientation, and experiences of discrimination, including gender-based violence (Cabral & Pinto, 2023).

In Portugal, despite legislative advances and greater social acceptance, LGBTQI+ people continue to face interpersonal and institutional discrimination in a variety of contexts, and these barriers can discourage them from seeking mental health support (Cabral & Pinto, 2023). Clinical practice should therefore include identifying unconscious conflicts associated with shame, exploring early attachment experiences, and processing unresolved trauma. Combining psychodynamic, trauma-focused, and compassion-oriented approaches can help challenge self-defeating beliefs, promote self-compassion, and strengthen identity resilience (Cabral & Pinto, 2023).

Our study contributes to mental health policies in Portugal, aligning with the National Mental Health Program (NMHP) (Direção-Geral da Saúde, 2025), by highlighting frequently overlooked needs in the sexual experience of people with severe mental illness. The results highlight the importance of integrating sexuality into well-being and rehabilitation programs, involving users and caregivers in the design of interventions, and strengthening the link between specialized and primary care. The study also highlights gaps in the training of health professionals, suggesting training programs in cultural skills and sexual sensitivity. Finally, it advocates for inclusive institutional policies that protect sexual rights and identity, promoting quality of life, psychological well-being, and a more just and inclusive society.

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