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Improving romantic and sexual functioning in people with psychosis: Current state of knowledge and evaluation of new resources

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Résumé

Le droit à une vie amoureuse saine et satisfaisante est indéniable pour tous les êtres humains. Pourtant, les personnes ayant vécu une psychose sont souvent confrontées à divers obstacles lorsqu'elles entrent sur la scène amoureuse. La recherche et la pratique clinique ont malheureusement pris du retard à répondre à la demande d'aide dans ce domaine. L'objectif de la présente thèse est de mieux comprendre les défis liés aux relations amoureuses et à la sexualité chez les personnes aux prises avec la psychose, ainsi que d'offrir des ressources utiles pour commencer à aborder ces difficultés. À cet fin, cette thèse a été divisée en trois parties.

Le premier article visait à recueillir, évaluer et synthétiser la littérature récente sur les relations amoureuses et la sexualité dans le contexte des troubles psychotiques, les résultats soulignant un besoin pour plus d'études axées sur le consommateur ainsi qu'une plus grande accessibilité aux services adaptés. Le deuxième article a examiné les propriétés psychométriques de deux mesures liées au fonctionnement romantique et sexuel des personnes vivant avec la psychose. Nos résultats suggèrent que les deux instruments sont fiables et valides dans cette population et peuvent donc être utilisés à des fins de recherche et cliniques. Le troisième et dernier article évaluait l'impact d'une nouvelle intervention de groupe, offerte en présentiel ou à distance, pour les jeunes hommes ayant vécu une psychose et cherchant à améliorer leur vie amoureuse. Les résultats suggèrent que le programme pourrait mener à des améliorations significatives au niveau de la symptomatologie, du fonctionnement romantique et de la cognition sociale (c'est-à-dire, les habiletés de mentalisation) des participants, avec les deux modalités de traitement étant tout aussi efficaces.

Nous espérons que ces résultats encourageront les chercheurs et les cliniciens à poursuivre leurs recherches sur le sujet, ainsi qu'à promouvoir le développement de ressources

supplémentaires pour les personnes aux prises avec la psychose ayant des difficultés sur le plan du fonctionnement romantique.

Mots-clés : Relations amoureuses, sexualité, psychose

Abstract

The right to a healthy and satisfying romantic life is undeniable for all human beings. Yet, people with psychosis are often confronted with unique obstacles when entering the dating scene. Research and clinical practice have unfortunately lagged behind the demand for assistance in this area. The aim of this thesis is to better understand the challenges relating to romantic relationships and sexuality among persons with psychosis, as well as offer useful resources to begin addressing these difficulties. For this purpose, this thesis was divided into three parts.

The first article sought to collect, evaluate, and synthesize the latest literature on romantic relationships and sexuality in psychotic disorders, with results highlighting a need for more consumer-oriented research and greater accessibility to tailored services. The second article examined the psychometric properties of two instruments measuring the romantic and sexual functioning of individuals with psychosis. Our findings suggest that both instruments are reliable and valid in this population and therefore can be used for research and clinical purposes. The third and final article evaluated the impact of a new group intervention, offered in-person or online, for young men with psychosis seeking to improve their dating lives. Results suggest that the program may lead to significant improvements in participants' symptomatology, romantic functioning, and social cognition (i.e., mentalization skills), with both treatment modalities being equally effective.

It is hoped that these findings will encourage researchers and clinicians to continue investigating this important topic and promote the development of additional resources for people with psychosis who struggle with romantic relationship functioning.

Keywords: Romantic relationships, sexuality, psychosis

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List of abbreviations

AAS	Adult Attachment Scale
ABCT	Attachment-based compassion therapy
AMOS	Analysis of moment structures
ANOVA	Analyses of variance
ASEX	Arizona Sexual Experiences Scale
BPRS-E	Brief Psychiatric Rating Scale – Expanded Version
BSI	Brief Symptom Inventory
CBT	Cognitive-behavioral therapy
CFI	Comparative fit index
CPQ	Communication Patterns Questionnaire
DAS	Dyadic Adjustment Scale
DISF-SF	Derogatis Interview for Sexual Functioning – Self-Report
DSFI	Derogatis Sexual Functioning Inventory
EFT	Emotion-focused therapy
FESFS	First-Episode Social Functioning Scale
IPT	Interpersonal psychotherapy
ISMIS	Internalized Stigma of Mental Illness Scale
LGBTQ2S+	Lesbian, gay, bisexual, transgender, queer or questioning, two-spirit
MSQ	Multidimensional Sexuality Questionnaire
PAM	Psychosis Attachment Measure
PRISMA	Preferred reporting items for systematic reviews and meta-analyses
PRSexDQ	Psychotropic-Related Sexual Dysfunction Questionnaire

PTSD	Post-traumatic stress disorder
RCT	Randomized controlled trial
RMSEA	Root mean square error of approximation
RQ	Relationship Questionnaire
RRFS	Romantic Relationship Functioning Scale
SCED	Single-case experimental design
SERS-SF	Self-Esteem Rating Scale – Short-Form
SFQ	Sexual Functioning Questionnaire
SPSS	Statistical package for social sciences
SRMR	Standardized root mean square residual
SST	Social skills training
STI	Sexually transmitted infection
TFPT	Trauma-focused psychological therapies
TLI	Tucker-Lewis index
UHR	Ultra high-risk

Dedication

This thesis is dedicated to my family and friends, whose support has been unwavering throughout my studies. I am forever grateful for their patience and encouragement, especially in moments of crisis. Thank you for always believing in me, for respecting my choices and my journey, and finally, for supporting the exploration of my identity both as a therapist and a person. I am extremely blessed to have so many loving people in my life.

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1. Introduction

According to previous research, loneliness is experienced by as much as 35% of the general population and has been found to contribute to a wide variety of physical and mental health problems, including depression, anxiety, cognitive and motor decline, and reduced immunity to disease (Alspach, 2003; Eglit et al., 2018; Stickley & Koyanagi, 2018). Other than the elderly, individuals with a serious mental illness, such as a psychotic disorder, are particularly at-risk of experiencing social isolation (Stain et al., 2012). Self-reported annual rates of loneliness among people with psychosis are 2.3 times that of the general public (between 76% and 80%), making loneliness a significant burden for this population (Eglit et al., 2018). Unfortunately, social isolation has also been linked to a worse quality of life and an enhanced risk of relapse in people with schizophrenia-spectrum disorders (Morin et al., 2017; Roe et al., 2011; Switaj et al., 2018). Social isolation can and often occurs across social networks, including family relationships and friendships, but may be even more pronounced in romantic relationships (Redmond et al., 2010).

Psychosis implies a loss of contact with reality and is found in a variety of psychiatric and medical conditions (Arciniegas, 2015). It is often associated with hallucinations or delusions (Gaebel & Zielasek, 2015). Psychotic disorders, which encompass schizophrenia and related diagnoses, also frequently include negative symptoms such as disorganized thinking, apathy, and social withdrawal (Arciniegas, 2015; Gaebel & Zielasek, 2015). Traditionally, psychiatry has adopted a rather pessimistic view of recovery for individuals with schizophrenia-spectrum disorders. The level of impairment and chronicity associated with psychotic diagnoses prior to the discovery of effective medications has undoubtedly contributed to the widespread perception that people with psychosis cannot or are unlikely to enjoy rich and fulfilling lives (Andresen et al.,

2011). While pharmacological advances have led to substantial improvements in the way of symptomatic remission, other aspects of rehabilitation, such as finding a stable job and becoming more socially active, have not received as much attention by researchers and health care providers (Davidson et al., 2005). This seems to be particularly true for romantic relationships, as evidenced by the lack of studies and psychosocial services specifically addressing intimacy and sexuality in the context of a psychotic disorder (McCann, 2010).

Being able to form and maintain romantic relationships is considered a critical developmental task and key marker of social competence. Failure to initiate and sustain romantic relationships in early adulthood is thought to have significant consequences for one's long-term well-being, regardless of mental health status (Rauer et al., 2013; Schulenberg et al., 2004). For individuals with a psychotic disorder, dating is often much more complex due to experiences with stigma and past trauma, as well as social-cognitive deficits and sexual difficulties resulting from symptoms and medication side-effects (de Jager & McCann, 2017; McCann et al., 2019). Despite the fact that healthy romantic relationships are known to play an important role in recovery from mental illness (Boucher et al., 2016), very few resources are currently available to help people with psychosis lead more satisfying romantic and sexual lives (Bonfils, Firmin, Salyers, & Wright, 2015; Helu-Brown & Aranda, 2016; Lecomte et al., 2005).

2. Theoretical background

2.1. Factors affecting romantic functioning in persons with psychosis

The romantic functioning of individuals with a psychotic disorder can be influenced by a number of factors, including a person's age and sex, whether they have experienced stigma or

trauma, and their cognitive and social skills. Each of these elements may contribute to one's success in romantic relationships and will be covered in the following sections.

2.1.1. Influence of age and sex

The average age of onset for schizophrenia-spectrum disorders has notable implications for the development of social skills in this population. Given that the transition from adolescence to early adulthood is often interrupted by emerging psychiatric symptoms, important social milestones, such as building lasting friendships and finding a romantic partner, may be especially difficult to achieve (Goldstein et al., 2017). This relationship instability is also likely to persist over time if there is little opportunity to further enhance one's interpersonal competencies, creating a cascade effect for future romantic relationships (Burt & Masten, 2010; Burt et al., 2008).

Although romantic relationships are challenging for both sexes, men with psychosis seem to be at an even greater disadvantage than their female counterparts when it comes to dating. Prior studies have indicated that less than 20% of men with a psychotic disorder are in a committed relationship and as many as 80% have been single for over five years (Bonfils et al., 2015; Pillay et al., 2018). This difference can be explained by a number of factors, including an earlier onset and greater severity of the first psychiatric episode, as well as poorer pre-illness functioning and higher rates of co-occurring maladaptive behaviors (e.g., substance abuse; Cotton et al., 2009; Leung & Chue, 2000; Morgan et al., 2008; Ochoa et al., 2012; Thorup et al., 2007).

2.1.2. Impact of stigma

Defined broadly as any form of prejudice or discrimination experienced as a consequence of a given condition or circumstance, stigma can be internal as well as external (Corrigan & Watson, 2002). The latter case, also known as public stigma, refers to any kind of unfair treatment inflicted by others upon an individual or a group with a particular status, such as a psychiatric diagnosis, whether this be through negative beliefs or actual behaviors. On a larger scale, public stigma often translates to limited access to good employment, safe housing, quality health care, and rich social networks for people with mental disorders, particularly those whose condition is considered more chronic, visible, or disruptive (Corrigan & Watson, 2002). Research suggests that people diagnosed with psychotic disorders, compared to those living with a more common condition, such as depression, are more likely to be viewed as dangerous, incompetent, or irresponsible, and consequentially, to experience distancing from others (Rusch et al., 2005; Van Dorn et al., 2005). This is also true for health service providers, whom may hold stigmatizing views about individuals with psychotic disorders' social interactions, especially romantic ones. In fact, many health professionals tend to view romantic relationships as risky or inappropriate for this population and may avoid discussing important sexual health information with service users (McCann, 2010; Meade & Sikkema, 2007; Walsh et al., 2014).

In contrast to public stigma, internal or self-stigma reflects an acceptance of, or agreement with, stigmatizing attitudes and is detrimental to one's self-esteem and sense of self-efficacy. These negative self-perceptions can also reduce one's motivation to participate in activities where stigma is likely to occur, such as dating (Corrigan & Watson, 2002). While public stigma may bring about experiences of rejection, self-stigma might lead to avoidance of social situations as individuals come to perceive themselves as unworthy of love and intimacy (Corrigan et al., 2009;

de Jager & McCann, 2017). In a qualitative study conducted by Latour-Desjardins and colleagues (2019), young men with first-episode psychosis described feeling worried about how future romantic partners might react to their diagnosis, as well as unsure whether they would have anything to offer in a romantic relationship. Others reported deteriorating relationships after experiencing a psychotic episode. These findings highlight how stigma can contribute both directly and indirectly to romantic relationship difficulties among people with schizophrenia-spectrum disorders (Pillay et al., 2018).

2.1.3. Self-disclosure

Revealing one's psychiatric history to a romantic partner is a significant concern for many people with a psychotic disorder, as they face potential rejection and risk having their individuality overshadowed by their diagnosis. The uncertainty surrounding self-disclosure makes this decision a highly personal one and requires careful thought and preparation, such as choosing when, what, and how to disclose (Pandya et al., 2011; Seeman, 2013). Though communicating mental health information to a significant other can be intimidating, self-disclosure is also likely to foster trust between partners and provide a greater sense of security to those affected by mental illness (Corrigan & Rao, 2012; Seeman, 2013).

2.1.4. The role of trauma

Post-traumatic stress disorder (PTSD) and serious mental illness share a comorbidity rate of about 15%, although studies limited to psychotic disorders often report estimates as high as 48% (Alvarez et al., 2012; Buckley et al., 2009; Lommen & Restifo, 2009). There is also strong evidence for a relationship between childhood trauma and serious mental illness, with research

showing that multiple forms of trauma (e.g., sexual, physical, and emotional abuse, neglect, bullying) constitute significant risk factors for the development of psychosis (Matheson et al., 2013; Mauritz et al., 2013; SAMHSA, 2019; Varese et al., 2012). Interestingly, some authors have proposed that traumatic life experiences might help explain the greater incidence of insecure attachment styles in people with serious mental illness (Bucci et al., 2017; Gabinio et al., 2018; Gumley et al., 2014; Kefeli et al., 2018).

Across several studies, anxious and avoidant attachment styles have been found to be more prevalent than secure attachment styles among individuals with psychotic disorders (Couture et al., 2007; Gabinio et al., 2018; Harder, 2014; Kefeli et al., 2018; Morriss et al., 2009). While avoidant attachment styles are associated with a need for independence and disengagement from emotional connection, anxious attachment styles involve fears of separation and rejection as well as excessive dependence on others (Mikulincer & Shaver, 2012). Decades of research have shown that each of these forms of attachment predict problems in romantic partnerships, including less commitment and trust, increased conflict, and lower relationship satisfaction (Favero et al., 2021; Simpson & Rholes, 2017). As for psychosis specifically, it is thought that these attachment styles may contribute to a greater disinterest in romantic relationships overall, as well as challenges in maintaining stable relationships once they have been initiated (Berry et al., 2008; Mikulincer & Shaver, 2012). These difficulties have also been identified by patients themselves, who have described being fearful about excessive proximity, worrying about potential abandonment, and having trouble disclosing information about oneself when dating (Latour-Desjardins et al., 2019).

Unfortunately, people with psychotic disorders are also more likely to be victims of violent acts as adults, including rape and homicide (Crump et al., 2013; Hiday, 2006; Karni-Vizer & Salzer, 2016). Women in particular seem to be at greater risk for domestic abuse, with numerous studies having shown that women with a serious mental illness are more vulnerable to verbal, physical, and sexual violence at the hands of a romantic partner than those without a psychiatric disorder (Friedman & Loue, 2007; Gonzalez Cases et al., 2014; Khalifeh et al., 2015). Like early childhood trauma, experiencing violence in adulthood can maintain insecure attachment patterns by reinforcing negative cognitive biases about the world and other people (Dutton & White, 2012). Such biases are likely to hinder the development of new romantic relationships, while also creating conflict in existing ones (Godbout et al., 2009).

2.1.5. Social cognition and communication

Many of the social difficulties observed in psychosis can be attributed to underlying metacognitive deficits. Metacognition is a spectrum of mental activities that includes, at one end, an awareness of discrete mental processes (e.g., a thought, an emotion) and at the other end, an integration of these distinct events into more complex mental representations (Lysaker et al., 2018). One of the most studied aspects of metacognition is theory of mind (i.e., the ability to infer others' mental states, intentions, and desires) (Lysaker et al., 2014). Multiple studies have linked psychotic disorders to poorer theory of mind (Bora et al., 2016; Sprong et al., 2007) and have highlighted its influence on functional outcomes, including independent living skills, work and school functioning, and interpersonal behavior (Couture et al., 2006; Fett et al., 2011).

In addition to metacognitive deficits, people with schizophrenia-spectrum disorders also present with specific communication difficulties (Kalin et al., 2015). According to the Social Problem-Solving framework, social interactions require the use of ‘‘receiving,’’ ‘‘processing,’’ and ‘‘sending’’ skills, the first two of which involve the perception and interpretation of incoming information, and the last of which involves the utilization of verbal and non-verbal skills in response to partners’ cues (Dickinson et al., 2007). Individuals with schizophrenia-spectrum disorders may not only have difficulty understanding what others are trying to convey in their words and actions, but may also lack the communication skills to respond effectively. For example, research has shown that people with psychosis tend to have poorer expressive skills (e.g., appropriateness of gaze, tone, and affect, conversational smoothness) compared to healthy controls, contributing to greater overall social disability for this population (Bellack et al., 1990; Keltner & Kring, 1998; Pinkham & Penn, 2006).

The nature and course of social deficits in psychosis have been extensively studied in recent years. Much like nonsocial cognition, impairments in social cognition and communication seem to be present at all stages of the illness (i.e., prodrome and first-episode psychosis to schizophrenia) and remain relatively stable across the lifespan (Green et al., 2019; Vaskinn & Horan, 2020). This suggests that these deficits are a predisposing factor and core symptom of psychotic disorders rather than a consequence of the illness or limited socialization experiences (Green et al., 2019).

2.2. Factors affecting sexual functioning in persons with psychosis

Several factors may influence the sexual functioning of individuals with a psychotic disorder, including sexual side-effects from antipsychotic medication and risky sexual behavior,

as well as shifts in sexual identity. Each of these elements may contribute to one's experience with sex and will be reviewed in the following sections.

2.2.1. Sexual function problems

Despite showing similar levels of interest for sexual activity as the general population, people with psychotic disorders are much more likely to experience a variety of sexual difficulties (de Boer et al., 2015; Dossenbach et al., 2005; Montejo et al., 2018). Numerous studies have identified greater impairments in the areas of desire, arousal, orgasm, and overall satisfaction in persons with schizophrenia-spectrum disorders compared to healthy controls, as well as individuals with other psychiatric conditions (Ben Mahmoud et al., 2013; Halouani et al., 2018; Serretti & Chiesa, 2011). The illness itself (i.e., more negative symptoms, greater overall psychopathology), medication side-effects, and psychosocial factors (e.g., limited social contact, low self-confidence, poor impulse control) all contribute to the increased incidence of sexual problems in this population (Montejo et al., 2018; Smith & Herlihy, 2011). At the same time, sexual dysfunction is also known to reduce treatment adherence (Kelly & Conley, 2004; Souaiby et al., 2019). Just as sexual difficulties may hinder the development of healthy sexual relationships, so too does the sexual risk behavior often observed in schizophrenia-spectrum disorders.

2.2.2. Sexual risk behavior

There is substantial evidence for heightened sexual risk behavior among individuals with serious mental illness. According to prior research, protection-related risks (e.g., lack or poor knowledge of sexually-transmitted infection (STI) prevention strategies, inconsistent condom use) are higher in persons with psychosis compared to those without psychiatric disorders (Brown et

al., 2011; Shield et al., 2005), as are partner-related risks (e.g., multiple sexual partners, partner substance use prior to sexual activity; Brown et al., 2010; Meade, 2006). Individuals with psychotic disorders may also be more likely to trade sex for money or drugs (Van Dorn et al., 2005) and experience STI symptoms (Nyamali et al., 2010) than people with other psychiatric conditions. These increased risks are linked to several factors, including a higher prevalence of comorbid substance use disorders and socio-economic disadvantage among people with psychosis (Cournos et al., 2005; Muntaner et al., 2004).

2.2.3. Sexual self-concept

Altered sexual self-perceptions are frequently encountered in persons with serious mental illness who report sexual dysfunctions. Although studies on sexual self-concept in this population are scarce, existing data suggest that individuals with psychotic disorders tend to perceive themselves as less sexually competent than those without a psychiatric condition (Peitl et al., 2009), although they may present with similar distortions to people with non-psychotic disorders like depression (Peitl et al., 2011). Gender identity and sexual orientation issues are also complexified in schizophrenia-spectrum disorders, as delusions and hallucinations involving sexual content may engender confusion and lead to instable sexual self-perceptions (Skodlar & Nagy, 2009; Stusinski & Lew-Starowicz, 2018).

2.3. The taboo surrounding romantic relationships, sexuality, and psychosis

Unlike medical models of psychotic disorders, the recovery model (Andresen et al., 2011) is based consumers' experiences with the illness and focuses on improving quality of life rather than the abatement of symptoms alone. A growing body of evidence has shown that many people

with schizophrenia and related diagnoses can lead productive and meaningful lives, even in the presence of recurring psychotic symptoms. This 'psychological' form of recovery is highly personal, but is often reflected in four overarching themes: (1) finding and maintain hope, (2) taking responsibility for health and well-being, (3) establishing a positive identity, and (4) finding meaning in life. Thus, recovery-oriented care utilizes a person's strengths, abilities, and values to achieve a variety of goals including acceptance and management of the illness, discovering or returning to activities that provide a sense of purpose and inspiration, and re-connecting with the self and with others (Andresen et al., 2011; Warner, 2010). Romantic relationships are one area where people with psychotic disorders can find hope, support, and become empowered to heal from the distressing and life-altering experience that is psychosis.

Despite increasing interest in the romantic and sexual needs of people with schizophrenia-spectrum disorders, these topics retain a taboo status in many scientific and psychiatric circles (Bonfils et al., 2015; Quinn et al., 2011). That is, harmful and unfounded beliefs about the suitability of romantic and sexual relationships for people with psychosis have impeded progress in both research and healthcare, as knowledge acquisition has been slow and primarily pathology-oriented (Bonfils et al., 2015; Higgins et al., 2008). The lack of resources for those seeking assistance with their dating lives may also lead to a loss of hope and a sense of powerlessness, further perpetuating the cycle of loneliness. Addressing this gap in the literature and in corresponding services is necessary if we are to facilitate recovery in persons with psychosis (McCann, 2010).

2.3.1. Current state of the literature

Although the romantic and sexual experiences of individuals with serious mental illness have been more deeply explored in recent years (de Jager & McCann, 2017; McCann et al., 2019), these topics have not received as much scientific attention as other aspects of recovery (e.g., re-integrating the workforce, obtaining independent housing, or mending family relationships) (Hampson et al., 2018; Jacob, 2015; Warner, 2010). Of the studies that have focused on romantic relationships and sexuality among people with a psychotic disorder, most are qualitative in nature. McCann and colleagues' (2019) systematic review attests to the growing interest towards this subject and provides rich data that are compatible with newer models of recovery, which tend to be less focused on symptomatic remission and more concerned about enhancing patients' quality of life (Andresen et al., 2011; Davidson et al., 2005). Nonetheless, while qualitative research has helped identify several obstacles met by persons with psychosis when dating, these findings cannot be generalized and do not allow for more sophisticated statistical analyses, such as meta-analyses (Latour-Desjardins et al., 2019; Yilmaz, 2013). With respect to quantitative research, the last review of the literature on romantic relationships and psychosis was conducted by McCann in 2003. Thus, an updated review is warranted, particularly in light of recent socio-cultural and technological changes, such as more positive attitudes towards mental illness and greater use of social media, which are likely to have a significant impact on individuals' social interactions (Angermeyer et al., 2017; Smith & Anderson, 2018).

2.3.2. Existing assessment measures

Several instruments have been developed in recent years to assess various aspects of romantic and sexual functioning in people with psychotic disorders. Most of these tools have

focused on identifying specific sexual dysfunctions that are often brought on by medication (e.g., ASEX; McGahuey et al., 2000; SFQ; Smith et al., 2002) rather than evaluating the psychological factors that might alter one's experience of intimacy and sexuality. Two instruments, the Romantic Relationship Functioning Scale (RRFS) and the Multidimensional Sexuality Questionnaire (MSQ), may be more useful in this second regard. However, neither of these measures have been empirically validated in samples of individuals having experienced psychosis.

The RRFS was developed by Bonfils and colleagues in 2016 and is based on findings from a previous study that evaluated experiences with and perceptions of romantic relationships in young adults with psychotic disorders (Redmond et al., 2010). It is composed of three subscales: Risks, Resources, and Stigma. The Risks subscale measures respondents' concerns about possible negative outcomes associated with romantic relationships, such as being taken advantage of and experiencing infidelity. The Resources subscale reflects respondents' perceptions of resources they can draw upon to help them manage romantic relationships effectively, including self-confidence, sufficient past experience, and good communication skills. The Stigma subscale evaluates how respondents react to stigma within the context of romantic relationships, such as being fearful of rejection or having difficulty disclosing aspects of one's mental health to romantic partners (Bonfils et al., 2016).

The MSQ was developed by Snell and colleagues in 1993 and is based on findings from prior research on different psychological tendencies associated with human sexuality (Allgeier & Allgeier, 1991). It contains 12 subscales: Sexual Self-Esteem, Sexual Preoccupation, Internal Sexual Control, Sexual Consciousness, Sexual Motivation, Sexual Anxiety, Sexual Assertiveness,

Sexual Depression, External Sexual Control, Self Monitoring, Fear of Sex, and Sexual Satisfaction. The Self-Esteem subscale measures respondents' tendency to positively evaluate how they relate to sexual partners. The Preoccupation subscale reflects respondents' tendency to become absorbed with sexuality-related thoughts. The Internal and External Control subscales assess how likely respondents are to believe that the sexual aspects of their lives are determined by influences within or outside their control, respectively. The Consciousness subscale evaluates respondents' tendency to reflect on their sexuality. The Motivation subscale measures respondents' desire to be involved in a sexual relationship. The Anxiety and Depression subscales evaluate how likely respondents are to feel tense and uncomfortable or sad and unhappy about their sexual lives, respectively. The Assertiveness subscale reflects how assertive respondents tend to be about their sexual needs and preferences. The Monitoring subscale measures respondents' tendency to be aware and concerned about others' perceptions of their sexuality. The Fear subscale evaluates respondents' apprehension towards engaging in sexual activity. Finally, the Satisfaction subscale reflects respondents' tendency to be satisfied with their sexual lives (Snell et al., 1993). In addition to validating instruments that measure romantic and sexual functioning among people with psychosis, intervention programs that target these areas of functioning must also be developed and evaluated as part of recovery-oriented care.

2.3.3. Recovery-oriented treatments

According to the stress-vulnerability-protective factors model, the nature and course of serious mental illnesses like schizophrenia is best understood through the interaction of biological, environmental, and behavioral factors (Anthony & Liberman, 1986; Liberman, 1986). While an individual's vulnerability to psychosis has traditionally been linked to genetic and other

predispositions (e.g., increased paternal age at conception, low birth weight), the stress and protective components of the model have mostly been tied to personal and contextual characteristics, such as adversity and coping skills. Extensive research suggests that elevated hereditary risk and early systemic injuries may set the stage for abnormal development, with eventual exposure to additional insults provoking the onset of psychotic symptoms (Lecomte et al., 2019). Because genetic vulnerabilities cannot be eliminated and it is not always practical nor possible to prevent environmental stressors, we must work to increase resilience in people with psychotic disorders. This means not only identifying protective factors against the onset of symptoms, but also preventing relapse by implementing strategies that augment resilience (Rutten et al., 2013; Shastri, 2013). For individuals with serious mental illness, adequate social skills are considered key protective factors against the deterioration of one's condition and are therefore main targets of most psychosocial interventions (Hendryx et al., 2009; Hui et al., 2018; Lecomte et al., 2019). However, while many existing treatment programs have proven effective at improving social functioning more generally, they do not typically offer assistance in areas of special concern for service users, such as romantic relationships.

While pharmacological treatments have historically predominated and have aided in the reduction of positive symptoms, such as delusions and hallucinations, psychosocial treatments have also allowed for the amelioration of negative symptoms in schizophrenia-spectrum disorders (Cetin, 2015; Dollfus & Lyne, 2017). Indeed, recent research has identified cognitive-behavioral therapy (CBT) as the most efficacious psychological intervention for decreasing positive psychotic symptoms (Lecomte et al., 2019; Turner et al., 2014) and social skills training (SST) as the most efficacious treatment for reducing negative psychotic symptoms (Kurtz & Mueser, 2008; Turner

et al., 2014; Turner et al., 2018). Unfortunately, few attempts have been made to address romantic relationships as part of a CBT or SST program for psychotic disorders. To our knowledge, Liberman and colleagues' (1993) ''Friendship and Intimacy'' module, which covers romantic and sexual skills, is the only existing intervention that is specifically tailored to this issue. However, this program adheres to certain stigmatizing principles (e.g., abstinence as best practice) and has never been empirically tested.

Group therapy has gained significant popularity as a treatment modality for an array of psychiatric disorders (Burlingame et al., 2016), with research indicating that it can be a valuable alternative to more resource-intensive individual therapy (McRoberts et al., 1998; Rosendahl et al., 2021). Group interventions have been found to promote unique therapeutic processes (e.g., normalization of one's experiences, vicarious learning, altruism) that cannot occur in a one-on-one format (Yalom & Leszcz, 2005). Furthermore, therapy programs focusing on interpersonal factors, particularly social skills such as communication and conflict resolution, may be most effective when conducted in a group setting (Turner et al., 2018). For individuals with a schizophrenia-spectrum disorder, group therapy has been shown to improve performance in clinical, social, and occupational domains (Burlingame et al., 2020; Orfanos et al., 2015). Importantly, previous research suggests that younger patients with psychosis may benefit more from group interventions than older patients due to differences inherent to the developmental period of early adulthood. That is, young adults may place greater emphasis on being accepted by their same-age peers, while also valuing their opinions more than older adults (Lecomte et al., 2008; Lecomte et al., 2012). Thus, programs targeting persons with early psychosis may achieve better outcomes when they are offered in group format.

In response to the COVID-19 pandemic, many health professionals have turned to videoconferencing in order to continue offering essential services (Bhatia et al., 2021; Monaghesh & Hajizadeh, 2020). Numerous studies have supported the use of videoconferencing as a viable alternative to traditional in-person psychotherapy, although existing research has primarily focused on individual interventions (Batastini et al., 2020; Thomas et al., 2021). This transition comes at a time when issues relating to treatment accessibility (e.g., transportation and scheduling difficulties) are also increasingly recognized (Kullgren et al., 2012; Moroz et al., 2020). These concerns are frequently cited by individuals with precarious living situations, including people with a serious mental illness (Hensel & Flint, 2015; Kim et al., 2007; Lawrence & Kisely, 2010). In a recent study evaluating group teletherapy for early psychosis (Lecomte et al., 2020), this delivery method was found to produce similar results to in-person interventions. Although these findings are promising, more research is needed to determine the efficacy of group psychotherapy focusing on romantic relationships in psychiatric populations.

3. Research aims

Given the increasing number of studies examining romantic relationships in the context of psychosis, a primary aim of this thesis was to gather and synthesize the latest literature on romantic relationships, sexuality, and psychotic disorders. Furthermore, in light of the lack of validated instruments measuring romantic and sexual competence in people with psychosis, a secondary aim of this thesis was to evaluate the psychometric quality of two instruments believed to be useful for both research and clinical purposes. Finally, due to the paucity of services currently available to help individuals with psychosis who are unsatisfied with their dating lives, another major aim of

this thesis was to evaluate the efficacy of a novel group intervention, offered in two modalities (in-person and online) and designed to improve the romantic skills of young men with psychosis. Three studies were conducted to achieve these goals.

3.1. Objective 1

In order to complete a comprehensive analysis of the most recent evidence on romantic relationships, sexuality, and psychosis, we conducted a systematic review of quantitative data published in the last 15 years on this topic.

3.2. Objective 2

In order to promote the wider use of instruments that measure romantic and sexual functioning among persons with psychosis, we examined the reliability and validity of the RRFS and the MSQ in a sample of adults with psychosis.

3.3. Objective 3

In order to evaluate the potential impact of a novel group therapy program offered in two modalities, we examined whether a new intervention (independent variable) had any effect on dating outcomes, as well as romantic and sexual functioning (dependent variables). We also sought to determine whether the intervention (independent variable) has any effect on self-esteem, self-stigma, and psychiatric symptoms (dependent variables). It was hypothesized that:

1. Positive dating outcomes (i.e., number of dates, number of committed relationships) would increase significantly after receiving the intervention.

2. Romantic functioning scores would increase significantly after receiving the intervention.

3. Sexual functioning scores would increase significantly after receiving the intervention.

4. Symptomatology and internalized stigma would decrease significantly after receiving the intervention.

5. Self-esteem and mentalizing skills would increase significantly after receiving the intervention.

Article 1

Romantic relationships, sexuality, and psychotic disorders: A systematic review of recent findings[1]

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Author contributions:

Briana Cloutier participated in the study's initial conceptualization, data collection and analysis, as well as manuscript writing.

Audrey Francoeur et Crystal Samson participated in data collection and manuscript revision.

Alexandra Ghostine participated in data collection and manuscript revision.

Tania Lecomte participated in the study's initial conceptualization and data analysis, as well as manuscript revision.

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Abstract

For individuals with a psychotic disorder, dating can present several challenges and lead many to be excluded from romantic relationships. These difficulties may stem from a number of factors, including impairments in social and sexual functioning. Although scientific interest in this topic is mounting, the last quantitative review of the literature dates back to 2003. Objectives: The aim of this systematic review was to collect, evaluate, and synthesize quantitative data from studies published in the last 15 years on romantic relationships and sexuality in the context of a psychotic disorder. Methods: Articles were retrieved from PsycINFO, PubMed, Web of Science, and ProQuest databases and were retained if they met the following inclusion criteria: (1) original research or meta-analysis, (2) complete or partial sample with a psychotic disorder diagnosis, (3) provision of quantitative data specific to the population of interest, and (4) studies focusing on romantic relationship and/or sexuality variables as correlates, predictors, mediators, or outcomes. Study quality was evaluated using PRISMA criteria. Results: 43 studies were identified, 24 of which were categorized as obstacle-related (e.g., focusing on negative aspects of romantic relationships and sexuality, such as risky behaviors) and 19 of which were deemed neutral or recovery-oriented (e.g., focusing on positive aspects, such as marital functioning). Conclusions and implications for practice: Results highlight a need for greater communication and assistance in the areas of romantic relationships and sexuality for persons with psychotic disorders. Better access to resources such as dating skills and couples therapy programs as well as more consumer-oriented research is needed.

Keywords: Romantic relationships, sexuality, psychotic disorder, systematic review

Introduction

Romantic relationships have a significant impact on our physical and mental health (Loving & Slatcher, 2013). Studies suggest that spouses influence their partners' lifestyle behaviors (Markey et al., 2007; Meyler et al., 2007) and contribute to changes in cardiovascular, endocrine, and immune functioning (Robles & Kiecolt-Glaser, 2003; Robles et al., 2014). While singlehood tends to increase one's risk of experiencing anxious, depressive, and somatic symptoms (Adamcyzk, 2017), healthy romantic relationships have been found to improve well-being (Braithwaite & Holt-Lundstad, 2017). For people living with mental illness, dating is often complex and comes with additional challenges (Boysen et al., 2018). This would seem to be particularly true for individuals with serious mental illness, such as a psychotic disorder (Ostman & Bjorkman, 2013), for whom difficulties may stem from a number of factors, including impaired social functioning and sexual dysfunction resulting from both the illness itself and medication side-effects (Chiesa et al., 2013; de Boer et al., 2015; Velthorst et al., 2017). Unfortunately, people with psychotic disorders often perceive romantic relationships as incompatible with psychosis, while also associating such relationships with ‘‘normality’’ and recovery (Latour-Desjardins et al., 2019). Given that psychotic disorders typically emerge at a time when dating increases significantly, that is, during adolescence or early adulthood (Redmond et al., 2010), it is important to consider how the illness alters one's experience of romantic relationships and sexuality. However, despite several studies having identified romantic relationships as a primary need among persons with psychotic disorders, this area of research remains understudied (Lecomte et al., 2005).

Psychosis, a common feature of many psychiatric and other medical disorders, involves impaired reality testing, either in the form of hallucinations, delusions, or both. In addition to this

core symptom, psychotic disorders are often also associated with disorganized thinking and negative symptoms, including loss of productivity and significant interpersonal difficulties (Arciniegas, 2015). The social networks of individuals with schizophrenia-spectrum disorders tend to be small and family-focused, as people with psychotic disorders frequently struggle to form and maintain more intimate relationships (Jakubowska et al., 2019). Although the romantic and sexual experiences of individuals with psychotic disorders have been more deeply explored in recent years (de Jager & McCann, 2017; McCann et al., 2019), these topics have not received as much scientific attention as other aspects of recovery (e.g., employment or housing) (Hampson et al., 2018; Jacob, 2015). This appears to be a consequence of stigma, as well as mental health professionals' reluctance to discuss such issues with patients (Quinn et al., 2011). Studies have shown that many nurses and psychiatrists are uncomfortable addressing romantic and sexual problems with this population, either because they prefer to view them as asexual or because they believe they do not have competencies to properly intervene (Nnaji & Friedman, 2008; Ostman & Bjorkman, 2013). The taboo surrounding romantic relationships and serious mental illness is also likely to discourage clients from talking about sexuality-related concerns with service providers (Wright & Martin, 2003). Unfortunately, this means that less effort has been devoted to studying the unique dynamics of romantic relationships in the context of a psychotic disorder diagnosis.

Of the studies that do address romantic relationships and sexuality among people with a psychotic disorder, most are qualitative in nature. McCann and colleagues' (2019) recent systematic review on qualitative studies attests to the growing interest towards this subject and provides rich data that are compatible with newer models of recovery (Andresen et al., 2011; Davidson et al., 2005). While qualitative research has uncovered several challenges met by

individuals with psychotic disorders when dating, including, for example, fears resulting from insecure attachment patterns and difficulties recognizing one's own and others' emotions, these findings cannot be generalized and do not allow for more sophisticated statistical analyses, such as meta-analyses (Latour-Desjardins et al., 2019; Yilmaz, 2013). With respect to quantitative research, the last review of the literature was conducted by McCann in 2003. Given the increasing number of studies focusing on the romantic relationships of persons with psychotic disorders, an updated review is warranted. This may be especially important in light of recent socio-cultural and technological changes, such as more positive attitudes towards mental illness and greater use of social media, which are likely to have a significant impact on individuals' social interactions (Angermeyer et al., 2017; Smith & Anderson, 2018).

Methods

The aim of this review was to evaluate the quantitative literature that has been published in the last 15 years on the romantic and sexual lives of people diagnosed with a psychotic disorder. In addition to cataloging the different topics addressed by researchers in this field, we also sought to identify variables associated with varying levels of romantic and sexual functioning. The following research question helped guide our initial article search:

- Apart from pharmacologically-related sexual dysfunctions, what do we know regarding the romantic and sexual lives of people with psychotic disorders?

The present study adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). No ethical approval was required to conduct this review.

Search strategy

The following terms were used to retrieve articles from the PsycINFO, PubMed, Web of Science and Proquest databases: (psychotic* or psychosis or psychoses or schizophren* or "serious mental illness" or "severe mental illness" or "serious mental disorder*" or "severe mental disorder*") AND (couple* or spouse* or dating or romantic or romance or partner* or intima* or "significant other*" or "sexual relation*" or sexuality or "sexual behavior*" or "sexual behaviour*" or "sexual intercourse" or "sexual activit*" or "sexual risk*" or "sexual function*" or "sexual dysfunction*" or "sexual difficult*"). Searches were limited to articles published between January 2004 and May 2019.

Inclusion and exclusion criteria

Peer-reviewed articles and PhD dissertations were included, provided they were available in English or in French. Selected studies met each of the following inclusion criteria: (1) original research or meta-analysis, (2) complete or partial sample with a psychotic disorder diagnosis (i.e., first-episode psychosis, schizophrenia, schizoaffective disorder, schizophreniform disorder), (3) provision of quantitative data specific to the population of interest, and (4) studies focusing on romantic relationship and/or sexuality variables as correlates, predictors, mediators, or outcomes. Studies were eliminated if they met any of the following exclusion criteria: (1) child and adolescent samples under 18 years of age, (2) provision of qualitative data only, (3) pharmacotherapy

research, genetics research, or animal research, and (4) limited focus and/or data on variables of interest. Studies including minors were excluded from the current review due to the limited literature on adolescence and psychotic disorders. While initial psychotic episodes can occur during adolescence, this is less common and makes recruitment for research difficult. Relatedly, obtaining ethical approval for studies involving adolescents with psychosis is particularly challenging and may discourage researchers from focusing on this particular subgroup.

Data extraction

The first author (BC) independently screened all articles, first by title, then by abstract. The authors AF and AG independently screened a portion of abstracts (≈50% each) after BC's initial title screening. Thus, all abstracts were screened twice by two reviewers. Disagreements were resolved through discussion. A final selection of full-text articles was completed after further screening and consultation with the author TL.

The following data was extracted from each study: (1) study characteristics (location, design, sample size), (2) sample characteristics (mean age and standard deviation, % sex, diagnoses, inpatient/outpatient status), and (3) findings (descriptive and/or correlative data, statistical comparisons between groups).

Quality assessment

BC and TL examined study quality, with TL evaluating approximately 50% of the studies. Quality indicators of selected studies were defined according to PRISMA criteria and included: (1) sample size, (2) study design, (3) attempts to control for risk of bias, (4) use of appropriate and

standardized measures, (5) use of appropriate statistics, (6) quality of the results presentation, and (7) generalizability.

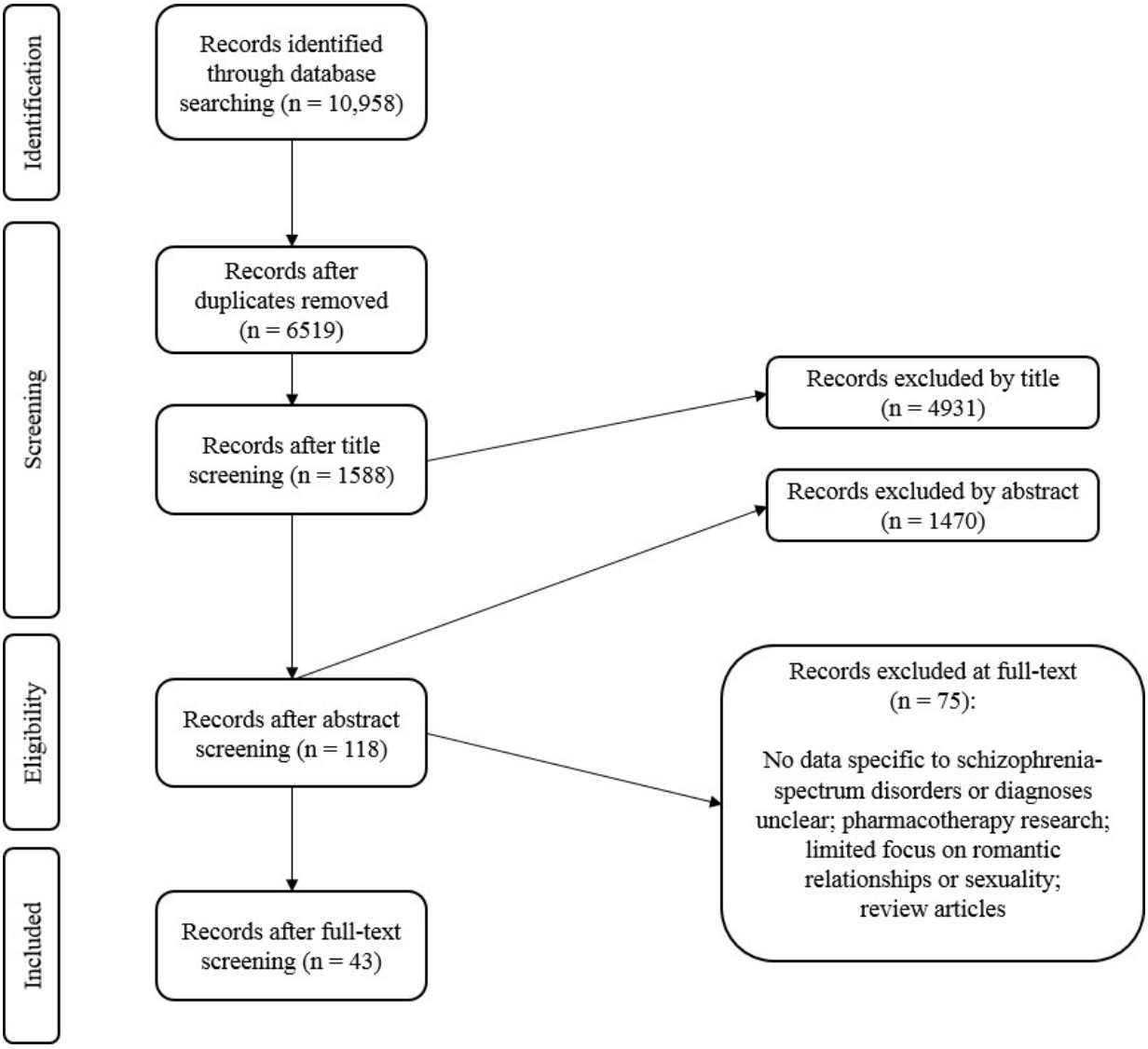
Analysis

Studies were classified first by topic and then by overarching theme (i.e., obstacle-related or neutral/recovery-oriented) according to the main variables of interest in each study. The final classification scheme emerged after several revisions and when consensus was reached among the authors. A point system was also developed based on PRISMA criteria in order to evaluate study quality.

Results

The search strategy yielded a total of 1,588 abstracts. 118 articles remained after applying inclusion and exclusion criteria, and another 75 articles were eliminated for different reasons following full-text verifications (see Figure 1).

Figure 1. Flow diagram of study selection process



Overall, 43 studies were deemed eligible (see Table 1). Studies were from the United States (n = 11), Croatia (n = 3), Australia (n = 2), Nigeria (n = 2), Brazil (n = 4), India (n = 3), Tunisia (n = 2), Taiwan (n = 1), Israel (n = 1), Turkey (n = 4), Italy (n = 1), Spain (n = 2), the United Kingdom (n = 1), Switzerland (n = 1), Canada (n = 1), Denmark (n = 1), Sweden (n = 1), England (n = 1), and China (n = 1). Sample sizes ranged from 30 to 173,559, with a total of 10,039 participants with a psychotic diagnosis, 11,286 participants with other (non-psychotic) diagnoses, and 195,746 with no psychiatric diagnosis. Most studies used questionnaires or surveys (n = 13), structured or semi-structured interviews (n = 3), or a combination of both (n = 22). Some studies used psychometric tests (n = 2) or administrative records (n = 5).

Main themes of selected studies

For the purpose of this review, we grouped studies into categories according to the major topics they addressed. We also completed a second categorization in which studies were classified as either obstacle-related (i.e., focusing on negative aspects of romantic relationships or sexuality) or neutral/recovery-oriented (i.e., focusing on positive aspects of romantic relationships or sexuality). Overall, 24 studies (55.8%) were considered to be obstacle-related and included topics such as sexual risk behavior (n = 11), abnormal sexual behavior (e.g., paraphilias, sexual offending; n = 5), sexual dysfunction (n = 5), intimate partner violence (n = 2), and stigma (n = 1). Meanwhile, 19 studies (44.2%) were considered neutral or recovery-oriented and included topics such as marital and sexual functioning (n = 9), sexual self-perception (n = 3), relationships (n = 2), family planning and reproductive health (n = 3), consent to sexual activity (n = 1), and sexual fantasies (n = 1).

Table 1. Summary of selected studies

Article type	Variable	Authors	Country	Diagnoses of population(s) studied	Sample size, age, sex	Study design	Instruments used	Key findings
Obstacle-related articles (n = 24)	Sexual risk behavior (n = 11)	Brown et al. (2010, 2011)	Australia	Nonaffective psychosis, affective psychosis, and brief psychotic disorder (n = 67); healthy controls (n = 48)	N = 115 Clinical sample: Age M = 22.0 ± 2.4 Sex = 72% M Control sample: Age M = 21.8 ± 3.6 Sex = 71% M	Cross-sectional, case-control	- Socio-demographic questionnaire - DSM-IV - BPRS-E - WAIS-II & III - Kessler 10 Psychological Distress Scale - RSES - MSPSS - OTI - Barratt Impulsiveness Scale	- Clinical participants reported more inconsistent condoms use with casual partners than controls (X^2 = 8.76; p < 0.01). - The odds of inconsistent condom use were 5.9 times greater for the clinical sample than the control sample. - No group differences were observed with respect to condom use at first sexual intercourse, lifetime number of sexual partners, or history of pregnancy or sex trading (all p > 0.05). - A greater proportion of clinical participants reported substance use by a sexual partner prior to the last sexual encounter (X^2 = 5.82, p < 0.05). - No differences were observed between type of psychotic disorder (affective psychosis vs. non-affective psychosis), symptomatology (positive, negative, manic, and depressive symptoms) or gender and sexual risk behavior (all p > 0.05).
		Carey et al. (2004)	United States	Mood disorder (66% of sample); Sz-spectrum (34% of sample)	N = 430 Age M = 36.4 ± 9.7 Sex = 47% M	Cross-sectional	- Socio-demographic interview - SCID-I for DSM-IV - TLFB	- Participants with Sz-spectrum disorders reported a greater number of sexual partners than those with mood disorders (t = 2.14; p < 0.05). - Participants with mood disorders reported a higher frequency of unprotected intercourse than participants with Sz-spectrum disorders (t = 2.56; p < 0.05).
		Dickerson et al. (2004)	United States	Sz (n = 97); mood disorder (n = 94)	N = 191 Age M = Not provided Sex = 48% M	Cross-sectional	- NHANES III	- Men with Sz reported fewer lifetime sexual partners than men with major mood disorders (IRR = 2.54; p < 0.05). - No group differences were observed with respect to age at first sexual intercourse, history of marriage, or history of pregnancy (all p > 0.05).
		Elkington et al. (2010)	Brazil	Sz (n = 49); BD (n = 27); MDD+P (n = 10); other psychotic disorder (n = 12)	N = 98 Age M= 41.8 ± 11.1	Cross-sectional	- SPISEW - MINI PLUS - BPRS - SERBAS	- No differences were observed for romantic relationship stigma across diagnostic groups (p < 0.05).

			Sex = 49% M			
Gonzalez-Torres et al. (2010)	Spain	Sz-spectrum (*n* = 235); mood disorder (*n* = 129); SUD (*n* = 69); PD (*n* = 50); neurotic disorder (*n* = 46); organic disorder or ID (*n* = 17)	*N* = 546 Age *M* = 41.1 ± 14.9 Sex = 56% M	Cross-sectional	- Socio-demographic questionnaire - ICD-10 - Semi-structured interview	- The Sz-spectrum disorder group had the lowest proportion of participants with sexual experience (81.3%) and non-users of condoms (39.8%). - The Sz-spectrum disorder group had the highest proportion of singles (74.0%).
Meade (2006); Meade & Sikkema (2007)	United States	Psychotic disorder (*n* = 61); nonpsychotic disorder (*n* = 91)	*N* = 152 Age *M* = 38.6 ± 9.3 Sex = 54% M	Cross-sectional	- SCL-R-90 - Dartmouth Assessment of Lifestyle Instrument - Network of Relationships Inventory - MOS Social Support Survey - Trauma History Questionnaire	- Having a psychotic disorder diagnosis was associated with more partner-related risks (r = 0.31; $p < 0.05$) and a lower likelihood of having a steady partner (r = -0.30; $p < 0.01$). - Having a psychotic disorder diagnosis predicted partner-related risk (*OR* = 5.32; $p < 0.05$) but not sexual activity (*OR* = 0.90; $p > 0.05$) or condom-related risk (*OR* = 1.30; $p > 0.05$). - Having a non-psychotic disorder diagnosis predicted greater sexual activity (*OR* = 3.14; $p < 0.01$), but not the likelihood of having multiple partners (*OR* = 0.72; $p > 0.05$), engaging in unprotected intercourse (*OR* = 0.58; $p > 0.05$), or trading sex for money (*OR* = 1.13; $p > 0.05$). - Among participants with psychotic disorders, active substance abusers were more likely to have engaged in partner-related risk (X^2 = 3.86, p = 0.05).
Nyamali et al. (2010)	Nigeria	Sz (*n* = 200); SUD (*n* = 200)	*N* = 400 Sz: Age *M* = 34.50 ± 7.98 Sex = 49% M Substance users:	Cross-sectional	- Socio-demographic questionnaire - WHO Drug-Injecting Study Questionnaire - WHO Questionnaire for Student Drug Use Survey	- More substance users had multiple primary sex partners than participants with Sz ($p < 0.05$). - More participants with Sz never used condoms with their casual partners than substance users ($p < 0.05$). - More participants with Sz had genital discharge, itching, and ulcers/sores than substance abusers ($p < 0.05$).

			Age *M* = 30.16 ± 7.12 Sex = 89% M		- National HIV/AIDS and Reproductive Health Survey Questionnaire	
Shield et al. (2005)	Australia	Early psychosis	*N* = 62 Age *M* = 21 ± 2.8 Sex ≈ 75% M	Descriptive	- Sexual knowledge, perceptions and behaviors questionnaire	- Among those who were sexually active, women reported higher numbers of partners than men ($p < 0.01$). - Knowledge of transmission of 12 STIs was fair only and largely equivocal by gender ($p > 0.05$). - 60% of participants reported having had a STI screen, with no gender differences ($p > 0.05$).
Van Dorn et al. (2005)	United States	Psychosis (*n* = 426)	*N* = 609 Age *M* = Not provided Sex = 63% M	Cross-sectional	-Socio-demographic questionnaire - AIDS Risk Inventory - Sexual abuse questionnaire - DALI - PCL-C for DSM-IV - SCID for DSM-IV - Community Exposure to Violence Instrument	- Having a psychotic disorder diagnosis reduced the risk of unprotected sex among all participants (*OR* = 0.44; $p < 0.01$). - Having a psychotic disorder diagnosis increased the likelihood of trading sex for money or drugs among males (*OR* = 2.21; $p < 0.01$).
Wainberg et al. (2008)	Brazil	Sz (*n* = 49); BD (*n* = 27); MDD+P (*n* = 11); Other psychosis (*n* = 13)	*N* = 98 Age *M* = 41.8 ± 11.1 Sex = 51% F	Cross-sectional	-Socio-demographic questionnaire - MINI PLUS - SERBAS-B - Brief HIV-KQ	- 54.1% of participants had been tested. - Only 22% of reported using condoms on every sex occasion. - Among sexually-active participants who did not use condoms, 50% of males cited trust in their partner(s). - Among females, 60.5% reported not using a condom due to their partners' preference.
Wright & Gayman (2005)	United States	Sz and Sz-A (*n* = 282); BD (*n* = 33); MDD (*n* =	*N* = 401 Age *M* = 37.7 ± 9.7	Cross-sectional	- Socio-demographic questionnaire	- No differences were observed for current sexual activity across diagnostic groups ($p > 0.05$).

			51); other SMI (*n* = 35)	Sex = 58% M		- Semi-structured interview - SERBAS - National Health and Social Life Survey	
Abnormal sexual behavior (*n* = 5)	Alden et al. (2007)	Denmark	Individuals hospitalized for any psychotic disorder (*n* = 4,424)	*N* = 173,559 Age *M* = Not provided Sex = 100% M	Birth cohort (1944 - 1947)	- Hospital records - Criminal records	- Men hospitalized for a psychotic disorder were more likely to have been arrested for sexual offenses than non-hospitalized men (*OR* = 3.76). - Men hospitalized for affective psychosis were less likely to be arrested for sexual offenses (*OR* = 1.61) than men hospitalized for schizophrenia (*OR* = 4.19), organic brain disorders (*OR* = 4.27) or other psychotic disorders (*OR* = 4.50). - The presence of a comorbid PD or SUD with psychosis increased men's risk of arrest for sexual offenses (*OR* = 2.24 to 7.87).
	Alish et al. (2007)	Israel	Sz sex offenders (*n* = 36); Sz offenders with other, non-sexual crimes (*n* = 80); non-Sz sex offenders (*n* = 57)	*N* = 173 Age *M* = 35.03 ± 9.71 Sex = 100% M	Retrospective	- Socio-demographic questionnaire - PANSS - CGI-S - CGI-I	- Sz sex offenders were more likely to be employed ($X^2 = 7.75$; $p < 0.05$), married ($X^2 = 7.12$; $p < 0.01$), and non-heterosexual ($X^2 = 25.74$; $p < 0.01$) than Sz offenders who committed non-sexual crimes. - Sz sex offenders had lower rates of APD ($X^2 = 8.41$; $p < 0.01$) and substance abuse ($X^2 = 4.89$; $p < 0.05$) than Sz offenders who committed non-sexual crimes. - Sz sex offenders had less negative symptoms ($t = 3.38$; $p < 0.01$) and less severe symptoms ($t = 3.07$; $p < 0.01$) than Sz offenders who committed non-sexual crimes. - Sz sex offenders more often assaulted females, while non-Sz sex offenders more often assaulted males ($X^2 = 20.84$; $p < 0.01$). - Non-Sz sex-offenders showed a greater tendency towards non-adult assault, while Sz sex-offenders showed a greater tendency towards adult assault ($X^2 = 3.36$; $p = 0.07$).

	del Mar Baños-Martin et al. (2017)	Spain	Sz-spectrum	*N* = 293 Age *M* = 39.18 ± 13.06 Sex = 54% M	Retrospective	- Hospital records - Clinical observations - Nursing incidents - Medical discharge reports	- More women's records reported sexual delusions, obscene language, and exhibitionistic behavior than men's records. - More men's' records reported sexual practices during hospitalization than women's' records.
	Faria Acha et al. (2011)	Brazil	Sz (*n* = 45); ID (*n* = 27); SUD (n = 13); PD (*n* = 12); epilepsy (*n* = 12); organic brain disorder (*n* = 4); mood disorder (*n* = 1)	*N* = 89 Age *M* = Not provided Sex = 100% M	Cross-sectional, case control	- Socio-demographic questionnaire - Hospital records - Criminal records	- Sz was more commonly diagnosed among non-sex offenders than sex offenders ($p < 0.01$), whereas ID was more commonly diagnosed among sex offenders than non-sex offenders ($p < 0.01$).
	Fazel et al. (2007)	Sweden	Sexual offenders (*n* = 8,495); controls (*n* = 19,935)	*N* = 28,430 Age *M* = 37.1 ± 14.3 Sex = 100% M	Cross-sectional, case control	- Hospital records - Criminal records	- Sexual offenders were more likely to have received a diagnosis of Sz (*OR* = 4.8) or other psychotic disorder (*OR* = 5.2) than controls. - Other psychotic disorder diagnoses were more prevalent among offenders convicted for rape ($X^2 = 16.0$; $p < 0.01$), but not child molestation ($p > 0.05$).
Sexual dysfonction (*n* = 5)	Ben Mahmoud et al. (2013)	Tunisia	Sz (*n* = 30); BD (*n* = 31)	*N* = 61 Age *M* = 37.3 ± 8.2 Sex = 96% M	Cross-sectional	- Socio-demographic questionnaire - Sexual Behaviour Questionnaire -CGI	- Participants with BD were more likely to be married than participants with Sz ($p < 0.01$). - Sexual dysfunctions (e.g., reduced desire and decreased excitation) were more frequently reported by participants with Sz than those with BD ($p < 0.01$).
	Halouani et al. (2018)	Tunisia	Sz (*n* = 32); healthy controls (*n* = 35)	*N* = 67 Age *M* = 38 ± 5.2 Sex = 100% F	Cross-sectional, case-control	- PANSS - FSFI	-100% of women with Sz reported that their physicians never discussed sexuality with them and did not inform them of possible medication side-effects. - 81.3% of women with Sz experienced sexual dysfunction. - Sexual dysfunction was linked to greater overall psychopathology ($r = -0.73$; $p < 0.01$) and negative symptoms ($r = -0.82$; $p < 0.01$).

Harley et al. (2010)	England	Sz and Sz-A	*N* = 137 Age *M* = Not provided Sex = 59% M	Cross-sectional	- Semi-structured interview - SFQ	- Compared to controls, women with Sz had greater sexual dysfunction in all areas except pain ($p > 0.05$), including desire, excitement, lubrication, orgasm, and satisfaction ($p < 0.01$). - 30% of participants were currently in a relationship, 58% had never had an intimate relationship, and 88% of participants had never had children. - Women were more likely to be in a relationship ($X^2 = 7.6$; $p < 0.01$), to have had an intimate relationship ($X^2 = 22.4$; $p < 0.01$) and to have had children ($X^2 = 9.2$; $p < 0.01$) than men. - 22% of participants were sexually active, with more women than men being currently sexually active ($X^2 = 4.0$; $p < 0.05$). - 82% of women and 74% of men reported at least one sexual dysfunction, with women experiencing more problems with desire (*OR* = 3.1) and men more problems with arousal (*OR* = 3.2).
Hou et al. (2016)	China	Sz	*N* = 607 Age *M* = Not provided Sex = 54% M	Cross-sectional	- Socio-demographic questionnaire - ASEX - BPRS - SAS - MADRS - SF-12	- Women were more likely to experience sexual dysfunction in all five domains (sex drive, arousal, erection or lubrication, orgasm, satisfaction) than men (all $p < 0.05$). - Female gender, single marital status, older age, and use of first-generation antipsychotics were associated with sexual dysfunction. - Quality of life did not differ between participants with and without sexual dysfunctions ($p > 0.05$).
Simiyon et al. (2016)	India	Sz	*N* = 63 Age *M* = 33.3 ± 4.3 Sex = 100% F	Cross-sectional	- Socio-demographic questionnaire - MINI - PANSS - HDRS - UKU Side Effects Rating Scale - MSQ - FSFI	- 57% of women reported poor marital quality. - Sexual dysfunction was most commonly experienced for desire (100%) and arousal (92%), followed by orgasm (76%), satisfaction (70%), lubrication (48%), and pain (37%). - Greater overall psychopathology ($p < 0.05$) and poor marital quality ($p < 0.01$) were linked to sexual dysfunction.

	Intimate partner violence (n = 2)	Afe et al. (2016; 2017)	Nigeria	Sz	N = 79 Age M = 38.3 ± 2.8 Sex = 100% F	Cross-sectional	- Socio-demographic questionnaire - SCID-I for DSM-IV - BPRS - Intimate partner violence questionnaire	- 75% of women reported at least one form of IPV. 73% reported verbal abuse, 53% reported physical abuse, and 25% reported sexual abuse. - Women who were younger were more likely to report verbal (Cohen's d = 0.87; p < 0.05) and sexual (Cohen's d = 0.67; p < 0.05) abuse. - Shorter relationship length was associated with sexual assault (Cohen's d = 0.67; p < 0.05). - Women who were employed had lower odds of being victims of IPV than unemployed women (OR = 6.00, p < 0.05). - Women who did not comply with medication reported more verbal abuse (X^2 = 5.05, p < 0.05). - Women who reported all three forms of IPV had greater overall psychopathology (Cohen's d = 1.60; p < 0.01).
		McPherson et al. (2007)	United States	Sz (n = 35); Sz-A (n = 34); MDD (n = 134); MDD+P (n = 40); BD (n = 41); BD+P (n = 53)	N = 324 Age M = 36.5 ± 6.5 Sex = 100% F	Longitudinal	- Socio-demographic questionnaire - DIS - DAST	- No differences were observed for intimate partner violence between different diagnostic groups (p > 0.05).
	Stigma (n = 1)	Sarisoy et al. (2013)	Turkey	Sz (n = 109); BD (n = 119)	N = 228 Sz: Age M = 35.48 ± 10.56 Sex = 52% F BD: Age M = 35.64 ± 9.93 Sex = 58% F	Cross-sectional	- Socio-demographic questionnaire -ISMIS - MRQ	- Stigma resistance was higher among BD participants than Sz participants (p < 0.05). - Relational esteem scores was higher among BD participants than Sz participants (p < 0.05). - Relational satisfaction, esteem, and assertiveness were lower, while relational anxiety, monitoring, and external control were higher in Sz participants with internalized stigma (p < 0.05).
Neutral or recovery-oriented articles (n = 19)	Marital and sexual functioning	Aggarwal et al. (2019)	India	Sz (n = 76); RDD (n = 58)	N = 134 Sz: Age M = 40.86 ± 8.43	Cross-sectional	- Socio-demographic questionnaire - MINI - HDRS	- Quality of marriage (X^2 = 3.01; p < 0.01), dyadic adjustment (X^2 = 2.39; p < 0.01), and sexual satisfaction (X^2 = 2.03; p < 0.05) was lower among participants with Sz than those with RDD,

(n = 9)				Sex = 45% M RDD: Age M = 43.44 ± 7.69 Sex = 31% M		- PANSS - DAS - QMI - MOFS - ASEX - NSSS	but sexual dysfunction did not differ between groups (p > 0.05). - Duration of marriage for participants with Sz was longer than participants with RDD (X^2 = 1.94; p = 0.05).
	Driscoll et al. (2010)	United States	Sz (n = 65); Sz-A (n = 57)	N = 122 Age M = 58.2 ± 7.02 Sex = 51% M	Cross-sectional	- SANS - RSES - BPRS - CESD	- Women reported lower sexual interest and activity than men (t = -2.73; p < 0.01).
	Hugue let et al. (2015)	Switzer-land	Sz (n = 11); Sz-A (n = 7); healthy controls (n = 21)	N = 39 Clinical sample: Age M = 39 ± 7 Sex = 100% F Control sample: Age M = 37 ± 9 Sex = 100% F	Cross-sectional, case-control	- PANSS - MARS - MRSS - GAF Scale - CTQ - SDS - FSFI - MSQ	- Women with psychosis were more frequently without a current partner and without children than controls (p < 0.01). - Women with psychosis had lower sexual-esteem, sexual-motivation, and sexual-satisfaction, as well as greater sexual-anxiety, sexual-depression, external-sexual-control, sexual-monitoring and sexual-fear (p < 0.05) than controls. - The sexual desire of women with psychosis was negatively associated with emotional and sexual abuse (p < 0.05).
	Incedere et al. (2017)	Turkey	Sz (n = 50); BD (n = 50); MDD (n = 50); Anxiety disorder (n = 50)	N = 200 Age M = 36.7 ± 10.34 Sex = 42% M	Cross-sectional	- ASEX	- Sexual dysfunction was higher among participants with Sz than other diagnostic groups (p < 0.01). - Women with Sz had the highest levels of sexual dysfunction (p < 0.01). - Participants with Sz had the least knowledge of STIs and used the least effective contraceptive methods of all of diagnostic groups.

Ma et al. (2018)	Taiwan	Sz	*N* = 317 Age *M* = 47.71 ± 9.54 Sex = 75% M	Cross-sectional	- Socio-demographic questionnaire - BPRS - ASEX - Sexual Behavior Scale - Sexual Attitudes Scale	- 88% of participants were heterosexual, 79% were unmarried, and 59% had sexual dysfunction. - Across all ages, women had higher rates of sexual dysfunction than men ($p < 0.05$). - Across all ages, greater psychopathology was associated with sexual dysfunction ($p < 0.05$).
Mate vosyan (2010)	United States	Sz (20.4%); BD (31.8%); MDD (36.8%); PTSD (36.8%); GAD (25%); mixed diagnoses (43.2%)	*N* = 44 Age *M* = 42 ± 11.4 Sex = 100% F	Mixed-method, cross-sectional	- Sexual functioning questionnaire - BISF-W - BASIS-24	- History of sexual abuse was associated with less sexual satisfaction among women with Sz, compared to those without history of sexual abuse ($p < 0.05$). - Pathological symptoms (e.g., dyspareunia, vaginal dryness, bleeding during and after intercourse) were less frequently reported among women with Sz.
Nyer et al. (2010)	United States	Sz (*n* = 126); Sz-A (*n* = 85)	*N* = 211 Age *M* = 52 ± 7.03 Sex = 79% M	Cross-sectional	- Socio-demographic questionnaire - SCID-I for DSM-IV - HAMD - MacCAT-CR - CDRS - PANSS - BSS - QLS	- Participants who were married or cohabitating had a later age of onset of the first psychotic episode or hospitalization than those who were single ($p < 0.01$). - Married participants rated their quality of life higher than those who were single ($p < 0.01$) and had less suicidal ideation than those who were divorced, widowed, or separated ($p < 0.05$). - No differences were observed for depressive symptoms, positive symptoms, or negative symptoms ($p > 0.05$) based on marital status.
Stewart et al. (2013)	United States	Sz (*n* = 69); Sz-A (*n* = 34)	*N* = 103 Age *M* = 46.3 ± 9.6 Sex = 85% M	Cross-sectional	-QLS -IPII -STAND -ISMIS -PANSS	- Most participants were never married or divorced, with only 7.4% currently being married. - Social withdrawal in the face of stigma and limited social worth were related to decreased socio-sexual functioning, both concurrently and prospectively ($p < 0.05$).
Vibha et al. (2013)	India	Sz (*n* = 52); MDD and BD (*n* = 50); RDD (*n* = 48)	*N* = 150 Age *M* = 35.8 ± 6.7 Sex ≈ 50% F	Cross-sectional	- Socio-demographic questionnaire - Marital Adjustment Inventory	- Quality of life was greatest for MDD and BD participants, followed by RDD participants, and Sz participants ($p < 0.01$). - 97.8% of participants with Sz rated themselves as having poor marital adjustment, compared with only 57.5% of participants with RDD and 51.1%

						-WHOQOL-BREF	of those with MDD and BD. This difference was not observed among spouses of patients, with nearly half of respondents in all groups (Sz = 41.3%; RDD = 62.5%; MDD and BDs = 66.7%) rating themselves as having good to average marital adjustment ($p < 0.05$).
Sexual self-perception ($n = 3$)	Ljubicic et al. (2007)	Croatia	Acute Sz ($n = 100$); chronic Sz ($n = 100$)	$N = 200$ Age range: 18 to 45 years Sex = Not provided	Cross-sectional	- Sexual self-perception questionnaire	- Among chronic Sz participants, those without hereditary predisposition had higher sexual self-scheme and sexual satisfaction than those with hereditary predisposition ($p < 0.05$).
	Peitl, et al. (2009; 2011)	Croatia	Sz ($n = 100$); MDD ($n = 100$); healthy controls ($n = 100$)	$N = 300$ Sz: Age M = 44.21 Sex = 59% M MDD: Age M = 52.49 Sex = 33% M Control: Age M = 34.07 Sex = 45% M	Cross-sectional	- Socio-demographic questionnaire - ASEX - Sexual self-perception questionnaire	- Participants with Sz were more often unmarried than married, while participants with MDD were more often married than unmarried. - Sz and MDD participants had lower sexual awareness, readiness, adventurism, and satisfaction than controls (all $p < 0.01$). No differences were observed between participants with Sz and MDD on any of these scales ($p > 0.05$). - Sz and MDD participants had greater perceptions of sexual incompetence ($p < 0.01$) than controls, with no differences between diagnostic groups ($p > 0.05$). - Among Sz participants of differing religious views, no differences were observed with respect to sexual experiences ($p > 0.05$). - Roman-Catholic Sz participants had greater sexual satisfaction than Atheist and Eastern-Orthodox Sz participants ($p < 0.01$). - Atheist and Roman-Catholic Sz participants had greater sexual consciousness than Eastern-Orthodox Sz participants ($p < 0.01$).
	Peitl, Rubesa, et al. (2009)	Croatia	Acute Sz ($n = 100$); chronic Sz ($n = 100$); healthy controls ($n = 100$)	$N = 300$ Acute Sz: Age M = 30.07 ± 8.24	Cross-sectional	- Sexual self-perception questionnaire	- Participants with Sz reported greater perception of sexual incompetence and lower sexual satisfaction ($p < 0.05$) than controls, while no differences were observed between acute and chronic Sz participants.

				Sex = 61% M Chronic Sz: Age *M* = 37.07 ± 6.32 Sex = 62% M Control: Age *M* = 29.25 ± 7.73 Sex = 41% M			
Relationships (*n* = 2)	McCann (2010)	United Kingdom	Sz (*n* = 20); Sz-A (*n* =10)	*N* = 30 Age *M* = 40.93 ± 10.01 Sex = 50% M	Cross-sectional	- Socio-demographic questionnaire - CAN - DSB	- 73% of participants defined their sexual orientation as heterosexual, 40% reported being in a relationship, and 33% indicated having children. - 90% of participants felt some need in relation to sexual expression and 83% felt some need in relation to intimate relationships. - Only 10% of staff recognized a need for sexual expression, while 43% of staff perceived a need for intimate relationships. - Gay and lesbian participants were more satisfied with their relationships than heterosexual participants ($X^2 = 8.72$; $p < 0.01$).
	Pillay et al. (2016)	Canada	Early psychosis (*n* = 23); single students (*n* = 31); students in a stable relationship (*n* = 29)	*N* = 83 Early psychosis: Age *M* = 26.2 ± 4.3 Sex = 100% M Single: Age *M* = 22.9 ± 4 Sex = 100% M	Cross-sectional	- SERS-SF - ASQ - FESFS	- Men with early psychosis had higher attachment preoccupation than students involved in a relationship group ($p < 0.01$). - Men with early psychosis and single students had more negative perceptions of their intimacy abilities and fewer intimacy behaviors than students in a stable relationship ($p < 0.01$). - When asked why they were single, most men with early psychosis said they had not find someone suitable and lacked self-confidence.

				Stable relationship: Age *M* = 24.3 ± 4 Sex = 100% M			
Family planning and reproductive health (*n* = 3)	Guedes et al. (2009)	Brazil	Mood disorder (*n* = 125); Sz-spectrum (*n* = 60); neurotic disorder (*n* = 48); PD (*n* = 11); other diagnoses (*n* = 11)	*N* = 255 Age *M* = Not provided Sex = 100% F	Cross-sectional	- Structured interview - Medical records	- Correct use of contraceptive methods did not differ between diagnostic groups ($p > 0.05$).
	Ozcan et al. (2014)	Turkey	Sz (*n* = 55); BD (*n* = 154); MDD (*n* = 62); Other diagnoses (*n* = 21)	*N* = 292 Age *M* = 36.46 ± 9.16 Sex = 100% F	Cross-sectional	- Determining Problems in Reproductive Health Questionnaire	- Women with Sz were the least likely to be currently married and most likely to be living separately or divorced ($X^2 = 24.14$; $p < 0.01$). - Quality of antenatal care during pregnancy was poorest for women with Sz.
	Pehlivanoglu et al. (2007)	Turkey	Sz (*n* = 50); BD (*n* = 50), MDD (*n* = 50); healthy controls (*n* = 50)	*N* = 200 Age *M* = Not provided Sex = 100% F	Cross-sectional	- Semi-structured interview	- Knowledge of contraceptive methods was lower among women with Sz than other diagnostic groups ($p < 0.05$). - Demand for family planning services was lower among women with Sz than other diagnostic groups ($p < 0.01$). - Number of pregnancies, births, abortions, miscarriages and number of children did not differ between diagnostic groups ($p > 0.05$) or between clinical participants and controls ($p > 0.05$).
Consent to sexual activity (*n* = 1)	Mandarelli et al. (2012)	Italy	Sz-spectrum (*n* = 31); BD (*n* = 54)	*N* = 85 Sz-spectrum: Age *M* = 38.4 ± 9.7 Sex = 29% M BD:	Cross-sectional	- Socio-demographic questionnaire - SCAS - BPRS-E - MMSE - SPM	- Participants with Sz were more likely to be unmarried ($X^2 = 7.69$, $p < 0.05$) and without children ($X^2 = 5.03$, $p < 0.05$) than those with BD. - Participants with BD displayed a greater capacity to consent to sexual activity than those with Sz-spectrum disorders ($p < 0.05$), a difference independent of symptom severity. - Participants with Sz-spectrum disorders had poorer basic knowledge of birth control methods

				Age *M* = 38.1 ± 13.4 Sex = 48% M			and more limited metacognitive abilities than those with BD.
Sexual fantasies (*n* = 1)	Colon Vilar et al. (2016)	United States	Sz (*n* = 19); Sz-A (*n* = 27); BD (*n* = 47); MDD (*n* = 33); non-clinical samples (*n* = 733)	*N* = 859 Age *M* = 36.75 ± 13.5 Sex = 32% M	Cross-sectional, case-control	- SCID-I & II for DSM-IV - WSFQ	- No differences were observed for the types of sexual fantasies reported by participants from different diagnostic groups ($p > 0.05$).

Note: AIDS, Acquired Immunodeficiency Syndrome; ASEX, Arizona Sexual Experience Scale; ASQ, Attachment Style Questionnaire; BASIS, Behavior and Symptom Identification Scale; BD, Bipolar Disorder; BD+P, Bipolar Disorder with Psychotic Features; BISF-W, Brief Index of Sexual Functioning for Women; BPRS-E, Brief Psychiatric Rating Scale-Expanded; Brief-HIV-KQ, Brief-Human Immunodeficiency Virus-Knowledge Questionnaire; BSS, Beck Scale for Suicidal Ideation; CAN, Camberwell Assessment of Need; CDRS, Calgary Depression Rating Scale; CESD, Center for Epidemiologic Studies Depression Scale; CGI-I-S, Clinical Global Impression Scale-Improvement-Severity; CTQ, Childhood Trauma Questionnaire; DALI, Dartmouth Assessment of Lifestyle Instrument; DAS, Dyadic Adjustment Scale; DAST, Drug Abuse Screening Test; DIS, Diagnostic Interview Schedule; DSB, Determinants of Sexual Behaviour; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders-IV; FESFS, First Episode Social Functioning Scale; FSFI, Female Sexual Function Index; GAD, Generalized Anxiety Disorder; GAF, Global Assessment of Functioning; HAMD, Hamilton Rating Scale for Depression; HDRS, Hamilton Depression Rating Scale; HIV, Human Immunodeficiency Virus; ICD-10, International Statistical Classification of Diseases and Related Health Problems 10th Revision Version Classification; ID, Intellectual Disability; IPII, Indiana Psychiatric Illness Interview; IPV, Intimate Partner Violence; ISMIS, Internalized Stigma of Mental Illness Scale; MacCAT-CR, MacArthur Competence Assessment Tool for Clinical Research; MADRS, Montgomery-Asberg Depression Scale; MARS, Medication Adherence Rating Scale; MDD, Major Depressive Disorder; MDD+P, Major Depressive Disorder with Psychotic Features; MINI, Mini International Neuropsychiatric Interview; MMSE, Mini Mental State Examination; MOFS, Marital Forgiveness Scale; MOS, Medical Outcomes Study; MRQ, Multidimensional Relationship Questionnaire; MRSS, Morningside Rehabilitation Status Scale; MSPSS, Multidimensional Scale of Perceived Social Support; MSQ, Multidimensional Sexuality Questionnaire; NHANES, National Health and Examination Survey; N/A, Not Applicable; NSSS, New Sexual Satisfaction Scale; OTI, Opiate Treatment Index; PANSS, Positive and Negative Syndrome Scale; PCL-C, Post-traumatic Stress Disorder Checklist-Civilian Version; PD, Personality disorder; PTSD, Post-traumatic Stress Disorder; QLS, Quality of Life Scale; QMI, Quality Marriage Index; RDD, Recurrent Depressive Disorder; RSES, Revised Self-Efficacy Scale; SANS, Scale to Assess Negative Symptoms; SAS, Scale of Extrapyramidal Symptoms; SCAS, Sexual Consent Assessment Scale; SCL-R-90, Symptom Checklist-Revised-90; SERS-SF, Self-Esteem Rating Scale–Short Form; SCID-I-II, Structured Clinical Interview for DSM-IV- Axis 1 disorders-Axis II disorders; SDS, Sexual Desire Scale; SERBAS-B, Sexual Risk Behavior Assessment Schedule-Brazil; SF-12, Medical Outcomes Study Short Form-12; SFQ, Sexual Functioning Questionnaire; SMI, Serious Mental Illness; SPISEW, The Stigma of Psychiatric Illness and Sexuality among Women Questionnaire; SPM, Standard Progressive Matrices; STAND, Scale to Assess Narrative Development; STI, Sexually-Transmitted Infection; SUD, Substance Use Disorder; Sz, Schizophrenia, Sz-A, Schizoaffective Disorder; TLFB, Comprehensive Timeline Followback Method; UKU, Udvalg for KliniskeUndersogelser; WAIS-II-III, Wechsler Adult Intelligence Scale-II-III; WFSQ, Wilson Sexual Fantasy Questionnaire; WHO, World Health Organization; WHOQOL-BREF, World Health Organization Quality of Life-BREF

Synthesis of factors facilitating recovery

None of the studies selected for review looked at variables that might promote healthy romantic relationships for persons with psychotic disorders. This highlights a significant gap in the quantitative literature.

Synthesis of obstacles inhibiting recovery

Several studies looked at variables that might hinder romantic relationships for individuals with a psychotic disorder. Sexual dysfunction resulting from medication side-effects (even though we eliminated many studies looking at sexual dysfunction in pharmacological studies) and psychiatric symptoms, history of abuse, poor sexual self-concept and low self-esteem/confidence, attachment insecurities, limited resources (intimacy skills and financial means), and internalized stigma were all linked to romantic and/or sexual difficulties (Ben Mahmoud et al., 2013; Halouani et al., 2018; Huguelet et al., 2015; Peitl et al., 2011; Pillay et al., 2018; Sarisoy et al., 2013; Stewart et al., 2013).

Quality of studies

As can be seen in Table 1, most studies used a cross-sectional design, many had small samples, and only a few included a control condition (either another clinical group or healthy controls). Although most studies used validated measures, the lack of control for potential biases, the convenience samples, and study designs resulted in studies being mostly in the poor-to-moderate quality range. Only three studies included larger samples, from various sites, with matched controls and/or longitudinal data (Carey et al., 2004; McPherson et al., 2007; Van Dorn et al., 2005).

Sexual risk behavior

Across studies, evidence for heightened sexual risk behavior in persons with psychotic disorders was mixed. Sexual activity did not differ between individuals with psychotic disorders and other psychiatric conditions in one study (Wright & Gayman, 2005), while two studies reported greater sexual activity among people with non-psychotic disorder diagnoses (Gonzalez-Torres et al., 2010; Meade, 2006; Meade & Sikkema, 2007). One study found that inconsistent condom use was more prevalent among individuals with a psychotic disorder than healthy controls (Brown et al., 2010, 2011). When compared to other psychiatric diagnoses, one study found no difference between psychotic and non-psychotic disorders with respect to condom-related risks (Meade, 2006, 2007), three studies found a reduced risk for people with psychotic disorders (Carey et al., 2004; Gonzalez-Torres et al., 2010; Van Dorn et al., 2005) and one study found an increased risk for those with a psychotic disorder diagnosis (Nyamali et al., 2010).

Regarding number of sexual partners, one study found no difference between healthy controls and individuals with a psychotic disorder (Brown et al., 2010), while another study found no difference between individuals with psychotic and other non-psychotic psychiatric disorders (Meade, 2006; Meade & Sikkema, 2007). One study identified a lower number of sexual partners among men with psychotic disorders compared to men with mood disorders (Dickerson et al., 2004), one study reported a higher number of sexual partners among people with psychotic disorders compared to those with mood disorders (Carey et al., 2004), and another study found a higher number of sexual partners among substance abusers compared to persons with a psychotic disorder (Nyamali et al., 2010). Because substance use is frequently encountered in psychosis

(Cournos et al., 2005), the risk for multiple sexual partners is amplified. One study also reported that women tended to have more sexual partners than men (Shield et al., 2005). Partner-related risks, such as substance abuse prior to sexual activity, were found to be greater among individuals with psychotic disorders compared to healthy controls (Brown et al., 2010; 2011) and individuals with other diagnoses (Meade, 2006; Meade & Sikkema, 2007). As for sex-trading, one study reported no difference between healthy controls and people with a psychotic disorder (Brown et al., 2010, 2011), one study found no difference between individuals with psychotic and non-psychotic psychiatric disorders (Meade, 2006; Meade & Sikkema, 2007), and another study found a greater risk for those with psychotic disorders compared to other diagnoses (Van Dorn et al., 2005).

Lack of knowledge about sexually-transmitted infections (STIs) was reported in two studies (Shield et al., 2005; Wainberg et al., 2008). In both studies, over 50% of respondents indicated having been tested for STIs (Shield et al., 2005; Wainberg et al., 2008). Another study found higher rates of STI symptoms among individuals with psychotic disorders compared to substance-abusers (Nyamali et al., 2010). When asked why they chose to engage in unprotected sex, trust in one's partner(s) was most frequently mentioned by males, while partner's preference to not use a condom was most frequently cited by females (Wainberg et al., 2008).

Abnormal sexual behavior

Five studies examined abnormal sexual behavior in persons with psychosis. While two studies found that sexual offenders were more likely to be diagnosed with psychotic disorders than controls (Alden et al., 2007; Fazel et al., 2007), another study found an increased prevalence of

intellectual disabilities, but not psychosis, among sexual offenders (Faria Acha et al., 2011). In one study, individuals with affective psychosis were less likely to commit a sexual offense, while the presence of a comorbid personality or substance abuse disorder increased the risk of sexual offending (Alden et al., 2007). Another study uncovered several major differences between sex offenders with schizophrenia and individuals with schizophrenia incarcerated for non-sexual crimes (Alish et al., 2007). Their findings suggest that the former group is more likely to be married, employed, and non-heterosexual, as well as less likely to be diagnosed with antisocial personality disorder and substance abuse. Those who sexually offended also tended to have fewer negative symptoms and lower global illness severity. When compared to sex offenders who do not have schizophrenia, sex offenders with schizophrenia were more likely to have female and adult victims (Alish et al., 2007). Finally, one study investigating inappropriate sexual behavior among individuals hospitalized for psychosis found more reports of sexual delusions, obscene language, and exhibitionistic behavior in female than male patients, although sexual activity during hospitalization was more frequently reported in men's records (del Mar Banos-Martin et al., 2017).

Sexual dysfunction

The increased incidence of sexual problems in persons with psychotic disorders is discussed in five studies. In one study, women with schizophrenia experienced greater sexual dysfunction in all areas except pain (i.e., desire, excitement, lubrication, orgasm, and satisfaction) than healthy controls (Halouani et al., 2018). Sexual dysfunction was also linked to greater overall psychopathology and more negative symptoms (Halouani et al., 2018). Although over 80% of women with schizophrenia reported sexual dysfunction, 100% of these women revealed that their physicians never discussed sexuality and medication side-effects with them (Halouani et al., 2018).

Two studies reported more sexual dysfunction among men than women (Harley et al., 2010; Hou et al., 2016). Poor marital quality was linked to greater sexual dysfunction among women in one study (Simiyon et al., 2016). When compared to individuals with bipolar disorder, one study noted higher rates of sexual dysfunction with respect to desire and excitation, but less difficulty achieving orgasm and higher satisfaction with one's sex life, in persons with schizophrenia (Ben Mahmoud et al., 2013). However, a greater proportion of people with schizophrenia were sexually inactive, which could be partially explained by a lower frequency of stable partnerships than individuals with bipolar disorder (Ben Mahmoud et al., 2013).

Intimate partner violence

Domestic violence exposure was examined in two samples with severe mental illness. Risk factors for intimate partner violence among women with schizophrenia were reported in one study and included younger age, shorter duration of the romantic relationship, unemployment, and medication non-adherence (Afe et al., 2016, 2017). The most common form of domestic violence was verbal abuse, followed by physical and sexual abuse. Women with schizophrenia exposed to all three forms of intimate partner violence also tended to display greater overall psychopathology (Afe et al., 2016, 2017). When compared to women with other severe mental disorders in another study, women with psychotic disorders were neither more nor less likely to be victims of intimate partner violence (McPherson et al., 2007).

Stigma

Only one study looked at stigma and its impact on romantic relationships in people with a psychotic disorder (Sarisoy et al., 2013). Individuals with schizophrenia were found to have lower

stigma resistance and poorer relational self-esteem than individuals with bipolar disorder. Among those diagnosed with schizophrenia, greater internalized stigma was linked to lower relational assertiveness and satisfaction, as well as higher relational anxiety, monitoring, and external locus of control (Sarisoy et al., 2013).

Marital and sexual functioning

The romantic relationship functioning of people with a psychotic disorder was consistently lower than that of healthy controls and individuals with other psychiatric conditions. Although quality of life may be higher among people with psychotic disorders who are married, marriage and cohabitation rates tend to be low in this population, especially for those with an earlier age of onset (Nyer et al., 2010; Ma et al., 2018, Stewart et al., 2013). Stigma, social withdrawal, and limited social worth may all contribute to this phenomenon (Stewart et al., 2013). In one study, individuals with schizophrenia displayed poorer quality of marriage, lower dyadic adjustment, and less sexual satisfaction than those with recurrent depressive disorder (Aggarwal et al., 2019). Marital adjustment was also found to be lower among people with schizophrenia than those with major depression and bipolar disorders, with spouses rating their marital adjustment significantly higher than participants themselves (Vibha et al., 2013).

Individuals with a psychotic disorder appear to experience more sexual dysfunction than those without a psychiatric diagnosis and those with other mental health conditions (Incedere et al., 2017). Compared to healthy controls, women with psychotic disorders may be more frequently sexually inactive, more often without a partner, and more often without children. They also tend to experience greater dysfunction in multiple areas of sexual functioning, exhibiting lower sexual

self-esteem, motivation, and satisfaction, and higher sexual anxiety, depression, and fear than women without a psychiatric diagnosis (Huguelet et al., 2015). Women with psychotic disorders also tend to report greater sexual dysfunction and lower levels of sexual interest than their male counterparts (Driscoll et al., 2010; Incedere et al., 2017; Ma et al., 2018), a finding that might in part be explained by women's increased exposure to emotional and sexual abuse (Huguelet et al., 2015; Matevosyan, 2010).

Sexual self-perception

Three studies investigated sexual self-concept and its influence on sexual functioning. When compared to healthy controls in one study, individuals with schizophrenia were found to have greater perceptions of sexual incompetence, as well as lower sexual satisfaction (Peitl et al., 2009). Such altered views seem to be equally present in people with acute and chronic psychosis (Peitl et al, 2009), although the presence of a hereditary predisposition may have an added negative effect on sexual self-concept and satisfaction among those with a more chronic condition (Ljubicic et al., 2007). Data from another study indicate that the sexual self-perception of people with psychotic disorders may not differ much from that of other psychiatric conditions, as individuals with schizophrenia and major depression were found to have similarly low levels of sexual awareness, readiness, adventurism, and satisfaction, as well as similarly high levels of sexual incompetence, when compared to healthy controls (Peitl et al., 2009, 2011). Religious orientations might also play a role in this population's sexual functioning, with Roman-Catholic participants reporting greater sexual self-consciousness and satisfaction than Eastern-Orthodox and Atheist participants (Peitl et al., 2009, 2011).

Relationships

Specific needs and relationship factors are discussed in two studies. According to one study, as many as 90% of persons with psychotic disorders feel some need in relation to sexual expression, and over 80% feel some need in relation to romantic relationships (McCann et al., 2010). Unfortunately, only around 10% of staff recognize a sexual need among service users, while only about 40% perceive a need for intimacy (McCann et al., 2010). Although individuals with a psychotic disorder are mostly heterosexual, those who identify as gay and lesbian appear to be more satisfied with their relationships (McCann, 2010). In another study, men with psychotic disorders were found to have higher attachment preoccupation, more negative perceptions of their intimacy skills, and fewer intimacy behaviors than healthy males who were in a stable relationship (Pillay et al., 2018). When asked why they believed they were single, men with psychotic disorders frequently indicated that they could not find a suitable partner and lacked the confidence to pursue a romantic relationship (Pillay et al., 2018).

Family planning and reproductive health

In one study, correct use of contraceptive methods did not differ between individuals with psychotic disorders and other psychiatric conditions (Guedes et al., 2009). Compared to females with other mental health conditions (e.g., bipolar disorder and major depression), women with schizophrenia may have poorer knowledge of contraceptive methods, higher abortion rates, and less frequent antenatal care during pregnancy (Ozcan et al., 2014; Pehlivanoglu et al., 2007).

Consent to sexual activity

Sexual consent was examined in one study, which found a greater capacity for consent among individuals with bipolar disorder than those with schizophrenia-spectrum diagnoses (Mandarelli et al., 2011). This difference was independent of symptom severity and may have been linked to poorer knowledge of birth control options and more limited metacognitive abilities in the latter group (Mandarelli et al., 2011).

Sexual fantasies

The sexual fantasies of persons with psychotic disorders and other psychiatric disorders were explored in one study. No differences were observed for the types of fantasies experienced between different diagnostic groups (Colon Vilar et al., 2016).

Discussion

The goal of the current systematic review was to collect, evaluate, and synthesize quantitative findings published in the last 15 years on romantic relationships, sexuality, and psychotic disorders. This led to a final selection of 43 studies, 24 of which were categorized as obstacle-related (i.e., focusing on negative aspects of romantic relationships or sexuality) and 19 of which were deemed neutral or recovery-oriented (i.e., focusing on positive aspects of romantic relationships or sexuality). In light of the societal stigma placed upon people with psychiatric conditions as romantic partners (Elkington et al., 2013, Wright et al., 2007), we found surprising to obtain similar numbers of obstacle-related studies and neutral/recovery-oriented studies. This may be indicative of changing attitudes towards serious mental conditions like psychosis, even if a global shift is unlikely due to cultural differences in the conception and treatment of mental illness (Bhugra et al., 2016). Because romantic relationships are known to have a protective effect

against emerging and worsening mental health problems in both young and older adults (Braithwaite et al., 2010; Braithwaite & Holt Lunstad, 2017), future studies must also take care to address intimacy and sexuality issues that are personally meaningful to consumers (e.g., disclosure to a partner, improving spousal communication) rather than focusing solely on symptoms or aspects of romantic relationships that are less amenable to change (Seeman, 2013; Ostman & Bjorkman, 2013).

Five major topics were addressed in studies categorized as obstacle-related (i.e., sexual risk behavior, abnormal sexual behavior, sexual dysfunction, intimate partner violence, stigma) and six major topics were discussed in studies categorized as neutral or recovery-oriented (i.e., marital and sexual functioning, sexual self-perception, relationships, family planning and reproductive health, consent to sexual activity, sexual fantasies). Most of these studies were descriptive, neglecting contextual factors, transactional processes and longitudinal pathways, unlike much of the recent literature on romantic relationships and sexuality in healthy adolescents and adults (Rauer et al., 2013; Van de Bongardt et al., 2015). In addition, several relevant topics, including attachment, dyadic adjustment, and impact of various life stresses (e.g., parenthood, experiences of separation or divorce, living arrangements and financial circumstances, etc.) are largely overlooked in studies involving samples with psychotic disorders, yet are extensively studied among members of the general population or individuals with more common psychiatric disorders (Falconier & Kuhn, 2019; Simpson & Rholes, 2017). These disparities must be addressed if we are to improve the quality of patients' romantic and sexual lives.

Many of our findings are consistent with those reported in McCann and colleagues' (2019) qualitative systematic review. For example, evidence for increased sexual risk behavior and exposure to violence among individuals with serious mental illness, particularly women, was largely unequivocal across reviews. In both cases, stigma was also found to decrease one's self-esteem and inhibit romantic relationships, although articles addressing this topic were much fewer in the present review. The studies included in our review featured the role of mental health practitioners, gender and sexual identity issues, and family and partner support to a lesser extent than those described in McCann and colleagues' (2019) review, highlighting significant gaps in the quantitative literature and important directions for subsequent research. From an applied standpoint, data from both reviews suggest that staff training should be enhanced in order to detect and adequately respond to patients' intimacy and sexuality concerns. The development of specialized services for singles and couples living with a psychotic disorder is also recommended, as such resources would help promote individual well-being as well as more positive interactions between partners (Helu-Brown & Aranda, 2016; McCann et al., 2019).

The overall quality of the studies was in the poor-to-moderate range. This can mostly be explained by methodological issues, as many studies had small convenience samples and only a few studies included control groups. Furthermore, several studies were poorly translated from their original language to English and lacked clarity when describing methods and reporting results. Future work will require larger, well-controlled studies and should include more standardized and objectives measures.

Limitations and recommendations

The current systematic review presents certain limitations. First, additional terms could have been added to the initial article search (e.g., marriage* or wife* or husband* or girlfriend* or boyfriend*) to be more inclusive. This may have led to the identification of other relevant articles and consequently, more diverse findings. However, such terms are less common in the literature, and we obtained a high volume of articles (N = 10,958) without including them. Second, we excluded all studies with samples under 18 years of age. Given that some initial psychotic episodes occur during adolescence (Ballageer et al., 2005) and that youth often begin dating before they reach adulthood (La Greca & Harrison, 2005), we may have excluded several pertinent articles in this age group. Future reviews could benefit from including studies with adolescent samples, particularly those with longitudinal designs so that the effects of romantic relationships on psychosis can be better quantified across time. Third, we did not include more recognized databases, such as Cochrane, when conducting our initial article search. Although we may have missed some higher quality studies as a result, it is likely that very few articles addressing our research question would have been identified using these databases. This illustrates a need for more and better-quality research on romantic relationships in persons with psychotic disorders. We also did not employ intensive thematic analysis when classifying articles into topic and direction categories, choosing instead to revise our classification scheme until a final consensus was reached among all authors. Of import, the studies included in our review were also conducted in various countries around the world. This has the advantage of increasing the generalizability of the results, but can be a limitation given that marriage and sexuality are culturally-influenced. For instance, in some East Asian countries, it is believed that marriage can heal mental illness, leading to higher marriage rates among individuals with psychiatric disorders than in Western countries (Behere et al., 2011; Srivastava, 2013).

To our knowledge, this systematic review is the first to collect and synthesize quantitative data on romantic relationships and sexuality in the context of a psychotic disorder diagnosis since McCann's review in 2003. Our results highlight a need for greater communication and assistance in the areas of intimacy and sexuality for people with psychotic disorders. Indeed, many individuals with a psychotic disorder feel that they lack the experience and resources to engage in romantic relationships (Redmond et al., 2010; White et al., 2019). Although efforts to understand and address these issues have increased in recent years, corresponding services (e.g., romantic skill-building and couples therapy programs) are still virtually non-existent. If we are to help people with psychotic disorders achieve greater success in this important aspect of recovery, better access to resources and more consumer-oriented research is needed.

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Article 2

Evaluating romantic and sexual functioning among persons with psychosis: Reliability and validity of two measures[2]

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Abstract

Despite increasing recognition of the difficulties faced by persons with psychosis with respect to romantic relationships and sexuality, there is a lack of valid and reliable instruments to measure these areas of functioning in this population. Objective: This study aimed to evaluate the psychometric properties (i.e., construct and convergent validity, internal consistency, test-retest reliability) of two measures, the Multidimensional Sexuality Questionnaire (MSQ) and the Romantic Relationship Functioning Scale (RRFS), in a sample of individuals with schizophrenia-spectrum disorders. Methods: Participants (N = 196) were administered a series of questionnaires online, with a subset of 40 respondents agreeing to complete the MSQ and the RRFS a second time at a two-week follow-up. Confirmatory factor analyses were employed to examine the construct validity of both measures, while internal consistency estimates and correlation coefficients were computed to assess each instrument's reliability and convergent validity. Results: The original factor structures of the MSQ and the RRFS were found to be acceptable, with alphas ranging from 0.68 to 0.94 and 0.74 to 0.86, respectively. Test-retest reliability and convergent validity with other measures (First-Episode Social Functioning Scale (FESFS) – Intimacy subscale, Self-Esteem Rating Scale – Short Form (SERS-SF), Brief Symptom Inventory (BSI) – Anxiety and Depression subscales) were also demonstrated. Conclusions and Implications for Practice: Future research should replicate these findings in larger samples and other languages, as well as evaluate additional aspects of the instruments' quality. Clinicians may benefit from using these tools to better understand the romantic and sexual needs of services users with psychosis and offer corresponding services.

Key words: Romantic relationships, sexuality, psychosis, validity

Introduction

Psychotic disorders, such as schizophrenia, are often associated with poor social functioning, which encompasses independent living skills (e.g., cleaning, cooking, hygiene), interpersonal relationships, and academic and occupational performance (Lecomte et al., 2008a; Velhorst et al., 2017). In the interpersonal domain, romantic relationships and sexuality seem to be especially challenging. In fact, many individuals with a psychotic disorder continue to struggle with dating and romantic relationships despite having established strong social ties with family and friends (Redmond et al., 2010). In addition to social skills deficits, attachment difficulties, such as fears of proximity or abandonment, issues with self-esteem and stigma, and sexual dysfunctions resulting from medication, all contribute to this group's lower functioning in romantic relationships (de Jager & McCann, 2017; Pillay et al., 2018; Redmond et al., 2010). Although healthy romantic relationships have been found to promote recovery from mental illness (Boucher et al., 2016; Braithwaite & Holt-Lunstad, 2017), romantic relationship functioning is rarely addressed by health professionals and few tools are currently available to adequately evaluate the romantic and sexual functioning of persons with a psychotic disorder (Cloutier et al., 2020; McCann et al., 2019).

To date, most instruments measuring romantic and sexual functioning among individuals with psychotic disorders have focused on identifying various sexual dysfunctions. The Arizona Sexual Experiences Scale (ASEX; McGahuey et al., 2000) is a rating scale designed to assess sexual dysfunction across five domains: drive, arousal, penile erection/vaginal lubrication, ability to achieve orgasm, and satisfaction with orgasm. It can be self- or clinician-administered, with total scores ranging from 5 to 30 and higher scores indicating greater sexual dysfunction. Despite

having demonstrated high internal consistency, high test-retest reliability, and convergent and discriminant validity in psychiatric populations (Rizvi et al., 2011), each domain is evaluated using a single item and the last three questions are only completed if the respondent has been sexually active in the past month. Given the lower rates of sexual activity among persons with a psychotic disorder compared to other disorders (Bianco et al., 2019; Cloutier et al., 2020), as well as the impact of other factors (e.g., fear and anxiety due to past trauma and discrimination; de Jager & McCann, 2017) on this group's sexual behavior, the ASEX may provide only a limited assessment of the sexual difficulties experienced in the context of a mental disorder. Similarly, the Psychotropic-Related Sexual Dysfunction Questionnaire (PR-SexDQ; Montejo & Rico-Villadermoros, 2008) is a 7-item clinician-administered rating scale that evaluates the presence of sexual dysfunction with respect to desire, arousal, and orgasm, as well as the respondent's subjective tolerance of the sexual dysfunction. Total scores range from 0 to 15, with higher scores indicating greater sexual dysfunction. Like the ASEX, the PR-SexDQ has demonstrated adequate reliability and validity in clinical populations (Montejo & Rico-Villadermoros, 2008), but does not explore alternative explanations for patients' sexual difficulties.

While the above measures can help detect problems at different stages of sexual activity among individuals with psychotic disorders, they are restricted to evaluating sexual dysfunctions at a physical level (mostly medication-induced) and fail to assess psychological factors that might influence respondents' overall sexual functioning. In this regard, the Derogatis Sexual Functioning Inventory (DSFI; Derogatis & Melisaratos, 1979) may provide a more detailed picture of respondents' sexual lives and functioning, as it touches upon themes such as experiences, attitudes, and body image. However, the original DSFI takes considerable time to complete and its

subsequent, condensed version (Derogatis Interview for Sexual Functioning – Self-Report (DISF-SR; Derogatis, 1997) utilizes separate forms for males and females, thereby excluding people with a non-binary gender identity. Thus, a non-gendered, self-report questionnaire that considers various psychological facets of the human sexual experience, such as the Multidimensional Sexuality Questionnaire (MSQ; Snell et al., 1993), may be better suited to identify specific targets for intervention. Indeed, the MSQ includes questions about confidence, self-awareness, and ability to communicate one's needs during sexual encounters, as well as distress linked to sexual experiences. However, the MSQ has never been empirically validated among persons with psychosis.

In addition to sexual functioning measures, high-quality instruments are also needed to assess this group's broader romantic functioning. To our knowledge, only the Romantic Relationship Functioning Scale (RRFS; Bonfils et al., 2016) has been specifically developed for use with people with serious mental illness and asks about perceived resources and obstacles associated with dating and committed relationships. Unfortunately, its psychometric properties have never been evaluated in a sample of individuals with psychosis.

There is a clear need for valid and reliable tools that can be used to evaluate this population's romantic and sexual functioning, and consequentially, offer corresponding services to improve their dating lives (Helu-Brown & Aranda, 2016; Lecomte et al., 2005). Given the potential research and clinical utility of the MSQ and the RRFS, the goal of the present study was to conduct a preliminary validation (i.e., construct validity, internal consistency, convergent validity, test-retest reliability) of these two instruments among persons with psychosis.

Methods

Participants

A total of 196 participants were recruited and self-referred from several clinics specializing in psychosis, as well as ads posted online (i.e., Facebook groups for people with psychosis, community mental health social media platforms). Individuals were included if they were 18 years of age or older, could read and understand either English or French, and had reported having been formally diagnosed with a schizophrenia-spectrum disorder (e.g., schizophrenia, schizoaffective disorder, schizophreniform disorder, etc.) or a mood disorder with psychotic features (e.g., bipolar I disorder, major depressive disorder). Descriptive statistics for the study sample can be found in Table 1.

Table 1. Participant characteristics

Characteristic		Total (N = 196)	
		n	%
Age		35.78 ± 11.84	
Mother tongue			
	French	88	44.9
	English	83	42.3
	Other	25	12.8
Gender identity			
	Cis man	72	36.7
	Cis woman	93	47.4
	Gender fluid	12	6.1
	Trans man	7	3.6
	Trans woman	2	1.0
	Does not identify with any option	7	3.6
	Prefers not to answer	3	1.5
Sexual orientation			
	Asexual	8	4.1
	Bisexual	39	19.9
	Gay	4	2.0
	Heterosexual	115	58.7
	Lesbian	3	1.5
	Queer	5	2.6
	Questioning	4	2.0
	Two-spirited	2	1.0
	Unsure	5	2.6
	Does not identify with any option	9	4.6
	Prefers not to answer	2	1.0
Civil status			
	Single	91	46.4
	In a relationship	45	23.0
	Common-law partner	13	6.6
	Married	26	13.3
	Separated/divorced	20	10.2
	Widowed	1	0.5
Education level			
	No high school diploma	25	12.8
	High school diploma	70	35.7
	College degree	19	9.7
	Bachelor’s degree	51	26.0
	Master’s or Doctorate degree	31	15.8
Occupation			

Working	74	37.8
Studying	37	18.9
Supported employment or vocational program	10	5.1
No occupation	47	24.0
Other (e.g., volunteering)	28	14.3
Source of income		
Work	55	28.1
Loan or scholarship	6	3.1
Parental assistance	14	7.1
Social assistance	56	28.6
Multiple sources	24	17.3
Other (e.g., spouse's salary)	31	15.8
Primary diagnosis		
Schizophrenia	74	37.8
Schizoaffective disorder	67	34.2
Schizophreniform disorder	1	0.5
Mood disorder with psychotic features	35	17.9
Other psychosis or unspecified	19	9.7

Measures

A sociodemographic questionnaire was used to collect descriptive data and included items relating to age, gender, sexual orientation, education level, civil and work status, as well as participants' current financial and living situation, and self-reported psychiatric diagnoses. Convergent validity was assessed using the Intimacy subscale of the First-Episode Social Functioning Scale (FESFS; Lecomte et al., 2014), the Self-Esteem Rating Scale – Short Form (SERS-SF; Lecomte et al., 2006), and the Anxiety and Depression subscales of the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983). The FESFS, the SERS-SF, and the BSI are available both in English and in French and have been validated in psychiatric samples (Derogatis & Melisaratos, 1983; Lecomte et al., 2006; Lecomte et al., 2014).

The FESFS is a 24-item self-report questionnaire that measures social functioning in different areas of life (e.g., independent living skills, relationships, school and/or work abilities). The Intimacy subscale contains 11 items and asks about attitudes and behaviors associated with recent dating experiences, romantic and sexual partners, and emotional intimacy. Higher scores on this subscale indicate greater intimate relationship functioning. Example items for the FESFS Intimacy subscale include ''*I feel I am able to share feelings, inner thoughts, and be close with my stable boy/girlfriend or spouse (when I have one)*'' (attitude) and ''*In the last three months, I have had sexual relations with someone*'' (behavior). This FESFS Intimacy subscale was chosen as a convergent measure because it is one of the few validated instruments measuring a construct closely related to romantic and sexual functioning.

The SERS-SF is a 20-item self-report questionnaire that measures positive and negative aspects of self-esteem, with higher, positively valued total scores indicating better self-esteem. Example items for the SERS-SF include ‘‘*I feel that I make a good impression on others*’’ and ‘‘*I feel that I am likely to fail at things I do*’’. The BSI is a self-report questionnaire that measures a variety of psychiatric symptoms. The Anxiety and Depression subscales of the BSI are composed of 5 items each, with higher subscale scores indicating greater symptom severity. Example items for the BSI Anxiety and Depression subscales include ‘‘*In the past 7 days, how often were you bothered by spells of terror or panic?*’’ and ‘‘*In the past 7 days, how often were you bothered by feeling blue?*’’. The SERS-SF and the BSI subscales were chosen as convergent measures because they assess constructs that are linked, albeit indirectly, to romantic and sexual functioning, as self-esteem and psychopathology have been shown to influence relationship and sexual health outcomes (e.g., satisfaction, self-efficacy, well-being; Harris & Orth, 2020; Orth et al., 2012; Reinhard et al., 2020; Sakulak et al., 2019). Moreover, low self-esteem is common in samples with psychosis and has been linked to this group’s self-perceptions of their social abilities (Benavides et al., 2018). The Anxiety and Depression subscales of the BSI were specifically selected over other subscales because they reflect symptoms that are experienced by a wide range of individuals, while also frequently displaying comorbidity with psychosis (Wilson et al., 2020). Thus, we expected self-esteem, anxious and depressive symptoms to be negatively associated with romantic and sexual functioning. We also expected a negative association between self-esteem and anxious and depressive symptoms.

The MSQ and the RRFS were the primary measures of interest for this study. The MSQ had previously been translated to French (Ravart et al., 1993), while a French translation of the

RRFS was completed by our team using the back-translation method. This procedure involves translating a document into a different language before re-translating it back into the original source language and reconciling discrepancies between the two versions (Vallerand, 1989).

The MSQ is a 60-item self-report questionnaire that measures several tendencies associated with human sexuality across 12 subscales: sexual self-esteem, sexual preoccupation, internal sexual control, sexual consciousness, sexual motivation, sexual anxiety, sexual assertiveness, sexual depression, external sexual control, sexual self-monitoring, fear of sexual relations, and sexual satisfaction. Higher subscale scores indicate greater levels of each respective sexual tendency. Example items for the MSQ include questions such as ''*I am very alert to changes in my sexual desires*'' and ''*I am disappointed in the quality of my sex life*''.

The RRFS is a 22-item questionnaire assessing various aspects of romantic competence, including beliefs and attitudes about romantic relationships, perceived social skills, and self-confidence. It contains the following three subscales: Resources, Risks, and Stigma. These subscales measure respondents' subjective perceptions of possible risks, personal resources, and stigmatizing experiences in dating and romantic relationships. Higher subscale and total scores are indicative of greater romantic relationship functioning. Example items for the RRFS include questions such as ''*I am good at communicating in romantic relationships*'' and ''*I am scared that a romantic partner would take advantage of me*''.

Procedure

Data was collected between July 2020 and April 2022. After providing informed consent, participants completed each of the above measures online through the Qualtrics platform. In addition, a subset of participants (n = 40) agreed to complete the MSQ and the RRFS twice to measure test-retest reliability, with the second administration occurring two weeks after the first. No financial compensation was offered for taking part in the study, but participants were automatically entered into a draw to win an iPad once data collection was completed. The project was evaluated and approved by the Institut universitaire en santé mentale de Montréal's ethics committee (project number: MP-12-2020-2138).

Analyses

Confirmatory factor analyses were performed using R version 4.0.0 to evaluate the construct validity of the MSQ and the RRFS subscales as originally conceptualized (Bonfils et al., 2016; Snell et al., 1993). Confirmatory factor analyses are generally preferred over other methods (e.g., exploratory factor analysis, principal component analysis) when testing a theoretical model of latent factors (Schmitt, 2011). Internal consistency calculations (Cronbach's alpha) were also computed in SPSS version 27, as were correlational analyses in order to assess convergent validity and test re-test reliability.

Results

CFA and internal consistency

As can be seen in Table 2, a 12-factor structure was endorsed for the MSQ. Model fit indices were acceptable (Fan et al., 1999; Hu & Bentler, 1999), with a Root Mean Square Error of Approximation (RMSEA) of 0.05, Standardized Root Mean Square Residual (SRMR) of 0.09,

Comparative Fit Index (CFI) of 0.88, and Tucker-Lewis Index (TLI) of 0.87. All items loaded significantly on their respective factors, ranging from 0.30 to 0.92. The highest factor loadings were observed for the Sexual Preoccupation and Sexual Satisfaction subscales. The weakest factor loadings were observed for the Internal Sexual Control and Sexual Monitoring subscales, including items 15, 34, and 39. Internal consistency coefficients were acceptable to excellent, ranging from 0.68 to 0.94. Global scores for the Positive and Negative aspects of the MSQ were also computed, with internal consistency estimates of 0.90 and 0.93, respectively.

Table 2. CFA and internal consistency of MSQ

Proposed subscale and associated items		Factor loading (standardized Beta)	z-statistic
Sexual self-esteem (α = 0.88)			
	Item 1	0.730	N/A
	Item 13	0.821	11.352***
	Item 25	0.712	9.264***
	Item 37	0.869	12.007***
	Item 49	0.730	10.227***
Sexual preoccupation (α = 0.94)			
	Item 2	0.846	N/A
	Item 14	0.824	15.021***
	Item 26	0.626	9.856***
	Item 38	0.898	19.890***
	Item 50	0.902	19.650***
Internal sexual control (α = 0.68)			
	Item 3	0.398	N/A
	Item 15	0.304	3.27**
	Item 27	0.744	3.799***
	Item 39	0.317	3.547***
	Item 51	0.762	4.067***
Sexual consciousness (α = 0.74)			
	Item 4	0.635	N/A
	Item 16	0.766	9.310***
	Item 28	0.437	5.192***
	Item 40	0.502	5.949***
	Item 52	0.719	7.253***
Sexual motivation (α = 0.90)			
	Item 5	0.828	N/A
	Item 17	0.804	14.84***
	Item 29	0.779	13.323***
	Item 41	0.814	14.540***
	Item 53	0.767	13.416***
Sexual anxiety (α = 0.85)			
	Item 6	0.690	N/A
	Item 18	0.629	7.972***
	Item 30	0.766	8.889***
	Item 42	0.619	8.447***
	Item 54	0.833	11.596***
Sexual assertiveness (α = 0.77)			
	Item 7	0.504	N/A
	Item 19	0.489	5.178***
	Item 31	0.465	4.941***
	Item 43	0.859	6.465***
	Item 55	0.757	6.553***
Sexual depression (α = 0.89)			

	Item 8	0.732	N/A
	Item 20	0.838	15.777***
	Item 32	0.886	15.396***
	Item 44	0.834	13.441***
	Item 56	0.650	10.074***
External sexual control (α = 0.85)			
	Item 9	0.690	N/A
	Item 21	0.782	11.056***
	Item 33	0.857	10.935***
	Item 45	0.821	10.127***
	Item 57	0.542	6.278***
Sexual monitoring (α = 0.82)			
	Item 10	0.627	N/A
	Item 22	0.845	7.563***
	Item 34	0.353	3.853***
	Item 46	0.784	7.692***
	Item 58	0.782	7.947***
Fear of sexual relations (α = 0.86)			
	Item 11	0.749	N/A
	Item 23	0.900	13.771***
	Item 35	0.893	12.406***
	Item 47	0.695	9.987***
	Item 59	0.421	5.545***
Sexual satisfaction (α = 0.90)			
	Item 12	0.800	N/A
	Item 24	0.871	16.746***
	Item 36	0.709	10.824***
	Item 48	0.680	9.469***
	Item 60	0.922	17.286***

N.B.: [a]** = $p \leq .01$; [b]*** = $p \leq .001$

As shown in Table 3, a 3-factor structure was also confirmed for the RRFS. Model fit indices were good (Fan et al., 1999; Hu & Bentler, 1999), with a RMSEA of 0.06, SRMR of 0.08, CFI of 0.91, and TLI of 0.89. All items loaded significantly on their respective factors, ranging from 0.28 to 0.80. The highest factor loadings were observed for the Resources and Stigma subscales. The weakest factor loadings were observed for the Resources and Risks subscales, including items 4 and 6. Internal consistency coefficients were acceptable to good, ranging from 0.74 to 0.86. A global score for the RRFS was also computed, with an internal consistency estimate of 0.89.

Convergent validity and test-retest reliability

Correlation coefficients between each measure of interest (MSQ, RRFS) and the FESFS Intimacy subscale, the SERS-SF, and the BSI Anxiety and Depression subscales can be found in Table 4. MSQ Positive and Negative scores were significantly correlated with FESFS Intimacy and SERS-SF scores. MSQ Negative scores were also correlated with BSI Anxiety and Depression scores, although MSQ Positive scores were not. Meanwhile, RRFS scores were significantly correlated with all convergent measures. Test-retest reliability was high for both MSQ Positive ($r = .90$, $p < .001$) and Negative ($r = .93$, $p < .001$) scores, as well as RRFS scores ($r = .90$, $p < .001$).

Table 3. CFA and internal consistency for the RRFS

Proposed subscale and associated items		Factor loading (standardized Beta)	z-statistic
Resources (α = 0.86)			
	Item 1	0.430	N/A
	Item 2	0.697	5.309***
	Item 3	0.658	5.758***
	Item 4	0.278	3.408**
	Item 7	0.550	4.660***
	Item 8	0.454	5.591***
	Item 11	0.487	4.189***
	Item 12	0.803	5.675***
	Item 14	0.561	5.078***
	Item 15	0.587	4.613***
	Item 17	0.780	5.365***
	Item 18	0.464	4.857***
	Item 22	0.617	4.724***
Risks (α = 0.77)			
	Item 6	0.394	N/A
	Item 10	0.646	4.138***
	Item 13	0.581	4.021***
	Item 16	0.732	3.705***
	Item 20	0.699	3.897***
	Item 21	0.610	3.715***
Stigma (α = 0.74)			
	Item 5	0.587	N/A
	Item 9	0.737	7.599***
	Item 19	0.762	7.022***

N.B.: [a]** = $p \leq .01$; [b]*** = $p \leq .001$

Table 4. Convergent validity for the MSQ and the RRFS

	1	2	3	4	5	6	7
1. MSQ Positive (α = 0.90)							
2. MSQ Negative (α = 0.93)	-.22**						
3. RRFS Global (α = 0.89)	.39**	-.52**					
4. FESFS Intimacy (α = 0.75)	.53**	-.26**	.51**				
5. SERS Global (α = 0.94)	.33**	-.45**	.63**	.23**			
6. BSI Anxiety (α = 0.88)	-.04	.33**	-.32**	-.02	-.55**		
7. BSI Depression (α = 0.89)	-.06	.44**	-.36**	-.10	-.62**	.60**	

N.B.: [a]** = $p \leq .01$

Discussion

This study aimed to evaluate the psychometric properties (i.e., construct validity, internal consistency, convergent validity, test-retest reliability) of two instruments measuring romantic and sexual functioning among persons with psychosis. Results showed that the MSQ and the RRFS can be used as originally intended with this population. The MSQ allows for a more comprehensive examination of sexual functioning than existing instruments due to its 12 subscales that measure constructs beyond sexual dysfunction, while the RRFS can inform mental health professionals about clients' functioning in romantic relationships and offer assistance in areas of special concern (e.g., resources). The lack of valid and reliable questionnaires for assessing romantic and sexual functioning among individuals with a psychotic disorder ultimately hinders advancements in research and clinical settings. Thus, it is our hope that the present study will stimulate greater scientific interest in this topic and lead to the development of corresponding services.

Observed differences in convergent validity for the MSQ Positive and Negative scores are worthy of further exploration. It is interesting to note that the BSI Anxiety and Depression subscales were uncorrelated with the MSQ Positive scores but significantly correlated with the MSQ Negative scores. One potential explanation for this finding is that the MSQ Negative score

includes items from both the Sexual Anxiety and Sexual Depression subscales. Respondents with greater anxious and/or depressive symptoms may also experience higher levels of anxiety and depression in the context of sexual experiences (Montejo, 2019; Soler et al., 2021). However, RRFS scores were also found to be significantly correlated with the BSI's Anxiety and Depressions scores. This is likely a reflection of the wording and content of several items in the RRFS, as many questions pertain to adverse dating experiences (e.g., rejection, loss, etc.). As such, participants' responses may have revealed associations between general psychopathology and negative experiences in romantic relationships. This finding highlights an important avenue for future research.

Future work should also consider optimizing the MSQ by reducing the length of the measure, as well as improving certain subscales (e.g., Internal Sexual Control, Sexual Consciousness, Sexual Assertiveness, Sexual Monitoring). Similarly, the RRFS could be enhanced by refining and/or adding items to the Risks and Stigma subscales. Future studies would also benefit from examining the psychometric properties of both instruments in other languages.

These findings must be considered in light of the present study's limitations. First, participants' psychiatric diagnoses were self-reported and therefore, could not be verified. Although we removed any entries where diagnostic information was unclear or did not meet our inclusion criteria, the accuracy of the remaining cases cannot be fully guaranteed. Second, other factors reflecting instrument quality (e.g., discriminant validity, sensitivity to change) were not explored and will need to be investigated in independent samples. Finally, responses for the English and French versions of both questionnaires were combined rather than analyzed separately

due to our small sample size. Thus, language-based properties of each measure could not be examined here but should be assessed in subsequent studies.

In conclusion, this study evaluated the psychometric properties of two instruments measuring romantic and sexual functioning, the MSQ and the RRFS, among persons with psychosis. Given that both measures were found to be valid and reliable when used with this population, researchers and clinicians may benefit from employing these tools to better understand the romantic and sexual experiences of individuals with a psychotic disorder. Such initiatives would allow for greater communication between service providers and consumers, ultimately enhancing service delivery. By taking interest in the romantic and sexual needs of this population beyond concerns with sexual dysfunction, we can move away from pathological models of mental illness towards recovery-oriented care, where interactions between people with psychosis, professionals, and stakeholders are less stigmatizing and more constructive (Andresen et al., 2011; Drake & Whitley, 2014).

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Article 3

Improving romantic relationship functioning among young men with first-episode psychosis: Impact of a novel group intervention[3]

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Abstract

Previous research has highlighted many of the challenges faced by individuals with psychosis in romantic relationships. The aim of the present study was to evaluate the impact of a novel group intervention for men with first-episode psychosis (FEP) on dating success, romantic and sexual functioning, self-esteem, self-stigma, mentalizing skills, and symptomatology, while using a repeated single-case experimental design and comparing results across two treatment modalities (i.e., in-person or online). Twenty-seven participants from 5 treatment sites completed a 12-week group intervention. Qualitative data was also collected to assess participants' subjective experiences with the program. In both modalities, significant improvements were observed for romantic functioning, mentalizing skills, and symptomatology, with effect sizes ranging from small to large. Several participants also attended more romantic dates and entered committed relationships after the intervention. Most participants indicated being satisfied with the program and many felt that they had learned new skills and gained confidence in dating. Future research should replicate these findings in larger and more inclusive samples.

Key words: Romantic relationships, sexuality, psychosis, group intervention, videoconferencing

Introduction

The ability to form and maintain healthy romantic relationships is considered a critical developmental task and defining feature of the transition to adolescence or early adulthood (Collins, 2003; Furman et al., 2007). Failure to initiate and sustain positive romantic experiences during this period can have deleterious consequences for an individual's long-term well-being and broader social functioning, as limited learning experiences hinder interpersonal skills acquisition (Rauer et al., 2013; Schulenberg et al., 2004). Unfortunately, emerging psychiatric symptoms may also interfere with one's achievement of important social milestones, such as developing romantic relationships (Goldstein et al., 2017; Redmond et al., 2010). This would seem to be especially true for individuals living with a psychotic disorder, for whom romantic relationships are much more difficult to navigate (Redmond et al., 2010).

Previous research has identified several obstacles to successful romantic relationships among persons with psychotic disorders, including stigma (de Jager & McCann, 2017; Latour-Desjardins et al., 2019; Van Dorn et al., 2005) and attachment difficulties (Gabinio et al., 2018; Harder, 2014; Pillay et al., 2018), social-cognitive deficits (Fett et al., 2011; Sprong et al., 2007), and medication side effects (e.g., sexual dysfunctions and weight gain; Addington et al., 2003; de Boer et al., 2015). Indeed, traumatic and discriminatory experiences are frequently reported (Van Dorn et al., 2005; Varese et al., 2012), as are low self-esteem and poor communication skills (Dickinson et al., 2007; Lysaker et al., 2007). While both men and women with a psychotic disorder are more likely to face additional challenges when dating compared to members of the general population, men may be at an even greater disadvantage due to an earlier and often more severe onset of the first psychotic episode (Cotton et al., 2009; Thorup et al., 2007).

In addition to pharmacological treatments, numerous psychosocial interventions have been developed to facilitate recovery from psychosis. Cognitive-behavioral therapy (CBT) has been found to reduce positive symptoms (e.g., hallucinations and delusions; Lecomte et al., 2019; Turner et al., 2014), whereas social-skills training (SST) has been shown to improve negative symptoms (e.g., apathy and social withdrawal; Kurtz & Mueser, 2008; Turner et al., 2014). An intervention aiming to improve romantic relationship functioning among individuals with psychosis could incorporate principles from both CBT and SST in order to target previously identified issues in dating and relationships. For example, cognitive restructuring might be employed to address negative or distressing beliefs that contribute to avoidance or conflict in romantic relationships (Gould et al., 2001). At the same time, various interpersonal skills (e.g., using verbal and non-verbal cues to signal one's interest, communicating emotions and problem-solving with a partner) can also be modeled by therapists and practiced by clients until sufficient competence is achieved (Browne et al., 2020). Thus, a program combining evidenced-based techniques from each approach may be more likely to promote success in romantic and sexual encounters than either treatment model alone.

Group therapy has been recognized as an effective treatment modality for a wide variety of psychological conditions (Burlingame et al., 2003; Burlingame et al., 2016). In psychiatry, group interventions may even be favored over individual therapy because of their cost-effectiveness (Tucker & Oei, 2007) and distinct therapeutic processes (e.g., normalisation of experiences, vicarious learning) that can only occur in a group setting (Yalom & Leszcz, 2005). Among persons with psychosis specifically, group therapy has been found to promote better clinical, social, and

functional outcomes (Burlingame et al., 2020; Orfanos et al., 2015), particularly at earlier stages of the disorder (i.e., first-episode psychosis (FEP); Lecomte et al., 2008; Lecomte et al., 2012).

The COVID-19 pandemic has generated significant interest in the use of videoconferencing to conduct therapy. Several studies have found videoconferencing to be a feasible and acceptable method for delivering psychological interventions (Backhaus et al., 2012; Batastini et al., 2020), although most research to date has focused on individual therapy. A recent study on group teletherapy for people with early psychosis suggests that this treatment modality may produce similar results to traditional in-person group interventions (Lecomte et al., 2020). Given the increasing use of videoconferencing in therapy and other benefits of this treatment modality (e.g., greater accessibility to services in remote areas), further research on group teletherapy is needed (Lecomte et al., 2020).

In light of the unique difficulties faced by individuals with psychotic disorders with respect to their romantic relationships and repeated requests for greater assistance in this area (Cloutier et al., 2020), our team developed a novel group intervention for men with psychosis seeking to improve their dating lives. Having obtained preliminary evidence of the program's impact in a recent pilot study (Hache-Labelle et al., 2020), the goal of the present study was to extend these findings by evaluating its effect on dating success, romantic and sexual functioning, self-esteem and self-stigma, mentalizing skills, and symptomatology in a different sample of young men with FEP using a within-subject, repeated single-case experimental design, as well as compare results across two treatment modalities (i.e., in-person or online via videoconferencing). Qualitative data was also collected to assess participants' subjective experience with the program.

The primary dependent variables of this study were dating success, romantic functioning, and sexual functioning. These outcomes were specifically selected because they directly reflected the objectives of the proposed intervention. Secondary dependent variables (self-esteem, self-stigma, mentalizing skills, symptomatology) were also included due to their indirect but nonetheless meaningful relationship to dating and sexuality. When compared to baseline, it was hypothesized that:

1. Dating success (i.e., number of dates and number of committed relationships) would increase after receiving the intervention.
2. Romantic and sexual functioning would increase after receiving the intervention.
3. Self-esteem and mentalizing skills would increase after receiving the intervention.
4. Self-stigma and symptomatology would decrease after receiving the intervention.

Methods

Design

This mixed-method study included a multi-site, multiple baseline single-case experimental design (SCED), with both primary and secondary outcome measures, as well as two different treatment modalities (in-person and online via videoconferencing). SCEDs aim to test the effect of an intervention using a small number of participants and repeated, systematic measurements (Krasny-Pacini & Evans, 2017). Participants act as their own controls over time as baseline phases are compared to subsequent phases where a treatment is generally introduced (Smith, 2012). Assignment to treatment modality was non-randomized as the intervention was offered in the

format that the treatment site had pre-determined. Thus, some treatment sites only offered the intervention in-person, while others only offered it online. These decisions were largely influenced by COVID-19 restrictions at the time of the study.

Participants

A total of 27 men between 20 and 36 years of age were recruited by service providers from three outpatient clinics in Montreal, Canada, as well as two outpatient clinics in Montpellier and Caen, France. Participants who expressed interest in the study were referred to the research coordinator. A poster advertising the project and the research team's contact information was also added to the waiting rooms of the clinics. To be eligible for the program, participants had identify as a heterosexual cisgender male, have experienced at least one psychotic episode (affective or non-affective), have stabilized symptoms (i.e., not in an acute phase of psychosis), and be able to read and understand French. Restrictions on gender identity and sexual orientation were included because we aimed for a more homogenous sample, which is generally recommended when evaluating a novel treatment with a small sample size (Jager et al., 2017). The presence of a psychotic episode or psychotic disorder diagnosis was confirmed by participants' treatment teams and consultation of their medical files. Individuals were excluded from the study if they were unable to consent to the study, if they had an organic disorder or mental disability, and if they were currently receiving psychotherapy services focusing on relational skills. Descriptive statistics for the study sample can be found in Table 1.

Table 1. Participant baseline characteristics

Characteristic	In-person group (n = 14)	Online group (n = 13)	Total (N = 27)
Age	28.15 ± 4.82	25.69 ± 5.22	26.96 ± 5.07
Recruited in Montreal	5 (35.7%)	13 (100%)	18 (66.7%)
Education level			
No high school diploma	5 (35.7%)	6 (46.2%)	11 (40.7%)
High school diploma	3 (21.4%)	4 (30.8%)	7 (25.9%)
College degree	1 (7.1%)	1 (7.7%)	2 (7.4%)
Bachelor's degree	3 (21.4%)	2 (15.4%)	5 (18.5%)
Master's or Doctorate degree	2 (14.3%)	0 (0%)	2 (7.4%)
Occupation			
Working	1 (7.1%)	4 (30.8%)	5 (18.5%)
Studying	2 (14.3%)	6 (46.2%)	8 (29.6%)
Supported employment or vocational program	7 (50.05%)	1 (7.7%)	8 (29.6%)
No occupation	2 (14.3%)	2 (15.4%)	4 (14.8%)
Other (e.g., volunteering)	2 (14.3%)	0 (0%)	2 (7.4%)
Living situation			
Alone	7 (50.0%)	1 (7.7%)	8 (29.6%)
With family	6 (42.9%)	11 (84.6%)	17 (63.0%)
Residential center	1 (7.1%)	1 (7.7%)	2 (7.4%)
Primary diagnosis			
Schizophrenia-spectrum disorder	11 (78.6%)	6 (46.2%)	17 (63.0%)
Mood disorder with psychotic features	1 (7.1%)	3 (23.1%)	4 (14.8%)
Other psychosis (e.g., episode)	2 (14.3%)	4 (30.8%)	6 (22.2%)

Measures

Participants were asked to fill out a brief socio-demographic questionnaire at baseline which included items relating to age, gender, education level, civil and work status, as well as participants' current financial and living situation, and psychiatric diagnoses. All other measures were administered at each of the four assessment sessions (T1 to T4).

Romantic functioning was measured using three instruments: the Romantic Relationship Functioning Scale (RRFS; Bonfils et al., 2016), the First Episode Social Functioning Scale – Intimacy subscale (FESFS; Lecomte et al., 2014), and a brief descriptive questionnaire on dating and committed relationships. The RRFS contains 22 items and three subscales (Risks, Resources, Stigma). These subscales measure respondents' subjective perceptions of possible risks, personal resources, and stigmatizing experiences in dating and romantic relationships. Higher subscale and global scores indicate better romantic relationship functioning (Risks and Stigma scores are reverse-coded). Sample items for the RRFS include ''*I am good at communicating in romantic relationships*'' and ''*I am scared that a romantic partner might take advantage of me*''. The FESFS Intimacy subscale contains 11 items and asks about attitudes and behaviors relating to recent dating experiences, romantic and sexual partners, and emotional intimacy. Higher global scores indicate better intimate relationship functioning. Sample items for the FESFS Intimacy subscale include ''*I feel I am able to share feelings, inner thoughts, and be close with my stable boy/girlfriend or spouse (when I have one)*'' (attitude) and ''*In the last three months, I have had sexual relations with someone*'' (behavior). The descriptive questionnaire on dating and committed relationships was created for the purpose of the study and asked two questions: how many dates they had attended in the last month and whether they had entered a committed

relationship in the last month (defined as both partners agreeing to exclusivity). If participants indicated having recently begun a committed relationship, they were also asked how long they had been dating this person (number of weeks).

Sexual functioning was measured using the Multidimensional Sexuality Questionnaire (MSQ; Snell et al., 1993), which contains 60 items and examines several tendencies associated with human sexuality, including awareness about sexual needs and preferences, emotions associated with sexual experiences, and sexual satisfaction. These tendencies are grouped into two categories reflecting positive and negative sexual functioning, respectively. Higher positive sexual functioning scores indicate between better sexual functioning, while higher negative sexual functioning scores indicate poorer sexual functioning. Sample items for the MSQ include ‘‘*I am very alert to changes in my sexual desires*’’ and ‘‘*I sometimes am fearful of sexual activity*’’. The RRFS, the FESFS, and the MSQ have demonstrated adequate reliability and validity in prior studies (Bonfils et al., 2016; Lecomte et al., 2014; Snell et al., 1993).

Self-esteem was measured using the Self-Esteem Rating Scale – Short Form (SERS-SF; Lecomte et al., 2006), which contains 20 assessing positive self-esteem (e.g., belief that one is interesting or has a good sense of humor) and negative self-esteem (e.g., feelings of shame or inferiority). Higher, positively-valued global scores indicate better self-esteem. Sample items for the SERS-SF include ‘‘*I feel that I make a good impression on others*’’ and ‘‘*I feel that I am likely to fail at things I do*’’. Self-stigma was measured using the Internalized Stigma of Mental Illness Scale (ISMIS; Ritsher et al., 2003), which contains 29 items and examines stigmatizing views including alienation and stereotype endorsement. Higher global scores indicate greater self-stigma.

Sample items for the ISMIS include ‘‘*People with mental illness cannot live a good, rewarding life*’’ and ‘‘*I am disappointed in myself for having a mental illness*’’. Social cognition abilities, specifically mentalization skills, were assessed using the Stories Test - Abridged Version (Achim et al., 2011). Respondents were asked to read 10 short stories and answer questions about the presence and nature of any implicit meanings in each story. Higher global scores on the Stories Test indicate better mentalizing skills. The SERS-SF, the ISMIS, and the Stories Test have also demonstrated adequate psychometric properties (Lecomte et al., 2006; Achim et al., 2011; Ritsher et al., 2003). Finally, a short qualitative questionnaire assessing participants' subjective experience with the program was also completed at T3. Respondents were asked by a research assistant what they liked and disliked about the group intervention, as well as whether they were generally satisfied with the program.

Symptomatology was measured using the Brief Psychiatric Rating Scale – Expanded Version (BPRS-E; Lukoff et al., 1986), a semi-structured interview conducted by raters trained to the UCLA gold standard (i.e., high inter-rater reliability with expert scores). The BPRS-E contains 26 items evaluating various aspects of psychopathology (e.g., anxiety, depression, suicidal ideation, delusions, hallucinations, etc.). Interviewers ask initial probe and follow-up questions before rating each symptom domain. Higher subscale and global scores indicate more frequent and severe symptoms. Sample items for the BPRS-E include ‘‘*Have you felt sad, depressed or down in the past two weeks?*’’ and ‘‘*Do you ever hear voices or sounds no one else hears?*’’. The BPRS-E has demonstrated good psychometric properties in psychiatric samples (Mouaffak et al., 2010).

Procedure

The project was evaluated and approved by the Centre hospitalier de l'Université de Montréal's ethics committee and was funded by the Fonds de Recherche du Québec and the Centre de recherche interdisciplinaire sur les problèmes conjugaux et les agressions sexuelles. This study followed a multi-site, repeated SCED. Although randomized controlled trials (RCTs) are considered the gold standard for evaluating the efficacy of a treatment, an SCED was favored in the present study because (1) drop-out rates tend to be extremely high (up to 80%) among individuals with a serious mental illness when they are randomized to a wait-list or treatment-as usual condition, which compromises internal validity, and (2) there is currently no validated treatment for romantic relationships that could be used as an active control condition (Lecomte et al., 2012). According to Smith (2012), SCEDs must show replication effects across a minimum of three conditions (e.g., subjects, settings, behaviors) to be of satisfactory methodological quality. Consequentially, different groups of participants received our intervention at different locations, and treatment effects were evaluated for different outcomes.

The outcomes of interest for this study included dating success, romantic and sexual functioning, self-esteem and self-stigma, mentalizing skills, and symptomatology. Given prior research showing improvements on both positive and negative symptoms of psychosis with CBT and SST interventions (Turner et al., 2014), we expected to see a decrease in participants' symptoms after our program. We also expected to see improvements on participants' romantic and sexual functioning due to our intervention's emphasis on dating and romantic skills, as well as advice for addressing sexual questions and concerns. Self-esteem was also expected to increase after the intervention as a consequence of increased knowledge acquisition and associated self-confidence. Similarly, self-stigma was expected to decrease after the intervention as a result of

participants' enhanced intimacy skills. Finally, we expected to see improvements on participants' mentalizing skills due to the program's teaching and practicing of the CBT model (i.e., seeking alternative explanations) in order to decipher ambiguous social situations. Each of these outcomes were assessed by a trained research assistant four weeks prior to the beginning of the intervention (T1), once immediately before (T2) and once immediately after the intervention (T3), as well as four weeks following the end of the intervention (T4). SCED methodologies must include more than one baseline assessment as well as more than one post-therapy follow-up assessment. As such, we included two pre-treatment assessments in order to demonstrate no change or difference on our outcome variables before the intervention was introduced, as well as two post-treatment assessments was to demonstrate maintenance of treatment effects. Assessments were either conducted in-person or online via Zoom, according to participants' preferences and research assistants' availabilities. The intervention itself occurred over a total of 12 weeks, with each session lasting 90 minutes and occurring once per week. Participants received a stipend (60$) for completing the questionnaires and interviews.

Treatment

The intervention, called *Power of Two*, is a group therapy program that combines CBT and SST principles and is designed to help individuals establish and maintain romantic relationships. It covers a wide range of topics, such as how to meet someone and show interest, how to recognize one's own and others' thoughts and feelings, sexual expectations, and how to manage conflicts and solve problems effectively (see Table 2 for a description of each session). The content and format of the intervention is based on insights gained from prior studies with the population of interest (e.g., McCann, 2010; Redmond et al., 2010), as well as previous research conducted by

our team (Latour-Desjardins et al., 2019; Pillay et al., 2018). The treatment manual was also modified based on comments from clinicians, sex and couples therapists, and people with lived experience. Two mental health professionals (a man and a woman) affiliated with each participating clinic delivered the intervention to groups containing between 4 and 8 participants. Although fidelity to the manual was not explicitly evaluated, therapists were required to complete a four-hour intensive training session with the program's creator (T.L.). Clinical supervision was also offered on an as-needed basis.

Table 2. Program description

Session title	Content
Session 1: Am I ready?	Rules and goals of the group, personal reasons for wanting to date, pros and cons of dating (support vs stress).
Session 2: Dating – Part 1	How and where to meet people, pros and cons of each method, how to describe oneself to potential partners.
Session 3: Dating – Part 2	How to get ready for a date, how to show interest or recognize it in someone else, small talk, reciprocal conversation (role-play).
Session 4: From dating to going out	What am I looking for, my values, how do I know if the person is right for me?
Session 5: My qualities as a partner and disclosure about mental illness	What are my qualities, what can I offer, when should I (if ever) disclose my mental health status and how? Pros and cons of each scenario.
Session 6: Recognizing my feelings and sharing them	How do I recognize when I am feeling specific emotions, how do I know if I'm in love, how can I share positive and negative feelings, how do I cope with difficult emotions?
Session 7: What is going on?	How to inquire about what the other person is thinking? Review of CBT model with alternative explanations and fact-checking.
Session 8: My story and my fears	What scares me about being in a relationship (abandonment, dependency, loss of independence)? How to talk about my fears, how to find the right distance between myself and the other person?
Session 9: Sex and intimacy – Part 1	Expectations. When should sex be proposed? How is consent determined? Pornography vs reality. Sexual preferences, exploration, identity.
Session 10: Sex and intimacy – Part 2	Protection/contraception. Sexual problems – What to do?
Session 11: Managing conflicts	Problem-solving steps and strategies.
Session 12 – Communication and happiness	Communication skills during conflicts. Strategies to keep a relationship healthy and happy. Review of the group module.

Analyses

Descriptive analyses were conducted for data on attendance, as well as participants' dating success. Mixed ANOVAs and post-hoc paired samples t-tests with Bonferroni adjustments were computed to evaluate changes on each scale over time, while also controlling for age, treatment site, education level, and psychiatric diagnosis. This analytical strategy was chosen because it allowed us to compare differences in scores across four timepoints (within-subjects factor), in addition to testing for interaction effects between time and treatment modality (between-subjects factor). Effect sizes were calculated using Cohen's *d* (Cohen, 1988). Qualitative data was examined and summarized by two of the authors, J.G.D. and M.E.G.R., using a frequency count strategy. Discrepancies were resolved through revision of key words and phrases until consensus was reached.

Results

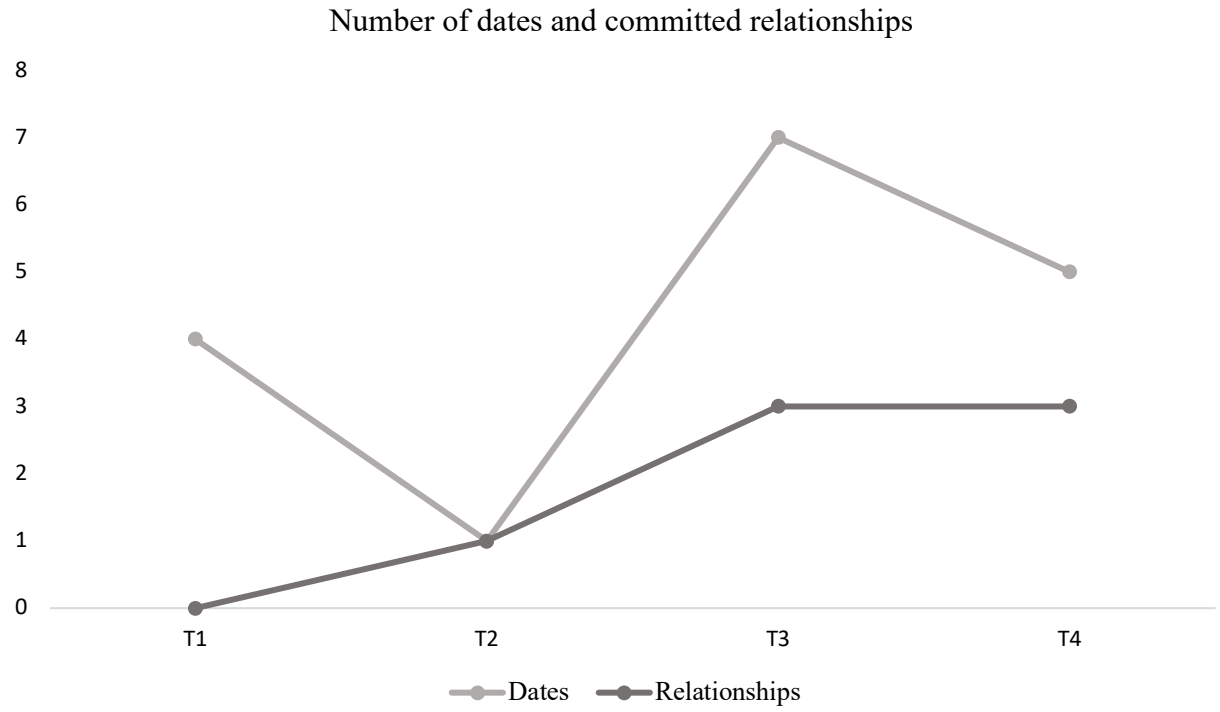
Quantitative data

A total of 7 groups were offered during the course of the project, with 3 groups being offered in-person and 4 groups being offered online. Two participants were excluded from our analyses due to low attendance (i.e., present for less than 6/12 sessions). Only participants who completed at least one pre- and one post-evaluation were retained for the analyses. In all, 22 completed all four evaluations, while 5 completed three evaluations. For the 27 participants included in our analyses, average attendance was 9.44 out of 12 sessions.

At T1 (baseline), none of the participants were in a committed relationship and only 4 (14.8%) had recently been on a date. At T2 (pre-group), one participant (3.7%) indicated being in a committed relationship, while another participant had recently gone on a date. At T3 (post-

group), three participants were in a committed relationship (11.1%) and seven other participants had recently been on a date (25.9%). At T4 (4-week follow-up), three participants were still in committed relationships, while five other participants (18.5%) had recently gone on dates. These trends are presented graphically in Figure 1.

Figure 1. Trends in dating and committed relationships across time



Within-group analyses revealed improvements on several outcomes of interest. As can be seen in Table 3, romantic functioning (RRFS-Total) was significantly higher after the intervention. This change was associated with a medium effect size (Cohen's $d = 0.65$). Age was also found to influence romantic functioning, with younger participants displaying significantly greater romantic relationship functioning than older participants, $F(1,\ 18.84) = 12.50, p < 0.01$. Both treatment modalities produced similar results on this outcome, as revealed by the non-significant Time x Modality interaction term. To better understand observed changes in romantic functioning, RRFS subscale scores were also analyzed. Scores on the Resources subscale (RRFS-Resources) and Stigma subscale (RRFS-Stigma) significantly increased following the intervention. Effect sizes were large (Cohen's $d = 1.22$) and small (Cohen's $d = 0.23$) for these two outcomes, respectively. The Time x Modality interaction terms were also non-significant. No changes were observed on the Risks subscale (RRFS-Risks).

Intimacy behaviors (FESFS-B) were significantly higher after the intervention, with a medium effect size (Cohen's $d = 0.51$). The Time x Modality interaction term was non-significant, indicating that results were similar across treatment modalities. No changes were observed for the Intimacy attitudes (FESFS-A) subscale. Mentalizing skills (ST-Mentalization) also significantly increased following the intervention. The effect size of this change was large (Cohen's $d = 0.86$) and the Time x Modality interaction term was non-significant.

Table 3. Results of main analyses

Outcomes	Mean and standard error (SE)									Timepoint comparisons						Cohen's *d* T1–T4	Time x Modality interaction
	Time 1		Time 2		Time 3		Time 4			T4-T1	T3-T1	T2-T1	T4-T2	T3-T2	T4-T3		
	Mean	SE	Mean	SE	Mean	SE	Mean	SE	*p*-value	*p*-value	*p*-value	*p*-value	*p*-value	*p*-value	*p*-value		*p*-value
RRFS-Total	2.96	0.11	3.11	0.10	3.23	0.10	3.31	0.10	**.019**	**.013**	**.043**	.450	.139	.432	1.00	0.65	.491
RRFS-Resources	2.75	0.17	2.87	0.15	3.19	0.16	3.22	0.15	**<.001**	**<.001**	**<.001**	.621	**<.001**	**<.001**	1.00	1.22	.177
RRFS-Stigma	3.07	0.19	3.29	0.20	3.22	0.17	3.52	0.17	**.022**	.097	1.00	.780	1.00	1.00	.088	0.23	.799
RRFS-Risks	3.08	0.18	3.16	0.15	3.27	0.15	3.22	0.15	.551	1.00	1.00	1.00	1.00	1.00	1.00	0.27	.272
FESFS-Attitudes	3.00	0.11	3.01	0.12	3.09	0.10	3.06	0.11	.663	1.00	1.00	1.00	1.00	1.00	1.00	0.21	.915
FESFS-Behavior	1.48	0.09	1.46	0.09	1.80	0,17	1.79	0.15	**.034**	.163	.215	1.00	.069	.075	1.00	0.51	.980
MSQ-Positive	2.78	0.14	2.95	0.16	3.06	0.15	2.94	0.15	.072	1.00	.079	.384	1.00	1.00	.909	0.39	.949
MSQ-Negative	2,38	0,18	2,35	0,19	2,20	0,17	2,18	0,17	.526	1.00	1.00	1.00	1.00	1.00	1.00	0.26	.080
SERS-Positive	42.78	2.77	42.90	2.54	45.32	2.74	43.37	2.37	.297	1.00	1.00	1.00	1.00	.554	1.00	0.27	.088
SERS-Negative	-32.21	2.76	-32.24	3.27	-31.85	3.29	-31.35	3.20	.952	1.00	1.00	1.00	1.00	1.00	1.00	0.09	.781
ISMI-Total	1.85	0.12	1.79	0.12	1.73	0.14	1.69	0.12	.312	.369	.841	1.00	1.00	1.00	1.00	0.39	.358
ST-Mentalization	16.54	0.97	17.49	1.04	18.92	1.08	19.65	1.04	**.003**	**.002**	**.010**	.523	**.024**	.082	1.00	0.86	.553
BPRS-Total	42.39	1.96	41.50	2.27	36.42	1.58	35.29	1.52	**<.001**	**<.001**	**<.001**	1.00	**.002**	**.002**	.933	1.08	.665
BPRS-Negative	9.49	0.54	9.14	0.52	7.67	0.41	7.21	0.33	**<.001**	**<.001**	**.006**	1.00	**.001**	**.005**	.745	0.87	.932

N.B.: Numbers in bold are statistically significant at $p < 0.0$

Although changes were non-significant, positive sexual functioning (MSQ-Positive) scores increased after the intervention. Given the small-to-medium effect size (Cohen's d = 0.39) associated with this change, a significant effect may have been observed with a larger sample size. The Time x Modality interaction term was non-significant but trending for negative sexual functioning (MSQ-Negative). As with positive sexual functioning, a significant effect may have been detected with a larger sample. Self-esteem (SERS-Positive and SERS-Negative) and self-stigma (ISMI-Total) scores did not improve significantly over time.

Global symptomatology (BPRS-Total) was significantly reduced after the intervention. The effect size associated with this change was large (Cohen's d = 1.08). Treatment site was also found to influence global symptomatology, with participants at one site displaying significantly less psychiatric symptoms than participants at each of the four other sites, $F(4, 22.36) = 7.20$, $p < 0.01$. Given the program's emphasis on social skills training, negative symptomatology (BPRS-Negative) was also examined and found to be significantly lower after the intervention. The effect size was large for this outcome (Cohen's d = 0.87). The Time x Modality interaction terms were non-significant for both BPRS outcomes.

Qualitative data

At the end of the program, the participants were asked what they liked about the modules, what they disliked and whether they were satisfied with the program. Of all the participants, 74% (21 out of 27) gave their opinion.

In general, participants liked having the opportunity to talk, exchange, and socialize, in a friendly, safe, and judgement-free space. Many also appreciated receiving concrete tools. For example, four participants particularly appreciated receiving ideas of activities they could do to meet potential partners. Others liked to reflect on relational issues. For example, three participants mentioned enjoying discussions on conflict resolution. In addition, two participants indicated that they enjoyed learning about women's point of view of love.

What may have been disliked by one participant was, simultaneously, appreciated by another. One participant felt that there lacked practice exercises, more precisely, role-playing, while two other participants found role-playing to be excessive. A few participants had trouble sharing about their sexuality. Two participants were bothered by psychotic symptoms present in other group members. Another participant said there lacked sharing and participation from other participants. One participant was disappointed at the end of the program because he did not find a romantic partner. Only one participant mentioned not having appreciated the videoconferencing platform.

The majority of participants (81% or 17 out of 21) said they were satisfied with the modules. Five of these underlined having learnt new things and three mentioned having gained confidence due to improved skills in communication and conflict resolution. Some participants did not elaborate on what satisfied them. A few mentioned dissatisfaction including feeling judged (one participant), feeling inadequately informed (one participant) and feeling general discomfort (one participant). Other participants suggested adding individual sessions in order to address matters specific to them and expressed interest towards mixed-gender groups.

Discussion

This study aimed to evaluate the impact of a novel group intervention for young men with FEP. We also sought to compare results across two treatment modalities – in-person and online. Similar improvements were observed on multiple outcomes for both modalities. For instance, romantic functioning also increased significantly after the intervention for participants in each delivery condition. This change was primarily driven by improvements in participants' Resources scores, suggesting that they left feeling more prepared for dating. This is unsurprising given the content of the program (e.g., discussions on fun and inexpensive date ideas, advice for interpreting romantic signals). Stigma scores were also improved after the intervention, though to a lesser degree. Different ways of addressing one's mental health history with a potential romantic partner were presented during the intervention, which may have helped reduce participants' concerns about experiencing discrimination while dating. Interestingly, younger participants displayed significantly greater romantic functioning than older participants. This difference could potentially be explained by older participants' greater exposure to previous negative romantic experiences and, consequentially, less self-confidence and more fears surrounding dating. Future research should investigate how age influences dating for adults with psychosis, as well as its implications for treatment.

Intimacy behaviors also increased significantly after the intervention for participants in each delivery condition, indicating that participants were engaging more with potential romantic partners following therapy. This was also corroborated by descriptive data on dating outcomes, which showed an increase in the number of dates and committed relationships after the

intervention. However, participants' attitudes towards intimacy did not improve over time. One possible explanation for this finding is that new experiences may be needed in order to change attitudes about intimacy (Frye et al., 2012; Glasman & Albarracin, 2006), as many individuals with psychosis have had few or mostly negative prior dating experiences (Latour-Desjardins et al., 2019). This may also be true for self-esteem and self-stigma, two outcomes that did not improve after the intervention. Thus, treatments with a greater focus on previous traumatic experiences may be needed to help shift unfavorable perceptions of dating (de Jager et al., 2021; White et al., 2021). Our findings suggest that stigmatizing attitudes could potentially be improved with our intervention (small effect size for RRFS-Stigma), but it would be interesting to evaluate whether adjunct trauma-based interventions could enhance these effects, particularly among individuals with a greater history of trauma exposure. Similarly, while our small sample size prevents us from drawing any firm conclusions, improvements in sexual functioning may have been observed if more of the program's content had been more devoted to sexuality, as only two sessions focused on this topic. Additional support for complex sexuality concerns may needed as part of an integrated care package for certain participants.

In addition to dating success and romantic functioning, mentalizing skills also increased significantly after the intervention for participants in each delivery condition. This was expected due to the program's emphasis on understanding emotions and implicit messages through numerous discussions and role-plays. Indeed, many participants expressed that this part of the program was especially helpful to them, as it offered concrete information on how to respond more effectively in realistic dating situations. Finally, both global and negative symptoms decreased significantly after the intervention for participants in each delivery condition. Although this cannot

be verified in the present study, it is likely that interacting regularly with other people as part of a group promotes symptomatic remission, even if this occurs at a distance via videoconferencing (Lecomte et al., 2015; Lecomte et al., 2020). Participants at one treatment site also differed significantly from other treatment sites with respect to global symptomatology. This variation could be explained by baseline differences in symptoms, as participants at this treatment site were considerably less symptomatic before starting therapy than those at the other treatment sites.

These findings should be considered in light of the present study's limitations. Most importantly, a small sample size may have contributed to power-related issues, restricting our ability to understand the treatment's impact on certain outcome variables. A larger study with more participants is needed to replicate these findings. In future studies, a two-armed RCT (*Power of Two* versus existing CBT or SST intervention) or a three-armed RCT (*Power of Two* versus existing CBT or SST intervention versus treatment-as-usual (TAU)) would allow us to further reduce the risk of bias, as well as evaluate whether our intervention is superior to standard care and, to some extent, a similar, established intervention. However, SCEDs can provide strong evidence for an intervention's efficacy through triangulation (i.e., replication of effects across a minimum of three conditions), which was demonstrated in the current study (Smith, 2012). Although an RCT design comparing the current intervention to a similar, evidenced-based intervention (e.g., SST or CBT program for psychosis) would have strengthened our findings, we are unaware of any existing active comparison that specifically targets romantic and/or sexual functioning. Another important limitation is the sociocultural context in which the study was conducted. It is impossible to assess exactly how the COVID-19 pandemic might have influenced the study's findings, although our results are largely consistent with those of the pilot study that

was conducted before the pandemic (Hache-Labelle et al., 2020). Finally, the majority of our results were based on self-reported data. However, two outcomes of interest, mentalizing skills and symptomatology, were evaluated by trained raters. The fact that significant improvements were observed across different assessment measures, in addition to different treatment sites, increases confidence in our findings (Smith, 2012).

In conclusion, this study was the first to evaluate the efficacy of a novel group intervention focusing on romantic relationships in young men with FEP and offered in two treatment modalities (in-person versus online). Results show that this program led to improvements in participants' dating success, romantic functioning, mentalizing skills, and symptomatology, with both traditional and videoconferencing treatment modalities being equally effective. Group members were largely satisfied with the content of the sessions and indicated benefitting from the intervention. In an effort to increase accessibility, future studies should replicate these findings in larger, more inclusive samples (e.g., including individuals with different gender and sexual orientation identities, other age groups, other languages). Furthermore, future research should investigate which components of the program are most effective, as well as which individuals might respond better or more poorly to the intervention (de Villiers et al., 2018; Hofmann & Hayes, 2019). Targeting trauma outside of group therapy, either before or during the intervention, may also be necessary for some participants to better benefit from this treatment (de Jager et al., 2021; White et al., 2021).

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5. Discussion

This thesis sought to address several important gaps in the literature on romantic relationships and psychosis. To do so, we conducted three separate studies that aimed to (1) present a comprehensive analysis of recent quantitative data on romantic relationships, sexuality, and psychosis, (2) assess the reliability and validity of two instruments measuring romantic and sexual functioning among individuals with psychosis, and (3) evaluate the efficacy of a novel group intervention, offered in-person or online, to improve romantic relationship functioning among young men with psychosis.

The results of these studies have numerous research and clinical implications. Study 1 allowed us to collect and synthesize data on different topics pertaining to romantic relationships, sexuality, and psychosis in the last 15 years. Through this systematic review, we found that the majority of studies were of low quality and tended to adopt a pathologizing posture, such that they mostly focused on negative aspects of romantic relationships and sexuality (e.g., risky sexual behavior, intimate partner violence, sexual dysfunction) to the detriment of positive aspects (e.g., dyadic adjustment, family planning) that can be more readily altered and therefore, help empower persons with psychosis (Grealish et al., 2013). Indeed, none of the reviewed studies examined factors that might promote recovery in the areas of romantic relationships or sexuality. This is concerning as it suggests that current research and clinical practices are not well-aligned with newer, evidence-based intervention models for schizophrenia-spectrum disorders (Andresen et al., 2011; Davidson et al., 2005). Moreover, our review also highlighted the significant contrast between existing research on romantic relationships in healthy individuals and the corresponding literature in samples with psychosis. Indeed, it appears that contextual, transactional, and

longitudinal processes are routinely neglected in studies on romantic relationships and sexuality involving people with psychosis. These issues are already evident from consumer-oriented studies, where service users have repeatedly criticized the lack of staff training and resources to address their intimacy and sexuality concerns (McCann et al., 2019; White et al., 2021).

Study 2 directly targeted the limited literature on romantic and sexual functioning by assessing the reliability and validity of two relevant measures among a sample of individuals with psychosis. This investigation allowed us to confirm that the RRFS and the MSQ retained adequate psychometric properties with this population and therefore, could be employed when exploring romantic and sexual questions in people with psychosis. Given the lack of instruments for evaluating romantic and sexual experiences beyond the presence of sexual dysfunctions, our study fulfilled a palpable need by providing both researchers and clinicians with a set of tools that can be used to better understand participants' and clients' difficulties in the realm of romantic relationships and sexuality. Seeing as prior research has found that many health professionals do not feel comfortable or equipped to discuss these sensitive topics with consumers (Higgins et al., 2008; White et al., 2019), access to measures that facilitate data collection may help resolve some of the observed communication challenges between practitioners and service users.

Study 3 evaluated a romantic skill-building group intervention for young men with psychosis, the very first of its kind. It also compared two treatment modalities, in-person and online, which is of significant importance for modern-day service delivery (Lattie et al., 2022). Indeed, challenges relating to treatment accessibility continue to prevent many individuals from receiving services that could help reduce their symptoms and improve their quality of life (Kim et

al., 2007; Kullgren et al., 2012; Moroz et al., 2020). This was particularly apparent during the COVID-19 pandemic, where service delivery was restricted and the rate of people reporting psychological distress or requesting assistance soared (Ornell et al., 2021; Xiong et al., 2020). Our study showed that similar outcomes could be achieved by offering the same intervention online, allowing greater flexibility for both services providers and users. When consumers' preferences and unique realities (e.g., work/school schedules, traveling difficulties) are taken into account, treatments are likely to become more appealing and adherence may increase (Matthias et al., 2012; Robinson et al., 2008). Because young adults with psychosis tend to display high disengagement from services, early and flexible intervention is critical for this population (Doyle et al., 2014; McGorry et al., 2008; Murphy & Brewer, 2011; Turner et al., 2007) in order to enhance treatment attractiveness and practicality. The proposed group intervention addressed this issue by targeting a key area of concern for persons with psychosis (i.e., romantic relationships), while also investigating whether it could be viably offered in two treatment modalities. Thus, this study can be viewed as a step in the right direction towards promoting recovery among individuals with psychosis.

5.1 Strengths and weaknesses

This thesis presents several strengths and weaknesses. In terms of strengths, it is the first to synthesize quantitative findings on romantic relationships, sexuality, and psychosis in the last 15 years. Such an endeavor allowed for the identification of substantial gaps in the literature that can now be readily addressed by researchers. The recognition that many meaningful topics (e.g., dyadic adjustment, family planning) have been overlooked as an object of study within this population is disappointing, but nonetheless holds promise for the future. By shifting researchers'

and clinicians' focus from pathology to recovery-oriented factors, interactions between mental health professionals and persons with psychosis can also become less stigmatizing and more constructive (Andresen et al., 2011). As mounting evidence suggests, adopting a recovery-oriented approach may be a key ingredient for successful rehabilitation when working with clients who experience psychosis (Drake & Whitley, 2014; Jacob, 2015).

Another notable strength of the current thesis is its contribution of new instruments for research and clinical purposes. The validation of two questionnaires measuring romantic and sexual functioning in a sample with psychosis not only supplies service providers with useful tools to better assist them with issues surrounding dating and sexuality, but also offers researchers additional measures for conducting studies on this topic. More broadly, it is hoped that these new resources will motivate mental health professionals to openly discuss clients' concerns about romantic relationships and sexuality, as well as encourage researchers to contribute to the currently limited literature. At present, very few measures can be reliably used with this population, which may hinder data collection in both research and applied settings. Thus, this thesis can be said to have removed some of the obstacles in the way of greater knowledge acquisition regarding romantic relationships and psychosis.

Similarly, the present thesis also evaluated the efficacy of a novel group intervention specifically targeting romantic relationship functioning in people with psychosis. After obtaining positive preliminary results for this intervention in a pilot study (Hache-Labelle et al., 2020), we conducted a follow-up study with new data and a larger sample size in order to ensure replicability. Findings were largely consistent across studies, suggesting that the program is effective at

improving romantic relationship functioning. Such an intervention offers hope to individuals with schizophrenia-spectrum disorders who have struggled with dating and are looking to form healthy committed relationships. By offering a resource where romantic skills can be worked upon, clients are reminded that their concerns matter and that they have agency over their romantic and sexual lives. Furthermore, many of the skills taught in our intervention (e.g., emotion regulation, problem-solving, conflict resolution, effective communication) are applicable to all relationships, with added nuances for romantic relationships. The fact that participants' mentalization skills were enhanced following the intervention is also noteworthy, as this is likely to have an impact on their broader interpersonal functioning (Sullivan et al., 2013). Consequentially, they may experience less social isolation and loneliness, a significant challenge for this population (Eglit et al., 2018; Stain et al., 2012).

The main weaknesses of this thesis are related to sampling, qualitative data analysis, and study design. Regarding sampling, in Study 1, data was collected on persons with psychosis who were at least 18 years of age. Although studies investigating romantic relationships in adolescents with psychosis are presumably scarce, the inclusion of this subgroup in our study could have added to our findings. For instance, we may have found longitudinal research examining dating in adolescence, which would have been very informative. Alternatively, we could have included individuals at ultra-high risk (UHR) for psychosis[4], which may have led to a more complete understanding of this topic. A recent systematic review (Ciocca et al., 2021) examined sexuality

[4]To be considered at Ultra High Risk (UHR) for psychosis, a person must fall within the age range at highest risk of experiencing psychosis (late adolescence to early adulthood), as well as meet one or more of the following criteria: (1) Genetic Vulnerability (i.e., first-degree relative with a psychotic disorder), (2) Attenuated Psychotic Symptoms (i.e., sub-clinical positive symptoms during the past 12 months), or (3) Brief Limited Intermittent Psychotic Symptoms (i.e., frank psychotic symptoms for less than 1 week with spontaneous resolution). For more information, see McHugh et al., 2018.

during the transition from UHR to FEP and noted several interesting findings, including the existence of sexual dysfunctions in the prodromal phase of psychosis and delusions of sexual content among persons at UHR who had experienced sexual abuse. Other studies (e.g., Boldrini et al., 2020; Gajwani et al., 2013; Russo et al., 2018) highlight the potential clinical relevance of considering attachment styles among clients at UHR for psychosis. While research in this area is still limited, existing studies suggest that insecure attachment styles may represent an obstacle to the development of strong therapeutic alliances and therefore, to treatment engagement and recovery from psychosis (Owens et al., 2013; Russo et al., 2018). Hence, taking an explicit interest in how factors linked to intimacy and sexuality evolve during the different stages of psychosis would undoubtedly provide a richer picture of romantic relationships in the context of schizophrenia-spectrum disorders.

Sampling issues also emerged during data collection for Study 2. Obtaining suitable sample sizes for the RRFS and the MSQ was more challenging than expected. The reasons behind these recruitment difficulties are unknown, although we believe that the sensitive nature of this topic and the fact that this study was conducted entirely online may have contributed to privacy concerns among potential participants (Kaminsky et al., 2003; Rosen et al., 2007). This possibility was further corroborated in Study 3, where some participants in the videoconferencing condition of the group intervention indicated feeling uneasy at times when discussing sexuality. For those who may have had prior negative experiences when addressing romantic and sexual issues with a mental health professional, participating in such a study might also be perceived as intimidating. In any case, it is evident that a larger sample would have been beneficial when validating these new measures.

Another related limitation is the self-reported nature of participants' primary psychiatric diagnoses in Study 2. Because many of these participants were recruited online through different social media platforms, it was not possible to confirm the diagnostic information provided by the respondents. Although numerous entries where participants had indicated a non-psychotic disorder or unclear diagnostic information were eliminated prior to the analyses, the validity of the remaining cases cannot be fully guaranteed. Thus, future research evaluating the psychometric properties of the MSQ or the RRFS should consider utilizing different recruitment strategies and/or additional methods for verifying diagnostic data.

Sampling difficulties were also encountered in Study 3, albeit to a lesser extent. Although a total of 27 participants were included in our analyses, we initially aimed for a sample size of 40. Several factors are believed to have contributed to this discrepancy, including research delays due to the COVID-19 pandemic and limited funding. Regarding the latter point, only one senior researcher, a research coordinator, and two volunteers were regularly implicated in running the study, which ultimately restricted the research process (e.g., obtaining ethical approval, conducting pre- and post-group evaluations, communicating with affiliated sites, training therapists, etc.). With access to greater resources, particularly research personnel, it is likely that we would have achieved our original sampling goal.

In a similar vein, participant recruitment may have been facilitated in Study 3 if our inclusion criteria had been less stringent. While homogenous samples present certain methodological advantages (Jager et al., 2017), we would have reached or even surpassed our

intended sample size ($N = 40$) if we had widened our scope. In fact, many interested persons were turned away from the program because they did not meet our inclusion criteria, despite having struggled with romantic relationships for years and seeking help with their dating lives. Moreover, many participants expressed great interest in mixed-gender groups, as it would allow them to be exposed to a wider range of perspectives on different topics addressed within the program. Future work could benefit from opening the group to a more diverse clientele (e.g., older individuals, women, participants from the LGBTQ2S+ community).

Limitations associated with qualitative data analysis were present in studies 1 and 3. In the first study, key themes were identified and categories were created using a consensus method rather than a more rigorous qualitative strategy. This technique was preferred due to the article's intended emphasis on quantitative data, as well as the existence of other systematic reviews where intensive thematic analysis had already been employed (e.g., de Jager & McCann, 2017; McCann et al., 2019). Nonetheless, it is important to acknowledge that our categories may have been named differently if an alternative coding strategy had been used, therefore potentially altering the interpretation of our findings. In the third study, qualitative data was also summarized through a consensus strategy. Given the article's central focus on clinical outcomes, the qualitative portion of the study was viewed as complementary and secondary to our main quantitative analyses. Although we were able to derive a general understanding of participants' experiences within the group intervention through basic qualitative analysis (i.e., frequency count of words, themes, or ideas mentioned), a more systematic coding strategy may have allowed for a richer description of their subjective feelings towards the program.

The advantages and disadvantages associated with Study 3's chosen design must also be considered when interpreting our findings. The primary weaknesses of SCEDs are related to the absence of a control or active comparison group, as well as their limited generalizability (Krasny-Pacini & Evans, 2018). Unlike RCTs that typically involve larger samples and compare a new treatment to no treatment or a similar treatment, SCEDs are usually conducted on a smaller set of participants that act as their own controls. This also means that a novel treatment cannot be compared to an established treatment in order to assess the relative effects and clinical utility of the new treatment (Wampold, 2001). Because of these differences, findings from SCEDs must be replicated repeatedly and can only be generalized to the subset of participants in the study (Krasny-Pacini & Evans, 2018), which in the present case represents young men with FEP. However, as mentioned previously, an SCED was deemed the most feasible option for evaluating the efficacy of our novel group intervention due to the absence of an active comparison treatment, as well as issues surrounding retention in control groups. Comparing the current intervention to a similar, evidenced-based intervention (e.g., SST or CBT group intervention for psychosis) as part of an RCT study would have been problematic, as none specifically target romantic and sexual functioning. Furthermore, high attrition rates in a potential control condition would likely have compromised our findings. Although we did not collect data during the treatment administration phase as is generally recommended for SCEDs (Krasny-Pacini & Evans, 2018; Wampold, 2001), the intervention's effect was evaluated and replicated across different settings, subjects, and behaviors (also known as triangulation; Smith, 2012). The fact that identical changes were observed on the same outcome variables (i.e., improvements in romantic functioning and mentalizing skills, no improvements for self-esteem and internalized stigma) as a previous pilot

study (Hache-Labelle et al., 2020) also adds to the evidence of replicability and therefore, strengthens the credibility of our findings.

Other limitations of this thesis are linked to the use of technology and case management difficulties. The implementation of the videoconferencing condition in Study 3 presented certain challenges. For example, some participants did not have access to stable Wi-Fi or a sufficiently private space throughout the program. In addition, both participants and therapists expressed initial confusion while adapting to the videoconferencing platforms (i.e., Zoom, Microsoft Teams). Such issues are commonly reported in studies investigating videoconferencing therapy and are not exclusive to the present intervention (Stoll et al., 2020; Thomas et al., 2021). However, many of the participants in our study did not have access to a computer or iPad and had to use their cellphones to attend group meetings. Given the length and interactive nature of the therapy sessions, a larger screen and more comfortable setting would have been preferable. Unfortunately, equipment-related barriers may be particularly salient for individuals with schizophrenia-spectrum disorders, as they are more likely to experience various forms of socioeconomic disadvantage (Muntaner et al., 2004; Sweeney et al., 2015; Sylvestre et al., 2017).

Finally, case management difficulties also emerged in Study 3. Across treatment sites, it was noted by both research personnel and therapists that many participants could have benefitted from additional support to address obstacles that directly impacted their treatment adherence. For example, several participants were seeking employment either before or during the program and were forced to quit the group intervention when their work schedules became incompatible with therapy. Others moved or changed their contact information frequently, which made reminders for

appointments and follow-ups difficult. Thus, it was suggested by some therapists that a designated 'resource-person' be assigned to each participant in order to help them navigate any barriers that they may come across while taking part in the program. Given our limited resources at the time of this study, future research should consider these issues carefully and offer solutions to problems that may ultimately influence the group's therapeutic impact.

5.2 Impact of findings and future directions

The recovery model (Andresen et al., 2011) posits that individuals with schizophrenia-spectrum disorders can and often do go on to lead normal and fulfilling lives. Several factors have been described by professionals and consumers to contribute to a greater quality of life among people with psychosis. Both quantitative and qualitative research have identified romantic relationships as an important area of recovery for this population. The present body of work was conceptualized, executed, and reported from a recovery-oriented perspective and lends further support to this model of care.

Overall, we hope that the current thesis will stimulate persistent interest in the romantic relationships and sexuality of people with psychosis. With knowledge of the current gaps in the literature, as well as new resources to begin addressing these gaps, it would be difficult to justify researchers' and clinicians' continued reluctance to explore this area of functioning, particularly considering its link with recovery (Boucher et al., 2016; Braithwaite & Holt-Lundstand, 2017). Moreover, future work touching upon topics relating to romantic relationships and sexuality in the context of psychosis will surely be welcome in an era where care is increasingly holistic and person-centered. Indeed, many emerging traditions within the field of psychology (e.g., positive

psychology, 3rd wave CBT) have shifted the focus away from attending to the individual's symptoms and deficits in favor of developing one's resources and utilizing his/her core values to promote optimal decision-making (Ahmed & Boisvert, 2006; Hayes & Hofmann, 2017; Seligman et al., 2006). Supporting service users in their efforts to improve their dating lives undoubtedly falls within this framework.

Throughout the research process that culminated in this thesis, it became evident that the extant literature on romantic relationships, sexuality, and psychosis is exceedingly narrow and restrained to a small selection of issues. Yet, there is still much to be explored in the way of romantic and sexual issues in this population. For example, little work has examined the unique experiences of people with schizophrenia-spectrum disorders who are also part of the LGBTQ2S+ community (Peta, 2020). Much like ethnic minority status, a growing body of research suggests that gender or sexual minority status increases the risk for psychotic symptoms, and that this relationship may be mediated by this group's greater exposure to social exclusion, discrimination, and intimidation (Gevonden et al., 2014; Post et al., 2021). A qualitative study by Kidd and colleagues (2011) delved into the challenges faced by individuals with serious mental illness who also self-identified as gay, lesbian, or trans. Participant narratives highlighted the need to adapt to the ''double-stigma'' of a psychiatric illness and gender/sexual minority status by choosing when and where to conceal one or both of these identities, as well as the fragmented sense of self and loss of community connection that often resulted from these experiences. At the same time, many participants yearned for relationships – romantic and non-romantic – where they could find acceptance and understanding. Non-judgmental and well-informed service providers were identified as key facilitators of recovery (Kidd et al., 2011). Though scarce, such studies clearly

underscore the importance of considering these dual identities in clinical practice so as to avoid further perpetuating the cycle of trauma.

Beyond the MSQ and the RRFS, future research must also develop and evaluate other instruments that measure various facets of romantic relationships and sexuality in samples with psychosis. Questionnaires that assess attachment styles and dyadic adjustment readily come to mind when contemplating potential contributions to the psychometric literature. Both researchers and clinicians could benefit, for instance, from studies evaluating the reliability and validity of the Adult Attachment Scale (AAS; Collins & Read, 1990) and the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) among persons with a psychotic disorder diagnosis. Notably, the Experiences in Close Relationships questionnaire (ECR; Brennan et al., 1998) measures attachment from a dimensional perspective and could therefore allow for a more nuanced exploration of attachment in psychosis samples. A short version of the ECR has also been developed and validated among individuals from the LGBTQ2S+ and couples with clinically significant distress (Lafontaine et al., 2016) but has yet to be employed with people experiencing psychosis. The revised Psychosis Attachment Measure (PAM; Pollard et al., 2020) may be the most suitable existing instrument for assessing the attachment styles of individuals with schizophrenia-spectrum disorders, but still requires further validation. Similarly, future studies could evaluate the psychometric properties of the Dyadic Adjustment Scale (DAS; Spanier, 1973) and Communication Patterns Questionnaire (CPQ; Christensen, 1987; Crenshaw et al., 2017) in this population. Once deemed appropriate for use with people with psychosis, such tools would then allow for the inclusion of new variables into incomplete theoretical models and clinical assessment batteries.

As our understanding of the relationship between romantic relationships, sexuality, and psychosis grows, corresponding intervention models will undoubtedly be revised and adapted to enhance their efficacy and effectiveness. In addition to examining if and how other subgroups (e.g., women, older adults, individuals with different gender and sexual identities) might benefit from our novel group intervention, the potential impact and clinical utility of complementary or adjunct interventions should also be investigated. The results of this thesis have highlighted two interesting avenues for future research: trauma and attachment. Offering additional assistance in areas of special concern for individuals participating in the *Power of Two* program may lead to greater treatment adherence and heightened improvements on different outcome variables, as well as longer-term retention of therapeutic gains. Trauma-focused psychological therapies (TFPT), including Eye Movement Desensitization and Reprocessing and Trauma-Focused Cognitive-Behavioral Therapy, could conceivably be offered to participants who report traumatic memories, especially when such experiences were highly interpersonal in nature. A meta-analysis by Sin and Spain (2016) found that TFPT were effective at decreasing intrusive thoughts and images, negative beliefs associated with traumatic memories, hypervigilance, and avoidant behaviors. Thus, future studies should examine whether the addition of TFPT has any impact on individual and/or group outcomes. The same can be said for interventions focusing on insecure attachment styles. Two therapeutic approaches directly derived from attachment theory, Interpersonal Psychotherapy (IPT; Weissman et al., 2017) and Emotionally Focused Therapy (EFT; Johnson, 2019), have garnered significant empirical support and focus primarily on repairing attachment injuries. Though much more recent, Attachment-Based Compassion Therapy (ABCT; Navarro-Gil et al., 2020) has also shown promise for increasing secure attachment and reducing avoidance. Given the

increasingly recognized association between schizophrenia-spectrum disorders, past trauma, and attachment difficulties, the incorporation of related principles and strategies into a comprehensive model of care is, in our view, worthy of further exploration.

Beyond early trauma and attachment-based interventions, one can easily envision the clinical utility of offering therapeutic programs for couples and parents who experience psychosis. The heightened risk for intimate partner violence against individuals with serious mental illness, particularly women, is well-documented in the literature (Gonzalez Cases et al., 2014; Khalifeh et al., 2015). Because domestic violence is associated with a myriad of negative psychological and physical health outcomes (Condino et al., 2016; Stewart et al., 2021), developing effective prevention and intervention strategies is critical. Over the last few decades, specialized programs and best-practice guidelines have been introduced to address spousal abuse in the general population. These interventions can be directed towards persons at-risk of experiencing violence or survivors of violence, as well as perpetrators of violence (Condino et al., 2016; Stewart et al., 2021). Although encouraging, current evidence suggests that these interventions may require unique adaptations to be used with psychiatric care consumers (Karakurt et al., 2022; Stewart et al., 2021). Thus, improving programs that target intimate partner violence among individuals affected by psychosis is an important avenue for future research. Even in the absence of domestic violence, when one or both partners is diagnosed with a mental illness, individual well-being may be compromised. Several studies have highlighted the difficulties faced by spouses of persons with a psychiatric disorder. These include increased stress associated with the burden of care and emotional instability (Idstad et al., 2010; Mokoena et al., 2019). Couples are also more likely to experience reduced communication and greater conflict due to the specific challenges brought on

by mental illness (Mokoena et al., 2019). Such issues may be even more evident and taxing in the context of a serious mental illness where symptom severity and chronicity are heightened (Jungbauer et al., 2004). In light of this information, couple-based interventions that help partners cope with and better respond to their partner's mental health difficulties – including but not limited to psychosis – should be implemented (Baucom et al., 2014).

Along with interventions focusing on domestic violence and mental health management, developing family planning and parenting programs for individuals with a serious mental illness is another valuable endeavor. Previous research indicates that women with schizophrenia and bipolar disorder are at-risk of experiencing deteriorating mental health both during and after pregnancy (Solari et al., 2009; Taylor et al., 2018). Pharmacological and psychosocial treatment plans should therefore be revised and enhanced during this sensitive period (Seeman, 2008). The quality of mother-child interactions after birth may also be comprised when mothers have a history of psychosis, as several studies have revealed unique parenting difficulties such as a reduced ability to interpret their children's cues (Davidsen et al., 2015; Healy et al., 2016; Solari et al., 2009). Despite facing lower overall risks than their female counterparts, men with serious mental illness also experience significant challenges during the transition to parenthood (Styron et al., 2002). Indeed, existing research suggests that psychosis may undermine the father-child dynamic and interfere with the ability to provide child-care more broadly (Evenson et al., 2008). Thus, future work should not only aim to improve service accessibility throughout pregnancy, but also provide evidenced-based interventions for future and new parents with a psychotic disorder or history of psychosis.

In conclusion, this thesis presents innovative findings on romantic relationships, sexuality, and psychosis. Despite limitations primarily related to sampling and study design, our results pave the way for significant theoretical and clinical advancements with respect to psychiatric evaluation and intervention. It is our hope that with greater access to resources, larger and more rigorous studies will be conducted on this topic, ultimately leading to improved services for this clientele. As the journey to recovery from psychosis is a highly powerful and personal one, we can no longer ignore consumers' repeated requests for assistance in the most intimate sphere of their lives.

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Appendix A – Consent forms

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT

Titre du projet de recherche :	Relations amoureuses et sexualité dans le contexte d'un trouble psychotique: Validation de deux mesures d'intimité
Chercheur responsable du projet de recherche :	Tania Lecomte, Université de Montréal, Institut universitaire en santé mentale de Montréal
Co-chercheur(s)/site(s) :	Amal-Abdel-Baki, Université de Montréal, Centre hospitalier de l'Université de Montréal; Martin Lepage, Université McGill, Institut Douglas; Marc-André Roy, Université Laval, Centre de recherche CERVO; Colleen Murphy, Université de Manitoba, Early Psychosis Prevention and Intervention Service
Membre du personnel de recherche :	Briana Cloutier, Université de Montréal
Installation(s) ou site(s) :	CIUSSS de l'Est-de-l'Île-de-Montréal, Centre hospitalier de l'Université de Montréal, CIUSSS de l'Ouest-de-l'Île-de-Montréal, CIUSSS de la Capitale-Nationale et Early Psychosis Prevention and Intervention Service

INTRODUCTION

Nous vous invitons à participer à un projet de recherche. Cependant, avant d'accepter de participer à ce projet et de signer ce formulaire d'information et de consentement, veuillez prendre le temps de lire, de comprendre et de considérer attentivement les renseignements qui suivent.

Ce formulaire peut contenir des mots que vous ne comprenez pas. Nous vous invitons à poser toutes les questions que vous jugerez utiles au chercheur responsable de ce projet ou à un membre de son personnel de recherche et à leur demander de vous expliquer tout mot ou renseignement qui n'est pas clair.

NATURE ET OBJECTIFS DU PROJET DE RECHERCHE

Le but de ce projet de recherche est d'évaluer la fiabilité et la validité de deux questionnaires portent sur l'intimité chez des individus ayant un trouble psychotique. Si ces deux instruments se trouvent à être efficaces, ils pourront éventuellement servir à identifier les difficultés que certaines personnes peuvent vivre dans le cadre de leurs relations intimes et offrir des services pertinents en conséquence.

Pour la réalisation de ce projet de recherche, nous comptons recruter 120 participants, hommes et femmes, âgés de 18 ans et plus. Nous visons à recruter un nombre équivalent de participants parlent l'anglais et le français, soit 60 personnes pour chaque langue.

DÉROULEMENT DU PROJET DE RECHERCHE

Ce projet de recherche se déroulera entièrement en ligne. Vous n'auriez pas à vous déplacer et il suffit d'avoir accès à l'Internet pour prendre part à l'étude.

1. Durée et nombre de visites

Votre participation à ce projet de recherche durera entre 45 et 60 minutes. Une fois que vous auriez lu ce formulaire d'information et de consentement et si vous acceptez toujours de participer, il vous sera demandé de remplir sept (7) questionnaires dans votre langue de préférence (anglais ou français). Des courriels vous

seront également envoyés dans les semaines qui suivent si vous ne compléter pas tous les questionnaires au même moment.

2. Nature de votre participation

Votre participation consistera à remplir une série de questionnaires en ligne sur la plateforme Qualtrics. Les questionnaires peuvent être complétés tous au même moment ou encore à des moments différents. Cependant, nous vous demandons de remplir les questionnaires au plus tard un mois après que vous auriez reçu votre code d'accès par courriel.

Par votre participation au projet, vous nous autorisé à communiquer avec votre psychiatre pour valider les informations de nature médical vous concernant.

AVANTAGES ASSOCIÉS AU PROJET DE RECHERCHE

Vous ne retirerez pas de bénéfices de votre participation à ce projet de recherche. Nous espérons que les résultats obtenus contribueront à l'avancement des connaissances scientifiques dans ce domaine et au développement de meilleurs traitements pour les patients.

RISQUES ET INCONVÉNIENTS ASSOCIÉS AU PROJET DE RECHERCHE

Outre le temps consacré à la participation à ce projet de recherche, il n'y a pas de risques ou d'inconvénients associés au projet de recherche. Le contenu de certaines questions pourrait vous causer un léger inconfort puisqu'elles s'intéressent à des sujets de nature plus personnelle (p. ex., la sexualité), mais vos réponses seront conservées séparément des informations permettant de vos identifier.

Au besoin, une liste de références vous sera fourni ou vous serez référé vers un professionnel pouvant vous aidez avec toute difficulté ayant émergée au cours de votre participation à ce projet de recherche.

PARTICIPATION VOLONTAIRE ET DROIT DE RETRAIT

Votre participation à ce projet de recherche est volontaire. Vous êtes donc libre de refuser d'y participer. Vous pouvez également vous retirer de ce projet à n'importe quel moment, sans avoir à donner de raisons, en informant l'équipe de recherche.

Votre décision de ne pas participer à ce projet de recherche ou de vous en retirer n'aura aucune conséquence sur la qualité des soins et des services auxquels vous avez droit ou sur votre relation avec les équipes qui les dispensent.

Le chercheur responsable de ce projet de recherche ou le Comité d'éthique de la recherche du CIUSSS de l'Est-de-l'Île-de-Montréal peuvent mettre fin à votre participation, sans votre consentement. Cela peut se produire si de nouvelles découvertes ou informations indiquent que votre participation au projet n'est plus dans votre intérêt, si vous ne respectez pas les consignes du projet de recherche ou encore s'il existe des raisons administratives d'abandonner le projet.

Sauf sur avis contraire de votre part, si vous vous retirez du projet ou êtes retiré du projet, l'information et le matériel déjà recueillis dans le cadre de ce projet seront néanmoins conservés, analysés ou utilisés pour assurer l'intégrité du projet.

Toute nouvelle connaissance acquise durant le déroulement du projet qui pourrait avoir un impact sur votre décision de continuer à participer à ce projet vous sera communiquée rapidement.

CONFIDENTIALITÉ

Durant votre participation à ce projet de recherche, le chercheur responsable de ce projet ainsi que les membres de son personnel de recherche recueilleront, dans un dossier de recherche, les renseignements vous concernant et nécessaires pour répondre aux objectifs scientifiques de ce projet de recherche.

Ces renseignements peuvent comprendre les informations contenues dans votre dossier médical, concernant votre

état de santé passé et présent, vos habitudes de vie ainsi que les résultats de tous les tests, examens et procédures qui seront réalisés. Votre dossier peut aussi comprendre d'autres renseignements tels que votre sexe, votre date de naissance et votre origine ethnique.

Tous les renseignements recueillis demeureront confidentiels dans les limites prévues par la loi. Vous ne serez identifié que par un code numérique. Le code reliant votre nom à votre dossier de recherche sera conservée par le chercheur responsable de ce projet de recherche.

Ces données de recherche seront conservées pendant au moins 5 ans par le chercheur responsable de ce projet de recherche. Seul les membres de l'équipe de recherche de l'université de Montréal auront accès aux données de recherche

Les données de recherche pourront être publiées ou faire l'objet de discussions scientifiques, mais il ne sera pas possible de vous identifier.

À des fins de surveillance, de contrôle, de protection, de sécurité, votre dossier de recherche ainsi que vos dossiers médicaux pourront être consultés par des représentants du Comité d'éthique de la recherche du CIUSSS de l'Est-de-l'Île-de-Montréal. Ces personnes adhèrent à une politique de confidentialité.

Vous avez le droit de consulter votre dossier de recherche pour vérifier les renseignements recueillis et les faire rectifier au besoin.

COMPENSATION

Vous ne recevrez pas de compensation financière pour votre participation à ce projet de recherche. Par contre, si vous complétez l'ensemble des questionnaires, vous courrez automatiquement la chance de gagner un IPad lors d'un tirage au sort incluant l'ensemble des autres participants de l'étude.

EN CAS DE PRÉJUDICE

En acceptant de participer à ce projet de recherche, vous ne renoncez à aucun de vos droits et vous ne libérez pas le chercheur responsable de ce projet de recherche et l'établissement de leur responsabilité civile et professionnelle.

IDENTIFICATION DES PERSONNSES-RESSOURCES

Si vous avez des questions ou éprouvez des problèmes en lien avec le projet de recherche, ou si vous souhaitez vous en retirer de l'étude, vous pouvez communiquer avec le chercheur responsable de ce projet de recherche ou avec une personne de l'équipe de recherche au numéro suivant : 514-343-6111, poste 4724.

Pour toute question concernant vos droits en tant que participant à ce projet de recherche ou si vous avez des plaintes ou des commentaires à formuler, vous pouvez communiquer avec le Commissaire aux plaintes et à la qualité des services du CIUSSS de l'Est-de-l'Île-de-Montréal au 514-252-3400, poste 3510.

SURVEILLANCE DES ASPECTS ÉTHIQUES DU PROJET DE RECHERCHE

Le comité d'éthique de la recherche du CIUSSS de l'Est-de-l'Île-de-Montréal a approuvé le projet et en assurera le suivi. Pour toute information, vous pouvez communiquer avec le secrétariat du Comité au 514-252-3400, poste 5708.

Titre du projet de recherche : Relations amoureuses et sexualité dans le contexte d'un trouble psychotique: Validation de deux mesures d'intimité

SIGNATURES

Signature du participant

J'ai pris connaissance du formulaire d'information et de consentement. On m'a expliqué le projet de recherche et le présent formulaire d'information et de consentement. On a répondu à mes questions et on m'a laissé le temps voulu pour prendre une décision. Après réflexion, je consens à participer à ce projet de recherche aux conditions qui y sont énoncées.

J'autorise mon psychiatre à fournir des informations de nature médical me concernant au chercheur responsable de la présente recherche.

_____

Nom et coordonnées du votre psychiatre

_____

Nom du participant Signature Date

Signature de la personne qui obtient le consentement

J'ai expliqué au participant le projet de recherche et le présent formulaire d'information et de consentement et j'ai répondu aux questions qu'il m'a posées.

_____

Nom et signature de la personne qui obtient le consentement Signature Date

Centre intégré universitaire de santé et de services sociaux de l'Est-de-l'Île-de-Montréal
Québec

Université de Montréal

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT

Titre du projet:	Étude pilote portant sur la faisabilité, l'acceptabilité et l'impact potentiel d'une intervention de groupe sur les relations amoureuses pour jeunes hommes ayant un trouble psychotique
Chercheuse responsable:	Tania Lecomte, chercheuse CR-IUSMM, Université de Montréal
Co-chercheurs:	Martin Lepage, chercheur, Institut Douglas; Amal Abdel-Baki, chercheuse et psychiatre, CHUM; Jean-Gabriel Daneault, chercheur et psychiatre, Centre de services ambulatoires de santé mentale Papineau
Financement:	Centre de recherche interdisciplinaire sur les problèmes conjugaux et les agressions sexuelles (CRIPCAS)
Identifiant multicentrique:	MP-02-2017-7086 (MP)
No de projet au CHUM:	16.403

PRÉAMBULE

Nous sollicitons votre participation à un projet de recherche parce que vous êtes un jeune homme majeur ayant un trouble psychotique et souhaitez être en relation de couple. Cependant, avant d'accepter de participer à ce projet et de signer ce formulaire d'information et de consentement, veuillez prendre le temps de lire, de comprendre et de considérer attentivement les renseignements qui suivent.

Ce formulaire peut contenir des mots que vous ne comprenez pas. Nous vous invitons à poser toutes les questions que vous jugerez utiles au chercheur responsable du projet ou aux autres membres du personnel affecté au projet de recherche et à leur demander de vous expliquer tout mot ou renseignement qui n'est pas clair.

NATURE ET OBJECTIFS DU PROJET

Il peut être difficile de faire des rencontres amoureuses après avoir fait un premier épisode psychotique. Plusieurs obstacles peuvent se présenter et il n'est pas toujours facile de déterminer si on se sent prêt, comment bien vivre une relation, et comment surmonter certains obstacles. L'objectif de ce projet vise à évaluer une intervention de groupe sur les relations amoureuses pour vous et d'autres hommes qui vivez des difficultés semblables et qui souhaitez être en relation de couple.

Notre équipe a donc mis sur pied une nouvelle intervention de groupe car nous émettons l'hypothèse qu'elle pourrait vous aider à mieux vivre vos relations amoureuses et intimes. Par cette étude, nous cherchons à vérifier la faisabilité, l'acceptabilité et à déterminer l'impact potentiel de cette nouvelle approche. Si elle s'avère prometteuse, une intervention multi-sites de grande envergure sera mise sur pied afin d'aider à long terme plusieurs jeunes hommes psychotiques dans la sphère amoureuse.

Nous émettons trois hypothèses concernant l'intervention à l'étude. En premier lieu, nous émettons l'hypothèse que l'intervention sera jugée faisable, puisqu'une revue de la littérature met en lumière votre volonté à vivre des changements favorables dans la sphère amoureuse. Ensuite, nous émettons l'hypothèse que l'intervention sera jugée acceptable, car celle-ci a été créée par des chercheurs compétents ayant des connaissances avancées en matière de psychose et d'intervention. Finalement, nous émettons l'hypothèse que l'intervention aura un impact positif significatif sur les différents aspects qui seront évalués chez vous si vous consentez à participer à l'étude.

NOMBRE DE PARTICIPANTS ET DURÉE DE LA PARTICIPATION

Quarante-cinq (45) hommes ayant un trouble psychotique seront recrutés au total, dont quinze (15) de la clinique externe où vous êtes desservis.

Cette étude durera environ vingt-quatre (24) mois, et la participation individuelle durera vingt (20) semaines.

NATURE DE LA PARTICIPATION DEMANDÉE

Si vous acceptez de participer à l'étude, et après avoir signé le présent formulaire, votre participation à ce projet consistera à suivre une intervention thérapeutique groupale de douze (12) séances d'environ 90 minutes chacune qui vont s'échelonner sur douze (12) semaines. Il y aura également deux (2) autres visites, avant et après cette intervention. Chaque séance abordera plusieurs sujets afin que vous acquériez autant de nouvelles connaissances que de nouvelles compétences. Il s'agit d'une intervention de groupe puisque plusieurs participants à la fois bénéficieront de celle-ci. Ainsi, autant vous pourriez

bénéficier de la participation des autres, que ces derniers pourraient aussi bénéficier de votre participation. Pour ce faire, il vous sera demandé par moments d'interagir avec les autres lors de ces séances. De plus, des exercices à faire à la maison vous seront également demandés après chacune de ces séances.

DÉROULEMENT DU PROJET/PROCÉDURES

Vous trouverez un tableau des visites et procédures à l'étude à la fin du présent formulaire.

Cette étude comportera 3 étapes:
1) la période pré-traitement;
2) la période de traitement et;
3) la période post-traitement.

Première visite:

Si vous consentez à participer à cette étude, et après la signature du présent formulaire, il vous sera demandé de remplir un court questionnaire sociodémographique, ainsi qu'un bref questionnaire sur votre situation amoureuse actuelle et une échelle d'évaluation psychiatrique (l'échelle brève de symptômes psychiatriques (BPRS)). Vous devrez aussi répondre à six (6) questionnaires, lesquels mesurent le fonctionnement amoureux (l'échelle du fonctionnement amoureux (RRFS)), le fonctionnement social (l'échelle de fonctionnement social pour premiers épisodes (FESFS)), la sexualité (l'inventaire multidimensionnel de la sexualité (MSQ)), l'estime de soi (l'échelle d'estime de soi brève (SERS – SF)), l'auto-stigmatisation (l'échelle de santé mentale sur l'auto-stigmatisation (ISMIS)) et la capacité à comprendre l'autre (le Test des histoires). Vous serez libre de ne pas répondre à certaines questions de ces questionnaires.

Deuxième à la treizième visite:

Quatre (4) semaines après la première visite aura lieu la première séance de groupe de l'intervention, durant laquelle il vous sera demandé de remplir à nouveau le questionnaire sur votre situation amoureuse actuelle et les six (6) questionnaires nommés plus haut.

Puis, pendant les douze (12) semaines qui suivront, douze (12) séances vous seront offertes, à raison d'une fois par semaine. Lors de la dernière séance de l'intervention, vous devrez encore une fois remplir le questionnaire sur votre situation amoureuse actuelle et les six (6) questionnaires. Il vous sera aussi demandé de répondre oralement et individuellement à un questionnaire de satisfaction face à l'intervention.

Visite finale:

Finalement, quatre (4) semaines après la dernière séance de l'intervention, vous devrez répondre au questionnaire sur votre situation amoureuse actuelle et aux six (6) questionnaires pour une dernière fois.

VOS RESPONSABILITÉS

En signant le présent formulaire d'information et de consentement, vous acceptez de vous présenter aux visites prévues en lien avec l'étude et de vous soumettre à toutes les évaluations requises dans le cadre de l'étude.

RISQUES ET INCONVÉNIENTS

La participation à cette étude vous exposera aux effets indésirables énumérés ci-dessous:

- inconforts liés à des souvenirs de vos relations de couple antérieures;
- inconforts liés à la gêne lors des partages en groupe ou lorsque vous répondrez aux questionnaires;
- inconforts liés à la longueur des séances.

AVANTAGES

Il se peut que vous retiriez un bénéfice personnel de votre participation à ce projet de recherche, mais on ne peut vous l'assurer. À tout le moins, les résultats obtenus contribueront à l'avancement des connaissances dans ce domaine.

CONFIDENTIALITÉ

Durant votre participation à ce projet de recherche, le chercheur responsable de ce projet ainsi que les membres de son personnel de recherche recueilleront, dans un dossier de recherche, les renseignements vous concernant et nécessaires pour répondre aux objectifs scientifiques de ce projet de recherche.

Ces renseignements peuvent comprendre les informations contenues dans votre dossier médical, concernant votre état de santé passé et présent, vos habitudes de vie ainsi que les résultats de tous les tests, examens, enregistrements et procédures qui seront réalisés. Votre dossier peut aussi comprendre d'autres renseignements tels que votre nom, votre sexe, votre date de naissance et votre origine ethnique.

Tous les renseignements recueillis demeureront confidentiels dans les limites prévues par la loi. Vous ne serez identifié que par un numéro de code. La clé du code reliant votre nom à votre dossier de recherche sera conservée par le chercheur responsable de ce projet de recherche.

Ces données de recherche seront conservées pendant au moins 10 ans par le chercheur responsable de ce projet de recherche. Les enregistrements du questionnaire de satisfaction face à l'intervention seront également conservés pendant au moins 10 ans par celui-ci.

Les données de recherche pourront être publiées ou faire l'objet de discussions scientifiques, mais il ne sera pas possible de vous identifier.

Vous avez le droit de consulter votre dossier de recherche pour vérifier les renseignements recueillis et les faire rectifier au besoin.

COMMUNICATION DES RÉSULTATS GÉNÉRAUX

Vous pourrez connaître les résultats généraux de cette étude si vous en faites la demande au chercheur responsable à la fin de l'étude.

COMPENSATION

En guise de compensation pour les frais encourus en raison de votre participation au projet de recherche, vous recevrez un montant total de 60.00$. Si vous vous retirez du projet (ou si nous mettons fin à votre participation) avant qu'il ne soit complété, la compensation sera proportionnelle à la durée de votre participation. Vous recevrez ainsi 15.00$ selon le nombre de fois où vous aurez répondu aux questionnaires, lesquels seront remplis aux deux premières visites (avant l'intervention) et aux deux

dernières visites (après l'intervention).

EN CAS DE PRÉJUDICE

Si vous deviez subir quelque préjudice que ce soit par suite de toute procédure reliée à ce projet de recherche, vous recevrez tous les soins et services requis par votre état de santé.

En acceptant de participer à ce projet de recherche, vous ne renoncez à aucun de vos droits et vous ne libérez pas le chercheur responsable de ce projet de recherche et l'établissement de leur responsabilité civile et professionnelle.

PARTICIPATION VOLONTAIRE ET DROIT DE RETRAIT

Votre participation à ce projet de recherche est volontaire. Vous êtes donc libre de refuser d'y participer. Vous pouvez également vous retirer de ce projet à n'importe quel moment, sans avoir à donner de raisons, en informant l'équipe de recherche.

Votre décision de ne pas participer à ce projet de recherche ou de vous en retirer n'aura aucune conséquence sur la qualité des soins et des services auxquels vous avez droit ou sur votre relation avec les équipes qui les dispensent.

Le chercheur responsable de ce projet de recherche et le comité d'éthique de la recherche peuvent mettre fin à votre participation, sans votre consentement. Cela peut se produire si de nouvelles découvertes ou informations indiquent que votre participation au projet n'est plus dans votre intérêt, si vous ne respectez pas les consignes du projet de recherche ou encore s'il existe des raisons administratives d'abandonner le projet.

Si vous vous retirez du projet ou êtes retiré du projet, l'information et le matériel déjà recueillis dans le cadre de ce projet seront néanmoins conservés, analysés ou utilisés pour assurer l'intégrité du projet.

Toute nouvelle connaissance acquise durant le déroulement du projet qui pourrait avoir un impact sur votre décision de continuer à participer à ce projet vous sera communiquée rapidement.

IDENTIFICATION DES PERSONNES-RESSOURCES

Si vous avez des questions ou éprouvez des problèmes en lien avec le projet de recherche, ou si vous souhaitez vous en retirer, vous pouvez communiquer avec la chercheuse responsable, Tania Lecomte, ou avec une personne de l'équipe de recherche, au numéro suivant: 514-343-6111, poste 4724.

Pour toute question concernant vos droits en tant que participant(e) à ce projet de recherche ou si vous avez des plaintes ou des commentaires à formuler, vous pouvez communiquer avec le commissaire local aux plaintes et à la qualité des services du CIUSSS de l'Est-de-l'Île-de-Montréal au numéro suivant : 514-252-3400, poste 3510.

SIGNATURE

J'ai pris connaissance du formulaire d'information et de consentement. On m'a expliqué le projet de recherche et le présent formulaire d'information et de consentement. On a répondu à mes questions et on m'a laissé le temps voulu pour prendre une décision. Après réflexion, je consens à participer à ce projet de recherche aux conditions qui y sont énoncées.

J'autorise l'équipe de recherche à avoir accès à mon dossier médical.

Nom (en lettres moulées)	Signature du/de la participant(e)	Date

SIGNATURE DE LA PERSONNE QUI OBTIENT LE CONSENTEMENT

J'ai expliqué au/à la participant(e) le projet de recherche et le présent formulaire d'information et de consentement et j'ai répondu aux questions qu'il/elle m'a posées.

Nom (en lettres moulées)	Signature de la personne qui obtient le consentement	Date

ENGAGEMENT DE LA CHERCHEUSE RESPONSABLE À L'IUSMM

Je certifie qu'on a expliqué au/à la participant(e) le présent formulaire d'information et de consentement, que l'on a répondu aux questions que le sujet de recherche avait.

Je m'engage, avec l'équipe de recherche, à respecter ce qui a été convenu au formulaire d'information et de consentement et à en remettre une copie signée et datée au/à la participant(e).

Nom (en lettres moulées)	Signature de la chercheuse responsable	Date

SIGNATURE D'UN TÉMOIN

OUI ☐ **NON** ☐

La signature d'un témoin est requise pour les raisons suivantes:

☐ Difficulté ou incapacité à lire - La personne (témoin impartial) qui appose sa signature ci-dessous atteste qu'on a lu le formulaire de consentement et qu'on a expliqué précisément le projet au (à la) participant(e), qui semble l'avoir compris.

☐ Incompréhension de la langue du formulaire de consentement - La personne qui appose sa signature ci-dessous a fait fonction d'interprète pour le ou la participant(e) au cours du processus visant à obtenir le consentement.

Nom (en lettres moulées)	Signature du témoin	Date

Veuillez noter:

Il faut consigner dans le dossier de recherche du(de la) participant(e), le cas échéant, d'autres renseignements sur l'aide fournie au cours du processus visant à obtenir le consentement.

APPROBATION PAR LE COMITÉ D'ÉTHIQUE DE LA RECHERCHE

Le comité d'éthique de la recherche du CHUM a approuvé le projet et assurera le suivi du projet pour les établissements du réseau de la santé et des services sociaux du Québec participants.

Tableau des visites et procédures à l'étude

Phase	Tâche du participant	Données recueillies	Interventions par l'équipe de chercheurs	Temps requis
Première visite – éligibilité et consentement, phase de pré-traitement	-Remplir le formulaire de consentement, le questionnaire socio-démographique, le questionnaire sur la situation amoureuse et le BPRS -Remplir les questionnaires RRFS, FESFS, MSQ, SERS-SF, ISMIS et Test des histoires	-Données socio-démographiques -Diagnostic (à partir du dossier médical) -Symptômes (à partir du BPRS) -Collecte de données des questionnaires	-Expliquer le projet et risques associés -Répondre aux questions -Assister à l'administration des questionnaires	Environ 90 minutes
De la seconde à la 13e visite – phase de traitement	-Remplir le questionnaire sur la situation amoureuse et le BPRS -Remplir les questionnaires RRFS, FESFS, MSQ, SERS-SF, ISMIS et Test des histoires avant la première séance de l'intervention et suite à la dernière -Répondre à voix haute au questionnaire de satisfaction face à l'intervention -Participer au groupe et faire les exercices à la maison	-Collecte de données des questionnaires	-Assister à l'administration des questionnaires -Donner la thérapie de groupe	Environ 90 minutes par séance, pour douze (12) séances au total sur douze (12) semaines
Dernière visite – phase de post-traitement	-Remplir le questionnaire sur la situation amoureuse et le BPRS -Remplir les questionnaires RRFS, FESFS, MSQ, SERS-SF, ISMIS et Test des histoires	-Collecte de données des questionnaires	-Assister à l'administration des questionnaires	Environ 90 minutes

Appendix B – Questionnaires

QUESTIONNAIRE SOCIO-DÉMOGRAPHIQUE (STUDY 2)

Comment avez-vous entendu parler de cette étude?

◯ En ligne
◯ À travers un professionnel de la santé (indiquer son nom) : _____
◯ Autre (veuillez spécifier) : _____

Quel âge avez-vous? _____ ans

Quelle est votre langue maternelle ?

◯ Français
◯ Anglais
◯ Autre. Précisez : _____

Quel est votre lieu de naissance ?

◯ Je suis né/e au Canada
◯ Je suis né/e ailleurs. Précisez : _____

Quel est votre état civil ?

◯ Célibataire
◯ En couple
◯ Marié
◯ Séparé/divorcé
◯ Conjoint de fait
◯ Veuf

Laquelle des appellations suivantes décrit le mieux votre genre ?

◯ Femme trans
◯ Femme (femme cis)
◯ Homme trans
◯ Homme (homme cis)
◯ Genre fluide (non-binaire)
◯ Je ne m'identifie pas à ces options. Précisez, si vous voulez : _____
◯ Je préfère ne pas répondre

Laquelle des appellations suivantes décrit le mieux votre orientation sexuelle ?

◯ Asexuel(le)
◯ Bisexuel(le)
◯ Gai
◯ Hétérosexuel(le)
◯ Lesbienne
◯ Incertain(e)
◯ En questionnement
◯ Queer
◯ Bi-spirituel(le)
◯ Je préfère ne pas répondre
◯ Autre (précisez, si vous voulez) : _____

Quel est votre plus haut niveau de scolarité complété ?

◯ Pas de diplôme d'études secondaires
◯ Diplôme d'études secondaires (DES ou DEP)
◯ CÉGEP (AEC ou DEC)
◯ Université premier cycle (certificat, baccalauréat)
◯ Université 2e-3e cycle

Nombre d'années de scolarité complétées (à partir de la 1e année de primaire) : _____

Quelle est votre occupation principale ?

◯ En emploi
◯ Aux études
◯ Programme d'insertion ou de réadaptation
◯ Pas d'occupation
◯ Autre. Précisez : _____

Quelle est votre source de revenu ?

	1- OUI	2- NON
Travail	◯	◯
Aide sociale/chômage	◯	◯
Prêt et bourse	◯	◯
Support des parents	◯	◯
Autre	◯	◯

Quel énoncé ci-dessous décrit le mieux votre situation résidentielle ?

◯ Vit de façon indépendante
◯ Milieu de vie familial
◯ Reçoit des services de soutien au logement ou de l'aide à domicile
◯ Milieu de vie encadré par un programme
◯ Lieu de traitement
◯ Sans domicile fixe
◯ Inconnu

Avec qui habitez-vous ?

◯ Conjoint/partenaire
◯ Vos parents
◯ Vos enfants
◯ Autre membre de votre famille
◯ Autre proche
◯ Seul
◯ Colocataire
◯ Autre. Précisez : _____

Avez-vous un diagnostic de trouble de santé mentale ?

◯ Non
◯ Oui. Précisez : _____

QUESTIONNAIRE SOCIO-DÉMOGRAPHIQUE (STUDY 3)

ID PARTICIPANT :

Date (Jr/Ms/An) ☐☐ / ☐☐ / ☐☐☐☐

Date de naissance (Jr/Ms/An) ☐☐ / ☐☐ / ☐☐☐☐ **Âge :** ☐☐

Origine :

◯ 1 – Citoyen canadien
◯ 2 – Né ailleurs : _____

État civil :

◯ 1 – Inconnu ◯ 4 – Séparé/divorcé
◯ 2 – Célibataire ◯ 5 – Conjoint de fait
◯ 3 – Marié ◯ 6 – Veuf

Langue maternelle :

◯ 1 – Français
◯ 2 – Anglais
◯ 3 – Autre : _____

Plus haut niveau de scolarité complété *:*

○ 1 – Pas de diplôme d'études secondaires
○ 2 – Diplôme d'études secondaires
○ 3 – CÉGEP
○ 4 – Université premier cycle
○ 5 – Université 2e-3e cycle

Nombre d'années de scolarité complétées (à partir de la 1e année du primaire) : _____

Occupation actuelle :

○ 1- En emploi

○ 2- Aux études

○ 3- Programme d'insertion ou de réadaptation

○ 4- Pas d'occupation

○ 5- Autre : _____

Quelle est votre source de revenu :	**1- OUI**	**2- NON**
Travail	○	○
Aide sociale/chômage	○	○
Prêt et bourse	○	○
Support des parents	○	○
Autre	○	○

Quel énoncé ci-dessous décrit le mieux votre situation résidentielle ?

○ 1 – Vit de façon indépendante

○ 2 – Milieu de vie familial

○ 3 – Reçoit des services de soutien au logement ou de l'aide à domicile

○ 4 – Milieu de vie encadré par un programme

○ 5 – Lieu de traitement

○ 6 – Sans domicile fixe

○ 7 – Inconnu

Avec qui habitez-vous ?

○ 1 – Conjoint/partenaire	○ 4 – Autre membre de votre famille	○ 7 – Colocataire
○ 2 – Vos Parents	○ 5 – Autre proche	○ 8 – Autre
○ 3 – Vos Enfants	○ 6 – Seul	

À PARTIR DU DOSSIER MÉDICAL

Catégorie du diagnostic principal :

○ 1 – Troubles de l'humeur (bipolaire, dépression, etc.)
○ 2 – Schizophrénies et troubles apparentés
○ 3 – Autre trouble psychotique
○ 4 – Troubles liés à une substance
○ 5 – Troubles de personnalité
○ 6 – Autre : _____

MSQ

Directive : Ci-dessous, vous trouverez plusieurs énoncés qui touchent le domaine des relations sexuelles. Lisez attentivement tous les énoncés et indiquez, dans l'espace qui les précède, à quel degré ils vous caractérisent. Certains renvoient à une relation sexuelle spécifique. Si possible, répondez en vous référant à votre partenaire actuel(le). Si vous n'avez jamais eu de relation sexuelle, indiquez ce que vous pensez que vous répondriez dans une telle situation. Répondez à tous les énoncés même si vous n'êtes pas complètement certain(e) de vos réponses et, bien sûr, soyez honnête dans vos réponses. Veuillez répondre en disant dans quelle mesure chacun des énoncés s'applique à vous en utilisant l'échelle suivante :

1 = Ne me caractérise **pas du tout**
2 = Me caractérise **un peu**
3 = Me caractérise **plus ou moins**
4 = Me caractérise **assez**
5 = Me caractérise **beaucoup**

1. J'ai confiance en moi en tant que partenaire sexuel(le).	
2. Je pense toujours à la sexualité.	
3. Je suis largement responsable de ma sexualité.	
4. Je suis très conscient(e) de mes sentiments par rapport à la sexualité.	
5. Je suis très motivé(e) à être sexuellement actif(ve).	
6. Je me sens anxieux(se) lorsque je pense aux aspects sexuels de ma vie.	
7. Je m'exprime très aisément sur les aspects sexuels de ma vie.	
8. Les aspects sexuels de ma vie me dépriment.	
9. Les aspects sexuels de ma vie sont principalement déterminés par des événements chanceux.	
10. Quelquefois, je me demande ce que les autres pensent des aspects sexuels de ma vie.	
11. J'ai plus ou moins peur de m'impliquer sexuellement avec une autre personne.	
12. Je suis très satisfait(e) de la façon dont mes besoins sexuels sont présentement comblés.	
13. Je suis un(e) assez bon(ne) partenaire sexuel(le).	
14. Je pense à la sexualité plus qu'à n'importe quoi d'autre.	
15. Les aspects sexuels de ma vie sont principalement déterminés par mes propres comportements.	
16. Je suis très conscient(e) de mes motivations sexuelles.	

1 = Ne me caractérise **pas du tout**

2 = Me caractérise **un peu**

3 = Me caractérise **plus ou moins**

4 = Me caractérise **assez**

5 = Me caractérise **beaucoup**

17. Je suis fortement motivé(e) à dévouer temps et efforts à la sexualité.	
18. Je suis préoccupé(e) par les aspects sexuels de ma vie.	
19. Je ne suis pas très direct(e) lorsque vient le temps d'exprimer mes préférences sexuelles.	
20. Je suis déçu(e) de la qualité de ma vie sexuelle.	
21. La plupart des choses qui affectent les aspects sexuels de ma vie m'arrivent par accident.	
22. Je suis très préoccupé(e) par la façon dont les autres évaluent les aspects sexuels de ma vie.	
23. J'ai quelquefois peur des relations sexuelles.	
24. Je suis très satisfait(e) de ma relation sexuelle.	
25. Je suis meilleur(e) dans les activités sexuelles que la plupart des gens.	
26. J'ai tendance à être préoccupé(e) par la sexualité.	
27. Je contrôle les aspects sexuels de ma vie.	
28. J'essaie toujours de comprendre mes sentiments sexuels.	
29. J'ai un fort désir d'être sexuellement actif(ve).	
30. Penser aux aspects sexuels de ma vie me laisse avec un sentiment de malaise.	
31. Je suis plus ou moins passif(ve) lorsque vient le temps d'exprimer mes désirs sexuels.	
32. Je me sens découragé(e) lorsque je pense à ma vie sexuelle.	
33. La chance joue un rôle important en influençant les aspects sexuels de ma vie.	
34. Je suis très conscient(e) de ce que les autres pensent des aspects sexuels de ma vie.	
35. J'ai quelquefois peur des activités sexuelles.	
36. Ma relation sexuelle à l'intérieur de mon couple comble mes attentes d'origine.	
37. Comme partenaire sexuel(le), je m'évaluerais assez favorablement.	
38. Je pense constamment à avoir des activités sexuelles.	
39. La principale chose qui affecte les aspects sexuels de ma vie, c'est ce que je fais moi-même.	

1 = Ne me caractérise **pas du tout**

2 = Me caractérise **un peu**

3 = Me caractérise **plus ou moins**

4 = Me caractérise **assez**

5 = Me caractérise **beaucoup**

40. Je suis très conscient(e) des changements dans mes désirs sexuels.	
41. C'est vraiment très important pour moi de m'impliquer dans des activités sexuelles.	
42. Je suis habituellement préoccupé(e) par les aspects sexuels de ma vie.	
43. Je n'hésite pas à demander ce que je veux lors d'une relation sexuelle avec mon/ma partenaire.	
44. Je me sens malheureux(se) lorsque je pense à mes relations sexuelles.	
45. Les aspects de ma vie sont principalement une question de bonne ou de mauvaise chance.	
46. Je suis préoccupé(e) par la manière dont les autres perçoivent les aspects sexuels de ma vie.	
47. Je n'ai pas vraiment peur de m'engager dans une activité sexuelle.	
48. Ma relation sexuelle est très bonne comparativement à celle de la plupart des gens.	
49. Je suis très confiant(e) dans une rencontre sexuelle.	
50. Je pense à la sexualité la majorité du temps.	
51. Ma sexualité est quelque chose que je contrôle.	
52. Je suis très conscient(e) de mes tendances sexuelles.	
53. Je vise à me garder sexuellement actif(ve).	
54. Je me sens nerveux(se) lorsque je pense aux aspects sexuels de ma vie.	
55. Je demande habituellement ce que je veux sur le plan sexuel.	
56. Je me sens triste lorsque je pense à mes expériences sexuelles.	
57. Que je fasse n'importe quoi, je ne suis pas près d'avoir du contrôle sur ma propre vie sexuelle.	
58. Je suis concerné(e) par ce que les autres pensent des aspects sexuels de ma vie.	
59. Je n'ai pas vraiment peur de devenir sexuellement actif(ve).	
60. Je suis très satisfait(e) des aspects sexuels de ma vie.	

RRFS

Veuillez répondre aux questions suivantes en indiquant à quel point vous êtes en accord ou en désaccord avec l'affirmation. Il n'y a pas de mauvaises réponses. Pour chaque affirmation, choisissez la meilleure réponse selon comment vous vous sentez présentement.

1. Je me sens déconnecté de mes pairs.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

2. J'ai confiance en mes compétences en relations amoureuses.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

3. Il est difficile de savoir comment agir dans une relation amoureuse.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

4. J'ai des difficultés dans mes relations familiales.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

5. J'essaierais d'éviter de parler de mes problèmes de santé mentale avec un partenaire amoureux.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

6. Je m'inquiète de perdre mon individualité si je m'engage dans une relation amoureuse.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

7. Il est facile pour moi de rencontrer des gens qui pourraient être de potentiels partenaires amoureux.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

8. J'ai des difficultés dans mes relations amicales.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

9. Des partenaires amoureux/de possibles partenaires amoureux me rejeteront si j'ai des problèmes de santé mentale.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

10. J'ai peur qu'un partenaire amoureux profite de moi.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

11. J'ai assez d'expérience dans les relations amoureuses.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

12. J'ai des difficultés dans mes relations amoureuses.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

13. Je vais à l'extrême pour réduire la possibilité de me blesser dans une relation.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

14. Je sais à quoi m'attendre si je vais à un rendez-vous avec quelqu'un.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

15. Il est facile pour moi de lire les signaux romantiques (e.g., savoir quand quelqu'un *flirt* avec moi).

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

16. Il est plus difficile pour moi que pour ce l'est pour les autres personnes de faire confiance à un partenaire amoureux.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

17. J'ai confiance en mes compétences en rencontres amoureuses.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

18. J'ai les ressources pour poursuivre une relation amoureuse (e.g., de l'argent, un endroit pour rencontrer mon partenaire, un accès à un transport, etc.).

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

19. Si quelque chose arrivait avec ma santé mentale, je crois qu'un partenaire amoureux pourrait l'accepter.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

20. Il est facile pour moi de faire confiance aux autres.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

21. J’ai peur qu’un partenaire amoureux soit infidèle dans notre relation.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

22. Je suis bon pour communiquer dans des relations amoureuses.

1	2	3	4	5
Totalement en désaccord	En désaccord	Neutre	En accord	Totalement en accord

ÉCHELLE de FONCTIONNEMENT SOCIAL d'un PREMIER ÉPISODE

Veuillez SVP répondre à chacune des questions le plus honnêtement possible en encerclant les choix suggérés. Si vous répondez « *Jamais »* ou si vous croyez qu'une question ne s'applique pas à votre situation et que vous répondez « *Aucune de ces réponses »*, veuillez SVP en expliquer la raison.

4. Intimité

4.1 FAIRE DES RENCONTRES AMOUREUSES

4.1.a Je suis tout à fait confortable lors de rencontres amoureuses.

Totalement en désaccord	En désaccord	En accord	Totalement en accord

4.1.b Au cours des 3 derniers mois, j'ai fait des rencontres amoureuses.

Jamais	Parfois (2 rencontre ou moins)	Souvent (plus de 3 rencontres)	Toujours (j'ai vu quelqu'un toutes les semaines)	Aucune de ces réponses

Si vous avez répondu « Aucune de ces réponses » ou « Jamais », veuillez s'il-vous-plaît expliquer: (ex : pas intéressé, j'essaie de faire des rencontres).

_____

_____

4.2 AVOIR UN COPAIN/COPINE OU CONJOINT(E)

4.2.a J'apprécie avoir un copain/copine ou conjoint(e) stable.

Totalement en désaccord	En désaccord	En accord	Totalement en accord

4.2.b Au cours des 3 derniers mois, j'ai passé du temps avec mon copain/copine ou conjoint(e) stable.

Jamais	Parfois (quelques semaines)	Souvent (1 fois/semaine pour moins d'un mois)	Toujours (chaque semaine pour plus d'un mois)	Aucune de ces réponses

Si vous avez répondu « Aucune de ces réponses » ou « Jamais », veuillez s'il-vous-plaît expliquer: (ex : je n'ai pas de copain/copine, je ne suis pas intéressé).

_____

_____

4.3 RELATION SEXUELLE

4.3.a Je suis intéressé au sexe.

Totalement en désaccord	En désaccord	En accord	Totalement en accord

4.3.b Au cours des 3 derniers mois, j'ai eu des relations sexuelles avec quelqu'un.

Jamais	Parfois (au moins 1 fois)	Souvent (2 fois/mois ou plus)	Toujours (chaque semaine)	Aucune de ces réponses

Si vous avez répondu « Aucune de ces réponses » ou « Jamais », veuillez s'il-vous-plaît expliquer: **(**ex : croyances religieuses, je ne suis pas intéressé).

_____

_____

4.4 INTIMITÉ ÉMOTIONNELLE

4.4.a Je sens que je suis capable de partager mes sentiments, mes pensées intérieures et être proche de mon copain/copine ou conjoint(e) stable (quand j'en ai un(e)).

Totalement en désaccord	En désaccord	En accord	Totalement en accord

4.4.b Au cours des 3 derniers mois, j'ai partagé mes sentiments, mes pensées intérieures et j'ai été proche de mon copain/copine ou conjoint(e) stable.

Jamais	Parfois (au moins 1 fois)	Souvent (2 fois/mois ou plus)	Toujours (chaque semaine ou plus)	Aucune de ces réponses

Si vous avez répondu « Aucune de ces réponses » ou « Jamais », veuillez s'il-vous-plaît expliquer: (ex : je n'ai personne avec qui partager, je ne suis pas intéressé).

_____

_____

4.5 COMPRÉHENSION DES SITUATIONS

4.5.a Je peux comprendre rapidement ce qui se passe dans la plupart de situations impliquant d'autres personnes.

Totalement en désaccord	En désaccord	En accord	Totalement en accord

4.5.b Au cours des 3 derniers mois, j'ai été capable de comprendre rapidement la plupart des situations impliquant d'autres personnes.

Jamais	Parfois (moins d'un fois/semaine)	Souvent (presque tous les jours)	Toujours (à tous les jours)	Aucune de ces réponses

Si vous avez répondu « Aucune de ces réponses » ou « Jamais », veuillez s'il-vous-plaît expliquer: **(**ex : je n'ai pas eu l'occasion, etc.).

_____

_____

Sur une échelle de 1 à 10, de façon général, à quel point est-ce important pour vous d'être bon dans les secteurs d'intimité mentionnés ci-haut (faire des rencontres, avoir un copain/copine ou conjoint(e), avoir des relations sexuelles, être proche de ses émotions et comprendre les situations)?

1 (pas du tout important)	2	3	4	5	6	7	8	9	10 (extrêmement important)

Commentaires: _____

_____

_____

SERS-SF

Ce questionnaire permet de mesurer ce que vous ressentez à propos de vous-même. Il n'y a pas de bonnes ou mauvaises réponses. Veuillez répondre à chacune des phrases en utilisant l'échelle ci-dessous :

1 = Jamais
2 = Rarement
3 = Quelquefois
4 = Parfois
5 = Souvent
6 = La plupart du temps
7 = Toujours

____ 1. J'ai l'impression que les autres font les choses beaucoup mieux que moi.
____ 2. Je suis confiant(e) dans mes capacités à interagir avec les gens.
____ 3. Je pense que j'ai tendance à ne pas réussir les choses que je fais.
____ 4. Je pense que les gens ont du plaisir à parler avec moi.
____ 5. Je pense être une personne compétente.
____ 6. Quand je suis avec des gens, j'ai l'impression qu'elles sont contentes en ma présence.
____ 7. Je pense faire bonne impression sur les autres.
____ 8. Je suis confiant(e) dans mes capacités à débuter de nouvelles relations, si je le souhaite.
____ 9. J'ai honte de moi-même.
___ 10. Je me sens inférieur(e) aux autres.
___ 11. Je pense que mes ami(e)s me trouvent intéressant(e).
___ 12. Je crois avoir un bon sens de l'humour.
___ 13. Je suis en colère contre moi-même.
___ 14. Mes ami(e)s me valorisent beaucoup.
___ 15. J'ai peur d'avoir l'air stupide face aux autres.
___ 16. Je voudrais disparaître quand je suis entouré(e) de monde.
___ 17. Je crois que si je pouvais davantage ressembler aux autres, je me sentirais mieux avec moi-même.
___ 18. Je crois que je me laisse marcher sur les pieds plus que les autres.
___ 19. Je pense que les gens ont du plaisir lorsqu'ils sont avec moi.
___ 20. Je voudrais être quelqu'un d'autre.

Internalized Stigma of Mental Illness

(Boyd Ritsher et al. 2003 ; Prouteau, Grados et al., en cours de validation)

Le terme de « trouble psychique » est utilisé dans ce questionnaire : n'hésitez pas à le remplacer par tout autre terme qui, selon vous convient le mieux.
Pour chaque affirmation, veuillez indiquer si vous êtes :

1	2	3	4
Pas du tout d'accord	Pas d'accord	D'accord	Tout à fait d'accord

1.	J'ai le sentiment de ne pas être à ma place dans le monde à cause de mon trouble psychique	1 2 3 4
2.	Les gens avec un trouble psychique ont tendance à être violents.	1 2 3 4
3.	Les gens me traitent différemment des autres, parce que j'ai un trouble psychique	1 2 3 4
4.	J'évite les contacts avec les gens qui n'ont pas de trouble psychique pour éviter d'être rejeté	1 2 3 4
5.	Je suis embarrassé(e) ou honteux(euse) d'avoir un trouble psychique.	1 2 3 4
6.	Les gens avec un trouble psychique ne devraient pas se marier.	1 2 3 4
7.	Les gens avec un trouble psychique apportent une importante contribution à la société.	1 2 3 4
8.	Je me sens inférieur(e) à ceux qui n'ont pas de trouble psychique.	1 2 3 4
9.	Je n'ai plus autant d'activités sociales qu'avant parce que mon trouble psychique pourrait me donner une apparence ou un comportement étrange	1 2 3 4
10.	Les personnes ayant un trouble psychique ne peuvent pas avoir une vie agréable et valorisante.	1 2 3 4
11.	Je ne parle pas beaucoup de moi parce que je ne veux pas ennuyer les autres avec mon trouble psychique.	1 2 3 4
12.	Les stéréotypes (les clichés) sur les troubles psychiques m'isolent du monde « normal ».	1 2 3 4
13.	Quand je suis entouré(e) de gens qui n'ont pas de trouble psychique je ne me sens pas à ma place ou pas à la hauteur	1 2 3 4
14.	Je me sens à l'aise quand je suis vu en public avec une personne qui a manifestement un trouble psychique	1 2 3 4
15.	Souvent les gens sont méprisants ou me traitent comme un enfant juste parce que j'ai un trouble psychique	1 2 3 4
16.	Je me déçois moi-même d'avoir un trouble psychique	1 2 3 4

1	2	3	4
Pas du tout d'accord	Pas d'accord	D'accord	Tout à fait d'accord

17. Avoir un trouble psychique a gâché ma vie.	1	2	3	4
18. Les gens peuvent dire que j'ai un trouble psychique rien qu'en me voyant	1	2	3	4
19. A cause de mon trouble psychique, j'ai besoin que les autres prennent la plupart des décisions pour moi.	1	2	3	4
20. Je reste à l'écart des situations sociales pour éviter à ma famille et mes amis d'être embarrassés	1	2	3	4
21. Les personnes qui n'ont pas de trouble psychique ne peuvent pas me comprendre.	1	2	3	4
22. Les gens m'ignorent ou ne me prennent pas au sérieux simplement parce que j'ai un trouble psychique	1	2	3	4
23. Je ne peux rien apporter à la société parce que j'ai un trouble psychique	1	2	3	4
24. Vivre avec un trouble psychique m'a rendu plus fort.	1	2	3	4
25. Personne ne voudrait avoir une relation intime avec moi parce que j'ai un trouble psychique	1	2	3	4
26. En général, je suis capable de vivre ma vie comme je le veux.	1	2	3	4
27. Je peux avoir une vie épanouissante, malgré mon trouble psychique	1	2	3	4
28. Les autres pensent que je ne peux pas faire grand chose dans ma vie parce que j'ai un trouble psychique	1	2	3	4
29. Les stéréotypes (les clichés) sur les troubles psychiques sont aussi valables pour moi	1	2	3	4

BSI – A

DIRECTIVES : Vous trouverez ci-dessous une liste de problèmes que peuvent avoir certaines personnes. Lisez attentivement chaque ligne et choisissez le nombre qui décrit le mieux *À QUEL POINT CE PROBLÈME VOUS A TROUBLÉ AU COURS DES 7 DERNIERS JOURS, Y COMPRIS AUJOURD'HUI*. Choisissez seulement un nombre par problème et n'oubliez aucun item.

	Pas du tout	**Un peu**	**Modérément**	**Beaucoup**	**Intensément**
1. Nervosité ou impression de tremblements intérieurs	0	1	2	3	4
2. Tendance à vous sentir effrayé(e) sans raison	0	1	2	3	4
3. Sentiment d'avoir peur	0	1	2	3	4
4. Sentiment de tension ou de surexcitation	0	1	2	3	4
5. Épisodes de terreur ou de panique	0	1	2	3	4
6. Vous sentir tellement agit(é)e que vous ne pouvez rester en place	0	1	2	3	4

BSI – D

DIRECTIVES : Vous trouverez ci-dessous une liste de problèmes que peuvent avoir certaines personnes. Lisez attentivement chaque ligne et choisissez le nombre qui décrit le mieux *À QUEL POINT CE PROBLÈME VOUS A TROUBLÉ AU COURS DES 7 DERNIERS JOURS, Y COMPRIS AUJOURD'HUI*. Choisissez seulement un nombre par problème et n'oubliez aucun item.

	Pas du tout	**Un peu**	**Modérément**	**Beaucoup**	**Intensément**
1. Pensées d'en finir avec la vie	0	1	2	3	4
2. Sentiment de solitude	0	1	2	3	4
3. Avoir le cafard	0	1	2	3	4
4. Manque d'intérêt pour tout	0	1	2	3	4
5. Vous sentir sans espoir face à l'avenir	0	1	2	3	4
6. Sentiment que vous ne valez rien	0	1	2	3	4

Formulaire BPRS-E

ID du sujet _____

Date _____

Séquence BPRS _____

Période d'observation _____

Intervieweur _____

Sévérité	Cote	# Question, Descriptions, Questions, Ancrages

1. PRÉOCCUPATION SOMATIQUE

Degré d'inquiétude sur l'état de santé somatique actuel. Coter à quel point la santé physique est perçue comme un problème pour le patient, que les plaintes aient ou non une base réaliste. Les idées délirantes somatiques doivent être cotées dans la gamme sévère qu'il y ait ou non une préoccupation somatique.

Note : Assurez-vous d'évaluer le degré de gêne fonctionnelle due aux préoccupations somatiques seulement et non celle liée aux autres symptômes (dépression). Si le sujet cote « 6 » ou « 7 » du fait d'idées délirantes somatiques, alors vous devrez coter le « contenu inhabituel de la pensée » au moins à « 4 » ou plus.

_ *Êtes-vous ou avez-vous été préoccupé au sujet de votre santé physique ces derniers temps ?*

_ *Avez-vous eu des maladies physiques ou avez-vous consulté un médecin ?*
A-t-il signalé que quelque chose n'allait pas ?
À quel point cela était-il sévère ?

_ *Est-ce qu'il y a quelque chose qui a changé dans votre apparence ?*

_ *Avez-vous déjà senti que certaines parties de votre corps avaient changé ou ne fonctionnaient plus bien ?*

_ *Est-ce que ça a interféré avec votre capacité de faire vos activités habituelles ou votre travail ?*

_ **[Si le patient rapporte des préoccupations somatiques ou des idées délirantes, posez les questions suivantes:]**

_ *Êtes-vous souvent préoccupé au sujet de cela (utiliser la description du patient) ?*

_ *Avez-vous déjà parlé de ces préoccupations aux autres ?*

Absent	**1**	Absent
Très léger	**2**	Préoccupation somatique occasionnelle dont le sujet parle peu aux autres.
Léger	**3**	Préoccupation somatique occasionnelle dont le sujet parle aux autres (famille et médecins).
Modéré	**4**	Expression fréquente de préoccupations somatiques ou exagération de maladies existantes OU quelques préoccupations sans retentissement fonctionnel non délirant.
Modérément sévère	**5**	Expression fréquente de préoccupation somatique ou exagération de maladies existantes OU quelques préoccupations ayant un retentissement fonctionnel modéré. Non délirant.
Sévère	**6**	Préoccupations somatiques qui interfèrent beaucoup avec le fonctionnement OU idées délirantes somatiques sans conséquences comportementales ni révélations aux autres.
Extrêmement sévère	**7**	Préoccupations somatiques ayant un retentissement fonctionnement sévère OU idées délirantes somatiques qui ont des conséquences dans le comportement ou révélées aux autres.

2. ANXIÉTÉ

Inquiétude, appréhension, crainte, tension, peur, panique. Ne considérer que ce que le patient rapporte lui-même et non de l'anxiété observée qui doit coter à l'item « tension ».

_ *Avez-vous été très inquiet durant (durée considérée pour la cotation) ?*

_ *Avez-vous été nerveux ou craignez-vous quelque chose ? À quel sujet ? Par rapport à vos finances ou de vos projets d'avenir ?*

_ *Êtes-vous préoccupé au sujet de quelque chose ?*

_ *Ou en êtes-vous de vos finances ou de vos projets d'avenir ?*

_ *Quand vous étiez nerveux, avez eu les mains moites, des battements de cœur exagérés (des palpitations ou bien le souffle court, des tremblements, sensations d'étouffement) ?*

_ **[Si le patient apporte une anxiété et/ ou des signes végétatifs), posez les questions suivantes]**

_ *Combien de temps cela a-t-il duré ?*

_ *Cela vous a-t-il gêné dans vos activités ou votre travail habituel ?*

Absent	**1**	Absent
Très léger	**2**	Le sujet indique qu'il est gêné par quelques craintes OU inquiétudes occasionnelles survenant plus souvent que chez la plupart des individus normaux.
Léger	**3**	Préoccupations fréquentes, mais peut facilement diriger son attention sur d'autres choses.
Modéré	**4**	Inquiet la plupart du temps, sans pouvoir facilement penser à autre chose, mais sans retentissement fonctionnel OU anxiété occasionnelle avec signes végétatifs, mais sans retentissement fonctionnel.
Modérément sévère	**5**	Accès d'anxiété avec signes végétatifs fréquents, mais non quotidiens OU anxiété ou inquiétude interférant avec certains domaines de fonctionnement.
Sévère	**6**	Anxiété quotidienne avec signes végétatifs, mais pas toute la journée OU plusieurs domaines de fonctionnement sont perturbés par l'anxiété ou une inquiétude permanente.
Extrêmement sévère	**7**	Anxiété avec signes végétatifs persistant toute la journée OU la plupart des domaines de fonctionnement sont perturbés par l'anxiété ou une inquiétude continuelle.

3. DÉPRESSION

Inclure la tristesse, l'anhédonie, les préoccupations sur des thèmes dépressifs, perte d'espoir, autodépréciation (insatisfaction et dégoût de soi-même ou sentiment d'inutilité). Ne pas inclure les symptômes végétatifs, par exemple, le ralentissement moteur, le réveil précoce, ni l'avolition qui accompagne le syndrome déficitaire.

_ *Comment est votre humeur ces derniers temps ?*

_ *Vous êtes-vous senti déprimé, triste, malheureux?*

_ *Arrivez-vous à vous changer les idées sur des choses plus agréables si vous le souhaitez ?*

_ *Trouvez-vous que vous avez moins d'intérêt ou prenez vous moins de plaisir aux choses que vous appréciez d'habitude, la famille, les amis, les loisirs ou regarder la télévision ou manger ?*

_ **[Si le sujet fait état de sentiment dépressif, posez les *questions* suivantes :]**

_ *Combien de temps ces sentiments ont-ils duré ?*

_ *Est-ce qu'ils vous ont gêné dans vos activités habituelles ou professionnelles ?*

Absent	**1**	Absent
Très léger	**2**	Occasionnellement, se sent triste, malheureux ou déprimé.
Léger	**3**	Se sent fréquemment triste, malheureux, mais peut facilement s'intéresser aux autres choses.
Modéré	**4**	Se sent fréquemment très triste, malheureux ou moyennement déprimé, mais capable de fonctionner au prix d'un effort supplémentaire.

Modérément sévère	**5**	Fréquentes périodes de dépression profonde, mais non quotidiennes OU certains domaines de fonctionnement sont perturbés par la dépression.
Sévère	**6**	Dépression profonde quotidienne, mais ne persistant pas toute la journée OU plusieurs domaines de fonctionnement sont perturbés par la dépression.
Extrêmement sévère	**7**	Dépression sévère quotidienne OU la plupart des domaines de fonctionnement sont perturbés par la dépression.

4. TENDANCES SUICIDAIRES

Désir exprimé, intention ou acte de se blesser ou de se tuer.

_ *Avez-vous déjà ressenti que la vie ne vaut pas la peine d'être vécue ?*

_ *Avez-vous déjà pensé à vous blesser ou à vous tuer ?*

_ *Vous êtes-vous déjà senti fatigué de la vie ou avez-vous déjà pensé que vous seriez mieux mort ?*

_ *Avez-vous déjà eu envie d'en finir ?*

_ **[Si le patient fait état d'idées suicidaires, posez les questions suivantes]:**

_ *A quelle fréquence y avez-vous déjà pensé à (Utiliser la description du patient) ?*

_ *Avez-vous un plan défini ?*

Absent	**1**	Absent
Très léger	**2**	Sentiment occasionnel d'être fatigué de vivre. Pas d'idées suicidaires explicites.
Léger	**3**	Idées suicidaires occasionnelles sans intention ou plan défini OU le sujet pense qu'il vaudrait mieux être mort.

Modéré	**4**	Idées suicidaires fréquentes sans intention ou plan.
Modérément sévère	**5**	Le suicide a été imaginé par des méthodes variées à de nombreuses reprises. Peut avoir envisager sérieusement de faire une tentative à un moment précis ou avec un plan défini OU tentative de suicide impulsive utilisant une méthode non létale ou devant des personnes pouvant la sauver.
Sévère	**6**	Le sujet souhaite clairement se tuer. Recherche de moyens et des moments appropriés OU tentative de suicide potentiellement sérieuses, sachant qu'il pourrait être secouru.
Extrêmement sévère	**7**	Plans ou intentions suicidaires spécifiés, (par exemple, « dès que… je ferai ceci ») OU tentative de suicide caractérisée par des modalités que le patient pense létales OU tentatives dans un lieu isolé.

5. SENTIMENT DE CULPABILITÉ

Préoccupations exagérées ou remords à propos d'une conduite passée. Ne prendre en compte que les dires du patient, ne pas inférer les sentiments de culpabilité de la dépression, de l'anxiété, des défenses névrotiques. Noter que si le sujet cote « 6 »ou « 7 », du fait d'idées délirantes de culpabilité, vous devrez coter le « Contenu inhabituel de la pensée », au moins à « 4 » ou plus, en fonction de son degré de préoccupation et du retentissement fonctionnel.

_ *Y a-t-il quelque chose au sujet duquel vous vous sentez coupable ?*

_ *Pensez-vous souvent à des problèmes anciens?*

_ *Avez-vous tendance à vous faire des reproches sur des choses qui se sont déroulées ?*

_ *Avez-vous fait quelque chose dont vous avez encore honte ?*

_ **[Si le patient rapporte des idées de culpabilité, de remords ou des idées délirantes, poser les questions suivantes :]**

_ *A quelle fréquence, avez-vous pensé que (utiliser la description du patient)?*

_ *Avez-vous parlé à d'autres de vos idées de culpabilité?*

Absent	**1**	Absent
Très léger	**2**	Soucieux de ne pas avoir tenu ses engagements vis-à-vis de quelqu'un ou à propos d'un échec, mais sans réelle préoccupation. Peut facilement penser à autre chose.
Léger	**3**	Préoccupé de ne pas avoir tenu ses engagements vis-à-vis de quelqu'un ou de quelque chose, tendance à exprimer cette culpabilité aux autres.
Modéré	**4**	Préoccupation disproportionnée avec culpabilité d'avoir fait quelque chose de mal, blesser d'autres personnes, en faisant ou en manquant de faire quelque chose, mais peut facilement détourner son attention sur d'autres choses.
Modérément sévère	**5**	Préoccupations avec culpabilité d'avoir manqué ses engagements vis-à-vis de quelqu'un ou de quelque chose, peut détourner son attention sur d'autres sujets, mais seulement au prix d'un grand effort, non délirant.
Sévère	**6**	Culpabilité délirante ou se fait des reproches déraisonnables très disproportionnés aux circonstances. Le degré de préoccupation reste modéré.
Extrêmement sévère	**7**	Idées délirantes ou se fait des reproches déraisonnables à l'évidence hors de proportion avec les circonstances. Le sujet est très préoccupé par sa culpabilité et en parle aux autres ou agit en rapport avec ses idées délirantes.

6. HOSTILITÉ

Animosité, mépris, agressivité, menaces, dispute, destruction d'objets, bagarres et toute autre expression d'attitude ou de comportement hostile. Ne pas inférer d'hostilité, de défense névrotique, anxiété ou plaintes

somatiques. Ne pas inclure les accès de colère appropriés ou des réactions manifestes d'autodéfense.

_ *Comment vous entendez-vous avec les autres (la famille, les autres pensionnaires, les collègues de travail...) ?*

_ *Avez-vous été irritable ou non ces derniers temps ? Comment le manifestez-vous ?*

_ *Le gardez-vous pour vous même ?*

_ *Avez-vous été si irritable que vous avez crié, vous avez déclenché des bagarres ou des disputes?*

_ *Avez-vous crié à des personnes que vous ne connaissiez pas?*

_ *Avez-vous frappé quelqu'un récemment ?*

Absent	**1**	Absent
Très léger	**2**	Irritable ou grognon, pas ouvertement exprimé.
Léger	**3**	Cherchant la dispute, ou sarcastique.
Modéré	**4**	Ouvertement en colère à différentes occasions OU se querelle avec les autres avec excès.
Modérément sévère	**5**	A menacé, claqué les portes ou lancé des objets
Sévère	**6**	S'est battu avec d'autres sans blessure, par exemple, bousculades, gifles OU destruction de biens, par exemple, renverser des objets ou casser les fenêtres.
Extrêmement sévère	**7**	Attaque d'autres avec une possibilité de les blesser ou en cherchant réellement à les blesser (par exemple, attaques avec un marteau ou une arme).

7. HUMEUR ÉLEVÉE

Sentiment envahissant, persistant et exagéré de bien-être, de bonheur, d'euphorie (c'est à dire une humeur anormale), optimisme hors de proportion avec les circonstances. N'inférez pas l'exultation seulement à partir d'une augmentation d'activité ou suite à des propos grandioses.

_ *Vous êtes-vous senti anormalement bien, si bien que d'autres personnes ont pu penser que vous n'étiez pas dans votre état normal ?*

_ *Vous êtes-vous senti d'excellente humeur sans véritable raison ?*

Absent	**1**	Absent
Très léger	**2**	Parait très heureux, de bonne humeur, sans vraie raison.
Léger	**3**	Une certaine impression de bien-être inexplicable et persistant.
Modéré	**4**	Décrit des sensations excessives ou inexplicables, de bien-être, de joie, de confiance ou d'optimisme inapproprié aux circonstances, une partie du temps. Peut fréquemment faire des blagues, sourire, ricanner ou être excessivement enthousiaste OU quelques occasions d'élévation nette de l'humeur avec euphorie.
Modérément sévère	**5**	Décrit un sentiment irréaliste de bien-être, de confiance ou d'optimisme inapproprié aux circonstances, la plupart du temps. Peut décrire une impression d'être « au sommet », comme « si tout trouvait sa place » ou « mieux que jamais » OU quelques moments d'élévation claires de l'humeur avec euphorie.
Sévère	**6**	Décrit de nombreux moments de nette élévation de l'humeur avec euphorie OU humeur clairement élevée, presque constamment au cours de l'interview, et inapproprié au contenu.
Extrêmement sévère	**7**	Le patient rapporte être d'une humeur exagérée ou apparait presque dans un état second, riant, plaisantant, gloussant, constamment euphorique, se sentant invulnérable, de façon tout à fait inappropriée.

8. MÉGALOMANIE - Idées de grandeur

Surestimation de soi-même, conviction d'être extraordinairement doué et puissant ou s'identifiant à quelqu'un de riche ou célèbre. Ne prendre en compte que les dires du patient, pas son attitude. Note: si le sujet cote « 6 » ou « 7 » du fait d'idées délirantes de grandeur, vous devez coter le *«Contenu inhabituel de la pensée »* au moins à « 4 » ou plus.

_ *Y a-t-il quelque chose de spécial vous concernant ?*

_ *Avez-vous des pouvoirs ou des capacités particulières ou spéciaux ?*

_ *Avez-vous déjà pensé que pouvez être quelqu'un de très riche ou de très connu ?*

_ **[Si le patient décrit des idées de grandeur ou des idées délirantes, demandez :]**

_ *A quelle fréquence, avez-vous pensé cela (utilisez la description du patient) ?*

_ *Avez-vous, déjà parlé de ces idées à quelqu'un ?*

_ *Avez-vous agi en rapport avec ces idées ?*

Absent	**1**	Absent
Très léger	**2**	Se sent important et dénie des problèmes évidents, mais reste réaliste.
Léger	**3**	Idées exagérées de lui-même, au-delà de son rapport avec ses capacités ou sa formation.
Modéré	**4**	Vantardise inappropriée, prêtant être brillant, particulièrement perspicace ou doué au-delà de proportion réaliste, mais en parle rarement ou n'agit pas en fonction de cette image de soi surfaite. Ne revendique pas des réussites grandioses.

Modérément sévère	**5**	Comme en « 4 », mais fait souvent état ou agit en fonction de ses idées de grandeur. Peut avoir un doute sur la réalité de ses idées de grandeur. Non délirant.
Sévère	**6**	Délirant. Prétend avoir des pouvoirs spéciaux comme la transmission de pensée, avoir des millions de dollars, inventer de nouvelles machines, assumer des professions à un niveau qu'il n'a jamais eu, être Jésus Christ ou un chef d'état. Le patient peut ne pas être très préoccupé.
Extrêmement sévère	**7**	Délirant. Comme en « 6 », mais le sujet est très préoccupé et a tendance à en parler ou agir en fonction de ses idées de grandeur.

9. MÉFIANCE

Expressions ou croyances apparentes que les autres ont eu des intentions mauvaises ou discriminatoires. Inclut la persécution par des agents surnaturels ou non humains (par exemple : le diable). Note : Cotation de « 3 » ou plus doivent aussi être cotées sous « *Contenu inhabituel de la pensée* ».

_ *Êtes-vous parfois mal à l'aise en public ?*

_ *Avez-vous l'impression que les autres vous surveillent ?*

_ *Êtes-vous inquiet des intentions de certaines personnes à votre égard ?*

_ *Est-ce que certaines personnes semblent vouloir délibérément vous nuire ou vous blesser ?*

_ *Ressentez-vous un danger quelconque ?*

_ ***[si le sujet décrit des idées persécutives (délirantes ou non), posez les questions suivantes:]***

_ *A quelle fréquence, avez-vous été inquiet que (utilisez la description du patient) ?*

_ *En avez-vous déjà parlé à quelqu'un ?*

Absent	**1**	Absent
Très léger	**2**	Semble sur ses gardes. Réticent à répondre à certaines questions « personnelles ». Décrit être mal à l'aise en public.
Léger	**3**	Décrits des incidents, qui semblent plausibles, au cours desquels d'autres l'ont blessé ou ont voulu le blesser. Le patient sent que les autres le surveillent, rient de lui, le critiquent en public, mais cela ne se produit seulement occasionnellement ou rarement. Pas ou très peu de préoccupation.
Modéré	**4**	Dit que les autres parlent de lui de façon, ont des mauvaises intentions, ou pourraient le blesser. Au-delà de la plausibilité, mais non délirant. Les incidents de persécution suspectée sont occasionnels (moins d'une fois par semaine) avec une certaine préoccupation.
Modérément sévère	**5**	Comme en « 4 », mais les incidents sont plus fréquents, plus d'une fois par semaine. Le patient est modérément préoccupé par ses idées de persécution OU le patient décrit des idées délirantes persécutives exprimées avec beaucoup de doutes (idées délirantes partielles).
Sévère	**6**	Délirant. Parle de complots par la mafia, du FBI ou d'un empoisonnement de sa nourriture, persécution par des forces surnaturelles.
Extrêmement sévère	**7**	Comme en « 6 », mais les croyances sont bizarres et plus préoccupantes. Le patient a tendance à en parler ou agir en fonction de ses idées délirantes de persécution.

10. HALLUCINATIONS

Description d'expériences perceptuelles en absence d'objets pertinents. Lorsque l'on cote le degré auquel le fonctionnement est perturbé par des hallucinations, inclure la préoccupation concernant le contenu et l'expérience de l'hallucination, de même que le fonctionnement perturbé par les actes en rapport avec le contenu hallucinatoire (par exemple, initier un comportement déviant sur ordre hallucinatoire). Inclure la pensée audible ou les pseudo

hallucinations (voix entendues à l'intérieur de la tête) si la voix est caractérisée.

_ *Avez-vous déjà eu le sentiment d'entendre votre nom appelé ?*

_ *Avez-vous déjà entendu des sons ou des personnes parler ou parlant de vous, alors que personne n'était présent?*

_ *Avez-vous déjà entendu des voix ?*

_ ***[S'il entend des voix :]***

_ *Qu'est-ce que ces voix disaient ?*

_ *Ces voix étaient-elles reconnaissables ?*

_ *Avez-vous déjà eu des visions ou avez –vous vu des choses que d'autres ne pouvaient pas voir ?*

_ *Ou encore, avez-vous senti les odeurs que d'autres ne pouvaient pas sentir ?*

_ ***[Si le patient décrit ces hallucinations, demandez]***

_ *Est-ce que ces expériences ont perturbé votre capacité à réaliser vos activités habituelles ou votre travail ?*

_ *Comment les expliquez-vous ?*

_ *À quelle fréquence ceci est survenu ?*

Absent **1** Absent

Très léger **2** Au repos ou au moment de l'endormissement, le sujet a des visions, sent des odeurs, ou entend des voix, des sons ou des chuchotements, en l'absence de stimuli externes, mais sans retentissement sur le fonctionnement.

Léger	**3**	À l'état d'éveil complet, entend une voix appeler son nom, expériences d'hallucinations auditives non verbales (par exemple, sons ou chuchotements), hallucinations visuelles mal formées, ou expériences sensorielles en la présence d'un stimuli pertinent (par exemple, illusions visuelles) non fréquent (1 à 2 fois par semaine) et sans retentissement fonctionnel.
Modéré	**4**	Hallucinations occasionnelles verbales, visuelles, gustatives, olfactives ou tactiles, sans retentissement fonctionnel OU hallucinations auditives non verbales/ illusions visuelles non rares ou avec retentissement.
Modérément sévère	**5**	Expériences hallucinatoires quotidiennes OU certains domaines de fonctionnement sont perturbés par les hallucinations.
Sévère	**6**	Expériences d'hallucinations verbales ou visuelles, plusieurs fois par jour OU beaucoup de domaines de fonctionnement sont perturbés par les hallucinations.
Extrêmement sévère	**7**	Hallucinations visuelles ou verbales persistantes, toute la journée OU la plupart des domaines de fonctionnement sont perturbés par ces hallucinations.

11. Contenu inhabituel de la pensée.

Idées insolites singulières, étranges ou bizarres. Estimer « l'inhabituel », ne pas tenir compte de la désorganisation du discours. Les idées délirantes sont manifestement absurdes, clairement fausses ou des idées bizarres sont exprimées avec une pleine conviction. Considérer que le patient a une conviction inébranlable s'il agit comme si la croyance délirante était vraie. Les idées de références de persécution peuvent se différencier des idées délirantes, par le fait qu'elles sont exprimées avec doute et peuvent contenir plus d'éléments de la réalité. Inclure les pensées imposées, les pensées volées et les pensées diffusées. Inclure des idées délirantes de grandeur somatiques et persécutrices même si elles sont cotées ailleurs.

Note : si les préoccupations somatiques, la culpabilité, la suspicion et les idées de grandeur sont cotées « 6 » ou « 7 » du fait des idées délirantes, alors le « contenu inhabituel de la pensée » doit être cotés à « 4 » ou plus.

_ *Avez-vous déjà reçu certains messages spéciaux venant de personnes ou de choses autour de vous ?*

_ *A t-on déjà parlé de vous, à la télévision ou dans les journaux ?*

_ *Est-ce que certaines personnes peuvent lire dans vos pensées ?*

_ *Avez-vous des relations spéciales avec Dieu ?*

_ *Pensez-vous que l'électricité, les rayons X ou les ondes peuvent vous affecter ?*

_ *Avez-vous l'impression que certaines pensées sont imposées de l'extérieur ?*

_ *Avez-vous déjà senti que vous étiez sous le contrôle d'une autre personne ou d'une force extérieure ?*

_ ***[Si le patient décrit des idées bizarres ou délirantes, demandez :]***

_ *A quelle fréquence pensez-vous à (utiliser la description du patient) ?*

_ *Avez-vous parlé à quelqu'un de ces expériences ?*

_ *Comment expliquez-vous ce qui est arrivé (spécifier les évènements en question) ?*

Absent 1 Absent

Très léger 2 Idées de référence, les personnes peuvent l'observer ou rire de lui, idées de persécution (des personnes ne traitent pas comme qu'il devraient). Croyance inhabituelle dans les pouvoirs psychiques des esprits, les extraterrestres ou une croyance non réaliste dans le pouvoir dans certaines personnes. Les idées sont peu défendues et il existe un certain doute.

Léger 3 Comme en « 2 », mais le degré de distorsion de la réalité est plus marqué comme l'indiquent des idées très inhabituelles ou une conviction plus forte. Le contenu peut être typique des idées délirantes (même bizarres), mais sans pleine conviction. Les

		idées délirantes ne semblent pas clairement formées, mais sont considérées comme une possible explication pour une expérience inhabituelle.
Modéré	**4**	Idées délirantes présentes, mais sans préoccupation ni gêne fonctionnelle. Peut être un délire enkysté ou une adhésion marquée et absurde à des expériences délirantes passées.
Modérément sévère	**5**	Présence d'idées délirantes bien formées avec préoccupation OU quelques domaines de fonctionnement sont perturbés par les pensées délirantes.
Sévère	**6**	Présence d'idées délirantes bien formées avec préoccupation importante OU plusieurs domaines de fonctionnement sont perturbés par les pensées délirantes.
Extrêmement sévère	**7**	Délires envahissants presque complètement le champ des préoccupations OU idées délirantes qui perturbent la plupart des domaines de fonctionnement.

12. COMPORTEMENT BIZARRE[1]

Description de comportements qui sont bizarres, inhabituels ou relevant d'un crime psychotique. Ne pas limiter à la période de l'interview. Inclure des comportements sexuels inappropriés.

Cotez selon les dires du patient et selon vos observations pendant l'entrevue.

_ *Avez-vous déjà fait quelque chose qui a attiré l'attention des autres ?*

_ *Avez-vous déjà fait quelque chose qui pourrait vous attirer des troubles avec la police ?*

_ *Avez-vous déjà fait des choses qui semblaient bizarres ou perturbantes pour les autres ?*

Absent	**1**	Absent

Très léger	**2**	Comportement légèrement bizarre ou excentrique en public, par exemple, ricane occasionnellement tout seul, n'établit pas un contact visuel approprié, mais cela ne semble pas attirer l'attention des autres OU comportement inhabituel, en privé, par exemple, rituel inoffensif qui n'attirerait pas l'attention des autres.
Léger	**3**	Comportement, en public, notablement singulier, par exemple, parle fort de façon inappropriée, établit des contacts visuels inappropriés OU comportement, en privé, qui attire parfois l'attention des autres, mais pas toujours, par exemple, entasse de la nourriture, a des rituels inhabituels, porte des gants à l'intérieur.
Modéré	**4**	Attitude clairement bizarre qui attire ou qui pourrait attirer (quand c'est en privé) l'attention des autres, mais sans nécessiter d'intervention. Le comportement survient occasionnellement, par exemple, garder les yeux au ciel pendant plusieurs minutes, répondre à des voix à une seule reprise, parler fort à soi-même.
Modérément sévère	**5**	Attitude et comportement clairement bizarre qui attire ou devrait attirer (si c'est fait en privé) l'attention des autres et des autorités, par exemple, fixer du regard d'une manière socialement perturbante, réponse occasionnelle aux voix, ingestion d'objets non comestibles.
Sévère	**6**	Comportement bizarre qui attire le regard des autres avec intervention des autorités, par exemple, perturbation du trafic, nudité en public, fixer du regard dans l'espace pendant des périodes longues, tenir une conversation avec des hallucinations.
Extrêmement sévère	**7**	Crimes sévères commis de manière bizarre, qui attirent l'attention des autres et le contrôle par les autorités, par exemple, allumer des feux et regarder des flammes et comportements constamment bizarres, par exemple, réponses seulement aux hallucinations et sans pouvoir engager une interaction.

13. NÉGLIGENCE PERSONNELLE

Hygiène, apparence ou comportement alimentaire en dessous des attentes habituelles, des standards socialement acceptés ou mettant en danger la vie du sujet.

Cotez selon les dires du patient et selon vos observations pendant l'entrevue.

_ *Comment vous occupez-vous de votre hygiène ces derniers temps ?*

_ *À quelle fréquence changez-vous vos vêtements ?*

_ *À quelle fréquence vous brossez-vous les dents ?*

_ *À quelle fréquence prenez-vous des douches ?*

_ *Quelqu'un s'est-il plaint de l'état de vos vêtements ou de votre manque de soin ?*

_ *Prenez-vous des repas réguliers ?*

Absent	**1**	Absent
Très léger	**2**	Hygiène ou apparence légèrement en dessous des standards usuels de la communauté, par exemple, tee-shirt sorti du pantalon, boutons non boutonnés, lacets non faits, mais sans conséquences sociales ni médicales.
Léger	**3**	Hygiène ou apparence occasionnellement en dessous des standards habituels, par exemple, bains ou douches irrégulières, vêtements tachés, cheveux non peignés, manquant régulièrement des repas. Pas de conséquences sociales ni médicales.
Modéré	**4**	Hygiène ou apparence notablement en dessous des standards usuels, par exemple, ne se lave pas ou ne change pas ses vêtements, vêtements très souillés, cheveux mal peignés, doit être poussé pour s'occuper de lui ; notable par les autres OU s'hydrate de façon irrégulière, avec des conséquences minimes sur le plan médical.

Modérément sévère	**5**	Plusieurs domaines de l'hygiène ou de l'apparence sont en dessous des standards de la population générale OU le manque de soin attire les critiques des autres et nécessite un encouragement régulier. La nourriture ou l'hydratation est irrégulière et insuffisante posant certains problèmes médicaux.
Sévère	**6**	De nombreux domaines d'hygiène et d'apparence sont en dessous des standards usuels, n'obtempère pas toujours aux sollicitations pour se laver ou changer ses vêtements. Le manque de soin est responsable d'un isolement social à l'école ou au travail ou nécessite une intervention. Alimentation erratique ou insuffisante qui peut nécessiter une intervention médicale.
Extrêmement sévère	**7**	Des domaines d'hygiène, d'apparence ou de nutrition sont extrêmement insuffisants et facilement remarqués comme en dessous des standards usuels OU hygiène/ apparence/ nutrition nécessitent une intervention médicale urgente.

14. DÉSORIENTATION

Ne comprend pas toujours les situations ou les échanges, par exemple les questions au cours de la BPRS. Confusions entre les personnes ou dans le temps. Ne pas prendre en compte si les réponses incorrectes sont dues à des idées délirantes.

_ *Puis-je vous poser quelques questions standard que nous demandons à tout le monde ?*

Quel âge avez-vous ?

_ *Quelle est la date ?*

_ *Où sommes-nous ?*

_ *Quel est votre âge ?*

_ *Qui est le premier ministre du Québec (ou du Canada) ?*

_ *Avez-vous entendu de bonnes blagues récemment, est-ce que vous aimeriez écouter une histoire drôle ? (pour item 16.)*

Absent	**1**	Absent

Très léger	**2**	Semble un peu perdu ou légèrement confus, 1 ou 2 fois au cours de l'interview. Bonne orientation des personnes, des lieux et dans le temps.
Léger	**3**	Occasionnellement embrouillé ou légèrement confus, 3 ou 4, pendant l'interview. Inexactitude mineure concernant les personnes, les lieux ou les dates, par exemple, erreur de date de plus ou moins 2 jours, ou indique un mauvais service de l'hôpital.
Modéré	**4**	Embrouillé durant l'interview. Inexactitude mineure concernant les personnes, les endroits ou les dates ; de plus, peut avoir des difficultés à se souvenir d'informations générales comme le nom du premier ministre.
Modérément sévère	**5**	Confusion marquée au cours de l'entretien ou concernant les personnes ou les milieux, les dates. Inexactitude significative notée, par exemple, erreur de dates de plus d'une semaine, ou ne peut pas donner correctement le nom de l'Hôpital. A des difficultés à se souvenir d'informations personnelles, par exemple, où il est né, son lieu de résidence ou a des difficultés à reconnaitre des personnes familières.
Sévère	**6**	Désorienté à la personne, au lieu ou au temps, dans 2 des 3 sphères.
Extrêmement sévère	**7**	Grossièrement désorienté dans chacune des 3 sphères.

15. DÉSORGANISATION CONCEPTUELLE OU DU LANGAGE[1]

Degré auquel le discours est confus, incohérent, imprécis, ou désorganisé. Coter la tangentialité, la circonstantialité, les brusques changements de sujets, l'incohérence, les déconnections, les pertes d'idées, les illogismes, les associations lâches et les néologismes. Ne pas prendre en compte le contenu ni la pression du discours.

Absent	**1**	Absent
Très léger	**2**	Usage singulier de mots, déraillements, mais le discours reste compréhensible.

Léger	**3**	Le discours est un peu difficile à comprendre et à interpréter du fait de la tangentialité, la circonstantialité ou des brusques changements de sujet.
Modéré	**4**	Difficultés, discours difficile à comprendre du fait de la tangentialité, la circonstantialité et utilisation idiosyncrasique de mots ou des changements de sujets à de nombreuses occasions ou 1 ou 2 exemples de phrases incohérentes.
Modérément sévère	**5**	Discours difficile à comprendre dû à la tangentialité la circonstantialité, néologismes, blocages, coqs à l'âne la plupart du temps ou 3-5 exemples de phrases incohérentes.
Sévère	**6**	Discours incompréhensible du fait de sévères perturbations, la plupart du temps. Beaucoup d'items ne peuvent pas être cotés du fait par le seul récit du sujet.
Extrêmement sévère	**7**	Discours incompréhensible tout au long de l'interview.

16. PENSÉE APPAUVRIE[2]

Appauvrissement qualitatif du processus de réflexion, altération négative de la pensée formelle. Les phrases sont pauvres, simplifiées, condensées, répétitives ou vagues; La compréhension des métaphores, analogies et généralisations est altérée; Si sévère le flux du discours peut être affecté par des délais ou un blocage. Cotez le contenu pauvre du discours, la pensée concrète, la difficulté à la pensée abstraite, la persévération, les blocages, l'augmentation du temps de réponse. Ne pas quantifier les troubles de la pensée formelle, tel que la pauvreté du discours.

Absent	**1**	Absent
Très léger	**2**	Les phrases sont légèrement pauvres, simplifiées ou condensées mais clairement compréhensibles; Peut avoir des problèmes à comprendre des concepts complexes ou abstraits, des métaphores, des analogies et des généralisations.
Léger	**3**	Les phrases tendent à être pauvres, simplifiées ou condensées mais généralement compréhensibles; A des problèmes à

		comprendre des concepts complexes ou abstraits, des métaphores, des analogies et des généralisations.
Modéré	**4**	Les phrases sont pauvres, simplifiées, condensées, vagues ou répétitives mais généralement compréhensibles; Démontre une compréhension des métaphores, des analogies et des généralisations seulement si celles-ci sont simples.
Modérément sévère	**5**	Les phrases sont pauvres, simplifiées, condensées, vagues ou répétitives et occasionnellement incompréhensibles; La compréhension des métaphores, des analogies et des généralisations est modérément altérée; Peut démontrer un délai minimal de réponse ou de rares blocages durant l'entrevue.
Sévère	**6**	La plupart des phrases sont difficiles à comprendre à cause de leur pauvreté marquée, de simplifications, de condensations, d'éléments vagues ou de persévérations. La compréhension des métaphores, des analogies et des généralisations est nettement altérée; Peut démontrer un temps de réponse augmenté ou des blocages durant l'entrevue.
Extrêmement sévère	***7***	Les phrases sont incompréhensibles à cause de leur extrême pauvreté, de simplifications, de condensations, d'éléments vagues ou de persévérations; Ne démontre aucune compréhension des métaphores, des analogies et des généralisations ou un délai de réponse constant durant toute l'entrevue avec des épisodes fréquents de blocages.

17. AFFECT EMOUSSÉ

Gamme limitée dans l'expression émotionnelle du visage, de la voix et des gestes. Indifférence marquée ou manque de réactivité quand les sujets pénibles sont débloqués. Dans le cas de patients euphoriques ou dysphoriques, coter « l'émoussement affectif », si le manque de profondeur affective est aussi clairement présent. Utiliser les propositions suivantes, à la fin de l'interview pour évaluer la réactivité émotionnelle.

Absent	**1**	Absent

Très léger	**2**	Gamme émotionnelle et légèrement inférieure à celle attendue ou réservée, mais montre des expressions faciales appropriées et un ton de voix dans la limite de la normale.
Léger	**3**	Expression des émotions franchement diminuée, atténuée, ou réservée. Peu de réponse spontanée avec émotion adéquate. Ton de voix un peu monocorde.
Modéré	**4**	Gamme émotionnelle globalement diminuée inférieure à celle attendue ou réservée, sans réponse émotionnelle fréquente, spontanée et appropriée. Le ton de la voix est légèrement monotone.
Modérément sévère	**5**	La gamme émotionnelle est très diminuée, le patient ne montre d'émotions, des sourires, ou ne réagit à des sujets pénibles que de façon minime ; peu de gestes ; les expressions faciales ne changent que rarement. Le ton de la voix est monotone la plupart du temps.
Sévère	**6**	Très petite gamme émotionnelle de l'expression. Le discours et les gestes sont mécaniques, la plupart du temps. Pas de changement de l'expression faciale. Le ton de la voix monotone, la plupart du temps.
Extrêmement sévère	**7**	Pratiquement aucune émotion ou expression, aucune gamme émotionnelle ou expressivité, mouvements raides. Le ton de voix est monotone, tout le temps.

18. RETRAIT AFFECTIF

Manque de contact affectif au cours de l'interview. A quelle degré, le patient donne t-il l'impression qu'il existe une barrière « invisible » entre lui et vous et son interlocuteur. Prendre en compte le retrait apparemment dû à un processus psychotique.

Absent	**1**	Absent
Très léger	**2**	Manque d'implication émotionnelle, visible par une absence de commentaires réciproques, occasionnellement occupé, ou sourit de façon guindée., mais s'engage spontanément avec l'interviewer, la plupart du temps.

Léger	**3**	Manque d'implication émotionnelle, révélé par un manque notable d'interactions, apparemment très préoccupé et manque de chaleur, mais répond à l'interviewer quand il est sollicité.
Modéré	**4**	Contact émotionnel absent durant une bonne partie de l'interview parce que le sujet ne fait pas de réponses élaborées, pas de contact visuel, ne semble pas se soucier si l'interviewer l'écoute ou peut être préoccupé par des évènements psychotiques.
Modérément sévère	**5**	Comme (4), le contact émotionnel n'est pas présent la plupart de l'interview.
Sévère	**6**	Évite activement une participation émotionnelle. Ne répond pas ou répond par oui ou non (pas seulement dû a des idées délirantes persécutrices). Réponse affective minimale.
Extrêmement sévère	**7**	Évite constamment toute participation émotionnelle, ne répond pas ou seulement par oui ou non (pas seulement dû à des idées délirantes de persécution), peut quitter l'interview ou seulement ne pas répondre du tout.

19. RALENTISSEMENT MOTEUR

Diminution de l'énergie visible par un ralentissement des mouvements et du discours, une diminution du tonus corporel, une diminution de mouvements spontanés. Coter sur la base du comportement observé du patient seulement. Ne pas prendre en compte la pression subjective du patient sur sa propre énergie. Coter sans chercher à déduire à d'éventuels effets des traitements.

Absent	**1**	Absent
Très léger	**2**	Mouvements ou langage légèrement ralentis ou réduits, comparé à la plupart des gens.
Léger	**3**	Mouvements ou langage notablement ralentis ou réduits, comparé à la plupart des gens.
Modéré	**4**	Large réduction ou ralentissement des mouvements ou du discours.

Modérément sévère	**5**	Bouge ou parle spontanément rarement OU mouvements raides très mécaniques.
Sévère	**6**	Ne bouge ou ne parle pas sauf si sollicité, ou si on l'incite.
Extrêmement sévère	**7**	Gelé, figé, catatonique.

20. TENSION

Manifestations physiques et motrices visibles de la tension et la nervosité et l'agitation. Les expériences de tension rapportées par le patient doivent être cotées à l'item anxiété. Ne pas coter si l'agitation est seulement due à l'akathisie, mais coter si l'akathisie est exacerbée par la tension.

Absent	**1**	Absent
Très léger	**2**	Plus d'agitation que la normale. Quelques signes transitoires de tension (se ronge les ongles, les bouts des pieds, se gratte la tête plusieurs fois, tapote du doigt).
Léger	**3**	Comme (2), mais signes plus fréquents et plus exagérés de tension.
Modéré	**4**	Signes nombreux et fréquents de tension motrice avec un ou plusieurs signes survenant simultanément (par exemple, remuer pieds tout en se tordant les mains). Il y a des moments où aucun signe de tension n'est présent.
Modérément sévère	**5**	Signes nombreux et fréquents de tension motrice avec un ou plusieurs signes pouvant fréquemment arriver en même temps ; il y a encore quelques rares moments où aucun signe de tension n'est présent.
Sévère	**6**	Comme en (5), mais signes de tension continuelle.
Extrêmement sévère	**7**	Manifestations motrices de tension multiples et continuellement présentes, par exemple, complètement agité, déambule et se tord les mains.

21. ABSENCE DE COOPÉRATION

Résistance et manque de volonté de coopérer lors de l'interview. Le manque de coopérativité peut résulter de méfiance. Coter le manque de la coopération en relation avec l'interview, pas les comportements impliquant les pairs et les membres de la famille.

Absent	**1**	Absent
Très léger	**2**	Montre des signes non verbaux de réticence, mais ne se plaint pas et ne discute pas.
Léger	**3**	Montre son mécontentement ou essaie d'éviter de faire ce qu'on lui demande, mais finit par le faire sans discussion.
Modéré	**4**	Résistance verbale, mais éventuellement répond après que les questions soient reformulées ou répétées.
Modérément sévère	**5**	Comme en (4), le patient fait de la rétention d'informations empêchant une cotation précise.
Sévère	**6**	Refuse de coopérer à l'interview, mais reste dans la pièce.
Extrêmement sévère	**7**	Comme en (6), avec des efforts actifs pour interrompre l'interview.

22. EXCITATION

Élévation de la tonalité émotionnelle ou augmentation de la réactivité émotionnelle vis-à-vis de l'interviewer ou des sujets abordés, visible par l'augmentation des expressions faciales, du ton de la voix, des gestes expressifs ou une augmentation dans la quantité et l'accélération du discours.

Absent	**1**	Absent
Très léger	**2**	Augmentation d'une intensité émotionnelle discrète et fugace ou douteuse. Par exemple, par moment apparait en alerte ou crispé.

Léger	**3**	Augmentation de l'intensité émotionnelle, discrète, mais persistante. Par exemple, expressions animées, celles de gestes et des variations dans le ton de la voix.
Modéré	**4**	Augmentation de l'intensité émotionnelle, caractéristique, mais occasionnelle, par exemple, réagit à l'interviewer ou à certains sujets discutés avec une intensité émotionnelle notable. Discrète accélération du discours.
Modérément sévère	**5**	Augmentation de la tonalité émotionnelle bien définie et persistante, par exemple, réagit à de nombreux stimuli pertinents ou non avec une émotion émotionnelle considérable. Fréquentes accélérations du discours.
Sévère	**6**	Augmentation marquée de l'intensité émotionnelle. Par exemple, réagit à la plupart des stimuli avec une intention émotionnelle inappropriée. A des difficultés à s'installer ou à rester dans la tâche. Souvent agité, impulsif et le discours est souvent accéléré.
Extrêmement sévère	**7**	Augmentation marquée et persistante dans l'intensité émotionnelle. Réagit à tous les stimuli avec une intensité inappropriée et une impulsivité. Ne peut pas s'atteler à une tâche ni la poursuivre. Très agité et impulsif, la plupart du temps. Accélération constante du discours.

23. MANQUE D'ATTENTION

Échec de la vigilance focalisée comme en témoignent des difficultés de concentration, une distractibilité par les stimuli internes et externes et des difficultés à se fixer sur un stimulus, à maintenir son attention ou à l'orienter sur de nouveaux stimuli. Coter les manifestations durant la conduite de l'entretien.

Absent	**1**	Absent
Très léger	**2**	Pathologie douteuse, sujet pouvant se situer dans les limites extrêmes de la norme.
Léger	**3**	Concentration limitée mise en évidence par une distractibilité occasionnelle ou une diminution de l'attention vers la fin de l'entretien.

Modéré	**4**	La conversation est perturbée par une tendance à la distraction, une difficulté de concentration prolongée sur un thème donné ou des problèmes pour changer de sujet.
Modérément sévère	**5**	La conversation est sévèrement perturbée par une mauvaise concentration, une distractibilité et des difficultés à changer de sujet de manière appropriée.
Sévère	**6**	L'attention ne peut être retenue que durant de brefs instants ou au prix de grands efforts, car le patient se laisse constamment distraire par les stimuli internes ou externes.
Extrêmement sévère	**7**	L'attention est si désorganisée qu'une conversation, même brève, est impossible.

24. HYPERACTIVITÉ MOTRICE

Augmentation de l'énergie, visible par des mouvements plus fréquents et un discours plus rapide. Ne pas coter si l'agitation est due à l'akathisie.

Absent	**1**	Absent
Très léger	**2**	Légère agitation, difficulté à rester assis tranquillement, expression faciale animée, et discrètement bavard.
Léger	**3**	Occasionnellement très agité, augmentation de l'activité motrice certaine, gestes animés, 1 à 3 brefs moments d'accélération du discours.
Modéré	**4**	Très agité, augmentation des expressions faciales ou mouvements moteurs sans but. Discours sous pression durant jusqu'à un tiers de l'interview.
Modérément sévère	**5**	Fréquemment agité, impatient. De nombreux moments de mouvements moteurs répétés sans but excessifs. La plupart du temps, en mouvement. Discours sous pression fréquent difficile à interrompre. Se lève à 1 ou 2 occasions pour marcher.
Sévère	**6**	Activité motrice excessive, agitation, ne tient pas en place, tape fortement, fait du bruit...pendant la plupart de l'interview. Le discours ne peut être interrompu qu'avec beaucoup d'efforts. Se lève en 3 ou 4 occasions pour marcher.

Extrêmement sévère	**7**	Activité motrice excessive constante, tout au long de l'interview, par exemple, déambule constamment, pression du discours constante s'impose, l'interviewer ne peut l'interrompre que très brièvement et seulement des informations limitées peuvent être obtenues.

25. MANIÉRISMES ET ATTITUDES

Comportement inhabituel et bizarre, mouvements ou actes maniérés, toutes postures qui sont clairement inconfortables et inappropriées. Exclure les manifestations évidentes d'effets secondaires des médicaments. Ne pas inclure le maniérisme nerveux qui n'est pas inhabituel ou bizarre.

Absent	**1**	Absent
Très léger	**2**	Maniérisme bizarre ou excentrique ou activités que des personnes ordinaires auraient du mal à expliquer, par exemple, faire des grimaces. Observé seulement sur une période brève.
Léger	**3**	Comme en (2), mais survient à 2 occasions sur une période brève.
Modéré	**4**	Le maniérisme ou les postures, c'est-à-dire, mouvements maniérés, stylés, les balancements, les mouvements de la tête, les frottements, les grimaces sont observés à plusieurs occasions pour des périodes brèves OU plus rarement, mais sont très étranges. Par exemple, une posture inconfortable maintenue pendant 5 secondes, plus de 2 fois.
Modérément sévère	**5**	Comme (4), mais surviennent plus souvent où plusieurs exemples de manières et de postures très bizarres propres au patient.
Sévère	**6**	Comportement stéréotypé fréquent, maintien de postures inconfortables et inappropriées, balancement intense, rituels étranges, position fœtale. Le sujet peut interagir avec les personnes et son environnement, pendant de brèves périodes, malgré ses comportements.
Extrêmement sévère	**7**	Comme en (6), le sujet ne peut interagir avec les personnes ou l'environnement à cause de ses comportements.

26. Affect inapproprié[2]

L'expressivité émotionnelle est qualitativement inappropriée, est ridicule ou incongrue par rapport à la situation ou au contenu du discours. Ne pas coter un affect plat ou émoussé.

Absent	**1**	Absent
Très léger	**2**	L'expressivité émotionnelle peut être considérée légèrement incongrue, mais pas clairement inappropriée, dans des conditions spécifiques, ex. dans des conditions émotionnellement stressantes. L'affect est approprié durant le reste de l'entrevue.
Léger	**3**	L'expressivité émotionnelle est légèrement inappropriée ou incongrue dans des conditions spécifiques, ex. dans des conditions émotionnellement stressantes. L'affect est approprié durant le reste de l'entrevue.
Modéré	**4**	Est légèrement ridicule ou démontre une expression émotionnelle modérément inappropriée et incongrue sans égards aux conditions spécifiques. Par contre, des réactions émotionnelles appropriées sont observées durant le reste de l'entrevue.
Modérément sévère	**5**	Est modérément ridicule ou démontre une expressivité émotionnelle modérément inappropriée et incongrue durant une grande partie de l'entrevue. Quelques réactions émotionnelles peuvent être toutefois appropriées.
Sévère	**6**	Est sévèrement ridicule ou démontre une expressivité émotionnelle sévèrement inappropriée et incongrue durant la majeure partie de l'entrevue. Les réactions émotionnelles ne sont jamais complètement appropriées.
Extrêmement sévère	**7**	Est extrêmement et constamment ridicule ou démontre une expressivité émotionnelle extrêmement et constamment inappropriée et incongrue durant toute l'entrevue.

Score total :

MISE À JOUR SUR LA SITUATION AMOUREUSE

Séance d'évaluation : _____

1. Dans le dernier mois, combien de rendez-vous avec vous eu avec un partenaire amoureux potentiel ? _____

2. Dans le dernier mois, avez-vous entamé une nouvelle relation amoureuse (oui/non) ? _____

2b. Si oui, depuis combien de temps êtes-vous en couple (en semaines) ? _____

Test des histoires
Cahier-réponse

Instructions :

« Ce test consiste en de courtes histoires que je vais vous demander de lire à voix haute. Après la lecture de chaque histoire, je vais vous poser 1 ou 2 questions. La première histoire est une pratique et sert à vous familiariser avec le type d'histoires, le type de questions et le type de réponses qu'on recherche. Faites de votre mieux, et nous continuerons ensuite avec les autres histoires. »

1. Histoire de pratique

C'est Noël et la mère d'Anne l'emmène au magasin de jouets. Au magasin, monsieur Gélinas, leur voisin, est habillé en Père Noël et donne des bonbons aux enfants. Anne court vers monsieur Gélinas et dit: « Bonjour, êtes-vous bien monsieur Gélinas? ». Monsieur Gélinas répond: « Non, je suis le Père Noël ».

QM de pratique: « Pourquoi est-ce que monsieur Gélinas a dit cela? »
Réponse correcte: Parce qu'il joue le rôle du Père Noël ou Parce qu'il veut faire croire qu'il est « le vrai » Père Noël.

Puisque cette histoire sert de pratique, en cas d'erreur ou de réponse incomplète, on donne la bonne réponse et on clarifie les instructions de façon à s'assurer que le participant a bien compris la tâche.

Avant de débuter le test, mentionner au participant : « Au besoin, n'hésitez pas à retourner dans l'histoire avant de répondre, il ne s'agit pas d'un test de mémoire ».

2. Sara et Ian sont à la gare car Sara doit prendre le train pour retourner à la maison. Sara habite à Ste-Foy, mais le train n'arrêtera pas à la station de Ste-Foy. Elle devra plutôt débarquer à Québec et prendre un taxi jusqu'à Ste-Foy. En attendant d'acheter son billet, Sara s'en va acheter un magazine pour lire lors du voyage. Pendant qu'elle est partie, il y a un changement à l'horaire et le train arrêtera maintenant à Ste-Foy. Le préposé avertit Ian de ce changement et Ian part alors à la recherche de Sara pour lui transmettre cette information. Cependant, avant que Ian ne trouve Sara, le préposé rencontre Sara et lui dit: « finalement, le train va arrêter à Ste-Foy ». Lorsque Ian trouve enfin Sara, elle vient juste d'acheter son billet.

QM: « Pour quelle station est-ce que Ian pense que Sara a acheté son billet? » _____

Rép.Att. = Québec ▢

0 = Ste-Foy ▢ ou Autre réponse incorrecte: _____

3. Luc va à l'épicerie avec sa mère. Ils arrivent dans l'allée des biscuits. Luc dit: « Wow! Ces biscuits ont l'air délicieux. »

QM: « Qu'est-ce que Luc tente de dire exactement ? » _____

Rép.Att. = Peux-tu m'acheter des biscuits maman; Je veux des biscuits

Si réponse incomplète (ne pas demander si réponse initiale clairement incorrecte):

Et si Luc poursuit en disant: « *J'ai faim, maman!* », qu'est-ce que Luc voudrait que sa mère fasse?

1 = Qu'elle achète des biscuits ▢

0 = Réponse initiale ▢ ou réponse supplémentaire ▢ incorrecte: _____

4. Donald veut coordonner un projet au travail, mais Richard, son patron, a demandé à quelqu'un d'autre de le faire. Donald dit: « C'est vraiment dommage, je ne suis pas très occupé en ce moment. »

QM: « Qu'est-ce que Donald tente de dire exactement ? »

_____

_____

_____

Rép.Att. = J'aimerais m'occuper de ce projet

Si réponse incomplète (ne pas demander si réponse initiale clairement incorrecte):

Et si Donald poursuit en disant: « *Ce projet est vraiment dans mon domaine*. », qu'est-ce que Donald voudrait que Richard fasse?

1 = Lui donner le projet

0 = Réponse initiale ▢ ou réponse supplémentaire ▢ incorrecte: _____

5. Ariane a des cheveux courts blonds. Elle était chez sa tante Carole quand ça a sonné à la porte d'entrée. C'était Marie, la voisine. Marie a dit: « Bonjour», a ensuite regardé Ariane et elle a dit « Oh, je ne crois pas avoir rencontré ce petit garçon. Comment t'appelles-tu? » Tante Carole a dit « Qui voudrait une tasse de thé ? ».

QM: « Dans l'histoire, est-ce que quelqu'un dit quelque chose qu'il/elle n'aurait pas dû dire? »

OUI ▢ ou NON ▢

Si oui: « Qu'est-ce que cette personne a dit qu'elle n'aurait pas dû dire? »

« Qu'est-ce qui fait en sorte que ce n'était pas correct de dire ça? »

Rép.Att. = Que Ariane est (ou a l'air d'un) garçon; Prendre Ariane pour un garçon

6. Thomas et Alexandre discutaient fermement sur une question importante. Alexandre n'écoutait pas les arguments de Thomas, et Thomas commençait à être sérieusement irrité. Thomas a dit : « Alexandre, je suis tellement content que tu écoutes mon opinion! ».

QM: « Qu'est-ce que Thomas voulait réellement dire en disant cela? »

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Rép.Att. = Par sarcasme/ironie; Tu ne m'écoutes pas; Je suis irrité de na pas être écouté

7. Julien a acheté un avion jouet à Richard pour sa fête. Quelques mois plus tard, ils jouaient avec l'avion et Julien l'a accidentellement échappé. « Ne t'inquiète pas » dit Richard, « Je ne l'ai jamais vraiment aimé de toute façon. Quelqu'un me l'avait donné pour ma fête. »

QMa: « Dans l'histoire, est-ce que quelqu'un dit quelque chose qu'il/elle n'aurait pas dû dire? »

OUI ▢ ou NON ▢

Si oui: « Qu'est-ce que cette personne a dit qu'elle n'aurait pas dû dire? »

« Qu'est-ce qui fait en sorte que ce n'était pas correct de dire ça? »

Rép.Att. = Qu'il n'aimait pas l'avion reçu de Julien

QMb: « Avant de dire « *Je ne l'ai jamais vraiment aimé de toute façon* », est-ce que Richard se souvenait que Julien lui avait donné l'avion jouet pour sa fête? »

2 = NON ▢

0 = OUI ▢

8. Un soir très tard, la vieille Madame Bissonnette marchait en revenant chez elle. Elle n'aime pas marcher seule dans le noir parce qu'elle a toujours peur que quelqu'un l'attaque et la vole. Elle est vraiment une femme très nerveuse! Tout à coup, ce soir-là, un homme est sorti de l'ombre. Il voulait demander l'heure à Madame Bissonnette, alors il a marché vers elle. Quand Madame Bissonnette a vu l'homme venir vers elle, elle s'est mise à trembler et a dit, « Prenez ma sacoche, mais s'il-vous-plaît, ne me faites pas de mal! ».

QM: « Pourquoi est-ce que Madame Bissonnette a dit ça? »

Rép.Att. = Elle pensait que l'homme voulait la voler/l'agresser

9. Un jour, alors qu'elle joue dans la maison, Annie accroche et brise accidentellement le vase de cristal préféré de sa mère. « Oh là là, quand maman va le découvrir elle va être vraiment fâchée! ». Alors quand la mère d'Annie rentre à la maison, voit le vase brisé et demande à Annie ce qui s'est passé, Annie dit: « Le chien l'a accroché, ce n'était pas ma faute! ».

QM: « Pourquoi est-ce qu'Annie a dit ça à sa mère? »

Rép.Att. = Parce qu'elle craignait de se faire chicaner

10. Nicolas et Sylvie sont ensemble au parc. Un marchand de crème glacée arrive au parc et leur propose différentes saveurs de crème glacée. Nicolas a très envie de s'acheter un cornet de crème glacée, mais il n'a pas d'argent sur lui. Le marchand lui dit qu'il peut aller chercher de l'argent chez lui et qu'il restera au parc pour l'attendre. Pendant que Nicolas reconduit Sylvie chez elle et passe chez lui pour chercher son argent, le marchand de crème glacée se déplace près de l'église. Plus tard, Nicolas croise le marchand de crème glacée près de l'église, mais Sylvie n'est pas au courant de cela car elle est rentrée à la maison plus tôt.

<u>QM:</u> « Où Sylvie pense-t-elle que Nicolas est allé pour acheter son cornet de crème glacée?»

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Rép.Att. = Au parc ▢

11. Jacynthe n'a pas d'argent, mais elle voudrait sortir ce soir. Elle sait que David vient tout juste de recevoir sa paye. Elle lui dit: « Je suis vraiment cassée! Tout est vraiment trop cher de nos jours! ».

<u>QM:</u> « Qu'est-ce que Jacynthe tente de dire exactement ? »

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Rép.Att. = Pourrais-tu me prêter de l'argent?; Voudrais-tu m'inviter ce soir?

<u>Si réponse incomplète (ne pas demander si réponse initiale clairement incorrecte):</u>

Et si Jacynthe poursuit en disant: « *Eh bien, j'imagine que je vais devoir me passer de sortie ce soir* », qu'est-ce que Jacynthe voudrait que David fasse?

1 = Lui prêter de l'argent ▢ <u>ou</u> L'inviter