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Exploring romantic need as part of mental health social care practice

Rachel Forrester-Jones^a , Jeremy Dixon^b  and Beth Jaynes^c

^aSchool of Health Studies, Faculty of Health Sciences, Western University, London, Ontario, Canada;

^bSocial Work, Department of Social & Policy Sciences, University of Bath, Claverton Down, Bath, UK; ^cSocial Policy, Department of Social & Policy Sciences, University of Bath, Claverton Down, Bath, UK

ABSTRACT

The ability to form strong relationships is viewed as central to mental health recovery. Few studies have explored the experiences of people with mental health problems in forming or maintaining romantic relationships. Our study addressed this gap through conducting focus groups with ten people with mental health problems, six carers and six professionals. All three participant groups considered romantic relationships to be important aspects of wellbeing and lamented this gap in the lives of people with mental health problems. Service users and carers perceived the physicality and outward trappings of 'being mentally ill', including treatment side effects and unemployment to impact negatively on romantic relationships. Service users reported self and societal stigma as a major barrier to relationships. Carers and professionals focused on vulnerability and risks. Professionals stated that they rarely supported people with mental health problems with their romantic relationships and were uneasy about discussing sexual intimacy.

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KEYWORDS

Mental health; mental illness; romantic relationships; carers; professionals; people with mental health problems

Points of interest

- This research used focus groups with people with mental health problems, family carers and mental health professionals. It explored how people with mental health problems experience romantic relationships and what support they might need.
- People with mental health problems said that they struggled to form and maintain romantic relationships. This was due to mental health symptoms, medication side-effects, stigma, a lack of confidence and worries about telling others about their mental health problems.

CONTACT Jeremy Dixon  j.dixon2@bath.ac.uk

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- Carers felt that romantic relationships were valuable but worried about their relatives being vulnerable or the relationship being stressful. They felt support should be provided by existing mental health services.
- Mental health professionals reported that they rarely provided support around romantic relationships. They were also reluctant to discuss sexual intimacy with the people they were working with.
- The study shows the need for staff training to enable better support in this area.

Introduction

Romantic love has been the subject of literature since the time of the ancient Sumerians, in 2500BC and remains a topic of interest for philosophers, linguists, neuroscientists, anthropologists, and sociologists (Plamper 2015). The concept of romantic love is contested but has been defined as the desire for an attachment to another which is intimate and reciprocal (Bates, Terry, et al. 2017; 2017). Research studies focussing on the experiences of people with mental health problems of romantic relationships are limited in number and scope (Cloutier et al. 2021; McCann et al. 2019). A systematic review of quantitative research on romantic relationships and sexual intimacy in people living with psychosis identified only two articles focussing specifically on romantic experiences from the 43 articles identified, with the majority concentrating on obstacles to intimacy (Cloutier et al. 2021). Whilst the literature is limited several points should be noted. Existing research suggests that people with mental health problems have a strong desire to 'meet a loving partner' (Boucher, Groleau, and Whitley 2016; Forrester-Jones et al. 2002; Forrester-Jones and Barnes 2008; Forrester-Jones and Grant 1997; McCann et al. 2019). For example, McCann's (2010) research with 30 people with a diagnosed mental health problem found that 83% felt the need for a romantic relationship. Developing and maintaining romantic relationships have been cited as positive factors for recovery, helping people with mental health problems to 'feel normal' and aiding their wellbeing (Braithwaite, Delevi, and Fincham 2010; Cohen and Sokolovsky 1979; Forrester-Jones and Grant 1997). However, people with mental health problems experience barriers to forming romantic attachments. Research with young men experiencing psychosis found that they lacked confidence in forming relationships in comparison to people without mental health problems (Pillay, Lecomte, and Abdel-Baki 2018). Individuals with mental health problems are also affected by societal stigma. Studies show that people are less likely to engage in a romantic or sexual relationship with an attractive partner after discovering that they have a mental health problem (Boysen, Issacs, Tretter and Markowski, 2020; Boysen, Morton, and Nieves 2019).

In England, where this study was set, the ability to form social relationships is regarded as central to recovery within mental health policy (HM Government

2011) and is a statutory outcome of 'wellbeing' (Care Act 2014). National charities view romantic need as an important component of mental health (MIND 2021; Relate 2021). However, services do not routinely consider romantic need as a social care priority. Some intervention projects have successfully used community mental health teams to increase people's social networks (Pinfold et al. 2015; Webber et al. 2016; Webber and Fendt-Newlin 2017) but these are rare. Supporting someone with mental health problems with a romantic need may also raise ethical issues. There is a question over the moral imperative of helping someone to find love; there may be unrealistic expectations by a support worker or the supported person; and service users need to have agency over their decisions. Nevertheless, the importance of developing romantic relationships appears to remain an 'unmet need' for people with mental health problems (Forrester-Jones and Hammond 2020).

Terminology

Participants in our sample used a wide range of terms to describe people with mental health problems. Some participants referred to having a mental illness, whilst others used terms like 'mad' to reflect a critical position to the medical model. In this paper we adopt the term mental health problems to encompass both positions. We also use the term romantic love, since this is how our study participants generally described the type of relationships they wished to develop and reflects the feelings of excitement and mystery associated with love in addition to sexual intimacy.

Research process

The purpose of our study was to consider the issue of *romantic* relationships for people with a mental health problem. Our approach was informed by discussions with our advisory group made up of a person with mental health problems, a family carer, a social worker, and a service manager. Our agreed aim was to explore the experiences of adults with mental health problems in relation to finding partners, as well as forming, and maintaining long term relationships. Using focus groups (FG), we enquired about the types of informal (family carers) and formal social care support available. One professional was unable to attend the focus group and so a professional interview (PI) was held with him. Three research questions guided our study:

1. What experiences do people with mental health problems have as regards romantic relationships?
2. How do family carers view romantic relationships for people with mental health problems?; and
3. How do social care practitioners support people with mental health problems to form and maintain romantic relationships?

Questions for the focus groups were drafted by the three authors after which the advisory group suggested amendments. People with mental health problems were asked about close friendships and romantic relationships and what impact if any their mental health problems had on these, whether they had received any support to form relationships and whether these issues had been addressed within care plans. Family carers were asked whether the person that they were supporting had formed and maintained close friendships or romantic relationships, what types of relationships they would like the person to have and about whether any professional support had been offered. Professionals were asked whether they had helped service users to form or maintain close or romantic relationships, what type of support had been requested by service users and whether there were any organisational impediments to providing such support.

Participants were recruited through two mental health charities and a mental health self-help network in the South of England. Of the ten adults with mental health problems who took part, two were female and eight were male. Two were married and eight were single. Six of the family carers were female and one was male. Five were providing care for an adult child whilst one was caring for their parents. Of the six professional participants, five were female and one was male. Two were social workers, one was a psychologist and three were care workers.

Focus group data were recorded and transcribed by Author 3. Data were analysed using thematic analysis (Braun and Clarke 2006). We adopted a contextualist position towards the data; which sits between essentialism and constructionism (Braun and Clarke 2006). In adopting this position, we held the view that individuals are shaped by their social context but retain agency to comment on their 'reality'. All authors familiarised themselves with the data by closely reading each transcript. Each transcript was coded independently by two authors, with codes being discussed and agreed at a meeting. Where disagreements occurred, a third coder arbitrated. All codes were reviewed to provide a final coding frame and overarching themes were discussed until saturation was reached. Substantive quotes were chosen to illustrate the themes.

Ethics

Favourable ethical opinion was given by the University of Bath's Social Sciences Research Ethics Committee (reference number: S19-066). Potential participants were sent an information sheet. This outlined the nature, risks and benefits of the research and stated that participation was voluntary. We ensured that participants had 'decisional capacity' (the ability to understand and process the information about the study, necessary to make an informed decision) and asked them to confirm their agreement through signing a

consent form (see, Biros 2018). Service users and carers received payment and expenses, in line with INVOLVE guidance (INVOLVE 2010). No payments were provided to professionals. We provided details of support services participants could contact afterwards if they wished. Participants were informed that discussions remained confidential and that confidentiality would only be breached in cases where participants identified that they posed a serious risk of harm to themselves or others. All recordings were uploaded to a secure University drive and the recorder subsequently cleaned of data. The first author presented the study findings at a dissemination workshop to which all participants were invited.

Pseudonyms have been utilised and references to places and services have been removed. Codes provided after each quote denote the particular focus group transcript from which the deidentified quote was extracted.

Results

Themes important to service users

Whilst our questions asked participants about close friendships and romantic relationships, most respondents focussed on the issue of romantic relationships. All individuals who took part in the service user focus groups acknowledged the importance of loving relationships to their wellbeing, including the physical and reciprocal nature of relationships, and support they provided, such as companionship and having a confidante:

Adam: '...someone to confide in, someone to support you, and you can support to share your day with' (FG1).

Barry: '...physical contact on a nightly basis' (FG1).

Whilst participants felt that platonic friendships were important, for many, having a romantic relationship was the one aspect of their lives that was lacking:

Harry: 'With regards to romantically, I've never been very lucky in that respect, I've gotta' be honest. I've always been quite uncomfortable around women. I worry I'm gonna' say the wrong thing and I think the harder you try, the less likely you are to succeed in that respect. I used to worry about it a lot at one time, but I don't now so much. My dear mum and dad used to worry about me being single and having mental health issues' (FG3).

Themes from the service user focus groups concerned interrelated social and systemic barriers to romantic relationships. Participants felt that the stigma attached to mental health problems precluded them from having a romantic relationship. They also feared the effects of mental health relapse on relationships and highlighted a lack of opportunities or support to meet others. In the face of such difficulties, participants cherished 'old friends', who

they could trust and find companionship with, but rarely formed new relationships. These themes are presented below.

Theme 1: romantic relationships – an unavailable entity?

Most participants perceived romantic relationships as unobtainable, or difficult to develop or maintain due to the symptoms of their mental health problems as well as treatment side-effects. Social determinants including self and social-stigma, and a fear of disclosing their health status to potential romantic partners were also seen to limit opportunities.

Subtheme: mental health symptoms and side effects of medication

Individuals talked about how their own symptoms, the side effects of medication as well as other related outcomes such as unemployment impacted their ability to develop romantic relationships.

Barry: 'The current medicines I'm on, the side effects mean I wouldn't really be much use [in a relationship] so I might have to get yet more medicine to help counteract that. I mean I'm quiet shy at the moment, I'm quite depressed and that's not a particularly attractive quality. You don't want to be looking for a relationship to solve all your problems, but I personally think it's part of a healthy life. I think just the pattern of my life. The lack of stability, not having a job and things like that, not being in mainstream society. That's probably the reason. I think a lot of time I'm not capable of it – not physically, but in terms of my mental health' (FG1).

Subtheme: self-stigma

In general, participants said they would prefer a romantic partner without mental health problems as illustrated by the following extract:

Gabbi: 'If I were to meet somebody, I'd prefer that they weren't mentally ill. And I wouldn't like to have a relationship with another schizophrenic. But I'd like to meet somebody who would take me out of that – a normal person – a person who doesn't suffer with mental health problems so I could live their way instead of worrying and anxiety' (FG3).

In describing an ideal romantic partner as 'normal', this quote denotes how individuals self-stigmatized themselves as 'abnormal'. Yet at the same time, many felt that a 'normal' partner might not understand their symptoms – adding weight to the perceived difference between so called 'normals' and 'abnormals':

James: 'The thought of it is nice. And I've had a few opportunities. But I haven't really followed them through and then I'll have a phase of thinking 'it'll be nice to get in a relationship' and then I have a week when I'm not feeling completely right and I think "would it actually work out? Would they understand the illness and how

extreme it can be?" "Cause I come across as being quite together and quite well, but I'm constantly fighting this battle of paranoia and anxiety. And I don't think anybody without mental health problems or somebody who hasn't experienced it in the past would really understand' (FG3).

Whilst the participant below stated that their emotional state was a factor in embarking on a romantic relationship, they also accepted the negative self-stigmatized narrative of voices in their head telling them that they would fail romantically:

Harry: 'The voice in my head has always told me that I would always fail romantically. And anybody I have got a little bit close to, it's funny that it always went wrong, and the voice was right – it told me that I was a complete failure in romance and best for me not to bother, not to put myself through the anxiety. In my emotional state I don't think I could stand going through that again' (FG2).

Subtheme: social stigma

Participants talked about how mental illness 'labels' caused fear in other people. The following participant prefers to describe their condition as paranoia since they perceive this label to be less pejorative than schizophrenia.

Gabbi: 'And I wouldn't tell them that I was schizophrenic – I'd say I was paranoid because I wouldn't want them looking at me funny to start with and thinking "oh is she going to attack me?"' (FG3).

Romantic rejection was a common experience, and one which most participants considered as an expected outcome of their mental health problems, as indicated in the following quote:

Isaac: 'I [have] sensed that feeling of rejection. The girl I was friendly with at the time, she just seemed to dismiss me overnight. One minute we were friends and the next minute that was it. I accepted it' (FG3).

James: 'I had one [girlfriend] when I became unwell but [then] I got sectioned [detained under mental health law] and I spent a year in hospital. She stayed with me for about 3, 4 months I think and then she just, she couldn't really cope with it. So, we called it a day and that was the end of that really. It was just too much for her' (FG4).

Others specifically said that they considered the social stigma of having a mental health problem to be the cause of romantic rejection:

Isaac: 'Yeah, yeah - rejection 'cause they [potential partners] didn't understand the illness and I think it's the fear factor of the stigma' (FG3).

James: 'As soon as you mention the word 'schizophrenia' or that you've got a mental health issue, people will just, you know, they get scared' (FG3).

Harry: 'I think there is a stigma with mental health and I think people are afraid when you tell them you hear voices and things. 'Cause I'm a voice hearer. But most people if they know you are mentally ill, they don't want to accept you' (FG3).

Subtheme: romantic hopes dashed

For many of our sample a combination of past rejections, and knowledge of how stigma affected romantic prospects impacted on their confidence to embark on romantic relationships:

Harry: 'I'm not romantically involved with anybody. I haven't really ever been, not properly really. When I was at school, I think there were some people that picked up that I had mental health problems and girls used to sort of pick on me and they said hurtful things...which made me extremely paranoid. And I believe it also makes me feel less confident in asking people out. I never found anybody that really took to me to be honest with you. Never, not romantically in any respect' (FG3).

For others, the onset of mental illness had altered their social networks and ideas about what was possible romantically. Some individuals felt they were being left behind by friends and this added to their feelings of marginalisation:

Isaac: 'I used to spend a lot of time down at the pub and meet acquaintances, and female and male friends. Some, you know, romantic relations. But since I became unwell I kind of changed tack. I don't mix with those people that I used to associate with, go down the pub and socialising and meeting females, I've got a different take on life now. I think if you have a mental illness, you have relapses and that effects your stability so it's hard to go forward in your life. So you kind of maybe get left behind 'cause I know my friends have kind of left me behind a bit, so it may be hard to get relationships for that reason 'cause you're not moving on. So yeah, its definitely a minus. You are more outside society' (FG3).

Subtheme: disclosing mental health problems to a potential partner

Societal and self-stigma resulted in some participants choosing not to disclose their mental health problems, especially at the start of a potential romantic relationship. The question of whether, when, and how to tell a potential partner about their mental health problem was a central discussion topic, as shown in this exchange between Gabbi and Isaac:

Gabbi: 'You've got to make someone fall in love with you first.

Isaac: Not offering full disclosure but saying – "I don't know about you, like, but I have experience [of mental health problems]." If you feel the relationship is gonna progress, you drip feed them a little bit more and tell them about your condition. I think you know when you're talking, whether you're talking with somebody with mental health problems or not. It's just to be honest from the start. Not have to give a full disclosure but gently coax them and then as the relationship progresses, you open up a little bit more.

Gabbi: It's probably best to keep it to yourself to be honest.

Isaac: No, its gonna come out one day you know. So why lie to that person all that time? Its best to be honest and lay your cards on the table' (FG3).

Theme 2: lack of opportunities and support from services for romantic relationships

All of the participants reported that the social care they received from services did not include help with developing or maintaining romantic relationships. Nevertheless, many felt ambiguous as to whether they wanted any formal support in this regard and what form this might take.

Subtheme: romance as a private affair

In general, participants felt reticent to ask for help from services about a life domain that they regarded as 'private':

Dave: 'I found that there was very little [social care] support offered. But at the same time, I wasn't demanding much' (FG3).

Barry: 'Care workers are people like anyone else [and] you're kind of asking them for advice on romance. I don't know. That's their life as well. They're gonna draw from their own life and knowledge and their romantic life might be private to them. I think it's a bit tricky that kind of thing' (FG2).

Participants also sensed that services might adopt a risk-adverse approach, as indicated below:

Isaac: 'I was in a relationship with a young lady. We were very good friends and when I became unwell, she got frightened and cooled the relationship instantly. And the services - they mentioned her name and said 'oh such and such, you've been harassing her.' It was difficult and I felt that the services didn't explain or come across for my defence and try and explain to her the situation. So that relationship ended' (FG3).

Because of such experiences, participants stated that there was a need for understanding and support for this aspect of their lives:

Ed: 'Number one would be to ignore the diagnosis and see to the person and try and get an assessment of what the difficulties are and in what way they can be supportive so it's very much a listening role rather than a telling role' (FG2).

Subtheme: lack of places and spaces to meet a romantic partner

Participants talked about the lack of places and spaces to meet potential partners, attributing this to financial cuts to services including the closure of day centres:

Ed: 'Yeah and I know a number of relationships that has been formed in those [mental health groups] I had one [romantic relationship] at one time. But a lot have been closed down or they've been very restricted' (FG2).

Charles: 'Care in the community has huge cuts. Especially day centres. 'Cause day centres - they give you a chance to mix and meet people and do group therapy,

like assertiveness training or anxiety management, confidence building and [to] meet people. And that's all gone' (FG2).

Theme 3: the importance of long-term friendships

Whilst practical support such as 'helping to move [from one] accommodation [to another]' and companionship was important to participants with mental health problems, they also talked about the significance of consistency of friendship, especially in the light of having few opportunities for romantic relationships as described in the following subthemes.

Subtheme one: 'sticking by me' – consistency in friendship

Friends who knew about an individual's mental health history, and who had "stuck with them despite it" were regarded as significant since these contacts made allowances for when they were unwell, enabling them to "relax with that person" and "be more candid", as illustrated below:

Barry: 'they're long term, so kind of give me a chance to say what I've done and so on, to salvage the relationship...they've been making allowances for me over the years' (FG1).

Continuity of these relationships - that fostered a level of trust - seemed to be the key quality that was important to individuals.

Subtheme two: depleted social networks

Friendship with others who shared a history of the person's mental health problems, even when they had no experience of mental health problems themselves, was precious to participants in the face of depleted social networks. Participants reported how friends were "few and far between" and that this became more pronounced as they grew older, or as they lost touch with family members:

Barry: 'I've got one close friend. As you get older, it's harder to make proper close friends' (FG1).

Gabbi: 'My family don't visit me. They contact in text or writing but they don't visit me and they don't want me to visit them' (FG3).

Themes important to carers

Carers viewed romantic relationships as being beneficial for those with mental health problems. They all reported the person they cared for either valued the relationship they were in or were actively seeking a relationship. However, they also highlighted challenges associated with forming or maintaining

them. Carers worried that their family members were emotionally vulnerable and that the stress of a romantic relationship might exacerbate their mental health problems. Nonetheless, the benefits were seen to outweigh the risks with carers identifying the need for effective mental health support.

Theme 1: emotional vulnerability

Carers perceived their loved ones as being vulnerable to emotional risks in relationships due to their mental health problems. For example:

Kim: 'I think there is a lot of social isolation for people with mental health issues and issues of trust really. About who you can trust. When you give yourself to somebody – are they going to take advantage of you or are they generally interested in you as a person?'(FG5).

Diana: 'I think that anybody in the world [can] have their own insecurities and anxieties and I think when you have a mental health condition, they can be amplified to a point that stops you from trying to build relationships or gets you into trouble in relationships' (FG4).

Subtheme: the challenge of developing and maintaining romantic relationships when experiencing mental health symptoms

Like the service users in our sample, carers reported that their loved ones were hostage to their own mental health symptoms, which hindered meaningful romantic relationships from developing:

Alex: 'There have been relationships with others. He's [son] a good-looking boy so he got himself involved with girls but then things break up because of his mood. Sometimes he doesn't do things that he should be doing with them, [like] go[ing] out [with them,] or he doesn't pick up the phone, and things break apart' (FG5).

Theme 2: romantic relationships as additional stressors

Some of the carers argued that romantic relationships could cause complexities which might exacerbate their relative's symptoms. This was the case for those who were already in a relationship as well as those who were looking for a partner. Below, a carer describes how their daughter's relationship had caused detrimental impacts to her mental health:

Beatrice: '[She] has been in hospital quite often. We've felt what's contributed to it - to the relapse - has been difficulties within that relationship' (FG2).

Similarly, Diana talked about how the difficult relationship her parents had with one another was exacerbated by their mental health problems, highlighting a lack of support in this area:

Diana: 'I think my concerns are that when they're [parents] unwell or when one of them is particularly unwell it can be kind of a concern about taking advantage of someone or being sometimes abusive to the other person and I think that's because of not having support around' (FG4).

Similarly, a participant caring for their son, who was not in a relationship but reported that he wanted one, argued:

Alice: 'It would depend on the quality of the relationship. If it was good, that would be fantastic. If there were problems that would be difficult for him, he doesn't cope well with stress at the moment' (FG4).

Despite these points, carers generally felt that the advantages of being in a romantic relationship outweighed the disadvantages. Several advantages were reported including, having someone to talk to and spend time with, a feeling of 'normality' or of following a 'traditional' life course, and having someone who could support them with their mental health conditions.

Theme 3. The need for professional support

Carers were asked about different types of external support that might assist with forming or maintaining romantic relationships. These included a dating website designed for people with mental health problems and existing professional mental health services. Responses from the carers were mixed with regards to the use of a dating website. Those with concerns raised the complexities of providing support if both partners in the relationship were unwell, with one carer arguing:

Sam: 'Two people with mental health problems in a relationship like that – a romantic relationship, I don't see how they can support each other if one becomes unwell. I think I would be very wary of that' (FG5).

Carers were more optimistic about the potential for support from existing mental health services. Paid carers who were involved in other aspects of mental health support such as work, housing and hygiene were seen as the ideal providers of such support:

Sam: 'When my daughter was with [organisation] and more or less had a support worker, they built up a relationship. So, I think somebody like that would be really good and really helpful. I think it would be somebody they would feel comfortable with – talking about things' (FG5).

The enthusiasm carers had for paid support extended to counselling and advice around safe practices within relationships:

Kim: 'An ongoing support system. When things start to go a bit wrong you [their loved ones] can make contact with somebody and just talk about what's going wrong for you. Anda couples counselling kind of service in a way might be quite useful to sort of intervene before things go wrong' (FG5).

However, carers voiced concerns that professionals might not consider relationships to be an important part of rehabilitation:

Diana: 'I've definitely heard conversations where professionals have advised [service users] 'actually you need to focus on you getting better' and actually, kind of forgetting that a relationship might help that. So, I think to have conversations about how to find a relationship safely, all around the sexual health side, I think all of those conversations need to be had' (FG4).

Carers identified several potential benefits of relationship support from services. First, participants felt that access to existing networks of mental health support would ensure that support was easy to access. Second, carers felt that sexual health advice should be provided by current services. Third, carers believed that services should tailor support to both partners, in cases in which they both experienced a mental health problem, to help them maintain their relationship.

Themes important to professionals

One overarching theme - *A risk-averse position to offering support for romantic relationships* was delineated in the interviews with professionals. Whilst professionals acknowledged that people with mental health problems desired close and romantic relationships, most reported that they had not supported service users to develop them. This is not to say that professionals had no knowledge of service users' social networks, but the default position seemed to be that this life domain was private and 'off limits'.

Subtheme: waiting for the 'need' to arise

Needs assessments and care plans were perceived as tackling the issue of romantic relationships indirectly, through asking what resources the person had in their lives, which might include relationships or their ability to form them. For the most part, professionals did not speak to service users about their relationships unless the service user, a professional or a family carer raised a risk related to it. Several examples were given, such as a concern that service users were vulnerable to financial exploitation (PI) or domestic violence (FG6). Where these issues arose, professionals reported responding to them, although such interventions were framed as safeguarding. In two exceptional cases (FG6, FG7), participants spoke of service users telling them that they wanted a romantic relationship. For example:

Phillipa: 'And then we get into "so what kind of skills would you need to develop a relationship?" "And what kind of situations would you put yourself in to meet someone?"' (FG6).

In this case, Phillipa spoke of tailoring support sessions around a person's wish to develop a romantic relationship, with support sessions focussing on

the skills that the person would need to develop to do so. However, a reactionary and piecemeal approach appeared to be taken overall.

Subtheme: romantic relationships as a 'new idea'

When the issue of romantic relationships was raised within focus groups, participants acknowledged that they were central to wellbeing and expressed surprise that they had not considered them more often:

Erica: I would like to do that [support people as regards romantic relationships]. I think it's an important part of wellbeing and relationships. I will have my doubts of how to be safe and how to address some things, but I would be happy to support someone with their romantic life.

Toni: 'Yeah, I would too. I wouldn't be sure like how to deliver it within boundaries because it can get quite personal. So, I'd wonder how to approach that in the safest way. I think it's really important to have relationships I think' (FG6).

Subtheme: the emotional risk of romantic relationships to service users

Concerns about safety were raised by both focus groups, being seen as the reason that discussions about relationships were avoided. Safety was conceptualised in several different ways. Romantic relationships were spoken of as posing an emotional *risk to* service users. For example:

Phillipa: '[...] So it feels like when you're working it's, when you look after a plant it's almost like you've got to the stage where the shoot is really tiny and delicate and it's like kind of, for me the relationship is like a tsunami could come through very fast and anything that has been brought up can deteriorate' (FG6).

Within this focus group, relationship breakup was presented as an emotional risk, with Phillipa highlighting service users' emotional fragility. Whilst people in the group acknowledged that positive risk-taking might lead to future benefits, the emphasis was on negative elements. Similarly, the concept of recovery was spoken of in terms of a remission of medical symptoms, with relationship break-up being positioned as something which might threaten it. As intimated by carers, professionals in both groups described a culture that encouraged service users to concentrate on stabilising their mental health, before developing a romantic relationship. This process was referred to as a 'hierarchy of needs' by Bryony, leading Ruth to reflect that staff practices were shaped by mental health paperwork, which asked service users about family relationships but made no reference to their romantic or sexual needs (FG7).

Subtheme: talking about intimacy – too much information?

Professionals identified that discussions with service users about sex was rare. Like conversations about romantic relations, discussions about sex were

seldom instigated by staff. Where such discussions did occur, they happened for two reasons. First, where service users expressed concerns about a lack of libido due to psychiatric drugs (PI, FG7). Second, where a service users' sexual relationship was raised as being an issue of concern. Concern was sometimes expressed because a service user was viewed as sexually vulnerable or where a sexual relationship was occurring on a hospital ward. Where the latter issue arose, participants spoke of advising service users to abstain from sex in that setting, with one individual relating that service users were encouraged to 'go for a coffee'. She said:

Ruth: 'When I say "go off and have a coffee", what I mean is: you can't go in each other's rooms'. That's it. [It's] got to be "we're not going to stop you, but you can't have a sexual relationship in here" and maybe – "why don't you two go out?"' (FG7).

This scenario was viewed as problematic by the participants who identified ward staff as adopting an 'out of sight, out of mind' approach. The reason for avoidance of this issue was partly explained by participants' own reactions to discussing sex. Professionals in Focus Group 6 said that conversations about sex made them feel uncomfortable or embarrassed. For example:

Phillipa: 'I think with me there's only so much I want to know about other people I support. I used to support an elderly woman who was too open about her hygiene habits than I actually wanted to know and felt I needed to be involved with. Like it's a little bit like that with sexuality also with that there's some things that I'm thinking, "do I really want to be involved with that?" Um so I think there's something about personal comfort zone' (FG6).

Participants in this group spoke of the need to become 'desensitised' to such feelings. Nonetheless, it was notable that conversations about people's sex lives prompted feelings of discomfort. Participants in focus group 7 also identified that they sometimes noted that physical affection was discouraged in ward environments on the grounds that it might be distressing to other patients.

Discussion

Several limitations can be noted with our study. Our sample was small, consisting of self-selected participants in one city. Our service user participants consisted of eight males and two females. Current statistics in England, show our sample was unrepresentative as women are slightly more likely to be in contact with mental health services than men (5.0% of women compared to 4.7% of men) (Baker 2020). The gender mix of carers in our sample was roughly equivalent to that of unpaid carers in the UK, in which 80% are female (Carers UK, 2022). As our professional sample was small and made up of a mixture of care workers, social workers, and psychologists, we cannot

comment on how representative this was. All our participants were white. A larger random sample would allow for wider analysis by gender and ethnicity and more generalisable results. Nevertheless, we were able to present the nuanced perspectives of service users, carers and professionals.

Whilst the service user participants expressed a wish and need for romantic relationships, corroborating previous findings (Urry, Chur-Hansen, and Khaw 2019), in our study carers and professionals also considered romantic relationships to be important to wellbeing, and all three groups lamented the gap of this fundamental desire in the lives of people with mental health problems. Both the service user and carer groups regarded the physicality and outward trappings of 'being mentally ill,' including symptoms, medication side-effects and unemployment as hindrances to individuals' ability to form and maintain relationships. Current evidence suggests that these issues may impact negatively on sexual expression, and subjective experiences of sexual activity (Basson and Gilks 2018; Cloutier et al. 2021; McMillan et al. 2017; Velthorst et al. 2017). Despite these findings, there have been few intervention studies or evaluations of interventions for sexual dysfunction in mental health populations with Taylor et al. (2013) advocating for more clinical trials to establish the efficacy of treatments. Additionally, McMillan et al. (2017) have advocated for more mental health service support for managing sexual dysfunction including screening for difficulties experienced, education for clinicians and those they support, and evidence-based interventions.

Views concerning other barriers to forming, developing, and maintaining romantic relationships differed between the groups. For service users, self- and social stigma affected their confidence when trying to instigate romantic relationships corroborating a qualitative study of 10 mental health service users with experience of psychosis by White et al. (2021). By internalising stigma and perceiving themselves as 'abnormal' many reported having given up on the idea of finding anyone who might understand them. In line with previous studies participants expressed concern about the willingness of others to 'put up with' with their symptoms as well as fearing stereotyped 'undesirable traits' such as unpredictability and dangerousness (Crisp et al. 2005, Jonason et al. 2015). Others, fearing rejection from potential romantic partners (in some cases as a response to past failed attempts or negative experiences) resorted to non-disclosure of their mental health problems. In addition, some participants exhibited 'alter-casting' in that they aimed to project an identity which they assumed would be more desirable to others (Weinstein and Deutschberger 1963), some even preferring to use - what they perceived - as less stigmatized labels (e.g. paranoid rather than schizophrenic). This added to the everyday pressures they experienced due to their illness or discrimination, leading to low self-esteem. In doing this, service users in this study showed signs of recognising that potential partners might be reluctant to enter into a relationship with them, echoing findings from

previous research (Boysen and Isaacs 2022). Many simply felt that romantic relationships were unobtainable. These findings have implications for future service provision. Recent populace movements by UK government (Mental Health Taskforce 2016) and mainstream media (Time to Change 2021) have attempted to destigmatise mental health problems, fostering more positive societal attitudes (Angermeyer et al. 2017). Nonetheless, our service user participants still experienced a great deal of stigma and felt that positive aspects of mental health identity remained unacknowledged by the public.

Carers and professionals focussed on vulnerability as the main barrier to romantic relationships. Carers worried that their family members were emotionally vulnerable, using phrases such as 'delicate', 'vulnerable', or 'emotionally fragile' to describe traits that they associated with mental health problems. They also thought that the stress of a romantic relationship might exacerbate the mental health condition of their family members. By articulating this risk, they inadvertently constructed barriers to supporting individuals to develop romantic relationships as also found in Bates et al. (2021). Like carers, the professionals in our study appeared to be stuck in a medicalised and paternalistic locus, using similar pejorative words to describe service users as the carer group. In practice, such views were translated into restrictive practices like those found in intellectual disability services (see Bates et al. 2020; Fish 2016; Grace, Greenhill, and Withers 2020; McCarthy 2014), often carried out in the name of 'safeguarding'. This jars with research that has shown that relationship and sexual wellbeing relates to life satisfaction (see Fish and Björnsdóttir 2022; White et al. 2021) as well as policies that advocate for service user empowerment and rights in the UK (see, DHSC 2018) and globally (see, Maylea 2019).

Despite current policy, and guidance (see, DHSC 2022) most of our service user and carer participants reported little support to help service users develop and maintain romantic relationships. Reflecting the lens of vulnerability, carers were wary of 'mainstream' support such as online dating agencies, stating their preference for support that was within the mental health system. Yet such support was missing. Steeped in policies emphasising privacy and dignity – professionals appeared to shy away from supporting this aspect of wellbeing. These findings are in line with other research indicating that professionals worry about feeling compromised when discussing sexual issues with service users (Quinn, Happell, and Browne 2011). Similar to Östman and Bjorkman's (2013) findings, romantic relationships remained a difficult - if not taboo - subject for professionals, who reported feeling uncomfortable addressing the 'private' aspects of people's lives. Since they regarded romantic expressions as outside of their professional duty, they deprioritized them corroborating findings by Urry et al. (2019). Such practices can be understood as 'institutional silencing', through which concerns remain off limits, either due to poor training or workplace cultures (Urry, Chur-Hansen,

and Khaw, 2022, p. 543). These dynamics continue despite policies emphasising the need for ‘holistic support’ and ‘recovery-orientated care’ (Urry, Chur-Hansen, and Khaw 2019). For example, among other duties, the UK Care Act 2014 requires Local Authorities to “reduce loneliness or isolation” through interventions such as befriending or community activities schemes (DHSC 2022, para 2.6). In cases where an individual is eligible for an assessment of their needs under the Care Act 2014, “local authorities should consider whether an adult, is lonely or isolated, either because their needs prevent them from maintaining the personal relationships they have or because their needs prevent them from developing new relationships” (para 6.106). Where an adult is eligible for social care support, local authorities are required to consider their health and social care needs holistically with a view to addressing the needs that the person themselves sees as important.

Lack of opportunities and spaces to meet potential romantic partners and limited support from professionals led to some people feeling that this aspiration was beyond their reach. In the absence of a loving partner, they relied on small dense social networks comprised of ‘old’ friends, staff/professionals, and family members as found in other studies (Forrester-Jones et al. 2012).

We offer three recommendations. First, a larger, broader mixed-method study should be conducted that seeks to a) examine social service care plans of people with mental health problems (where they provide consent) so that calculations can be made as to whether their romantic needs have been considered by social care workers, and b) an in-depth exploration of what type of social care individuals think would help them in their quest for romantic relationships. Second, drawing on literature from the intellectual disability field, support groups could be established for service users and carers (see, Fish and Björnsdóttir 2022). For example, sessions might focus on talking about relationships and sexuality, rights and safety, respectful relationships, and sexual identity (Fish and Björnsdóttir 2022; O’Shea and Frawley, 2020). Staff training should include sexual citizenship and how to support this as well as supportive measures and resources to adequately respond to clients’ romantic concerns (McCann et al. 2019) in relation to their wellbeing. This should outline the hopes and aspirations that people with mental health problems have about forming romantic attachments and should identify the views of carers. Training should focus on how ways in which the topic may be sensitively broached within assessment and care reviews. Third, in the absence of day care facilities, commissioners should investigate alternative support platforms such as social events, including appropriate transport to and from venues (Fish and Björnsdóttir 2022) for people with mental health problems who wish to find a partner.

Romance, intimate relationships and sexual intimacy are seen as core elements of human experience (Boucher et al. 2016). Despite this, research

exploring the ways in which the romantic needs of people with mental health problems might be met are lacking from the international research literature. This study has identified the importance of romantic relationships for people with a mental health problem. Our service user participants highlighted several important aspects of how 'being mentally ill' and social stigma impacted negatively on their ability to form romantic relationships. By contrast, carers and professionals focused on vulnerability and risks. Whilst carers identified the need for professional support, professionals reported rarely supporting people with mental health problems to develop or maintain romantic relationships and were uneasy about discussing sexual intimacy. Our study has focussed on the views of mental health service users, carers and mental health professionals in England, but our recommendations have salience for international researchers and service providers. The World Health Organization (2023) reported that the success of its goal of levelling up mental health care by 2023 across the globe assumed that mental health care would focus on all phases of life. This includes respecting individual's rights to participation and inclusion, as well as decision making. Yet there remains scant research that systematically investigates the need and right for romantic relationships and mental health (McIntyre et al. 2023). Our study indicates the need for mixed-method studies that examine what (if any) health and social care supports are provided to people with mental health problems internationally, and whether romantic and sexual needs are being considered within care and support plans. Co-produced studies that include what people with mental health problems consider to be important for developing romantic relationships will help authenticate future health and social care practice. Mental health services can also learn lessons from the intellectual disability field through providing support groups for service users and carers focussing on supporting romantic relationships and training for professionals to develop their confidence in supporting people with mental health problems in this area. Lastly, support platforms, such as social groups or specialist dating agencies such as NoLongerLonely (2023) should be evaluated and if proven positive, advanced to enable people with mental health problems to develop romantic relationships with others. Since being in a romantic relationship clearly matters for people with mental health problems globally, it should matter to mental health services across the world.

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ORCID

Rachel Forrester-Jones  <http://orcid.org/0000-0002-6840-6715>

Jeremy Dixon  <http://orcid.org/0000-0003-0656-5646>

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