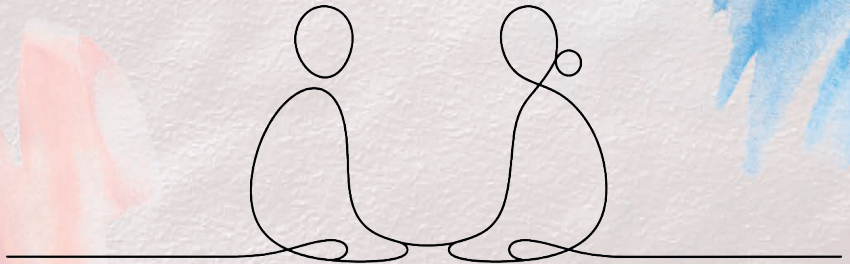


**Peter Falkai
Ángel Luis Montejo González
Mihaela Osadcii**

THE CANDID BOOK ³



Living, Loving, Recovering
on intimacy and reproductive well-being in schizophrenia

edited by **Peter Falkai**

Peter Falkai
Ángel Luis Montejo González
Mihaela Osadcii

THE CANDID BOOK 3

Living, Loving, Recovering
on intimacy and reproductive well-being in schizophrenia

edited by **Peter Falkai**

supported by



The Spanish Association of Sexuality and Mental Health formally endorses 'The Candid Book 3: Living, Loving, Recovering', recognising its scientific and educational value and its contribution to improving understanding of intimacy, sexual health and reproductive well-being in people living with schizophrenia.



GEDEON RICHTER

The Candid Book 3

Living, Loving, Recovering

on intimacy and reproductive well-being in schizophrenia

by Peter Falkai, Ángel Luis Montejo González, Mihaela Osadci

Published by Masterdruck Ltd.
540342 Targu Mures, Lapusna 6C, www.masterdruck.ro

Copyright © 2026 Masterdruck Ltd.

All rights reserved. For enquiries concerning permission
for reproduction contact masterdruck@masterdruck.ro

The information contained in this book is
provided for educational and informational
purposes only. It is not intended as medical
advice, nor is it intended to diagnose, treat, cure,
or prevent any disease or health condition.

Please consult a physician or qualified healthcare
professional before acting on any advice, suggestions,
or recommendations contained in this book.

The authors, publisher, contributors, and other
representatives assume no responsibility or legal
liability for any errors or omissions in the text, or
damages arising from or related to the use of this book.

You acknowledge that this book is not intended to
replace consultation with a physician, healthcare
professional, or other licensed practitioner.
Before beginning any healthcare program or
making significant lifestyle changes, consult
your physician or another qualified healthcare
professional to ensure that such actions are
appropriate for your individual circumstances.

This book contains information related to physical and/
or mental health conditions. By using this book, you
acknowledge and agree to the terms of this disclaimer.

All names appearing throughout this book are
fictitious. Any resemblance to actual persons, living
or dead, or to actual events is purely coincidental.

First hardcover edition August 2026.
ISBN: 978-606-9696-17-0

Contributors:

Medical writing:



Diana Osadci, MD, PhD, is a medical
writer with a strong background in scientific
communication and development of
evidence-based medical content.
Her professional experience spans scientific
articles, peer-reviewed publications,
and patient education materials across
a range of therapeutic areas.
Diana is the founder of DOMinoMedical, a
company specializing in medical affairs and
medical writing, based in Budapest, Hungary.

Artwork:



Timea Szabó is a fine artist specializing
in oil painting, watercolor, digital
art, and large-scale murals.
A graduate of the Faculty of Arts and
Design at the West University of Timișoara,
Romania, she blends classical techniques
with contemporary and symbolic imagery.
Internationally recognized, her work
explores emotion, beauty, and the hidden
dimensions of human experience.
Timea lives and works in Parajd
(Praid), Transylvania, Romania.

Book design: István Fodor

Printing by: Masterdruck Ltd.

Supported by:



Prof. Peter Falkai is Professor and Chairman of the Department of Psychiatry and
Psychotherapy at Ludwig-Maximilians-University Hospital Munich, Germany and Professor and
Chairman of the Max-Planck Institute for Psychiatry.

Professor Falkai has worked in the field of psychiatry for more than 30 years. His primary
research focus is the neurobiology of psychotic disorders, particularly schizophrenia. He
has been a member of numerous German and international scientific societies, including the
Schizophrenia International Research Society (SIRS). From 2021 to 2023, he served as President
of the European Psychiatric Association (EPA) and currently serves as President of the World
Federation of Societies of Biological Psychiatry (WFSBP).

Prof. Falkai has led multidisciplinary research teams whose clinical and scientific work focuses
on the neurobiological origins, pathomorphological aspects, and causal treatment approaches
of psychotic disorders.

He is one of 17 LMU researchers among Clarivate's most successful "Highly Cited Researchers".
Prof. Falkai resides in Munich, Germany.



Prof. Ángel Luis Montejo González is Full Professor of Psychiatry at the University of
Salamanca, Head of the Department of Psychiatry at Salamanca University Hospital, and Head
of the Neuroscience Research Group at the Biomedical Research Institute of Salamanca (IBSAL),
Spain. He is also President of the Spanish Association of Sexuality and Mental Health and a
member of the International Academy of Medical Sexology.

His research has focused on the interface between psychiatry and sexual medicine, with
particular emphasis on psychotropic-induced sexual dysfunction, psychopharmacology,
hyperprolactinaemia, and the safety and tolerability of psychotropic treatments. He developed
and validated the Psychotropic-Related Sexual Dysfunction Questionnaire (PRSexDQ-SALSEX),
which has been translated and used internationally.

Professor Montejo has served as Principal Investigator in numerous competitive research
projects and more than 100 international clinical trials, contributing to the development of novel
treatments for depression, schizophrenia, anxiety disorders, mild cognitive impairment, and
dementia. He has also participated in international scientific advisory boards and clinical trial
steering committees.

He has authored more than 300 national and international scientific publications, which have
received over 8,500 citations, and has published seven books. His work integrates clinical
psychiatry, psychopharmacology, sexual medicine, and translational clinical research.
Prof. Montejo resides in Salamanca, Spain.



Mihaela Osadci holds a Master of Science in Clinical Psychology and Mental Health from
the University of Sussex, UK. Her postgraduate research examined the neural mechanisms
underlying conditioned responses to drug-related environments, reflecting her broader
interest in the neurobiological processes underlying psychopathology and behaviour.

Mihaela has clinical experience across residential and supported living settings, working with
adults presenting with complex and enduring mental health difficulties, including schizophrenia
and other psychotic disorders, as well as associated comorbidities and support needs. She
previously worked as a Psychological Support Worker at Conifer Lodge and Venture-People
in Brighton, UK, and currently works as a Mental Health Support Worker in supported living,
providing ongoing support to individuals with severe and persistent mental health conditions.

Mihaela's professional and academic interests lie at the interface of clinical psychology,
psychiatry, and neuroscience, with a particular interest in the phenomenology, neurobiology,
and clinical management of severe mental disorders. Her experience combines postgraduate
training in clinical psychology and mental health with direct clinical work supporting individuals
living with complex psychiatric conditions. She resides in Brighton, UK.

Living, Loving, Recovering

on intimacy and reproductive well-being
in schizophrenia



Schizophrenia does not erase a person's capacity to love, to seek closeness, or to imagine a future that includes relationships or family.

A word before we begin

Caring for someone living with schizophrenia means walking alongside them through many dimensions of life, not only illness, but also relationships, identity, and personal hopes for the future.

For many families, the first focus is on understanding the condition and finding stability. Questions about relationships, intimacy, or the future often come later, and sometimes feel harder to ask.

While much attention is given to clinical aspects and treatment, other deeply human experiences often remain in the background. Questions about closeness, partnership, self-confidence, and the possibility of becoming parents are often present but not easily brought up in conversation.

At the same time, these questions are rarely simple. They are often accompanied by uncertainty:

Is this still possible? Is it safe? Are we ready?

These moments of hesitation are part of real life, and they deserve space. It is within this space that many important questions begin to take shape, often quietly, and not always easily expressed.

About The Candid Book series

This book is the third volume in **The Candid Book Series**, created to open important aspects of life with schizophrenia gently and to support those who walk alongside someone they care about.

The first volume focused on understanding the illness and managing the early stages of care, while the second addressed a particularly complex reality: the co-occurrence of schizophrenia and substance use. This third volume moves the conversation further into everyday life, focusing on areas that are deeply personal, often unspoken, and sometimes difficult to approach: intimacy, sexuality, reproductive health, and the possibility of building a future.

Rather than returning to what schizophrenia is, this book explores how people continue to live, connect, and make meaningful life decisions while living with it. For many families, these questions arise later in the journey, when stability begins to return, and attention gradually shifts toward what life can become.

What this book offers

This book opens an honest dialogue about topics often left unspoken. It is written for families, partners, friends, and caregivers who want to better understand and support the emotional lives of people living with schizophrenia.

It does not aim to provide perfect answers, but rather to make these questions easier to approach. Instead of focusing only on pathology, it explores the need for intimacy, the experience of relationships, the role of physical and hormonal factors, as well as fertility, family planning, and the realities of building a future.

Each chapter combines scientific insight, clinical experience, and real-life perspectives - offering clarity without overwhelming detail, and reassurance without oversimplifying complexity.

Developed through a collaborative effort among experienced clinicians and mental health professionals, it reflects a shared commitment to translating this expertise into language that is accessible, respectful, and meaningful in everyday life.

Who are the voices in this book?

The conversations in this book are guided by two voices.

Elena Maurer, a health journalist, represents the perspective of families, partners, and caregivers. She asks the questions many people are thinking, but may not always feel comfortable expressing. **Dr. Lukas Stein**, a psychiatrist and researcher, brings clinical experience and scientific understanding, translating complex medical topics into practical and relatable insights.



Together, they reflect the kind of dialogue that may take place in clinical settings, sometimes clear, sometimes uncertain, but always focused on understanding. Their exchange is not meant to provide definitive answers to every situation, but rather to offer a way to think, to ask questions, and to begin conversations that can continue beyond the pages of this book.



How this book is structured

The book unfolds across five interconnected chapters:

Sex Differences and Their Impact in Schizophrenia; Understanding the Need for Intimacy; Intimacy and Relationships in Schizophrenia; Treatment Considerations and Intimate Well-being; and Reproductive Health and Family Planning.

Each chapter can be read independently, while also contributing to a broader understanding. Together, they reflect how these topics often overlap and interact in real life, moving from understanding to experience, to managing challenges, and eventually to planning.

Why these topics matter

Intimacy and reproductive health are not secondary concerns. They are closely connected to self-esteem, identity, emotional stability, relationship quality, engagement with treatment, and overall quality of life.

When these aspects are not addressed, people may feel isolated or uncertain, sometimes gradually, without it being immediately visible. When they are acknowledged, something important begins to change: people feel seen, communication becomes easier, and trust can grow.

Schizophrenia does not erase a person's capacity to love, to seek closeness, or to imagine a future that includes relationships or family.

These possibilities may look different. The path may require more support, and at times more patience. But they remain deeply human and deeply important.

Not every question will have a simple answer. But understanding can grow, step by step.

And sometimes, that is where the connection begins.

Let us begin...

Chapter

1

Women and Men Living With Schizophrenia: Understanding Emotional and Relational Differences

Explore Chapter 1

This chapter invites you to follow a warm and open conversation about some of the sensitive aspects of living with schizophrenia, how the illness may affect women and men in similar or different ways, and how these differences can shape emotions, closeness, relationships, and family life.



1.1
Do women and men experience schizophrenia differently?



1.2
Why does closeness feel different, strained, or harder to access?



1.3
Why may it become harder to understand each other emotionally?



1.4
How can schizophrenia influence dating, intimacy, and long-term relationships?



1.5
Pregnancy and motherhood in women living with schizophrenia



Clinical Stories





Mini-Glossary

Psychosis

A mental state in which perception of reality may be altered, sometimes involving hallucinations, unusual beliefs, or confusion about what is real.

Negative symptoms

Symptoms that involve a reduction in normal emotional or behavioral functioning, such as reduced facial expression, lower motivation, or social withdrawal.

Social cognition

The brain's ability to interpret other people's emotions, facial expressions, intentions, and social signals.

Affective symptoms

Emotional symptoms such as anxiety, sadness, irritability, or mood changes.

Relapse

The return or worsening of symptoms after a period of stability.

Caregiver

A family member, partner, or friend who provides practical or emotional support to a person living with an illness.

Emotional regulation

The ability to manage and respond to emotional experiences in a balanced way.

Intimacy

Emotional closeness, trust, and vulnerability shared between people in a relationship.

Welcome to podcast #1

Understanding emotional and relational differences in women and men living with schizophrenia

with **Elena Maurer**, Health Journalist, and
Dr. Lukas Stein, Psychiatrist and Researcher

Elena:

Welcome to *Living, Loving, Recovering*, the podcast where we talk openly about what it means to support a loved one living with schizophrenia.

Today, we're exploring something many families notice, but often find difficult to put into words:

Do women and men experience schizophrenia differently, and how might these differences shape closeness and relationships?

To help us better understand this, I'm joined by psychiatrist and researcher Dr. Lukas Stein.

Thank you for being here, Dr. Stein.

Dr. Stein:

Thank you, Elena. And thank you to everyone listening, caregivers, partners, and family members. Your presence and involvement truly make a difference in the recovery journey.

This is an important topic, and one that is often overlooked.

We don't always speak openly about the emotional and intimate aspects of schizophrenia, even though they play a central role in relationships, in a person's sense of dignity, and in long-term well-being

1.1

Do women and men experience schizophrenia differently?



“What may look like indifference, irritability, or emotional instability is often part of how the illness is expressed, not a reflection of love, character, or commitment.”

Elena:

Let’s start with a question many caregivers ask, sometimes quite directly:

Is schizophrenia different in women and men?

Dr. Stein:

That’s a very fair question. And the short answer is yes, we do see some consistent differences.

At the same time, it’s important to approach this carefully. *These are not strict rules or stereotypes, but patterns we observe in both research and everyday clinical practice.*

Elena:

When we talk about differences, we’re not labeling people, but trying to understand better what families experience.

Dr. Stein:

Exactly. Over time, clinicians notice certain tendencies, how symptoms develop, how emotions are expressed, and how relationships are affected. These patterns don’t define any one person, but they can help make sense of experiences many patients and partners describe.

Some families put it very simply:

“I know it’s still him... but something feels different, and I don’t always know how to reach him.”

Elena:

That’s something many people recognize, the feeling that the person is still there, but harder to reach.

Dr. Stein:

Yes, and these changes can show up in everyday life in different ways.

For example, **men often develop symptoms a little earlier, usually in their late teens or early twenties**. Because this happens during an important period of education and social development, it can interrupt friendships, studies, or early career plans.

Elena:

And for women, the timing is often different?

Dr. Stein:

That's right. **Women tend to experience their first symptoms slightly later**. In some cases, there may also be a **second period of vulnerability later in adulthood**, often during phases of hormonal transition, when changes in hormone levels can influence emotional and cognitive stability.

Elena:

So biology may play a role not only at the beginning, but also later on.

Dr. Stein:

Yes, it can. And we also see differences in how symptoms are expressed. **Negative symptoms, such as reduced motivation, less facial expression, or social withdrawal, are often more noticeable in men**. Families may experience this as emotional distance or feel that something in the connection has changed.

Elena:

That's often interpreted as "he doesn't care anymore," even when that's not the case.

Dr. Stein:

And in **women**, we often see something different. **Emotional symptoms such as anxiety, sadness, or mood changes may be more prominent**. They may remain expressive, but at times feel more easily overwhelmed.

Elena:

So the expressions are different, but the emotional experience is still there.

Dr. Stein:

Very much so. And that's why understanding these patterns is so important. They are not predictions, and they are never absolute. Every person is unique. But recognizing them can help prevent misunderstandings.

What may look like indifference, irritability, or emotional instability is often part of how the illness is expressed, not a reflection of love, character, or commitment.

1.2

Why does closeness feel different, strained, or harder to access?



“Patience is often the bridge back to closeness.”

Elena:

Many caregivers describe a painful realization. They say, “It’s not only the symptoms. It feels like something in our closeness has changed.” Is that something the illness can really influence?

Dr. Stein:

Yes, and this is one of the more delicate aspects of schizophrenia. Opening up to intimacy is never simple. **It means allowing another person to see your fears, your needs, your imperfections.** In many ways, **intimacy is the highest expression of trust.** It says, “I feel safe enough with you to let you see who I truly am.”

Elena:

And that sense of safety can become fragile when someone is struggling internally.

Dr. Stein:

Exactly. Imagine how difficult that becomes when a person is also dealing with anxiety, suspicious thoughts, emotional confusion, or moments of uncertainty about what is real.

Even brief changes in perception can interfere with something very basic: the ability to feel secure in how we interpret other people’s intentions.

From a clinical perspective, psychosis can affect how the brain processes social signals. Facial expressions may be misread. Neutral comments may feel threatening. Small misunderstandings can quickly grow.

And when that internal sense of safety becomes unstable, opening up emotionally may no longer feel safe.

Elena:

So when a partner says, “You don’t talk to me anymore,” it may not be rejection.

Dr. Stein:

Often, it’s not rejection at all. It may be a form of self-protection.

When someone is trying to manage intrusive thoughts or internal uncertainty, their emotional energy is often directed inward. Reaching outward, even toward someone they deeply love, can feel overwhelming.

Some people become quieter.
Some avoid eye contact.
Some seem emotionally distant.

But inside, the need for connection is often still there.
“I can feel that they still care... but I don’t know how to meet them there anymore.”

Elena:

That’s a very difficult place for both partners to be in.

Dr. Stein:

It is. And this is where compassion becomes essential.

If the response is pressure, “Why are you shutting me out?”, the withdrawal may deepen. But if the response is gentler, even something as simple as “I’m here,” trust can slowly begin to return.

Elena:

And even that can feel difficult to say.

Dr. Stein:

Yes. Many partners hesitate. They wonder, “What if I say the wrong thing?
What if I make it worse?”

At the same time, it’s important to say that **gentleness does not mean self-sacrifice.**

Caregivers and partners are not responsible for absorbing all fear, uncertainty, or emotional distance without limits. Supporting someone through schizophrenia requires patience, but also balance.

Elena:

Support also includes taking care of oneself.

Dr. Stein:

Healthy boundaries are not a sign of withdrawal or lack of love.
They are a form of stability.

A partner might say:
“I’m here for you.”

“I understand you need space.”

“And I also need moments to rest and take care of myself.”

This balance is essential. When caregivers become emotionally exhausted, relationships can become strained, and resentment may quietly build.

Elena:

Stability in the caregiver also supports the relationship.

Dr. Stein:

Very much so. When caregivers maintain their own well-being, sleep, social contact, and personal time, they are better able to offer a calm and consistent presence. And that consistency helps restore a sense of safety.

Intimacy, in this context, is not about constant closeness.
It is about reliable presence.

Trust begins to return when the person living with the illness feels accepted, and when the partner feels supported and not alone.

Both individuals need emotional safety. And when that safety is shared, the connection often becomes stronger and more resilient.

Elena:

So **intimacy may change, but it doesn't disappear.**

Dr. Stein:

Exactly. It may grow more slowly, more carefully. But it can still exist, sometimes even more consciously and tenderly than before.

And when we understand that psychosis can temporarily disrupt trust, it becomes easier not to take the distance personally.

That understanding often transforms confusion into patience.

And patience is often the bridge back to closeness.

1.3

Why may it become harder to understand each other emotionally?



*“It’s not about losing love.
It’s about learning new ways of staying connected under
different conditions.”*

Elena:

Another question caregivers often ask is:
“Why does my partner seem emotionally distant or hard to reach?”
And others wonder,
“Why does she react so intensely to small things?”
Is this related to differences between men and women?

Dr. Stein:

Sometimes, yes, but what matters most is how these experiences are perceived within the relationship.

Elena:

What do you mean by that?

Dr. Stein:

Partners often notice changes, but they don’t always know how to interpret them.

One partner may feel that the other has become distant, less responsive, harder to reach. The other may feel emotionally overwhelmed, reacting more strongly or struggling to find balance. These differences can create a sense that the two are no longer meeting each other in the same way.

Elena:

So it’s not just what is happening internally, but how it is experienced between two people.

Dr. Stein:

This is where misunderstandings often begin. When closeness starts to change, many partners instinctively interpret behavior in personal terms. **Quietness may be experienced as indifference. Emotional intensity may feel unpredictable or overwhelming. Reduced initiative may be interpreted as rejection.**

Elena:

Even though that may not be the intention at all.

Dr. Stein:

In many cases, it isn't. What is happening is often far less intentional and far less personal than it appears. **Schizophrenia can** influence how emotions are processed, expressed, and regulated. A person may still feel love and attachment just as strongly, but have difficulty showing it in familiar ways. At times, emotional responses may seem muted or delayed. At other times, they may feel heightened or harder to manage.

Elena:

So the emotional connection is still there, but it may not be communicated in the same way.

Dr. Stein:

That's right. And when that shift is not understood, it can easily lead to painful conclusions. Instead of thinking, "He doesn't care," a partner might begin to ask, "Is he having difficulty expressing what he feels?" Instead of assuming, "She is overreacting," they might wonder, "Is she feeling overwhelmed right now?"

Elena:

That's a very different way of seeing the same situation.

Dr. Stein:

It is. And that shift can protect the relationship from unnecessary hurt. Of course, this change in perspective doesn't happen immediately. Many partners go through confusion, frustration, and even a sense of loss.

Elena:

And it's natural to feel that way.

Dr. Stein:

Absolutely. But when that understanding develops, something important changes. Emotional distance becomes less threatening. Reactions feel less personal. **Changes in emotional expression are not signs that love is disappearing. They are signs that the emotional system is working under different conditions.**

Elena:

Dr. Stein, may I ask something many listeners might be wondering? Are these kinds of changes specific to schizophrenia, or do we see them in other chronic illnesses as well?

Dr. Stein:

That's an excellent question. And the answer is no, this is not unique to schizophrenia.

Across many chronic conditions, whether physical or mental, we see similar patterns. **Living with a long-term illness can affect energy, self-confidence, identity, and communication.** Over time, partners may take on different roles, and emotional and physical closeness may shift.

Elena:

So relationships are adapting to new conditions.

Dr. Stein:

Exactly. **Relationship strain is one of the most common challenges across chronic illness.**

What schizophrenia adds, however, is that it can directly affect perception and social understanding. This may make it harder, at times, to interpret tone, facial expressions, or intentions accurately, which can make closeness feel more fragile.

Elena:

The challenge may feel more intense, but the process itself is not unique.

Dr. Stein:

That's right. The broader principle remains the same: relationships adjust.

Couples who develop open communication, realistic expectations, and a shared understanding of what is happening tend to find a way forward.

Elena:

What we are describing **is not a relationship failure...**

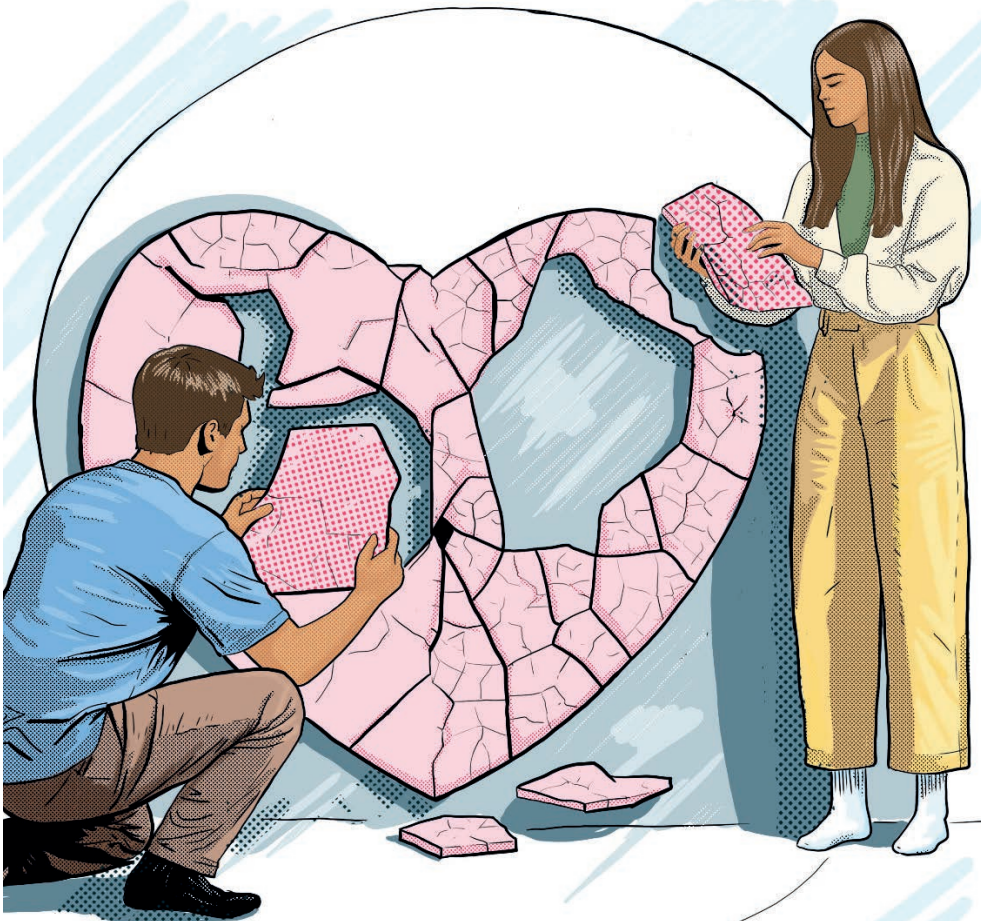
Dr. Stein:

...but a relationship adaptation.

It's not about losing love. It's about learning new ways of staying connected under different conditions.

1.4

How can schizophrenia influence dating, intimacy, and long-term relationships?



“It can change how love is expressed, but not the capacity to love itself.”

Elena:

Let me ask a very direct question, one that many caregivers and partners quietly worry about, even if they rarely say it aloud:
Does schizophrenia change how someone experiences love and closeness?

Dr. Stein:

It can change how love is expressed, but not the capacity to love itself.

Many patients describe it in very simple, but powerful terms:
“I still feel everything... I just can’t show it the way I used to.”

Elena:

That must be very confusing for both partners.

Dr. Stein:

It often is. One person may feel deeply connected, but struggle to express it in ways that are recognizable to the other. Schizophrenia can affect several systems that are important for relationships: emotional expression, motivation, reward processing, and social perception.

This means that even when the emotional bond is intact, the ability to act on it, to show it, or to respond to it spontaneously may be reduced or inconsistent.

Elena:

It’s not only about feelings, but also about how those feelings are translated into behavior.

Dr. Stein:

Exactly. Some individuals may experience reduced motivation or initiative, especially in moments that require emotional engagement. **This can affect meaningful actions, such as starting a conversation, initiating affection, or maintaining emotional reciprocity.**

Elena:

These are often the building blocks of intimacy.

Dr. Stein:

Yes, and when those small actions change, the relationship can begin to feel different, even if the underlying feelings have not changed. At the same time, emotional responsiveness may become uneven. Some moments feel distant or muted, while others may feel more intense or overwhelming. This variability can be difficult for both partners to interpret.

Elena:

So **the relationship may feel less predictable.**

Dr. Stein:

That's a good way to put it. And **unpredictability can create uncertainty.** Partners may begin to question whether the connection is still there, or whether something has been lost. The ability to read facial expressions, tone of voice, and intentions can be affected. This may lead to misinterpretations, even in close relationships, where understanding is usually more intuitive.

Elena:

Even familiar interactions can feel more complicated.

Dr. Stein:

Yes. And that can lead to a subtle distancing, not because people want to disconnect, but because interactions require more effort and carry more uncertainty.

Elena:

Where do the differences between men and women come into this?

Dr. Stein:

They can influence how these changes are experienced. **Some men may take longer to express emotion or initiate closeness, especially when motivation or emotional expression is reduced.** Some **women**, on the other hand, **may experience periods of increased emotional sensitivity or vulnerability, which can make relational interactions feel more intense.**

Elena:

So the timing and intensity may differ between partners.

Dr. Stein:

And this can create a kind of mismatch. **One partner may need more time and space, while the other may seek reassurance or emotional closeness. Without understanding, this difference can be experienced as rejection or pressure.**

Elena:

Which can easily create tension.

Dr. Stein:

Yes, but it's important to emphasize that this is not a fixed pattern, and not a sign of incompatibility. It's a dynamic that can be understood and gradually adjusted.

With the right support, something very important can happen. Couples begin to develop new ways of connecting. They may communicate more explicitly, rely less on assumptions, and become more attentive to each other's emotional rhythms.

Elena:

In a way, the relationship becomes more intentional.

Dr. Stein:

And in many cases, that leads to a deeper form of connection.
Not necessarily easier, but often more conscious, more patient,
and sometimes more resilient.
Couples who develop shared understanding, open communication,
and realistic expectations are more likely to maintain
satisfying relationships over time, even in the context of chronic illness.

Elena:

Then it's not about returning to how things were before.

Dr. Stein:

No. It's about adapting.

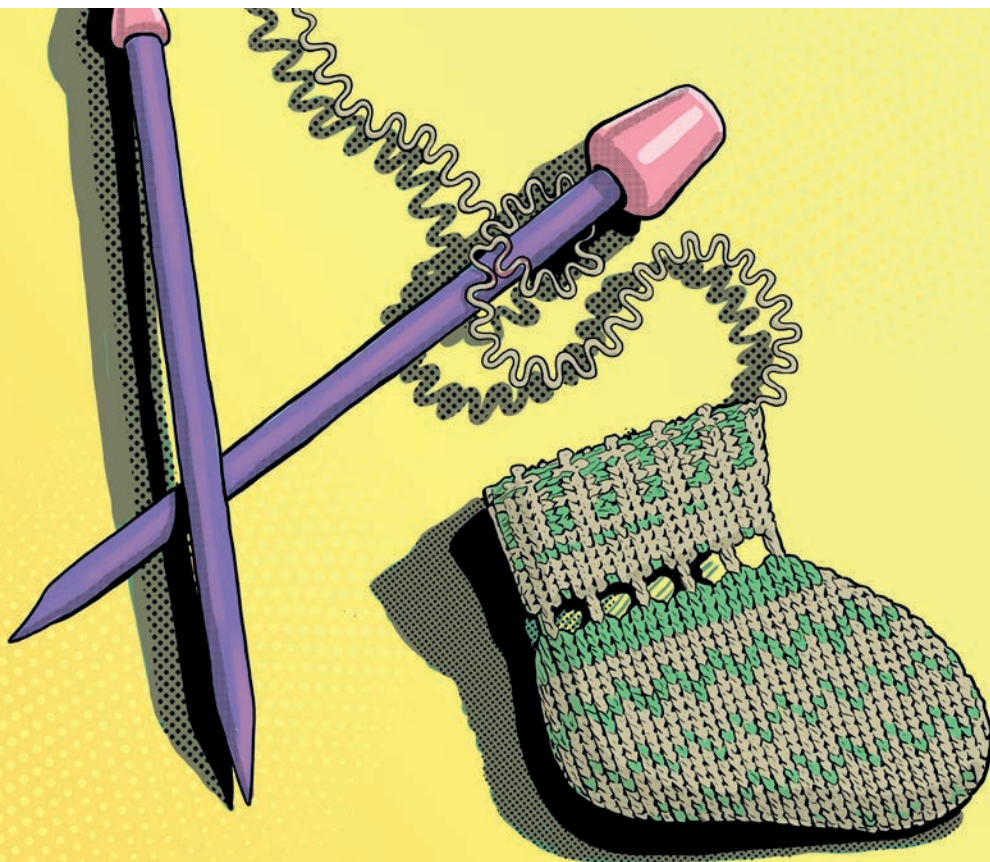
Intimacy may look different. It may grow more slowly, require more reassurance, or depend more on stability than spontaneity. But it can still be meaningful, and in some cases, even stronger.

I've seen many couples move from confusion to understanding, and from distance to a different kind of closeness. When partners begin to recognize what is happening, they often stop interpreting changes as personal failures and start working together.

And that shift can make all the difference.

1.5

Pregnancy and motherhood in women living with schizophrenia



“Pregnancy planning should always be discussed early with the treatment team. When decisions are made collaboratively, most risks can be carefully managed.”

Elena:

Many families wonder whether a woman living with schizophrenia can safely become a mother.
Is pregnancy possible?

Dr. Stein:

Yes, it is possible. In fact, many women with schizophrenia do become mothers, and this has become more common as treatment and social support have improved.

At the same time, pregnancy in this context requires careful planning and close medical follow-up. For many couples, this is not only a medical decision, but it also brings mixed emotions. There can be hope, but also fear, uncertainty, and sometimes different expectations between partners.

Elena:

This seems to be both a medical and an emotional process.

Dr. Stein:

Exactly. **The goal is always to ensure stability of the illness, appropriate treatment, and a strong support system.**

Some challenges may arise. Women may experience increased sensitivity to stress, difficulty maintaining treatment routines, or a slightly higher risk of certain pregnancy-related complications.

Elena:

That sounds concerning, but also manageable.

Dr. Stein:

That's a very good way to put it. With coordinated care, between psychiatrists, obstetricians, and family support, many pregnancies proceed safely.

Elena:

So **pregnancy is possible, but it should be carefully planned.**

Dr. Stein:

Yes, planning allows us to protect both the mother's mental health and the development of the child.

Elena:

Another question families often ask is whether schizophrenia is inherited. If a parent has schizophrenia, does the child automatically develop the illness?

Dr. Stein:

No, it does not work in a deterministic way.

Schizophrenia does have a genetic component, but it is influenced by many factors, biological, psychological, and environmental. Even when a parent has the condition, most children do not develop it.

Elena:

Does it mean that genetics increases the risk, but does not determine the

outcome?

Dr. Stein:

Exactly. We now understand that it is a combination of vulnerability and life experience.

Factors such as **prenatal health, early childhood environment, exposure to stress, substance use, and the presence of stable relationships all play a role in shaping outcomes.**

Elena:

That explains why families may still feel uncertain, even when they understand the science.

Dr. Stein:

Yes. Questions like "What if something happens?" are very difficult to completely silence.

But it is important to emphasize that many children of parents with schizophrenia grow up completely healthy.

Elena:

Are pregnancies themselves more risky in women with schizophrenia?

Dr. Stein:

They can be slightly more complex, but not necessarily dangerous.

Some studies report higher rates of complications such as preterm birth or lower birth weight. However, these risks are strongly influenced by factors like stress, smoking, inconsistent medical care, or untreated symptoms.

Elena:

The context matters as much as the diagnosis.

Dr. Stein:

Very much so. **When women receive consistent prenatal care and psychiatric follow-up, outcomes improve significantly.**

One of the most important protective factors is continuity of care.

Elena:

Another sensitive question families often ask is about medication. Can antipsychotic treatment continue during pregnancy?

Dr. Stein:

This is one of the most important questions, and the answer requires balance. In many cases, treatment can and should continue, but always with individualized decisions and close collaboration between psychiatry and obstetrics. On one hand, we consider the potential effects of medication exposure. On the other hand, untreated psychosis can carry significant risks for both mother and child.

Elena:

Then stopping treatment is not necessarily safer.

Dr. Stein:

Exactly. In fact, abrupt discontinuation is often not recommended, especially in individuals with a history of severe relapse.

Recent large studies have shown that many antipsychotic medications can be used during pregnancy when clinically necessary, without a strong increase in major congenital risks. Some small risks may exist, but they are often influenced by additional factors such as stress or overall health.

Elena:

So the goal is not to avoid medication at all costs.

Dr. Stein:

No. The goal is stability, with the lowest effective treatment burden. Untreated relapse can lead to sleep disruption, emotional distress, and difficulty maintaining care, which may be more harmful than carefully monitored treatment.

Elena:

If caregivers remember just one thing about pregnancy and treatment, what should it be?

Dr. Stein:

I would say this: **never make these decisions alone.**

Pregnancy planning should always be discussed early with the treatment team. When decisions are made collaboratively, most risks can be carefully managed.

The goal is not simply to avoid medication, but to protect both mother and child while maintaining stability and dignity.

And with proper support, that balance is often very achievable.

Is breastfeeding possible in mothers with schizophrenia?

Elena:

And after the baby is born, what about breastfeeding? Many mothers hope to breastfeed if possible.

Dr. Stein:

That's another important and often very personal conversation. Some antipsychotic medications do pass into breast milk in small amounts. In many cases, breastfeeding is still possible, but it depends on several factors, the specific medication, the dosage, and the health of both the mother and the infant.

Elena:

This does not seem to be a simple Yes-or-No decision.

Dr. Stein:

Indeed. Doctors usually look at the situation as a whole. They consider the stability of the mother's mental health, the treatment she is receiving, the baby's development, and also something very practical but essential, the mother's ability to rest and recover after childbirth.

Elena:

Sleep seems to be a key factor here.

Dr. Stein:

It is. Sleep is particularly important in this period. Breastfeeding can be physically and emotionally demanding, and sleep deprivation is a well-known trigger for relapse in some women.

Because of that, some families and clinicians decide that protecting the mother's stability and sleep may be more important than breastfeeding. In other situations, breastfeeding can proceed safely, with careful monitoring and support.

Elena:

Again, the key is individualized decision-making.

Dr. Stein:

There is no single rule that applies to everyone.

Elena:

And after childbirth, what challenges might families expect?

Dr. Stein:

The postpartum period can be emotionally intense for any parent, and especially for women living with schizophrenia. During this time, several factors come together. There may be sleep deprivation, hormonal changes, increased stress, and, in some cases, a higher risk of relapse, particularly if treatment is interrupted.

Elena:

So it's a period that requires close attention.

Dr. Stein:

Yes, and also strong support. Many clinicians recommend a structured support system after birth. This often includes family involvement, regular mental health follow-up, and practical help with childcare.

Elena:

Support is not only emotional, but also very practical.

Dr. Stein:

Early and consistent support can make a significant difference, not only for the mother's well-being, but also for the development of a healthy and secure bond between parent and child.

Clinical Story

***"No... I'm just moving slower than before."
(The story of Anna and Mark)***



Note: The clinical stories in this chapter are created for educational purposes. Names and identifying details do not represent specific individuals.

Elena:

Before we finish, Dr. Stein, could you share a story from your practice? Something that shows how these sex-related patterns actually play out in relationships?

Dr. Stein:

Of course. Let me tell you about a couple I worked with, we'll call them Anna and Mark.

Mark had his first episode in his early twenties. Before that, he was lively, expressive, always the one making people laugh. After the episode, he became quieter, slower. His emotions were still there, but they didn't appear on his face the way they used to. Anna, who was naturally warm and expressive, felt the change deeply. She once said, *"He's here, but I can't feel him anymore."* She later said, "I wasn't sure if this was the illness... or if I was losing him."

One day in session, she asked him, through tears,
"Are you slipping away from me?"

Mark hesitated, then said softly,
"No... I'm just moving slower than before."

It was a simple sentence, but it shifted everything.

Anna started noticing the small signs of affection she'd been missing:
the tea he made quietly in the morning,
the way he always walked on the outside of the pavement to shield her,
how he remembered her smallest preferences even when words were hard.

And Mark began practicing small moments of expression, a check-in, a touch on the shoulder, a half-smile he had to consciously produce.

They found a new rhythm.
Slower, but profoundly real.

Elena:

It sounds like they rediscovered each other once they understood **what illness was** and **what love was**.

Dr. Stein:

Exactly. *Understanding didn't erase the symptoms; it softened the fear around them.*

Clinical Story

"One step at a time" *(The story of Sofia and Lukas)*

Elena:

Could we hear one more story, perhaps from the perspective of a woman living with schizophrenia?

Dr. Stein:

Absolutely. Let's talk about Sofia and Lukas.

Sofia was someone who felt life intensely, joy, curiosity, worry, everything. After her second episode, though, her emotions became unpredictable. Some days she was open and affectionate. Other days, she felt overwhelmed, anxious, or fatigued for reasons she couldn't explain. This pattern, stronger affective symptoms, is something we often observe in women.

These shifts worried her.

One day, she told Lukas,
"I'm afraid you'll think I'm too much." She hesitated before saying it, as if unsure whether the words themselves might change how he saw her.

Lukas replied,
"You're not too much. **You're going through something, and I'm here.**"

He didn't try to fix her feelings; he anchored them.

Over time, they developed gentle rituals:
evening walks,
shared music to calm the mind,
a rule to pause before reacting during emotional storms.

Slowly, the intensity became more manageable.
Sofia's spark returned, not as a burst of fire, but a steady warmth.

One evening during their walk, she said quietly,
"Sometimes I wonder if we could have a family one day."

Lukas did not rush to answer.

He simply squeezed her hand and said,
 “One step at a time. First we take care of you. Then we see what life brings.”
 Their relationship didn’t collapse under the symptoms — it adapted. And in that
 adaptation, the future slowly felt possible again.

Elena:

Their relationship didn’t collapse under the symptoms; it adapted.

Dr. Stein:

When partners understand the emotional landscape of the illness, they stop
 fighting each other and start **moving forward together**.

Elena:

Hearing these stories, I’m struck by how much misunderstanding can disappear
 simply through awareness.

Dr. Stein:

Yes. When partners learn **how symptoms affect emotional behavior, the
 relationship often becomes softer. Distance becomes less frightening.
 Emotion becomes less confusing.**

Understanding does not solve every challenge.
 But it softens the edges.

It opens a door, sometimes the very first door, back to closeness.

Elena:

So the lesson of this chapter is simple and profound: When we understand the
 person behind the symptoms, closeness becomes possible again.

Dr. Stein:

And with that understanding, we can move into the next chapter, where we explore
 intimacy itself: how it changes, how it can be rebuilt, and how couples find their
 way back to each other.

Final reflection

What should families remember?

Elena:

What would you say to families listening right now who want to support someone
 they love?

Dr. Stein:

I would highlight three important messages for families listening today.

First:

Differences between men and women can exist in how schizophrenia appears, but
 they do not define the person.

These patterns help us understand certain experiences, but they should never be
 used to label or limit someone’s potential.

Second:

Changes in emotional expression or intimacy are often related to the illness, not to
 a lack of love or commitment.

What may look like distance, withdrawal, or emotional intensity is frequently a
 reflection of how the brain is processing stress, emotions, and social signals during
 the illness.

Third:

With understanding, communication, and proper medical support, people living
 with schizophrenia can build meaningful relationships and, in many cases, plan for
 family life as well.

Pregnancy and parenthood are possible for many individuals when they are
 carefully planned and supported by healthcare professionals and family members.

When families respond with patience, openness, and compassion rather than fear or misunderstanding, relationships often grow stronger. This does not happen perfectly. Most families learn this gradually, through trial, error, and many small conversations along the way. And that supportive environment can make an enormous difference for recovery, stability, and hope for the future.

Elena:

Thank you, Dr. Stein, for this clear and compassionate look at how sex and gender influence emotional life in schizophrenia.
To all caregivers and partners listening:
Your presence matters more than you know.
Understanding these patterns is the first step toward connection and recovery.

*(Stay with us for the next episode, where we explore **intimacy and romantic connection** more deeply.)*

References

- Bucci P, Giordano GM, Mucci A, et al. Sex and gender differences in clinical and functional indices in subjects with schizophrenia and healthy controls: Data from the baseline and 4-year follow-up studies of the Italian Network for Research on Psychoses. *Schizophrenia Research*. 2023;251:94-107.
- Seeman MV. Sex differences in schizophrenia relevant to clinical care. *Expert Review of Neurotherapeutics*. 2021;21(4):443-453.
- Li R, Ma X, Wang G, Yang J, Wang C. Why sex differences in schizophrenia? A systematic review. *Psychol Med*. 2021;51(2):241-250.
- Ochoa S, Usall J, Cobo J, Labad X, Kulkarni J. Gender Differences in Schizophrenia and First-Episode Psychosis: A Comprehensive Literature Review. *Schizophrenia Research and Treatment*. 2012;2012:1-9.
- Kraus J, Čavojská N, Harvanová S, Hajdúk M. Interpersonal distance in schizophrenia: A systematic review. *Schizophrenia Research*. 2024;266:1-11.
- Lee CY, Ahmed N, Ikhtabi S, et al. The experience of loneliness among people with psychosis: Qualitative meta-synthesis. V. *Plos One*. 2024;19(12):e0315763.
- White G, Haddock G, Haarmans M, Varese F. Being more satisfied with romantic relationship status is associated with increased mental wellbeing in people with experience of psychosis. *Frontiers in Psychiatry*. 2023;14.
- Rodolico A, Bighelli I, Avanzato C, et al. Family interventions for relapse prevention in schizophrenia: a systematic review and network meta-analysis. *The Lancet Psychiatry*. 2022;9(3):211-221.
- Sisodia S, Hammond Z, Leonardi-Bee J, Hanlon C, Asher L. Sexual and reproductive health needs of women with severe mental illness in low- and middle-income countries: A scoping review. *Plos One*. 2025;20(1):e0311554.
- Galbally M, Snellen M, Power J. Antipsychotic drugs in pregnancy: a review of their maternal and fetal effects. *Therapeutic Advances in Drug Safety*. 2014;5(2):100-109.
- Huybrechts KF, Hernández-Díaz S, Paterno E, et al. Antipsychotic Use in Pregnancy and the Risk for Congenital Malformations. *JAMA Psychiatry*. 2016;73(9):938. doi:10.1001/jamapsychiatry.2016.1520
- National Institute for Health and Care Excellence. Psychosis and schizophrenia in adults: prevention and management [Internet]. London: NICE; 2014 [updated 2025 Jul 29; cited 2026 Aug 21]
- Montejo AL, de Alarcón R, Prieto N, Acosta JM, Buch B, Montejo L. Management Strategies for Antipsychotic-Related Sexual Dysfunction: A Clinical Approach. *Journal of Clinical Medicine*. 2021;10(2):308.

Chapter 2

What intimacy means in the lives of people living with schizophrenia

Explore Chapter 2

This chapter brings attention to the often-overlooked role of intimacy in schizophrenia, exploring how it may change during periods of illness, relapse, and recovery.

It highlights the importance of preserving the couple's sense of partnership through mutuality, healthy boundaries, everyday moments of connection, and emotional presence.



2.1
What is intimacy, really?



2.2
How symptoms can create misunderstandings in relationships



2.3
How can couples rebuild closeness after a relapse?



2.4
How can partners balance support, boundaries, and emotional care?



2.5
Does intimacy contribute to recovery?



Clinical Story





Mini-Glossary

Emotional availability

The ability to be present with someone else's feelings without withdrawing or becoming overwhelmed.

Mutuality

The sense that both partners contribute emotionally, even in uneven proportions.

Attachment security

The sense of feeling valued and safe within a close relationship. This sense of security may fluctuate during periods of illness.

Relational boundaries

Healthy distinctions between roles, such as partner vs caregiver, and between illness-related needs vs personal needs.

Social cognition

The brain's ability to understand emotions, facial expressions, tone, and intentions.

Co-regulation

Two people helping each other calm down emotionally through presence, tone, and predictable interactions.

Relational resilience

A couple's ability to maintain connection through stress, misunderstanding, and recovery periods

Welcome to podcast #2

What intimacy means in the lives of people living with schizophrenia

with **Elena Maurer**, Health Journalist, and
Dr. Lukas Stein, Psychiatrist and Researcher

Elena:

Welcome back to *Living, Loving, Recovering*.

Today's topic is at the heart of human life: intimacy. The quiet kind, the emotional kind, the kind that makes someone feel safe next to another person.

Many caregivers ask: *"Is intimacy even possible after a diagnosis like schizophrenia?"*

Dr. Stein:

Very much so.

The desire for closeness, companionship, romantic connection, it all remains deeply present. People with schizophrenia continually describe love, closeness, and emotional warmth as key parts of a meaningful life.

Sometimes intimacy becomes more fragile, not less important. Understanding how it changes is essential for partners and families.

2.1

What is intimacy, really?



“People living with schizophrenia continue to value closeness, companionship, and meaningful relationships. Many describe these as essential to a fulfilling life.”

Elena:

Let's begin with something that sounds simple, but often isn't. What do we really mean when we talk about intimacy?

Dr. Stein:

That's a very important question, because intimacy is often misunderstood. Many people immediately think of romance or physical closeness. But in everyday life, intimacy is much broader and, in many ways, much quieter.

At its core, intimacy is the feeling of being emotionally connected to another person. It's the sense that you can be yourself, with your thoughts, your fears, your hopes, and still feel accepted.

Some people describe it very simply:
“I don't need everything to be perfect. I just need to feel that I can be myself next to them.”

Elena:

In other words **it's less about what we do and more about how we feel with someone.**

Dr. Stein:

And often, it shows itself in very small, everyday moments.

It might be the feeling of being understood without having to explain everything. Or trusting someone enough to show vulnerability, even in subtle ways. Sometimes it's sharing something personal; other times, it's simply sitting together in silence and feeling at ease.

Elena:

It sounds as though intimacy is something that grows quietly, almost in the background of daily life.

Dr. Stein:

Yes, that's a very good way to put it.

It often develops through simple routines: a morning coffee, a short walk, a quiet message during the day, or the comfort of knowing someone is there, even without words.

And sometimes, people only realize how meaningful these small moments are when they begin to fade.

Elena:

That feels very different from how intimacy is often portrayed.

Dr. Stein:

It is. In reality, intimacy is rarely dramatic. **It's built slowly, through presence, trust, and repeated experiences of emotional safety.**

Sexuality can be part of intimacy, but it is only one dimension. What sustains relationships over time is something deeper: the feeling of being seen, valued, and emotionally safe with another person.

Elena:

And this need doesn't disappear in schizophrenia?

Dr. Stein:

Not at all.

People living with schizophrenia continue to value closeness, companionship, and meaningful relationships. Many describe these as essential to a fulfilling life.

What may change is not the desire for intimacy, but the way it is expressed or experienced.

Elena:

The connection is still there, even if it looks different.

Dr. Stein:

Sometimes the illness affects how emotions are communicated. A person may feel deeply connected, but find it harder to express those feelings clearly. At other times, interpreting social signals, tone, facial expression, or subtle emotional cues can become more challenging.

Elena:

This can lead to misunderstandings between partners.

Dr. Stein:

Yes. Both people may care deeply about each other, but still misread each other's signals. One may feel close internally, while the other experiences distance.

Elena:

So the connection may still exist, but not always be visible.

Dr. Stein:

That's an important point.

The need for intimacy remains. What changes is the pathway through which it is expressed.

And when partners understand that, it becomes easier to remain patient and open, even when closeness feels less obvious on the surface.

Intimacy is not defined by intensity or dramatic moments. It grows through feeling understood, emotionally safe, and quietly connected over time.

2.2

How symptoms can create misunderstandings in relationships



“The emotional world becomes quieter, not absent.”

Elena:

Caregivers often say things like:

“He doesn’t look at me... maybe he doesn’t care.”

Or,

“She reacts so strongly... she must be angry on purpose.”

How often do these situations turn out to be misunderstandings?

Dr. Stein:

Very often.

What we see is that **behaviors are interpreted through a relational lens, when in fact they may be shaped by the illness.**

Elena:

So what looks like a message... may not actually be one.

Dr. Stein:

Moments that appear distant, intense, or even hurtful can have a very different meaning internally. Someone may seem quiet or withdrawn, but actually be overwhelmed or trying to regulate what they are feeling. Emotional reactions may appear unusually intense to others, not because of intention, but because they may be harder to regulate in that moment.

Elena:

The reaction we see on the outside doesn’t always reflect what is happening inside.

Dr. Stein:

That’s right. And this is where many painful misunderstandings begin.

Partners often describe looking back and realizing,
“At the time, I took it personally. I thought I was being pushed away.”

Elena:

Which is a very natural reaction.

Dr. Stein:

It is. But when we begin to look at these moments differently, something important shifts.

Instead of asking, “Why is this happening to me?”

We may begin to ask, “What might be happening for the other person right now?”

When distance looks like rejection

Sometimes behaviors that feel hurtful or distant are not signs of rejection, but ways of coping with internal stress.

What it may look like

- Less eye contact
- Brief or quiet responses
- Spending more time alone
- Limited emotional reactions
- Slower responses in conversation

What it may reflect

- Feeling overwhelmed by social or emotional input
- Difficulty expressing emotions clearly
- A need to regulate internal tension
- Emotions that are present but less visible
- More time needed to process interactions

What may help partners

- Gentle curiosity – “You seem quiet today. I’m here if you want to talk.”
- Patience – allowing time for emotional expression
- Presence – being nearby without pressure
- Reassurance – showing that closeness remains welcome

Emotional withdrawal may be a form of self-protection rather than a loss of affection.

Understanding this difference can protect the relationship and keep communication open.

Elena:

The meaning behind a behavior is not always what it seems.

Dr. Stein:

And when partners begin to see symptoms rather than intention, relationships often soften.

Elena:

Some caregivers also say, “They tell me they want closeness... but they don’t seem to feel it.” Why does that happen?

Dr. Stein:

That’s another difficult experience.

Sometimes there is a gap between emotional desire and emotional experience. A person may still want connection, but feel less emotional intensity in the moment.

Other times, internal anxiety competes with that sense of closeness, or the brain’s reward system responds less strongly.

Elena:

The wish for connection is still there, but the feeling may be quieter.

Dr. Stein:

That can be confusing for both partners. **It may look like a loss of interest, but in reality, it is often the illness affecting how emotions are experienced.**

It does not necessarily indicate a lack of love. It may reflect a change in how affection is experienced or expressed at that moment

Elena:

So **the emotional world becomes quieter, not absent.**

Dr. Stein:

That’s a very important distinction.

2.3

How can couples rebuild closeness after a relapse?



“Relationships, like people, need time to recover.”

Elena:

Relapse is one of the hardest moments for couples.

Partners often say, “I want to be close again, but I don’t know how. Everything feels fragile.”

How do people find their way back to each other after something so overwhelming?

Dr. Stein:

That sense of fragility is very real.

A relapse can affect both partners, not only the person experiencing symptoms, but also the one who lived through the uncertainty, the fear, and sometimes the feeling of losing connection.

Elena:

In a sense, **both partners are recovering.**

Dr. Stein:

They are, although their experiences of recovery may be different. And what many couples discover is that closeness does return, but rarely all at once.

It tends to come back quietly, through small, steady moments rather than a single turning point. And in the beginning, that can feel uncertain.

Many people wonder,
“Is this real? Are we actually getting closer again?”

Elena:

'It sounds more like a gradual rediscovery than a clear step forward.'

Dr. Stein:

Closeness often returns through that kind of gradual process.

At first, what matters most is a sense of safety. When symptoms are still settling, emotional closeness is not the immediate priority. What helps most is calm presence, gentle communication, and the absence of pressure.

Elena:

Almost creating a space where closeness can return on its own.

Dr. Stein:

Exactly.

As things begin to stabilize, something slowly shifts. Couples often start to make sense of what happened, sometimes through small conversations, sometimes through a shared, unspoken understanding.

Naming fears, recognizing what belonged to the illness, and acknowledging each other's experience can gradually rebuild a sense of connection.

Elena:

Almost like finding a shared language again.

Dr. Stein:

Yes, and once that begins, small moments of connection often start to reappear.

Sitting together with a cup of coffee, going for a short walk, or sharing a quiet activity. These moments may seem simple, but they are often where closeness begins to grow again.

Elena:

Everyday moments may therefore matter more than one big conversation.

Dr. Stein:

They often do. Repeated with care, these ordinary moments can help partners feel like "us" again.

At the same time, **it's important not to rush**. Many couples feel internal pressure to return to how things were.

"We should be back to normal by now."

But **relationships, like people, need time to recover**. There may be warmer days and quieter ones, and both are part of the process.

Elena:

So the goal is not to go back immediately, but to move gently forward.

Dr. Stein:

Yes. **Movement matters** more than speed.

And as closeness slowly returns, reassurance becomes very powerful. Simple words like "I'm here," or "We'll find our way through this," can help soften the sense of distance or self-doubt that often follows a relapse.

Elena:

So part of rebuilding intimacy is helping the person feel close and worthy of closeness again.

Dr. Stein:

Exactly.

When that sense of worth begins to return, connection becomes easier. And over time, many couples find that their relationship is not only restored, but sometimes even more understanding and resilient than before.

Intimacy after a relapse rarely returns all at once. It grows again through safety, shared understanding, small everyday moments, patience, and gentle reassurance.

Small rituals that help closeness return

After difficult periods, intimacy often comes back through small, predictable moments—not through big gestures or intense conversations.

Moments that help couples reconnect

- *A quiet check-in at the beginning or end of the day*
- *A short walk side by side, without pressure to talk*
- *Sharing a simple meal or routine*
- *Sitting together in silence, watching or listening to something familiar*
- *Gentle questions like, “How was your day?” or “Is there anything you need tonight?”*

Why these moments matter

They help restore emotional safety, reduce pressure, and create a sense of rhythm in the relationship. Over time, they rebuild the feeling of “we.”

Intimacy often grows from ordinary moments repeated with care. Consistency matters more than intensity.

2.4

How can partners balance support, boundaries, and emotional care?



*“Healthy boundaries do not reduce care.
They protect the relationship.”*

Elena:

In many relationships, especially during difficult periods, partners gradually take on a caregiving role. They help with appointments, medication, and daily organization.

But over time, some partners describe a subtle change. They say,
“I still love them... but I don’t recognize our relationship anymore.”

How does that shift affect intimacy?

Dr. Stein:

That’s a very important and delicate question.

When someone lives with a chronic condition like schizophrenia, it is natural for a partner to become more involved. **Supporting practical needs, offering reassurance, and paying closer attention to well-being are all expressions of care.**

But when the relationship begins to revolve mainly around managing the illness, something can slowly shift.

Elena:

What kind of shift do you mean?

Dr. Stein:

Time together may become less about sharing life and more about maintaining stability. Conversations may focus on symptoms, appointments, or routines, while moments of simple companionship become less frequent.

At the same time, the supporting partner may begin to carry more and more responsibility, not only for practical matters, but for the emotional balance of the relationship. **Over time, affection may become overshadowed by a growing sense of duty.**

And this change often happens quietly.

Elena:

The relationship is still there, but its tone changes.

Dr. Stein:

The bond remains, but the sense of being partners can fade into the background.

Partners in these situations often carry a significant emotional load, especially when they feel they are the main source of stability. Over time, this can lead to fatigue, even in relationships built on strong commitment.

Elena:

The challenge, then, is not caregiving itself, but maintaining balance.

Dr. Stein:

Precisely. **Caregiving is an expression of love and commitment.**
What matters is balance.

When support and partnership can exist side by side, the relationship remains not only stable but also emotionally alive.

Elena:

And where do boundaries come into this?

Dr. Stein:

Boundaries are essential, and often misunderstood.

Many caregivers worry that setting limits means stepping back or being less supportive. They may think, “If I take space, am I abandoning them?”

But **healthy boundaries don’t reduce care.** They protect the relationship. They allow partners to remain partners, not only caregivers.

Elena:

Boundaries are therefore not about distance, but about balance.

Dr. Stein:

They create space for both people to maintain a sense of identity. **There is still support, but also room for rest, personal needs, and moments that are not defined by the illness.**

Over time, this makes a real difference. It allows responsibility to be shared more realistically, and it helps bring ordinary life back into the relationship.

Elena:

That sounds like something that helps both partners breathe a little more.

Dr. Stein:

Yes, and that’s a very good way to describe it.

When partners can step back at times without guilt, they are less likely to become emotionally exhausted. And when that exhaustion is reduced, connection and affection have more space to remain present.

Elena:

Many partners also say they feel they always have to be the strong one.

Dr. Stein:

That’s a very common experience.

Partners often carry what we call an “invisible emotional load.” It may include ongoing worry about relapse, uncertainty about the future, and the feeling of needing to stay alert to changes in the other person’s well-being.

Elena:

Stability on the surface does not necessarily remove the partner’s ongoing worry.

Dr. Stein:

Over time, that constant sense of responsibility can become emotionally demanding. Partners may feel fatigue, anxiety, or even isolation, especially if they feel they must manage everything alone.

But this doesn’t mean the relationship is failing. More often, it means that the balance of emotional care has shifted too much in one direction.

Elena:

A caregiver may therefore become depleted gradually, without immediately recognising it.

Dr. Stein:

Yes. And when that happens, their own needs may gradually fade into the background. Over time, this can lead to exhaustion, or sometimes a quiet sense of resentment, even in a loving relationship.

Elena:

What can help restore that balance?

Dr. Stein:

What we often see in more resilient relationships is that **emotional care flows in both directions.**

It doesn’t have to be equal in a strict sense. But even during difficult periods, small moments of reciprocity matter: a word of appreciation, a shared moment of humor, or simply recognizing each other’s effort.

Elena:

Even small gestures can keep the relationship mutual.

Dr. Stein:

These moments remind both partners that the relationship is still alive, still shared.

Elena:

Many partners also struggle with how to encourage emotional openness without pushing too hard.

Dr. Stein:

That’s an important point.

When someone feels overwhelmed, direct pressure can make communication harder. What helps more are gentle invitations.

Instead of asking for immediate explanations, it can be enough to say, “I’m here when you feel ready,” or “Take your time.”

Elena:

Presence may be more helpful than pressing for immediate answers.

Dr. Stein:

People may still feel emotions deeply, but find it difficult to put them into words. When conversations are calm and low in pressure, it becomes easier for those emotions to emerge naturally.

Sometimes the most supportive message is also the simplest: **“You don’t have to talk right now, but you’re not alone.”**

Elena:

Many caregivers also mention that their partner becomes more protective of personal space.

Dr. Stein:

Yes, and that can be confusing.

A need for personal space can serve an important function.

Elena:

Respecting temporary distance may therefore make later connection easier.

Dr. Stein:

Giving someone space without withdrawing support can help closeness return.

Elena:

Is it normal for intimacy to change over time in these relationships?

Dr. Stein:

Very much so.

In all long-term relationships, closeness tends to move in waves. There are periods of connection, moments of distance, and then times of finding each other again.

Elena:

Some fluctuation in closeness is therefore normal.

Dr. Stein:

It is. When schizophrenia is part of the relationship, these shifts may feel more noticeable.

But they don't mean the relationship is failing. More often, they reflect how both partners are adapting to a more complex situation.

Elena:

A period of distance does not necessarily mean that affection has disappeared.

Dr. Stein:

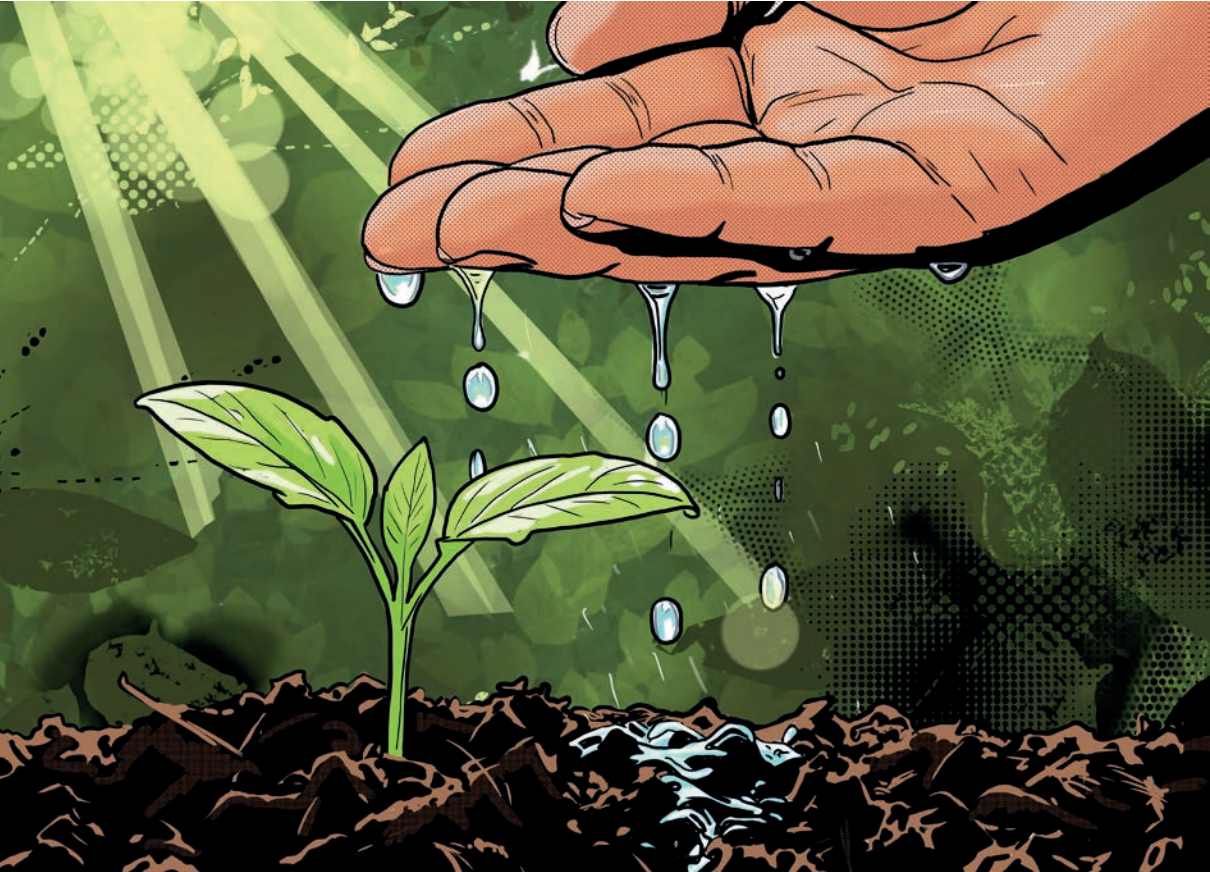
Many couples remain deeply connected, even when communication or intimacy is temporarily affected. What matters most is how those moments are understood.

When partners respond with patience rather than fear, they are more likely to reconnect.

Understanding that closeness can expand and contract over time helps couples stay grounded and find their way back to each other.

2.5

Does intimacy contribute to recovery?



“Recovery is not only about reducing symptoms. It’s also about rebuilding a life that feels meaningful.”

Elena:

Does intimacy contribute to recovery?

Dr. Stein:

Yes, it can, and often in ways we don’t immediately recognize.

Recovery is not only about reducing symptoms. It’s also about rebuilding a life that feels meaningful. That includes relationships, personal goals, and a sense of belonging. Emotional closeness can be an important part of recovery.

Some patients describe it very simply:

“When I feel connected, everything else feels a little more manageable.”

Elena:

In other words, closeness can be part of recovery rather than something secondary to it.

Dr. Stein:

When people feel understood and supported, they tend to cope better with stress.

Difficult moments, changes in symptoms, social challenges, or adjustments in treatment can feel less overwhelming when there is someone who listens and offers reassurance.

Elena:

So support changes how those experiences are lived.

Dr. Stein:

Yes, it softens them.

We also see that relationships influence how people stay engaged with care. When someone feels supported by a partner or family member, they are often more likely to attend appointments, follow treatment plans, and communicate openly with clinicians.

It’s not about pressure; it’s about feeling that what they are doing matters to someone.

Elena:

And beyond that?

Dr. Stein:

There is something even deeper.

Living with a serious illness can sometimes narrow a person's sense of identity. Over time, they may begin to feel defined by their diagnosis, and that can be a quiet but painful shift.

Close relationships help reopen that sense of self.

Through shared moments, affection, and everyday connection, a person is reminded that they are more than their symptoms. They are a partner, a friend, a parent, or simply someone who matters.

Elena:

Intimacy can therefore help restore not only connection, but also the sense of identity.

Dr. Stein:

Exactly.

It supports resilience, strengthens engagement, and helps people reconnect with who they are beyond the illness.

Elena:

So intimacy is not simply a comforting addition; it actively supports recovery.

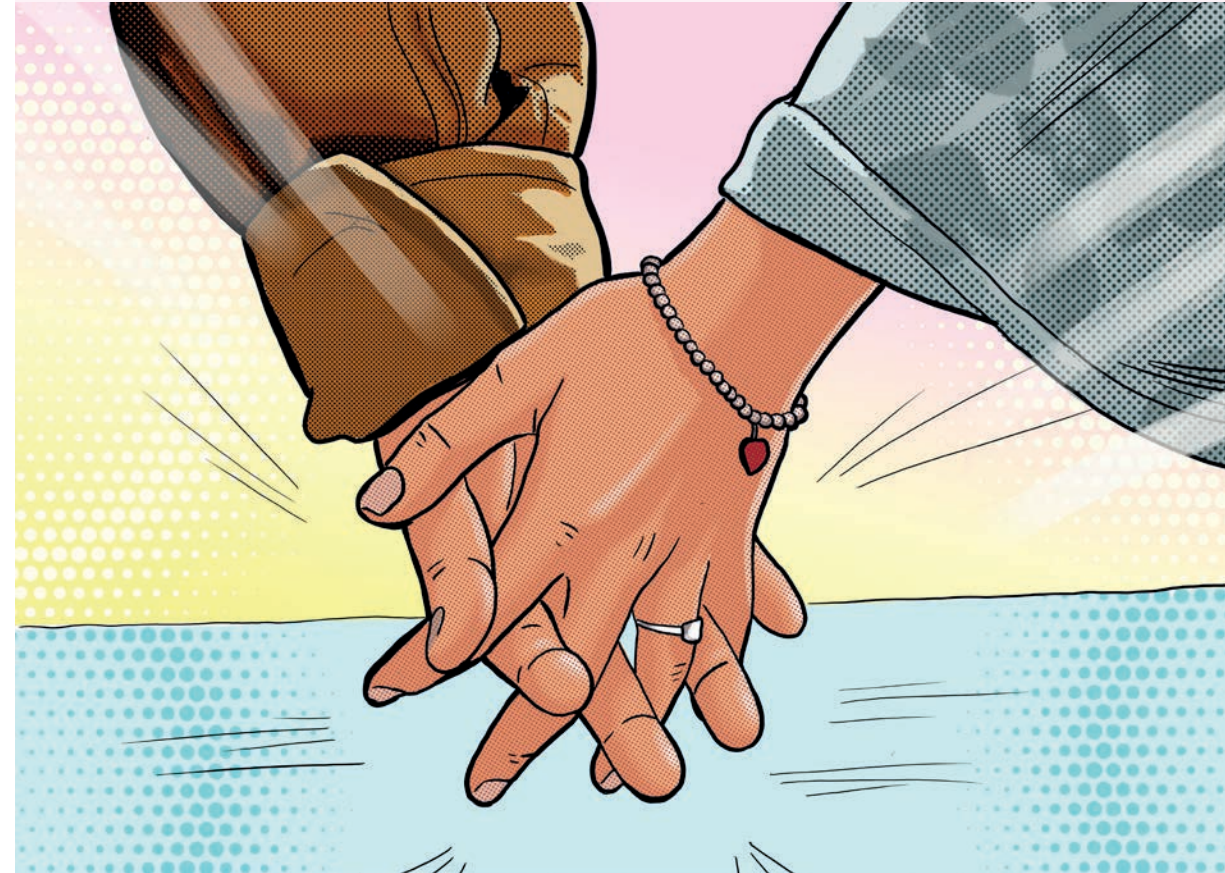
Dr. Stein:

Yes. It is part of what helps people move forward.

When people feel emotionally connected, they are often better able to face challenges, rebuild confidence, and sustain recovery over time.

Clinical Story

***“I’m here with you, even when things feel unclear.”
(The story of Mila and Jonas)***



Note: The clinical story in this chapter is created for educational purposes. Names and identifying details do not represent specific individuals.

Elena:

Before we close this chapter, Dr. Stein, could you mention a moment from clinical practice, something that reflects this kind of closeness?

Dr. Stein:

Yes. Let me tell you about Mila and Jonas.

Mila had been living with schizophrenia for nearly a decade. She was thoughtful and perceptive, but after episodes, she often felt a quiet sense of shame, as if parts of her had become difficult to reach again.

Jonas, her partner, was patient. But at times, he worried that he was losing her behind something he couldn't fully understand.

One winter evening, after a difficult week, Jonas came home and found the apartment dimly lit, with a single lantern glowing by the window. Mila was sitting on the floor, wrapped in a blanket.

"I didn't know if I could talk tonight," she said softly.

"But I wanted you to know I'm here."

She later shared that she had been thinking about it for hours, unsure whether she had the energy to speak at all.

Jonas didn't move closer right away.

He sat down a short distance from her, on the opposite wall, giving her space while still sharing the room.

For a few moments, they remained in silence, not an uncomfortable silence, but one that gently held them both.

Mila leaned her head slightly in his direction.

She didn't speak.

She didn't move closer.

But the gesture said enough:

"Thank you for not leaving me alone in the dark."

Jonas reached out and placed the lantern between them, letting its soft light fill the space.

Closeness didn't return through explanations or big conversations.

It returned through presence.

Through small, steady acts that said:

Elena:

This story reminds us that intimacy does not require perfection; it requires presence.

Dr. Stein:

People living with schizophrenia often move through experiences we cannot fully see from the outside. But the need for closeness, warmth, and connection remains central.

Sometimes it is expressed more slowly.

More gently.

Sometimes through gestures rather than words, or through silence instead of explanation.

But it is still closeness.

Still connected.

Still part of healing.

And when partners understand how the illness shapes emotional expression, misunderstandings soften, and intimacy has space to grow again.

Final reflection

Elena:

Today's conversation reminds us that **intimacy is not something that disappears with illness**. It may change, become quieter, or require more patience, but it **remains an essential part of human connection**.

Dr. Stein:

Even in the presence of symptoms, the need for closeness, understanding, and emotional connection remains strong. What often changes is not the desire for intimacy, but the way it is expressed and experienced.

Elena:

Intimacy doesn't have to be perfect to be real.

Dr. Stein:

Not at all.

It grows in small moments, in presence, in understanding, and in the willingness to stay connected, even when things feel uncertain. Not perfectly, and not always in a straight line.

Elena:

Thank you, Dr. Stein.

In the next chapter, we will explore how physical health and body-related changes can influence emotional life and relationships, and how understanding these aspects can support both confidence and connection.

References

- Budziszewska MD, Babiuch-Hall M, Wielebska K. Love and Romantic Relationships in the Voices of Patients Who Experience Psychosis: An Interpretive Phenomenological Analysis. *Frontiers in Psychology*. 2020;11:570928
- Belluzzo M, Esposito C, De Alfieri E, Giaquinto V, Volpe D, Amodeo AL. Romantic relations, sexuality and intimacy among young adults and adolescents with severe mental illness: a review of the literature. *BMC Psychiatry*. 2025;25(1).
- Cloutier B, Francoeur A, Samson C, Ghostine A, Lecomte T. Romantic relationships, sexuality, and psychotic disorders: A systematic review of recent findings. *Psychiatric Rehabilitation Journal*. 2021;44(1):22-42
- Lysaker PH, Gumley A, Luedtke B, et al. Social cognition and metacognition in schizophrenia: evidence of their independence and linkage with outcomes. *Acta Psychiatrica Scandinavica*. 2012;127(3):239-247.
- Lee CY, Ahmed N, Ikhtabi S, et al. The experience of loneliness among people with psychosis: Qualitative meta-synthesis. V. *Plos One*. 2024;19(12):e0315763.
- White R, Haddock G, Campodonico C, Haarmans M, Varese F. The influence of romantic relationships on mental wellbeing for people who experience psychosis: A systematic review. *Clinical Psychology Review*. 2021;86:102022.
- Özden SE, Tekindal M, Tekindal MA. Quality of Life of people with Schizophrenia: A meta-analysis. *International Journal of Social Psychiatry*. 2023;69(6):1444-1452
- Rodolico A, Bighelli I, Avanzato C, et al. Family interventions for relapse prevention in schizophrenia: a systematic review and network meta-analysis. *The Lancet Psychiatry*. 2022;9(3):211-221.
- Montejo AL, Montejo L, Baldwin DS. The impact of severe mental disorders and psychotropic medications on sexual health and its implications for clinical management. *World Psychiatry*. 2018;17(1):3-11.

Chapter 3

The role of body image and physical well-being in intimacy and relationships

Explore Chapter 3

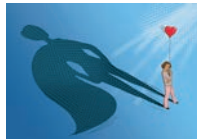
This chapter explores how body image and physical well-being can shape confidence, self-perception, intimacy, and social connection in people living with schizophrenia. It also considers how physical health and personal priorities can support a stronger sense of self and fuller participation in everyday life.



3.1
Why does body image influence intimacy?



3.2
Why do metabolic health and weight changes matter for intimacy?



3.3
Why should physical health be part of personal and relationship decisions?



3.4
Why is recognizing individual life priorities so important?



3.5
Why do people with schizophrenia often feel lonely despite wanting connection?



Clinical Stories





Mini-Glossary

Body image

The way a person perceives, thinks about, and emotionally experiences their own physical appearance.

Metabolic health

A broad description of factors such as blood glucose, blood lipids, blood pressure, body weight, and energy regulation that influence physical health.

Metabolic syndrome

A group of medical conditions, including increased waist circumference, elevated blood pressure, abnormal cholesterol levels, and impaired glucose regulation, that together increase the risk of cardiovascular disease.

Cardiometabolic risk

The combined risk of heart and metabolic conditions is influenced by factors such as weight, blood sugar, cholesterol, and blood pressure.

Insulin resistance

A condition in which the body's cells respond less effectively to insulin, which can contribute to higher blood glucose levels.

Comorbidity

The presence of one or more physical health conditions occurring alongside schizophrenia, such as diabetes, hypertension, or cardiovascular disease.

Social cognition

The ability to understand and interpret other people's emotions, intentions, and social cues during interactions.

Emotional reciprocity

The natural exchange of emotional signals between people supporting mutual understanding and connection in relationships.

Social anhedonia

A reduced capacity to experience pleasure from social interaction, which may affect motivation to engage in relationships.

Welcome to podcast #3

The role of body image and physical well-being in intimacy and relationships

with **Elena Maurer**, Health Journalist, and
Dr. Lukas Stein, Psychiatrist and Researcher

Elena:

In the previous chapters, we discussed relationships and emotional closeness. Today, we explore another dimension that can influence intimacy: how people experience their own bodies and physical well-being.

Many caregivers notice changes such as reduced confidence, withdrawal from social activities, or discomfort with appearance.

Dr. Stein, how important are these factors?

Dr. Stein:

They are very important. **Physical well-being and body image are closely connected to how people perceive themselves as partners.**

Research shows that individuals living with schizophrenia often experience metabolic health challenges and weight changes, which can influence confidence, social participation, and relationship dynamics.

Metabolic syndrome and obesity are consistently reported to be more prevalent among people with schizophrenia than in the general population.

These changes are closely connected to how individuals perceive themselves in social and romantic contexts.

3.1 Why does body image influence intimacy?



“Self-perception is dynamic, not permanent.”

Elena:

It sounds as though body image is about more than appearance.

Dr. Stein:

Yes, it is closely connected to identity and self-confidence.

Body image can influence how comfortable people feel when approaching relationships, physical closeness, or romantic situations.

When individuals feel embarrassed or ashamed about their physical appearance, they may withdraw socially, even if they still desire connection. And this can be confusing for others. A partner might think, “They don’t want to go out anymore,” when in reality, the desire is still there, but the confidence is not.

In clinical practice, we often hear this expressed very directly. Some people say they avoid going out, not because they don’t want to, but because they don’t feel comfortable in their own body. Many describe a kind of internal hesitation:

“I want to go... but I don’t feel like I can show myself like this.” Others describe wanting closeness, but not feeling confident enough to allow someone to come near.

Dissatisfaction with physical health and body image is strongly associated with reduced social participation and lower life satisfaction.

For caregivers, **this means that social withdrawal is sometimes linked to self-perception, not to a lack of interest in relationships.**

Elena:

Dr. Stein, caregivers sometimes say:

“He used to feel comfortable with himself... now something has changed.”

Why does this happen?

Dr. Stein:

That is a very important observation.

Changes in how a person perceives their body or physical self usually do not happen suddenly. They tend to develop gradually, often influenced by several factors acting together over time.

Sometimes people describe this as feeling “different in their own skin,” even when others may not notice any visible change. And often they can’t fully explain what has changed. They just know something feels off.

These changes may often develop through shifts in physical health or weight, lower energy, changes in daily routines, or social experiences where a person may feel judged or misunderstood.

Elena:

The change may therefore be gradual rather than immediate.

Dr. Stein:

That gradual development can make it difficult to recognise at first. Sometimes people close to the individual notice a change before the person is able to identify or describe it.

Over time, these small changes can influence how someone feels in social situations or intimate contexts.

Elena:

That sounds like something that could be difficult to reverse.

Dr. Stein:

It can be challenging, but it is not fixed.

What is important to understand is that **self-perception is dynamic, not permanent.**

Supportive environments, attention to physical well-being, and positive relational experiences may help people rebuild confidence and develop a more comfortable sense of self.

In clinical practice, we often hear this expressed very directly.

Some patients tell me they feel exposed or judged in ways that are hard to explain, even when others don’t notice anything different.

Others say they still want closeness, but don’t feel confident enough in their own body to get close to someone.

These are not abstract concerns, they are lived experiences that shape how people move through relationships.

3.2

Why do metabolic health and weight changes matter for intimacy?



“Supporting physical well-being often restores energy, confidence, and the sense that one can fully participate in life.”

Elena:

Dr. Stein, earlier, we talked about body image and physical well-being. Many families also hear doctors mention *metabolic health*. What does that actually mean?

Dr. Stein:

Metabolic health refers to how the body manages energy, weight, blood sugar, cholesterol, and blood pressure. These systems influence not only long-term physical health but also everyday well-being, energy levels, sleep quality, and overall vitality.

Research shows that people living with schizophrenia have a higher risk of metabolic changes compared with the general population. These may include increased body weight, changes in cholesterol levels, or difficulties with blood sugar regulation.

Elena:

Why do these changes occur more often in this illness?

Dr. Stein:

Several factors can contribute. The illness itself can influence metabolism and lifestyle patterns. Periods of stress, reduced physical activity, sleep disruption, or social isolation may affect eating habits and energy balance. In addition, some treatments may also influence weight or metabolic processes.

It is important to remember that these factors interact. Metabolic health is rarely determined by one single cause.

Elena:

And how does this connect to intimacy and relationships?

Dr. Stein:

Many people describe this in simple terms. They may say they feel less confident going out or more hesitant in social or romantic situations, even when the desire to connect remains. When someone experiences significant weight changes or reduced physical energy, they may feel less confident socially or romantically.

Someone might stop accepting invitations, not because they don't want to go, but because they don't feel comfortable being seen. And they may not say why.

From the outside, it can look like disinterest, but inside, it often feels like discomfort.

Others describe pulling back from physical closeness, even in stable relationships, simply because they don't feel at ease in their own body.

And sometimes it shows up as hesitation, wanting to connect, but holding back, wondering how they are being perceived.

Elena:

What practical steps can families take to support metabolic health?

Dr. Stein:

Small, sustainable routines are often the most effective. What tends to help is not a perfect plan, but small, shared routines.

A short walk together in the afternoon.

Eating at roughly the same time each day.

Keeping evenings a bit more predictable.

And from time to time, checking in on physical health with a doctor, not as something alarming, but simply as part of taking care of everyday life.

These small things don't just support the body; they often bring back a sense of rhythm and confidence. And importantly, they don't feel like "treatment."

They feel like normal life slowly coming back.

These habits support both **physical well-being and emotional confidence**, which ultimately helps individuals feel more comfortable participating in relationships.

What should be monitored for physical well-being?

Physical health can be supported through simple, regular checks.

Key areas to monitor

- Body weight and waist circumference
- Blood pressure
- Blood glucose levels
- Cholesterol and lipid profile
- Energy levels and sleep quality

Why it matters

Regular monitoring helps:

- detect changes early
- prevent long-term complications
- support energy and daily functioning
- maintain confidence and participation in life

Monitoring is not about worry.

*It is about **prevention, awareness, and informed actions**. Still, for some families, it can feel like one more thing to manage. That's why keeping it simple and routine is so important.*

Elena:

Supporting metabolic health may therefore also support participation in social life.

Dr. Stein:

Supporting physical well-being often restores energy, confidence, and the sense that one can fully participate in life, including intimacy and meaningful relationships.

When the body is under tension through fatigue, metabolic imbalance, or reduced physical activity, emotional resilience may also decrease. People may feel more vulnerable, less motivated, or less confident in social situations.

On the other hand, improvements in physical well-being are often accompanied by better mood, increased engagement in daily activities, and greater openness to social and relational experiences.

This is why doctors view physical and emotional health not as separate domains, but as part of the same process of recovery, one that supports both personal well-being and the capacity for meaningful relationships.

Elena:

Dr. Stein, when families hear about physical health risks, they may feel overwhelmed.

Is this something that can actually be influenced early, or does it develop inevitably over time?

Dr. Stein:

That's an important question.

Addressing physical health early can prevent many long-term complications.

Even small changes in daily habits can have a meaningful impact over time.

Early awareness allows people to maintain both health and confidence in their social and personal lives.

Elena:

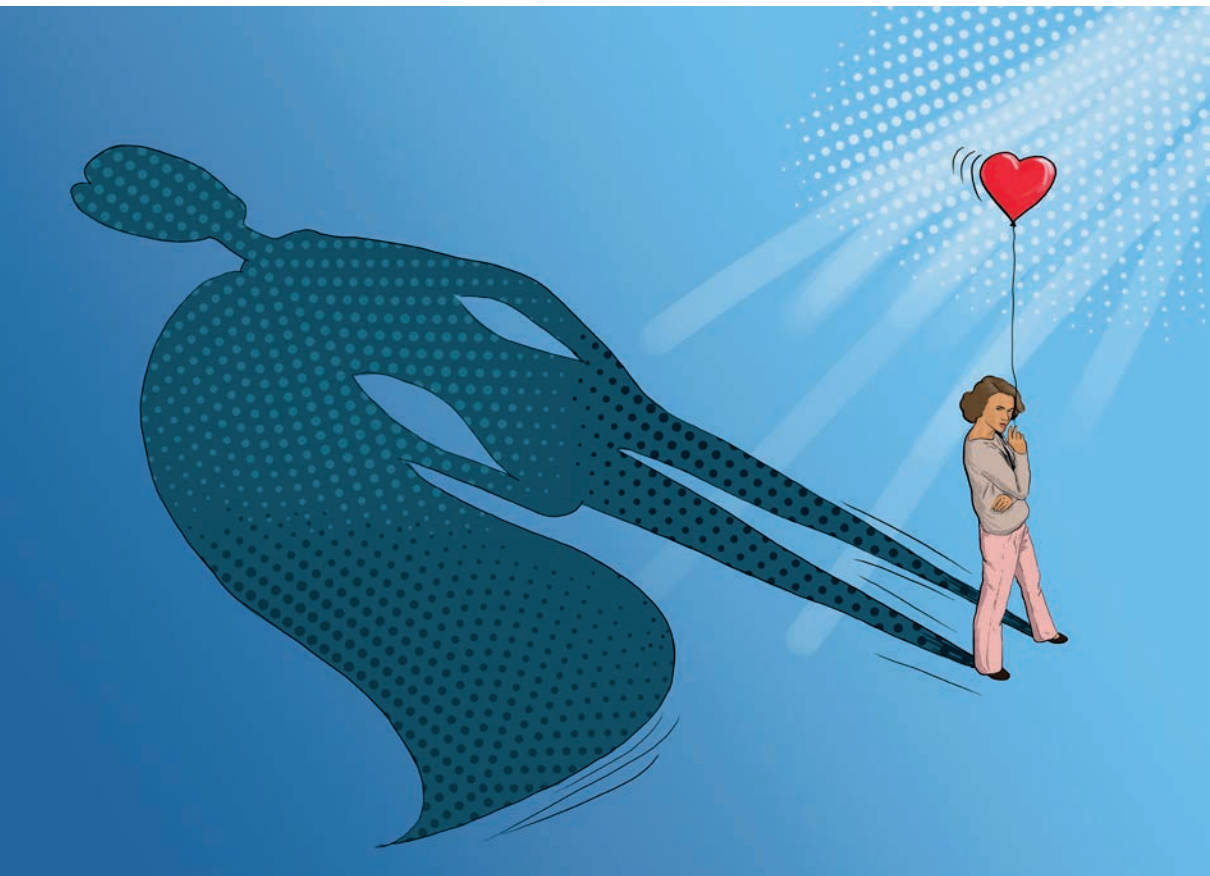
So it's not about making major changes all at once, but about paying attention early and taking small, consistent steps.

That sounds reassuring, because it means that even simple daily actions can support both well-being and relationships over time.

In many ways, these physical changes are not separate from relationships; they are part of how people experience themselves within them.

3.3

Why should physical health be part of personal and relationship decisions?



“These conditions are not inevitable, and they can be managed.”

Elena:

Dr. Stein, we’ve talked about body image and metabolic health. Families also hear about physical health problems occurring alongside schizophrenia. What should they understand?

Dr. Stein:

It’s an important topic, and it helps to look at it calmly and clearly.

People living with schizophrenia may sometimes experience changes in their physical health, things like weight fluctuations, blood sugar or cholesterol changes, or changes in blood pressure. These may sound like medical terms, but for the person experiencing them, they are very personal. And for many people, they do feel distant at first, until they begin to affect everyday life. They affect energy, confidence, and how someone feels in their own body, and sometimes even how they experience closeness or think about relationships and family life.

These conditions are important not only from a medical perspective but also because they can influence **energy, confidence, comfort in one’s body, and participation in relationships.**

Some patients describe this quite simply:

“I don’t feel like I have the same energy for life or relationships as before.”

Others say they worry about how these changes affect their future, including relationships or having children.

Why do these conditions appear?

Elena:

Are these problems caused by the illness itself?

Dr. Stein:

They usually arise from **several interacting factors**.

Some are related to the illness itself, including biological vulnerability and changes in stress regulation.

Others are part of everyday life, like moving less, sleeping differently, or eating at irregular times.

These may seem like small changes, but over time, they can influence physical health in meaningful ways.

And some may be influenced by treatment.

But the key message is this:

These conditions are not inevitable, and they can be managed. Even so, it's common for people to worry at first: "Is this something that will just keep getting worse?"

Why do they matter for intimacy and life planning?

Elena:

How do these physical aspects connect to relationships?

Dr. Stein:

They influence several areas that are central to personal life:

- body image and self-confidence
- sexual well-being and comfort with closeness
- energy and participation in relationships
- reproductive health and future planning

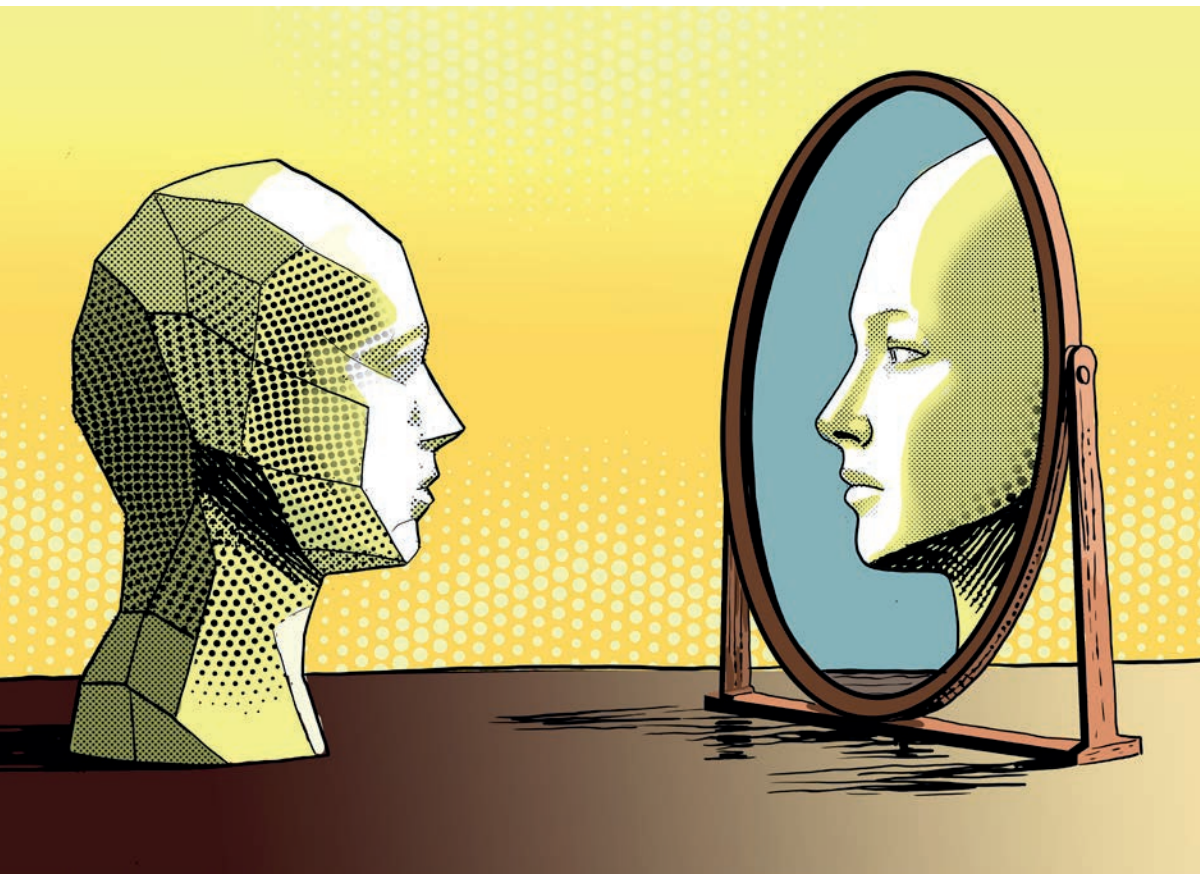
For example, when someone experiences significant weight changes or reduced physical energy, they may feel less confident in social or romantic situations.

Hormonal changes can sometimes influence sexual desire or reproductive health. And chronic physical conditions, such as diabetes or cardiovascular problems, may affect overall vitality and long-term life planning.

These are not only medical issues; they can also affect relationships and personal life decisions. And sometimes, they are not talked about openly, even between partners, which can make them feel heavier than they need to be.

3.4

Why is recognizing individual life priorities so important?



*“There is no single ‘right’ priority.
The goal is finding a balance that feels
meaningful and sustainable.”*

Elena:

This sounds like a lot to take in. How can patients and families make sense of all these aspects?

Dr. Stein:

It can feel complex at first, but it becomes much clearer when we remember something simple: people don’t all want the same things at the same time. And sometimes partners don’t want the same things at the same time, which can be difficult to understand.

What matters to someone often depends on where they are in life.

Elena:

Priorities may therefore change over time.

Dr. Stein:

They often reflect a person’s stage of life, current health, relationships, and future plans.

For some people, especially earlier in life, feeling confident about appearance or being comfortable in social situations may be very important.

For others, what matters more is emotional closeness, stability in a relationship, or feeling secure day to day.

And at certain moments, people may begin to think more about the future, about having children, staying physically well, or maintaining independence.

Elena:

There is no single priority that is “right” for everyone.

Dr. Stein:

Not at all.

What feels essential for one person may be less important for another, and that's completely normal.

In conversations, you can often hear this very clearly. One person may talk about confidence and connection, while another is more focused on health, stability, or plans.

When physical health meets personal priorities

People value different things at different stages of life.

For some, it may be confidence and body image.

For others, intimacy, future plans, or maintaining independence.

What this means in practice:

- *care should reflect what matters most to the individual*
- *priorities may change over time*
- *decisions should fit both life situation and personal values*

There is no single “right” priority.

The goal is finding a balance that feels meaningful and sustainable.

What matters is being able to talk about it, even when it's not easy.

Elena:

These priorities should be part of conversations with clinicians.

Dr. Stein:

Very much so.

When these topics are included naturally in discussions, physical health, emotional well-being, relationships, and plans, decisions become more personal and more realistic.

It's no longer just about treating symptoms, but about supporting a life that feels right for the person.

Elena:

Some families may feel concerned hearing about risks. Is there also a more reassuring perspective?

Dr. Stein:

Yes, definitely.

Today, there are many more ways to understand and manage physical health early on. Often, it's not about making big changes, but about small, consistent steps, paying attention, checking in, and adjusting when needed.

Care is also evolving. We now think much more in terms of the whole person, not just the illness.

Elena:

Better understanding can therefore help people feel more involved in their decisions.

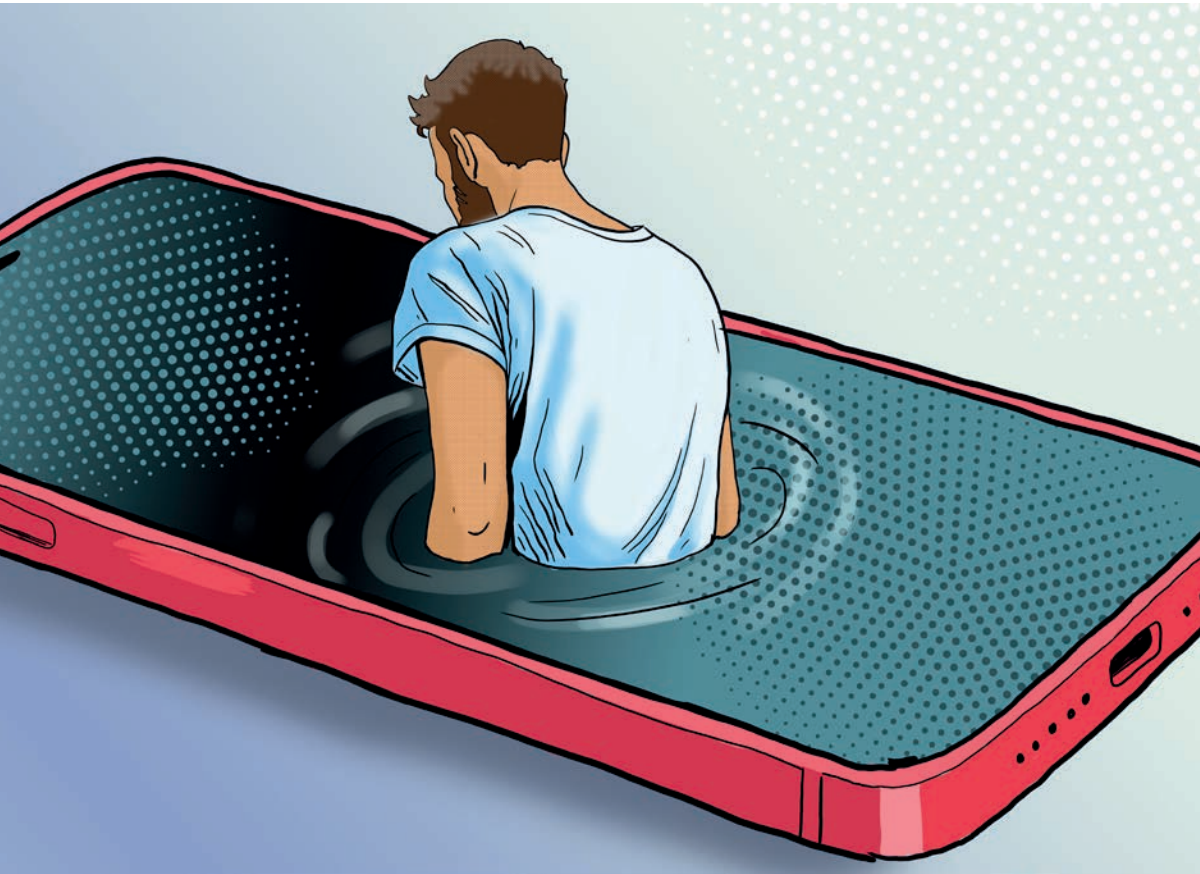
Dr. Stein:

When people understand what is happening and what matters to them, they can make choices that support both their health and their personal life.

And that's **really the goal: not only stability, but a life that feels meaningful, connected, and fully lived.**

3.5

Why do people with schizophrenia often feel lonely despite wanting connection?



“Loneliness in schizophrenia does not mean a lack of desire for connection.

More often, it reflects how difficult it can feel to experience connection in a way that feels safe and natural.”

Elena:

Something that has surprised many researchers is how frequently loneliness appears in studies of schizophrenia.

Dr. Stein:

Yes. Loneliness is frequently reported in research involving people living with schizophrenia. Studies show that a large proportion of people living with schizophrenia report significant loneliness.

Importantly, loneliness is not simply the absence of social contact. A person may be surrounded by others and still feel emotionally disconnected.

Elena:

Loneliness is more about how connection is experienced, not just whether it exists.

Dr. Stein:

Loneliness often grows in subtle ways. And often, people don’t speak about it directly.

They may simply withdraw a little more each time.

Sometimes it’s a fear of being misunderstood or rejected.

Sometimes it’s a loss of confidence in social situations.

And sometimes it’s simply that interactions feel harder to read or respond to, which can make connections feel uncertain or fragile.

Over time, this can lead to a sense of distance, even when people are physically present.

Loneliness is closely linked to both symptom severity and social functioning difficulties.

Elena:

Even when relationships are present, the feeling of connection may still be fragile. Is that right?

Dr. Stein:

Indeed. That is why emotional understanding and patience are so important.

The goal is not to force social interaction, but to create **safe, predictable, and supportive experiences of connection**. Because when connection feels forced, it can increase distance instead of reducing it.

Elena:

What can families and partners do in practical terms?

Dr. Stein:

Support does not have to be complex. Small, consistent actions can make a real difference.

For example:

- spending time together in low-pressure situations
 - sharing simple daily activities
 - maintaining regular routines
- offering calm and non-judgmental presence

These approaches help rebuild **confidence, trust, and emotional safety**.

Loneliness is not the same as being alone

Loneliness reflects *how connection is felt*, not how many people are present.

It may be influenced by:

- self-confidence
- past experiences
- social understanding
- stigma and expectations

What helps

- calm, predictable interactions
- shared everyday activities
- emotional patience
- feeling accepted without pressure

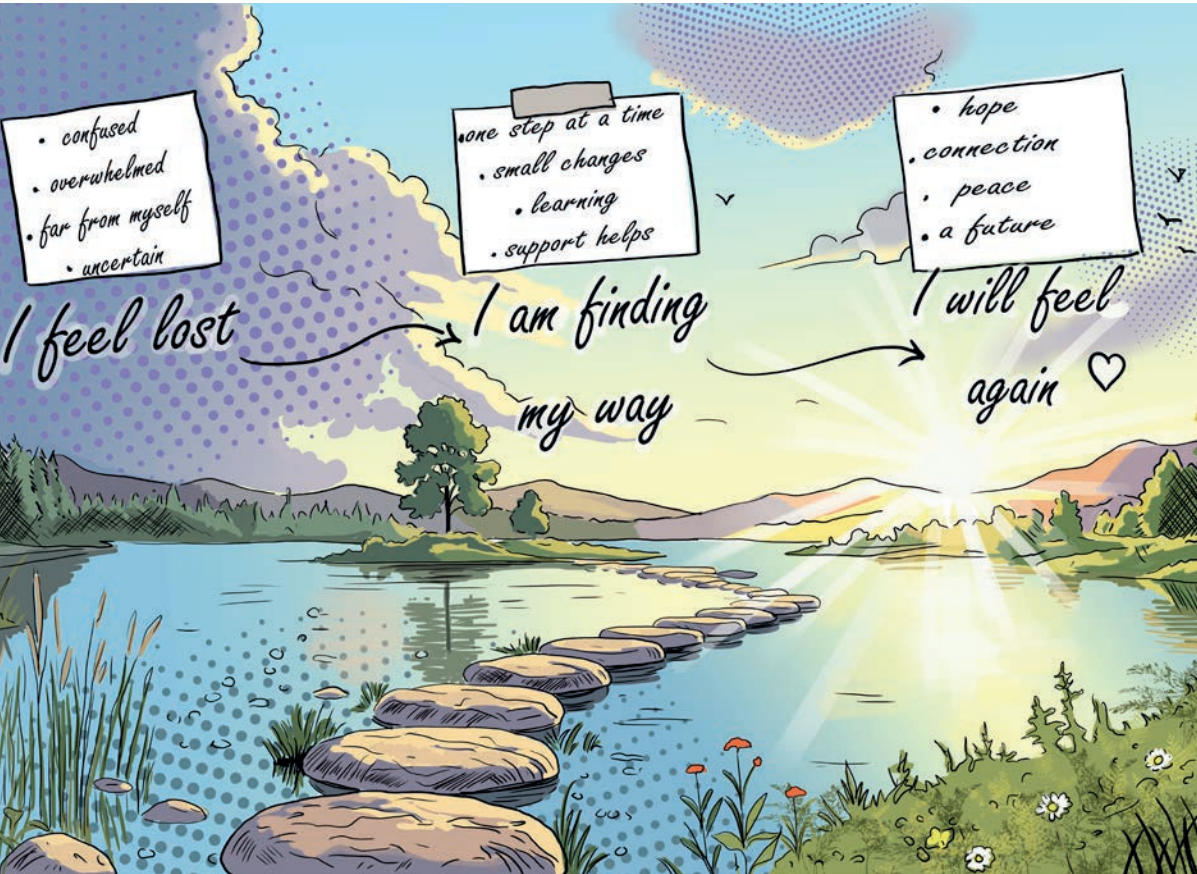
Loneliness in schizophrenia does not mean a lack of desire for connection.

More often, it reflects how difficult it can feel to experience connection in a way that feels safe and natural.

With understanding and supportive relationships, this experience can gradually change.

Clinical Story

“I miss how you looked before, but more, I miss how we used to spend time together.”
(The story of Mark)



Note: The clinical stories in this chapter are created for educational purposes. Names and identifying details do not represent specific individuals.

Elena:

Dr. Stein, before we close this chapter, could you share a story that reflects what we've discussed today?

Dr. Stein:

Of course. Let me tell you about Mark.

Mark was in his late twenties. His symptoms had stabilized, and from a clinical perspective, things were going well. But he stopped meeting friends, avoided social events, and declined invitations.

When I asked him why, he hesitated at first. Then he said:

“I don't feel like myself anymore.” He hesitated before saying it, as if unsure whether it sounded superficial or important enough to mention.

Over the past year, he had gained weight. His energy was lower. But what affected him most was how he saw himself.

“I don't think anyone would find me attractive now,” he said.

He also admitted, almost as an afterthought:

“I feel like people notice it immediately... even if they probably don't.”

His partner, however, saw things differently. She told him:

“I miss how you looked before, but more, I miss how we used to spend time together.”

That changed something.

They didn't start with big plans. Just short walks. Then shared meals. Then small routines.

Over time, Mark didn't just regain physical strength; he regained **confidence**.

Not because everything changed quickly, but because he **began to feel present again in his own life and relationship**.

Clinical Story

“Feeling Seen Again” (The story of Anna)

Elena:

And perhaps an example from a woman’s perspective?

Dr. Stein:

Yes, gladly. I remember Anna.

Anna was in her early thirties. She was thoughtful, reflective, and deeply cared about relationships. But after a period of illness and physical changes, she withdrew.

She once said:

“I feel like people only see the illness... or the changes. Not me.” She paused after saying it, as if weighing whether she was being too harsh, or simply honest.

What affected her most was not the physical change itself, but the feeling **of losing her identity as a woman, as a partner.**

With time, and with gentle support, something shifted.

Her partner began to focus less on “fixing things” and more on simply being present.

He would say:

“I like spending time with you. That hasn’t changed.”

They started doing small things together, cooking, watching films, and talking without pressure.

Gradually, Anna began to feel **seen again, not as a diagnosis, not as a body that changed, but as a person.**

And with that, her confidence slowly returned.

Final reflection

Elena:

What I take from today is that intimacy is shaped not only by emotions, but also by how someone feels in their own body.

Dr. Stein:

Exactly. When people begin to feel a bit more comfortable in themselves again, physically and emotionally, it often opens the door to reconnecting with others.

These changes don't have to be dramatic. Often, they begin with small moments: a shared routine, a sense of being understood, or simply feeling less alone. Not always consistently, and not always in a straight line.

And over time, those moments can grow into something more stable and meaningful.

Elena:

In our next chapter, we will continue this conversation by exploring how treatment can influence intimacy, and how these choices can be discussed openly and thoughtfully.

Until then, take care, and we look forward to being with you again.

References

- Correll CU, Solmi M, Croatto G, et al. Mortality in people with schizophrenia: a systematic review and meta-analysis of relative risk and aggravating or attenuating factors. *World Psychiatry*. 2022;21(2):248-271.
- Vancampfort D, Stubbs B, Mitchell AJ, et al. Risk of metabolic syndrome and its components in people with schizophrenia and related psychotic disorders, bipolar disorder and major depressive disorder: a systematic review and meta-analysis. *World Psychiatry*. 2015;14(3):339-347.
- Seda Attepe Özden, Melike Tekindal, Mustafa Ağâh Tekindal. Quality of Life of people with Schizophrenia: A meta-analysis. *International Journal of Social Psychiatry*. 2023;69(6):1444-1452.
- Lee CY, Ahmed N, Ikhtabi S, et al. The experience of loneliness among people with psychosis: Qualitative meta-synthesis.V. *Plos One*. 2024;19(12):e0315763.
- Abplanalp SJ, Green MF, Wynn JK, et al. Using machine learning to understand social isolation and loneliness in schizophrenia, bipolar disorder, and the community. *Schizophrenia*. 2024;10(1).
- Okruszek Ł, Jarkiewicz M, Piejka A, et al. Loneliness is associated with mentalizing and emotion recognition abilities in schizophrenia, but only in a cluster of patients with social cognitive deficits. *Journal of The International Neuropsychological Society*. 2024;30(1):27-34.
- Firth J, Siddiqi N, Koyanagi A, et al. The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. *The Lancet Psychiatry*. 2019;6(8):675-712.
- Firth J, Solmi M, Wootton RE, et al. A meta-review of “lifestyle psychiatry”: The role of exercise, smoking, diet and sleep in the prevention and treatment of mental disorders. *World Psychiatry*. 2020;19(3):360-380.
- Vancampfort D, Firth J, Schuch FB, et al. Sedentary Behavior and Physical Activity Levels in People with schizophrenia, Bipolar Disorder and Major Depressive disorder: a Global Systematic Review and meta-analysis. *World Psychiatry*. 2017;16(3):308-315.
- De Hert M, Correll CU, Bobes J, et al. Physical Illness in Patients with Severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*. 2011;10(1):52-77.

Chapter 4

Treatment considerations in sexually active patients living with schizophrenia

Explore Chapter 4

This chapter explores how treatment may affect sexual well-being, intimacy, and relationships. It emphasizes the importance of identifying possible side effects, discussing personal priorities openly, and making treatment decisions collaboratively so that care supports both clinical stability and quality of life.



4.1
Why is sexual well-being part of recovery?



4.2
Can treatment affect intimacy and relationships?



4.3
Why are intimacy-related side effects often not discussed?



4.4
What does shared decision-making look like in practice?



4.5
Why does treatment choice have ethical implications?



4.6
What can caregivers do to support communication and trust?



Clinical Story





Mini-Glossary

Sexual functioning

A broad concept that includes desire, arousal, satisfaction, and emotional engagement in intimate relationships.

Prolactin

A hormone involved in reproductive and sexual functioning. Elevated levels may influence libido, menstrual cycles, and overall sexual well-being.

Hyperprolactinemia

A condition in which the level of prolactin in the blood is above the expected range, potentially affecting sexual function, fertility, and hormonal balance.

Treatment adherence

The extent to which a person follows the agreed treatment plan. It is closely linked to trust, communication, and perceived tolerability of treatment.

Side effects

Unintended effects of treatment that may influence physical, emotional, or sexual well-being.

Shared decision-making

A collaborative process in which clinicians and patients make treatment decisions together, based on medical evidence and personal preferences.

Therapeutic alliance

The relationship of trust and collaboration between a patient and clinician, which supports engagement and long-term outcomes.

Autonomy

The patient's right to make informed decisions about their own care, based on understanding and personal values.

Welcome to podcast #4

Treatment considerations in sexually active patients living with schizophrenia

with **Elena Maurer**, Health Journalist, and
Dr. Lukas Stein, Psychiatrist and Researcher

Elena:

Welcome back to Living, Loving, Recovering.

In the previous chapter, we explored how body image and physical well-being shape confidence, relationships, and closeness.

Today, we take the next step, looking at something that often becomes part of that experience: treatment.

How does treatment influence intimacy, and how can these decisions be made in a way that respects both clinical needs and personal priorities?

Dr. Stein:

Thank you, Elena. These topics can be discussed openly, and in many cases concerns can be assessed and addressed.

Elena:

Many families may find it reassuring to know that these concerns can be discussed and addressed rather than simply accepted.

4.1

Why is sexual well-being part of recovery?



“When we address sexual well-being, we are not shifting attention away from symptom control. We are strengthening recovery.”

Elena:

Let me start with a very direct question. Some people might say,

“When someone has schizophrenia, shouldn’t we focus on symptom control first? Isn’t sexuality secondary?”

Dr. Stein:

Sexual functioning is not an optional add-on to recovery. It is closely connected to quality of life, identity, self-esteem, partnership stability, and long-term treatment engagement.

When we talk about recovery in schizophrenia, we no longer mean only “reducing hallucinations or delusions.” Modern psychiatric care also looks at:

- social functioning
- emotional well-being
- relational stability
 - autonomy
- life satisfaction

Sexual well-being sits at the intersection of all of these. And because of that, it’s often one of the hardest things to talk about. In practice, this is often where patients struggle quietly. Some say, *“Everything is more stable, but I don’t feel like myself in my relationship anymore.”* Others say it more hesitantly:

“I didn’t want to complain... because in many ways things are better.”

Research consistently shows that sexual difficulties are common among people living with schizophrenia. These difficulties can include reduced desire, problems with arousal, difficulties with orgasm, or emotional detachment during intimacy.

When these concerns are ignored, they can lead to frustration, lowered self-confidence, relationship strain, and sometimes silent non-adherence to medication.

From a clinical perspective, we also see very clearly how much this matters in everyday life.

When sexual well-being is affected, it often shows up in different ways, such as how satisfied someone feels overall, how stable a relationship feels, and even how motivated someone is to continue treatment.

We also know that individuals who feel their intimate life is respected and supported are more likely to remain engaged in care and communicate openly with clinicians.

So no, sexuality is not secondary. It is part of whole-person care.

When we address sexual well-being, we are not shifting attention away from symptom control. We are strengthening recovery.

Because recovery is not only about reducing symptoms, it is about restoring a meaningful life.

Sexual well-being is part of recovery

Sexual functioning is linked to:

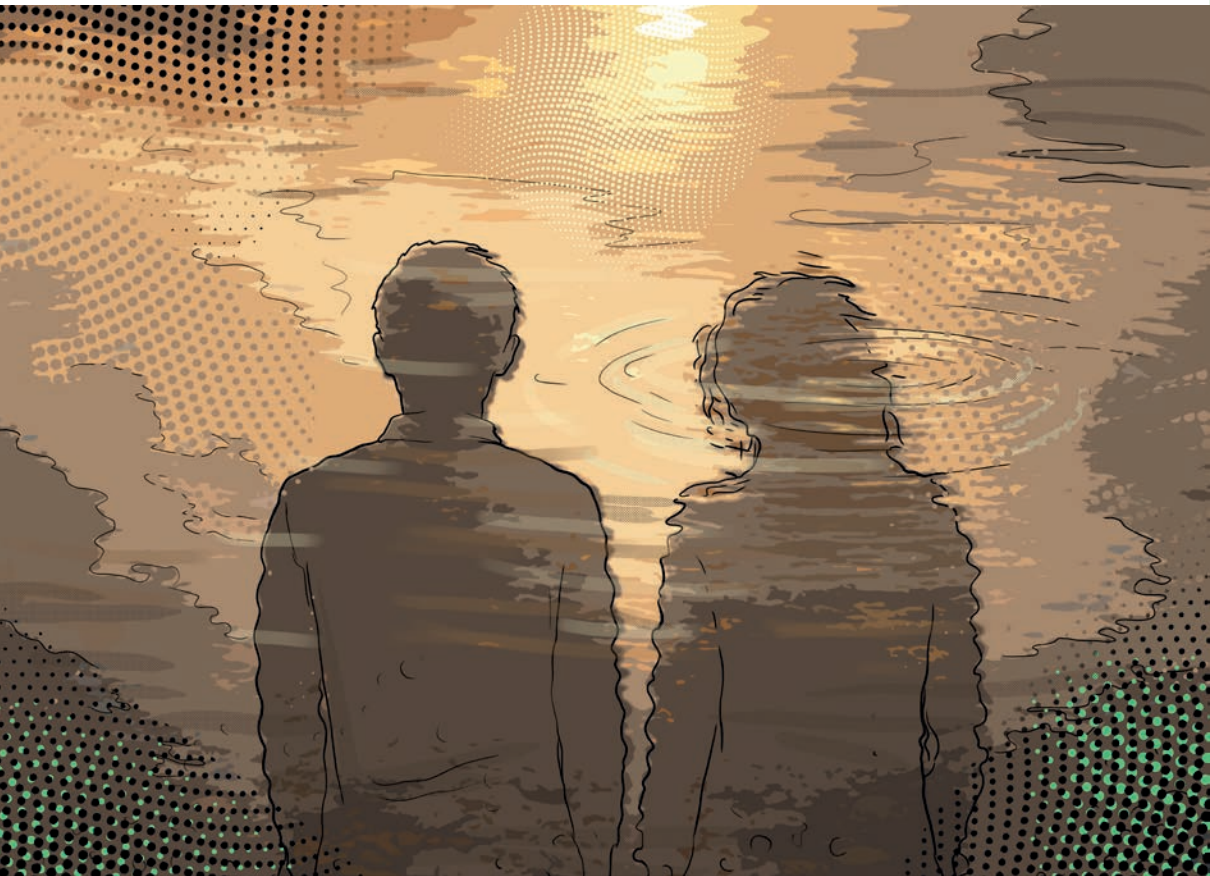
- *quality of life*
- *self-esteem*
- *emotional connection*
- *relationship stability*
- *treatment adherence*

✓ Addressing it supports recovery

✗ Ignoring it may weaken engagement in care

4.2

Can treatment affect intimacy and relationships?



“The most important point is that treatments are not identical in how they influence sexual functioning.”

Elena:

Families often ask, “*Does treatment affect sexuality?*” What should they understand?

Dr. Stein:

The most important point is that **treatments are not identical in how they influence sexual functioning.**

Some antipsychotic medications can increase prolactin, a hormone that plays a role in sexual desire, reproductive physiology, and menstrual cycles. When prolactin rises significantly, it can contribute to reduced libido, changes in sexual response, menstrual irregularities, or breast-related symptoms.

Other antipsychotic options have minimal or no impact on prolactin levels.

Large comparative analyses show that prolactin response varies considerably between treatments and even by dose. So, if a patient experiences changes in intimacy, there may be options.

Elena:

This isn’t something patients simply have to accept?

Dr. Stein:

No. **It’s something to discuss. Most treatment-related sexual changes are manageable.**

Elena:

Dr. Stein, if changes in intimacy can be related to treatment, how can families or patients recognize when something is happening?

Dr. Stein:

That's an important question, because these changes are often subtle at first.

Someone might feel less interested in closeness or notice that emotional or physical responses feel different. Many people don't connect it to treatment.

They may think, "Maybe it's just me... maybe something has changed in the relationship."

Others begin to avoid intimacy or feel less confident in their relationships without fully understanding why.

These signs are not always immediately linked to treatment. They can easily be misunderstood as emotional distance or relationship difficulties. And that uncertainty can make it harder to bring up.

Elena:

The risk may therefore be misinterpreting the situation?

Dr. Stein:

What matters is not to jump to conclusions, but to stay attentive and open.

A helpful approach is to notice patterns over time rather than focusing on a single moment.

Elena:

And how should this be discussed?

Dr. Stein:

Gently and without pressure.

Simple, open questions can be very effective, such as:

- "Have you noticed any changes in how you feel emotionally or physically?"
- "Do you feel comfortable with how things are in your relationship?"

These questions create space without creating discomfort.

Elena:

The aim is to open a conversation, not to assume that there is a problem.

Dr. Stein:

When changes in intimacy are recognized early and discussed openly:

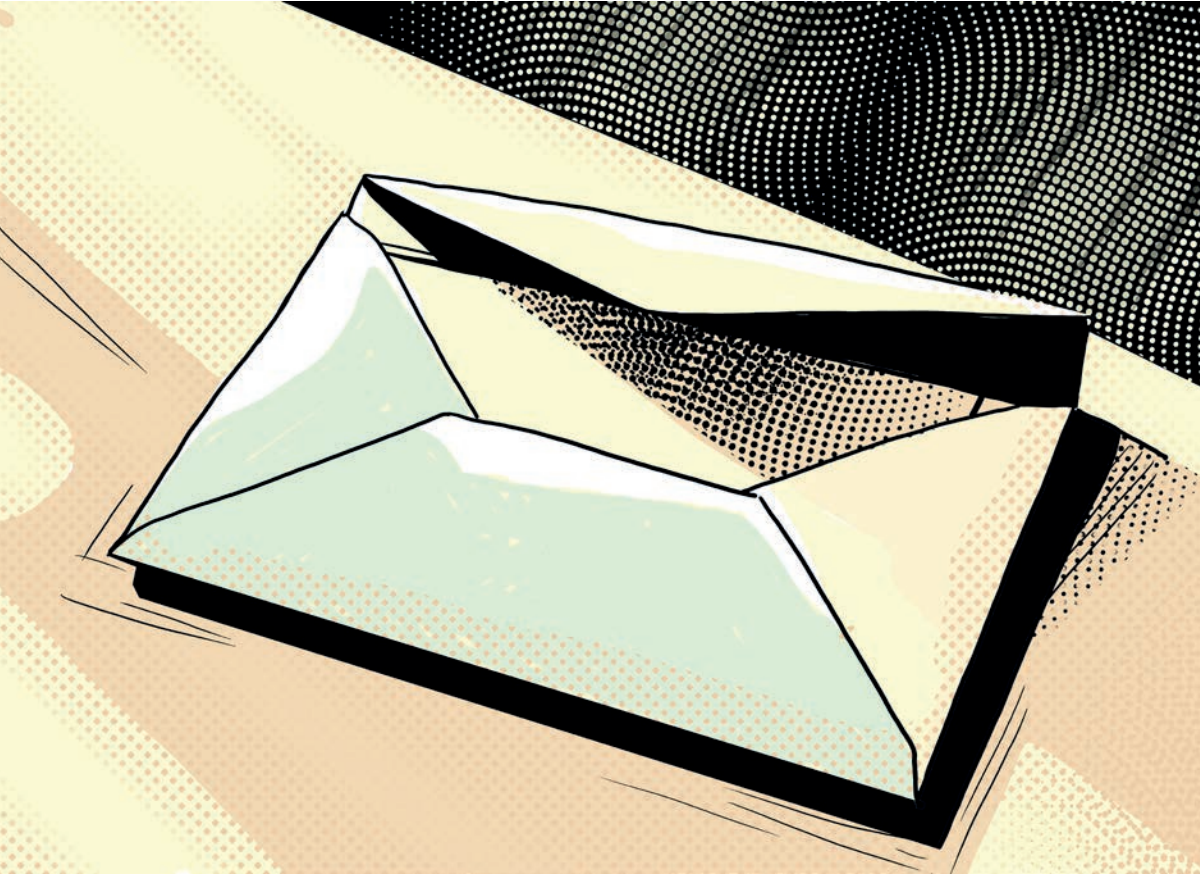
- misunderstandings can be avoided
- treatment can be reviewed if appropriate
- communication and trust can be supported

Recognizing changes early is not about searching for problems.

It is about **protecting communication, trust, and well-being.**

4.3

Why are intimacy-related side effects often not discussed?



*“You don’t have to explain everything right now.
I’m here, and I’m not going anywhere.”*

Elena:

If sexual well-being is so important, why is it still so rarely discussed in consultations?

Dr. Stein:

There isn’t just one reason. In practice, it’s usually a combination of very human factors.

For many people, sexuality is a sensitive topic. It can feel uncomfortable to bring it up, especially in a psychiatric setting. Some people worry that they will not be taken seriously or fear being judged. Others simply don’t know how to start the conversation, or whether it’s appropriate to bring it up at all.

Elena:

Even when a concern is important, a person may find it difficult to raise.

Dr. Stein:

And sometimes it’s not only about the patient. **If the topic isn’t asked about directly, it can easily remain in the background.** People may assume it’s not something they’re supposed to talk about here.

Elena:

The concern can remain invisible in the consultation.

Dr. Stein:

And there’s another layer as well. Some people are not sure where the changes are coming from. They may think, “Maybe this is just part of the illness,” and not realize that treatment could also play a role.

When there isn’t a clear explanation, silence can feel like the easier option. Some people think, “Maybe I should just accept it,” even when it affects them more than they expected.

Elena:

But that silence can have consequences.

Dr. Stein:

It can.

In practice, these kinds of side effects are one of the reasons why people sometimes reduce or stop treatment without saying so. Not because they don't want help, but because something important in their life has changed and hasn't been addressed. And often, this happens quietly, without discussion, which makes it harder to understand what is really going on.

Elena:

What can make the difference?

Dr. Stein:

Often, it's something very simple.

When clinicians create space for these topics, even with a gentle question, people feel more able to speak.

A question like:

"How has treatment been affecting your energy, mood, or intimacy?" can open the conversation in a natural way.

Elena:

A simple question may be enough to open the discussion?

Dr. Stein:

Very much so.

When intimacy is recognized as part of overall health, people feel seen. And when they feel seen, they are more likely to stay engaged, to talk openly, and to continue treatment.

Why patients may not talk about intimacy

Common reasons include:

- embarrassment or shame
- fear of being misunderstood
- assumption that nothing can change
- not being asked directly

✓ A simple question can open the conversation

✓ Open dialogue improves adherence

Why might someone hesitate to open up to their partner after diagnosis?

Elena:

Dr. Stein, we've talked about why people don't always report changes in intimacy or side effects.

But sometimes, the difficulty starts even earlier, right after diagnosis.

Some partners notice that their loved one becomes more open with family, but more distant or reserved with them. Why does that happen?

Dr. Stein:

That's a very important observation.

Receiving a diagnosis like schizophrenia can deeply affect how a person sees themselves, not only medically, but also personally and relationally.

Many people begin to wonder:

- “*Will I still be seen as the same partner?*”
- “*Am I still attractive, still trustworthy, still ‘enough’?*” These thoughts are often not shared out loud, but they shape how someone behaves.

Elena:

The hesitation may reflect fear of how disclosure could affect the relationship, rather than a lack of trust.

Dr. Stein:

Exactly.

In clinical practice, we often see that people may feel safer sharing information with parents or family members first. These relationships are usually perceived as more stable, less dependent on intimacy, attraction, or future expectations.

With a partner, the stakes can feel higher. Especially when the relationship is important, the fear of losing it can become very strong.

Elena:

Holding back may function as a form of protection.

Dr. Stein:

Yes, emotional self-protection.

People may internalize fears of rejection, even when there is no actual rejection. This can lead to silence, distance, or partial sharing.

From the outside, it may look like withdrawal.

But internally, it is often:
“*I don’t want to lose you.*”

Elena:

That must be very confusing for partners.

Dr. Stein:

It is.

One partner may think:

“*Why is he shutting me out?*”

While the other is thinking:

“*I’m afraid to let you see everything.*”

Elena:

What can help in that situation?

Dr. Stein:

Creating safety over time.

Not pushing for immediate openness, but showing:

- consistency
- acceptance
- and patience

Simple messages can help:

“You don’t have to explain everything right now.”

“I’m here, and I’m not going anywhere.”

Over time, when fear decreases, openness usually follows.

What happens when desire is present, but circumstances don’t allow expression?

Elena:

Dr. Stein, there is a topic that many people feel, but rarely talk about openly.

What happens when someone has sexual or emotional needs but cannot express them, for example, during hospitalization or when they are not in a relationship?

Dr. Stein:

That's a very important question, and one that deserves to be addressed with openness and respect.

First, it's important to say clearly:

Having sexual desire is a normal part of being human, including for people living with schizophrenia.

The illness does not remove the need for closeness, affection, or physical expression.

Elena:

But the situation may not always allow those needs to be fulfilled.

Dr. Stein:

There are periods when circumstances limit expression:

- during hospitalization
- during unstable phases of illness
- or simply when someone is not in a relationship

This can create frustration, loneliness and sometimes also confusion, "What am I supposed to do with these feelings?"

Some people may even feel that these needs are "inappropriate" or something they should suppress, which is not the case.

Elena:

The existence of the need is not itself a problem.

Dr. Stein:

Not at all. The key is how it is understood and managed. Not ignoring it, but also not feeling overwhelmed by it.

From a clinical perspective, we focus on **healthy, respectful, and safe ways of coping with these needs.**

This may include:

- understanding that desire can exist without immediate action
- finding other forms of connection, such as emotional closeness, conversation, or supportive relationships
- maintaining routines that support overall well-being, including physical activity and social interaction
- and, when appropriate, discussing concerns openly with a clinician

Elena:

So it's about acknowledging the need, but not feeling overwhelmed by it.

Dr. Stein:

Exactly.

When these needs are recognized as natural, they become easier to manage.

When they are ignored or associated with shame, they can become more distressing.

Elena:

And does this change over time?

Dr. Stein:

Yes.

As stability improves, opportunities for relationships, intimacy, and personal expression often return.

So these phases are usually **temporary**, even if they feel difficult at the moment.

4.4

What does shared decision-making look like in practice?



“When treatment aligns with a person’s values and life plans, it becomes much easier to continue.”

Elena:

We hear the term *shared decision-making* quite often in modern psychiatry. But for families listening, it can sound a bit abstract. What does it actually look like in real life?

Dr. Stein:

You’re right, it can sound theoretical. But in practice, it’s actually quite simple.

It starts with a conversation. And sometimes that conversation feels uncertain at first, for both sides.

Instead of decisions being made only from a medical perspective, there is a dialogue. The clinician brings clinical knowledge, and the patient brings their own experience, priorities, and what matters most in their life. Both sides are important.

Elena:

It’s more of a partnership than a one-sided decision.

Dr. Stein:

When people feel part of that process, something important happens. They feel more comfortable, more understood, and more willing to stay engaged with treatment over time.

Elena:

What does that conversation look like in practice?

Dr. Stein:

Often, it **begins with very simple questions**. There isn't always a clear answer immediately, and that's okay.

For example, a clinician might ask:

"What is most difficult for you right now?"

"What would feeling better actually look like in your daily life?"

"What matters most to you at this moment, your work, your relationships, your independence?"

And sometimes:

"How important is intimacy or closeness for you right now?"

Elena:

The focus remains on the person's life, not only the symptoms.

Dr. Stein:

Treatment doesn't exist in isolation. It has to fit into someone's life.

For one person, maintaining a relationship may be very important. For another, being able to concentrate at work may come first. These differences matter, and treatment should reflect them as much as possible.

Elena:

And what about caregivers? Where do they fit in?

Dr. Stein:

With the person's agreement, caregivers can play a very helpful role.

They can share what they observe, support follow-up, or help express concerns that might be difficult to put into words. But it's important that they support the conversation, not take it over.

Elena:

The person therefore remains at the centre of the decision.

Dr. Stein:

Always.

Shared decision-making is not about pressure or choosing between options quickly. It's about finding an approach that feels right, medically sound, and personally meaningful.

When treatment aligns with a person's values and life plans, it becomes much easier to continue. When it feels imposed, people may withdraw, sometimes quietly. Even if the intention is good, it can feel difficult to accept.

Elena:

This may influence more than communication; it may also affect engagement with care and outcomes.

Dr. Stein:

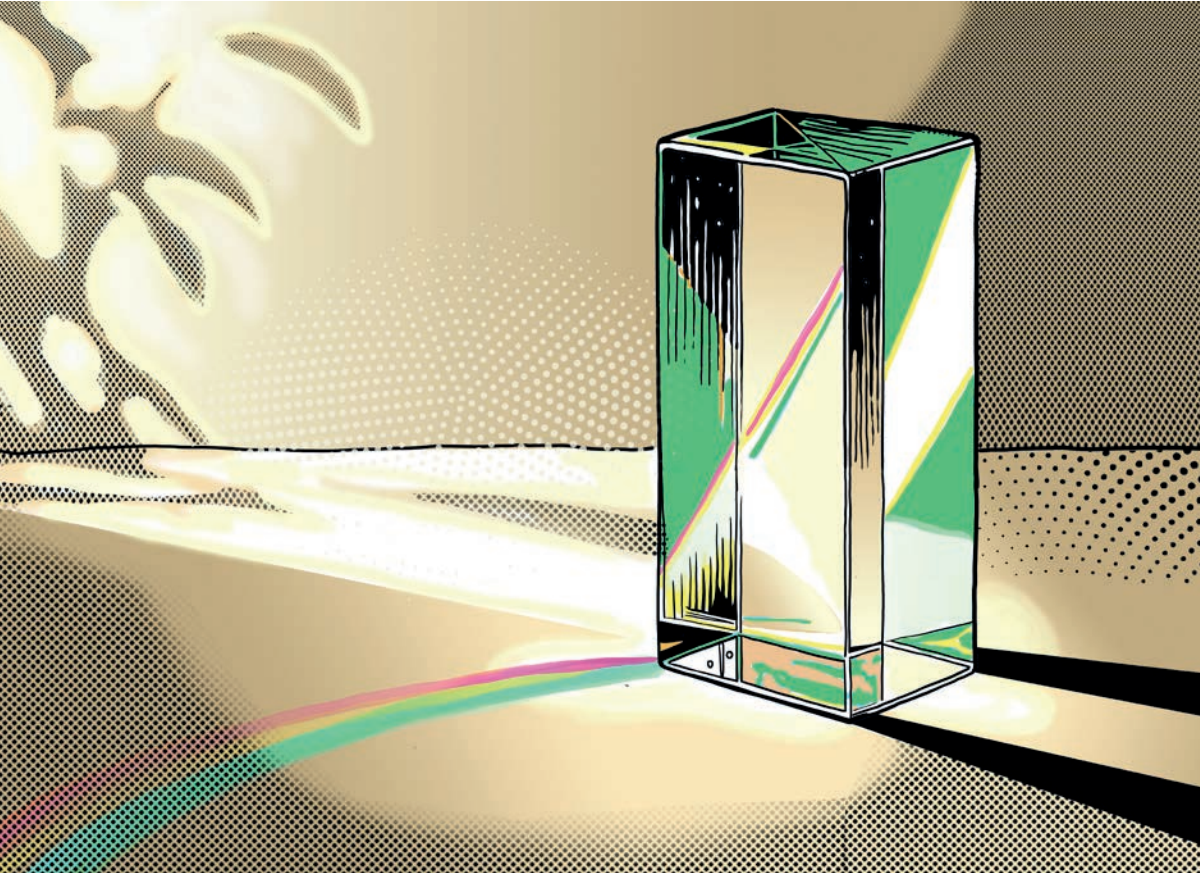
Very much so.

In many ways, it helps protect long-term stability. When people feel heard and involved, they are more likely to stay engaged, to speak openly, and to continue treatment.

And **when topics like intimacy, relationships, or plans are part of that conversation, treatment becomes not only effective but also human.**

4.5

Why does treatment choice have ethical implications?



*“Silence often creates uncertainty.
Openness creates a sense of safety.”*

Elena:

Earlier, you used the word “*ethical*” when talking about treatment choices. That sounds quite strong. Why do you see it that way?

Dr. Stein:

Because these decisions affect much more than symptoms.

Treatment doesn’t only influence hallucinations or mood. It can also affect how someone feels in their body, their energy, their emotions, and sometimes even how they experience closeness or intimacy.

Elena:

It touches very personal aspects of life.

Dr. Stein:

When something that personal is involved, it becomes important to talk about it openly. If we only focus on symptom control and ignore how a person feels in their relationships or in themselves, we’re only seeing part of the picture. This can happen unintentionally, not because anyone is ignoring it, but because it is not always easy to talk about.

Elena:

The ethical dimension includes considering the whole person, not symptoms alone.

Dr. Stein:

Yes.

People have the right to understand how treatment might affect different areas of their lives, including their intimate lives. **When they have that understanding, they can make decisions that feel right for them.**

Elena:

And what happens if these aspects are not discussed?

Dr. Stein:

Then important things can remain unspoken.

Sometimes a treatment is helping clinically, but at the same time, something feels different in a very personal way, and if that isn't acknowledged, it can affect confidence, relationships, and even willingness to continue treatment. **And that can create a difficult internal conflict.**

Elena:

So openness is key.

Dr. Stein:

Indeed.

This doesn't mean overwhelming people with information, but gently letting them know that these topics are valid and can be discussed.

Simple things matter:
letting someone know that changes are possible,
naturally asking about them,
and being ready to adjust if something becomes difficult.

Elena:

Discussing these effects openly can help build trust.

Dr. Stein:

When people feel they can speak openly, they feel respected. And when they feel respected, they are more likely to stay engaged in care.

Elena:

So raising the topic doesn't create anxiety; it can actually create security.

Dr. Stein:

Yes.

Silence often creates uncertainty. Openness creates a sense of safety.

When someone knows, "*If something changes, I can talk about it,*" it protects both the therapeutic relationship and the personal relationship.

Elena:

Ethical care involves not only what is chosen, but also how the decision is discussed.

Dr. Stein:

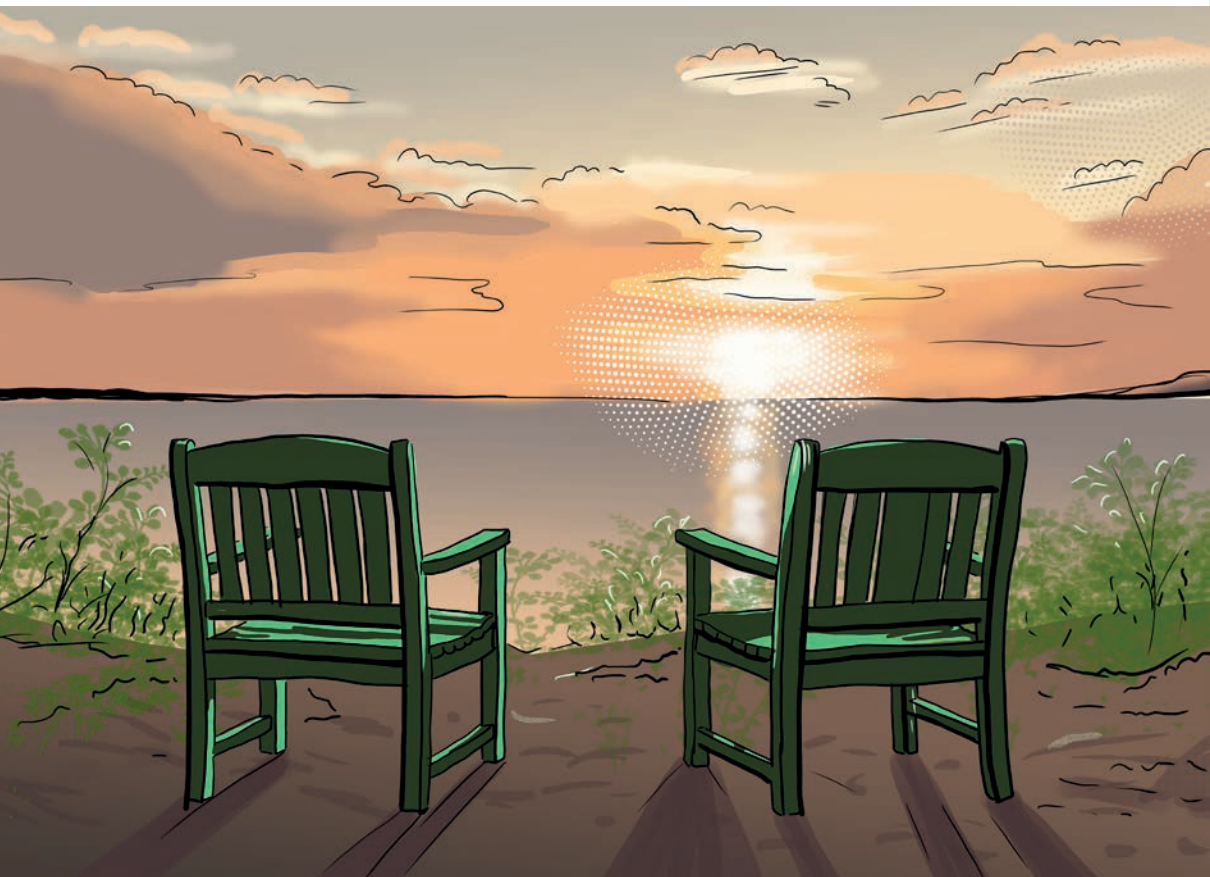
Exactly.

It's also about how we talk about it, how we listen, and how we adapt it to the person.

And when that happens, treatment becomes something people can trust, and that trust supports recovery.

4.6

What can caregivers do to support communication and trust?



“What helps most is staying calm, staying curious, and keeping the conversation open.”

Elena:

Let’s bring this into everyday life. Many caregivers listening might be thinking, *“This makes sense, but what do I actually say? How do I even start?”*

Dr. Stein:

That’s a very real question. **Many caregivers worry about saying the wrong thing. Often, it doesn’t start with finding the perfect words, but simply with creating a safe space to talk.**

Sometimes something as simple as saying,
“I care about how you feel. If something changes, it’s okay to talk about it. There may be ways to help,”
can already make a big difference.

Elena:

The tone may matter as much as the exact wording. Is that right?

Dr. Stein:

Yes, definitely.

When the conversation feels calm and without judgment, people are much more likely to open up. When it feels pressured or critical, they often withdraw, even if something is really bothering them.

Elena:

And what should caregivers be careful about?

Dr. Stein:

It helps to avoid reactions that might unintentionally add pressure.

For example, saying things like
“You’re not interested in me anymore,”
or

“You need to fix this.”
can make the situation feel heavier.

And **even when frustration is understandable, it’s important not to turn it into a conflict about treatment.**

Elena:

The goal is not to solve everything in one conversation.

Dr. Stein:

What helps most is staying calm, staying curious, and keeping the conversation open. Even though that is not always easy in emotionally charged moments.

Caregivers can also support in simple, practical ways, like encouraging follow-up appointments, noticing changes over time, or offering to come along to a consultation if that feels helpful.

Elena:

Support can therefore be both emotional and practical.

Dr. Stein:

Yes.

And there's one point that is very important to remember.

Changes in intimacy are very rarely about a loss of love or connection. But in the moment, it can feel that way. In many cases, they are linked to treatment or biological factors, and that means they can be discussed and, often, improved.

Elena:

Understanding that several factors may be involved can reduce blame and tension.

Dr. Stein:

Very much so.

A simple suggestion such as, "Would you like us to discuss this with your doctor?" can help move the concern from something stressful to something manageable.

Elena:

The caregiver's role is not to fix, but to support the conversation.

Dr. Stein:

That means listening, remaining present, and helping the person access professional advice if wanted.

Because in the end, the goal is not perfection in intimacy. It's maintaining trust, both in the relationship and in the care process.

And that trust is one of the strongest supports for long-term stability and recovery.



What caregivers can do

Helpful approaches:

- speak calmly and without pressure
- normalize discussion about intimacy
- encourage medical consultation
- support, but do not control decisions

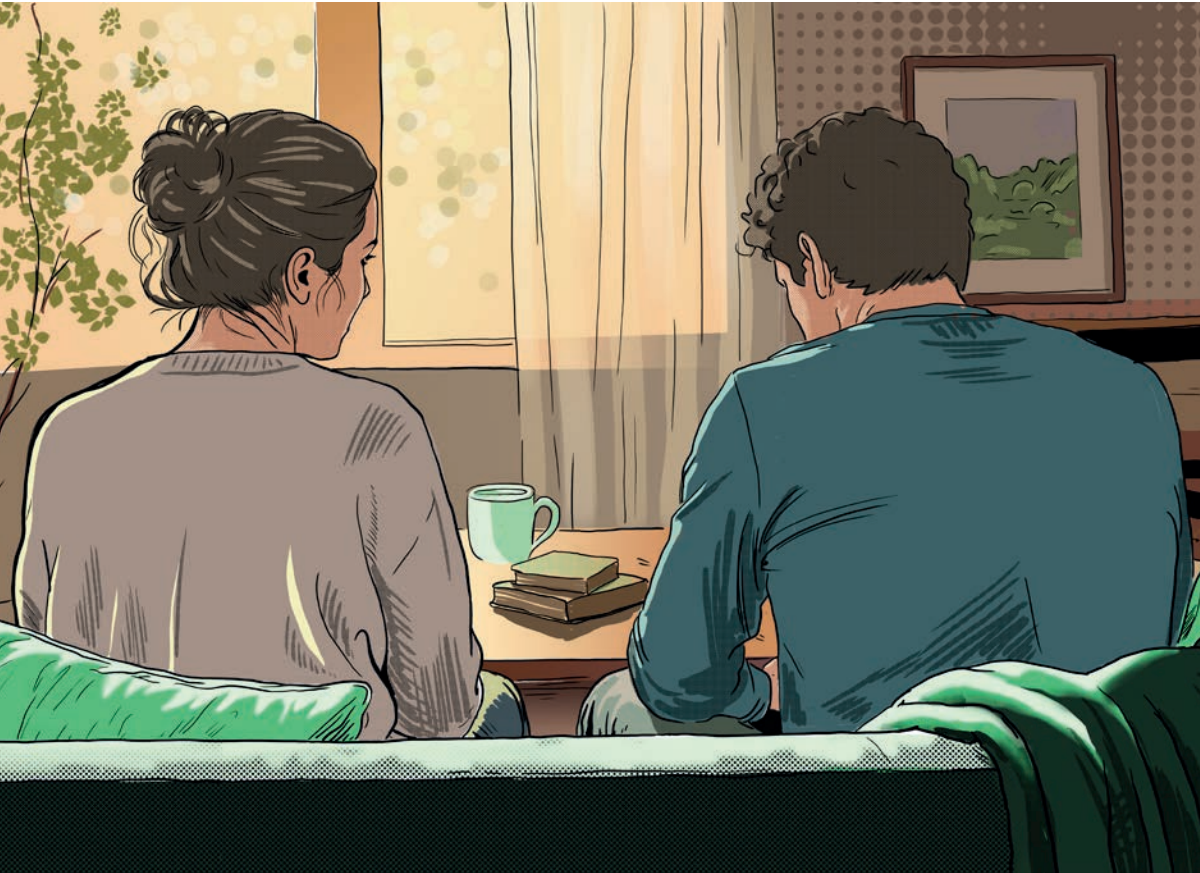
Avoid:

- blame or accusations
- suggesting stopping treatment
- interpreting changes as loss of love

The goal is communication, not correction

Clinical Story

“I didn’t know if this was something I was allowed to talk about...”



Note: The clinical story in this chapter is created for educational purposes. Names and identifying details do not represent specific individuals.

Elena:

Before we close, Dr. Stein, could you share an example that brings all of this together?

Dr. Stein:

Of course.

I remember a man in his early thirties. His symptoms had improved significantly, and from a clinical perspective, everything seemed stable.

But during a follow-up visit, his partner mentioned that something had changed. He had become distant. Less affectionate. Less engaged.

At first, they both thought this was part of the illness.

But when we gently explored the topic, he admitted something he hadn’t said before:

“I don’t feel like myself anymore... not in that part of my life.” He paused and then added quietly, “I didn’t know if this was something I was allowed to talk about.”

He had been experiencing changes in sexual functioning, but felt too uncomfortable to bring it up.

Elena:

The issue wasn’t the relationship itself.

Dr. Stein:

It was a **treatment-related effect that had never been discussed.**

Once the conversation was opened, we reviewed options together. Adjustments were made carefully, and over time, both his confidence and the relationship improved.

Elena:

So the turning point was simply talking about it.

Dr. Stein:

Yes. Not a dramatic intervention. Just a **safe conversation**.

Sometimes, what appears to be emotional distance is actually **an unspoken, manageable issue**.

When patients, partners, and clinicians speak openly:

- trust improves
- adherence strengthens
- relationships recover.

Final reflection

Elena:

What I take from today is that treatment does more than reduce symptoms; it can also influence how people experience themselves, their relationships, and intimacy.

Dr. Stein:

Treatment is part of everyday life, not separate from it. When it fits well, it supports not only stability but also confidence, connection, and the ability to be present in relationships.

And when something doesn't feel right, especially in such a personal area as intimacy, it's important to know that this can be discussed, understood, and often adjusted.

Elena:

The goal is not to avoid treatment, but to stay engaged with it, and to talk openly about how it affects real life.

Dr. Stein:

When people feel heard, and when their personal experiences are part of the conversation, treatment becomes something they can live with, not something they have to endure. And often, it's these conversations, simple, honest, and sometimes difficult, that protect both relationships and recovery over time. **Not always comfortable, but often necessary.**

Elena:

And in many ways, this brings us to another important question that naturally follows.

If treatment, physical health, and intimacy are all connected, what happens when people begin to think about having children?

Dr. Stein:

That's a very important step.

Questions about fertility, reproductive health, and family planning often come at a time when people are beginning to feel more stable and are thinking about their future more seriously.

These decisions are deeply personal, but they are also closely connected to everything we've discussed: treatment, physical health, relationships, and confidence.

Elena:

Family planning is therefore not a separate topic, but a continuation of the same conversation.

Dr. Stein:

With the right information, planning, and support, these conversations can become not a source of uncertainty, but a way to build a future that feels both safe and meaningful.

Elena:

In our next chapter, we'll explore how fertility, reproductive health, and family planning can be approached in a thoughtful and informed way.

Until then, take care, and we look forward to continuing this conversation with you.

References

- Korchia T, Achour V, Faugere M, et al. Sexual Dysfunction in Schizophrenia: A Systematic Review and Meta-Analysis. *JAMA Psychiatry*. 2023;80(11):1110-1120.
- Schneider-Thoma J, Dong S, Kim DD, et al. Sexual dysfunction and other prolactin-related side effects of antipsychotic drugs in schizophrenia: Protocol for a systematic review with single-arm, pairwise, and network meta-analyses of randomized controlled trials and non-randomized studies. *F1000Research*. 2025;13:973.
- Lin X, Spyridon Sifafis, Tian J, et al. Antipsychotic-Related Prolactin Changes: A Systematic Review and Dose–Response Meta-analysis. *CNS Drugs*. Published online 2025;39(10):937–947.
- Jiang Q, Li T, Zhao L, et al. Treatment of antipsychotic-induced hyperprolactinemia: an umbrella review of systematic reviews and meta-analyses. *Frontiers in psychiatry*. 2024;15:1337274.
- Lu Z, Sun Y, Zhang Y, et al. Pharmacological treatment strategies for antipsychotic-induced hyperprolactinemia: a systematic review and network meta-analysis. *Translational Psychiatry*. 2022;12(1).
- Pérez-Revuelta JI, González-Sáiz F, Pascual-Paño JM, et al. Shared decision making with schizophrenic patients: a randomized controlled clinical trial with booster sessions (DECIDE Study). *Patient Education and Counseling*. 2023;110:107656.
- Jackson KN, Lee AG, Ali JM, et al. Shared Decision-Making in the Management of Schizophrenia: A Systematic Review. *Cureus*. 2025;17(6):e87069.
- Fiorillo A, Barlati S, Bellomo A, et al. The role of shared decision-making in improving adherence to pharmacological treatments in patients with schizophrenia: A clinical review. *Annals of General Psychiatry*. 2020;19(1).
1. National Institute for Health and Care Excellence. Psychosis and schizophrenia in adults: prevention and management [Internet]. London: NICE; 2014 [updated 2025 Jul 29; cited 2026 Aug 21]

Chapter 5

Fertility, reproductive health, and family planning when living with schizophrenia

Explore Chapter 5

This chapter turns to the practical and personal questions that arise when people living with schizophrenia think about fertility and having children. It explores how reproductive health, contraception, pregnancy planning, and postpartum care can be approached through informed choices, coordinated medical support, and respect for each person's own timing and life goals.



5.1
Can fertility be affected in schizophrenia?



5.2
How do hormones influence reproductive health?



5.3
Why is contraception an important part of care?



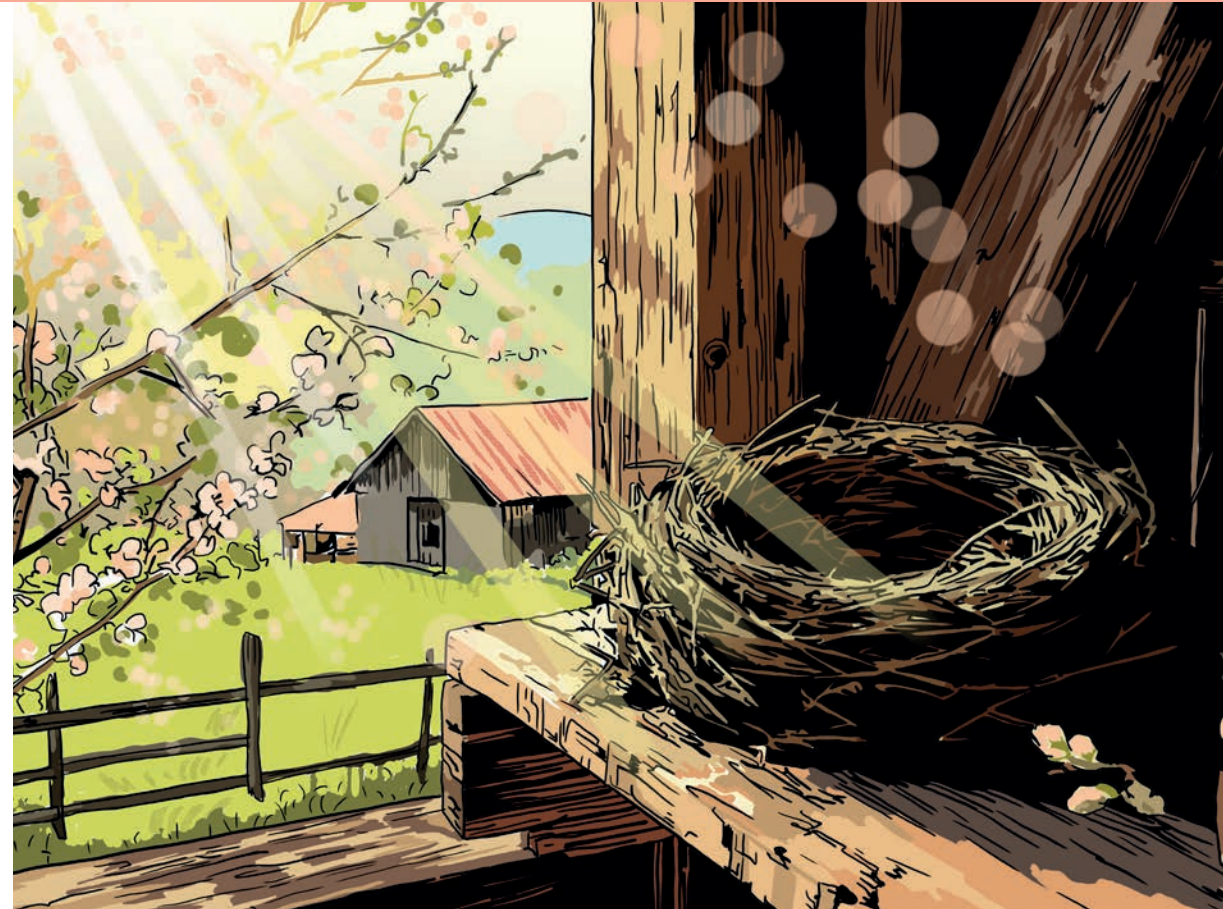
5.4
How can pregnancy be planned safely?



5.5
Why do partners sometimes feel out of sync in their lives and expectations?



Clinical Story





Mini-Glossary

Fertility

The ability to conceive a child. It may be influenced by hormonal, physical, and lifestyle factors.

Hypothalamus-pituitary-gonadal (HPG) axis

A system of communication between the brain and reproductive organs that regulates hormones such as estrogen and testosterone. It plays a central role in controlling menstrual cycles, ovulation, and sperm production.

Prolactin

A hormone that, when elevated, can affect menstrual cycles, ovulation, sexual function, and fertility.

Contraception

Methods used to prevent pregnancy, allowing individuals to plan if and when to have children.

Preconception Planning

Preparing physically and medically for pregnancy to ensure the best possible outcomes for both parent and child.

Postpartum Period

The time after childbirth, during which physical and emotional changes occur and additional support may be needed.

Welcome to podcast #5

Fertility, reproductive health, and family planning when living with schizophrenia

with **Elena Maurer**, Health Journalist, and
Dr. Lukas Stein, Psychiatrist and Researcher

Elena:

In our previous conversations, we explored how body image, physical health, and treatment can shape intimacy, confidence, and relationships.

For many people, as stability grows, another question naturally appears:

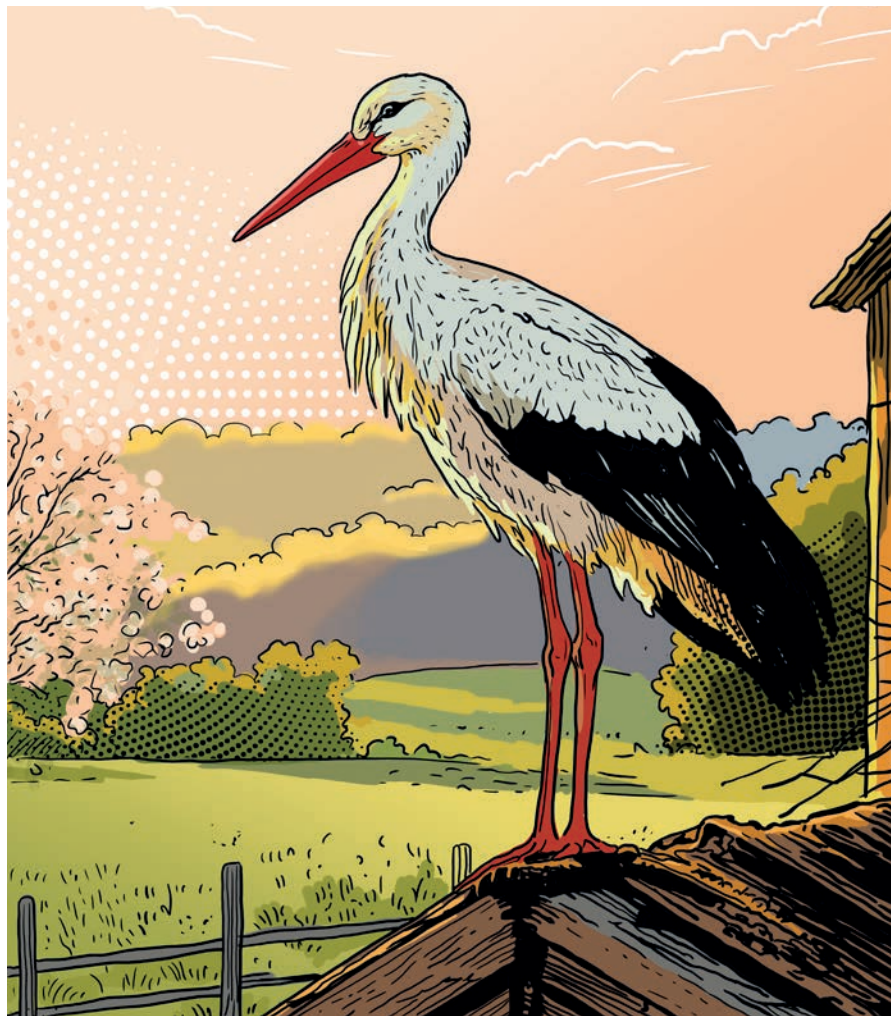
What about the future? What about having children?

Thank you, Dr. Stein, for joining us.

Dr. Stein:

Thank you, Elena. These are important and very personal questions for many families.

5.1 Can fertility be affected in schizophrenia?



“The short answer is: fertility is usually preserved, but several interacting factors can influence it.”

Elena:

Dr. Stein, many families wonder whether schizophrenia affects the ability to have children. Is fertility reduced?

Dr. Stein:

That’s a very important and very common question.

The short answer is: **fertility is usually preserved**, but several interacting factors can influence it. Even with this information, many people still feel uncertain. “Does this apply to me?” is a common question.

Fertility in people living with schizophrenia is not absent, but it may be **lower on average or more variable**, depending on individual circumstances.

Elena:

The issue is not impossibility, but variability?

Dr. Stein:

Historically, people with schizophrenia have had **lower birth rates**, but this is not only due to biological factors. It is also influenced by social and health-related aspects, such as relationship opportunities, overall health, and access to care.

Today, this is changing, as care improves and more people can plan their lives, including having children. But for many, the question still comes with hesitation, not only hope.

What factors can influence fertility?

Elena:

What are the main things that can influence fertility?

Dr. Stein:

There isn't just one single factor.

In real life, it's usually a combination of different things that come together, sometimes biological, sometimes related to overall health, and sometimes connected to everyday life.

Elena:

Can you give us a sense of what that looks like?

Dr. Stein:

Of course.

Sometimes it starts with the body's internal balance. Hormones play an important role in fertility, and one hormone we often look at is prolactin.

When prolactin levels are higher, it can affect things like menstrual cycles in women, or testosterone and sperm production in men.

What's important to know is that these changes don't always come only from treatment. They can also be part of how the illness affects the body itself.

Elena:

It's not always something people can see or immediately notice.

Dr. Stein:

Beyond hormones, there are also very everyday aspects of health that matter.

Things like changes in weight, general physical condition, or habits such as smoking can influence fertility over time. These are not specific to schizophrenia, but they tend to appear more often in this context, which is why we pay attention to them.

Elena:

Is fertility also connected to general well-being?

Dr. Stein:

Yes, it is.

And there is another layer that is just as important.

Fertility is not only about biology. It's also about life circumstances.

Things like feeling stable in a relationship, having access to care, or simply being able to talk openly about plans all play a role.

In practice, we often see that these elements are closely connected. Sometimes people expect a simple explanation, and it can be frustrating when things are more complex. It's not just one factor, but how they come together in a person's life. And that can feel confusing at first, because there isn't always a single clear answer.

Elena:

When families hear that fertility may be affected, it doesn't mean that having children is unlikely.

Dr. Stein:

It's more accurate to say that fertility can be influenced, sometimes in subtle ways, but not removed.

In many cases, these challenges can be understood and addressed. And with the right support and planning, many people may have children.

Fertility: Key Points

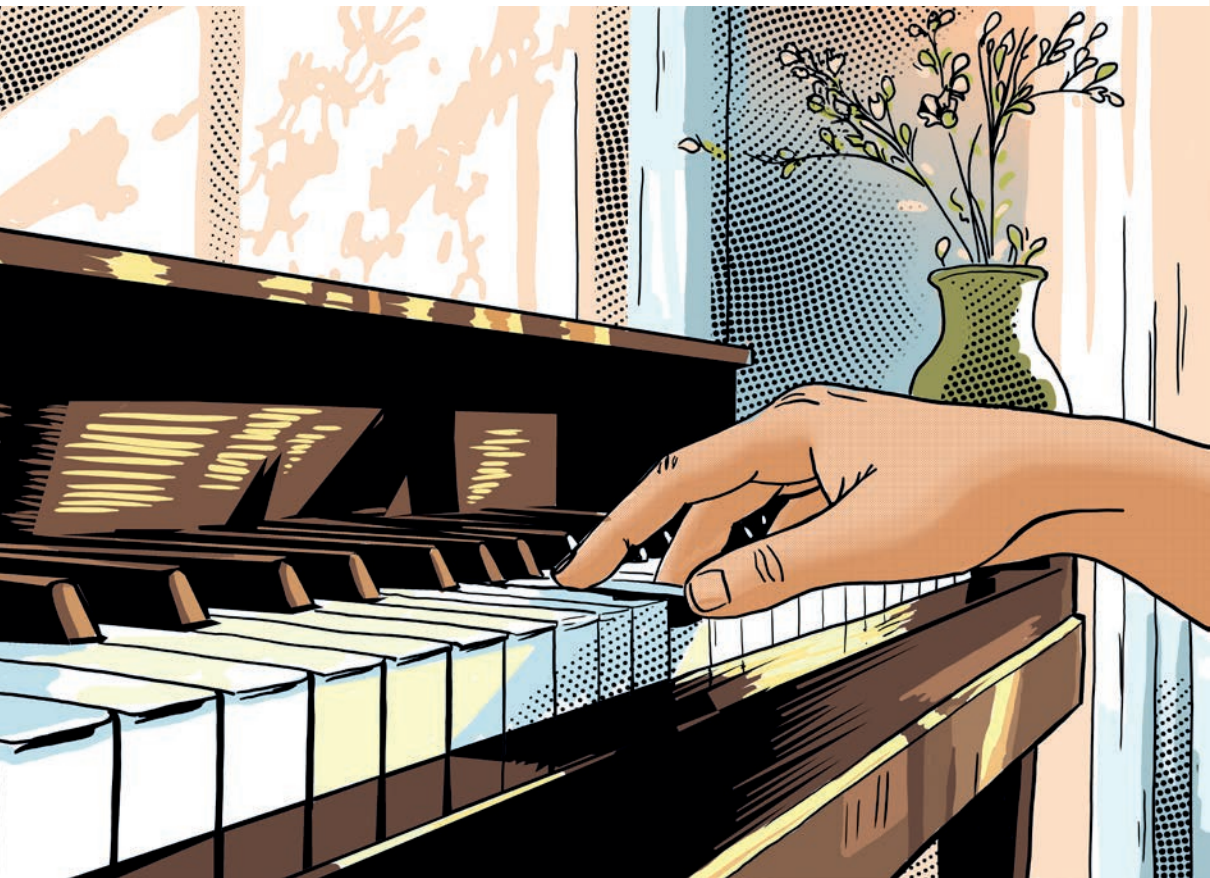
- *usually preserved*
- *influenced by multiple factors*
- *varies between individuals*

✓ planning improves outcomes

Understanding these factors helps guide the next steps in planning and care.

5.2

How do hormones influence reproductive health?



“Reproductive health depends on a balance between several hormones.”

Elena:

Dr. Stein, earlier, you mentioned hormones. Could you help us understand this a bit more simply - how do they actually influence reproductive health?

Dr. Stein:

Of course.

One way to think about hormones is that they help keep the body's rhythm stable.

When that rhythm is balanced, things like menstrual cycles, sexual function, and fertility tend to work more smoothly.

Elena:

And when that balance changes?

Dr. Stein:

Even small changes can have an effect. And often, people don't notice it immediately, which can make it harder to understand what is happening.

For example, one hormone we often talk about is prolactin. When prolactin levels are higher, women may notice changes in their cycle, and men may experience differences in sexual function or hormone levels.

Elena:

Is this something people usually notice directly?

Dr. Stein:

Sometimes yes, but often not immediately.

Some people only become aware of it when they start thinking about having children, or when something feels slightly different in their body without a clear reason.

Sometimes it comes as a surprise, especially when everything else seemed stable.

Elena:

So these changes can be quite subtle.

Dr. Stein:

And that's why it's important to look at them in context. Hormonal changes are just one part of the picture, but when we understand them, they can often be monitored and, if needed, adjusted.

Why can hormones fluctuate in schizophrenia?

Elena:

Dr. Stein, one thing that may not be immediately obvious is why hormones seem more sensitive in people living with schizophrenia. Is there a simple way to understand this?

Dr. Stein:

Yes, there is.

One helpful way to think about it is that the systems in the brain that regulate emotions, thinking, and body functions are closely connected.

In schizophrenia, some of these regulatory systems may work a bit differently, and because they are linked to hormonal regulation, this can make hormones more sensitive to change.

Elena:

Are the same systems influencing both the mind and the body?

Dr. Stein:

Yes, they are. Because of this connection, hormones like prolactin, estrogen, or testosterone can sometimes shift more easily, either due to the illness itself or in response to treatment.

This doesn't happen in everyone, but it helps explain why changes in reproductive health can occur and why it's important to pay attention to them. And that variability can be confusing, especially when comparing experiences with others.

Elena:

Let's take prolactin, since it comes up often. What does it actually do?

Dr. Stein:

Prolactin is one of the hormones involved in regulating the reproductive system.

When its levels are higher than usual, it can affect how that system works.

For example, women may notice changes in their menstrual cycle, while men may experience differences in sexual function or hormone levels.

Elena:

Again, these are changes that may not always be obvious at first.

Dr. Stein:

Sometimes they are subtle, and people only notice them when something feels different, or when they begin thinking about fertility.

Elena:

And prolactin is just one part of a bigger picture?

Dr. Stein:

Yes.

Reproductive health depends on a balance between several hormones. When that balance shifts, even slightly, it can influence both fertility and general well-being.

There is also growing evidence that some of these changes may be linked not only to treatment, but also to the condition itself, even early on.

What can be done if hormonal changes appear?

Elena:

Should families be worried when they hear about these hormonal changes?

Dr. Stein:

It's completely understandable to feel concerned. Some people worry more than they say out loud.

But in most cases, what helps more than worry is **awareness**.

These hormonal changes are not rare, but they also don't affect everyone in the same way. And importantly, **when they are noticed, they can often be followed and, if needed, adjusted.**

Elena:

Is this something to pay attention to, but not something to be alarmed about?

Dr. Stein:

The key is to recognize when something feels different, and to talk about it openly with a clinician.

In practice, many of these changes become manageable simply because they are identified early and not ignored.

Elena:

Understanding what's happening already makes a difference.

Dr. Stein:

Hormones are an important part of reproductive health, but they are only one part of the picture. When we approach them with awareness, regular follow-up, and open communication, they become something we can work with, not something we need to fear.

5.3 Why is contraception an important part of care?



“Planning means giving yourself the chance to choose the right moment.”

Elena:

Dr. Stein, contraception is not always something families think about when discussing schizophrenia. Why does it matter in this context?

Dr. Stein:

It’s an important question.

Contraception becomes important when people begin to think about their future, about whether and when they would like to have children.

In the context of schizophrenia, this is especially relevant because **it allows those decisions to happen at the right moment, when someone feels more stable, prepared, and supported. Even so, these conversations are not always easy to start.**

Elena:

It’s not only about prevention, but also about timing.

Dr. Stein:

It helps people keep a sense of control over an important part of their life.

Elena:

Is the situation different for people living with schizophrenia?

Dr. Stein:

The need itself is the same as for anyone else.

But in practice, things can become a bit more complicated.

Sometimes these conversations simply don’t happen often enough. People may not receive clear information, or they may not feel comfortable bringing up the topic.

At the same time, **fertility is sometimes underestimated, which can lead to situations that were not planned.**

Elena:

Part of the challenge is that the topic is not always addressed early enough.

Dr. Stein:

Yes, and that's why it's important to bring it into the conversation naturally and respectfully.

When people have the right information and feel supported, they are much more able to make decisions that fit their life, health, and plans for the future.

Why is family planning important?

Elena:

Is contraception really about planning?

Dr. Stein:

Planning simply means giving yourself the chance to choose the right moment.

Many people feel that there is never a "perfect" moment.

A moment when things feel a bit more stable, when there is enough energy, and when both partners feel ready, not only physically, but also emotionally. And sometimes partners don't feel ready at the same time.

Elena:

It's about feeling prepared, not rushed.

Dr. Stein:

It also gives people time to think about support, who will be there, how daily life might look, and what kind of help might be needed along the way.

Elena:

Planning creates a sense of safety.

Dr. Stein:

It's not about limiting choices.

It's about creating the conditions where decisions can be made with more confidence, and where the experience can feel supported rather than overwhelming.

What types of contraception exist?

Elena:

Without going into too much detail, could you give us a sense of what options exist?

Dr. Stein:

There are several different ways people can choose to protect themselves, and the best option really depends on what feels comfortable and practical in their daily life. Some people try more than one option before finding what feels right.

Some methods involve hormones, such as pills or longer-acting options. Others are more straightforward, like condoms. There are also longer-term solutions that don't require daily attention, such as devices or implants that work over time.

Elena:

There isn't just one "right" option.

Dr. Stein:

Each method has its own advantages, and the choice is always personal. It depends on things like health, lifestyle, and what feels manageable and safe for the person.

Why is individual choice so important?

Elena:

You've mentioned individual choice several times. Why is it so central?

Dr. Stein:

Because these decisions are very personal, and sometimes also emotionally complex.

When people think about having children, they're not only thinking medically. They're thinking about their life, their relationship, their future, and what feels right for them.

Elena:

It can go beyond clinical factors.

Dr. Stein:

People living with schizophrenia should have the same opportunity as anyone else to understand their options and to make decisions that reflect their own values and priorities.

That means having information that is clear and accessible, feeling supported in the process, and knowing that their preferences are taken seriously.

Elena:

It's not about finding the "correct" answer.

Dr. Stein:

There isn't a single path that fits everyone. What matters is that the decision feels informed, respected, and aligned with the person's life.

What obstacles may exist?

Elena:

Are there things that make these conversations more difficult in real life?

Dr. Stein:

Yes, sometimes there are.

Often, **it's not one big obstacle, but several smaller ones that come together, which can make it feel easier to avoid the topic altogether.**

Some people feel unsure about bringing up intimate topics, especially if no one has asked them directly before. Others may not know who to talk to, or may find that different aspects of care, mental health, and reproductive health are not always well-connected.

Elena:

It seems it's not only about the person, but also about how the system is organized.

Dr. Stein:

And because of that, these topics can remain unspoken, even when they are important.

Elena:

What helps overcome that?

Dr. Stein:

Often, it starts with a simple, respectful conversation.

When the topic is approached in a natural way, without pressure or judgment, it becomes much easier for people to ask questions and express what they need.

What is the role of caregivers?

Elena:

And how can caregivers support without overstepping?

Dr. Stein:

That's a very important balance. **Caregivers can play a supportive role, but in a way that keeps the person at the center of the decision.**

Often, it starts with creating space for open and respectful conversations. Not pushing, but making it easier for these topics to be discussed when the person feels ready.

Elena:

This seems to be more about opening the door than leading the way.

Dr. Stein:

Caregivers can also help in practical ways, for example, by supporting access to healthcare or helping organize appointments when needed.

But just as important is respecting privacy and personal choices. **These decisions are deeply personal, and feeling in control of them makes a real difference.**

Elena:

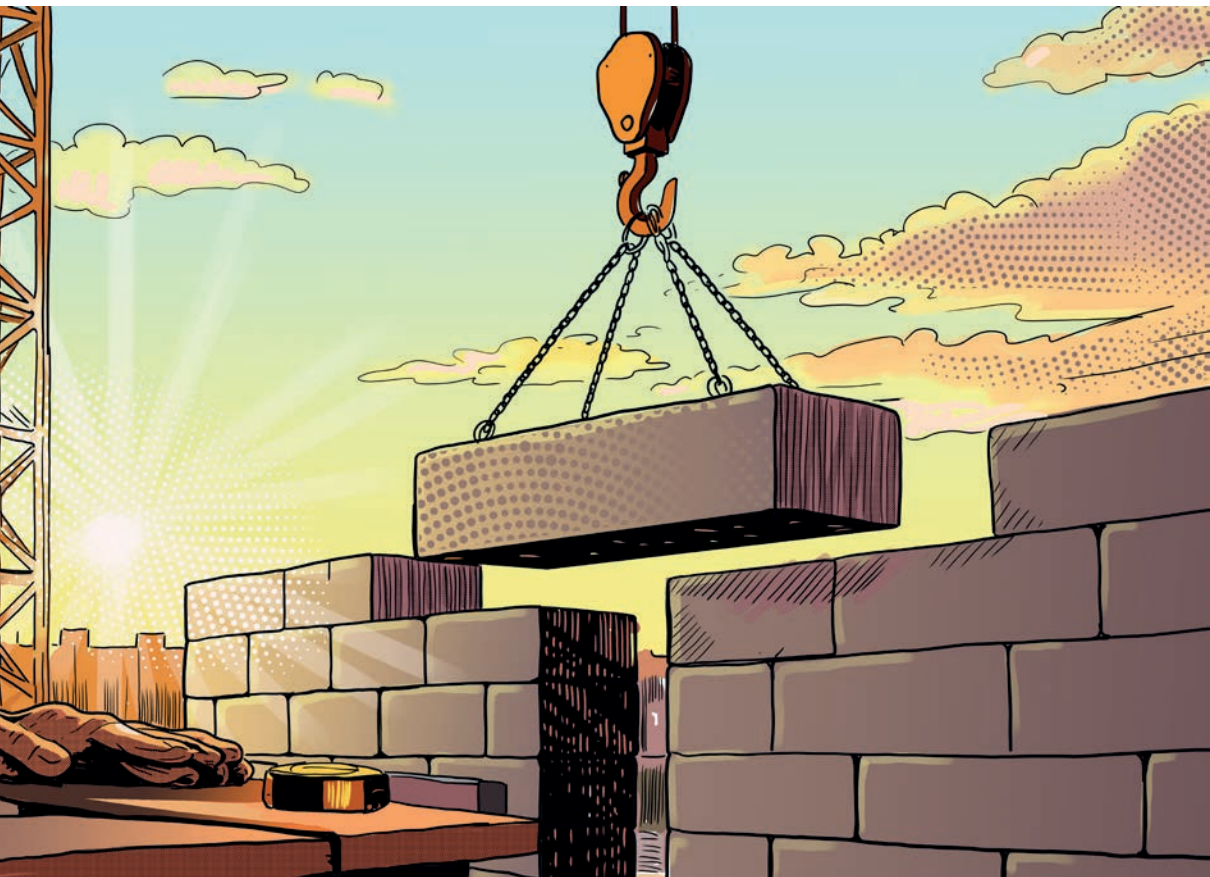
Support doesn't mean taking over.

Dr. Stein:

Not at all. The goal is to stay present and supportive while allowing the person to make their own decisions at their own pace.

5.4

How can pregnancy be planned safely?



“...it’s not just a medical decision.”

Elena:

Planning is clearly important. What does “safe planning” actually mean in real life?

Dr. Stein:

In simple terms, it means **choosing a moment when things feel more stable and supported. Even though many people don’t feel completely ready, only “ready enough to try.”**

Usually, that includes a period where symptoms are well controlled, and daily life feels a bit more predictable. It also involves talking things through with healthcare professionals, so that treatment and physical health can be reviewed in advance.

Elena:

It’s something that is prepared step by step.

Dr. Stein:

Exactly. It’s also about looking at the broader picture, how someone is feeling physically, what kind of support is available, and how the couple feels about taking this step. And sometimes realizing that not everything can be planned in advance.

Elena:

Seems not just a medical decision.

Dr. Stein:

Safe planning is really about **creating a stable and supportive environment before pregnancy begins, so that both the person and the future child have the best possible starting point.**

Pregnancy: what matters most

- clinical stability
- medical consultation
- physical health
- support system

✓ Preparation reduces risks

What becomes important during pregnancy?

Elena:

Once pregnancy begins, what becomes most important?

Dr. Stein:

One of the key ideas is finding the right balance. And that balance can feel different from one person to another.

During pregnancy, it's very important **to keep mental health stable**. When treatment is stopped suddenly, the risk of relapse can increase, and that can be difficult both for the mother and for the developing baby.

Elena:

Stability remains central.

Dr. Stein:

At the same time, every situation is different. **Care is usually adapted step by step, with close follow-up and good communication between the mental health team and the obstetric team.**

Elena:

It's a shared effort.

Dr. Stein:

When care is coordinated and decisions are made together, it becomes much easier to support both the health of the mother and the development of the child.

Why is the postpartum period a sensitive phase?

Elena:

We often hear that the **period after birth** is especially important. Why is that?

Dr. Stein:

Because it's a time of major change, both physically and emotionally. Even for those who felt prepared, it can still be overwhelming at times.

For women living with schizophrenia, this period can be more sensitive, as the risk of relapse may increase, especially if treatment has been interrupted.

Elena:

Stability remains just as important after birth.

Dr. Stein:

The first weeks after delivery can be demanding for any parent. Sleep is often disrupted, routines change, and there is a new level of responsibility. All of this can place additional strain on emotional and mental balance.

Elena:

That sounds like a time when support becomes essential.

Dr. Stein:

Very much so. When there is a plan in place, continued care, and support from family and professionals, this period can be managed much more safely and confidently.



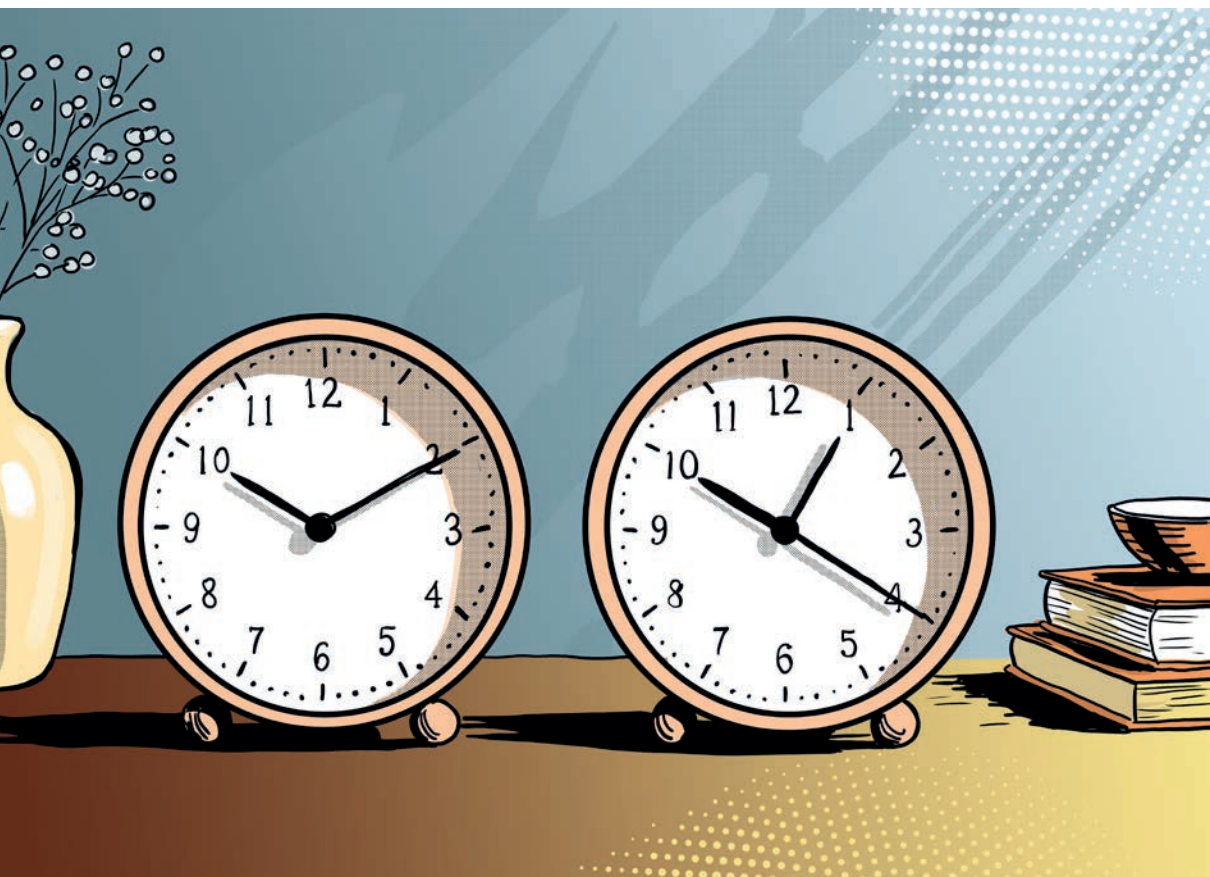
Postpartum: Why Support Matters

- *higher relapse risk*
- *importance of sleep and support*
- *need for monitoring*

✓ *Early planning is protective*

5.5

Why do partners sometimes feel out of sync in their lives and expectations?



“Not perfect solutions, but honesty, patience, and flexibility.”

Elena:

Dr. Stein, there is something many couples experience but rarely say openly.

Sometimes, it feels like the two partners are no longer moving at the same rhythm. One is trying to stay afloat, while the other is ready to move forward with life, plans, intimacy, or even the idea of having children.

And partners sometimes ask a very difficult question:

“I have to live my life... but he doesn’t understand. How long am I supposed to wait?”

How should we understand this?

Dr. Stein:

That is a very real and important question.

And it deserves to be said openly, because many partners feel this, even if they don’t always express it.

In clinical practice, we see this situation often.

When someone goes through a difficult phase of illness, many areas of life can slow down at once: health, energy, plans, work, and confidence. People sometimes describe it as feeling “underwater,” trying to keep up with everything.

At the same time, their partner may still be moving forward, with their own rhythm, their work, their personal goals, their need for closeness, and intimacy.

Elena:

Both partners are under pressure, but in different ways, and sometimes neither of them feels fully understood.

Dr. Stein:

Indeed.

The person who is struggling may feel:

- guilty for slowing things down
- afraid of holding the relationship back
- uncertain about their future

And the partner may feel:

- the need to continue their own life
- the tension of waiting without knowing for how long
 - and sometimes a quiet conflict between love and their own needs and expectations

Elena:

And that question, “How long do I wait?”, doesn’t have a simple answer.

Dr. Stein:

No, it doesn’t.

But it’s important to say this clearly:

Wanting to live your life is not selfish. It is natural. Even if it sometimes feels that way.

At the same time, the other partner is not choosing to slow things down. They are often doing everything they can just to regain balance.

In many ways, **both partners are going through a form of trial, just in different directions.**

Elena:

That makes the situation more understandable, but still difficult.

Dr. Stein:

Yes, and this is where relationships require something very human, and that is not always easy, even in strong relationships.

Not perfect solutions, but **honesty, patience, and flexibility.**

What helps is not forcing the same rhythm, but recognizing that:

- sometimes one partner carries more
 - sometimes the other does
- and this can change over time

Elena:

The relationship doesn’t need to stop, even if the pace changes.

Dr. Stein:

Couples can still move forward, even if not at the same speed.

What helps is:

- speaking openly about fears and expectations
 - avoiding silent pressure or guilt
- making decisions step by step, not all at once
 - and keeping a sense of shared direction

With time, support, and appropriate care, many people regain energy, stability, and confidence.

And when that happens, **couples often find their rhythm again, sometimes differently than before, but still together.**

Clinical Story

“Protecting both, step by step”



Note: The clinical story in this chapter is created for educational purposes. Names and identifying details do not represent specific individuals.

Elena:

Dr. Stein, in this chapter, we’ve talked about planning and preparation.

But real life is often more complex. What happens when pregnancy occurs while treatment is already ongoing?

Dr. Stein:

That’s a **serious and very realistic situation**.

I’m thinking of a woman in her late twenties who has been stable for several years. She was in a supportive relationship, working part-time, and feeling that her life had become more predictable. Her partner was also at a moment in life where he was thinking about the future, about building something stable, about having a child, about moving forward.

But he also felt something he found difficult to say out loud:

“I want us to move forward... but I don’t know how long we have to wait.”

It wasn’t a lack of commitment. It was the tension between love and the natural desire to continue life as planned.

When she discovered she was pregnant, her first reaction was not joy, but fear.

She later said she felt both at the same time.

Elena:

Fear of the illness returning?

Dr. Stein:

Yes. And also fear of the unknown.

She asked:

“Should I stop treatment? Will it harm the baby? What is safer?”

These are questions many women face.

Elena:

Stopping treatment is not always the safest choice?

Dr. Stein:

In this case, after careful discussion and monitoring, treatment was continued. The pregnancy was followed closely, with collaboration between psychiatric and obstetric care.

Over time, something important happened.

The fear gradually shifted into confidence, not all at once, but step by step. And for both of them, something else shifted as well, the sense that they were no longer waiting for life to begin, but building it together, even if the pace had been different for a while.

Elena:

Confidence in the plan?

Dr. Stein:

Yes, and in herself.

She once said:

“I realized this wasn’t about choosing between my health and my baby.

It was about protecting both, step by step.”

Elena:

That’s a powerful shift.

Dr. Stein:

It is.

The pregnancy progressed without major complications, and after delivery, careful follow-up helped maintain stability during the postpartum period.

Pregnancy during schizophrenia is not a situation of “either-or.”

With careful planning and medical guidance:

- stability can be maintained
- risks can be managed
- and informed choices can support both mother and child

Closing Reflection

Elena:

This is not about risk alone, it's about preparation.

Dr. Stein:

Fertility and parenthood are not defined by diagnosis alone, but often accompanied by questions, doubts, and important decisions.

With the right support, information, and planning, individuals can make decisions that reflect both their **health and their life goals**.

References

Montejo AL, Montejo L, Baldwin DS. The impact of severe mental disorders and psychotropic medications on sexual health and its implications for clinical management. *World Psychiatry*. 2018;17(1):3-11.

González-Rodríguez A, Monreal JA, Natividad M, Cobo J, Palacios-Hernández B, Susser LC. Reproductive and Fertility Care of Women with Schizophrenia: A Narrative Review. *Healthcare*. 2025;13(18):2349.

Sisodia S, Hammond Z, Leonardi-Bee J, Hanlon C, Asher L. Sexual and reproductive health needs of women with severe mental illness in low- and middle-income countries: A scoping review. *PLoS one*. 2025;20(1):e0311554.

Tort-Nasarre G, Galbany-Estragués P, Saz Roy MÁ, Romeu-Labayen M. Sexual and Reproductive Healthcare Provided to Women Diagnosed with Serious Mental Illness: Healthcare Professionals' Perspectives. *Nursing Reports*. 2025;15(4):119.

National Institute for Health and Care Excellence. *Antenatal and postnatal mental health: clinical management and service guidance* [Internet]. London: NICE; 2014 [updated 2025; cited 2026 Aug 21].

Kang S, Yang JS, Yun BH, Gelaye B, An SK, Jung SJ. Antipsychotic continuation during pregnancy and risk of postpartum relapse in women with schizophrenia: nationwide register-based study. *The British journal of psychiatry: the journal of mental science*. 2025;227(3):614-621

Herold R, Tényi T, Herold M, Tóth T. Cariprazine maintenance treatment during pregnancy – a case report. *Frontiers in Psychiatry*. 2024;15:1421395

NOTES

NOTES



This book gives voice to the deeply human side of living with schizophrenia - the need to feel understood, loved, close to others, and hopeful about the future.

It follows the personal questions that often remain unspoken, showing how care, trust, and honest communication can help people and families protect connection, dignity, and the possibility of a meaningful life together.



Farma Media

ISBN: 978-606-9696-17-0