PERCEPÇÕES CONSTRUÍDAS EM TORNO DA SEXUALIDADE DE HOMENS COM TRANSTORNO AFETIVO BIPOLAR E DESAFIOS NAS PRÁTICAS DE CUIDADO EM SAÚDE

Perceptions constructed around sexuality of men with bipolar affective disorder and challenges on health care practices

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ABSTRACT: Promoting sexual health in people diagnosed with bipolar disorder (BD) is a priority in their mental health care. In this work, analyzed perceptions constructed around sexuality of men diagnosed with bipolar disorder, as well as challenges in care practices related to men's sexual health. The perceptions of people with BD and health professionals are analyzed, based on a qualitative methodology with a phenomenological design and through a reflective analysis of social discourse. To this end, a semi-structured interview was conducted with 12 mental health professionals, 7 men with BD, and 2 focus groups. An analysis of the contained inductive theme was carried out and ATLAS.ti was used for the information process. Among the main results, it was identified that mental health professionals perceive that the main problem of a sexual nature in these men is the alteration of sexual functioning and impulse control, manifestations considered as part of the symptoms related to bipolar disorder. Therefore, care practices for sexual health are limited to the control of episodes related to the disease. Men, seeing that there is no real attention to their sexual health, tend to use alternative non-prescription drugs to improve sexual functioning or stop

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taking psychiatric drugs that are associated with decreased sexual functioning and desire. In the same vein, it is identified that sexual health interventions are linked to social norms that reproduce hegemonic masculinity and that limit the true understanding of the priorities that these men live.
Keywords: Mental health. Sexual health. Bipolar disorder. Men's health.

RESUMO: Promover a saúde sexual em pessoas com diagnóstico de transtorno bipolar (TB) é uma prioridade para os cuidados de saúde mental. Neste trabalho analisamos as percepções construídas em torno da sexualidade de homens com diagnóstico de TB, bem como os desafios nas práticas de cuidado relacionadas à saúde sexual masculina. São analisadas as percepções das pessoas com transtorno bipolar e dos profissionais de saúde, com base em uma metodologia qualitativa com desenho fenomenológico e por meio de uma análise reflexiva do discurso social. Para isso, foi realizada uma entrevista semiestruturada com 12 profissionais de saúde mental, 7 homens e 2 grupos focais. Foi realizada uma análise de conteúdo temática indutiva. Dentre os principais resultados, identificou-se que os profissionais de saúde mental percebem como principal problema de natureza sexual nesses homens, a alteração no funcionamento sexual e no controle dos impulsos, manifestações consideradas como parte dos sintomas relacionados ao transtorno bipolar. Portanto, as práticas de atenção à saúde sexual limitam-se ao controle dos episódios relacionados à doença. Os homens, vendo que não dão atenção real à sua saúde sexual, tendem a usar medicamentos alternativos sem receita para melhorar o funcionamento sexual ou a parar de tomar medicamentos psiquiátricos associados à diminuição da função sexual e do desejo. Na mesma linha, identifica-se que as intervenções em saúde sexual estão vinculadas a normas sociais que reproduzem a masculinidade hegemônica e que limitam a verdadeira compreensão das prioridades que esses homens vivem.
Palavras-chave: Saúde mental. Saúde sexual. Transtorno bipolar. A saúde dos homens.

1 BACKGROUND

Globally, mental disorders are a major cause of morbidity and disability and can cause people to die 10 to 20 years earlier than the general population (WORLD HEALTH ORGANIZATION, 2018). In the Latin American and Caribbean region, it has been estimated that the prevalence of mental disorders varies between 18.7% and 24.2% (PAN AMERICAN HEALTH ORGANIZATION, 2023); in Mexico, the prevalence of any mental disorder in a lifetime is 26.1% (MEDINA-MORA et al., 2007). Bipolar Disorder (BD) is placed among the main causes for disabilities in the world (VIETA et al., 2018). A meta-analysis based on 25 studies finds that pooled lifetime prevalence of BD type 1 was 1.06% (95% confidence interval [95%CI] 0.81-1.31) and that of BD type 2 was 1.57% (95%CI 1.15-1.99) (CLEMENTE et al. 2015), and according to the last National Survey of Psychiatric Epidemiology (NSPE) in Mexico it is of 1.9% (OFICINA DE INFORMACIÓN CIENTÍFICA Y TECNOLÓGICA PARA EL CONGRESO DE LA UNIÓN, 2018).

People with BD face, daily, adverse effects of the illness which affects different areas of their life: emotional, academic, family, and social (AMERICAN PSYCHIATRIC ASSOCIATION, 2013); in addition to the social stigma that delineates care-spaces, disease management and even their sexual life (JACKSON-BEST; EDWARDS, 2018; MONTEJO; MONTEJO; BALDWIN, 2018). Relating to the last point — sexual health —, symptomatology associated to the illness has been recorded such as sexual recklessness, increase in sex drive, sexual indiscretions and loss of or decreased libido (LATIN AMERICAN PSYCHIATRY ASSOCIATION, 2012).

Research studies indicate that people with BD are comparatively more vulnerable to sexually transmitted diseases (STD) and HIV than THE general population as well as people with other affective disorders (GALARZA-TEJADA; CABALLERO-HOYOS; RAMOS-LIRA, 2017). Most of the studies mention greater risks to this group of people, However, It is necessary to specify the social conditions that are involved in the greater risk in said population. Two of the works indicate that rules in socialization of sexual roles create limiting effects for the development of preventive practices based in the partner's interaction (COLLINS; VON UNGER; ARMBRISTER, 2008; AGÉNOR; COLLINS 2013). Another research indicates that women with BD were significantly more sexually distressed in comparison with Danish women from

the background population, but they did not have a higher prevalence of impaired sexual function (SØRENSEN; GIRALDI; VINBERG, 2017)

A research study conducted between men and women diagnosed with BD indicates that people with this condition experience: a) an increase in activity and sexual desire during mania and hypomania episodes, b) a decrease in sexual activity during depressive episodes or because of medication consumption; furthermore, their sexual health becomes vulnerable by being exposed to sexual regulations attributed by genders (GALARZA-TEJADA; CABALLERO-HOYOS, RAMOS-LIRA, 2013). Relating to sexual functioning, it has been recorded that one third of BD patients experience sexual dysfunction when medicated with lithium, which is also blamed for bad medication adherence (GROVER et al*.,* 2014).

The relevance to deepen on processes of sexual health care of this group of people is clear and has been reported as a priority in the context of mental health care (MONTEJO; MONTEJO; BALDWIN, 2018); however, it is similarly important to understand normative structures of male sexuality and their impact in the promotion/care of sexual health in population of males with BD. According to Connell, gender is a way to structure the social practice and social processes that shape and in turn perpetuate what he named “hegemonic masculinity” (CONNELL 2005).

Based on the assumptions described, the present study’s aim was to understand the perceptions being constructed around sexuality of men with BD and the challenges over their care practices on sexual health. All of that comes from a reflexive analysis of social discourses of both men diagnosed with BD and mental health professionals.

2 METHODS

A qualitative study was done under the phenomenological approach of social construction of reality, so inductive procedures were included to formulate interpretations based on perceptions of social actors and their experiences (BERGER; LUCKMANN, 2006).

The study was conducted at two mental health care institutions and at a Civil Association — a non-profitable organization — in Guadalajara, Mexico.

Individual semi structured interviews were done to mental health professionals, and later on, we requested records to contact men diagnosed with BD. Each interview of men with BD was done in depth and within their housing context, in the focus groups inside the association's facilities; some men participating in focus groups were individually interviewed to go deeper.

The sample was purposive and that allowed us to maximize opportunities to discover variations among concepts, so we could make denser categories in terms of their properties and dimensions (TEDDLIE; YU, 2007). According to the purpose of the study, informants with the following criteria were selected:
Men diagnosed with bipolar disorder

- Ages between 20 and 35 years (young and young adults).
- Those diagnosed with the disorder for at least 3 years before the interview (temporality with the diagnostic allowed informants to have experience and knowledge on the disorder and a greater contact with health services).
- Those getting psychiatric care
- In euthymic and with illness stability at least for three months[1] (just to be sure that the participant could be interviewed).
- Professionals of mental health
- Health professionals closely and frequently working with people diagnosed with BD.
- Professionals who were highly interested or were specialized on the treatment and offered psychiatric care to people with BD
- Professionals of mental health who were part of one of the institutions, whether practice in private office

For techniques of information collection, we used participant observation in therapeutic groups within the association (MELLA 2003), focus groups (YIN 2010) Semi-structured and mainly in-depth interviews (MELLA 2003; MUÑOZ 2003) and recording information in a field diary.

Transcriptions were revised to guarantee the transcription quality, so they can be analyzed later on.

For the analysis of the information, inductive thematic content analysis procedures were used. The coding of the information implied the reading of the texts and their fragmentation into themes (HSIEH; SHANNON, 2005). Four

major categories were identified that include different perceptions regarding the social and cultural challenges faced by men with bipolar disorder regarding the exercise of their sexuality: 1) Perceptions of mental health Professionals: wait until medication works… 2) The absence of my sexual desire terminated a couple of relations 3) Anyone becomes more uninhibited 4)To be a man. To be a real man! In the end, an interpretative synthesis was built based on the relationships of the themes of the categories. Data organization was done using Atlas.ti 7.

This work maintains the anonymity of the participants and the institutions in which they work. Authorization in writing and under informed approval was requested to both the informants and a witness chosen by them. Before the interviews, medical doctors and psychologists, taking care of the informants daily, were contacted; just in case reference is needed.

3 RESULTS

The following are the findings obtained from four categories, which are accompanied by textual quotations taken from the interviews and focus groups.

Perceptions of mental health Professionals: wait until medication works…

A semi-structured interview was conducted to 12 mental health professionals, 4 ones of psychiatry, 6 ones of psychology and 2 ones of nursing (see table number 1).

Table 1. Interviewed health-professionals (2018)

Pseudonym	Profession	Sex	Institutional Sector where they mainly work
PF1	Psychiatry	Female	Public Institution
PF2	Psychiatry	Female	Public Institution
PM1	Psychiatry	Male	Public Institution
PM2	Psychiatry	Male	Public Institution

PSF1	Psychology	Female	Public Institution
PSM1	Psychology	Male	Public Institution
PSM2	Psychology	Male	Civil Association
PSM3	Psychology	Male	Civil Association
PSM4	Psychology	Male	Private Stay
PSM5	Psychology	Male	Private Stay
EM1	Nursing	Male	Public Institution
EM2	Nursing	Male	Public Institution

Source: table prepared by the authors (2020)

Health professionals mention an impaired sexual functioning of men with BD; they perceive them as problems or sexual "nuisance" derived from the disorder and some medications administered to treat BD. During depression, a lack of interest in sexual activity is identified; during mania, they say that impulsivity and risky conducts are common. Furthermore, when using antidepressants, erectile dysfunction may be present.

> ***PF1****: (…) in bipolar disorders of the bipolar spectrum, they can be impulsive; lack adequate judgment and have risky conducts.*
>
> ***PM2****: A patient who is being treated with antidepressants may have some erectile dysfunction, loss of sexual appetite, then hmm… when they start; when they are in a depressive episode, they more likely are uninterested in having sexual activity but once they get recovered than they start being interested, but they cannot! Because the medication may cause that as a secondary effect (referring to erectile dysfunction), then… it starts being a nuisance, it starts to be a problem when dealing with it, alternatives must be found etc.*
> *Reduction in sexual activity may cause problems with the partner.*
> ***PF1:*** *What comes from them is… if there is a problem when having sexual activity, some say — "is because my woman complains" — or — "my woman has asked me if I am seeing another woman"-.*

Besides alterations in activity and sexual desire, according to professionals, cognitive alterations and impulse control may appear such as a combination of symptoms that may bring out risky conducts that lack a reflection process. A psychologist indicates that after the episode, when symptomatology stops, then men reflect about what happened and feel remorse, something referred to as “moral hangover”.

> ***PSM1****: when they are in mania or have a lack of impulses control, for example, they have no limits to precisely know about the risk they take! That means, At that moment there is no ability, common sense nor logic helping them to determine — “How will I go to bed or have sexual contact with that person that I just met?” […] Generally, until the euphoric stage or impulses end, it is when they reflect and fall into remorse and a moral-hangover.*

Health professionals implement some interventions to improve sexual health and avoid risks; most of them are oriented to handle medications, especially to avoid erectile dysfunction. Just a little is spoken about other interventions that support a partner's dynamic or over psycho-education-processes that allow both partners to understand what really happens.

> ***PM2****: (…) there are medications causing a problem in a lower percentage; a change of medication may be tried, and if even after changing medication the patient continues having the problem, then the patient… so we can use this one… a medication for erectile dysfunction.*

Care measures during manic episodes, when having the presence of symptoms such as hyper-sexuality and disinhibiting, are also referents to the handling process with medications.

> ***PF2:*** *When they are in an acute phase in which they are hyper-sexual, disinhibited, well, generally it is a patient that will be here hospitalized and obviously here, hmm… men are over here and women over there, everybody is separated and obviously all we have to do is wait for medications to work.*

When talking about public institutions, both tests for HIV or pregnancy detection are the measures recognized as prevention and are mostly used when patients present risk factors.

> ***EM1****: We have patients who have the psychiatric disorder plus HIV, so… when we see that the patient has the risk factor, we require serology, but all what you have to say is "You know what? … You have HIV".*

In the private health sector, psychologists explain that the way to promote sexual health is by controlling sexual practices with help coming from relatives, and, if needed, they must be held back when these practices are considered as BD symptomatology.

Sexual health promotion is not valued as an urgent aspect when dealing with BD; health professionals require implementing intervention-strategies when the person needs it or when it is evident around symptomatology. A psychiatrist who works at a public institution and in the private sector, shares his/her interest on a psycho-educative project where topics are discussed on sexual and on the inherent risk of the symptomatology.

> ***PF2****: hmm, Sexuality… is one of those things that must be worked in groups as part of the risk. It is crucial; just imagine a patient with bipolar disorder and HIV.*

Health professionals perceive higher risks for sexual health and especially for HIV transmission to those men with BD; those at a high socio-economic level, capable to have access to sexual practices with multiple partners.

> ***PF2**: because they are people who can pay for prostitutes; they are people who can have money and have more intimate girlfriends. If we go with a peasant, the mother knows, the whole ranch knows and if he gets sexually involved with the ranch's prostitute, he will pay for the consequences, won't he? He does not have money to commute, no money to pay with.*

Socio-economic and structural conditions influence on the risk prevention of this population as well as on the perception we have on these population-groups. Other factors considered as risky are: a lack of care opportunities for the most disadvantaged groups and people without a family support network.

> ***PF2**: Now, I have a patient facing such luck (referring to HIV) and we had already dealt with the matter, unfortunately he is a person from a precarious environment and without a family support network. He used to work as a construction worker and no matter how much he made as salary, he never provided any money to the family; he spent it with women until he started to get thinner… he was asked to be checked through laboratory analyzes and finally was diagnosed positive with HIV.*

It is unlikely to get information about sexual health within the institutional context. Time and the psychiatrist's perception over what really matter during a visit to the doctor are factors that intervene in the limited information. Furthermore, interventions to promote sexual health privilege pharmacological management for the symptomatology's control and put aside identity, social influence and gender rules that determine sexual activity.

The absence of my sexual desire terminated a couple of relations

Because of the contexts in which the sample was taken, we included men of medium and medium-low socio-economic level in the focus groups (see table number 2).

Table 2. Sociodemographic Characteristics of focus groups' participants (2018)

Pseudonym	Academic Level	Age	Time with BD	Civil-Status	Institutional Sector where gets attention	Working activity
RE	Degree	24	3	Single	Private Institution, Private health care and Civil Association	Activity related to training in the health sector
JE	Incomplete Degree	34	8	Married	Private Institution, Private health care	Administrative activity in commercial sector
OM	Degree	36	6	Single	Public Institution, Private health care and Civil Association	Self-employed family business
TJ	Incomplete Degree	46	13	Divorced	Private Institution y Civil Association for Anonymous Alcoholics	Support at the Civil Association
TR	Jr High School	24	5	Single	Public Institution	Support at informal Family business
AL	Incomplete High School	25	2	Single	Public Institution, care at Drugs Abuse detoxification Center	None
SG	High School	49	11	Divorced	Public Institution and Civil Association	Own Business and Civil Association
JP	High School	32	7	Married	Civil Association	Sales in Commercial Sector
HU	Elementary	22	3	Single	Public Institution, care at Drugs Abuse	None

					detoxification Center	
AR	Incomplete Degree	53	18	Divorced	Private Institution	Scenic Arts

Source: table prepared by the authors (2020)

Men say that the main problem related to their sexual health is the lack of both “libido” and “sexual activity” during depressive episodes. This is in-line with the care request that psychiatrists continuously get. An interesting point is that the request made to psychiatrists is based on the demand of patients’ sexual partners and social influence. Now, it is relevant to mention that difficulties in sexual activity during depression are linked to other partner-related problems, and it affects the masculine social image.

> ***TJ**: […] problems like these with the partner, serious… that you are in tremendous depression; your partner tells you “you do not want anything, not even me nor working; you are a lazy-bum, or you do not even want to try”. Deep down you feel a lot of impotence, and you even want… I said so many things that were kept in my mind and then told her “once I recover I promise I will go away from here”.*

Men talk about their difficulty to explain to their partners that the lack of desire they experience is because of their illness and not because of a dynamic issue with their partner. A young man indicates that the partner can be a support, but if the partner does not know what really happens in their sexual life when he is in a depressive episode, it may create a conflict.

The participants mentioned experiencing vulnerability in their sexual practices when they manifest episodes related to bipolar disorder. Men try to hide the difficulties they identify in their sexual life and when discovered by their sexual partners, they feel exposed and betrayed in their trust.

> *OM: when I was in my depressive phase, the first sexual situation was pushing me by my partner… I delivered my whole trust and believed that she was a good person and even thought she would*

not notice my illness. Then it was very hard for me to have sexual contact, so she noticed that.

Within the care context, the use of medication is a condition, which has minimally been analyzed from the point of sexual and reproductive health, however, it has important implications in the lives of men with bipolar disorder. Sometimes men decide to carry out self-care practices not supervised by a health professional, due to the lack of guidance from the health workers.

JE: One day I had erection problems, that is something psychological, right? so I self-medicated myself with Cialis! (Medication used for erectile dysfunction), I said, "no", how can that be at my age?, I visited my doctor and said:

— Listen to me doctor, I have this problem

— Yes, do not worry, it is because of Citalopram (antidepressant),

— Yes, but…

— Are you married?

— No

— So, why do you worry?

— Well (smiles)

— You do not have obligation, why do you worry about? No, no, immediately, you better worry about being stable, then you worry about anything else

I told myself, "yea, right". I had problems with that, then with Sertraline.

Some men who blame medication for causing alterations in sexual activity, they don't self-medicate; they prefer to stop taking the medication at all.

Anyone becomes more uninhibited

At this point, men agree that there is a growing sexual desire and disinhibiting during the manic episode; however, they differentiate the ease to be sexually involved with partners from having risky sexual practices; these are

attributed to other factors. Mainly they allude to masculinity the greater sexual desire, compared with women.

> ***TJ:*** *But it is so easy to get involved with a woman, well, even with men, right?, but this is not my case. I am very repressed (smiles).*
>
> ***JP:*** *right, we become more disinhibited, we dare more to get closer to gals, or, hmm… you try to hook up with them and, as SG says, I believe that it has to do with everyone's personality, right? That means, if you are a very open person or clearly accept promiscuity and that, well, you will do it, right? But not necessarily because you are bipolar, that if… let's say that it is, come on, a sparkle.*

For men, sexuality is natural under the idea of "eroticized mind"; for them, this "masculinity quality" of eroticism legitimated in a joke is related with the animal instinct.

> ***SG*** *(adult man): at least I can permanently be with my eroticized mind, even if I am not in a sexual relationship, like in this case that I have been apart from my wife for three months; but my mind is eroticized, just like dogs at the butcher's, they just see meat, and they let little-tears run down.*
> ***AL*** *(adult man): I have heard a joke, says that a woman thinks of sex once a day, while a man just thinks of it all day long. I will not say that it is just like that, but obviously, I agree.To be a man. To be a real man!*

To be a man. To be a real man!

To be a real man" or "to be the man of the house" were daily expressions among the interviewed men, as a masculine identity which must be accomplished. Most of the interviewees did not know how to define the expression, the majority explained it as being "the real man", not only as an

image desired by social recognition but also as a man who is not very expressive of his emotions.

> ***TR:*** *The real man is like that… the real one, hmm, who is not afraid, who has a strong temper, gives himself, is hard working oriented, courageous, the family's backbone and things like that, right? Because that is the image more or less, and my father in some way met that criteria. The only thing is that he was emotionally weaker than my mom, but he had the rest; then, my father's image was not ugly, he just did not provide security emotional; that means, I wish my father had told me "son, I love you very much, let me give you a hug", "happy birthday or merry Christmas", nothing, a very rare style; I have no idea where it came from. I do believe that he was like that, not because he was a bad person.*
>
> *The search for recognition leads men to demand themselves and see their intentions frustrated to reach the ideal concept of "being the man of the house".*

> ***JE:*** *I believe that what I expect from myself generates a lot of conflict for me, my demands pushed me into emotional states that are not very pleasant, hmm… I like to say, "I am the man of the house providing money sufficient".*
>
> *As it is explained by one of them, expressing feelings is difficult, even when they are men experiencing episodes in which their emotions are altered; they try hard to hide feelings the most they can.*
>
> ***HU:*** *It is hard for me to cry, something forceful has to happen, strong, for… of course I cry. One day I cried, I mean, I stamped my mom very hard and started feeling guilty and then ran up here; the only thing I found… I took shelter in thinner and started inhaling it.*

The same deficiency to express emotions is identified in other men, companions, relatives, or friends.

> ***OM:*** *to be honest, I do not see my friends being expressive, all that they express is anger, annoyance … I have seen two of my friends cry, one of them was drunk, and the other one was talking on the phone to his girlfriend.*

An attempt to show affection among men is interpreted out of what is expected to be a “man”.

> ***HU:*** *what happens is that I went to Plaza Patria (a shopping mall) with my uncle, and I do not know now … I hugged him, then he told me: — “No! We look like gay” -.*

Some men mention that the symptoms associated with bipolar disorder, denote the lack of the attributes expected towards them, in their masculinity, which is why they prefer to cover up their feelings and move away, instead of expressing it to their romantic partners.

> ***JE:*** *When I experience such depression or those moods, I clearly lose clarity, I stop, I don't even know myself, I do not know who I am. At some times, I am very confident and capable and can speak, and also am strong; on the other side there is a time in which I am powerless, a coward, with nothing, that means, all-afraid. Then, the first, this first relationship that I had, hmm… I discredited myself, right? She wanted to be with me in a good and formal way, in all possible ways; but I was terrified, and I never told her “I am afraid” or things like that, hmm, I avoided her, and then she got in despair, and we stopped seeing each other. I would not tell her, she would probably say, “What a coward you are ".*

For men, experiencing fear, abulia, anhedonia and recurrent feelings of worthlessness is like breaking with the expected social rules.

> ***OM:*** *A man, in all cases that I have seen, including mine, easily bends his hands because we as a man said: "How can it be that I am afraid to go out on the street? I am a man".*

Suicide is the extreme way of self-destruction; it is the most frightening risk experienced by patients and their families. In this way, the attempt is a manifestation of self-destructive behaviors, which are experienced by people with this illness when there are moments of uncertainty, and despair related to what is socially expected from them as men.

> ***JE:*** *I thought a lot about emotional instability, I said, "well, let see what I reach; if I want an important position, whenever I experience mania, what will I do in a meeting? I will go crazy talking and talking, ignoring points of view that are different from my own. On the other hand, if I am in depression, I will not talk, and I will feel lots of fear, so what future do I have! And I did think about that like three times on different days, about the plan, but I never got the guts!, I said (lowering the voice) "no, that is not the way".*

It is well known that feelings of uselessness and guilt are clinically considered as part of depression; however, among these men suffering goes beyond the illness itself; it represents an existential paradox, surrounded by a cultural halo.

A possibility of pregnancy represents a moral and economic responsibility, the desires to become parents, at times, are guarded by insecurity caused when being aware of a mental suffering and by implications that this disorder's constructions have for their life.

> ***RE:*** *Having children frightens me because of the matter of emotional stability; I see these kids playing (pointing at some kids playing at the garden where the interview was taking place) and imagine myself with my children, being all depressive and say, how will I do that?*

4 DISCUSSION

A variety of clinical and epidemiological studies point out the risks and problems that affect the sexual health of people with BD. Some research indicates that the use of medications, the symptoms associated with the disease, and sociocultural regulations limit the possibilities of care to improve the sexual life of these people. However, few studies have analyzed perceptions socially constructed around sexuality of men diagnosed with Bipolar Affective Disorder. This study shows how social perceptions derived from gender norms are reproduced and shows how they affect health care practices.

On the one hand, men with bipolar affective disorder perceive some difficulties related to their sexual health and that repercute in the management of mental health. For example, the use of some medications without prescription, the lack of information on the symptomatology related to the decrease or increase in sexual desire and little or no sexual healthcare in the outpatient clinic.

Previous studies have argued that the lack of attention to sexual health and a deterioration in the couple's relationships affect the management of mental health in patients with depression (ÖSTMAN, 2008) the same seems to occur in people diagnosed with BD.

Although this evidence is not a finding, since it has already been widely described in clinical theory, there are unfortunately no proposals for sexual health care that are sensitive to the sociocultural conditions of people with mental disorders.

The study shows that the perceptions of men and health professionals reproduce in their discourses the social norms of gender that favor the search for prestige and the dominant and powerful masculinity. There is an urgent need to include discussions on gender equality and sexuality in health professionals' training and activities (NASCIMENTO; UZIEL; HERNÁNDEZ, 2018).

In the case of these participants, the limited expression of emotions as a result of gender norms becomes a problem. Research indicates how gender regulations can raise a mental anguish that ends in depressive symptomatology (VALKONEN; HÄNNIEN 2012).

At this point, we must emphasize the importance that men give to the expression of emotions in their relationships as a couple and not only the importance of sexual functioning in biological terms. As has already been discussed in other studies in which men's perception and attitudes about sexual functioning are deepened (NIMBI et al. 2020).

Kaufman (1997) warns that hegemonic acquisition in masculinity is constructed in a swinging movement between sociocultural expectations and — he adds up to the proposal — oneself implying unconscious matters eliminating emotions, needs, and possibilities such as female qualities. In repeated occasions the participants related the impossibility to comply with the rules attributed to his gender about sexual practices with the condition have been depressive or medicament be used.

Even health professionals confirm in their speech the norms of gender that are not reached or ignore their need and demand for attention to their sexual health.

It is understood that the problem is not only sexual functioning in biological terms, but also what represents for him his sexual and reproductive health at the social level.

Thus, the intervention should not only circumvent the condition in its sexual functioning through pharmacological treatment. But in a psychological intervention that involves the couple and critically discuss the gender norms that limit the expression of their sexuality and their emotions.

Psycho-educative interventions ignoring gender norms that are involved in sexual practices will be little effective. Similarly, we consider necessary to carry out a profound study about male gender rules that may result in other potential risks such as suicide. It is a dimension that was repeated in the discourse of the men interviewed, and that was related to the suffering caused by the problems in their sexual life and relationships. A study conducted in Turkey documented that sexual dysfunctions were significantly associated with suicide attempts of BD patients, and the constant changes of sexual partners were significantly associated with thoughts of death. (DELL'OSSO et al. 2009).

5 FINAL REMARKS

The results cannot be generalized to the population of men with bipolar disorder, however, the constructionist approach (which implied the use of various data collection techniques, various sources of information and analytical procedures), allows us to highlight that the results do they can be transferable to sociocultural spaces under similar conditions. In particular, we can speak of transferability in those results that coincide with other empirical studies that have addressed the issue of sexual health in men with bipolar disorder.

Nursing, medicine and psychology professionals try to provide the most appropriate treatments to improve the quality of life of people diagnosed with BD. They have knowledge about the effects of some medications, the impact of symptomatology on sexual life, and the importance of sexual and reproductive health for their patients. However, they reflect little on the role of social perceptions in therapeutic management and decision-making in clinical intervention.

It is recommended to begin with an understanding of the importance of sexual health on social interaction and the wellbeing of patients. It is also important to begin a reflexive process on the reproduction of social perceptions derived from the gender norms that affect mental health care treatments.

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