PARTICULARITIES OF FAMILY PLANNING IN WOMEN WITH MENTAL DISORDERS

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The study aimed to identify the gynecological and obstetric profile of women with mental disorders; to verify the association between medical diagnosis of mental disorder and correct/incorrect use of contraceptive methods, and verify diagnoses, frequency of hospitalizations and varieties of medication consumed. Participants were 255 women who received care in a Psychosocial Care Service. Data were collected through medical record review and structured interview. The inheritance of some mental disorders, psychiatric hospitalization as the cause to interrupt contraception, use of contraceptives that do not depend on personal control, drug interactions between psychotropic drugs and oral contraceptives; participation of the partner and/or relatives in the reproductive choice and contraceptive practice were particularities of this target audience in family planning. There was no statistical association between medical diagnoses and correct or incorrect use of contraceptives. Women suffering from mental disorders need specific and comprehensive family planning care.

DESCRIPTORS: women; mental disorders; family planning

PARTICULARIDADES DE LA PLANIFICACIÓN FAMILIAR DE MUJERES PORTADORAS DE TRASTORNO MENTAL

Se tuvo como objetivo identificar el perfil ginecológico y obstétrico de mujeres portadoras de trastorno mental, verificar la asociación entre diagnóstico médico de trastorno mental y uso correcto/incorrecto de los métodos anticonceptivos y verificar diagnósticos, frecuencia de internaciones y variedades de medicamentos consumidos. Participaron 255 mujeres atendidas en un Centro de Atención Psicosocial. Los datos fueron recolectados por medio de revisión de fichas y entrevista estructurada. La hereditariedad de algunos trastornos mentales, la internación psiquiátrica como causa de interrupción de la anticoncepción, el uso de anticonceptivos que independen del controle personal, la interacción medicamentosa entre psicotrópicos y anticonceptivos orales, la participación del compañero y/o de familiares en la elección reproductiva y la práctica anticonceptiva, constituyeron particularidades en el planificación familiar de ese público. No hubo asociación estadística entre los diagnósticos médicos y el uso correcto o incorrecto de los métodos anticonceptivos. Las mujeres portadoras de trastorno mental presentan una demanda para la atención de la planificación familiar específica e integral.

DESCRIPTORES: mujeres; trastornos mentales; planificación familiar

PARTICULARIDADES DO PLANEJAMENTO FAMILIAR DE MULHERES PORTADORAS DE TRANSTORNO MENTAL

Objetivou-se identificar o perfil gineco-obstétrico de mulheres portadoras de transtorno mental, verificar a associação entre diagnóstico médico de transtorno mental e uso correto/incorreto dos métodos anticoncepcionais e verificar diagnósticos, frequência de internações e variedades de medicamentos consumidos. Participaram 255 mulheres atendidas em um Centro de Atenção Psicossocial. Os dados foram coletados por meio de revisão de prontuário e entrevista estruturada. A hereditariedade de alguns transtornos mentais, internação psiquiátrica como causa de interrupção da anticoncepção, uso de anticoncepcionais que independem do controle pessoal, interação medicamentosa entre psicotrópicos e anticoncepcionais orais, participação do parceiro e/ou de familiares na escolha reprodutiva e prática anticoncepcional constituíram particularidades no planejamento familiar desse público-alvo. Não houve associação estatística entre os diagnósticos médicos e uso correto ou incorreto dos métodos anticoncepcionais. Mulheres portadoras de transtorno mental possuem demanda para atendimento de planejamento familiar específico e integral.

DESCRITORES: mulheres; transtornos mentais; planejamento familiar

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INTRODUCTION

Family planning (FP) care should provide women, men and/or couples with the necessary information for the free choice and effective use of contraceptive methods that better adapt to their individual conditions[1]. Public policies enforced in recent years have focused on the search for equity, freedom and social justice in female sexual and reproductive health, overcoming prejudices, discrimination and structural problems.

The interface between public women's health and mental health policies need to move beyond official discourse and become practice in care delivery to women with mental disorders. FP of women with these problems, focus of this study, is an example of the need for effective interaction between the mentioned policies. Women with mental disorders are protected by Law n. 9.263, issued on January 12 1996[2], which indiscriminately universalizes the participation of men and women in FP actions and specific mental health policies to recover citizenship, respect differences, autonomy and social inclusion, based on Law n.10.216, from April 6 2001[3].

The current Comprehensive National Women's Health Care Policy (PNAISM) introduces actions targeting specific social sectors, such as women with mental disorders, into the public health network. In its policies, comprehensive women's health care should be guided by respect for differences, without dis-crimination of any kind and without imposition of values and personal beliefs[4].

Delivering care to women in the FP area should be a priority in primary care. Nevertheless, these actions should ensure the equity of sexual and reproductive rights of women with mental disorders. On the other hand, the Psychosocial Care Services (CAPS), also in the perspective of comprehensive actions, should offer biopsychosocial care to women with mental disorders, serving as technical support for primary care teams and vice versa.

Incidence levels of unplanned pregnancies are high among psychiatric patients, due to the frequent lack of insight caused by mental disorders, lack of planning and behavioral control, besides potential medication interaction between hormonal contraceptives and some psychotropic drugs, reducing contraceptive effectiveness[5]. Moreover, these women's maternity performance can be jeopardized by recurrent psychiatric hospitalizations, impaired autonomy and limitations of their self and family care functions. In this perspective, it is relevant to know the particularities of this population's FP, aiming to contribute to a fairer and more human care, complying with legal instruments' determinations on sexual and reproductive rights.

Thus, this study aimed to identify the gynecological and obstetric profile of women with mental disorders; to verify the association between medical diagnosis of mental disorder and correct/incorrect use of contraceptive methods and verify diagnoses, frequency of hospitalizations and varieties of medication consumed, thus characterizing the particularities of FP in this target public.

METHODS

This is a cross-sectional study with a mixed approach. The cross-sectional design permitted data collection at one moment, so as to obtain a momentary and short-term picture of family planning among women with mental disorders. The mixed data collection method involves qualitative and quantitative collection and analysis, integrating the information when interpreting the general results[6]. Qualitative data referred to participants' statements, were organized by the categorical analysis technique[7] and then processed using the Statistical Package for Social Science (SPSS).

The study was carried out at a Psychosocial Care Service (CAPS) in Fortaleza, state of Ceara, between May and August 2007. Part of the data was surveyed in patient files and the remainder was collected through statements during structured interviews. Several statements were included in the discussion section for the sake of illustration, followed by participants' age and medical diagnosis of mental disorder.

The population consisted of 747 women registered in the mentioned CAPS, with a medical diagnosis of mental disorder. To define the sample, significance level was set at 5%, sample error at 6% and ratio at 50%, as this was the maximum sample size after determining significance and sample error. These values were applied in the formula to calculate finite populations, obtaining a sample of 255 women of reproductive age (12 to 49 years) and who have started their sexual life. To analyze the association between medical diagnosis and mental disorder and the use of correct/incorrect contraceptive methods,

the Fisher-Freeman-Halton test was used, with significance level at 5%.

The study followed the Resolution 196/1996 of the National Health Council regarding research involving human subjects. It was approved by the Ethics and Research Committee of the Federal University of Ceara - COMEPE (Protocol n. 81/07). After being informed about the study's objectives and general aspects, participants voluntarily signed the free and informed consent agreement. They were ensured anonymity and access to research information.

RESULTS AND DISCUSSION

Almost half of the women, that is, 119 (46.6%) were at the extremes of reproductive age, represented by 2 (0.8%) up to 19-year-old and 117 (45.9%) over 35-year-old. Educational level was predominantly between 8 and 10 years and from 4 to 7 years of study, corresponding to 67 (26.3%) and 79 (31%), respectively. Only 35 (13.7%) had completed secondary school (11 years or more of study); 114 (44.7%) did not have income or earned less than one minimum wage per month. Most women were housemaids, 179 (70.2%). Only 14 (5.5%) women had a formal job and performed occupational activities. The universe of married women, 119 (46.7%), prevailed over other marital status.

As shown in Table 1, more than half of the women had at least one pregnancy (n=144), of whom 125 (86.8%) had between one and four pregnancies and 19 (13.2%) had more than four. The age of the first delivery varied between 13 and more than 35 years of age, and the longest interval between deliveries was of 20 to 35 years, corresponding to 70 (51.4%) of the sample. Fifty-four (59.3%) reported a pregnancy interval longer than two years, 38 (14.9%) suffered spontaneous or provoked abortion, as 13 (34.2%) and 25 (65.8%) of the participants indicated, respectively.

The gynecological and obstetric profile confirms that the pregnancy of women with mental disorders is a reality. Taking into consideration that these women have problems that can compromise their autonomy, it is essential to provide individual care in family planning, involving partners and other relatives implied in decision-making. Hence, the pregnancy/mental disorder relationship, which is a delicate relationship, would be treated as a sexual and reproductive right of this population.

Partners have are privileged in the deinstitutionalization proposal of the Psychiatric Reform. Thus, men perform an important role in their partner's rehabilitation and, as FP is a choice of the couple, CAPS and primary care service staff should more closely involve them in FP and make them co-responsible for contraceptive practices.

Table 1 – Distribution of the number of women with mental disorder, according to obstetric and gynecological profile. Psychosocial Care Service. Fortaleza, CE, May-August 2007

Variables	n	%
Pregnancies (n=144)		
1-4	125	86.8
>4	19	13.2
Age at first delivery (n=136)		
13-15	9	6.6
16-19	56	41.1
20-35	70	51.4
>35	1	0.9
Interval between pregnancies (n=91)		
> 2 years	54	59.3
< 2 years	37	40.7
Abortion (n=38)		
1	33	86.8
2	4	10.5
3	1	2,7
spontaneous	13	34,2
caused	25	65,8

Table 2 – Distribution of the number of women with mental disorder regarding the planning of pregnancies and contraceptive practices. Psychosocial Care Service. Fortaleza, CE, May-August 2007

Variables	N	%
Planning of pregnancies (n=144)		
Yes	34	23.6
No	47	32.6
Sometimes	63	43.8
Family planning care during the research		
Yes	15	5.9
No	240	94.2
Using contraceptive methods (n=35)		
Oral contraceptive	22	62.9
Condom	11	31.4
Injectable contraceptive	2	5.7
Correct use of the method (n=35)		
Yes	8	22.8
No	27	77.2
Tubal sterilization (n=255)		
Yes	40	15.7
No	215	84.3

According to Table 2, 34 (23.6%) participants reported having planned all pregnancies. Mental disorder influences this situation, which requires partners' and/or responsible relatives' support, who should have access to contraceptive information and methods. These were used by only 35 (13.7%) of the women, while the others were at the risk of an unplanned pregnancy. Supporting this issue, participant 189, 47 years, with bipolar disorder, affirmed: *I only started to take contraceptive drugs after the forth pregnancy*.

Some of the women in the study are aware of medication interaction between hormonal contraceptives and psychotropic drugs. Participant 79, 29 years, with anxiety disorder, reported: *I never took pills to avoid pregnancy, because of the medication I already took for my treatment*. Oral hormonal contraceptives interact with anticonvulsants (barbiturates, diphenylhydantoin**,** primidone and carbamazepine) reducing their efficacy, as they induce hepatic enzymes[1].

Although 233 (91.4%) of the women, according to the reported marital status (married or with casual partners), had an active sexual life, the number of participants who used contraceptive methods and those who received family planning care was significantly low, corresponding to 15 (5.9%) and 35 (13.7%), respectively. Among those using methods, 22 (62.9%) used oral hormonal contraceptives, 11 (31.4%) used condom and 2 (5.7%) used injectable contraceptives. The analysis of this results, from the perspective of the number of women who received FP-targeted care, reveals that 20 (57.1%) used the methods without formal care, which could be related to the incorrect use by 27 (77.2%) of these women.

Tubal sterilization, reported by 40 (15.7%) of the researched women, is an important aspect for analysis. In people's imagination, and even in the view of many health professionals, the surgical method is the only one indicated for women with mental disorder, which is prejudiced and unethical. Contraceptive methods that do not need patient control are, indeed, the most efficient for women with severe mental disorders. However, appropriate ethical behavior towards these patients presupposes respect for their sexual and reproductive rights, which implies individual treatment to each person with mental disorder. Of the participants who had undergone tubal sterilization, 6 (15%) reported it was not a personal choice. Instead, other people (physicians, mother, sister and partner) made this decision, as demonstrated in some women's statements: *my mother thought it was better. Sometimes I think I got worse regarding my disease because of that. She paid the physician and he did it* (participant 6, 30 years, with schizophrenic disorder). *When I woke up I was told I had been sterilized. During delivery the doctor asked me how many children I had and performed the tubal sterilization* (participant 99, 36 years, with bipolar disorder). *During the nine months of the last pregnancy I was mentally ill, then my husband signed the papers and the physician performed the tubal sterilization* (participant 16, 43 years, with bipolar disorder). For people absolutely incapable, the FP Law ensures the performance of tubal sterilization, provided it is authorized in court, at the risk of arrest if not followed[2]. In the studied group, the characteristic of complete incapability was not observed, which shows the ways in which these procedures occurred in the researched group.

Table 3 – Distribution of medical diagnosis of mental disorder regarding correct or incorrect use of contraceptive methods. Psychosocial Care Service. Fortaleza, CE, May-August 2007

Medical diagnosis	Use of methods during the research (n=35)			
	Correct		Incorrect	
	N	%	N	%
Mood disorders	5	14.2	19	54.4
Schizophrenia and other psychotic disorders	1	2.8	3	8.6
Neurotic disorders	1	2.8	3	8.6
Personality disorders	1	2.8	2	5.8

Fisher's p = 0.685

There was no significant statistical association among the variables presented in Table 3 (p=0.685). However, the aspects related to the low number of women using contraceptive methods (n=35) and who were assisted by family planning actions (n=15) during the research should be considered. Of the women who used contraceptive methods incorrectly (n=27), 19 (54.4%) had been diagnosed with mood disorder, followed by schizophrenia and other psychotic disorders, both present in 3 (8.6%) of the women participating in the study. The personality disorder was present in 2 (5.8%) of the women who used contraceptive methods incorrectly.

For these people, methods that do not depend on personal control should be preferred, due to the possibility of users' altered behavior. Thus, male condom, injectable contraceptive, IUD and surgery are the most appropriate methods. Moreover, partners should be involved in following the use of the contraceptive method, as this is a unique opportunity for men to assume the responsibility for FP and opt for the male methods.

Obstacles that prevent access to health services make the insertion of these women in family planning actions more complicated, as stated by participant 3, 36 years, with psychotic disorder: *I went there to register, but on that day they were not registering*. Aiming to mitigate these obstacles, CAPS nurses should not only forward women to primary care services for FP care, but also follow and guide them in this respect, promoting comprehensive care.

Table 4 – Distribution of the number of women with mental disorder, according to medical diagnosis, number of psychotropic medications in use and psychiatric hospitalizations. Psychosocial Care Service. Fortaleza, CE, May-August 2007

Variables	N	%
Medical diagnosis (n=255)		
Mood disorders	125	49
Schizophrenia, schizotypal and paranoid disorders	60	23.6
Neurotic, stress and somatoform-related disorders	48	18.8
Personality and adult behavior disorder	11	4.3
Others	11	4.3
Number of psychotropic medications in use (n=246)		
1	23	9.3
2 to 3	168	68.3
4 and more	48	19.5
No statement	7	2.8
Psychiatric hospitalization		
Yes	128	50.2
No	127	49.8

Mood disorders are more frequent, affecting almost half of the women in the study, followed by schizophrenia and neurotic disorders. Prevalence rates of these disorders are high in the world population, and are the cause of significant patient losses. It is a disease with an important genetic factor, whose inheritance is characterized by complex transmission mechanisms, involving multiple genes influenced by countless environmental factors[8]. The heredity of the mentioned disorder was a concern the participants mentioned as a factor against the desire to get pregnant. Participant 4, 32 years, with mood disorder emphasized: *I'm afraid to have a child like me. How will I take care of him/her?* Professionals who work in mental health and FP should inform the woman and/or couple about the heredity burden of this pathology, so that the decision to have children or not can be taken conscientiously.

Another particularity of family planning for women with mental disorders regards the use of psychotropic drugs during pregnancy, used by almost all women in the study, as most of them are teratogenic, like lithium, one of the mood stabilizers used to treat bipolar disorder. Children of women under treatment with lithium are exposed to congenital abnormalities in 4 to 12% of cases, against a risk from 2 to 4% in the general population[9]. Bipolar disorder can aggravate during pregnancy, due to the need to decrease drugs contraindicated for perfect fetal development. Thus, the permanent interaction between pregnant women, family, obstetrician and psychiatrist is an important resource to support risk-benefit analysis in decisions. Nevertheless, research data on the use of antidepressive agents is already available for pregnant and breastfeeding patients[10].

From an ethical viewpoint, one cannot prohibit patients with mental disorders from getting pregnant, due to their right to freely choose conception, like every other woman, for which they should receive care in all dimensions. Services involved in care to women with mental disorders need to understand, regarding their right to choose motherhood, that the health system should be prepared to respond to this demand, respecting women who have decided in favor of conception, despite the risks, monitoring children concerning the possible appearance of the disorder and promoting proper follow-up.

The use of medication is seen as the main therapeutic practice in the different levels of the public health system[11]. This is an aggravating factor, as it can be the only available resource for those who need this kind of care and becomes permanent in these patients' life, making them dependent on medications.

Psychiatric hospitalization, reported by more than half of the participants, can worsen the gestational risk of women with mental disorder, as well as interrupt the contraceptive practices. One of the analyzed women, 37 years, with bipolar disorder, confirmed that hospitalization makes her susceptible to interrupt the use of the contraceptive method and, thus, to a possible unexpected pregnancy: *I did not*

prevent correctly. When I was hospitalized I did not take the pills.

Psychiatric hospitalization has a double function in care to patients, which is to treat and protect patients with mental disorders, at the risk of limiting their citizenship rights and contributing to sexual and reproductive risks. To decrease these possibilities, the current mental health actions, guided by the law on the protection and rights of people with mental disorders, recommend psychiatric hospitalization only when all other community resources have already been exhausted[3]. These resources consolidate the psychiatric reform and are considered innovative projects, capable of guaranteeing quality care to carriers of mental disorders, based on premises like singularity and the right to decent health and life[12].

FINAL CONSIDERATIONS

Particularities of family planning for women with mental disorders were recognized in the present study, such as hereditariness of some mental disorders, psychiatric hospitalization as a cause for interrupting the contraceptive practice, multivariate use of psychotropic drugs that can have medication interactions with oral hormonal contraceptives and cause teratogenic effects, use of contraceptive methods that require personal control, which was jeopardized due to the altered behavior and the importance of participation by the partner and/or family members responsible for reproductive and contraceptive choices.

The studied group suffers intervention by a fragmented health system, which denies comprehensive care and women's sexual and reproductive rights. Results show the need for interaction between public family planning and mental health policies, which would permit the rescue of citizenship, respect for differences, autonomy, and social inclusion of users. Future studies can strengthen changes in the dynamics of FP care to women with mental disorders, in which CAPS and health unit teams can better respond to this demand.

REFERENCES

1. Ministério da Saúde (BR). Secretaria de Política de Saúde. Área Técnica de Saúde da Mulher. Assistência em planejamento familiar. Manual Técnico. 4ª ed. Brasília (DF): Ministério da Saúde; 2002.

2. Ministério da Saúde (BR). Lei Ordinária nº 9263 de 12 de janeiro de 1996. Regula o parágrafo 7 do artigo 226 da Constituição Federal, que trata do planejamento familiar, estabelece penalidades e dá outras providências. DOU. Brasília (DF): Ministério da Saúde; 1997.

3. Ministério da Saúde (BR). Lei Ordinária nº 10216 de 06 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. DOU. Brasília (DF): Ministério da Saúde; 2001.

4. Ministério da Saúde (BR). Política Nacional de Atenção Integral à Saúde da Mulher – Princípios e Diretrizes. Secretaria de Atenção à Saúde, Departamento de ações Programáticas Estratégicas. Brasília (DF): Ministério da Saúde; 2004.

5. Pheula GF, Banzanato CEM, Dalgalarrondo P. Mania e gravidez: implicações para o tratamento farmacológico e proposta de manejo. J Bras Psiquiatr 2003; 52(2):97-107.

6. Creswell JW. Projeto de pesquisa: métodos qualitativo, quantitativo e misto. 2ª. ed. Porto Alegre: Artmed; 2007.

7. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1979.

8. Michelon L, Vallada H. Fatores genéticos e ambientais na manifestação do transtorno bipolar. Rev Psiquiatr Clín 2005 janeiro/fevereiro; 32(supl.1):21-7.

9. Andrade LHSG, Viana MC, Silveira CM. Epidemiologia dos transtornos psiquiátricos na mulher. Rev Psiquiatr Clín 2006 março/abril; 33(2):43-54.

10. Buist A. Managing depression in pregnancy. Aust Fam Physician; 2000 July; 29(7):663-7.

11. Dimenstein M, Santos YF, Brito M, Severo AK, Morais C. Demanda em saúde mental em unidades de saúde da família. Metal [online] 2005 novembro [Acesso 11 set 2008]; 3(5): 33-42. Disponível em: http://pepsic.bvs-psi.org.br/scielo.php?script=sci_arttext&pid=S1679-44272005000200003&lng=pt&nrm=.

12. Soares SRR, Saeki T. O Centro de Atenção Psicossocial sob a ótica dos usuários. Rev Latino-am Enfermagem 2006 novembro-dezembro; 14(6):923-9.

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