Contraceptive options for women with mental disorders

Further basic information on this topic can be found at www.fptraining.org

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Mental disorders: Contents

1. General considerations
2. Feeding and eating disorders
3. Psychotic disorders
4. Some aspects of contraception in disabled women

Mental disorders

There are no WHO recommendations on contraception in women with mental disorders

The content of this session is based on current evidence given in the notes

General considerations

Women with mental disorders have special sexual and reproductive needs

- Their use of contraception is lower than among the general population
- The rate of unplanned pregnancy and abortion are higher than among the general population

Feeding and eating disorders

1. Classification of eating disorders
2. Prevalence
3. Global health risks
4. Main gynaecological problems
5. Fertility rate
6. Contraceptive choices

Feeding and eating disorders

Classification (DSM-5):

1. Anorexia nervosa

BMI <15 -17 kg /mm2, fear of weight gain, disturbance in the way body weight/shape is experienced/denial of seriousness of current low body weight

2. Bulimia nervosa

Recurrent binge-eating and

compensatory behaviours once a week for >3 months *

3. Binge-eating disorder

Recurrent binge eating once a week for >3 months

4. Avoidant/restrictive food intake disorder

Eating/feeding disturbance resulting in failure to meet nutritional needs without

body image disturbance

5. Other specified eating/feeding disorders

This broad diagnostic category includes patients presenting with symptoms similar to anorexia or bulimia nervosa that do not meet all of the diagnostic criteria for those disorders

Ref 1

Feeding and eating disorders

Prevalence

- Anorexia
  - 0.5–2.0%
  - The male-to-female ratio for anorexia nervosa is estimated to be between 1:10 and 1:15
- Bulimia
  - 0.9–3.0%
  - The male-to-female ratio for bulimia nervosa is estimated to be between 1:15 and 1:20
- Other eating disorders
  - 4.8%

Aetiology

Not very well delineated

- Biological
- Psychosocial
- Genetic

Medical complications

High morbidity and mortality

- Multisystem

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Feeding and eating disorders:
Potential gynaecological symptoms

- **Delayed puberty**
- **Menstrual disturbance:** Amenorrhoea, oligomenorrhoea
- **Polycystic ovary syndrome (PCOS):** Present mainly in overweight women with bulimia and binge-eating disorder
- Decreased libido, higher sexual anxiety, decreased self-focused sexual activity, chronic sexual impairment (mainly bulimia)
- Endometrial cancer (risk related to obesity)

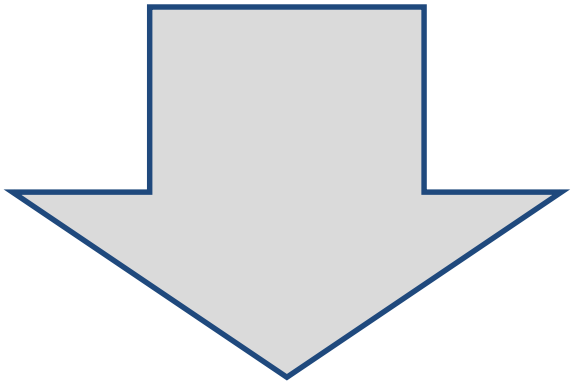
Good choice, discuss bleeding pattern

Particular considerations on contraceptive choices

Contraceptive method	Notes
COC/POC	Could be a choice, but it is important to explain the risks of no effective contraception in the presence of vomiting
Vaginal ring	Good choice
Transdermal patch	Good choice
DMPA	Not first choice
LARC (highly effective) • Implant • LNG-IUS • Copper IUD	Good choice

Ref 1

Contraceptive choices



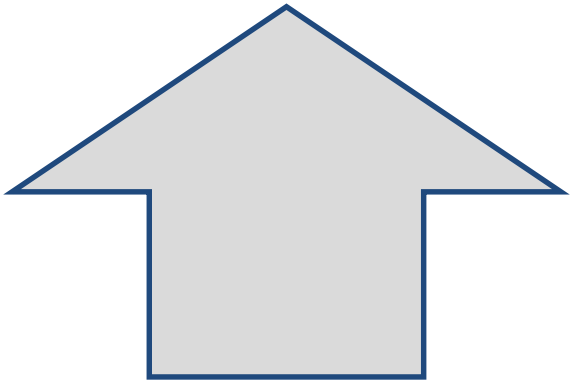
Effective contraception

Individualised contraceptive options considering behaviour

Signs and complications of disease

The non-contraceptive benefits could mask the signs of the disease

CHC do not have a positive impact on BMD in anorexia and bulimia



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Psychotic disorders: Schizophrenia

Agenda:

1. Prevalence
2. Main gynaecological problems
3. Fertility rate
4. Contraceptive choices

Psychiatric disorders are not included in the WHO MEC
The following statements are based on evidence from the current literature

Schizophrenia: Background

- Schizophrenia is a debilitating mental health disease that currently affects about 1% of the world's population
- The typical age of onset of the disease in females is 25–30 years old, meaning that many women with this disease are of childbearing years
- Psychiatrists need to address contraception during regular psychiatric visits from all seriously ill women in their reproductive years
- It is important to make sure that women have capacity to make an informed choice

Schizophrenia: Background

A 2009 review of 84 studies on reproductive health in women with serious mental illness, compared with the general population, concluded that:

- The rate of lifetime sexual partners is high
- Contraceptive use is relatively low
- There are high rates of both unwanted pregnancy and sexually transmitted infections (STIs)

Ref 1

Schizophrenia: Specific recommendations on contraceptive use and choice

- Contraceptives can only be prescribed with a woman's full understanding of what they are for
- Clinicians should be alert for interactions among contraceptives and therapeutic drugs
- Remember also to address STI prevention

Ref 1

Contraceptive methods: schizophrenia

	Issues concerning women with schizophrenia
Natural methods	• The calculations involved may be too demanding for women with cognitive impairment such as is often present in schizophrenia • Rhythm methods may not be effective in this population if antipsychotic drugs disrupt, as they often do, the regularity of menstruation ➢ No protection from STIs
Female barrier methods	• Difficulty ensuring proper maintenance and use of barrier contraceptives, as well as lack of sufficient executive functioning to plan for their use in advance
Male barrier methods	• Women may have difficulty insisting that their male partner wear a condom

Contraceptive methods: schizophrenia

	Issues concerning women with schizophrenia
CHCs (oral, vaginal, transdermal)	• Discuss user dependency (daily use, could be difficult for women who may not have a routine) • See other topics of this course regarding contraception and comorbid conditions
Progestin-only pill	• Discuss user dependency (daily use could be difficult for women who may not have a routine) • Progestin-only methods all cause some degree of menstrual disturbance that may be a problem for these women
	➢ See the topic *drug interactions* ➢ No protection from STIs

Contraceptive methods: schizophrenia

LARC	Issues concerning women with schizophrenia
DMPA	• Requires an injection only every 12 weeks • DPMA injections may cause weight gain in a subset of women and lower glucose tolerance in women with diabetes with no clinical impact (MC session: obesity) • An association between DMPA and depression has been reported, but a causal relationship is uncertain • There is low risk for drug interactions
Etonogestrel implant	• See the topic: *MC drug interactions* • Inserted and removed by a physician
	➢ Progestin-only methods all cause some degree of menstrual irregularity ➢ No protection from STIs

Ref 1

Contraceptive methods: schizophrenia

LARC	Issues for women with schizophrenia
Intrauterine contraception (IUD, LNG-IUS)	• No risk of drug interaction • Efficacy not dependent on user cooperation • Inserted and removed by a physician • The WHO MEC for IUD/ IUS use must be respected • The LNG-IUS may also have adverse effects such headache, acne, breast tenderness and functional ovarian cysts • Progestin-only methods all cause some degree of bleeding irregularity that may be a problem for these women ➢ No protection from STIs
Comment	• Copper-T-IUD: heavy menstrual flow, dysmenorrhoea • LNG-IUS: headache, acne, breast tenderness, hair loss, functional ovarian cysts

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Take home message
Contraceptive choices- Schizophrenia

Contraceptive method	Notes
COC/POC	Good choice, but discuss user dependency
Vaginal ring	Good choice, less user dependency
Transdermal patch	Good choice, less user dependency
DMPA	Good choice, discuss bleeding pattern
LARC (highly effective) • Implant • LNG-IUS • Copper IUD	Good option if insertion is acceptable Discuss bleeding pattern

Ref 1

Disability – Major concerns

General recommendations

- Discuss the best choice considering risks and non-contraceptive benefits included immobilisation
- Consider menstrual hygiene, STIs, sexual abuse
- Considerer pharmacologic interactions with other medications
- There are no interactions between HC and ritaline
- Take very good care if permanent methods are demanded from caretakers or family (recommendations below)

IMPORTANT: FIGO and WHO recommendations on procedures that unavoidably result in permanent sterility or termination of pregnancy in severely disabled women are mentioned in the notes