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Research report

Unplanned pregnancies and reproductive health among women with bipolar disorder

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ABSTRACT

Background: The aim of this study was to investigate reproductive health and level of planning of pregnancies among women with bipolar disorder (BDW).
Methods: 63 euthymic women, with bipolar disorder type I, II or not otherwise specified diagnosis, were included and were matched with a control group of 63 healthy women. Demographic and clinical data, structured reproductive health measures and planning level of pregnancies were obtained and compared between groups.
Results: Lower level of planning of pregnancies and higher frequency of unplanned pregnancies were found among BDW. Women with bipolar disorder reported history of voluntary interruption of pregnancies more frequent than women from control group. Current reproductive health care showed no differences between groups.
Limitations: Data based on self-report of participants and retrospective nature of some collected measures may be affected by information bias. The pregnancy planning measure has not been validated in this population before. Demographic and clinical characteristics of the sample study limit generalization of these findings.
Conclusions: Adverse reproductive events, as unplanned pregnancies and elective interruption of pregnancies, may be more frequent among BDW. Clinician must be aware of the reproductive health during treatment of young BDW and take measures to improve better family planning access.

1. Introduction

Reproductive health, within the framework definitions of World Health Organization, comprises not only the absence of reproductive diseases but also the ability to have a responsible, satisfying and safe sexual life. In this context, the reproductive health includes different aspects of family planning and the access to reproductive health care of subjects (United Nations, 1995). A main goal for health organizations and global sanitary policies is to reach appropriate reproductive health care for different populations since that unsafe sex practices represent one of the main risk factors for disease, disability and death for people around the world (Glasier et al., 2006).

Bipolar disorder, like other severe mental illnesses, is considered a condition with enhanced risk of practicing unsafe sex (Meade and Sikkema, 2005). Particularly, their chronic course and frequent onset on adolescence and young adulthood imply that many women suffer these affective disorders and receive treatment during their reproductive age. However, research on sexual and reproductive health of this population has not received particular attention. Studies conducted among samples with a broad spectrum of major psychiatric disorders revealed a low use of contraceptive methods (Raja and Azzoni, 2003); higher frequency of reported abortion (Coverdale et al., 1997); higher proportion of women who ever lost a pregnancy (Dickerson et al., 2004), and different degrees of risk for sexually transmitted infections (Meade and Sikkema, 2005). However, the assumption that these findings could describe specific reproductive health risks among people with bipolar disorder could be inaccurate given the evidence of different patterns of sexual behaviors according to diagnostic category (Carey et al., 2004). Unsafe sex practices in BD have been empirically related to manic episodes because of symptoms of hypersexuallity, cognitive impairment and substance and alcohol abuse. Nonetheless, some of these symptoms could be present throughout the different mood states of the disease and therefore may affect sexual behaviors and reproductive health care not only during manic episodes. In fact, there is only a published study to date, which specifically

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addressed frequency of contraceptive methods use in euthymic BDW and it showed a suboptimal use of contraception (Magalhães et al., 2009).

Unsafe sex carries health risk for both sexes because of sexually transmitted diseases, but for women also suppose the risk of unplanned pregnancies (UP). Unplanned pregnancies may entail negative health, social, and psychological outcomes for women and children (Gipson et al., 2008). Moreover, UP are a concerning issue among BDW for significant reasons. First, UP may lead to unaware embryo–fetal exposition to drugs with teratogenic risk like most of mood stabilizers. On the other hand, rapid discontinuation of mood stabilizers treatment, a usual behavior when an UP is recognized, prompts greater risks of relapse for BDW (Viguera et al., 2000; Viguera et al., 2007). Finally, higher rates of elective terminations of pregnancies are another possible consequence of UP (Grimes et al., 2006). Althoug UP among BDW are a matter of concern, they have been not deeply studied.

Then, the aim of this study was to compare level of planning pregnancies and reproductive health among euthymic BDW and a healthy control group. The main hypothesis were that BDW would have higher lifetime prevalence of reproductive events associated with unsafe sex practices as unplanned pregnancies and elective termination of pregnancies, and lower reproductive health care measures compared to healthy women.

2. Methods

Sixty-three female outpatient with bipolar disorder diagnosis from Bipolar Disorder Program of Favaloro University were consecutively included in this study if they met the following inclusion criteria: age between 18 and 55 years old; diagnosis of BD type I (BDI), type II (BDII) or no otherwise specified (BDNOS) according to DSM-IV using Structured Clinical Interview for DSM-IV (SCID) (First et al., 1996); and euthymic [defined by Hamilton Depression Rating Scale ≤ 8 (Hamilton, 1960) and Young Mania Rating Scale ≤ 6 (Young et al., 1978)] for at least 8 weeks. Patients were excluded if they have any clinical condition that could affect the ability to comprise instructions and complete study questionnaires. In addition, 63 women without history of psychiatric diagnosis were included as part of control group. They were recruited from same socio-economic population and matched by age and years of education with patients.

The study was approved by the Ethics Committee of Favaloro University and all subjects gave written informed consent for their participation after receiving a complete description of the study. Interviews to BDW and healthy women were conducted by first author according to a standardized order.

2.1. Demographic and clinical assessment

Information about age, years of education, marital status, current stable partnership condition, and religion were collected in all participants. All participants completed the clinical evaluation using Structured Clinical Interview for DSM-IV (SCID) (First et al., 1996) in order to confirm bipolar disorder diagnosis (subjects) or the absence of any major psychiatric diagnosis (control group). All BDW were evaluated with the Hamilton Depression Rating Scale (HDRS), Young Mania Rating Scale (YMRS) and Global Assessment of Functioning (GAF), and additional clinical data was obtained.

2.2. Reproductive health assessment

All participants were assessed for age at menarche and age at menopause (if applicable) to estimate reproductive state condition. Likewise frequency of gynecological visits with pelvic examination and cervical cytology screening during last 3 years, history of sexual activity with men during last 3 months, and contraceptive method used during last 3 months were assessed. Reported contraceptive method were classified as: (a) condom (the only barrier method reported in study sample); (b) oral hormonal contraceptives (OC) (the only hormonal method reported in study sample); (c) intrauterine devices (IUD); (d) double contraceptive method (simultaneous use of condom and OC or IUD); (e) others (permanent surgical contraception, chemical contraceptive method or natural methods were grouped because its low reported frequency) and (f) none (Ministerio de Salud Argentina, 2012). For analysis of contraception use, only premenopausal and sexually active women were considered.

Besides, lifetime number of pregnancies, age at each pregnancy, lifetime number of pregnancies that did not result in a live birth, and history of electively interrupted pregnancies were assessed in both groups. In addition, subjects and controls with previous history of pregnancies completed the London Measure of Unplanned Pregnancy (LMUP) (Barrett et al., 2004) for every event, no matter the outcome of the pregnancy (live birth, miscarriage, stillbirth or abortion). This structured measure is a self-questionnaire that scores from 0 to 12 and higher scores represent increasing degree of pregnancy planning. The scores were analyzed both as continuous and categorical data using scores suggested by the authors as cut points of three planning categories: planned pregnancy (10–12) ambivalent intention to get pregnant (4–9); and unplanned pregnancy (0–3). The LMUP was translated and adapted from English to Spanish by process of translation and back-translation from original by professional translator.

2.3. Data analysis

Initial data were explored with descriptive statistics. Normality of variables was assessed with Kolmogorov–Smirnov test. Mann–Whitney test was employed for between group comparisons on continuous nonparametric variables. Chi-squared tests or exact Fisher tests were employed to evaluate associations between categorical variables. Spearman correlation coefficients were calculated to explore the relationship between continuous clinical variables and planning level of pregnancies. Adjustments for multiple comparisons were conducted using Bonferroni corrections. All tests were two-tailed. 20.0 version of SPSS (Statistical Package for the Social Sciences) (SPSS, 2008) was used for all statistical procedures.

3. Results

3.1. Demographic and clinical characteristics

The detailed information of main demographic characteristics of BDW and control group is shown in Table 1. There were no differences between both groups in age, years of education and religion. BDW showed trends to significance in lower proportion of women who report to be ever married and to be in a current stable partnership compared to healthy controls.

Data about clinical current state and detailed psychiatric history are shown in Table 1.

3.2. Reproductive health characteristics

Main measures of reproductive health care showed no differences between groups (see Table 2). Among sexually active BDW in reproductive age ($n=49$), reported current contraceptive