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Sexual risk behaviors among women with bipolar disorder

Eliana Marengo^{a,b}, Diego J. Martino^{a,b}, Ana Igoa^a, Guillermo Fassi^a, María Scápolo^a, Mariana Urtueta Baamonde^a, Sergio A. Strejilevich^{a,*}

^a Bipolar Disorder Program, Institute of Neurosciences, Favaloro University, Buenos Aires, Argentina

^b National Council of Scientific and Technical Research (CONICET), Argentina

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ABSTRACT

The aim of this study was to investigate sexual health and sexual risk behaviors for sexually transmitted infections (STI) among women with bipolar disorder (BDW). Sixty-three euthymic women diagnosed with bipolar disorder type I, II or not otherwise specified were included and matched with a control group of 63 healthy women. Demographic and clinical data, structured sexual health measures and extensive assessment of sexual risk behavior were obtained and compared between groups. BDW had casual partners, were in non-monogamous sexual partnerships and had sex with partners with unknown HIV condition more frequently than healthy control women. History of two or more STI was more frequent among BDW. Inclusion of sexual behavior risk assessment among BDW in treatment is necessary to better identify those women with higher risk for STI and to take measures to improve their sexual health.

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1. Introduction

Unsafe sex represents one of the main risk factors for disease, disability and death around the world (Glasier et al., 2006). Consequences of unsafe sex are unintended pregnancies and sexually transmitted infections (STI). Sexually transmitted infections are caused by bacterial, parasitic and viral pathogens, including HIV, which are transmitted through sexual contact. They are a significant cause of morbidity and mortality for women if they are not early diagnosed and treated (Low et al., 2006). Sexually transmitted infections in women are associated with pelvic pain, infertility, ectopic pregnancies, obstetric complications, and different types of genital cancer (WHO, 2012). They may also affect offspring health if women are pregnant or give birth while infected (WHO, 2012).

Women with severe mental illness (SMI) constitute a population considered to be especially vulnerable to unsafe sexual practices. Sexual risk behaviors like having unprotected sex, having multiple sexual partners, trading sex, and using injected drugs have been found to be more prevalent in samples of people with SMI (for a detailed review see Meade and Sikkema, 2005). Particularly, women with SMI may be victims of sexual coercion or

more frequently fail to have their male partners using condoms compared with control women (Coverdale et al., 1997). There is evidence that HIV infection is more frequent in people with SMI than in the general population (De Hert et al., 2011) but less is known about the prevalence of other sexually transmitted infections (Rosenberg et al., 2001; King et al., 2008).

As in the general population, women with SMI have STI more frequently than men (Aral et al., 2004; Chandra et al., 2003; Carey et al., 2004). While some investigations have been conducted on sexual and reproductive issues of women with schizophrenia (Miller, 1997; Seeman, 2013), sexual health of women with bipolar disorder (BDW) has received less attention. This is notorious because changes in sexual behavior are commonly present during affective episodes of illness (Goodwin and Jamison, 2007). It was found that recent manic episode was associated with increased HIV risk behaviors among subjects with bipolar disorder and substance use disorders (Meade et al., 2008). Likewise, this high-risk pattern could exceed manic episodes, because loss of sexual inhibition was highly reported also during hypomanic episodes (Fletcher et al., 2013). However, to the best of our knowledge, there are no studies conducted on euthymic patients to elucidate if sexual risk behaviors remain beyond manic or hypomanic episodes. Then, the aim of this study was to compare sexual health focusing on risk behaviors for STI between euthymic BDW and healthy control women.

* Correspondence to: Congreso 2477 Dto. D (1428) Ciudad de Buenos Aires, Argentina.

E-mail address: sstreji@gmail.com (S.A. Strejilevich).

2. Methods

Sixty-three female outpatients with bipolar disorder diagnosis from the Bipolar Disorder Program of Favaloro University were consecutively included in this study if they met the following criteria: (a) age between 18 and 55 years old; (b) diagnosis of bipolar disorder type I, II or not otherwise specified according to DSM-IV-SCID criteria (First et al., 1996); and (c) euthymia [defined by Hamilton Depression Rating Scale ≤ 8 (Hamilton, 1960) and Young Mania Rating Scale ≤ 6 (Young et al., 1978)] for at least 8 consecutive weeks. Patients were excluded if they had any clinical condition that could affect the ability to understand instructions and complete study questionnaires. Additionally, 63 healthy women with no history of psychiatric disorders were included as part of the control group. They were recruited from the 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. Structured interviews were conducted with BDW and healthy women by the first author.

2.1. Demographic and clinical assessment

Information about age, years of education, marital status, current stable relationship condition, and religion were collected from all participants. Subjects completed the clinical evaluation using the Structured Clinical Interview for DSM-IV (SCID) (First et al., 1996) in order to confirm bipolar disorder diagnosis. 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 were obtained from structured interview and clinical records when it was needed.

2.2. Sexual health assessment

Information about sexual health was collected in both groups with a structured interview that includes age at first intercourse, history and number of lifetime sexually transmitted diseases, history of gynecologic screening examination in the last three years and sexual activity with partners during the last three months. Among subjects and controls who were sexually active during the last three months, the HIV-risk Timeline Followback interview (TLFB) (Weinhardt et al., 1998; Carey et al., 2001) was conducted. The HIV-risk TLFB is a structured interview designed to provide a comprehensive assessment of HIV and STI risk, and to yield frequencies of protected and unprotected sex, use of alcohol or substances before sex and describe other sexual partner characteristics (i.e. casual or regular partner, HIV status, bisexuality and monogamous condition).

2.3. Data analysis

Initial data were explored with descriptive statistics. Normality of variables was assessed with Kolmogorov–Smirnov test. The low frequency of most of sexual behaviors reported required non-parametric statistical analysis strategies. Mann–Whitney test was employed for between-group comparisons on continuous non-parametric variables. Chi-squared tests or exact Fisher tests were employed to evaluate associations between categorical variables. Events reported by less than 5% of both study and control groups were excluded from further analysis because of their extremely low frequency. All tests were two-tailed. Statistical Package for the Social Sciences (SPSS) (SPSS, 2008) version 20.00 was used for all statistical procedures.

3. Results

3.1. Demographic and clinical characteristics

The detailed information of demographic characteristics of both groups and clinical state and psychiatric history of BDW are shown in Table 1.

3.2. Sexual health and behavior characteristics

3.2.1. Sexual health characteristics

Detailed information about sexual health characteristics of BDW and the control group is shown in Table 2.

Most women in both groups reported gynecologic examination frequency according to local guidelines (BDW = 93.7% [$n=60$] vs. Controls: 95.2% [$n=61$], Fisher's exact Test, $d.f.=1$, $p=1.00$). There were no differences in reported history of at least one STI between groups, but BDW reported more frequently having been diagnosed two or more times with STI. Exploratory bivariate subanalysis was conducted among BDW that had reported two or more STI (STI ≥ 2) versus those with one or none STI (STI ≤ 1). Repeated STI in BDW was associated with earlier age at onset of bipolar disorder (STI ≥ 2 : Median = 15 years [interquartile range = 14–16], vs. STI ≤ 1 : 18 years [15–25]; Mann–Whitney $Z=-2.095$, $p=0.036$); longer diagnostic delay (STI ≥ 2 : Median = 15 years [interquartile range = 7–18], vs. STI ≤ 1 : 8 years [5–12]; Mann–Whitney $Z=-1.985$, $p=0.047$), and higher number of manic/hypomanic episodes (STI ≥ 2 : Median = 9.5 episodes [interquartile range = 5–15], vs. STI ≤ 1 : 3 episodes [2–5]; Mann–Whitney $Z=-2.927$,

Table 1

Clinical and demographical characteristics of women with bipolar disorder and healthy controls (continuous values are expressed as median, interquartile ranges are shown in brackets).

	Women with BD ($n=63$)	Healthy controls ($n=63$)	Test/ p -value
Age	33 (28–33)	33 (29–37)	$Z=-0.369^a$; $p=0.71$
Years of education	16 (15–17)	17 (14–17)	$Z=-1.226^a$; $p=0.22$
Married/living with a partner	31.7%	60.3%	$X^2=10.351^b$; $d.f.=1$; $p=0.001$
In current stable relationship	61.9%	77.8%	$X^2=3.768^b$; $d.f.=1$; $p=0.05$
Religion			$X^2=2.315^b$; $d.f.=2$; $p=0.31$
None	39.7%	47.6%	
Catholic	54%	50.8%	
Others	6.4%	1.6%	
Clinical subtype (% type I)	33.3%		
Current Axis I comorbidity	30.2%		
Age at onset	18 (15–23)		
BD diagnostic delay (in years) ^c	8 (5–13)		
No. of total previous affective episodes	8 (5–15)		
History of hospitalization	36.5%		
History of substance abuse disorder	28.6%		
History of rapid cycling	19%		
YMRS Score	1 (0–2)		
HDRS Score	2 (1–4)		
GAF Score	85 (75–90)		

Abbreviation; BD: Bipolar disorder; YMRS: Young Mania Rating Scale; HDRS: Hamilton Depression Rating Scale, GAF: Global Assessment of Functioning.

^a Mann–Whitney.

^b Chi-square.

^c Calculated as the difference between age at onset of BD and age at BD was diagnosed.

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