



Short Communication

A Study on the Knowledge, Attitude and Practice about Contraception among Women with Severe and Persisting Mental Illness versus Women with Medical Illness

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ABSTRACT

Sexuality and Contraceptive needs of women have been long kept in dark in the Indian scenario. Minimal attempts have been made to explore on such needs among women with severe and persisting mental illnesses despite the evidences showing that women with mental illnesses also have reproductive and sexual needs. The present study assessed the knowledge, attitude and practices with respect to contraception among women with severe and persisting mental illness (SPMI) and compared them to those with medical illness. The study sample consisted of 200 subjects: 100 subjects with severe and persisting mental illness and 100 subjects with medical illness. Data was collected using a validated semi-structured proforma developed for the purpose. The overall analysis revealed that 94.0% of the study subjects had a history of unprotected sexual intercourse. Only 62.8% of them had the knowledge of being exposed to the risks of contracting a sexually transmitted disease. Knowledge about safety and effectiveness of contraceptive methods was significantly lower in the psychiatry group compared to the medical group.

Key Words: Contraception, Severe, Persisting, Mental illness, Medical illness, Women.

INTRODUCTION

Sexuality and Contraceptive needs of women have been long kept in dark in the Indian scenario. The reproductive needs of women suffering from Severe and Persisting Mental Illnesses have not been explored upon despite various studies pointing out that their needs are much similar to other women.⁽¹⁻³⁾ The entire concept of motherhood may be magnified as source of self esteem as it can be pursued despite

multiple losses in role functioning as a consequence of the mental illness.⁽⁴⁾ However pregnancy and childbirth can have adverse consequences for women with Severe and persisting Mental Illnesses, with a greater severity for a woman with post partum onset having persisting and long lasting effects. The effects of severe and persisting mental illnesses may include the diagnosis of pregnancy itself, prenatal concerns, abortions, practical issues related

to parenting, post partum psychiatric illnesses including acute sleep disturbances, postpartum blues, postpartum neurotic depression and puerperal psychoses. ⁽⁵⁾ Thus exploring the knowledge, attitude and practices of contraception among women with Severe and persisting Mental illness becomes essential.

Women with medical illness such as Hypertension, Diabetes and Thyroid disorders though not a population stigmatized like the mentally ill share similar patterns of reproductive and sexuality needs. Thus, in the present study women suffering from medical illnesses were used as a comparative group to study the contraceptive awareness in contrast with women with severe and persisting mental illness.

MATERIALS AND METHODS

Sample: the study sample consisted of 200 female patients attending the Out-Patient Department of our Tertiary Care Centre. 100 female patients attending the psychiatric OPD and 100 female patients attending the Physician's Outpatient unit were chosen. The sample of 100 female patients attending psychiatric OPD consisted of 26 cases of Schizophrenia, 10 of Schizo affective disorder, 43 cases of Severe Depression, 19 BPAD and 2 cases of Delusional Disorder.

Inclusion criteria:

- Female patients aged between 18-45 years, who have been availing the Outpatient services for at least 1 year meeting the criteria for diagnosis of Severe and Persisting Mental Illness but currently in remission.
- Psychiatric Sample: Axis 1 psychiatric disorders (according to DSM-IV-TR Criteria).
- Non-Psychiatric Sample: Women attending the Physician's OPD; inclusive of disorders -Hypertension, Diabetes, and Thyroid Disorders-

availing the Outpatient services for at least 1 year.

Exclusion criteria:

- Axis 1 disorders of alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions
- Psychiatric Sample: Women with Axis 2 co morbidities (according to DSM-IV-TR Criteria).
- Non-Psychiatric Sample: Women with any psychiatric history.

Method of data collection:

Tools used:

1. Semi Structured Interview Schedule:

A semi structured schedule was designed by the research team to elicit information both on the socio demographic details and family planning concerns. The schedule was validated through focused group interactions and inputs from Mental Health Professionals. Through the Schedule the following were collected- Socio demographic details, Menstrual and Obstetric history and Knowledge, Attitude and Practice of contraceptive methods.

Procedure:

With the establishment of an initial rapport, the subjects were clearly explained about the implications of the study and assured of anonymity. An informed and voluntary consent was then obtained from each study sample. The semi structured interview schedule was administered on the study sample by the members of the research team (Consultant Psychiatrists, a DNB Resident and a Psychiatric Rehabilitator). Each interview lasted for about 25-30 minutes.

Analysis of data:

The data analysis was carried out using the SPSS 16.0 software. Descriptive method of analysis was carried out. Subjects were compared using large sample test of Z-test and one-way ANOVA for

continuous variables and categorical variables using chi square.

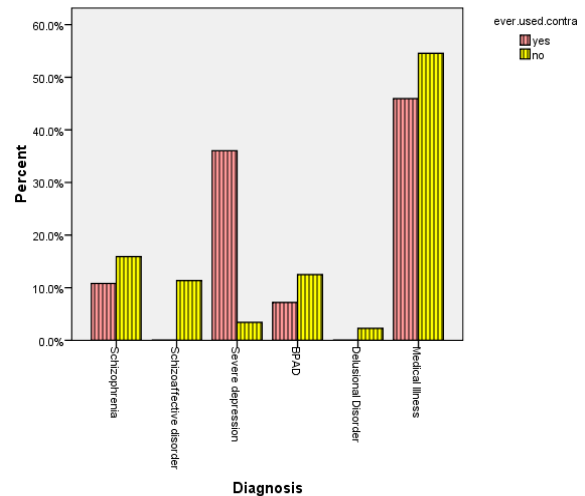
RESULTS & DISCUSSION

Most of the patients were in the age group of 26-35 years (47.7%) hailing from an urban background. 99% in the medical group felt contraception was safe whereas among the psychiatry group it was only 37%. Only 40.9 % of the study subjects had planned pregnancies. Though the percentage of abortions in the study sample was recorded to be 10.2%, it was equally seen in both women with medical illness and in women with persisting chronic mental illness.

The overall analysis revealed that 94.0% of the study subjects had a history of unprotected sexual intercourse. Only 62.8% of them had the knowledge of being exposed to the risks of contracting a sexually transmitted disease. It was noted that husband independently took the decision regarding use of contraception in 58.0% of the cases. The main reason for not practicing contraception in psychiatry group was objection from the partner and fear of side effects.

Knowledge about safety and effectiveness of contraceptive methods was significantly lower in the psychiatry group compared to the medical group. The most significant results with regard to the knowledge, attitude and practice of contraception was obtained with respect to the source of information of family planning; 66.8% of the study subjects reported that the media was their source of information, Health Care facilities and other family members contributing by 3.0% and 30.2% respectively. The overall analysis through descriptive statistics revealed that 97.0% of the individuals in both the samples reported of neither the doctor discussing nor themselves discussing the use of contraception. The data on analysis revealed

that 54.3% of the study subjects expected the doctor to discuss the issue regarding the use of contraception, while 22.1% of them were unsure if it is relevant and “allowed” to discuss contraceptive issues with their doctor. The data revealed that only 9.68% of the doctors had discussed about family planning issues with the individual.



Graph 1. Showing the use of contraception in the study sample

CONCLUSIONS AND IMPLICATIONS

Pregnancy can be demanding even under the best of circumstances, and poses even greater risks and challenges for women with severe and persisting mental illnesses. According to the WHO, 2001 statistics, there are 0.4 psychiatrists and 0.02 psychologists per 100,000 people, and 0.25 mental health beds per 10,000 populations. (6) Evidently there is dearth of recent statistical data. However such an out numbered ratio puts the mental health professionals in a tough position to address all the needs of their individual patients. More so, in the Indian Scenario owing to the stigmas with regard to the issue of sexuality, the presence of a male doctor is a clear cut “no-discussion” situation.

However, the results also point out that many individuals would not will to discuss the “sensitive” issue of

contraception with a male doctor which might contribute to the obtained results that only 9.68% doctors discussing the issue of contraception. The major knowledge deficits related to contraception among psychiatrically ill women in this study could be related to their poor access to information regarding contraception. With devastating statistical evidence that points out at the imbalanced doctor patient ratio, it is laborious for the treating clinicians to spend time discussing contraceptive issues during the follow ups. The results revealed that many of them wished that they would be referred to a gynaecologist by their treating psychiatrist so that they could openly discuss the issues of family planning. Furthermore, the data revealed that the mass media was a major source of information with regard to contraception that further stresses upon the failure of the clinician to fulfill the role of as a source of information.

The study though limited in terms of nature and size of the sample, the implications of Psychiatric illnesses and family history that have been a topic of debate since decades and the current understanding of the genetic loading of mental illnesses calls for the to address the need for contraception among women with mental illnesses, to reduce the burden of

both unwanted pregnancies and also pregnancy related complications.

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