

Out of sight, out of mind: Female sexuality and the care plan approach in psychiatric inpatients

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INTRODUCTION: *This study examines how often issues surrounding sexuality were taken into account when managing 56 women inpatients of reproductive age.*

METHOD: *Examination of the records of women discharged from the psychiatric wards of a hospital.*

RESULTS: *80% for whom there was no mention of contraceptive usage were taking at least one drug that is inadvisable in pregnancy, and 53% of this group had an identified sexual partner. There was a lack of recorded data on other aspects of sexual health. When children were mentioned in the admitting history, details were incomplete.*

CONCLUSION: *It is argued that a thorough approach to assessment and care planning is needed in this population. (Int J Psych Clin Pract 2000; 4: 307–310)*

Keywords

women
contraception

sexual health
children

serious mental illness

INTRODUCTION

Women's sexual, mental and emotional health are complex and often inter-related. Knowledge of these aspects of a woman's personal history is often helpful in the management of psychiatric disorders. This is recognized in The Royal College of Psychiatrists working party report on sexual abuse and harassment in psychiatric settings¹ (January 1996), which states that an individual's sexuality and needs should be part of the routine assessment and incorporated into the care plan, as should the capacity to consent.

Current rates for conception and birth in women with severe persistent mental disorder are similar to those in the general population.² The administration of atypical antipsychotics, which have a minimal effect on prolactin, is likely to increase the fertility of those women who were previously taking large doses of classical antipsychotics. They may also increase the potency of seriously mentally ill men.³ Heterosexually active psychiatric patients are more likely to have multiple sexual partners, to have been pressured into unwanted sexual intercourse, and to have a history of unwanted pregnancy and induced abortion.⁴ General adult psychiatrists should remember that their patients may become pregnant, as this has implications for

reducing the risk of post-natal problems.⁵ Twenty-five percent of adult psychiatric patients have children under 16 years and 10% of newly referred women have children under 5 years old.⁶ Adult psychiatrists have a duty of care to assess and manage risk in the families of their patients.

METHODS

All women aged between 16 and 45 years discharged from the general adult psychiatric wards of a teaching hospital between 1 October 1997 and 1 January 1998 were included. Handwritten admission notes, subsequent entries, discharge letters and care plans were all searched for mention of advice on contraception, pre-conceptual care, sexual health issues, relationship issues, protection from sexual exploitation and notes about capacity to consent to a sexual relationship. A 'care plan' was taken to mean any plan written in the notes on the day of discharge or in the discharge summary and any care plan form completed. The family status of the women and the drugs which they were taking when discharged were also noted. These drugs were subdivided into those which are of longstanding use and relative safety in pregnancy, and those which are either known to carry risk in pregnancy or too new to have a

proven safety record. The latter category included atypical antipsychotics, specific serotonergic re-uptake inhibitors (SSRIs), serotonin noradrenaline reuptake inhibitors (SNRIs), lithium preparations, sodium valproate, carbamazepine, thyroxine, monoamine oxidase inhibitors (MAOIs) and phenytoin. The number of different classes of these inadvisable drugs being taken by potentially fertile women was noted.

RESULTS

Sixty patients between 16 and 45 years of age were discharged between 1 October 1997 and 1 January 1998; the notes of 58 were located. As two sets of notes had no record of the patient being admitted on the dates given on the computer listings, a total of 56 patients' records were scrutinized.

ADMISSION ASSESSMENTS

On admission, 28 of the 56 women (50%) had an identifiable sexual partner, described as husband, boyfriend, fiancé or partner. One woman (1.7%) specifically had no current partner and in the notes of 22 women (39%) no clarification was given. The living situations of five women defied categorization: for example, living with ex-husband or ex-boyfriend. For 24 (43%), children were mentioned in the case notes, and three (5%) were specified as childless. Of the 24, for only 11 (46%) was the age of the children recorded; and for seven (29%), care arrangements were specified. Twenty-nine (52%) case notes did not mention children.

Eleven (19.7%) of the assessments contained information about fertility; two women were pregnant, one possibly pregnant, three women (5%) were using oral or depot contraception; three women had had hysterectomies, one was sterilized, and one was described as infertile. No mention was made of fertility or contraception in 45 (80.3%) sets of notes.

Other aspects of sexuality included a past history of rape or child sexual abuse (nine patients); one patient was admitted with deliberate self-harm to the vagina; and one was admitted with an attempted self-induced termination. One patient was assessed on admission as 'sexually vulnerable' and one patient complained of being sexually assaulted while an inpatient.

CARE PLANS

None of the care plans scrutinized made any mention of advice on pre-conceptual health, sexual health, protection from sexual exploitation or assessment of capacity to consent to a sexual relationship. Three care plans mentioned oral or depot contraception, two patients were referred to a psychosexual counsellor, and one was referred to a sexual abuse survivors group.

DRUGS ON DISCHARGE

Of the 45 patients who were not protected against conception, 26 (57.7%) were prescribed one type of drug deemed inadvisable in pregnancy; seven (15.5%) were prescribed two different drugs of this type and three (6.6%) were prescribed three drugs from different inadvisable categories, a total of 36 patients (80%). Nineteen (53%) of these 36 patients had identified sexual partners, according to their notes. Eight patients were taking lithium without mention of current contraceptive usage.

DISCUSSION

There was a striking paucity of data in the notes and care plans about any aspect of sexual health. Although the women are all of reproductive age, usage of contraception was hardly mentioned. It was not possible to deduce the proportion of women in this group who were sexually active, but the General Household Survey⁷ shows sexual activity in 66% of single women aged 16–49 and 99% if married or cohabiting. Furthermore 77% of women in this age group were using contraception and one-quarter of these use the oral contraceptive pill. In this study only two women out of 56 were reported as taking the oral contraceptive pill.

It is predictable that women admitted in crises will not report whether they are taking oral contraceptives unless specifically asked (enquiring about tablets or medicine is not enough), and are at risk of missing doses as a consequence. An omission of one or more doses impairs efficacy for at least 7 days.⁸ It is possible that women who stay only a few days as inpatients will be discharged at increased risk of pregnancy, and for this reason scrupulous attention should be paid to this point on all inpatient admissions.

The first systematic investigation of reproductive behaviour in this population⁹ discovered that less than 5% of women interviewed answered 'yes' to the question: 'Has any one talked with you about family planning?' It seems that not much has changed in the subsequent quarter of a century.

Of the forty-five patients whose use of contraceptives was unknown, 36 (80%) were discharged on at least one drug whose effect in pregnancy is potentially teratogenic or uncertain. It is important that women understand the possible complications of any medication they are taking, and that psychiatric staff consider the benefits and risks of particular medication, bearing in mind the possibility of pregnancy. Up to one-third of chronically mentally ill women who do not wish to become pregnant may not use any contraception when sexually active.¹⁰

It is possible that many of these patients received adequate verbal advice about contraceptive status, pre-conceptual care, and relationship issues, and that the capacity to consent to sexual relationships was adequately

assessed. Similarly, information about the number of dependent children and child protection issues may have been held in the memory of the consultant concerned or in previous admission records. It is argued that this is insufficient, as many of these issues are liable to change between admissions and therefore should be assessed and recorded on each occasion. Indeed, it is worrying that evidence of troubled sexuality (such as the case of the vaginal self-mutilation) is not recorded as having been assessed, and the one patient who complained of sexual assault by a fellow patient did not have her complaints dealt with by the recommended procedure.¹¹ In one case the patient was assessed by the admitting doctor as vulnerable to sexual exploitation. Unfortunately, this concern was not reflected by any strategy in the care plan. As stated in the Royal College report,¹ there is a lack of debate about the assessment of capacity to consent to sexual activity, and perhaps this was why there was no discussion on this point in any of the notes scrutinized. It is ironic that the public's caricatured perception of a psychiatrist as being primarily interested in the patient's sex life is so completely refuted by this study. Staff may find the issue difficult to discuss with patients for many reasons, including embarrassment, fear of showing ignorance, or the ideas that attempts at intervention in sexual relationships are old-fashioned or prudish.¹¹ However, patients may have been reluctant to report sexual difficulties, and specific enquiries may facilitate disclosure.¹²

These results corroborate the findings of Singh and Beck, who found that almost three-quarters of inpatient notes lacked a recorded sexual history, and in 22% this was limited to 'reduced libido', leaving only 3% with fuller details.¹³

It may be that junior psychiatric staff are uncomfortable discussing sexuality and reproductive health. It is possible that contraceptive usage is actually much higher in this study population than was detected. However, it would surely be prudent to follow the advice of Oates⁵ and others that discussing contraception and the likely effect of pregnancy, not only on mental health but on capacity to care for their child physically and emotionally, should be part of ordinary psychiatric practice, especially with regard to those living a more chaotic lifestyle.

Another serious oversight is the lack of information on dependent children. In only 14 (25%) cases was there either a clear statement of there being no children, or their age (and thus dependency) was recorded. Only seven cases

had recorded details of child-care arrangements: for example, 'living with grandparents', 'being fostered', or 'child protection team involved'. This corroborates an earlier study that found enquiries about children in only 29% of case notes.¹⁴

Children with parents suffering from chronic mental illness are known to accommodate to chronic neglect and emotional abuse, particularly when it is the result of acts of omission.¹⁵ They are at greater risk of developing psychopathology than are children of parents who are not mentally ill.¹⁶ The Children Act 1989 places a duty on all professionals to put the child's needs above all other people and issues, and hence psychiatrists have a responsibility to consider the well-being of the children of our mentally ill patients.¹⁷ Since in 14 of the cases we studied, no details at all about the children of inpatients were recorded, other than their existence, it is unlikely that their well-being was considered explicitly. A patient who is a parent should always be asked about the effects of mental illness on their children, and irritable patients need to be asked specific questions about anger towards children as a part of the risk assessment process.

It may be that the inpatient setting itself favoured an approach that was based on ameliorating the presenting complaint, rather than considering the women in the context of daily family life, and a community-based study might have yielded different results. Nonetheless, this study reveals a need for a more comprehensive approach to women inpatients, addressing their role as sexual, reproductive beings and mothers.

KEY POINTS

- Sexuality, fertility and contraception are under-recorded in women's inpatient case notes and care plans
- The advent of atypical antipsychotics makes unplanned pregnancy more likely
- Many women in this study are taking drugs that are inadvisable in pregnancy
- In spite of the Children Act, the needs of children are not addressed by professionals caring for their mothers

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