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Guest Editorial

Women's Mental Health: Focus on Sexual and Reproductive Issues

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Over the past decade, clinicians and researchers have paid growing attention to women's health issues, including sexual and reproductive health concerns throughout the female life cycle. Articles in this issue by Dr Robert Segraves and Dr Adele Viguera reflect this interest by capturing 2 important topics: sexual dysfunction in women (1) and the treatment of mood disorders during pregnancy (2).

Women and men with psychiatric disorders are women and men first

Few topics seem to generate such a spectrum of emotional responses—often very mixed—from psychiatrists as do sexual and reproductive issues in persons with serious mental illnesses. Clinicians often experience very mixed emotions (3,4). While we want to help both male and female patients to participate fully in life to the extent of their abilities, it may be challenging to include optimal sexual and reproductive functioning in the treatment plan. At an intellectual level, we accept that sexuality is an important subject to explore with our patients, but on a daily basis we often fail to take a sexual history (5). In my clinical experience, this is especially true in the case of women with psychotic disorders, where there is often great reluctance to inquire about sexual and reproductive functioning. By understanding the multiple factors that affect fertility and sexuality, clinicians can more effectively collaborate with patients to improve their quality of life.

The ability to function sexually is an important but historically neglected psychiatric outcome. Persons with psychiatric disorders often suffer chronically and may require lifelong treatment with psychotropic medications that affect their sexual health. Those working in this field need to know the consequences of sexual and reproductive dysfunction occurring during adolescence and young adulthood—the time of onset of many major psychiatric conditions. How does drug-induced sexual dysfunction affect compliance? What are the relations among the underlying illness, the drugs used to treat it, the individual's medical health and psychosocial condition, and sexual functioning and the ability to engage in fulfilling, intimate relationships? There are many unanswered questions. While this issue's "In Review" section focuses on women's mental health, sexual dysfunction is not only a women's issue. Nevertheless, as Dr Segraves points out, "Information concerning female sexuality has consistently lagged behind our knowledge of male sexuality" (1). His article provides a welcome update.

"Childbearing, from the standpoint of psychological medicine, is the most complex event in human experience"

As this quote (6) suggests, the desire (or lack thereof) for children is a human issue that does not disappear with the diagnosis of a psychiatric disorder. When confronted with a pregnant woman who has a serious mental illness such as schizophrenia or bipolar disorder, clinicians understandably often feel overwhelmed by the complexity of the situation. Over the past decade, there has been increased recognition of the risks for the mother and fetus of not treating the underlying psychiatric disorder. Dr Viguera's article supports what has become increasingly clear: no decision—whether to discontinue, change, or continue psychotropic medication—is risk-free. Clinicians in these situations face the following questions: What are the benefits and risks of the medications? Should the medications be stopped or changed? If I do that, what is the risk to the mother? What is the risk to the fetus? What genetic counselling should be offered and when? Does the woman have the support system she requires to optimize outcomes, not only

during the pregnancy but also during the years of parenthood that will follow? As psychiatrists, we have much-needed expertise that we can share with our colleagues to improve the care of pregnant women with psychiatric disorders.

Sexuality and reproductive functioning are obvious topics to discuss from the perspective of gender roles and sex differences. However, there is also a need to expand on the work done during the 1990s on gender roles and psychopathology, on neurobiological differences between the sexes, on sex differences in psychopharmacology, and on policies that encourage the inclusion of women in clinical trials of new treatments. Becoming more gender-sensitive in our clinical practices, program planning, and research endeavours does not mean becoming a "male" or "female" specialist. Ultimately, sensitivity to and acknowledgement of sex and gender role differences can improve psychiatric care for both men and women. I hope that the contributions from Dr Viguera and Dr Segraves will help clinicians develop this sensitivity in their evolving practices and encourage researchers to consider these issues in their psychiatric research. Gender issues are not synonymous with women's issues; I hope, too, that we can look forward to a future *Journal* "In Review" section on men's mental health issues.

References

1. Segraves RT. Female sexual disorders: psychiatric aspects. Can J Psychiatry 2002;47:419–25.
2. Viguera A. Clinical issues in the management of bipolar disorder during pregnancy: weighing the risks and benefits.Can J Psychiatry 2002;47:426–34.
3. Dickson RA, Hogg L. Pregnancy of a patient treated with clozapine. Psychiatr Serv 1998;49:1081–3.
4. Coverdale JH, Bayer TL, McCullough LB, Chervenak FA. Respecting the autonomy of chronic mentally ill women in decisions about contraception. Hospital and Community Psychiatry 1993;44:671–4.
5. Singh SP, Beck AJ, No sex please, we're British. Psychiatric Bull 1997;21:99–101
6. Ian Brockington. Motherhood and mental health. Oxford University Press; New York 1996.

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