Family Planning and the Scope of the “Reproductive Psychiatry” Curriculum

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The National Task Force on Women’s Reproductive Mental Health, which was founded in 2013, has concluded that it is time for all psychiatrists to acquire basic knowledge and skills in reproductive psychiatry [1]. While working to create a clear subspecialty definition, the Task Force has identified several critically important topic areas to teach. These include the influence of sex hormones on women’s health, premenstrual dysphoric disorder, antenatal stress and depression, postpartum depression, and the risks of treatment to both the mother and fetus, among others [1]. The Task Force has suggested that the reproductive mental health education of psychiatrists has been lagging behind clinical, public policy, and research initiatives [1].

In this issue, members of the National Task Force have published two important and innovative research articles concerning the education of psychiatrists on reproductive mental health [2, 3]. The first concerns a web-based survey of psychiatry residency training directors (response rate 29%) regarding the current state of reproductive psychiatry in residency education [2]. Reproductive psychiatry was defined in this survey as the study and treatment of psychiatric illness during reproductive transitions. Those reproductive transitions were characterized by hormonal flux and/or social role change and specifically included pregnancy, the postpartum period, infertility, pregnancy loss, the premenstrual period,

and perimenopause. The survey included an open-ended question that allowed program directors to describe the current educational offerings in reproductive psychiatry. Most program directors reported that some training was required in reproductive psychiatry [2]. Nearly all programs that required reproductive psychiatry education taught about related mood disorders and psychotic disorders. Family planning was not formally mentioned, however [2].

The second article identified post-residency training programs in reproductive psychiatry by an online search, a list-serv query, and an announcement at a national meeting [3]. Of the twelve Women’s Mental Health training programs identified, the most common clinical experiences occurred in specialized inpatient consultation-liaison services and specialized outpatient clinics. Only two of the six programs that offered their full didactic programs for review reportedly offered didactic sessions on family planning [3]. A third article [4] surveyed residents across specialties (family practice, internal medicine, obstetrics-gynecology, and psychiatry) in order to ascertain their perceived adequacy of training on contraceptive prescribing and family planning for patients with major mental disorders. Although only a very small percentage of the target population responded, those who did tended to agree that education and training on family planning and contraception was lacking for this population of patients.

Our goal for this editorial is to highlight the critical importance of including family planning in the purview of reproductive psychiatry. We aim to emphasize the importance of routinely assessing and attending to the family planning needs of adult and adolescent patients and the importance of teaching on this topic. Scope, or the sum of all activities and learning experiences, is a basic principle of curriculum construction and organization [5]. Formal inclusion of family planning in the reproductive psychiatry curriculum should enable its integration and articulation with the other topics taught on reproductive psychiatry. This in turn should remind learners of their

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important public health role in preventing unwanted pregnancies as understood by patients' own perspectives.

We will focus here on the family planning needs of patients with major mental disorders, especially those with schizophrenia-spectrum disorders and bipolar disorders. We recognize that there are many common elements, however, between teaching about the family planning needs of patients with major mental disorders and the family planning needs of other vulnerable groups such as adolescents and patients with neurocognitive disorders. In focusing on the family planning needs of patients with major mental disorders, we will discuss the important topics of violence against women, termination of pregnancies, the ethical issues associated with managing the family planning needs of patients, and sexual history-taking. These topics reveal the absolute necessity of teaching about family planning as a part of the reproductive psychiatry curriculum.

Family Planning Needs of Patients with Major Mental Disorders

Some evidence suggests that the family planning needs of patients with major mental disorders may not be routinely addressed in psychiatric settings [6, 7]. Yet patients with major mental disorders, including schizophrenia-spectrum disorders, may have an enhanced risk when compared to groups of patients without mental disorders for both unwanted pregnancies and children given up for others to raise [8, 9]. Although the literature is scant on the family planning needs of patients with major mental disorders, one review found that many women with schizophrenia had multiple partners, high rates of coerced or forced sex, high rates of HIV risk behaviors, and limited knowledge about sexuality [10]. Even when many heterosexually active women with major mental disorders do not want to become pregnant, they may not use birth control consistently, if at all [9, 11]. Alcohol or illicit substance use disorders, which are likely more common in those with major mental disorders [12, 13], may contribute to the risk for unwanted pregnancies and the adverse consequences of those pregnancies. Moreover, some of the risks of psychiatric disorders in women with major mental disorders who have unwanted pregnancies also extend to their infants, particularly if these women are depressed, psychotic, or have histories of trauma or addiction.

Mental health service providers should therefore be attuned to these risks and they should educate and counsel patients accordingly. Mental health service providers should also educate other clinicians, including family practitioners, gynecologists, pediatricians, and other primary care providers, who might serve this population. An early example of an innovative program providing family planning services for psychiatrically ill patients occurred in three state psychiatric hospitals

in Massachusetts [14, 15]. The program served an important educational function; many women welcomed an opportunity to learn about contraception and welcomed the possibility of relief from the worry that they might have unintended pregnancies [15]. Providing family planning services within mental health services improves access to those services [8, 14] and provides opportunities for integrating family planning with other programs such as parenting classes, substance abuse treatment, and services for protecting against sexually transmitted infections [16]. Mental health service providers should be alert to the fact that women of child bearing potential who are prescribed psychotropic medications potentially harmful to pregnancy may become pregnant [17, 18]. Mental health services providers should also appreciate and appropriately manage the tricky ethical issues related to preventing pregnancy when referring women of child bearing potential to clinical trials [19].

Sexual Violence and Family Planning

Violence against women is a global and clinical problem of epidemic proportions [20, 21], which is linked to systematic and global gender inequalities [22]. Forced and early marriage, sex trafficking, rape, female genital mutilation, and the exertion of power and control over contraceptive and pregnancy choices are all types of violence against women and girls [21, 23]. Interpersonal violence, including sexual violence, is also a major public health problem in the United States [24]. Unwanted pregnancies and sexually transmitted infections are two possible consequences of sexual victimization. Only a small percentage of violent incidents are reported to health care clinicians or law enforcement agencies [24] and sexual violence can also go undetected in mental health services [25]. Patients with major mental disorders are at an elevated risk of becoming victims of violence, including sexual violence [26, 27]. Thus, in one survey on formal training in women's issues in psychiatry, most responding programs offered a course on women and violence, including domestic violence [28]. Similarly, in a review of clerkship directives in the undergraduate psychiatry curriculum, those pertaining to abuse and violence were particularly comprehensive [29].

Taking an adequate sexual history, screening for violence, and identifying victims of abuse are necessary steps in order to provide support, manage consequences, and prevent re-victimization. Psychiatric service providers should therefore be trained in methods that compassionately and validly elicit information about abuse, including sexual abuse. The "funnel technique" is one example that transitions from less sensitive to more sensitive and specific interview questions [30]. "Rape myths," which can undermine identification of needs and service provision, should also be formally addressed in teaching

[31]. Well-educated psychiatrists can lead in teaching these skills to family practitioners and gynecologists.

Female gender is also a risk factor for becoming a victim of sex trafficking [32]. Although not clearly established, other risk factors perhaps include diagnosis of a major mental disorder and substance use disorders. Furthermore, psychiatric disorders, including depression, anxiety, and post-traumatic stress disorders, are common sequelae of being trafficked [33, 34]. Possible consequences of sex trafficking include pregnancies and sexually transmitted infections [35, 36]. In addition, it has been suggested that some girls who are prostituted are beaten to induce miscarriages [37]. By one estimate, there are more than 300,000 trafficked victims in Texas alone, many of whom were sex trafficked [38]. Trafficked victims may not be recognized when they present with health problems [39, 40], so it is important to remain vigilant for signs of abuse.

Training in addressing sexual violence and the possible consequences of sexual violence should aim to ameliorate the anxieties of interviewers at asking sensitive questions. Mental health providers and other multidisciplinary healthcare team members may understandably eschew questions that might uncover traumatic histories because of potentially painful or distressing personal consequences. Failing to uncover traumatic histories, however, is a disservice to patients. Outrage against the epidemic of violence against women, appreciation of women's suffering, and recognition that those with major mental disorders are especially vulnerable to abuse, trafficking, and violence should motivate us all to learn and re-learn the requisite skills to routinely identify and assist victims. Indeed, mental health professionals, including psychiatrists, are obligated to continue to develop educational and clinical programs to address this epidemic of violence and to educate the public about the unacceptability of all forms of violence against both women and men.

Termination of Pregnancies

A key decision every pregnant woman must make is whether to continue the pregnancy through to viability and to term. Mental health professionals must be ready to assist women in this decision. The findings of two studies suggest that, compared to non-psychiatrically ill groups, patients with major mental disorders, including schizophrenia, may be more likely to terminate their pregnancies [8, 9]. Should these findings be found to be reliable, they may reflect a number of concerns from prospective mothers. These prospective mothers may be worried about lack of financial means to raise a child, lack of social support, the possibility of obstetrical complications that are somewhat elevated in those with major mental disorders [41, 42], the belief that their mental disorder may impair mothering, or the fact that prospective children

may also be at risk for mental disorders. These findings may also reflect the possibility that some pregnancies were unwanted and the result of coerced sex, or these findings may reflect a lack of foresight, education, and planning in avoiding unwanted pregnancies.

One important strategy for preventing unwanted pregnancies would therefore be to educate patients on the following: how to resist unwanted sexual advances, contraception and possible benefits and risks of pregnancy, the management of mental illness during pregnancy, and how to advocate for condom use among male partners (which protects women from sexually transmitted infections). Male patients with mental disorders should be taught about family planning in relation to their own needs and interests [43].

It is also important to be cognizant of the psychiatric aspects of terminations of pregnancies. Because misinformation about abortion is rife, it is incumbent on mental health professionals to discuss and destigmatize contraception and abortion and help female patients through the process of having abortions [44, 45]. Restrictive laws and barriers to abortion in the United States impede access [45] and, although mental health risks have been provided as a rationale for some restrictive laws, there is a solid body of evidence demonstrating the absence of such negative effects [45]. Indeed, in one prospective longitudinal cohort study that recruited women from abortion facilities in 21 states throughout the United States, being denied an abortion was associated with a greater risk of initially experiencing adverse psychological outcomes compared with having an abortion [46].

Ethical Issues

Ethical challenges unique to this population of the seriously mentally ill involve managing patients' decision-making about contraception and termination of pregnancies. These ethical challenges can become especially daunting when patients are severely impaired in their decision-making capacity [14]. A comprehensive framework for addressing any ethical issues that arise enables such decisions to be well thought through in clinical practice. The history of eugenics in the United States and other nations [47, 48] highlights the priority of effectively establishing a comprehensive framework.

The family planning program that was conducted in state mental hospitals in Massachusetts emphasized the importance of obtaining informed consent for contraception, the importance of voluntarism, and the importance of an exclusive reliance on reversible methods of contraception [14, 49]. A preventive ethics strategy involves proactively discussing family planning with patients with mental disorders in order to reduce the risk of ethical dilemmas and adverse ethical outcomes [50]. Key components of an ethical framework for preventing unwanted pregnancies in patients with major mental disorders

include balancing autonomy and beneficence-based obligations to the patient [51, 52]. It has not been shown that coercing or manipulating a patient's decision-making regarding contraception is ethically justified when at risk of unwanted pregnancies, even when the patient has impaired decision-making [51, 52]. Although long-acting reversible contraception methods are highly effective and safe for use in almost all women [53], potential ethical problems occur when these are not removed at a patient's request.

Similarly, complex ethical issues arise when a patient with a major mental disorder requests a termination of pregnancy [54]. Clinicians have beneficence-based obligations to the pregnant woman and to the fetal patient when the pregnant woman confers that moral status on the preivable fetus and when the fetus is viable absent fatal anomalies [55, 56]. Other considerations for a comprehensive approach to managing ethical issues include managing clinicians' strong feelings whenever these arise and incorporating assisted and surrogate decision-making [56]. Patients should be assisted to make a decision consistent with their long-standing values and beliefs and in keeping with the clinician's own beneficence-based obligations to the fetal patient. Education and identification and treatment of barriers to decision-making are important clinical strategies in enhancing patients' autonomy and decision-making. Patients should be assisted through education to make a decision about all issues at stake concerning the pregnancy as well as about treatment of the underlying mental disorders that impair decision-making capacity.

Sexual History-Taking

Conducting an adequate sexual history is the first step in identifying those at risk for unwanted pregnancies and children given up for others to raise. Areas of potential relevance to sexual history-taking include sexual orientation, number of sexual partners, methods and consistency of contraceptive use in relation to attitude toward becoming pregnant, alcohol and illicit substance use, and gynecological and obstetric history. Patients' history of sexual abuse, including a history of being forced into unwanted sexual encounters and associated distressing psychological consequences of abuse, should also be ascertained.

The importance of teaching about sexual history-taking is well appreciated. There have been few attempts to evaluate teaching sexual history-taking to trainees, however. According to one review, there are several controlled trials on teaching sexual history-taking in other specialties, although none were found in psychiatry [57]. We need to learn more, therefore, about how to effectively teach about sexual history-taking.

Moreover, psychiatric services should take account of barriers to sexual history-taking and the provision of family planning services. There are many advantages to integrating family

planning services into community mental health settings as well as to integrating mental health services into sexual health and family planning services [58]. Efforts to collaborate with and educate other physicians are also best done in models of integrated care. Administrative support should be provided to enable the integration of services. Many patients do not have the funding or resources to attend primary sexual health or family planning clinics. Although the Affordable Care Act currently mandates coverage for contraceptive methods and counseling for all women, changes to the Act or to women's access to contraception may jeopardize their health [59].

The topics of health care and human reproduction can generate strong feelings, which, in turn, can undermine sexual history-taking as well as reason, policy, and public health. There are reportedly erroneous claims in the political arena that, for example, contraception is ineffective, that not one woman cannot afford birth control on her own, or that contraceptives are abortifacients [60]. We have an important obligation to get the medical facts right so that we can educate our patients well. We should also educate policy decision-makers about our patients' vulnerabilities and advocate for policies that are compassionate and aligned with well-justified arguments and science.

In conclusion, we have argued that it is imperative that mental health professionals become educated about family planning as part of a reproductive psychiatry curriculum. First, as we have shown, patients with major mental disorders are vulnerable to unwanted pregnancies, termination of pregnancies, and children given up for others to raise. Second, they are also vulnerable to sexual abuse and other forms of violence that can impact their family planning needs. Third, identifying patients' family planning needs provides an opportunity to learn about risk for sexually transmitted infections and risk for being a victim of violence. Fourth, preventing unwanted pregnancies prevents some of the problems that can be very complex to manage during pregnancy. Fifth, the associated ethical issues can be clinically challenging, and these too deserve attention in the curriculum so that they can be managed well.

Our profession must do all it can to formally and comprehensively support women with major mental disorders, to assist their autonomous decision-making about family planning, and to promote their reproductive choices. We should also not forget to educate about the needs of other especially vulnerable populations, including adolescents and the intellectually and developmentally disabled. A failure to comprehensively address these issues educationally, clinically, and administratively will limit patients' contraceptive choices and risk unwanted pregnancies.

Compliance with Ethical Standards

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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