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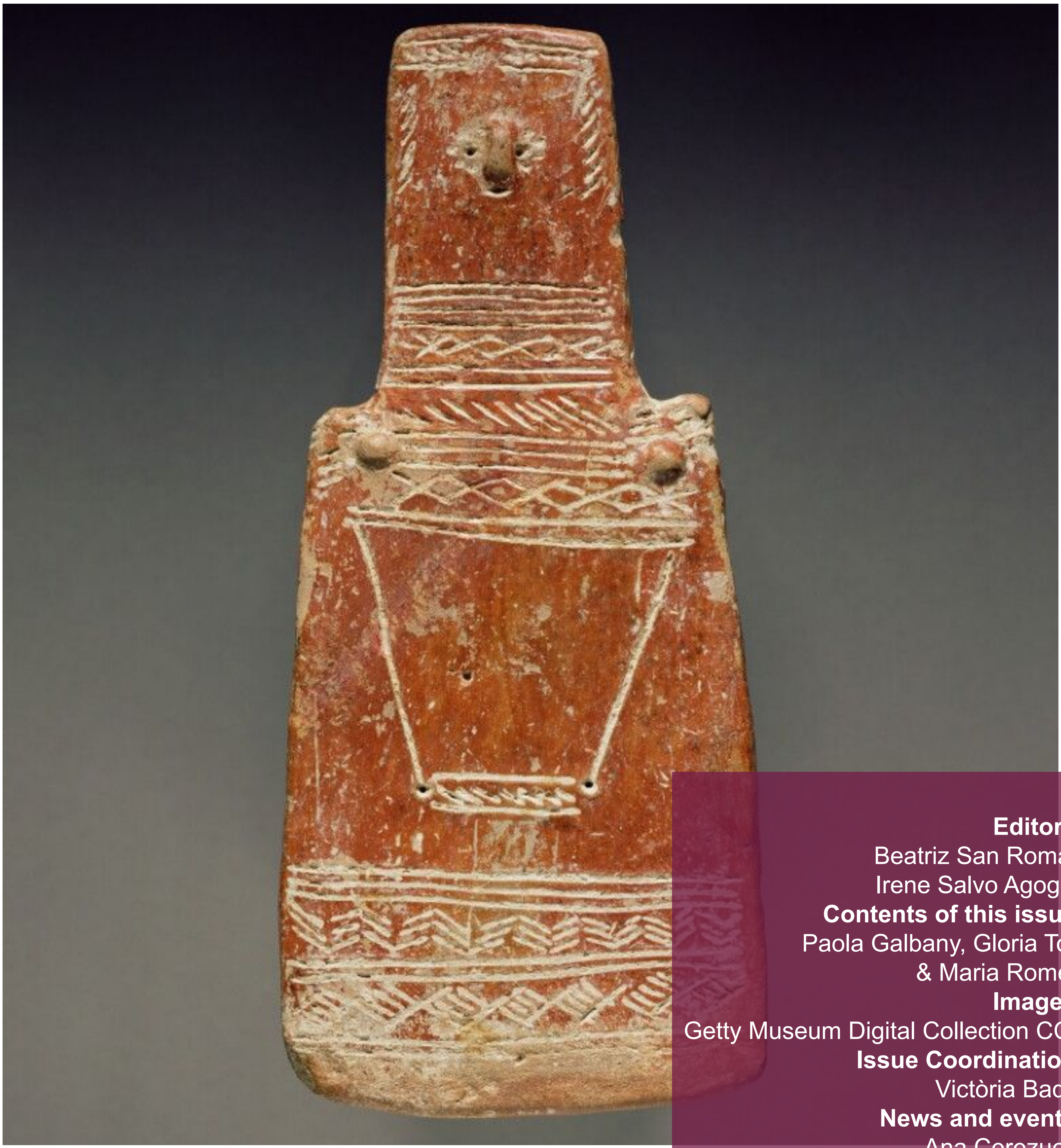
Between Desire and Barriers: Sexual and Reproductive Health among Women with Mental Health Problems



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Sexuality and reproduction are part of everyone's life. They are connected to important decisions about one's own body and each person's life project. However, not everyone is able to live and exercise them. For women with severe mental health problems, these decisions are often strongly shaped by both the social environment and the healthcare system.

In this article, we share the results of research on how women diagnosed with a severe mental disorder, that is, intense and long-lasting mental health problems such as schizophrenia or bipolar disorder, experience sexual and reproductive health. We are interested in understanding what helps them take care of themselves, the difficulties they encounter, and how the healthcare system and social environment influence their decisions.

Many of these women want to become mothers, but this desire often goes unacknowledged within the healthcare system and in research. Their experiences are often overlooked or approached primarily from a clinical perspective, which does not always consider their desires, decisions, or the conditions under which those decisions are made. For this reason, in this work, we focus on their narratives. The aim is not only to identify difficulties but also to understand how personal, social, and institutional factors interact and how this interaction can generate or reproduce inequalities in the exercise of sexual and reproductive health.

To explore this reality in greater depth, we interviewed eight women. Their trajectories differed, but they shared a common experience: taking care of their sexual and reproductive health does not always depend solely on them. Some maintained regular follow-up, while others gradually abandoned it along the way. Their accounts help us understand how they experience care for their sexual and reproductive health, why accessing services can be difficult at times, and what factors influence their decisions.

Statuette of Kore.
About 480 B.C.
Getty Museum Collection.

In their narratives, motherhood appears as a central theme, full of meaning but also of tensions. They spoke about their desire to become mothers, but also about the fears that accompany it and the preconceived ideas circulating in their environment. Many of these beliefs — such as the idea that they will not be capable of being mothers or that they will make poor decisions because they have a mental disorder — end up being internalized.

Added to this are renunciations and decisions not to have children, which are part of complex life trajectories and, in many cases, are shaped by stigma.

We also include the voices of mental health and sexual and reproductive health professionals (psychiatrists, mental health nurses, gynecologists, and midwives) who accompany these women at different moments in their lives. Their testimonies help us better understand what works in everyday practice and where the main difficulties arise, especially when services do not communicate with one another or fail to provide coordinated care.

This article brings women's experiences into dialogue with the perspectives of professional teams in order to approach what is really happening in practice. Drawing on these voices, we seek to make visible the persistent difficulties, what remains missing in care, and what concrete changes could make a difference in the experiences and health outcomes of women with severe mental disorders in sexual and reproductive health.

When sexual and reproductive health is pushed into the background

Sexual and reproductive health is a right, but for many women with severe mental health problems, it is pushed to the background. In practice, this means fewer preventive checkups, less support for family planning, and greater difficulty in resolving important questions. The healthcare system itself contributes to this situation: consultations are rushed, schedules are overloaded, and different services do not always coordinate effectively.

Female Figure of the Early Spedos Type.
2700–2500 B.C.
Getty Museum Collection.

In this context, motherhood is marked by silences and by fear of judgment. Some women want to become mothers but do not find spaces where they can express this desire with confidence. Others decide not to become mothers but feel they must constantly justify their decision. In both cases, the lack of clear information and contradictory messages (especially regarding medication, pregnancy, or breastfeeding) create insecurity and reinforce the feeling of facing these decisions alone. Many women explain that even when they want to take care of themselves, the way the system functions does not always make it easy. Inflexible schedules, appointments spaced far apart, unclear care pathways, or the need to attend different services to resolve a single issue make follow-up more difficult. This lack of continuity not only delays care but also creates uncertainty and distress.

Additionally, in many mental health consultations, the priority is placed on avoiding relapse or controlling symptoms, leaving aspects such as sexuality, contraception, or reproductive desires in the background. For the women themselves, however, these issues are not secondary: they are part of their well-being, their identity, and their life project.

Wanting to be a mother… or not: deciding between prejudice and silence

When a woman with mental health problems says she wants to become a mother or does not want to, she is sharing something deeply intimate. A close, respectful response can build trust. By contrast, a distant attitude, or one that minimizes what the woman feels and expresses, may lead her not to raise the issue again for years. Deciding is not only about choosing; it is also about feeling heard and accompanied.

The fears expressed are legitimate: fear of not being up to the task, of becoming unwell again during pregnancy or the postpartum period, of the baby being affected by the illness or the medication, or even fear of losing custody if something is interpreted as a "risk." One of the women interviewed described an experience of losing custody of her children during a hospital admission as follows:

> *"I was being admitted, and meanwhile, they were processing the adoption. It was completely involuntary. What I wanted most was my children. They declared me incapable of being a mother. They incapacitated me, yes. It is horrible. The helplessness was brutal. It is as if you constantly had*

Statuette of an Amazon (300–200 B.C.).
Getty Museum Collection.

Statuette of a Mother with Child.
6th–5th century B.C.
Getty Museum Collection.

> *something pricking your heart from the inside and making it bleed, because it is horrible. I would not wish it on anyone. Horrible, horrible."*

Other women explain that they ruled out motherhood because they never found a space where they could raise the issue with confidence, without feeling judged or infantilized. For their part, those who decide not to become mothers consider it necessary that their decision be respected without being questioned again and again, and without feeling obliged to convince each professional that their choice is valid.

Prejudice remains very present, both the prejudice that comes from the environment and the prejudice many women have internalized. However, these women have capacities, resources, and life projects as diverse as anyone else's. What they need is clear information, real support, and professionals who trust them. When this happens, their confidence increases, they become more involved in prevention, and they find a more stable path toward their life goals. As one of the nurses interviewed summarizes: "Everything revolves around stigma; the truth is that there is a lot of ignorance: people discriminate and easily label the mentally ill."

Motherhood never follows a straight path, and for women with mental health problems, this journey can be even more complex and may require more support. Some women need time and take years to feel ready. Others, by contrast, experience pregnancy with excitement but need very close support during pregnancy, childbirth, and the first months after giving birth.

Good support involves very concrete aspects: knowing which warning signs to watch for, how to manage fatigue, when and whom to ask for help, how to adjust medication, and how to rely on people and resources that support everyday life. In the most positive accounts, a similar combination always appears: professionals who coordinate with one another, clear information about the possible risks of pregnancy, shared agreements about medication, real social support, and close follow-up during pregnancy and the first weeks after childbirth.

When one of these pieces fails, doubts increase, abrupt changes in treatment may appear, or fear may even lead women to hide the pregnancy because they are afraid of judgment or of receiving a negative response from the healthcare system. For health professionals, the starting point is usually that the woman should be well and stable before considering pregnancy. Adjusting medication, reviewing which treatments are safer, increasing the number of visits, or coordinating among different professionals is not intended to impose limits but to accompany the process safely. What is essential is that the decision (whether to become a mother or not) is respected and that there are clear pathways to support it, without unnecessary obstacles.

When prevention does not arrive

Prevention in sexual and reproductive health involves much more than sending reminders to undergo a medical test. It requires facilitating access, reducing barriers, and adapting care pathways to each woman's reality. Making an appointment can be difficult when a person is going through a period of emotional ups and downs. Visiting an unfamiliar health center can cause anxiety, and managing multiple visits makes it harder to maintain follow-up. For this reason, small adaptations — such as flexible schedules, personalized reminders, or professionals trained in mental health — can make a major difference.

Contraception also requires clear explanations and close, respectful treatment. Several women said they had never been told about options adapted to their personal situation, or that they had received contradictory messages about whether their medication could interfere with contraceptive methods. When mental health services and sexual and

Statuette of a Woman.
8th–14th century.
Getty Museum Collection.

reproductive health services work without effective communication, information arrives fragmented and incomplete, and decisions are made without an overall view.

In addition, sexual education adapted to different realities remains an unresolved issue. Most women appreciate spaces where they can ask questions without shame about consent, pleasure, boundaries, sexually transmitted infection prevention, or unequal relationships. This is not only about information but about having spaces of care that increase the capacity to make decisions, avoid risks, and experience sexuality with greater confidence.

Statuette of a Seated Female Figure with a Child.
5th century B.C.
Getty Museum Collection.

As one of the psychiatrists interviewed noted, this difficulty is also evident in consultation:

> *"It is not that I go through one topic after another, but rather that you talk more about adverse effects in general. Men usually bring it up spontaneously, women do not, so you do not really ask further either… I don't know if it is because they are embarrassed to talk about it, I don't know."*

When services do not coordinate

When mental health services and sexual and reproductive health services are not connected, women receive contradictory messages about contraception, pregnancy, or medication. This lack of coordination generates doubts, delays important decisions, and can affect both women's emotional well-being and their physical health.

Continuity of care should not depend on a professional's goodwill or on a woman's ability to explain her situation again and again in each consultation. This lack of coordination between services also has consequences that are not always evident during the consultation itself. As one gynecologist explains, in many cases, information about patients' situations does not arrive directly but in a fragmented or even accidental way:

> *"Many times, patients do not tell you. You may even go into the shared medical record and see there that she has been seen by the psychiatrist, that she even has temporary disability, or that she has had a crisis, and many times you find out, but indirectly, because you entered the shared*

> *record looking for a blood test or something else. This stigma around it can mean that patients do not say anything. And in the end, this is important for better monitoring of pregnancy, postpartum, and everything."*

Coordination, however, is possible through very concrete changes: clearly defining who communicates with whom, facilitating transitions between services during pregnancy and postpartum, sharing the same information among professionals, and agreeing on a joint care plan. The point is not to reinvent the system but to make what already exists work better so that the burden of care does not fall solely on the woman.

Small changes that make a difference

Consultations, although brief, are important moments. Asking "How do you feel about your sexual health?" or "Do you have any questions about contraception, pregnancy, or breastfeeding?" can completely change the experience of care. Normalizing these questions helps reduce shame, anticipate needs, and create spaces of trust.

It is also useful for health professionals to routinely include explanations of how hormonal changes can affect mood, what to do if an unplanned pregnancy occurs, and how to ask for help if postpartum anxiety appears.

Reviewing preventive tests, helping manage appointments, or clarifying treatments are small actions, but they have a direct impact: they prevent women from being lost to follow-up and increase their sense of safety.

Statuette of Minerva.
50 B.C.–A.D. 25
Getty Museum Collection.

Coordination does not require major changes, but concrete gestures: informing the midwife of a pregnancy, sharing medication changes among professional teams, or agreeing on who will be the contact person. When this happens, an important burden is reduced: the burden of having to explain one's own story again and again in every consultation.

Providing better care in everyday practice

The improvements that can be introduced into everyday practice do not require major changes to the system but rather a closer, more coherent way of providing care across all consultations. This means asking naturally whether the woman wants to become a mother or not, reviewing prevention without waiting for her to request it, ensuring that healthcare staff communicate coherent information — especially about medication, pregnancy, and breastfeeding — and establishing agile pathways that allow for a rapid response when a pregnancy occurs or during the postpartum period. It is also essential to respect and support reproductive decisions, offer clear and understandable information, and create spaces where women can speak without fear of judgment.

Statuette of Roma or Virtus (A.D. 50–75). Getty Museum Collection.

Just as it is important to care for women, it is equally important to care for professional teams, because the sustainability of this support over time depends on them. The quality of care depends not only on protocols but also on everyday practices. Through simple gestures such as asking, informing, coordinating, respecting, and accompanying, care becomes more accessible, more humane, and safer.

The key: a system that accompanies

What women value most is feeling that the health and social system accompanies them. For them, this can be summarized in five key elements: being asked whether they want to be mothers or not; keeping preventive care up to date without having to request it themselves; receiving clear and coherent information; having a contact person to resolve doubts; and not having to act as intermediaries between services.

When these five pieces fit together, the experience of care changes: fear decreases, security increases, and decisions are experienced with greater calm. Families and close social networks can also be allies if they are integrated from the beginning and if the woman's will is always respected. Accompanying is not the same as medicalizing; it means offering understandable and accessible support.

What makes the difference is not large-scale health programs, but the sum of small clinical practices that generate continuity. When this happens, uncertainty and fear decrease, trust in care grows, and decisions about motherhood are made with greater confidence and with less sense of loneliness.

Coordination, listening, and respect for women's decisions are pillars of integrated care that understands reproduction as part of life and not as something isolated. Incorporating this perspective means recognizing that autonomy is not built individually, but strengthened when the system accompanies, communication is transparent, and women feel they have the right to decide about their future.

Conclusions

Exploring the sexual and reproductive health of women diagnosed with severe mental health problems shows that the key is not only to add more resources but also to change how support is provided: to move from a system that responds late to one that anticipates and accompanies. When the healthcare system listens, informs, and coordinates, women not only receive better care but also gain security and participate more actively in their own health.

The capacity to decide begins with something as basic as providing clear, understandable information without contradictory messages. This may seem obvious, but in practice it does not always happen, especially when different services function in a disconnected way.

A good model of care is not limited to avoiding risks. Rather, it places the woman at the center, takes into account her life situation, and allows her to move forward from her own life project, without pressure or decisions made by others. It also recognizes that decisions are not made in a vacuum but in contexts shaped by relationships, expectations, and real possibilities. Listening to what she wants, attending to her concerns, and agreeing on care together are not minor gestures: they are actions that generate real and lasting change.

Moving toward fairer and more humane care requires a collective commitment: from health teams, from the functioning and organization of services, and from society. The challenge is to ensure that no woman feels she must choose between caring for her mental health and caring for her sexual and reproductive health. Both must be able to move forward together, with real accompaniment, clear information, and a support network that sustains women's decisions in a dignified and respectful way. In this sense, understanding how women's sexual and reproductive decisions are constructed and lived means recognizing that these decisions do not depend solely on them but on the conditions the system itself creates to make them possible — or to limit them. Making these conditions visible is an essential first step toward transforming them.

About the authors

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Diploma in Nursing from Universitat Ramon Llull (URL)-Blanquerna (1998), Bachelor's degree in Social and Cultural Anthropology from the Universitat de Barcelona (UB) (2001), Postgraduate Diploma in Intensive Care Nursing from URL (2006), PhD in Nursing Science from UB (2012), and Postdoctoral Fellowship at the Bloomberg Lawrence S. Faculty of Nursing, Toronto, Canada (2015-2016). Dean of the Facultat de Ciències de la Salut i el Benestar at the Universitat de Vic-Universitat Central de Catalunya (UVic-UCC) from 2017 to 2020, and tenured professor in the Nursing degree program. President of the Col·legi Oficial d'Infermeres i Infermers de Barcelona (COIB) from 2020 to 2024. Currently, she is an associate professor in the Department of Fundamental and Clinical Nursing at the Facultat d'Infermeria, Universitat de Barcelona.

Since 2011, she has been a member of various research groups, notably the AFIN Group at the Universitat Autònoma de Barcelona (UAB), a research group focused on social sciences, humanities, and health sciences, where she actively collaborates as a researcher.

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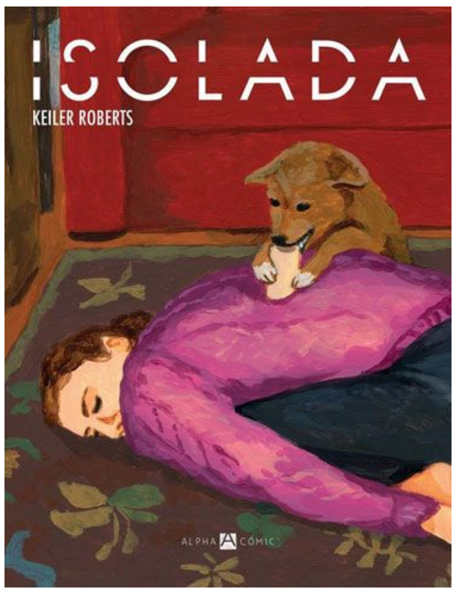
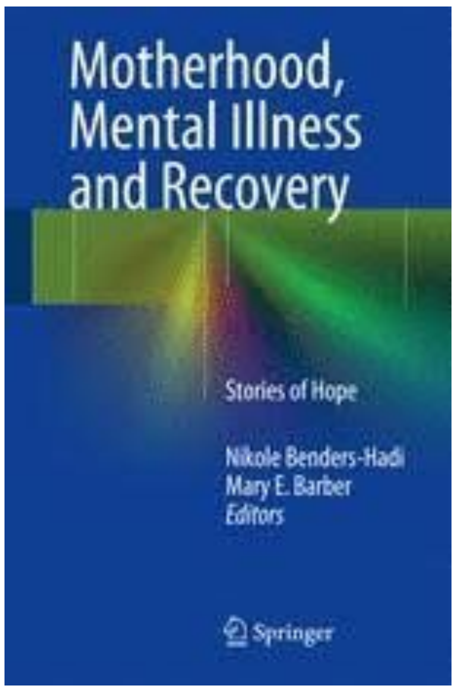


Keiler Roberts (2020)

Isolada

Alpha Decay

Isolada is an autobiographical comic that explores a territory rarely touched upon in literature: motherhood from the perspective of a woman diagnosed with bipolar disorder. Keiler Roberts, an American artist and mother, weaves a fragmented yet honest account of her daily life raising her daughter Xia whilst managing her mental illness. Roberts uses a quirky sense of humour and disarming candour to present both bright and dark moments with the same ‘poisonous lucidity’, crafting uncomfortable, endearing and deeply human exchanges between mother and daughter. The result is a work that demystifies the idea of perfect motherhood and highlights the reality of many women who face the challenges of parenting whilst living with mental health issues.



Nikole Benders-Hadi y Mary E. Barber (2014)

Motherhood, Mental Illness and Recovery: Stories of Hope

Springer

This book compiles research and stories about mothers with severe mental illness, including personal experiences, stigma, challenges and recovery, contextualizing the role of motherhood in the lives of women with serious psychiatric diagnoses, and how this influences their desire or their maternal experience.

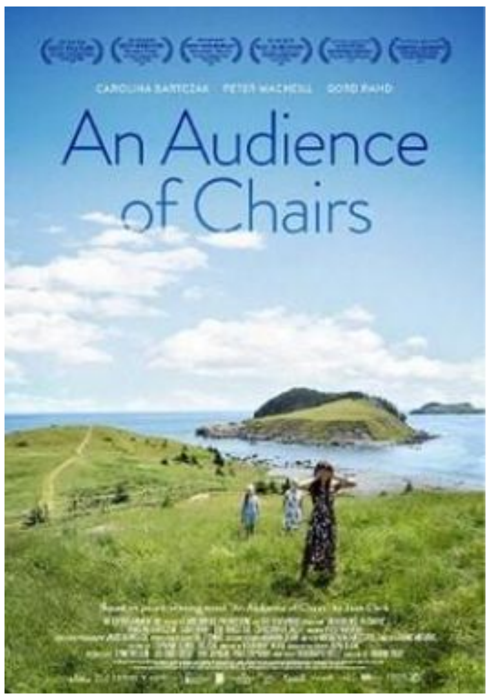
To watch

Ketevan Vashagashvili (2025)

Witches

United Kingdom, 90 min

This British documentary weaves together the author's own experiences with anxiety, depression, and postpartum psychosis with the stories of other women and historical film footage about witches and mental health. The documentary reflects on how women with mental health issues have been stigmatized throughout the centuries and offers testimonies, expert opinions, and cultural examples to challenge these narratives.



Deanne Foley (2018)

An Audience of Chairs

Canada, 93 min

A woman with a severe mental disorder (bipolar disorder) struggles to rebuild her relationship with her two daughters after episodes of illness that put them at risk. The film explores the impact of the disorder on her identity as a mother and her desire to be with them again.

AFIN News

Miguel Gaggiotti wins Best Short Film at BAFTSS 2026

Dr Miguel Gaggiotti, lecturer in the Department of Film and Television at the University of Bristol and member of the AFIN Research Group, has been awarded first prize for Best Short Film at the 2026 edition of the British Association of Film, Television and Screen Studies (BAFTSS), held recently. As part of several AFIN Group projects, Gaggiotti has created and produced various series of short films addressing themes linked to childhood, family and reproduction studies.

A new article titled "'Smile, even though it hurts': A photovoice study exploring the practices, experiences and spaces for menstrual care in Spain" has been published in *Social Science & Medicine – Qualitative Research in Health*, with Astrid Boe Hüttel of the AFIN Group as first author and Laura Medina Perucha of the Institut Universitari d'Investigació en Atenció Primària (IDIAP Jordi Gol) as last author.

The study uses the photovoice method to analyse how white and cis-heteropatriarchal social structures worsen experiences of menstrual discomfort and often hinder menstrual care practices. Through photographs and personal accounts, participants reveal the social pressure to hide and suppress their menstrual discomfort, highlighting a critical lack of menstrual knowledge and a systemic dismissal of their experiences.

However, by focusing the analysis on the concept of menstrual care, the research also highlights the positive aspects of menstrual experiences: they are meaningful moments of creativity, introspection, rest and opportunities to give and receive care.

This work is part of the project *Salud menstrual, salud mental y calidad de vida en España*, led by the Institut Universitari d'Investigació en Atenció Primària (IDIAP Jordi Gol) in collaboration with the AFIN Group.

The article is available open access here.

“Resonant Voices” on early pregnancy loss

On Tuesday 21 April, the activity “Voces en resonancia: relatos audiovisuales, debate interdisciplinario y reflexión colectiva sobre la pérdida gestacional temprana” took place, organised by the AFIN Barcelona Group.

The event was held in the UAB cinema hall to watch and discuss the short film *MUY LLENA*, under the artistic direction of Miguel Gaggiotti (University of Bristol, AFIN) and produced by AFIN, thanks to the grant for knowledge transfer activities in the university sphere awarded by the Instituto de las Mujeres of the Ministerio de Igualdad of Spain and available open access on the AFIN YouTube channel.

This is the third series of short films resulting from the project *Pérdidas reproductivas precoces: del malestar físico y emocional invisible al posible duelo personal, familiar y social*, funded by the Fundación “la Caixa” and led by Prof. Diana Marre.

The session was moderated by Carolina Remorini (AFIN, UAB), and the discussion included Diana Marre (AFIN, UAB), Bruna Alvarez (AFIN, UAB), Manuel Fernández Alcántara (UA), Sandra Guevara (UAB) and Purificación Escobar García (UAB), together with an audience of lecturers, researchers and students from various degree programmes at UAB.

The UAB Master’s in Anthropology opens admission

The Universitat Autònoma de Barcelona has opened the admission process for the Master’s in Anthropology: Advanced Research and Social Intervention for the 2026/27 academic year. It is an on-campus programme designed to understand contemporary social phenomena from a critical perspective and to intervene in contexts of cultural diversity using ethnographic tools.

The master’s offers two specialisation pathways: Research, geared towards academic or applied projects, and Social Intervention, which includes 90 hours of placement in partner organisations.

Classes will be taught at the Facultat de Lletres (UAB), on an intensive timetable from 16:00 to 20:00, from September to March. The teaching staff, drawn from the UAB Department of Anthropology, has extensive research experience in areas such as ecological crisis and maritime studies; global health, bodies and medicalisation; gender, sexualities and families; childhoods and education;

exclusion and vulnerability processes, and migrations, urbanism and mobilities.

The admission period will remain open until 30 September and 30 places are offered. For more information, please visit this link or write to bruna.alvarez@uab.cat.

“Impossible Maternities” series at Palau Macaya

Bruna Alvarez (AFIN Group, UAB) participated in the “Maternidades imposibles” series, held at Palau Macaya and organised by the UNESCO Chair in Women, Development and Cultures at the Universitat de Vic-Universitat Central de Catalunya. The conversation, shared with Sandra Ezquerra (Universitat de Vic) and Laia Forné (IDRA), revolved around the difficulties of becoming a mother and the tension between capital and life.

Self-care strategies of abortion accompaniers in Northern Mexico

Bruna Alvarez (AFIN, UAB), together with Suzanne Veldhius (Colegio de la Frontera Sur, México), has published the article “‘I need to take care of myself as well’: self-care strategies of abortion *acompañantes* in Northern Mexico”. The text analyses the care needs of abortion accompaniers on Mexico’s northern border.

This work is part of the *Repromob. Gobernanza reproductiva y movilidades en Europa, África del Norte y América Latina: Cuestionando la justicia y los derechos reproductivos en un contexto de austeridad y disminución de la fecundidad*, a coordinated project made up of a sub-project at the Universitat Autònoma de Barcelona and another at the Universitat de Barcelona, both involving researchers from various national and international institutions.

The article is available open access at this link.