ARTICLE

Ethical issues in treating pregnant women with severe mental illness

GEETHA DESAI, PRABHA S CHANDRA

Department of Psychiatry, National Institute of Mental Health and Neurosciences, Hosur Road, Bangalore 560 029 INDIA email: desaigeetha@gmail.com prabhachandra@rediffmail.com

Abstract

Severe mental illness tends to occur and recur among women in the reproductive period. Both the disorders and the treatments may have effects on the mother and the foetus. The clinician hence is often in a dilemma when treating pregnant women with severe mental illness and is challenged with ethical issues related to decision making in this regard. Both treatment and non treatment are not without risks and this is particularly challenging if the mother has active symptoms and cannot make decisions because of impaired capacity. This paper highlights some of these ethical and clinical dilemmas through case vignettes based on data from a specialised perinatal psychiatry service.

Severe mental illness tends to occur among women in the reproductive period. These illnesses include bipolar disorders, psychotic depression, schizophrenia and other psychotic disorders. The onset is usually in the second and third decades of life and the condition is often chronic in nature with significant disability. The treatment of the condition involves long-term use of psychotropics. With the advances in psychiatric treatment, more women are responding to treatment, getting married and considering pregnancy.

The treatment of mental illness that occurs during pregnancy poses various challenges to professionals. Since a majority of pregnancies among women with mental illness are unplanned, the issues become even more complicated. Most important is the effect of the mental illness on the pregnant mother, ie, risk to herself. The other problem is the risk to the foetus, which may be due to the illness or the effect of the mother's treatment. Having untreated severe mental illness during pregnancy can adversely affect the well being of the mother. She may neglect her health, not receive adequate antenatal care, have nutritional deficiencies and also indulge in substance use secondary to the illness. The illness may impair a woman's judgement in making decisions related to the pregnancy and the foetus, resulting in further complications.

Coverdale et al have discussed the clinical implications of respect for autonomy in the psychiatric treatment of pregnant patients with depression and have recommended strategies for assessing decision-making abilities and for enhancing their autonomy (1). They suggest that nondirective counselling be used when the foetus is pre-viable and that directive counselling is ethically justifiable when the foetus is viable.

When a pregnant woman presents with severe mental illness, the initial decision she has to make is whether to continue the pregnancy or to terminate it. Dudzinski and Sullivan have discussed the ethical dilemma faced by the clinician in the case of a woman with schizophrenia who had impaired decision-making capacity (2).

The clinician faces an ethical dilemma when it comes to respecting the autonomy of a patient whose decision-making capacity may be impaired. The clinician also needs to protect the rights of the viable foetus. The clinician needs to discuss various aspects with the patient related to the treatment of the illness, the use of psychotropic drugs, the effect of these on the foetus and the effect of untreated illness on the foetus. The patient should be able to assimilate this information and then make a decision. So, before making a decision, the clinician needs to determine the decision-making capacity of the individual.

McCullough et al have outlined a seven-step decision-making process that highlights the necessary cognitive, attitudinal, and evaluative capacities (3). First, the patient should be able to attend to medical information. Second, the patient needs to absorb, retain, and recall the information. Third, the patient must possess cognitive abilities to reason about the relationship of present events and decisions to future consequences. Fourth, the patient ought to appreciate that these consequences could affect her, her foetus, and her future child. Fifth, the patient should be able to evaluate consequences based on her own values and beliefs. Sixth, the patient can express a voluntary decision to accept or reject the physician's recommendation. Seventh, the patient can explain her decision.

Mental illness can affect any of these steps. For example, concentration difficulties may make it difficult for the client to attend to the clinical information and this would impair her decision-making capacity. The presence of a low or elevated mood may either enhance her risk perception or diminish it. In such a situation, involving the family and the spouse in decision-making becomes pertinent and may enhance the support system.

We present, in this paper, some of the ethical challenges faced by the treating team at the perinatal psychiatric clinic at National Institute of Mental Health and Neuro Sciences (NIMHANS). This clinic has services for pre-pregnancy counselling, for care of pregnant women with mental illness

and for post-partum psychiatric disorders. These services have been available for two years now and 135 cases have been registered. 44 of the 135 women who were referred (32%) had a history of accidental exposure to psychotropic drugs. Only 24 (18%) of the 135 women with psychiatric disorders were referred for pre-pregnancy counselling. All these 135 women presented at various stages of pregnancy.

Among the 44 women who had accidental exposure to psychotropics, only 23% had received some information from the treating psychiatrists regarding the effect of psychotropics on the foetus, or had any discussions regarding planned pregnancy. Unplanned pregnancies and accidental exposure was common even among those women who had discussions with their doctors. Spouses were involved in the discussion only in the case of 17% of the women. Contraceptive issues were discussed with 15% of the women.

The following two cases exemplify the dilemmas faced by psychiatrists in these situations.

Case 1

Clinical history and pregnancy related issue: Mrs A, 23 years old and diagnosed with paranoid schizophrenia, presented to us in the second trimester of pregnancy with a history of being withdrawn, laughing to herself, poor initiative to do work, reduced social interaction and suspiciousness. She had been on treatment since the age of 18. The treatment was stopped two years later, when she got married. Her husband was not informed about the illness. She started experiencing residual negative symptoms. After one year of marriage she started to show symptoms following which treatment was initiated with parenteral antipsychotics. She had taken the treatment for the first five months of her pregnancy and continued to have negative symptoms. She was not sure about continuing the pregnancy, did not participate in the discussion, and showed lack of interest in discussions related to her pregnancy. Her parents wanted the pregnancy to continue because they feared that her husband would desert her if the pregnancy was terminated.

Ethical dilemma: From the history it was evident that Mrs A continued to have negative symptoms despite being on treatment, which was interfering with her functioning.

How the team handled it: The team decided that Mrs A should be treated to enable her to participate in decisions regarding her pregnancy. The issues were explained to her parents. After a month she said that she wanted to continue the pregnancy despite being dysfunctional at home.

Case 2

Clinical history and pregnancy related issues: Mrs B, a 29-year-old married woman, presented after 10 weeks of pregnancy while on escitalopram and olanzapine. Around eight months prior to that she had been admitted with a diagnosis of severe depression with psychotic symptoms following the first childbirth, which was a stillbirth. After receiving treatment she had shown significant improvement and had been maintaining well on treatment. One week earlier to her visit to the clinic, Mrs B came to know that she was pregnant and hence stopped all medications. Four days after she stopped her medication, she suffered a relapse, but was still unwilling to take medicine as she feared it would affect her child. Her husband was concerned about her condition.

Ethical dilemma: In this situation the client was ill but was not willing to take treatment as she feared the effect of the drugs on the foetus. The client had a history of attempted suicide, was currently symptomatic and presented a risk to herself.

How the team handled it: In view of the severity of the problem, the effect on the foetus of not treating the mother was discussed, and Mrs B was called for another session for further evaluation. She was unwilling to take treatment despite having symptoms. After a few weeks her condition deteriorated and then she agreed to take medications for a short period of time.

The above cases highlight different aspects of the ethical issues involved in the treatment of pregnant women. In both cases the pregnancies were unplanned. Since psychotropics are associated with effects on the foetus, it is important to plan pregnancies.

Conclusion

The treatment of mentally ill pregnant women poses serious challenges to the clinician. Healthcare providers have to be sensitive to the issues of autonomy, the levels of which may vary. Having a paternalistic attitude is unfair to mentally ill women. It is important to involve the women in making the decisions along with a family member. This involves treating the woman to enable her to participate in the decision-making.

McCullough and Chervernak describe a shared decision-making model in which the patient, surrogate, and physician interact dynamically throughout the decision-making process, each with areas of expertise and knowledge that are critical to informed decision-making (4). First, the physician elicits what the patient believes about her condition, diagnosis, prognosis, and the alternatives available to manage it. Second, the physician corrects factual errors and supplements the patient's and the surrogate's knowledge base. Third, the physician provides and explains his or her clinical judgment about all available management strategies, including a wait-and-see approach. Fourth, the physician works with the patient and the surrogate, as needed and requested, to help them develop as complete as possible a picture of the patient's condition and treatment alternatives. Fifth, the physician helps the patient and the surrogate identify the patient's relevant values and beliefs. Sixth, the physician helps evaluate treatment alternatives in light of the patient's beliefs. Seventh, the patient and the surrogate try to cognitively and evaluatively understand her condition and management strategies. Eighth, the physician makes a recommendation based on the clinical judgment expressed in the third step. Finally, a mutual decision is reached and is implemented.

Since a majority of pregnancies among mentally ill women are unplanned, it is important for doctors to educate their patients regarding the issues of becoming pregnant while being on medication and the options available for planning pregnancy.

In the Indian setting the scene is further hampered because of the limited time a psychiatrist can spend with any one patient given the large number of patients to whom he or she has to cater. Further, women may not disclose some of their concerns regarding their pregnancy if the treating clinician is a male. Women may also not have control over issues of contraception and thus may have accidental exposure despite pre-pregnancy counselling. So the issues may remain largely unaddressed and increase the risk of accidental exposure.

References

1. Coverdale JH, McCullough LB, Chervenak FA, Bayer T, Weeks S. Clinical implications of respect for autonomy in the psychiatric treatment of pregnant patients with depression. *Psychiatr Serv*. 1997 Feb;48(2):209-12.
2. Dudzinski DM, Sullivan M. When agreeing with the patient is not enough: a schizophrenic woman requests pregnancy termination. *Gen Hosp Psychiatry.* 2004 Nov-Dec; 26(6): 475-80.
3. McCullough LB, Coverdale JH, Chervenak FA. Ethical challenges of decision making with pregnant patients who have schizophrenia. *Am J Obstet Gynecol*. 2002 Sep;187(3):696-702.
4. McCullough LB, Chervernak FA. *Ethics in obstetrics and gynecology.* New York: Oxford University Press; 1994.

This paper was presented at the second National Bioethics Conference in November 2007.