

Understanding and Treating Women with Schizophrenia during Pregnancy and Postpartum

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ABSTRACT

This article provides a synopsis of clinically relevant data pertaining to sexuality, pregnancy, the postpartum period, parenting and family planning in women with schizophrenia. Based on this information, we propose recommendations for the non-pharmacological management of these patients. Along with the deinstitutionalization of people with severe and persistent mental illness, there has been a concurrent increase in relative fertility in women with schizophrenia.

Understanding the nature and experience of sexuality in women with schizophrenia helps elucidate the context in which pregnancies occur. Schizophrenia does not diminish sexual desire or activity. However, the quality and relational context of sexuality may be markedly different. Pregnancy appears to worsen mental health in a subset of women with schizophrenia. Psychotic denial of pregnancy is a symptom that poses especially high risks for poor outcomes if not addressed. Psychoeducation can reduce the risks of pregnancy complications for women with

schizophrenia. Short-term, focused psychotherapy can be useful for some pregnant women with schizophrenia. Some modifications need to be made in the inpatient treatment of pregnant patients with schizophrenia. In the postpartum period, women can be especially susceptible for acute exacerbation of their schizophrenia. With regards to parenting, many women will provide intermittent parenting for their children while others will lose custody of their children. Those mothers with schizophrenia who do raise their children may face unique challenges in parenting. Both positive and negative symptoms can interfere with the demands of being a parent.

A comprehensive parenting assessment of the patient can provide guidance for the implementation of supportive services. Proactive family planning could reduce the high rate of unwanted pregnancies, as women with schizophrenia tend to have more limited knowledge of their contraceptive options.

Sexuality in Women with Schizophrenia

Understanding the nature and experience of sexuality in women with schizophrenia helps elucidate the context in which pregnancies occur. Schizophrenia does not diminish sexual desire or activity. Compared with demographically equivalent controls, women with schizophrenia had similar frequency of sex and age of first intercourse.¹ However, the quality and relational context of sexuality may be markedly different. Women with schizophrenia had substantially more lifetime sex partners, fewer current partners, were less satisfied with sex, and reported more rape and sex exchange behavior than controls.² Women with schizophrenia reported a high frequency of engaging in sexual behaviors that put

them at risk for HIV infection, such as sex with multiple partners and infrequent use of condoms. One study found that patients with multiple partners had lower overall functioning and more positive symptoms than monogamous patients.³ These studies suggest that the sexual landscape for women with schizophrenia is more dangerous and less satisfying than for those without mental illness.

Pregnancy in Women with Schizophrenia

The relative fertility among the chronically mentally ill has increased in parallel with the deinstitutionalization of these patients.⁴ Most recent studies show comparable numbers of pregnancies for women with schizophrenia and women in the general population. However, more of the pregnancies among women with schizophrenia are unplanned and unwanted.² As compared to healthy control women, women with schizophrenia report receiving less prenatal care, and are more likely to be a victim of violence when pregnant.² Pregnancy appears to worsen mental health in a subset of women with schizophrenia. As compared to pregnant controls without a history of psychosis, pregnant women with non-organic psychosis reported more anxiety, material-situational and interpersonal problems, panic about delivery, and lack of confidence about their ability to parent.⁵ Among women with schizophrenia, those who were younger and who had experienced more negative effects on physical health during pregnancy were the ones most likely to report worsened mental health.⁶ Both positive and negative symptoms of schizophrenia may pose unique risks during pregnancy. Such symptoms can lead to delayed recognition of pregnancy, misinterpretation of signs of labor, attempts at premature self-delivery, and precipitous delivery. Overall, women with schizophrenia have an increased risk of obstetric complications, including placental abnormalities and antepartum hemorrhages.⁷

One especially high-risk symptom during pregnancy is psychotic denial of pregnancy. Pregnant women who maintain the delusion that they are not pregnant may refuse prenatal care. Some such women fail to recognize labor, and may have precipitous, unassisted deliveries. In some cases, this can lead to neonaticide, either passively (e.g., a woman thinks she is having a bowel movement and delivers her baby into a toilet) or actively (e.g., a woman is so emotionally shocked by the presence of a baby that

she buries the baby). Psychotic denial of pregnancy can be intermittent. It occurs more frequently in women who have previously lost custody of a child, leading to the hypothesis that psychotic denial of pregnancy represents a coping mechanism for dealing with anticipated loss of the infant.⁸

The Postpartum Experience in Schizophrenia

The postpartum period is a time of especially high risk for exacerbation of schizophrenia. In one study, fifty-five percent of mothers with schizophrenia experienced a psychiatric episode during the first year postpartum, most often in the first three months, and were also more likely to be depressed than controls.⁹ In a prospective study of pregnant women with major mental illness, twenty four percent of the women with schizophrenia experienced a postpartum psychotic episode.¹⁰ Among women with schizophrenia-spectrum disorders, those with a total lifetime history of more than three months of psychiatric hospitalization, more severe mental illness, and active symptoms in the six months before pregnancy were the most vulnerable to postpartum exacerbation of illness.¹¹ Women with schizophrenia who became psychotic postpartum developed postpartum symptoms later than their affective counterparts.¹¹ Postpartum psychotic symptoms can include delusions that the baby is dead or defective, delusions that the birth did not occur, and auditory hallucinations to harm the baby.¹²

Challenges in Parenting

While no large-scale epidemiologic data are available, smaller studies suggest that thirty to seventy percent of mothers with schizophrenia experience custody loss of their children.¹³ Since many mothers with schizophrenia consider parenting very rewarding, custody loss can be devastating.¹³ Intermittent parenting, where children of patients with schizophrenia live with their mother part of the time and live with others in formal or informal care giving arrangements at other times, appears to be the norm.¹³

Those mothers with schizophrenia who do raise their children may face unique challenges in parenting. Some of these difficulties stem directly from the symptoms of the illness. Positive psychotic symptoms can include command hallucinations to harm a child, as well as delusions that interfere with

parenting (for example, a mother who interprets normal regurgitation after her baby's feeding as a sign that a demon resides inside her baby and is spitting the food back out). Negative symptoms of schizophrenia can interfere with a mother's ability to read her baby's nonverbal cues, and may reduce her capacity to communicate with and appropriately stimulate her baby. Women with schizophrenia who lack social support may find parenting especially stressful. For some women with schizophrenia, paranoia interferes with their ability to form and maintain supportive relationships, and/or to trust others to help with child care.

Treatment of Women with Schizophrenia during Pregnancy

The treatment of pregnant women with schizophrenia has as its foundation antipsychotic medication. Special considerations regarding pharmacotherapy for schizophrenia during pregnancy can be found in the accompanying article by Einarson. Prognosis for women and their offspring can be substantially improved by a comprehensive treatment plan that includes psychoeducation, psychotherapy, parenting support and family planning. These non-pharmacologic components of the treatment plan are summarized here.

Assessment

A thorough clinical assessment of the patient can guide a comprehensive treatment plan.

Key elements to include in this assessment are:

- Checking for delusions about the pregnancy or the fetus, including psychotic denial of pregnancy.
- Evaluating the patient's knowledge about the normal bodily changes of pregnancy, including knowledge of how to recognize signs of labor.
- Ascertaining whether the patient has a history of rape and/or sexual abuse that could influence her reactions to pregnancy, labor and delivery.

- Checking for available instrumental and social support during pregnancy and postpartum, including transportation to prenatal visits, access to prenatal vitamins and healthy food, access to emergency care, etc.

Psychoeducation

Psychoeducation plays an essential role in reducing risks of pregnancy complications for women with schizophrenia.

Useful psychoeducational interventions include:

- Review normal bodily changes associated with pregnancy and labor.
- Review ultrasounds to elicit and rectify psychotic interpretations.
- Promote reality-based expectations about the birthing process by visiting labor and delivery floors prior to labor and delivery.¹⁴
- Have women draw and discuss self portraits while pregnant. This can identify body image distortions, and delusions and fantasies about the fetus, which can then be addressed in a reality-based way.¹⁴

Psychotherapy

Short-term, focused psychotherapy can be useful for some pregnant women with schizophrenia.

Consider psychotherapy for the following:

- Women who are having difficulty accepting a pregnancy.
- Women with distorted or negative feelings towards their fetuses.
- Women who have anxieties about parenting.

- Women for whom pregnancy or delivery may reactivate traumatic memories, such as memories of rape or sexual abuse.
- Women who lack the social skills to develop and maintain support networks
- Women who are unable to be assertive with their partners – e.g. about the use of condoms after delivery, or the sharing of parental responsibilities.
- Women who are grieving the loss of a prior baby, including custody loss, or who are having anticipatory grieving about losing custody of the baby they are carrying.¹⁵
- Women whose delusions are fueled by emotional issues.

An example of the latter is a woman who had the delusional belief that a devil was inside of her instead of a baby, and the devil was stealing all her nutrients. Psychotherapy revealed that this belief was based on the patient's emotional experience that once she became pregnant, her family members were more concerned about the baby's well-being than about hers. Once she had articulated this, she was able to ask her family members for more support, which they readily offered.

Inpatient Treatment

Special considerations apply to the inpatient treatment of pregnant patients with schizophrenia.

The following interventions can promote healthier outcomes:

- Nutrition orders must be modified to include ordering extra food and prenatal vitamins.¹⁶
- After about 20 weeks' gestation, the pregnant uterus is large and heavy enough to compress the aorta and vena cava when the patient lays in a supine position. If full leather restraints or electroconvulsive therapy are to be used in a woman who is at more than 20 weeks' gestation, a wedge will need to be placed below her right hip, thereby reducing aortocaval compression and

allowing for continued placental perfusion.¹⁶ A foam wedge, pillows, or rolled-up blankets can serve this purpose if their position is sufficiently monitored.

- Establish collaborative arrangements and clear lines of communication with obstetric staff, as well as cross-training of staff to recognize the other specialty's emergencies.

Assessment of Parenting Capability and Provision of Parenting Support

While schizophrenia sometimes leads to serious difficulties in parenting, having this illness does not automatically translate into inability to parent. Assessing a woman's parenting strengths and weaknesses can help clinicians implement effective parenting support interventions for women who need them.

The sources of information regarding woman's parenting capability include¹⁷:

- A psychiatric evaluation that includes eliciting symptoms directly relevant to the mother-infant relationship, such as delusions and hallucinations about the baby.
- Review of the patient's records, including child welfare agency records when applicable.
- Gathering collateral history – e.g. from family members who have observed the patient care for other children.
- Determining whether the patient has basic knowledge about how to care for a baby (e.g. feeding, soothing, diapering) and whether the patient has an adequate working knowledge of child development. This can be facilitated by the use of the Parent Opinion Questionnaire.¹⁸
- Assessing the patient's level of insight into her mental illness. Among women with major psychiatric disorders, insight into mental illness has been found to correlate with parenting capability, while diagnosis has not.¹⁹ This assessment can be facilitated by using the Schedule for Assessment of Insight (SAI).²⁰
- Finding out whether the patient reports a history of being neglected or abused in her own childhood, and assessing the potential effects of these early traumas on her parenting.²¹

- Directly observing the mother-baby interaction, with a focus on the mother's ability to read and respond to the baby's nonverbal cues.
- Evaluating the home environment, and available social support for parenting.

When parenting assessment reveals potential weaknesses or risks, proactive provision of supportive services may improve the chances of successful parenting.

Parenting interventions can include¹³:

- Parenting classes: useful to learn the basics of parenting.
- Parent support groups: can provide a forum for collaborative problem solving and role modeling.
- Co-parenting support: identifying a relative or friend who becomes a co-parent, with the roles of the parent and co-parent being clearly outlined.
- Parenting coaching: a hands-on intervention that identifies and builds on the strengths of the parent. Numerous techniques are employed with the goals of increasing the parent's ability to read and respond appropriately to the baby's cues, increasing the parent's empathy for the baby's experience, and decreasing distorted perceptions of the baby.

Family Planning for Women with Schizophrenia

Proactive family planning could reduce the high rate of unwanted pregnancies in women with schizophrenia, and improve outcomes due to women becoming pregnant when they choose to and feel ready. As compared to non-mentally ill women, women with schizophrenia have a relative lack of family planning knowledge and discussion of family planning with others. For example, in one study²², only thirty four percent of study participants with schizophrenia reported having discussed birth control with their mental health care providers. As compared to healthy controls, study participants with schizophrenia knew fewer methods of birth control and, when presented with a list, had heard of fewer

birth control options. In particular, very few knew about long acting, reversible contraception. This is particularly relevant because in women with schizophrenia, the most frequently endorsed reason for not using birth control was that they did not expect to have sex.²² Clinicians can help by discussing family planning with patients of reproductive age, and by assessing barriers to contraception for women who do not wish to become pregnant.

These may include:

- Unplanned or unwanted sexual activity (reduces the likelihood that condoms or diaphragms will be effective).
- Difficulty with recall, planning or consistent adherence (reduces a woman's ability to reliably use oral contraceptive pills).²³
- Delusions of control (in some cases, interferes with a woman's ability to use long-acting contraceptive implants).

Easing logistical barriers to contraception can also facilitate family planning. For example, long-acting contraceptive injections (e.g. medroxyprogesterone) can be co-administered with long-acting antipsychotic injections.²²

Summary and Conclusions

Pregnancy can be demanding even under the best of circumstances, and poses even greater risks and challenges for women with schizophrenia. By addressing pregnancy-specific symptoms, providing psychoeducation and psychotherapy as needed, assessing and supporting parenting capability, and assisting women with proactive family planning, clinicians can greatly improve outcomes for women with schizophrenia and their children.

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