INPATIENT PRACTICE

# Treating Schizophrenia During Pregnancy

Pregnancy is a time of heightened vulnerability for women with schizophrenia and their offspring.

Compared with women who are not mentally ill, those with schizophrenia have more unwanted sex and pregnancies, less prenatal care, a greater risk of being a victim of violence during pregnancy, and a reduced likelihood of having a partner. These disadvantages in social context compound the risks from direct effects of the illness.

BY LAURA MILLER, M.D.

This month, CLINICAL PSYCHIATRY NEWS talks with Dr. Laura Miller about inpatient work with women who have schizophrenia and are pregnant. Dr. Miller, an expert in women's mental health, runs a perinatal mental health project in Illinois.

**CPN:** What are the key risks of pregnancy and the postpartum period in women with schizophrenia?

**Dr. Miller:** During pregnancy, key risks include delayed recognition of pregnancy, less prenatal care, failure to recognize labor, and a greater incidence of obstetric complications. A particularly high-risk symptom is psychotic denial of pregnancy, a condition in which the woman denies that she is pregnant despite clear indications, and thereby refuses prenatal care, misinterprets signs of labor, risks precipitous and unassisted delivery, and fails to bond with the baby.

The postpartum period is a time of increased risk for exacerbation of schizophrenia. Symptoms and sequelae of schizophrenia can also adversely affect parenting capability, which leads to high rates of custody loss. At times, delusions and/or hallucinations about the baby directly interfere with bonding and parenting.

Negative symptoms of schizophrenia, such as apathy or difficulty expressing emotions, may contribute to understimulation or neglect of a baby. The additional risks of obstetric complications and parenting difficulties for offspring who may be genetically vulnerable further heightens the long-term risk of psychiatric morbidity in the children of women with schizophrenia.

**CPN:** What can psychiatrists treating inpatients do to help these patients?

**Dr. Miller:** Proactive interventions can greatly reduce risks. When women with schizophrenia require hospitalization during pregnancy, there is a unique opportunity to implement comprehensive risk reduction strategies that promote a healthy pregnancy, delivery, postpartum period, and parenting experience. This first step is a comprehensive assessment.

**CPN:** How do you assess women with schizophrenia who are pregnant?

**Dr. Miller:** First, it is important to assess the patient for delusions about the pregnancy or the fetus, including psychotic denial of pregnancy. The patient should then be evaluated for her understanding of the normal bodily changes of pregnancy, labor, and delivery—with identification of gaps in knowledge.

After that, it is important to identify comorbidities that could increase the risk of adverse obstetric outcome, including substance addiction and HIV infection.

Although parenting capability cannot be comprehensively assessed during pregnancy, inpatient clinicians can identify parenting strengths and weaknesses, as well as the specific effects of symptoms on parenting attitudes and behaviors.

**CPN:** What kind of treatment plan works best for these patients?

**Dr. Miller:** An optimal treatment plan includes medication and psychoeducation. Medication can be chosen based on a pregnancy-specific risk-benefit analysis. Be prepared to consult a reproductive psychiatrist as needed.

**CPN:** What should be the goal of psychoeducation at this point?

**Dr. Miller:** Psychoeducation can fill in knowledge gaps identified in the assessment, including helping women understand the normal bodily changes accompanying pregnancy. The aim is to reduce delusional misinterpretation of these changes and improve recognition of signs related to pregnancy complications and labor.

Specific measures can be taken to reduce comorbid risk factors. For example, there is a high prevalence of smoking during pregnancy in women with schizophrenia. Smoking cessation interventions and—if necessary—nicotine therapy systems, can reduce resultant risks to maternal and fetal health.

**CPN:** Should routine hospital orders or routines be modified in any way for patients who are pregnant?

**Dr. Miller:** Absolutely—it is important to modify certain orders for these patients. For example, order prenatal vitamins and extra food (e.g., double portions and snacks).

Also, include orders for recommended prenatal monitoring after consulting with an obstetric colleague.

If a pregnant woman at more than 20 weeks' gestation requires an intervention that necessitates lying supine (e.g., for physical restraint or electroconvulsive therapy), wedge her hip to displace her uterus from the great vessels to allow for adequate placental perfusion.

**CPN:** How should psychiatric and obstetric staff work together?

**Dr. Miller:** I advise the following measures:

► Make collaborative arrangements for an obstetrician or obstetric service to provide prenatal care on the psychiatry unit, and transfer to an obstetric unit for delivery with necessary precautions in place (e.g., a hospital sitter, if needed).

► Establish clear lines of communication between psychiatric and obstetric staff, including ways to efficiently and reliably share essential medical information without violating mental health confidentiality.

► Cross-train staff so that psychiatry staff members are trained to recognize obstetric emergencies, and obstetric staff members know how to prevent and manage psychiatric emergencies.

**CPN:** Can inpatient clinicians do anything to improve the chances of successful parenting and long-term prognosis for a woman with schizophrenia?

**Dr. Miller:** Being proactive can greatly facilitate successful parenting. An inpatient treatment team can initiate parenting psychoeducation, support, coaching, and rehabilitation and/or coparenting strategies as needed.

It also makes sense to discuss family planning with these patients during the hospital stay, in an effort to minimize the risk of subsequent unintended pregnancies.

Interpersonal psychotherapy and/or assertiveness training can help patients learn to negotiate effectively with sexual partners, reduce the risk of being a victim of violence, and successfully establish a support network for parenting. ■

DR. MILLER *is director of the Perinatal Mental Health Project, University of Illinois at Chicago.*

# Use of Coercive Interventions Varies Across Europe

BY JAMES BUTCHER
*Contributing Writer*

MADRID — The use of coercive interventions—such as physical or mechanical restraint—to control imminent and actual dangerous behavior by people with acute mental illness was discussed at a symposium at the 15th European Congress of Psychiatry.

Dr. Tilman Steinert, of the University of Ulm (Germany), presented data obtained by the European Violence in Psychiatry Research Group. Those data looked at the way in which violent patients are managed across Europe, and whether real-life practice followed legislative guidelines.

The researchers prepared three representative case vignettes and asked experts from 14 European countries (Ireland, Scotland, Wales, England, the Netherlands, Luxembourg, Germany, Switzerland, Austria, Italy, Slovenia, Turkey, Finland, and Estonia) to describe how they would treat each patient and whether legislation in each country would allow the use of different forms of restraint.

The first case was that of a voluntary inpatient who assaults a staff member. Experts from all of the countries except Switzerland would treat such a patient with an involuntary intramuscular injection, but experts from only five of the countries would use an involuntary intravenous medication.

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Physical restraint was used in five countries and mechanical restraint in seven. Net beds are banned by legislation in most European countries, but psychiatric staffs in Luxembourg and Austria use them.

The second case involved that of an involuntary patient who does not behave violently, but who refuses medication. In cases like this, involuntary intramuscular injection is given in seven European countries, and involuntary intravenous medication is given in just two. Any form of involuntary medication is banned in the Netherlands and in Switzerland.

The researchers concluded that there is wide diversity of legislation and practice across Europe, and, importantly, in the way in which psychiatric professionals interpret their own legislation. "We need evidence on what is the best practice before we enforce uniformity," Dr. Steinert said.

In a separate presentation, Richard Whittington, Ph.D., of the health and community care research unit at the University of Liverpool (England), presented data on the psychological and social context surrounding the decision by staff to restrain a patient on the floor.

Dr. Whittington and his colleagues did an audit study of 20,000 incident forms, describing incidents involving 5,000 patients from 46 secure and general wards over a 5-year period. They looked to see how often control and restraint procedures were used, and found that 20% of all incidents were managed in this way. However, 50% of reported incidents involving interpersonal violence resulted in the use of control and restraint procedures.

Interestingly, restraint was used in 42% of "first incidents" but was used only 24% of the time when the patient had been involved in more than five incidents in the past. "If a staff member does not know a patient, he or she is more likely to use control and restraint," he said. ■