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.

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 precipitating difficulties for the offspring who may be genetically vulnerable further heightening the long-term risk of psychopathology 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 parental 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 schizophrenia-specific risk-benefit analysis. It may be helpful 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.

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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, professor of the University of Ulm (Germany), presented data obtained from 14 European countries (Ireland, Scotland, Luxembourg, 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 countries would use an involuntary intramuscular medication. Physical restraint was used in five countries and mechanical restraint in seven. Net beds are banned by legislation in most European countries.

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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 way to control 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 3-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 violence, and successfully establish a support network for parenting.

Dr. Miller is director of the Perinatal Mental Health Project, University of Illinois at Chicago.