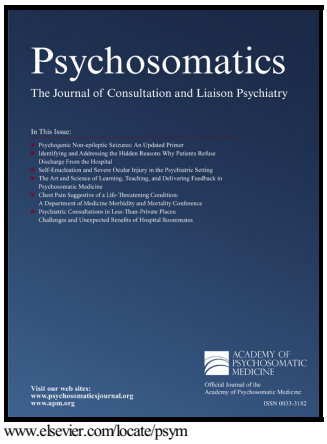

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www.elsevier.com/locate/psym

PII: S0033-3182(16)30170-0
DOI: http://dx.doi.org/10.1016/j.psym.2016.12.002
Reference: PSYM714

To appear in: *Psychosomatics*

Cite this article as: Carmen Croicu, Jennifer Piel and Suzanne B. Murray, Clinical and Ethical Challenges: Managing Acute Psychosis in Pregnancy, *Psychosomatics,* http://dx.doi.org/10.1016/j.psym.2016.12.002

Clinical and Ethical Challenges: Managing Acute Psychosis in Pregnancy

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Introduction

Treatment of acute psychosis during pregnancy presents numerous clinical challenges. First, although newly-published data is reassuring regarding the risks of fetal malformations associated with prenatal exposure to antipsychotic medication [1, 2], other risks associated with antipsychotic use remain largely uncertain. Second, limited and sometimes conflicting data regarding the effects of exposure to psychotropic medications during pregnancy can be puzzling to the psychiatrist. This extends beyond clinical management to raise questions of ethics, legal concerns, and risk-management issues. Third, the treatment is often complicated by the patient's impaired insight into their disease and refusal of treatment, sometimes warranting involuntary treatment. What follows is a case that illustrates some of the challenges and complexities that can arise when treating an involuntarily-committed pregnant woman who is refusing antipsychotic treatment.

Case report

Ms. A, a single, 24-year-old woman 25 weeks pregnant with a history of unspecified psychotic disorder, was brought to the emergency department (ED) by her sister due to changes in her behavior. According to her sister, Ms. A was unable to keep her obstetric appointments and needed to be reminded to eat and drink adequately. In the ED, Ms. A exhibited disorganized thinking, irritability, paranoia and delusions that her family was plotting against her. Although she denied hearing voices, she reported hearing loud noises. She denied suicidal or homicidal ideation. Given the patient's inability to care for herself, impairment of reality testing, disorganized thinking, and lack of insight into her mental illness, the patient was involuntarily committed on the basis of grave disability and admitted to the inpatient psychiatric unit. Her psychiatric history was notable for one prior psychiatric admission. Ms. A had no previous history of suicide attempts. She was not engaged in outpatient mental health treatment.

The treatment team recommended haloperidol to treat her psychosis, but Ms. A refused any antipsychotic medication out of concern for her fetus's well-being. She also believed that an antipsychotic was not indicated for her situation. Psychiatric evaluation revealed that her decisional capacity to refuse treatment was limited by lack of insight into her psychiatric illness and an impaired understanding of the associated risks and benefits of the proposed treatment. Despite repeated counseling from her psychiatric team and obstetrics consultation that the benefit of treatment with an antipsychotic in ameliorating her condition outweighed the risk for her fetus related to exposure to haloperidol, Ms. A remained steadfast that she had no intention to take haloperidol or any other antipsychotic during her pregnancy. She would have required physical restraint in order to deliver the medication.

The treatment team decided not to initiate steps to compel an antipsychotic. Also, the treatment team did not pursue electroconvulsive therapy (ECT) for lack of clear indication and challenges similar to those for compelling an antipsychotic. Ms. A did not meet criteria for severe depression, psychotic agitation, high suicide risk, severe physical decline due to malnutrition or dehydration, or other life threatening conditions, in which case ECT would have been an