Commentary: A Curious Conception

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Nau *et al*. describe a woman with schizophrenia who remains in denial of her pregnancy. They raise several legal issues including involuntary commitment, capacity to decide treatment, and conservancy. They review potentially pertinent legal decisions that might inform treatment decisions of women who refuse care during pregnancy. They then conclude that no clear precedents are available that clearly inform the treatment decisions in this particular case: hard cases make bad law (and vice versa). Reconsidering the case from a purely clinical perspective, there may have been some lost opportunities to find common ground or make a compromise with the patient, thus avoiding court altogether. Reconsidering the diagnosis raises questions about the use of antipsychotic medication during this pregnancy.

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I commend the authors for assembling the complicated and sometimes contradictory assortment of decisions related to denial of pregnancy and other apparent incapacities during pregnancy. Perhaps some of the inconsistencies are due to the sometimes inconsistent care delivered to pregnant women under difficult circumstances. Even normal pregnancy can stir up a lot of feelings around a patient. Care of abnormal pregnancies can be rife with countertransference and, as the legal maxim warns, hard cases make bad law.[1]

Having been invited to provide clinical commentary on "Psychotic Denial of Pregnancy: Legal and Treatment Considerations for Clinicians" by Nau *et al.*,[2] I will approach it with an eye toward clinical problem-solving.[3] The clinical material cited comes directly from the text of the article.

> The patient was a . . . homeless woman who presented to a free clinic, self-reporting a history of schizophrenia, requesting an albuterol inhaler for an asthma exacerbation, and complaining of stomach pain [Ref. 2, p 31].

There is little here to catch our attention. Homeless patients carrying the diagnosis of chronic psychotic disorder are quite common. We expect them in charitable or government-supported clinics. And, like *The Invisible Man* of G. K. Chesterton's detective story, we hardly notice them.[4] It is possible that no one documented basic information in the course of the patient's initial physical examination: dress, body habitus, and grooming. This information may be needed later to inform clinical decisions.

The individual is a patient—that is to say, a person who voluntarily exerted some effort to seek professional medical assistance for bodily complaints. And, the patient is agreeable to some medical testing:

> Noting that she appeared visibly pregnant, clinic staff obtained her permission for a urine pregnancy test, which confirmed the pregnancy [Ref. 2, p 31].

Other test results are omitted: pH, ketones, blood, and the other routine dipstick tests for urine samples. Urine specific-gravity measurement requires only slightly more than a simple dipstick test: it is well within the capacity of small clinics (by reagent strip, refractometer, or hydrometer). The case history does not report whether these tests were done, were normal, and the results noted, or whether unusually careful attention to patient consent led clinic staff to believe they could test the patient's urine only for β-HCG (human chorionic gonadotropin; another dipstick style test). Without such information and without other elements of the physical examination (vital signs, weight, and height), the clinical commentary becomes quite speculative. The importance of such data is accentuated because of a disagreement between the patient and her treaters:

> The patient denied the validity of the [pregnancy] test and began to express bizarre and paranoid thoughts [Ref. 2, pp 31–32].

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As the common saying goes, now it gets interesting. The patient was transferred to a hospital for obstetrical care.

We are not told the reasons for the transfer. One could speculate that the clinic staff were worried that the patient's abdominal pain signaled impending delivery, that they were following a routine protocol to transfer all pregnant patients to labor and delivery, or that they were primarily concerned about bizarre and paranoid thoughts, but believed medical clearance from the obstetrics service was necessary before acceptance by any local psychiatric facility. From a psychotherapeutic perspective, the clinicians may have lost a prime opportunity to explore the patient's stance vis-à-vis the medical profession. She may be delusional, even paranoid about conception and pregnancy, but she demonstrated some positive valence toward medical professionals:

> [At Labor and Delivery], she allowed a bedside sonogram that confirmed a third-trimester, viable, intrauterine pregnancy [Ref. 2, p 32].

The result suggested that in the next two to seven weeks, the patient was likely to go into labor and deliver. The ultrasound eliminates from consideration the two most acute and most dangerous complications of pregnancy: placenta previa and tubal pregnancy (perhaps already eliminated in an abdominal examination). Two other conditions might still be of concern—diabetes and eclampsia—but these should have been evident from vital signs and urine dipstick results.[5,6]

> She denied that the ultrasound showed a fetus, calling it a "phantom pregnancy" and refusing further evaluation [Ref. 2, p 32].

The clinicians seem bound and determined to argue with the patient, as if it would break through her delusion. Psychiatry residency usually cures clinicians of this misconception, but psychiatry is not involved until the next step.

> The obstetrics service sent her to the psychiatric emergency service, where the psychiatrist placed her on a 72-hour involuntary hold for grave disability . . . and admitted her to the inpatient psychiatry unit [Ref. 2, p 32].

This transfer by the obstetrics service confirms our clinical impression that there is no immediate, life-threatening obstetric or medical emergency.

> Although she was generally cooperative and pleasant with staff on the psychiatry unit, she became irritated and suspicious when the subject of her pregnancy arose [Ref. 2, p 32].

Her pleasant demeanor suggests that the patient had some positive valence, transference if you will, to medical and mental health professionals. It resurrects the question: could this doctor-patient relationship be saved? Could no one see the way clear to treating the patient without insisting that she admit that she was pregnant, perhaps out of wedlock, and likely without means to care for a child? Was this a local requirement for medical care?

Suppose the clinical teams involved had taken the stance: "We're sorry to hear your belly is bothering you. To relieve the discomfort and continue treating your asthma effectively, we believe we need to run more (blood) tests. In fact, it might be more convenient if you stayed in the hospital." Would it be so surprising if the patient agreed? Even if the patient did not agree, what about a shelter or a crisis and respite facility? Was there any outreach team available? Unfortunately, the pregnancy remains front and center, like a riff on Hawthorne's *The Scarlet Letter*.[7]

> She explained her enlarged abdomen as a "paranormal" phenomenon that had been "projected" onto her and as a prolonged reaction to eating granola the month before. She reported having been pregnant in the past as a result of "switching bodies with another woman" and "swapping bodily fluids" [Ref. 2, p 32].

It is impossible at this juncture to resist reminding readers of less-than-scientific accounts of conception and their place in myth, civilization, and religion. From the ancient Greeks we have Leda and the swan. From the Old Testament we have Eve springing from Adam's rib. From followers of the New Testament we have both the Feast of the Immaculate Conception and Christmas in the month of December. And, many American readers may remember something about a stork delivering babies; however, paranormal phenomena are at the fringe of standard North American culture.

Jumping ahead a little:

> She refused to allow the treatment team to contact others for collateral information. She refused laboratory work, vital sign monitoring, obstetric care, and medications, including prenatal vitamins [Ref. 2, p 32].

Her refusals left the treating clinicians in a bit of a bind, even if it was partly of their own making. Her refusals also raised local concerns regarding health records, privacy, and confidentiality and the requirements of HIPAA (the Health Insurance Portability and Accountability Act). However, good clinical practice requires knowledge and use of local re-

sources. What was on file for the patient at the clinic, the obstetrical service, and the psychiatric emergency service? Did anyone contact the patient's pharmacy to confirm a prescription for albuterol? Did the pharmacy have records of other prescriptions?

> She also recounted having had a child removed from her custody by the child protective service system many years earlier [Ref. 2, p 32].

It is unlikely this patient had left no clinical trail to be reviewed by her current clinicians. Local laws and clinical custom may limit access; on the other hand, HIPAA arguably opens access between treaters. (These subjects go beyond the parameters of this clinical commentary.)

> She spoke with a nutritionist, who learned that for several weeks before admission she had been eating one meal per day and had not been meeting the nutritional requirements of pregnancy [Ref. 2, p 32].

Apparently, the clinicians did not believe the patient's account of her child's conception or the role of granola in causing abdominal discomfort, but they did believe her accounting of meal details, enough to allow calculation of her caloric intake. Objective readers might wish to know the patient's height, weight, general appearance, skin condition, and prior weights if recorded in any accessible records. It might also be helpful to know if the patient was observed to be restricting her caloric intake on the psychiatric ward, and if not, whether she seemed to be gaining significant weight.

> The psychiatrist then placed the patient on a 14-day hold for grave disability, based in large part on the nutritional assessment. The patient subsequently lost her probable-cause hearing and a second hearing that determined her right to refuse psychotropic medications. She thus remained on the inpatient psychiatry unit and was administered psychotropic medication [Ref. 2, p 32].

This brings us to the clinical question: diagnosis. Let us jump back to the following observation:

> The patient denied auditory or visual hallucinations and was noted to have above-average intelligence. Her verbal communication was characterized by some tangential speech, but when redirected, her thought process could be linear [Ref. 2, p 32].

It seems safe to conclude that the patient was delusional. But what is her diagnosis? Her claim of a diagnosis of schizophrenia was not substantiated by reports of any psychotic symptoms beyond delusional thinking about her pregnancy. A diagnosis of delusional disorder is quite possible. Delusional disorder is much less responsive to pharmacologic management and casts doubt on a recommendation for inpatient psychiatric stabilization. The following outcome is not surprising:

> [S]he was prescribed haloperidol, with the dose titrated to 15 mg/d administered orally. She maintained that she was not pregnant. . . . [Ref. 2, p 37].

Then we learn that:

> . . . when asked for a substituted judgment—that is, when asked what she would want to do if she were pregnant—the patient said she would want to deliver the baby [Ref. 2, p 37].

Her response seems to be further evidence that the patient's fixed beliefs are quite circumscribed and leave room for some cooperation with medical personnel. Might she have accepted some dietary advice if it were not explicitly coupled to pregnancy? Might she have accepted regular multivitamins with iron if prenatal vitamins had not been mentioned first?

The critical outcome was:

> . . . a normal spontaneous vaginal delivery. After the delivery, she began to acknowledge the baby as her own and expressed a desire to mother him. She remained delusional in her thinking about the pregnancy [Ref. 2, p 37].

There is no mention of APGAR scores, and so we can presume that there were no obvious side effects from haloperidol, which is consistent with reports in the literature.[8] Third-trimester medications are unlikely to lead to congenital malformations (setting aside tetracycline tooth stains). Still, clinicians should remember that the newborn will start life with maternal medications.

Finally:

> She was released with intensive case management, and her child was placed in the custody of the child protective service system. Initially, she fought for parental rights, but, as of the writing of this article, she had abandoned that struggle and moved to another city [Ref. 2, p 37].

This mother and her treaters certainly never bonded. And maybe that is too ambitious a goal, given the patient's history. However, establishing a working relationship with patients is crucial to the long-term care of their chronic mental illnesses. Finding some workable compromise, some common ground, might have allowed this patient and her delivery to be handled in a less contentious fashion. It is hard to know, from the information available, how much of the difficulty with this case was a byproduct of her illness and how much was a byproduct of the contentious stance taken by her treaters who were influenced by the presence of the pregnancy.

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