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Psychotic Denial of Pregnancy

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Introduction

Denial of pregnancy is a potentially dangerous condition that poses risks of increased maternal and neonatal morbidity, unassisted delivery and neonaticide.

Case

A 38-year-old multiparous woman with a background of schizophrenia presented to antenatal clinic for the first time at 38 weeks of gestation, expressing denial of her newly diagnosed pregnancy. At the time of initial presentation, she was on olanzapine 10mg daily with no regular psychiatric follow-up. She was previously known to the community mental health team, but stopped attending reviews as she believed that members of the team were actively trying to kill or poison her. She was admitted to the maternity ward for ongoing psychiatric review and for concerns of risk of harm to herself and the foetus. Her ongoing distrust of the medical team also made it unlikely that she would represent for review in an emergency, and she was detained involuntarily under the Mental Health Act. She also refused any increased antipsychotic doses.

The decision was made for an induction of labour due to lack of antenatal care and uncertain gestation, however the patient had paranoid delusions and was suspicious of staff, believing that there was a conspiracy to harvest her reproductive organs. This made her resistant to the idea of certain procedures which may be required, including an emergency Caesarean section or a procedure under general anaesthetic. Due to concerns regarding her capacity to provide consent, an emergency tribunal awarded her husband with guardianship rights and the authority to override objections to treatment. Her labour was induced soon after the tribunal. There were no intrapartum concerns until an abnormal red CTG in second stage, and birth was expedited with a vacuum delivery.

Outcome

She had post-partum hypertension without any other clinical features of pre-eclampsia, and was commenced on daily slow release nifedipine. Following the birth, the patient reported feeling an instant bond with her child. She stated that she believed that the baby was truly hers as she was able to watch her vaginal birth. She was admitted to the Mental Health Unit for post-partum monitoring and was subsequently discharged into the care of community mental health maintained.

Discussion

An ongoing concern regarding this patient was her capacity to consent to medical interventions, as the level of a patient's capacity to consent depends on the procedure for which consent is required. Our patient could appropriately consent to vaginal examinations and CTG monitoring, however explicitly withheld consent for any surgical procedures due to her delusions regarding organ harvesting. Although she was involuntarily detained under the Mental Health Act, the act does not allow for actions to be taken in foetal interest, only maternal interest. Additionally, a Caesarean section was be classified as a 'special medical treatment' as there was a possibility of permanent infertility if an emergency hysterectomy was required. These treatments can only be performed with specific consent by a tribunal or if necessary as a matter of urgency to save a patient's life. With this in mind, balancing the patient's autonomy with her limited insight into her condition required many discussions in a multidisciplinary setting, which eventuated in approaching a guardianship tribunal for advice as to how to proceed.

Women with denied pregnancies have a significantly increased risk of maternal and foetal morbidity, including the rare but incredibly serious risk of neonaticide. In this case, our patient was admitted to hospital as she was unable to identify and acknowledge signs of labour or other red flag symptoms related to pregnancy. The admission aimed to reduce both the risks associated with precipitous or an unattended delivery, but also the risks of absent antenatal care. From a Mental Health perspective, the sudden resolution of her psychosis following her delivery required further monitoring to ensure that it was maintained. There were also concerns regarding deterioration of mental state as a result of the stress of parenting immediately post-partum, and an admission was deemed the best option to ensure safe discharge planning into the community with appropriate medications and community supports in place. Although an increased anti-psychotic dose was recommended during her inpatient stay, it was deemed more important to maintain a good therapeutic relationship with the patient when she was distrustful of any increased doses. Her olanzapine dose was increased successfully following her delivery with her consent.

Conclusion

This was a complex case fraught with medicolegal and ethical issues, including that of capacity, the woman's vs the foetus' best interests, and involuntary detention in hospital. The key features of appropriate management include a multidisciplinary team approach with integrated psychiatric and obstetric care, and ensuring appropriate discharge planning to monitor the patient in the community. There was also a large emphasis placed on ensuring the patient's autonomy was respected, and compromising where possible to maintain a good therapeutic relationship with the patient.