

Fertility Treatments and Psychiatric Disorders: Ethical Considerations Regarding a Patient's Desire to Become a Mother

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Reproductive issues play a significant role in the personal autonomy of women. Motherhood can be seen as an opportunity for positive self-endorsement, as a chance to reintegrate the fragmented parts of the self, order and focus life's tasks, affirm life, overcome stigma, and experience an emotionally rich and rewarding role [1].

Pregnancy and motherhood among women with mental disorders is complex. Pregnant women with mental disorders face many decisions, but in some cases their capacity for decision making may be impaired. This process involves the ability to attend to medical information, i.e., to absorb, retain and recall it. The patient must possess cognitive abilities to reason regarding the relationship of present events and decisions with future consequences. The patient must appreciate that these consequences could affect herself, her fetus and her future child. The patient should also be able to evaluate consequences based on her own values and beliefs. Finally, the patient must be able to express a voluntary decision to accept or reject the clinician's recommendations and must be able to explain her decision [2].

Clinicians face an ethical dilemma when it comes to respecting the autonomy of a patient whose decision-making capacity is evaluated as impaired. Desai and Chandra [2] argue that the clinician needs to protect the patient as well as the rights of the viable fetus. The

clinician and the patient have to discuss the treatment of her illness, the use of psychotropic drugs, the effect of these on the fetus, and the effect of the untreated illness on the fetus.

Clinicians' ethical dilemmas arise even before pregnancy is realized, when facing the patient's desire for a child. Evaluations of professionals' attitudes towards patients' desire for children indicate the complexity of this ethical dilemma. Clinicians are often unaware of their patients' birth control status and are unwilling to discuss these issues with them. Vigurea et al. [3] claim that mental health professionals tend to adopt a negative approach towards their patients' desire for children. Recent research indicates that patients' desire for children is perceived as the patient's own decision as part of her "reproductive autonomy." This is reflected in a natural or non-directive professional behavior. From this perspective, the well-being of the future child is subordinate to the patient's well-being.

PATIENT DESCRIPTION

This patient is a woman in her late forties, single, the only child of a married couple in their sixties. Her history includes many psychiatric hospitalizations, with diagnoses of anorexia, borderline personality disorder and obsessive compulsive disorder. Her anorexia began at childhood with severe food restriction, and over time she developed rituals concerning food and hygiene, committed acts of self-harm and had several suicidal attempts. She described a complex relationship with her parents, characterized by aggressive and limited communication. She claimed to have been physically and

emotionally abused by her mother as a child, while her father was passive and absent. She had never had a relationship with a man and said she was not interested in such. She had never had a friend although she lives in a small neighborhood where people have known her since she was a child. She feels deeply lonely and isolated from other people.

Around the age of 30, she decided she wants to become a mother. She felt that motherhood would mend all she had been through and give purpose to her life. She began fertility treatments but failed to become pregnant. Nonetheless, she was determined and said she felt her life was not worth living if she did not have a baby. Every unsuccessful treatment caused her distress and exacerbation of symptoms. Finally, she was admitted to hospital following an act of self-harm. She revealed that she was undergoing fertility treatments and asked her physicians to help her cope with the treatments and serve as the support system she lacked. She said she felt she had to become a mother or she would kill herself. The staff was concerned and troubled by several issues: Was she capable of undergoing fertility treatments, i.e., did her clinical state allow this? Was the pregnancy even possible with her chronic anorexia? Should the staff intervene with her decision and inform the gynecologist of her mental state? Was she capable of functioning as a mother, in view of her life circumstances?

The staff decided not to intervene unless the gynecologist asked for their opinion. The patient was treated in the department; after her discharge she remained in psychiatric follow-up and continued psychotherapy.

She became pregnant about a year after her last discharge and gave birth to a healthy

baby. She raised the baby with the help of her parents; the child is presently 2 years old. At the last follow-up her clinical state had never been better: her weight was low but stable, her rituals almost completely non-existent, and she felt fulfilled and blessed with her baby. She said she had never seen her mother so affectionate and the relationship with her parents was greatly improved. She was continuing her psychiatric treatment and therapy sessions.

COMMENT

This case is ethically challenging, primarily because of the psychiatric history. The patient was coping with chronic anorexia, borderline personality disorder and obsessive compulsive disorder. Eating disorders during pregnancy increase the risk of prenatal and postnatal complications, such as miscarriage, preterm labor, delivery by cesarean section, and postpartum depression. The risks to the newborn include a greater likelihood of low birth weight, microcephaly and small for gestational age.

In addition, her diagnosis of borderline personality disorder is associated with impulsivity, affective instability, and history of extreme acts of self-harm. The common perception is that the combination of emotional and behavioral dysregulation experienced by women with severe borderline personality disorder may cause risk during pregnancy and through motherhood. Another issue is her obsessive compulsive disorder. Research has shown that pregnancy and delivery appear to influence the course of this disorder. The obsessions and compulsions are frequently related to the fetus or the newborn and may involve aggressive obsessions towards the newborn [4].

Apart from the difficulties caused by her mental state, the patient had to cope with the process of fertility treatments. Fertility treatments have been linked to a high prevalence of distress, depressive symptoms and even greater risk for development of psychiatric disorders. In this process the infertility becomes a chronic stressor as the physical and emotional demands of this medical procedure are exacting. Women often view

unsuccessful attempts to conceive as a loss, an existential crisis that influences their sense of wholeness and well-being. In our case, the patient's difficulty coping with unsuccessful treatments had led her to seek professional help through psychiatric hospitalization.

Nonetheless, the decision to attempt to conceive may indicate her strength and search for a purpose in life. Since she had decided to become a mother she exhibited a goal-oriented behavior that may have contributed to remission of her anorexia and a significant decrease in acts of self-harm. She persisted with the fertility treatments despite the difficulties and never relinquished her wish for a child.

Another worrisome issue was her constant lack of social support, which led her to seek support inside the hospital. The staff was troubled by the question whether this was appropriate grounds for hospitalization, and what the professionally "right" approach would be in this case.

In contrast to the above-described restrictions stands the patient's right for personal autonomy. She demonstrated full insight regarding her state and believed she was completely capable of functioning as a mother. She had a remarkable sense of purpose while both deciding and carrying out her decision. According to the ESHRE Task Force [5], when the fertility physician faces the decision whether or not to treat, the strictest standard is the "maximal welfare" which demands optimal conditions for the future child. The "minimum threshold" claims medical assistance is unacceptable only if the quality of life of the future child is so low that it would have been better off not to be born. The intermediate standard is "reasonable welfare" according to which assistance is acceptable if the future person will have the abilities and opportunities to realize those dimensions and goals that in general make a human life valuable. Although in our case the patient's physicians were not those who performed the treatment, there was a sense of responsibility since her continued treatments involved hospitalizations for those treatments. The staff was troubled by the question whether or not to contact her physician. Some of the

staff argued that her mental state and her threat to kill herself unless she became pregnant indicate her inability to go through this process and function as a mother. Should a child serve as the meaning to his or her mother's life? How will it affect the child's development and the mother's mental state in the future? Some staff members argued that it is not the physicians' decision to make and they do not have the right to evaluate the patient's maternal capacity. A special concilium of the staff and the hospital's management discussed this case and decided not to intervene unless required by her fertility physician. The guideline was her right for autonomy and her sincere efforts that manifest in the improvement of her condition.

In conclusion, this unique case and the sequence of events that led to her pregnancy and birth raised an important ethical discussion among her physicians. Any woman has the right to become a mother but is it the physician's role to support this right in cases of women in psychiatric hospitalization? If so, what should the extent of support be? Moreover, while this case indicates a positive outcome, what does the future hold for her and her child? Or, is this question beyond mental health professionals' area of responsibility?

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