

Ethical dilemmas in perinatal psychiatry

Rosalind Ramsay and Channi Kumar

This paper discusses ethical dilemmas that arise in parenting assessments on an in-patient Mother and Baby Unit with reference to one subject, a mother with schizophrenia who had been referred for a specialist opinion. The case raises ethical issues about the sometimes conflicting needs and wishes of mothers and their infants, and considers the requirements of the Children Act.

Ms A, a 41-year-old woman, was referred by her local social services to a Mother and Baby Unit (MBU) for a 6-week assessment of her ability to parent her 4-month-old baby, B. Ms A had a 16-year history of paranoid schizophrenia, but she had had one long-lasting relationship. The local psychiatrist, who had known her for over ten years, reported that she cooperated intermittently with anti-psychotic medication; when she relapsed in recent years she became hostile, paranoid, deluded and unpredictable. At other times she related pleasantly without any behavioural abnormality. Ms A had met the baby's father, Mr C, the previous summer. He was at the time dependent on alcohol and when he was intoxicated he and Ms A fought and were occasionally violent to each other, which had led her to take out an injunction against him. Mr C underwent detoxification, his relationship with Ms A improved and by the time of the referral she was in the process of revoking the injunction. Ms A had had one other child seven years earlier who was brought up by another person with whom she had no contact.

Early in the recent pregnancy she stopped taking her medication, and her mental state started to deteriorate. After B was born staff in the maternity unit became concerned about Ms A's behaviour and her parenting skills, and thought she might be relapsing. She was transferred to the local psychiatric unit on a section with her baby and medication restarted. Ms A was aggressive and hostile towards staff. She winded the baby roughly and often allowed staff to take care of her. Social services placed B in temporary foster care and requested a parenting assessment of Ms A on the MBU. While in foster care Ms A had access to her daughter three times a week for one hour.

On admission to the MBU Ms A's mental state was normal. She understood that she had a chronic mental illness and required long-term medication. Psychological assessment showed some deterioration in her cognitive abilities consistent with a diagnosis of chronic schizophrenia. Ms A initially seemed anxious about whether she would be able to cope with the baby, but gradually became more confident, spending increasing amounts of time with her, and seeking advice from staff when appropriate. B was an unsettled baby with an unusual high pitched scream, but over the six weeks she became more settled. Nursing staff observed that Ms A made good eye contact and vocal contact with her and after appearing a little hesitant and stiff in handling B, her physical contact became more comforting and affectionate, and seemed safe with no perceived risk to the baby. Mr C visited the unit each day to see Ms A and the baby. There was one incident during the six-week assessment when Mr C became argumentative with Ms A after he had drunk several shandies.

In meetings with the local social services, the MBU team recommended that Ms A be allowed to return home with her daughter. Both Ms A and Mr C as well as B would need monitoring and support in the community by mental health, primary care and social services. Social services accepted the recommendations and also decided to place B on the 'at risk' register. Factors which the MBU team thought could jeopardise Ms A's ability to care for B were first if Ms A stopped her medication and second if Mr C started to drink again and his relationship with Ms A deteriorated.

Discussion

This case presents an ethical dilemma involving possibly conflicting duties of care, uncertainties of best interest, and issues of justice. Staff on an MBU who carry out parenting assessments must try to answer the question "is the mother able to care for herself, and her child, physically and psychologically, now and in the future?" The professional team is involved in a number of

processes: the techno-clinical question of risk assessment, judgements of risk and danger and the ethical implications of these judgements.

Is the definition of 'parenting skills' some sort of quasi-moral standard, or a simple matter of facts and practical ability? Do we accept different parenting skills in different women, for example, in mothers from different cultures or socio-economic groups, or with different disabilities or disadvantages? How do parenting skills differ between women with and without schizophrenia? The course of the illness in an individual patient is uncertain, which leads to uncertainty about predicting parenting skills in the future. If there is no 'gold standard' of parenting skills how do professionals judge them, or resolve any differences of opinion within the multidisciplinary assessment team, or between professional teams? In this case at one point social services removed the infant, but later, following a specialist assessment on the MBU, social services accepted recommendations to allow mother and infant to return home together.

A further issue concerns whether in assessing parenting skills, particularly knowing that legal action may follow, professionals require a higher standard of care by vulnerable mothers than would be considered acceptable in the 'normal' situation at home when there is not a comprehensive assessment of a mother's ability. By admitting the mother and infant to an MBU are professionals medicalising the situation with the risk that to be successful the mother must be observed to fulfil professional criteria for 'normal' parenting ability; how do her parenting skills differ under 24-hour assessment in hospital compared with the real life situation when she is in a familiar environment at home with her child without 24-hour supervision and support?

In their recommendations to social services at the end of the assessment MBU staff have two separate individuals, mother and child, to consider. Social services make the potential dilemma explicit by allocating one social worker from the children's or families' team for the child, and in most cases a social worker from the adult team for the mother. This would imply the needs of the mother and child are separate rather than integrated. However, can a decision-making framework that sees their needs as separate, even opposing be correct or may it produce a result which is ethically unjustifiable? Alternatively we could argue that the needs of a mother who is ill and lacks insight differ from those of her child and the two should be considered separately, not as a unit.

With the introduction of the Children Act (1989) the legal rights of children who may be suffering or are likely to suffer significant harm (Williams, 1992) have been highlighted. Although the Act does not discuss the needs of infants in particular,

in general it states that the welfare of children must be the paramount consideration when the courts are making decisions about them, and the concept of parental responsibility replaces that of parental rights. Decisions made under the Children Act require information on which to base them. Asking for a report from a specialist mental health team allows social services some sharing of responsibility for the difficult decision of whether or not a mother should be allowed to care for her child, and under what level of supervision. The decision is likely to have immediate and long-term effects for both mother and infant, with evidence that decisions about separation made at discharge from an MBU are likely to remain unchanged, even though for the individual patient her functioning may later alter, for example, with changes in medication or in relationships. The father of the child or another family member may provide long-term support; concern about the mother's parenting ability may be increased if, as in this case, the father appears unstable. However, we lack evidence which would allow categorical statements of whether or not a child is at risk. The Children Act states that delay in deciding questions concerning children is likely to prejudice their welfare and that local authorities have a duty to identify children in need implying that if there are any concerns about a mother's parenting ability, social services should be proactive in getting an assessment of the mother.

For a mother with schizophrenia, bringing up a child will help connect her with other mothers, playgrounds, schools and so on, the role of motherhood offering meaningful work and a social situation with easy access to others with a mutual interest providing someone to care for or as someone to care about her in a 'normal' way (Apfel & Handel, 1993). Is it, however, ethically justifiable to 'use' another person to provide a normal experience for a sufferer from schizophrenia, especially when the other person is a child who cannot give consent?

Another dimension to consider is the effect of loss on mother and child if the two are separated. Biological mothers who have given up their infants for adoption continue to think about those children over their entire lives (Rynearson, 1982); similarly people who have mental illness can experience an enormous sense of loss when they talk of children who might have only existed for them in hopes and fantasy (Hilgard & Newman, 1959). The child too may suffer through being separated from the mother, given evidence about the possible adverse consequences of out of home care, and the lack of guarantee that residential or foster family care produces a good outcome (Woking & Rushton, 1994).

Finally, considering resources, if the provision of adequate support and supervision for the mother at home is more expensive than out of

home care there may be decisions to make about the allocation of resources to these subjects.

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Rosalind Ramsay, *Senior Registrar, The Bethlem Royal and Maudsley NHS Trust, London SE5*; and Channi Kumar, *Professor of Perinatal Psychiatry, Institute of Psychiatry, London SE5*

Prevention of Anxiety and Depression in Vulnerable Groups

Joanna Murray

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