Review

Grappling with the Issue of Motherhood in Women with Schizophrenia

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Posted Date: 8 October 2023

doi: 10.20944/preprints202310.0420.v1

Keywords: Antipsychotics; Child Custody; Interventions; Mothers; Parenting; Schizophrenia; Stigma; Support; Women

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Abstract: While persons with schizophrenia, for the most part, find steady employment difficult to sustain, many of the women with this diagnosis take on the most difficult task of all – motherhood. The aim of this paper is to review the challenges of motherhood in this population and the treatment strategies needed to keep mothers and children safe, protecting health and fostering growth. This is a narrative review reflecting the author's life experience and a non-systematic search of the recent literature. Topics included are: the stigma against motherhood in the context of schizophrenia, mothers' painful choices, issues of contraception, abortion, and child custody, fostering and kin placement of children, the effects of antipsychotics, specific perinatal delusional syndromes, and parental supports. Recommendations are to work collaboratively with mothers who struggle with serious mental illness, take note of their strengths as well as their failings, offer a wide array of family services, monitor closely for safety, and appreciate the challenges these women daily face.

Keywords: antipsychotics; child custody; interventions; mothers; parenting; schizophrenia; stigma; support; women

1. Introduction

The rate of gainful employment among persons with schizophrenia is generally low, reportedly ranging between 8% and 35% in Europe [1]. In Denmark, when income is counted over 35 adult years, individuals with schizophrenia have been found to earn only 14% of the wages earned by peers who are free of schizophrenia [2]. Barriers to steady employment include, among other factors, societal stigma, self-stigma, fear of loss of disability benefits, lack of initiative and confidence to search for jobs, cognitive problems, unpredictable moods and behavior, and unreliable work attendance. And yet, 50% of women with schizophrenia perform the most difficult job of all. They become mothers, often having to do this demanding job on their own, without guidance nor support. It is not surprising that these women face a host of tough challenges and require specialized assistance. The aim of this paper is to describe the challenges and review the steps needed to keep women with schizophrenia and their children safe from harm and living well.

2. Materials and Methods

This is a narrative not a systematic review. The PubMed database was scoured for what was considered the most relevant, most recent, and best quality articles (judged on clarity of writing, clinical importance, logical organization, well-analyzed data and novel interpretations) pertaining to the challenges of motherhood in women with schizophrenia, and to the social and mental health support services that these women required. The specific choice of articles has been admittedly subjective, and the author apologizes for inadvertent omissions.

 doi:10.20944/preprints202310.0420.v1

3. Results

3.1. Complex Decisions

Although the precise rate varies from study to study, approximately 50% of women with schizophrenia become mothers, a similar rate to that of women in the general population [3-6]. Many women with a schizophrenia diagnosis, however, are unpartnered or in unstable relationships, making motherhood doubly difficult [7]. A meta-analysis of 1404 participants in the United Kingdom with a schizophrenia diagnosis (mean age = 39.9), found that merely 15.6% were married [8]. This percentage varies, of course, from region to region, dependent on cultural, religious, and economic factors. It is relatively high in India, for instance, where prevailing beliefs are that marriage can cure psychiatric illness [9]. In addition to being single, many women with schizophrenia, for symptom and behavior-related reasons, are alienated from their family of origin [10]. Many are homeless [11]. In some parts of the world, they subsist on governmental disability pensions. In other parts of the world, they depend on charity. The monthly government support is usually supplemented when they become mothers, but it still does not provide for much beyond bare necessities [12]. Most women with schizophrenia are likely, at some point in the trajectory of their illness, to be offered antipsychotic treatment and, for two thirds of those who accept it, the most evident of their psychotic symptoms (delusions and hallucinations) are well-controlled [13]. The other third, and those not in treatment, struggle with often debilitating symptoms. Beyond delusions and hallucinations, many women with schizophrenia report negative symptoms (apathy, anhedonia, social alienation), cognitive symptoms (problems with attention, memory, analytic skills) [14], as well as depression, and anxiety [15]. Constant symptoms such as these can be incompatible with what Winnicott referred to as "good enough" infant and child care [16], especially in the context of economic insufficiency and meager social support. These are some of the reasons why, given this diagnosis, family, friends, and medical personnel, as well as the women themselves, are wary about having children. There is justifiable concern for the safety and well-being of children because severely ill mothers have difficulties putting, as they must, their children's needs before their own. Health care providers and relatives also worry about the effect of the added responsibility and stress of motherhood on the mothers' health [17].

During the pregnancy itself, and especially postpartum, the severity of psychotic symptoms tends to increase [18]. There are also high rates of obstetric difficulties in this population [19, 20]. The great fear for mothers as well as for health providers is that children will not only inherit a susceptibility to schizophrenia but be made even more susceptible by difficult gestations, birth complications, inadequate parenting, traumatic experiences, poor schooling and low income [21].

Furthermore, there is a widespread fear of the effects on mother and child of antipsychotic medication. Many of the drugs used to treat schizophrenia have strong sedative properties and can over-sedate mothers to a degree where they are frequently unable to respond appropriately to their offspring [22,23]. From a research point of view, human parenting behaviors are so varied and complex that it is difficult to investigate the potential impact of drugs [24]. Drug effects are more easily studied in rodents where antipsychotics have been shown to markedly interfere with maternal behaviors such as pup retrieval, pup licking, nest building and pup nursing [25-27]. A constant worry for mothers with severe mental illnesses is that antipsychotic side-effects, such as slow movements, clouded thinking, delayed responses, and emotional blandness, will make it seem to observers that they were unable to appropriately care for their children. For these reasons, they may stop taking their drugs, exposing themselves to repeated relapses.

A major concern in the field is that antipsychotic medications during pregnancy exerts adverse effects on the development of children born to mothers with schizophrenia [28]. This is an important concern, but mental health workers do not sufficiently monitor the health of these children to know whether they are being adversely affected. They rarely inquire about the children and they are insufficiently acquainted with the extent or quality of their patients' parenting capabilities. Very few patient charts contain information about the physical or mental health of the patient's children nor about the size or nature of the patient's support network [29].

Sight is sometimes lost of the fact that many women with disabilities such as schizophrenia function successfully as mothers [30]. Network assistance from family, friends, volunteers, co-patients, children's aid agencies, social agencies, and medical/psychiatric support programs are able to make the parenting journey less stressful than otherwise, providing significant benefit to mothers and children. Looking only at diagnosis, it is impossible to determine whether one aspect of life, -e.g., being a mother, constitutes a health risk or an advantage. This is especially so when discussing schizophrenia, where symptoms range from mild to severe, constant or intermittent, where some individuals are fully functional while others are barely so, and where some have family and other supports that act as safety nets. Whenever social/medical personnel decide, based on diagnosis alone, that motherhood is unwise for a client/patient, this decision falls clearly into the realm of bias. It is a common bias. A schizophrenia study by Thornicroft et al. [31] discovered that, when asked, 38% of study participants reported that they were treated dismissively by mental health staff when they tried to discuss starting a family.

3.2. Pharmacology and Technology to the Rescue

New tools are now available that can make the choice of motherhood, in some ways, easier for women. Should a woman prefer to wait before conceiving, she has a variety of contraceptive and "morning after" choices that no longer rely solely on the co-operation of male partners [32-34]. One important caveat when women with schizophrenia make contraceptive choices is that medical advice should always be sought because there are potential interactions between hormone prescriptions and some of the psychiatric drugs they may be taking [35].

There are other pregnancy choices (not always easily accessible for women with schizophrenia). A woman can freeze her eggs, postponing parenting to when her circumstances or improvements in her health will make her a more competent mother. If women are worried about carrying disorder genes or about the effects of medications on their fetuses, they can now utilize the help of surrogates. If they do not have a male partner, they can take the route of *in vitro* fertilization [36].

With respect to induced abortion, 50% of the pregnancies in women with schizophrenia are unplanned and 25% of those unplanned pregnancies are terminated because the mother recognizes her inability to care for a child [37]. These are high rates, attributable to relative lack of knowledge about contraception [38] and also to a high reported rate of sexual coercion in this population [39-41]. Even so, depending on jurisdictional regulations, religious denomination, insurance coverage, distance from metropolitan areas, general knowledge, and social capital, abortions are not accessible for many women with schizophrenia.

These are all personal decisions that women with disabilities must make [42] but, in the context of schizophrenia, women's decisional capacity is sometimes deficient and her choices can, in such cases, be overruled by surrogate decision makers. Determinations of capacity are needed when a woman with schizophrenia is considering the pros and cons of an abortion, or of a tubal ligation or of adopting a baby. When she is judged incompetent to make a decision, there is sometimes a dilemma with respect to the surrogate. The woman may, for instance, designate her intimate partner whereas her parents may claim that they are the ones most concerned with her wellbeing and most aware of the potential consequences of her decision. While surrogate decision makers are asked to decide as the patient would do were she well, they are sometimes tempted to act in their own self-interests instead [43], an issue that can lead to serious ethical/legal quandaries [44].

3.3. Sexual Issues in Women with Schizophrenia

Women with schizophrenia report a similar degree of sexual desire as other women of comparable age [45], but their opportunities for interpersonal sex are relatively few. Much is unknown because patients' sexual practices are rarely inquired about during psychiatric visits with schizophrenia patients [39;46].

Seeman [47] has underscored the importance of discussing contraception with all women of childbearing age because they are all potential mothers. Topics such as interest in being in a relationship or becoming a parent, sexual dysfunctions, and family planning need frank discussion

[48]. One reason why such discussions are important is for protection of women with schizophrenia who may otherwise place themselves at risk by engaging with short term partners or strangers [49].

Induced abortion can be psychologically traumatic. Bearing a child and giving the child away for adoption is also very difficult. Currently, in some jurisdictions, it is sometimes possible for birth mothers to visit with their biological children – which appears to lessen the pain of separation [50]. Adopted children of mothers with schizophrenia who do not know their birth mothers very often search for them and eventually locate them. If the mother has severe schizophrenia symptoms, the reunion may be very traumatic for the child. The effects of such reunions on both parties, mother and child, have not been studied.

3.4. Mothering with Schizophrenia

As mentioned, many women with schizophrenia are effective mothers, despite the many challenges [51,52]. They are able to garner support, make the necessary provisions should they suffer relapse and hospitalization, and be conscientious about the care of their children as well as seeing to their own health needs. Nevertheless, they encounter many problems [53, 54]. Many studies conclude that these women struggle with parenting tasks and with fear of the possible effects of their illness on their children [55-57]. Motherhood, however. is important to these women, as it is to most women, and becomes a major aspect of their identity [58]. Loss of child custody is an enduring tragedy in their lives [59].

3.5. Child Custody

In terms of custody loss, the first year of a child's life is the most vulnerable period for women with schizophrenia. Her symptoms may not have recovered from postpartum exacerbation and, at the same time, this is the time period during which the child is totally dependent on the mother. Child protection agencies know that there is a significant relationship between parental perinatal mental health problems and risk of child maltreatment [60]. Under the influence of delusional thinking, mothers with psychosis may physically hurt their child [61] or, as a result of negative symptoms or adverse effects of antipsychotics on cognition, mothers may neglect to feed or provide much needed child care. When this occurs, child protective services (CPS) step in and temporarily (sometimes permanently) remove the child to a foster home. With adequate support, psychiatric liaison and parental training, however, this may not be necessary. Bilson and Martin [62] reported that child agencies sometimes go too far, that, in children born in 2009–2010, one of every nine was a CPS parental child abuse suspect. The consensus is that this high a level of suspicion and intervention is rarely justifiable.

Involvement with CPS can be counterproductive; in the case of parental serious mental illness, detrimental effects on both children and parents have been shown [3]. Custody loss can be prevented not only by attending to a mother's mental health but also by addressing the contributions to poor parenting by factors such as lack of education, non-existent social support, domestic violence, substance abuse, and poverty [63]. Parents of children subject to care proceedings have complicated health and social needs that need solutions more humane than removing children from the only home they know. With respect to the well-being of the mother, a review of pertinent studies concluded that parental health issues are exacerbated by child removal [64].

Custody challenges may arise outside of those brought by CPS, for example during divorce proceedings. One survey found that approximately one third of 596 parents with serious mental illnesses had experienced familial disputes over their ability to care for their children [65]. The authors recommended that psychiatric rehabilitation practitioners be aware of threats to continued parenting and, through therapy, parent training, support, and advocacy, bring family members together to prevent unnecessary custody loss.

 doi:10.20944/preprints202310.0420.v1

3.6. Kinship Care

Childcare agencies, more and more, are advocating kinship care in preference to foster care when they determine that children require placement [66,67]. In very many instances, grandparents, usually grandmothers, step in to help. Mental illness in a parent is an important reason why children are brought up in their grandparents' home [68]. This allows for safe and affectionate care and for an uninterrupted relationship with their mother. The rapport between mother and grandmother can, however, be a difficult one in the context of schizophrenia and children can suffer from the disharmony. The burden on elderly grandparents of caring for two generations can prove onerous, and can sometimes take a heavy toll on their health [69].

3.7. Perinatal Syndromes

There are several syndromes related to pregnancy that are sometimes seen in women with schizophrenia and frequently described, mainly in case reports.

- Delusional Denial of Pregnancy

It is possible to remain unaware of being pregnant until late into the pregnancy and sometimes even until delivery. This is not uncommon; it is more prevalent in the general population than giving birth to triplets. Delusional denial of pregnancy is different. In delusional denial, the signs and symptoms associated with pregnancy are acknowledged but attributed to factors other than pregnancy, despite medical evidence of a fetus. The denial sometimes continues even after the child is born, the mother adamantly stating that the child is not hers [70,71]. Continued delusional denial of pregnancy despite antipsychotic treatment may necessitate involuntary hospitalization, as well as curtailment and potential termination of parental rights. This is necessary due to evidence that mothers with these delusions neglect the child and may inflict injury on the child.

- Postpartum Psychosis and Filicide

Filicide, killing one's infant, is most often seen as a sequela of postpartum psychosis, although it usually occurs not during the acute psychosis but sometime later, often in conjunction with suicide [72]. Although delusional depression is the diagnosis usually linked to filicide, filicide is sometimes seen in the context of a schizophrenic disorder [73]. The most predictive symptoms are delusions that directly involve the patient's children. Other warning signs are unprovoked aggressive behavior, suicidal or homicidal ideation, deteriorating judgment, the presence of command hallucinations, and a rapidly changing mental state [74]. An in-depth study from France of 17 maternal filicide perpetrators found that under half suffered from psychotic disorders. In these, the killing was committed either under the influence of hallucinations or delusions or in the context of threat of separation from the children, the threat being sometimes real and sometimes imagined [75].

- Delusional Pregnancy

Antipsychotic-induced hyperprolactinemia results in amenorrhea, breast swelling and tenderness, galactorrhea, and weight gain – characteristic signs of pregnancy [76, 77]. As a consequence, when a woman prone to delusions is treated with antipsychotics that raise prolactin levels, a delusion of being pregnant (especially if this has been a secret, fervent wish or, perhaps, a fearful apprehension) is not difficult to understand. Delusional pregnancy can present as a single delusion or, more commonly in schizophrenia, in association with other delusions. A recent case report describes denial of pregnancy at one time of life and, in the same schizophrenia patient, delusional pregnancy at a later time period [78]. Many cases are over age 45, suggesting that, as women approach the age when they can no longer have a baby, their wish for one becomes overwhelming [79]. Women with delusional pregnancy need to be treated as any delusional disorder is treated, with psychological insight and an increase in antipsychotic dose (which, however, the patient may not want to take if she believes she is pregnant, and which may also increase her pregnancy-mimicking symptoms).

- Postpartum Delusional Misidentification Syndrome

 doi:10.20944/preprints202310.0420.v1

A recent report describes eight cases of delusional misidentification syndrome in the postpartum period, a dangerous situation because a misidentified infant is at risk of harm from an ill mother [80]. Such syndromes are rare but their early recognition can avert tragedies.

3.8. How to Support Women with Schizophrenia Who Are, or Are About to Be, Mothers

- Economic Support

One avenue to effective intervention for women with schizophrenia who are mothers is to improve their economic circumstances [81]. Increases in household income can improve maternal mental health, the quality of parenting, and household well-being. Linking mothers to sources of aid such as loans, foodbanks, budgeting advice, skill development, therapeutic support, enabling them to meet practical needs (for furniture, food, clothing, rent), introducing employment opportunities, and ensuring welfare rights all lead to positive impacts such as crisis resolution, prevention of children's entry into care and a strengthening of the mother's therapeutic alliance with her mental health team. Axford and Berry [81] acknowledge, however, that the evidence for the long-term effectiveness of income support is extremely thin.

- Social Support

Bacon et al in 2023 [82] synthesized 41 studies of parent and practitioner experiences of support for parents with mental health needs. They noted that difficulties mentioned most often by parents, such as financial issues, tended to be absent in the papers they reviewed. Mothers whose children have been removed by child protection agencies report feeling ashamed, hopeless, and increasingly isolated and facing more and more adversity. Services that focus on child protection often neglect the mental health of parents, so the authors recommend integration of child and parental services. Parents reported that CPS interventions were stressful and intrusive but they did appreciate the provision of family case management and of 24-hour crisis services. Parents often felt judged, however, and believed that involvement with services exacerbated their mental health problems. Custody loss was a constant threat hanging over their heads. A further recommendation found in the literature was to include parents in decision-making as to what was needed to keep children safe and to base decisions on a strength-based, rather than a deficit-based, perspective of parental capacity [83,84].

- Peer Support

Trained and responsible peer support, increasingly utilized in behavioural health services, is very helpful to women as it is easier to talk to someone who has had similar experiences than to unburden oneself to a professional care provider [85]. Peers, and also professionals, can suggest strategies and resources that aid safe and successful parenting. The main recommendations, as discussed in [86] are: A) to maintain one's own mental health, which includes a healthy diet, adequate sleep, routine exercise, attending regular mental health and other medical/dental visits, cancer screenings, and vaccination appointments and adhering to all prescribed regimens. B) to self-monitor for signs of psychotic relapse. Such signs vary among individuals but often take the form of insomnia, lapsed hygiene, increasing suspiciousness about the meaning of events or of people's intentions. Recognition of such signs, the ability to increase antipsychotic doses as needed and 24 hour access to a crisis line are vital components of safety. C) to develop a plan of action should hospitalization be necessary. The children need to know who to contact in an emergency and the proposed contact persons need to be familiar with the plan. The plans need to be shared with the children's school and doctors and the surrogate care givers need to have school and medical routines written down, as well as the children's food preferences and allergies, friend contact numbers, favourite toys and activities. D) to take advantage of available parenting resources (parent training classes, support groups, parent coaching, home visiting, respite services, online courses. E) to document personal parenting styles – how emotional problems are addressed, how children's safety is ensured, how limits are set, how conflicts are resolved, how children are socialized. F) to learn how to navigate the legal system with respect to child abuse reporting mandates, parental rights, time limits by which goals set by child protection agencies must be met. From the side of child protection,

 doi:10.20944/preprints202310.0420.v1

workers need to be acquainted with the nature of the disabilities presented by mothers with schizophrenia [87], not only the problem areas, but also the competencies.

- Specific Interventions

Radley et al. [88] offer a scoping review of 34 interventions designed to support parents who suffer from psychosis. The authors conclude that they have all been imported from parental assistance programs implemented for parents with other disabilities and that very few have been properly investigated for effectiveness in this specific population. Randomized controlled trials are needed to determine the effect of parent buddy systems, parent discussion groups, formal education about parenting, parenting camps, nurse visitors, respite arrangements, family therapy, online courses and other forms of parenting support on outcomes of mothers with psychotic disorders and their children.

4. Discussion

In the 1960s and 70s, the decades when psychiatrists believed that parents caused schizophrenia, evidence of parental guilt was observed seemingly everywhere. Weakland and Fry [89] found it in the "incongruent communication" of letters that mothers wrote to their sons. This is an example of how a theoretical conviction can interfere with our ability to see clearly. The authors comment on the contradiction sexpressed in the letters but fail to notice the affection. Something similar is occurring today in the ways mental health practitioners negatively view the capabilities of mothers with schizophrenia.

Recent in-depth interviews with eight parents with schizophrenia (five mothers and three fathers) show a different side of the story [90]. The investigators' conclusions are that practitioners need to support parents with schizophrenia, moving away from risk-focused approaches to targeting stigma and promoting family-centred, compassionate help with a very difficult task. The data suggest that a risk focus is counterproductive, leading vulnerable mothers away from seeking help and away from accessing the supports they need to be able to provide the kind of nurturing they are capable of. For reasons of safety, especially when the symptoms expressed are associated with potentially dangerous outcomes, close monitoring is inescapable, but what one attends to while monitoring must be not only maternal deficiencies but also their skills, efforts, and triumphs.

5. Conclusions

This paper reviews the challenges involved in fulfilling the world's hardest task – being a good parent, a task made exceedingly difficult when the parent is also undergoing a serious psychiatric illness. The challenges are inherent in the illness – schizophrenia – but also in the attached stigma, poverty, social isolation, and life circumstances, which include the constant threat of child removal. There are difficult decisions to be made and a lack of needed resources and guidance. Assistance is available in many potential forms, but not always accessible, and almost never guaranteed to prove effective. Recommendations are to partner with mothers with schizophrenia, appreciate their strengths as well as their frailties, offer a wide array of family services, monitor closely, and take well-earned pride in successful outcomes.

Author Contributions: I am the sole author.

Funding: This research received no external funding.

Institutional Review Board Statement: Institutional review was not required.

Informed Consent Statement: Consent was not required.

Data Availability Statement: Search data are available.

Acknowledgments: I acknowledge the informational and motivational contributions of the patients who were members of the Women's Clinic for Psychosis .

Conflicts of Interest: The author declares no conflict of interest.

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