ETHICAL ASPECTS OF COUNSELING PEOPLE WITH MENTAL DISORDERS WHO ARE PLANNING THEIR PREGNANCY

Lobanova IV, Sataev AE, Manaeva TA ✉

Yaroslavl State Medical University, Yaroslavl, Russia

This article highlights the ethical aspects that arise when the attending psychiatrist communicates with patients and their family members on the issues of planning a pregnancy. While counseling people with mental disorders about their reproductive plans, it is difficult from an ethical point of view to discuss some issues such as the risks of pathology in an unborn child and a possibility of reducing the risks, in particular the probability of genetic inheritance of a mental disorder; the expediency of discontinuing psychotropic drugs used by the expectant mother and/or father to treat or prevent a mental disorder exacerbations, given that drugs can affect the quality of reproductive biological material, whereas cancellation of therapy is associated with risks to the mental health of expectant parents; the need to inform the patient's family members about his/her mental disorder, the treatment used and all available personal risks to offspring. Different literature sources, including domestic and foreign ones, were reviewed. The keywords used in literature were "genetics", "psychiatry", "ethical aspects of genetic counseling", "psychopharmacotherapy during pregnancy", "the effect of psychotropic drugs on spermatogenesis" with filtering by language (Russian and English) and document type. Two own clinical observations are presented. The purpose of the article is a comprehensive analysis of ethical aspects of counseling people with mental disorders on pregnancy planning by a psychiatrist.

Keywords: genetic counseling, ethical aspects of counseling, pregnancy planning, psychotropic drugs

✉ **Correspondence should be addressed:** Tatyana A. Manaeva

Yakovlevsky passage, 1, b. 25, Yaroslavl, 152280, Russia; manaeva002@gmail.com

Received: 13.11.2024 **Accepted:** 05.12.2024 **Published online:** 23.12.2024

DOI: 10.24075/medet.2024.025

ЭТИЧЕСКИЕ АСПЕКТЫ КОНСУЛЬТИРОВАНИЯ ЛИЦ С ПСИХИЧЕСКИМИ РАССТРОЙСТВАМИ ПРИ ПЛАНИРОВАНИИ ДЕТОРОЖДЕНИЯ

И. В. Лобанова, А. Е. Сатаев, Т. А. Манаева ✉

Ярославский государственный медицинский университет, Ярославль, Россия

В данной статье освещаются этические аспекты, возникающие при общении лечащего врача-психиатра с пациентами и членами их семей по вопросам планирования деторождения. В ходе консультирования лиц с психическими расстройствами по поводу их репродуктивных планов сложным с этической точки зрения оказывается обсуждение следующих вопросов: риски возникновения патологии у будущего ребенка и возможности их снижения, в частности вероятность генетического наследования психического расстройства; целесообразность отмены психотропных препаратов, применяемых будущими матерью и/или отцом для лечения психического расстройства или профилактики его обострения, учитывая, что лекарственные средства могут влиять на качество репродуктивного биологического материала, а отмена терапии сопряжена с рисками для психического здоровья будущих родителей; необходимость информирования членов семьи пациента об имеющемся у него/нее психическом расстройстве, применяемом лечении и всех имеющихся персональных рисках для потомства. Проведен обзор литературы, включая отечественные и иностранные источники. Поиск литературы осуществлялся по ключевым словам, таким как «генетика», «психиатрия», «этические аспекты генетического консультирования», «психофармакотерапия при беременности», «влияние психотропных препаратов на сперматогенез» с фильтрацией по языку (русский и английский) и типу документа. Представлены два собственных клинических наблюдения. Целью статьи является разносторонний анализ этических аспектов консультирования психиатром лиц с психическими расстройствами по вопросам планирования беременности.

Ключевые слова: генетическое консультирование, этические аспекты консультирования, планирование деторождения, психотропные препараты

✉ **Для корреспонденции:** Татьяна Алексеевна Манаева

Яковлевский проезд, д. 1, к. 25, г. Ярославль, 152280, Россия; manaeva002@gmail.com

Статья поступила: 13.11.2024 **Статья принята к печати:** 05.12.2024 **Опубликована онлайн:** 23.12.2024

DOI: 10.24075/medet.2024.025

Modern possibilities of psychopharmacology, medical and psychological support, rehabilitation of people with mental disorders reach the level with a desire for a high quality of life, including such aspects as maintaining working capacity, a possibility of full-fledged independent functioning, and building personal and intra-family relationships. The issue of childbearing potential becomes relevant as well.

In recent years, more and more patients with various mental disorders have turned to a psychiatrist for advice, planning to conceive a child, wanting to know the existing risks for themselves and for their future children and the possibilities of reducing the risks. In this article, the issues of counseling by a psychiatrist of patients with preserved critical abilities, including those treating their existing mental disorder critically, are discussed.

It is well known that most mental disorders have a hereditary component in their etiology. Despite the fact that a significant number of mental health professionals believe that mental disorders are genetic in nature, most patients report that psychiatrists have never discussed ethical issues of psychiatric genetics with them. This contrasts with the data that in the families of a large number of patients there were questions related to genetics of mental disorders, and that almost half of the patients were worried about transmission of a mental disorder to their offspring [1]. Consultation of patients on the issues of psychiatric genetics should be aimed at providing accessible information about the genetic

risk of mental disorders, at communicating theses about their multifactorial polygenic nature, and eliminating misconceptions about the causes of their occurrence [2]. The same variations in the number of copies of genes can occur in different mental disorders, i.e. variations in a number of copies of genes predispose to a number of neuropsychiatric disorders [3]. Multiple single nucleotide polymorphisms rather emphasize the tendency to neuropsychiatric diseases than being a marker of a specific disease [4]. The phenotypic consequences of single nucleotide polymorphisms depend on the genetic background of the individual. Since mental illnesses are multifactorial and polygenetic, it is impossible to talk about a high risk of mental disorders in a patient based only on the data of genetic testing. The circumstance should be stressed while communicating with patients and their families. It is necessary to show incompleteness of genetic knowledge to date, as well as make it clear to patients that quantitative data on the risk of developing mental disorders obtained in epidemiological studies cannot be extrapolated to the personal risk of developing psychopathology in the patient, his relatives and planned children [5]. After all, individually, the most common genetic variants have an extremely insignificant effect size for development of mental disorders [6].

The European Psychiatric Association's policy document on ethical aspects of communication with patients and their families (Carpiniello B, Wasserman D, 2020) postulates the following key rules for psychiatrists in genetic counseling.

- Take special care while communicating with patients and families about genetic risks and provide updated information on the current state of affairs in this area.
- Make it clear that modern genetic knowledge is still incomplete, as it is an evolving scientific field and future results may change our existing ideas.
- Remember that disclosure of the results can cause negative and destructive effects not only in patients, but also in other family members.
- Discuss with the patient the possibility of sharing genetic information with family members and obtain explicit consent to disclosure of this information.
- Counselors should consider ethical implications of disclosing genetic information and complexity of the psychological consequences and be prepared to offer psychotherapeutic support as part of the counseling process.
- Genetic counseling on the issues of planning of family and abortions should include all the information necessary to help patients make decisions; in these cases, psychiatrists should treat values and decisions of patients with special respect [7].

In addition to genetic predisposition, factors associated with adverse environmental influences are definitely essential in the development of mental disorders, which must be taken into account and discussed when advising patients on childbearing planning, since some of these risks are modifiable. Epigenetic mechanisms imply that certain genes can either manifest under the influence of external causes, or be suppressed in the process of ontogenesis. It depends on many factors whether the alleged inherited genetic disorders of offspring will manifest or not. An important role is played by living conditions, environmental problems, poor nutrition, physical inactivity, stress, and disharmonious upbringing. Thus, the social status and psychological microclimate of the family are important. The latter is vulnerable in the presence of a mental disorder in one or both parents, possibility of financial and other support from relatives and other surroundings.

An increased likelihood of developing a mental disorder may also be due to medical and biological influences, the effect of damaging factors on gamete, embryo, and fetus. For example, the use of alcohol, cannabinoids and other psychoactive substances by future parents and smoking will significantly increase the risk of psychopathology in offspring. It is necessary to discuss the unequivocal exclusion of these harmful effects with patients. However, drugs can produce a damaging effect as well. It is difficult for a doctor to decide on withdrawal of a drug by a woman while planning pregnancy in order to prevent a risk to the health of the fetus or newborn (the danger of the formation of congenital malformations, pre- and neonatal complications, etc.). Psychotropic drugs can penetrate through placenta and have an adverse effect on the fetus. The constant use of drugs by a pregnant woman can lead to drug dependence of the fetus and ultimately to withdrawal syndrome in a newborn [8].

There are three classes of teratogenicity of psychotropic drugs: class A — teratogenicity in animals is absent, there are no studies of the risk of teratogenicity in humans or teratogenicity in animals has been established, but is absent in humans; class B — teratogenicity in animals has been established, there are no studies of the risk of teratogenicity in humans or there are no studies of the risk of teratogenicity in both animals and humans; class B — teratogenicity has been proven, but the benefits associated with prescribing drugs sometimes exceed the risk (for example, in a life-threatening situation) [8].

Obviously, psychotropic drugs taken during conception and pregnancy would increase potential prenatal risks to the fetus. Thus, withdrawal of the medications is desirable. However, when choosing such an alternative (the proportion of benefit to the mother and potential risk to the child), it is necessary to take into account a number of other circumstances, including the influence of the mother's mental state on her quality of life, the ability to carry out pregnancy and take further care of the newborn, as well as the possibility of a negative impact of severe mental state of the mother during pregnancy on the fetus development. The issue of the use of psychotropic drugs during gestation should be solved individually after careful consideration of the benefit/risk of pharmacotherapy and its absence. When choosing therapy for pregnant women with chronic mental disorders in stable remission, it is recommended to take into account, in particular, the frequency of previous episodes, age, family situation, and the possibility of providing care to a newborn in case of relapse in the mother [9].

Another aspect that requires discussion and an informed decision is the use of psychotropic drugs by the future father. Many psychotropic drugs produce undesirable effects on sexual function, spermatogenesis and ejaculate quality. In January 2024, the safety committee of the European Medicines Agency (EMA) recommended precautionary measures regarding the potential risk of neurodevelopmental disorders in children born to men who took valproate. In the UK, the Medicines and Healthcare Products Regulatory Agency (MHRA) has introduced stricter precautions, warning against prescribing valproate to people under 55 years of age [10]. The use of selective serotonin reuptake inhibitors (SSRIs) is common among men of reproductive age. There are studies indicating a decrease in sperm parameters among men taking SSRIs: an increase in the number of single-strand and double-strand breaks in the DNA molecule. There is also a drop in sperm concentration and motility [11]. Other antidepressants that regulate serotonin, norepinephrine and/or dopamine levels in synapses may have toxic effects similar to SSRIs, but most

of them have not been studied as far as this subject goes. Most antipsychotic drugs contribute to an increase in prolactin levels, a decrease in testosterone levels and cause side effects related to sexual function [12]. For some drugs, the effect of their administration on sperm quality has not been sufficiently investigated. In order to avoid an increase in risk factors for the fetus, it is advisable for the future father to stop taking drugs for about three months before the planned conception, since during this period the ejaculate indicators practically return to their initial values. In the studies of Tanrikut S, improvement in sperm quality was observed 1–2 months after drug withdrawal [13]. However, when making such a decision, it should be borne in mind that in many cases the risk of deterioration of a man's mental state increases, exacerbation of symptoms in chronic mental disorder, which will certainly negatively affect his health and quality of life, may entail a more or less significant change in social status and working capacity, cause financial problems and generally worsen the psychological climate in the family.

When consultation is looked for by one of the spouses, the issue of informing the partner is difficult from an ethical point of view. The right of patients to confidentiality of data concerning their health in general and mental health in particular is recognized by law. However, in case of pregnancy planning, there is the following opinion: the patient's family members should be informed about genetic and other risks (for example, those associated with taking psychotropic drugs), in possible development of a disease in relatives, and burdening relatives with caring for a family member at risk of developing a mental illness [14]. However, it is worth considering that within the family, this information can provoke conflicts, which in turn is an epigenetic risk.

The patient's right to receive personal information about his diagnosis is generally recognized [15]. At the same time, patients have the right not to know about their diagnosis if they do not wish to do so.

The "right not to know" should be applied ethically to stigmatization-related disorders [16]. However, when the patient/patient seeks advice on planning the conception of a child, it becomes necessary to more clearly identify his/her mental health problems and estimated prognosis of his/her further development. If the patient is ready to discuss all these issues, the specialist should competently approach their disclosure. It is necessary to assess whether the patient feels comfortable enough, whether he is in an acute condition or experiencing serious worries at the moment. It is important to take into account the cultural aspect, which also plays an important role. The specialist should find out how well the patient is familiar with the nature of mental disorders, their determinants, the contribution of genetics to the disease [17], based on the data obtained, provide information and hold discussions, respond sensitively to patients' emotions in connection with the news they receive, respond to individual needs, providing additional opportunities to discuss the problem and related issues [18].

Here are some clinical observations.

CLINICAL EXAMPLES

Observation 1

Male, 36 years old. Diagnosis: bipolar affective disorder type II, drug-induced remission.

Higher education. He works as a programmer, has a good income, but changes jobs every year.

He neither smokes nor drinks alcohol.

He has been married for 10 years, and has been raising a 9-year-old daughter. Family relations are currently stable and trusting.

There is a history of psychopathology hereditary burden, recurrent depressive disorder in his sister.

The patient has been under supervision of a psychiatrist for five years (since the age of 31), episodes of moderate depression are noted annually, mainly in autumn and winter, lasting about a month, phase inversion was recorded twice, hypomanic episodes lasting for about two weeks. During the last year, pharmacological remission has been observed, two weeks ago he canceled treatment independently as he was planning conception of the second child.

His wife does not have chronic mental disorders, she previously contacted a psychotherapist about an anxiety-depressive state associated with an adaptation disorder, currently has no complaints, does not take psychotropic drugs. He works in the civil service, has a stable income. The spouse is aware of her husband's existing mental disorder and the treatment he is receiving.

The 9-year-old daughter is studying in the 3rd grade of secondary school. She had no mental health problems at preschool age. While studying in the 1–2 grade, she needed psychological support due to emotional and behavioral disorders, including problems of interaction with her father, partly due to his unstable mental state.

They required a consultation to discuss reproductive plans. The patient and his spouse wanted to ask if it was possible to inherit the father's mental disorder, and discuss the benefits and risks of canceling supportive treatment.

During the conversation with the patient and his wife, the attending physician identified existing genetic risk factors, given that BAR refers to endogenous mental disorders and there is a hereditary burden in the patient. However, the impossibility of unambiguous prediction of risks for a particular child was emphasized, the multifactorial polygenic nature of mental disorders and the importance of epigenetic factors were explained. When deciding on the birth of the second child in this family, it is necessary to keep in mind the uncertain prognosis regarding further development of a mental disorder in the father, possible difficulties associated with raising a child, given the psychological problems that have already arisen in the eldest daughter. Financial and economic difficulties may also arise due to the unstable labor potential of the patient. The main issue discussed at the consultation concerned modifiable risk factors related to the use of psychotropic drugs by the father. Considering that the patient had independently stopped maintenance therapy before the consultation, a joint decision was made not to resume taking drugs for three months. The attending physician explained the high probability of deterioration of the patient's mental state, and made an observation plan with an increased frequency of visits. The patient's condition destabilized after a month, and it was necessary to resume psychopharmacotherapy. The final decision on the conception of a child is made by the family independently, taking into account all the risks and a variety of personal motivations (cultural, social, etc.).

Observation 2

Female, 28 years old. Diagnosis: recurrent depressive disorder.

Higher education. She works as a self-employed math tutor.

She doesn't smoke. She does not drink alcohol.

Married for three years, no children. She has a friendly relationship with her husband, but there is not enough trust.

Heredity is not psychopathologically burdened.

He has been observed by a psychiatrist for four years, there were two depressive episodes with a pronounced anxiety component that required observation in a day hospital of a psychiatric clinic. During the year, the condition is stable, remission is of good quality, and supportive treatment is provided.

She applied for a consultation in connection with pregnancy planning. She is observed by a gynecologist and endocrinologist for pituitary microadenoma, hyperprolactinemia. Hormonal therapy is being provided, including that aimed at preparing for pregnancy.

It is known that her husband has a higher education and is stably employed. The family is financially secure.

The patient categorically refuses to tell her husband about her mental health problems and that she is taking psychotropic drugs, believing that he will not be able to understand her problems and intra-family conflicts will arise. From an ethical point of view, the issue of whether it is necessary and possible for the attending physician to inform the father of the unborn child about all the risks identified in this article is difficult and debatable. The patient's reproductive plans are clearly outlined, preparations for pregnancy are being carried out under the supervision of a gynecologist, the only relevant question for her sent to a psychiatrist concerned the assessment of the benefits/risk of withdrawal/continuation of psychopharmacotherapy. Despite the assumed high risk of relapse of depression, taking into account all the circumstances, a joint decision was made to gradually cancel medications and increase the frequency of visits to the attending psychiatrist. The pregnancy occurred two months later. Remission persisted until 22 weeks of gestation. In the future, anxiety and depression were developed. Taking into account the ratio of benefit to the mother and risk to the fetus, treatment with a SSRIs antidepressant is prescribed, which can be used during pregnancy. Gradually, a drug-induced remission was achieved. The issue of prolongation of psychopharmacotherapy was raised repeatedly during the further management of the patient, a joint decision was made to continue taking an antidepressant drug, informing the obstetrician-gynecologist hereof, and additional psychological support was provided. Childbirth and the postpartum period proceeded without complications in the mother and the newborn. Further, it became necessary to solve the dilemma with continuation/cancellation of supportive treatment during the lactation period. The patient decided to artificially feed the newborn. During catamnestic observation, the patient has been into remission for two years, successfully taking care of and upbringing the child.

CONCLUSIONS

Despite the ethical complexity, treating psychiatrists need to discuss reproductive plans with their patients. The data of fundamental science should be reasonably translated into understandable theses on the genetics of mental disorders. The expectant mother or father should take a joint and balanced decision on the issue of prolongation/ cancellation of psychopharmacotherapy, taking into account all possible risks and benefits. While counseling patients with mental disorders who are planning a pregnancy, the doctor is required to exercise a delicate approach and choose correct wording, taking into account the individual characteristics of the patient's personality, mental state, intra-family relationships, and readiness to discuss certain issues at the present moment.

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