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# Addressing Pregnancy And Parenting In Mental Health Care: Perspectives Of Women With Serious Mental Illness

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**ABSTRACT** Women living with serious mental illness (SMI) are at increased risk for adverse pregnancy and parenting outcomes. However, little is known about the experiences and preferences of women with SMI related to addressing pregnancy and parenting with their mental health providers. We conducted semistructured interviews with twenty-two reproductive-age cisgender women patients living with SMI. Participants characterized discussions about pregnancy and medication teratogenicity with their mental health providers as limited or unsatisfactory. Participants' openness to discussing pregnancy varied by topic and its perceived relevance to their individual circumstances, and it hinged on participants' trust in their providers. Participants characterized discussions about parenting with their mental health providers as helpful and identified additional opportunities for parenting support. Our findings highlight critical gaps in the delivery of information, support, and resources that can inform efforts to increase providers' capacity to address pregnancy and parenting with women living with SMI.

Women living with serious mental illness (SMI) such as major depression, bipolar disorder, schizophrenia, and schizoaffective disorder are at increased risk for negative outcomes related to pregnancy and parenthood. They are more likely to experience unintended pregnancies, pregnancy complications (for example, preeclampsia and gestational diabetes), and negative birth outcomes (for example, low birthweight and preterm birth).<sup>1–4</sup> They must weigh concerns about continuing to take psychotropic medications (some of which have harmful or unknown impacts on the fetus) versus the risks of untreated mental illness (which may be even more detrimental to both mother and baby) during pregnancy and postpartum.<sup>5,6</sup> Further, women with SMI may experience parenting challenges related to psychiatric symptoms and

treatment, and they are more likely to lose custody of their children than women without SMI.<sup>7,8</sup> These negative outcomes may be prevented or addressed through improved attention to reproductive issues and the integration of reproductive services in routine mental health care.

Outpatient mental health clinics often serve as the main point of contact with the health care system for people with SMI,<sup>9</sup> offering an opportunity to support women in family planning, managing psychotropic medications during pregnancy, and addressing parenting and custody challenges.<sup>10</sup> However, mental health providers might not routinely discuss pregnancy and parenting with patients because of a lack of training, discomfort with the topics, and competing treatment priorities.<sup>11–13</sup> In addition, the reproductive rights of women with SMI have historically been violated, and women may be

reluctant to discuss pregnancy and parenting with their mental health providers because of fears about stigmatization, questions about their parenting competence, and custody loss.<sup>7,14-16</sup>

More information about how women living with SMI view discussions about pregnancy and parenting in routine mental health care is needed to guide efforts to integrate reproductive services into mental health services. We conducted a qualitative study to investigate the experiences, perspectives, and preferences of women with SMI related to addressing pregnancy and parenting with their mental health providers. This work is grounded in a reproductive justice framework,<sup>17</sup> which considers how historical and ongoing reproductive control and coercion of women with mental illness may affect women's experiences at the intersections of pregnancy, parenting, and mental health care.

## Study Data And Methods

Data came from a larger project developed in partnership with leadership at the Los Angeles County Department of Mental Health (LACDMH), in California—a safety-net mental health system serving people living with SMI. The project goal was to inform the development and implementation of interventions to improve care for women served by the department.<sup>11</sup> We used a community-partnered participatory research approach, including coleadership, co-ownership, and knowledge exchange, throughout project development.<sup>18</sup> Specifically, LACDMH clinical leadership codesigned the overall study, codeveloped interview questions, and participated in data analysis. In addition, the LACDMH Reproductive Mental Health Advisory Board, consisting of diverse mental health staff, many with lived experience of mental health treatment, pregnancy, and parenting, participated in the interpretation of the results. Study procedures were approved by the University of California Los Angeles Institutional Review Board and the LACDMH Human Subjects Research Committee.

**PARTICIPANTS AND DATA COLLECTION** We selected four LACDMH outpatient mental health clinics, based on geographic region and the racial and ethnic diversity of the patient population. We recruited patient participants via flyers and provider referrals; patients and providers were informed that the purpose of the study was to hear patients' perspectives on pregnancy, parenting, and mental health care. All English-speaking women patients ages 18–45 were eligible to participate. One of the authors (Nichole Goodsmith, the study's principal investigator, who is a psychiatrist and health services re-

searcher) conducted semistructured telephone interviews with participants between November 2020 and October 2021. Interviews lasted approximately forty minutes and were audio-recorded and professionally transcribed. Participants received a \$30 gift card for participation.

Interview questions focused on participants' experiences discussing reproductive topics with mental health providers (for example, "Can you tell me any experiences you have had talking about pregnancy with your mental health providers? What about talking with your mental health providers about taking medications during pregnancy?") and reproductive and parenting support (for example, "If you wanted to have a baby, what could your mental health providers/clinic do to support you?").

**ANALYSIS** We used thematic analysis to identify themes and contextualize participants' experiences and perspectives.<sup>19</sup> Two research team members (Goodsmith and Karissa Fenwick) summarized major topics in each transcript.<sup>20</sup> These summaries informed development of codes (descriptive labels assigning a summative, salient, or emotionally evocative attribute to data segments across transcripts).<sup>21</sup> Using the initial codebook, the two team members independently applied codes to one interview transcript, discussed discrepancies, and adapted the codebook as needed. Next, they each coded 50 percent of the remaining transcripts and then reviewed each other's coding. They discussed discrepancies until reaching consensus and iteratively refined the codebook throughout the analytic process. The research team met regularly to support theme and codebook development. The final codebook captured both a priori topics derived from the interview guide and those generated from the data.<sup>19</sup> We used ATLAS.ti, version 22, for data management and analysis.

**LIMITATIONS** We acknowledge several limitations. This study was conducted in a large, urban, safety-net mental health system serving people living with SMI, and results might not generalize to other settings (for example, rural locations) or populations (for example, those with greater access to financial resources). In addition, our study was limited to English-speaking women, so we are therefore missing representation of people from other linguistic backgrounds and gender identities. Finally, patients who participated in this study may be more open to discussing pregnancy and parenting than those who chose not to participate (selection bias). To mitigate this bias, we present perspectives from all participants, including those who were less open to discussing pregnancy and parenting in mental health treatment.

### Study Results

Exhibit 1 presents study participants’ characteristics. Participants ( $n = 22$ ) were cisgender women ages 23–45; fifteen participants had children. The majority were Black or Latina, had education beyond high school, and were not employed. Exhibit 2 presents primary themes from qualitative analysis, descriptions of themes, and illustrative participant quotes. Some quotes in exhibit 2 and the text below have been edited for brevity and clarity.

**DISCUSSING PREGNANCY** Most participants had little to no experience discussing pregnancy intentions or plans with their mental health providers (exhibit 2). Participants who did recall discussing their pregnancy intentions or plans

with providers described the interaction as a “quick conversation” (age thirty-seven, no children) that usually took place at their initial appointment. Some participants attributed the lack of discussions to the fact that they were not planning for pregnancy and therefore did not bring it up, implying that they (rather than their providers) should introduce the topic: “I never said [to my provider], ‘I’m trying to have a baby.’ I never said anything to open that door” (age thirty-seven, no children).

Participants’ openness to discussing pregnancy intentions with their mental health providers was mixed. Some participants wanted more opportunities to discuss pregnancy with their providers, others were open to discussion but did not view it as pressing, and others preferred not to discuss pregnancy with their providers.

Openness to discussing pregnancy intentions often hinged on whether participants perceived these topics as relevant to their personal circumstances and plans. For example, some participants who were not planning pregnancy or believed that they were unlikely to conceive because of lack of sexual activity, long-acting contraception, absence of a male partner, or older age expressed that they did not feel a need for pregnancy-related discussions with their providers: “I don’t want to talk to no one about [pregnancy,] because it’s not a thing that’s in my plans right now” (age thirty-one, one child).

Openness to discussing pregnancy intentions also depended on participants’ trust in their providers. Participants who described strong therapeutic relationships expected that their providers would be supportive and nonjudgmental: “[My providers] don’t judge me—it seems like you can easily talk to them about anything.... I’d want to talk to them about [pregnancy,] because it’s so important” (age thirty-seven, no children). In contrast, participants who viewed their providers as generally unsupportive anticipated a negative response if they were to share a desire for pregnancy. “They would tell me, ‘Don’t have it. You’re not ready for it.’...But I’d tell them, ‘This is my life. I’m going to have my baby’” (age forty-two, more than five children).

**DISCUSSING MEDICATION SAFETY IN PREGNANCY** Of the twenty-two participants, most had little to no recollection of discussing the teratogenicity of psychotropic medications with their providers before becoming pregnant. Of the minority of participants who recalled discussing medication teratogenicity before pregnancy ( $n = 3$ ), experiences were mixed. One participant asked her provider about the potential impact of medication on pregnancy and was satisfied with the response she received (age forty-two, no children). However, another felt “un-

#### EXHIBIT 1

**Characteristics of women using Los Angeles County Department of Mental Health services who participated in interviews about therapeutic attention to pregnancy and parenting, 2020–21**

Characteristics	No. of participants
Total	22
Gender	
Cisgender women	22
Age, mean years (range)	36 (23–45)
Race and ethnicity	
Black or African American	11
Latina or Hispanic	5
Asian	2
White	1
Multiracial	1
Other	1
Declined	1
Sexual orientation	
Straight or heterosexual	17
Bisexual	2
Other	3
Ever pregnant	17
Any children	15
Median no. of children, if any (range)	2 (1–11)
Housing	
Permanent	16
Shelter or transitional housing	6
Education completed	
High school or less	7
Some college	10
College degree or higher	5
Employment	
Not working	11
Disabled	5
Working for pay	5
In school	1

**SOURCE** Authors’ analysis of sociodemographic data collected from 22 women with serious mental illness receiving treatment in the Los Angeles County Department of Mental Health system who participated in interviews about pregnancy and parenting, November 2020–October 2021. **NOTE** Race and ethnicity were self-identified by participants; those who did not distinguish race versus ethnicity were not asked to do so.

**EXHIBIT 2**

**Perceptions of women using Los Angeles County Department of Mental Health services on therapeutic attention to pregnancy and parenting, 2020–21**

Themes	Descriptions	Example participant quotes
<b>PARTICIPANTS' EXPERIENCES DISCUSSING PREGNANCY WITH MENTAL HEALTH PROVIDERS</b>		
Limited discussions	Brief or absent discussions with providers about pregnancy intentions or medication teratogenicity	"I've never talked about pregnancy with [my providers]. They asked if I was pregnant, and I just told them no." (Age 40, 5 children)
Unsatisfactory discussions	Vague or dismissive provider responses to questions about medication teratogenicity during pregnancy	"I didn't get the answers I was looking for in terms of if [the medication] does harm...I needed more clarification." (Age 34, 1 child)
<b>PARTICIPANTS' OPENNESS TO DISCUSSING PREGNANCY WITH MENTAL HEALTH PROVIDERS</b>		
Mixed openness to pregnancy discussions	Varying degrees of comfort with and openness to discussing pregnancy intentions with providers	"Intellectually I get [the need to discuss pregnancy] but it makes me uncomfortable emotionally." (Age 37, no children)
Desire for more teratogenicity information	Desire to discuss medication teratogenicity with providers more frequently or in more detail	"I wanted to know if [medication] would interfere with pregnancy or getting pregnant... Does it harm the baby?" (Age 39, 1 child)
Relevance to personal situation	Openness to discussing pregnancy depended on perceived relevance of pregnancy to individual plans and circumstances	"I never talk about [pregnancy]. I'm 37 and too old to get pregnant I think." (Age 37, no children)
Trust in providers	Openness to discussing pregnancy depended on strength of trust in and therapeutic relationships with providers	"I feel comfortable because [my provider] always gives me really great feedback." (Age 23, no children)
<b>PARTICIPANTS' EXPERIENCES DISCUSSING PARENTING WITH MENTAL HEALTH PROVIDERS</b>		
Positive discussions	Helpful and supportive discussions with providers about parenting	"[My provider] was very uplifting [during parenting discussions]...she was really on my side." (Age 45, 3 children)
Custody-related concerns	Fears that disclosure of certain mental health symptoms or children's behaviors may provoke or exacerbate child protective services involvement	"I'm fearful that [bringing up parenting] will make me automatically involved with social services." (Age 31, 2 children)
Desired support and resources related to parenting	For example, coordination with children's services (such as schools), parenting education, on-site child care, resource referrals (such as baby supplies)	"Where can we get diapers, where can we get formula, where can we get kids' clothing?" (Age 37, 2 children)

**SOURCE** Authors' qualitative analysis of interview data collected from 22 women with serious mental illness receiving treatment in the Los Angeles County Department of Mental Health system who participated in interviews about pregnancy and parenting, November 2020–October 2021. **NOTE** The mean participant age was 36 years (range, 23–45).

comfortable" that her providers "seemed like they were adamant on giving me medication that is harmful to the reproductive system" and described the conversations as "negative" (age thirty-one, two children).

Participants who received mental health treatment during pregnancy ( $n = 8$ ) stated that conversations about teratogenicity occurred only after they became pregnant. Some of these participants were dissatisfied with the information they received or the way in which it was communicated. For example, participants felt that their questions about teratogenicity were dismissed or that they were given "vague" answers: "I was wondering if there was harm in taking [diphenhydramine and aripiprazole].... I never did [get answers to my questions]. It was just, basically you can either take the medicine or try not taking it" (age thirty-three, no children).

Two of the participants reported satisfactory experiences with discussing the teratogenicity of medications with providers during their pregnancies. Notably, these participants recalled re-

ceiving differing recommendations for the same medication (quetiapine). One stated that her psychiatrist "recommended" quetiapine because "the side effects were low enough that I didn't have to worry about transmission of the medicine to my daughter" (age forty-two, three children), whereas the other was told that "you shouldn't take [medications like quetiapine] when you're pregnant" and therefore discontinued the medication (age thirty-one, one child). Both participants appreciated receiving clear recommendations related to medications from their providers.

Some participants who viewed their conversations about medication teratogenicity with providers as limited or unsatisfactory conducted their own research or made medication-related decisions without providers' input. Some of these participants concluded that psychotropic medications were harmful during pregnancy: "I read up on a lot of things about these medications, when you want to get pregnant or are breastfeeding. You can't take none of those psych



pills” (age forty-two, more than five children). Some shared that they discontinued their medications without providers’ input after becoming pregnant or that they planned to discontinue their medications if they became pregnant in the future.

Most of the participants, including some who were less open to discussing pregnancy intentions with their providers, wanted more information from their providers about medication teratogenicity: “I definitely would like for [medication safety in pregnancy] to be part of the conversation, part of the treatment plan that I am receiving.... It’s something that should be discussed more and should be given importance” (age thirty-seven, no children). Most of the participants wanted to have conversations about teratogenicity early in their treatment or on first prescription of a new medication and before becoming pregnant. Specifically, participants wanted their providers to review whether and how medications may harm fertility and conception, prenatal development, and infant and child outcomes. One participant also wanted provider reassurance that taking psychotropic medication during pregnancy would not prompt Child Protective Services involvement because of concerns about harm to the baby.

**DISCUSSING PARENTING** Most of the participants with children ( $n = 15$ ) discussed parenting issues with their mental health providers regularly. They characterized these discussions as helpful and supportive, describing them as “a relief,” “uplifting,” and yielding “good advice.” Examples included a participant who appreciated that her psychotherapist “makes it her business every time we talk to check in, even if it’s just a little while,” about her young child (age thirty-three, one child), and another whose provider helped her navigate an evolving relationship with teenage daughters (age forty, two children). Participants also described the parenting support groups at their mental health clinics as “helpful” and “excellent.” They found therapeutic value in connecting with others going through similar mental health and parenting challenges: “I don’t feel alone, so the struggle is not as bad” (age thirty-three, one child).

Although most participants shared positive experiences related to discussing parenting with their providers, some also expressed concerns that disclosing their mental health symptoms, thoughts of self-harm, or child’s “attitude or tantrums” could lead to “false allegations” to social services or child custody loss (age thirty-three, one child; age forty, five children). These participants emphasized that losing custody of their child or children would be devastating to their mental health and well-being: “It’s a struggle

## Our findings have implications for efforts to improve integrative and collaborative mental health treatment.

when you’re trying to get the support you need and being transparent and having the risk of losing your child...and sometimes the only thing that’s holding us here is our child” (age thirty-five, two children). The six participants who volunteered that they had discussed open custody cases with their mental health providers expressed mixed views about whether their providers offered adequate support related to their cases. One was frustrated that her providers focused more on medication management than regaining custody of her child: “They give me pills, pills, pills, pills. I don’t want pills. I want you all to help me with my daughter” (age forty-two, more than five children). However, another participant believed that medication management and “checking in” with her providers about symptoms helped her custody case and “made being a mom possible,” explaining, “Here’s the thing: If I’m not properly taken care of, I can’t take care of my children” (age forty-two, three children).

Participants identified ways in which their mental health clinics and providers could better support them as parents. Some suggested improving coordination with child-focused organizations and systems, including children’s mental and physical health care, child welfare, and schools. Others suggested enhancing parenting support and education services, including via classes and support groups: “I didn’t have any guidance with either of my two children.... I would hope, should I have a third child, [that my providers] would be very much coaching me like a teacher. So...I would feel confident, I would feel ready” (age thirty-seven, two children). One participant emphasized that parenting support and education services should be oriented toward “prevention” of parenting problems, instead of intervening only once “they see you’re in dire need” (age forty-two, three children). Additional participant suggestions focused on offering on-site child care during mental health

# Openness related to discussing pregnancy depended on the quality of women's therapeutic relationships with their mental health providers.

appointments. One pointed out that on-site child care may be especially beneficial for engaging patients who have histories of interpersonal trauma: "Maybe have some kind of day care or some separated room [at the mental health clinic] where the mother can feel comfortable. Because some parents, like me...because of certain things that transpired in my life, you don't want to just leave your child with anybody" (age thirty-five, two children). Finally, participants wanted their mental health providers and clinics to offer information about and referrals to external resources such as baby supplies, housing, and prenatal care.

## Discussion

This qualitative study examined the experiences and preferences of women living with SMI related to discussing pregnancy and parenting with their mental health providers. Results identified critical gaps in information, support, and resources related to pregnancy planning, the potential teratogenicity of psychotropic medication, and parenting in mental health services. Our findings align with previous evidence demonstrating unmet reproductive health and parenting needs among women with SMI,<sup>15,22</sup> and they have implications for efforts to improve integrative and collaborative mental health treatment.

Most women in this study did not have regular or comprehensive discussions about future pregnancy with their mental health providers. This finding complements other research indicating that providers do not routinely bring up pregnancy or family planning with women with SMI.<sup>22</sup> Women in this study expressed mixed degrees of openness to discussing future preg-

nancy with their mental health providers, which often hinged on women's perceptions of their personal likelihood of becoming pregnant. These results highlight the need to tailor pregnancy-related discussions to women's individual situations, while also grounding interventions in the reality that many pregnancies are unplanned.<sup>1</sup> Openness related to discussing pregnancy also depended on the quality of women's therapeutic relationships with their mental health providers, underscoring the importance of cultivating safe, supportive treatment environments. This point was particularly salient in our study, in which the majority of participants were Black or Latina—groups whose trust in health care providers may be influenced by past experiences of racism, coercion, or judgment in reproductive health care.<sup>17,23</sup>

In addition to a lack of discussion about future pregnancy, many women with SMI in this study did not receive satisfactory counseling about the potential teratogenicity of psychotropic medications. As a result, some sought out their own information, concluded that their medications were unsafe to take during pregnancy, or stopped taking medications without providers' input. Other studies have found that women in the general population tend to overestimate the teratogenic risks of medications and may discontinue medications or skip doses in response to vague or conflicting information about safety.<sup>24–26</sup> These findings are concerning, given that abruptly discontinuing medication can trigger relapse and that untreated mental illness has serious ramifications for both mother and baby (for example, reduced prenatal care, increased maternal substance use, and low birthweight).<sup>5,27–29</sup> More work is needed to identify and implement strategies for counseling patients about medication risks and benefits in pregnancy that align with the needs and preferences of women living with SMI.

In contrast to discussions about pregnancy and medication teratogenicity, women characterized discussions with their mental health providers about parenting as beneficial and satisfactory. This finding is encouraging, given evidence that parenting holds critical emotional importance and is integral to mental health recovery for many women.<sup>30</sup> However, concerns related to potential Child Protective Services involvement prevented some women from disclosing parenting challenges and psychiatric symptoms, echoing findings from other studies and suggesting that fears about custody loss can hinder access to effective treatment.<sup>15</sup> These fears may be elevated in Black women, who face increased rates of separation from children.<sup>17</sup> Interventions to support parents with SMI should balance encourag-

ing patients to disclose parenting challenges and psychiatric symptoms (which may improve treatment and ultimately prevent custody loss) with acknowledging providers' responsibilities as mandated reporters. Study findings also identified organizational and system-level strategies for supporting parents, such as improving coordination of mental health services with children's services (for example, school, health, and mental health providers) and parenting resources.

### Implications For Mental Health Policy And Administration

Overall, results underscore the need for greater integration of pregnancy and parenting interventions, education, support, and resources into mental health services for women living with SMI. Previous research suggests that mental health providers view reproductive topics as clinically important but lack sufficient training and guidance for addressing them in routine practice.<sup>11,12,31</sup> Incorporating educational content related to pregnancy and parenting into academic, professional, and continuing education curriculums can help close this knowledge gap. The recently developed National Curriculum in Reproductive Psychiatry shows promise in increas-

ing the capacity of psychiatry trainees to treat perinatal and postpartum women with mental illness.<sup>32</sup> Researchers, intervention developers, and mental health administrators can use National Curriculum in Reproductive Psychiatry materials as a starting point for efforts to train providers in other professional disciplines. Incorporating principles of trauma-informed care and reproductive justice into provider education can raise providers' sensitivity to historical discrimination and stigma surrounding pregnancy and parenting for women living with SMI.<sup>17,33</sup>

### Conclusion

Our study findings support the integration of pregnancy and parenting discussions into routine mental health services, but they also reinforce the importance of ensuring that discussions occur in the context of supportive patient-provider relationships, are tailored to individual patient contexts, and are part of ongoing therapeutic dialogues about patients' needs. Policies and procedures that increase mental health providers' capacity to address pregnancy and parenting can improve the treatment experiences of women living with SMI and ultimately advance maternal and child outcomes. ■

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