fortune Journals

Case Report

JOURNAL OF PSYCHIATRY AND PSYCHIATRIC DISORDERS

ISSN: 2572-519X

Desire For Procreation and Therapeutic Compliance in Patients on Antipsychotics.

Asseman Médard Koua[1], François Djo Bi Djo[1], Konan Koffi Paulin Ahou[2], Brahim Samuel Traoré[2], CN Djariata[2], Mariam Baldé[1], Y Jean-Marie Yéo-Ténéna[2]

Abstract

The authors discuss the problem of compliance with antipsychotic treatment and its impact on the sexuality and desire for procreation of stabilized psychotic patients. The ethical and deontological principles, individual, family or cultural values that determine the choices and attitudes of each care provider (patient, couple, family, mental health professionals) raise ethical problems observed in the therapeutic process. The sexological and/or gynecological care of mentally ill patients must be better coordinated. Parenting assistance for mentally ill patients must be strengthened through collaborative work involving the psychiatrist, the gynecologist, the midwife, the couple and the family. The paternalistic model of care in psychiatry is gradually giving way to a construction of the psychiatric clinic around the autonomy of the patient and the couple in order to ensure their quality of life and care.

Keywords: Mentally ill; sexuality; Procreation; Therapeutic Compliance; Antipsychotics

Introduction

In psychiatry, the quality of life of any patient with a mental disorder constitutes the main objective of psychiatric care. However, issues relating to sexuality and procreation are rarely addressed in psychiatric practice [1].

When mentally ill people express the desire to have a child, professionals are very concerned about the child's future and the mother's mental state and parenthood.Health professionals believe that due to the pathological specificity and therefore psychological fragility and the possible presence of associated cognitive deficits, it would be risky for these patients to invest emotionally in a couple relationship or even they would be incapable of assuming their parental responsibility. This attitude contrasts with the African cultural and religious context where building a family, getting married, being a father or mother or having offspring is a criterion of balance, social success and honorability [2]. This perception also poses a problem because clinical practice has shown that during the follow-up of patients with serious and stabilized mental disorders, the concerns addressed by patients and relatives relating to sexuality and the desire to procreate are recurrent. In addition, therapeutic compliance is conditioned by it. Discontinuation of treatment is either linked to the side effects of psychotropic drugs on the quality of genital life or related to a normal desire for motherhood in a patient of childbearing age [3].

It is therefore through a series of five clinical observations collected at

Affiliation:

[1]UFR Medical Sciences, Alassane OUATTARA University, Ivory Coast

[2]Mental Hygiene Service, INSP, Abidjan, Ivory Coast

***Corresponding author:**

Djo Bi Djo Francois, Assistant Master, Department of Psychiatry, UFR Medical Sciences, Alassane Ouattara University – Bouaké.

Citation: Asseman Médard Koua, François Djo Bi Djo, Konan Koffi Paulin Ahou, Brahim Samuel Traoré, CN Djariata, Mariam Baldé, Y Jean-Marie Yéo-Ténéna. Desire For Procreation and Therapeutic Compliance in Patients on Antipsychotics.. Journal of Psychaity and Psychaitric Disorders. 9 (2025): 41-45.

Received: December 17, 2024
Accepted: January 06, 2025
Published: January 23, 2025

Koua AM, et al., J Psychiatry Psychiatric Disord 2025
DOI:10.26502/jppd.2572-519X0236

the Mental Hygiene Department of the National Institute of Public Health in Abidjan that we approach the experience of sexuality and procreation of subjects with mental disorders in relation to therapeutic compliance. In this work, a place is made for the patients' discourse without insisting on the nosographic framework.

Observations

Observation 1

Miss YEL is the ninth of a monogamous family of 10 children and has been followed for nine (9) years; she was 21 years old at the time of her first admission in April 2005. The first disorders coincided with her traditional discharge ceremony after giving birth. She is said to have abandoned her during this first pregnancy by her partner. The diagnosis of puerperal psychosis was made. The favorable clinical evolution under psychotropic medication allowed her to resume classes, obtain the Brevet d'Etudes du Premier Cycle and form a new romantic relationship. During her second pregnancy, metrorrhagia occurred in the second month. This situation led to the discontinuation of treatment. After the birth of the second child, the patient had a second relapse. Interruptions of treatment due to metrorrhagia during pregnancy were also observed during the third and fourth pregnancies with relapses after each delivery. All of Mrs. YEL's children were male and were artificially breast-fed.

During interviews with Ms. YEL and the father of her last three children, the couple attributed the occurrence of metrorrhagia observed during pregnancies to psychotropic medication. Furthermore, Ms. YEL always expressed the desire to procreate again in order to have a daughter despite the risks involved.

Observation 2

MS is 34 years old, terminal level, he is the eldest of a family of 4 children and comes from a polygamous family. He has been followed since July 2010 in psychiatry at the request of his family. The diagnosis of simple schizophrenia was retained. The patient was then put on a slow-release antipsychotic. Coming from a Muslim family and at the initiative of his parents, Mr MS entered into a religious and customary marriage. After three years of living together and in the absence of children, MS's family is worried.

She again prompts an interview with the team and the couple with a view to finding a solution. During the interview, Mr MS claimed that he had never had sexual intercourse before his marriage. For her part, the patient's wife complained that he rarely if ever expressed a desire to have sexual intercourse with her. When questioned about his wife's claims, Mr MS did not deny this fact.

For him, it's psychotropic drugsprescribed drugs that would induce sleep and make him lazy, which would be a real obstacle to his desire for sexuality. To resolve this difficulty, Mr MS, together with the parents and the doctor treating patients have opted for the use of aphrodisiacs.

Observation 3

Mrs. DA, 36 years old, Malinke, has been followed in psychiatry since January 2006 for a repeated acute delusional state. Coming from a polygamous family, she is the fifth child of a family of nine children on the paternal side and the first of five children on the maternal side. Currently customarily married to a planter, Mrs. DA is a housewife with no level of education. She is the 5th gesture 3rd parent, including a twin (fifth pregnancy).Multiple interruptions of treatment caused acute psychotic decompensations for several years.

In order to understand the situation that Mrs DA was experiencing, interviews were conducted. Mrs DA stated that before her first consultationIn our services, she had two children, the second of whom died after the birth. She currently has three (03) children out of a total of five (05) pregnancies contracted with her husband.

The last three (03) pregnancies have been took place during psychiatric care. This was as much for the fourth pregnancy where the relapse of the mental illness caused a premature delivery at eight months of a stillborn following psychomotor agitations. Indeed, during these last pregnancies, Mrs DA had stopped the treatment that had been prescribed for her.

So during her third pregnancy, The interruption of treatment led to a relapse resulting in an abortion at three months. During the fifth pregnancy when Mrs DA was living with her mother, the relapse due to the cessation of treatment did not result in an interruption of this twin pregnancy. Mrs DA stated that it was on the recommendation of non-psychiatric doctors that she had interrupted the treatment as well as the appearance of the adverse effects of the treatment, in particular heaviness in the limbs and hypersomnolence during this period.

Mrs DA's two children (twins) are now being breastfed and are being cared for by their grandmother. Given the frequent relapses caused by the interruption of treatment during pregnancies, the patient no longer wishes to have children. For her mother, it was not up to her to decide; the decision was up to the family and her husband.

Observation 4

Miss OM, 32 years old, single, of evangelical faith, has been followed since April 2014 for acute delusional disorder under delayed neuroleptic; she is the 4th of a family of five children. She is a seller of traditional medicines. During the follow-up, the patient presents non-pregnancy amenorrheafor a year. She claims not to have had sexual intercourse for more than two years. She is not currently interested in sexual intercourse due to amenorrhea and her religious affiliation. Miss OM expresses the desire to have a child and claims to have all the skills to take care of one. In addition,his mother

Koua AM, et al., J Psychiatry Psychiatric Disord 2025
DOI:10.26502/jppd.2572-519X0236

and the other members of Her family is pressuring her to find a man in order to to have offspring. To solve the problem of amenorrhea, the patient stated that although she sold traditional medicines that would improve fertility; she could not consume them for fear of drug interaction. She plans to consult a gynecologist in order to receive adequate care.

Observation 5

Mrs. ACV is 36 years old, from a polygamous family whose father died, she is part of a group of fifteen (15) children on the paternal side and is the third child on the maternal side out of a total of seven (07). Mrs. ACV holds a Baccalaureate, legally married since July 2006 and mother of two (02) children; according to her, fulfilling her role as a mother without difficulty before presenting a psychiatric disorder. She has been medically treated since December 2009 for an acute delusional state. After four months of follow-up, the patient reports the onset of non-pregnancy amenorrhea. A reduction in the doses of psychotropic drugs and gynecological care are carried out.

After a few months of regularization of the menstrual cycle, amenorrhea reappeared. This situation seems to be a tragedy for the couple. In reality, according to their plan, the couple wanted to have four (04) children. At the level of the wife's family, some members suggested that because of the age of the last child (07 years), she should have another one and she would like to give birth to a girl (the first two being boys).

Discussion

Pregnancy in women with recognized mental illnesses is a common reality. In the streets of our cities and villages, we observe almost with indifference mixed with indignation that women suffering from severe mental disorders are victims of unwanted pregnancies, without an identified father and without medical follow-up. Although we do not have national statistics on the prevalence and interdisciplinary management of pregnancies in people with psychiatric pathologies, medical practice confronts us with it. Very often, the course of pregnancy takes place outside of any psychiatric control and often against the advice of the psychiatrist. However, pregnancies in psychotic patients are recognized as high-risk pregnancies.

Indeed, the disorganization and relational difficulties inherent in the disease hinder patients in monitoring their pregnancy. Thus, MacCabe et al. [4] and King-Hele et al. [5] found a significant increase in the risk of premature delivery, intrauterine growth retardation, low birth weight and having a stillborn child. The observations of this study highlight the difficulty of health services in addressing the problem of sexuality and procreation of the mentally ill on the one hand and the weakness of the care offered in supporting the parental project on the other.

Therapeutic compliance in mentally ill patients is also determined by the quality of life of patients involving the quality of sexual relations and the need within the couple to have a child. In our study, the problems of compliance with antipsychotic treatment are related to sexual disorders, namely non-pregnant amenorrhea in two women (P4 and P5) and a sexual desire disorder in the man (P2). The problems thus encountered all appeared after the outbreak of the various acute or chronic psychotic pathologies.

The prescription ofClassic or atypical neuroleptics of short or long duration are incriminated in the occurrence of side effects such as sexual disorders. Rosenberg showed in a study that among the 51patientsWhen questioned, 62.5% of men and 38.5% of women believed that their psychiatric treatment was the cause of their sexual disorders and that there was a correlation between sexual disorders and therapeutic compliance; 41.7% of men and 15.4% of women had stopped their treatment because of the induced sexual disorders [3]. According to MacDonald, men reported decreased desire, decreased erectile capacity, earlier ejaculations, and decreased orgasm quality. In addition, sexual dysfunction in patients seemed to be correlated with the negative symptomatology of schizophrenic pathology [6]. In our study, patient P3 had a sexual desire disorder probably related to the deficit symptoms of chronic psychotic pathology. The use of aphrodisiacs reflects the urgency for the patient and also for his family to have offspring and to honor the image of the family.

Furthermore, the issues of therapeutic compliance and procreation are underpinned by the values at stake in the therapeutic process, giving rise to ethical conflicts.

Indeed, the principle of beneficence guides medical decision-making. The medical good would be for psychiatry to ensure monitoring and maintain antipsychotic treatment at effective doses to prevent relapses. Sexuality and the desire to have children should be secondary. In this paternalistic stance, we also note that the information given to the patient or family ignores the risks inherent in taking psychotropic drugs, either for fear of an interruption of treatment or by assuming that the patient is still not able to consent to care. Furthermore, since the patient is not able to assume the maternal function, the possibility of pregnancy would be risky and therefore not recommended [7]. It is also in this vein that contraceptive or sterilizing practices of the mentally handicapped without consent fall into line [8].This paternalistic posture seems to contrast with a number of guidelines and recommendations at the international level developed for better management of pregnancies in patients with serious mental illness [9; 10]. The management of pregnancy in psychotic subjects is well codified. The medical decision must take into account the benefit/risk factor in the treatment of psychiatric disorders during pregnancy.

Citation: Asseman Médard Koua, François Djo Bi Djo, Konan Koffi Paulin Ahou, Brahim Samuel Traoré, CN Djariata, Mariam Baldé, Y Jean-Marie Yéo-Ténéna. Desire For Procreation and Therapeutic Compliance in Patients on Antipsychotics.. Journal of Psychaity and Psychaitric Disorders. 9 (2025): 41-45.

Koua AM, et al., J Psychiatry Psychiatric Disord 2025
DOI:10.26502/jppd.2572-519X0236

It is proposed to do everything possible to support the parenting of people with mental disabilities. Neuroleptics are not contraindicated during pregnancy. Similarly, they can be introduced at any time. These treatments can be used at effective doses regardless of the term, but it is preferable, if possible, to reduce the doses in the 3rd trimester and to perform a 2nd level fetal ultrasound in the event of use in the 1st trimester. Correctors that aggravate the anticholinergic effects and "delayed" forms should be avoided. Although first-generation antipsychotics are responsible for sexual dysfunction, treatments based on Chlorpromazine or haloperidol at effective doses are better tolerated and do not present major teratogenic risks [11; 12]

Furthermore, it is also important to distinguish within the principle of beneficence, the medical good and the existential good. The existential good is related to the legitimate aspirations of a person even if suffering, his desires, the perception of the quality of life, the values which construct and determine it culturally. Thus the existential good would be for the couple of whom one or both suffer and his family to have descendants. In addition, in the name of the principle of autonomy, the stabilized patient must be better informed about the long-term treatment and the side effects responsible for sexual disorders. The disorders observed affect the very identity of people and the foundation of all human society.

In Africa, the identity of woman or man, the status of the couple is combined with procreative power.The purpose of marriage is procreation. The role of the woman is essential within the couple since the extended family expects a large number of children from her. The African, whatever his religious belief, cannot conceive of a marriage without children; he considers it absurd. Consequently, children occupy a very important place in society. They are the source of great pride and very often, the prestige of a family is determined by the number of children. The reproductive capacity of women is a major assurance of permanence and stability in marriage, in the family and in the clan. The worst calamity that can befall an African woman is the inability to bear children. A barren woman has no place in traditional African society.

Moreover, in case of sterility of the couple, tradition dictates that only the woman is held responsible. Sterility is one of the themes that is often treated in African novels. Very often, it causes divorce.

Another problem that can affect a couple is the inability to obtain a male heir. In the traditional society where patriarchy reigns, sons inherit their father's property. If a man dies without a son, his brothers appropriate his property and his wife and daughters live in poverty. It is in this context that we must understand the approach of the patient who is always looking for a boy. The stability of her relationship depends on it [2].

Questions of sexuality and procreation pose real ethical problems. BalancingEthical principles in psychiatric practice are often difficult. These challenges increase in complexity when clinicians must simultaneously consider the needs of a pregnant woman and her fetus, a postpartum woman and her baby, or a woman planning a pregnancy [13]. In an attempt to resolve these dilemmas, clinical ethics in psychiatry through a case-by-case, casuistic approach must be favored according to the parental project. This approach implies that caregivers are ready to question themselves and review their professional practices. The evolution of patients' rights, particularly concerning the possibility of being able to express themselves on the care received, whatever the disability, will have to be accompanied by a parallel evolution of the mentalities of caregivers.

Conclusion

Improving the quality of life of patients and their compliance with antipsychotic treatment necessarily involves the dimension of sexuality and the desire for procreation of the psychiatric population. The attitude of “hiding” behind contraindications in principle risks leading to pregnancy against the advice of a psychiatrist and outside of any medical monitoring. The consistency of the speeches and behaviors of the different stakeholders (psychiatrist, obstetrician-gynecologist, midwife, pediatrician) is essential for appropriate care and its stability over time.

The field of psychiatric clinic confronts ethical and deontological values of medical practice with personal, family values nourished culturally. The resolution of the ethical dilemmas observed requires networking in order to ensure quality medical-psychological care in the interest of the patient and the couple.

References

1. McCann E. Investigating mental health service user views regarding sexual and relationship issues. J Psychiatr Ment Health Nurs 17 (2010): 251-9.
2. M Ijere. Traditional marriage in Africa and its many fascinating facets. Black Peoples African Peoples 9 (1986): 72-93.
3. Rosenberg KP, Bleiberg KL, Koscis J, et al., A survey of sexual side effects among severely mentally ill patients taking psychotropic medications: impact on compliance. J Sex Marital Ther 29 (2003): 289-296.
4. MacCabe JH, Martinsson L, Lichtenstein P, , et al., Adverse pregnancy outcomes in mothers with affective psychosis. Bipolar Disord 9 (2007): 305-309.
5. King-Hele S, Webb RT, Mortensen PB, Appleby L, Pickles A, Abel KM.Risk of stillbirth and neonatal death linked with maternal mental illness: a national cohort study. Arch Dis Child Fetal Neonatal 94 (2009): 105-110.

Citation: Asseman Médard Koua, François Djo Bi Djo, Konan Koffi Paulin Ahou, Brahim Samuel Traoré, CN Djariata, Mariam Baldé, Y Jean-Marie Yéo-Ténéna. Desire For Procreation and Therapeutic Compliance in Patients on Antipsychotics.. Journal of Psychaity and Psychaitric Disorders. 9 (2025): 41-45.

Koua AM, et al., J Psychiatry Psychiatric Disord 2025
DOI:10.26502/jppd.2572-519X0236

6. McDonald S. Nithsdale schizophrenia surveys 24: Sexual Dysfunction, a case-control study. Br J Psychiatry 182 (2003): 50-56.

7. Silvia Krum, Carmen Checchia, Gisela Badura-Lotter, et al., The attitudes of mental health professionals towards patients' desire for children. BMCMedical Ethics 15 (2014): 18

8. UNAPEI. Report of the UNAPEI Ethics Reflection Committee on Life Sciences in the Field of Mental Disability. Part One: Sexuality and Procreation (1994): 11-35.

9. McCullough L, Coverdale J, Bayer T, et al., Ethically justified guidelines for family planning interventions to prevent pregnancy in female patients with chronic mental illness. Am J Obstet Gynecol 167 (1992): 19–25.

10. Babbitt KE, Bailey KJ, Coverdale JH, et al., Professionally responsible intrapartum management of patients with major mental disorders. Am J Obstet Gynecol 210 (2014): 27-31.

11. Newport DJ, Stowe ZN. Psychopharmacology during pregnancy and lactation. In: Schatzberg A, Nemeroff CB, editors. The American psychiatric publishing textbook of psychopharmacology, 4th ed. Arlington (VA): American Psychiatric Publishing, Inc (2009).

12. Pezzolo S, Lang JP, Weil M, et al., On the proper use of psychotropic drugs and substitution treatments during pregnancy and breastfeeding. Synapse 230 (2006): 48-52.

13. Miller L. Ethical issues in perinatal mental health. Psychiatr Clin North Am 32 (2009): 259-270.