NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

# Reproductive Life Cycle
## Clinical Vignettes
## *Answer Key for Self-Study*
## *Emergency Contraception and Pregnancy Termination*


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### Part 1: Psychotropic Medication and Emergency Contraception

### Pre-Reading

- ACOG Practice Bulletin on Emergency Contraception: https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb152.pdf?dmc=1
- Optional (more in-depth): Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-4): 34-36. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1

### Learning Objectives

At the completion of this session, participants will be able to:
1. Describe the menstrual cycle and identify when a woman is fertile.
2. Explain how a woman can have a negative pregnancy test and still be pregnant.
3. Recognize risk factors for unplanned pregnancy.
4. Define emergency contraception and list which types of contraception are typically used in this fashion

### Case Scenario

Angela Jones is a 38 year old G3P1021 (Three Pregnancies, One Full Term Delivery, Zero Pre-Term Delivery, Two Miscarriages/Abortions/Ectopic, One Living Child) with a history of depression being seen by you in psychiatric emergency services for crisis due to suicidal ideation. In spite of her tearful state and flat affect, she is well groomed and seems to be organized in her thought process. She reports that she has been compliant with her fluoxetine 40 mg, prescribed by her general practitioner, and that she sees a therapist in the community. During the patient interview, she discloses that her suicidal thoughts are due to her husband of 15 years disclosing his recent infidelity after they had intercourse last night. She is not using birth control, but does not want to be pregnant, and asks for your help. She completes a urine pregnancy test in the emergency room and it is negative. In addition to determining the best level of care for her psychiatrically right now, what other factors do you need to consider for this patient's optimal medical care?

### Discussion Questions

1. Is it possible that this patient is pregnant? How might you counsel a patient about emergency contraception use if she could possibly be pregnant?

Yes, if she has had intercourse and ovulated in the last few days she could be pregnant and not yet have a positive pregnancy test. A great way to establish her risk is to find out if she is in the follicular (before ovulation) or luteal (after ovulation) phase of her cycle. Remember the luteal phase lasts 14 days always. So if a women has 28 day cycles, she ovulates on day 14. Assuming she has regular menstrual cycles, find out when her last menstrual period occurred. If she is menstruating or the week after (for a 28 day cycle female), she is not pregnant. If she is in the last two weeks of her cycle (luteal phase), she might be pregnant. Sperm can live in the female reproductive tract for 120

hours. Using Emergency Contraception does not cause an abortion. An abortion ends an existing pregnancy. Emergency Contraception prevents pregnancy from occurring. Emergency Contraception does not work if pregnancy has already occurred.

2. What are the options for Emergency contraception?

a. There are three types of oral emergency contraception. All of these methods delay ovulation. If the patient has already ovulated, they are likely not effective, but as we don't have Level One evidence around this and most women will not know the moment of ovulation, we recommend taking the medication as soon as possible after unprotected intercourse.

i. Progestin Only Pills. Plan B One Step (levonorgestrel) is a commonly used ECand is available over the counter. It stops or delays ovulation. It is most effective when taken within 3 days of unprotected sex.

ii. Ella/Ulipristal- this is the most effective of the oral options for EC. This medication affects how progesterone works in the body. It is thought to delay or prevent ovulation. It can be taken up to 5 days after unprotected intercourse. It can be ordered online, without seeing a doctor. https://www.prjktruby.com/about/

iii. Combined Estrogen/Progestin Pills- this is the least effective option of the oral options for EC. Taken in higher amounts they can be used for EC. They work by delaying ovulation. The number of pills needed varies by type of combined oral contraception. The website www.not-2-late.com has useful information for determining number of pills needed for EC.

b. Copper IUDs can also be used for emergency contraception and are the most effective of all the EC options. Copper IUDs work by preventing sperm from fertilizing an egg or (if the egg already fertilized) preventing implantation. For use as EC, they should be inserted within 5 days of unprotected intercourse. As this requires a physician or provider trained in placement, this is likely not applicable in this case.

3. When should I give emergency contraception?

Emergency contraception should be given within 120 hours of unprotected intercourse for Plan B, and up to 5 days for Ella. See above.

## Part 2: Mental Illness and Pregnancy Termination

## Pre-Reading

- www.prochoiceamerica.org: This is the website for The National Abortion and Reproductive Rights Action League (NARAL). There is an interactive map where one can click on their state and find political information, abortion-care policies, family planning policies, and other important issues.

- www.Guttmacher.org: The Guttmacher Institute is a primary source for research and policy analysis on abortion in the United States. There is also relevant data by state.

## Learning Objectives

At the completion of this session, participants will be able to:
1. Describe the current law (federal and state) that allows women the choice of pregnancy termination.
2. Explain how a psychiatrist may be asked to provide psychiatric clearance for the medical/surgical procedure. How does a woman's mental illness affect her ability to make decisions about termination, continuation of pregnancy, or adoption?
3. How might a woman's health insurance affect her ability to access abortion services?

4. Be familiar with local and national abortion information services where patients can access information about their local options and available providers.

## Case Scenario

Jennifer Brown is a 32-yearold G2P1001 at 19 weeks gestation whom you have been seeing for many years for Major Depressive Disorder. Her current pregnancy was planned and she has been maintained on sertraline 100 mg throughout. Her current partner has just been arrested for attempted murder following a "road rage" incident. She reveals that during this pregnancy she has discovered he is not the man that she thought he was and she is no longer interested in having a child; she asks for your help in finding a clinic to terminate her pregnancy.

## Discussion Questions

1. Do you think this patient is properly treated given the current dose of sertraline?

See our perinatal depression module for more information. This is a low dose of sertraline, and dose will increase across pregnancy due to pharmacokinetic changes – if she is having symptoms on this dose now, then it is not enough!

2. How do you find out what the laws are in your state regarding elective termination of pregnancy?

a. http://www.Prochoiceamerica.org This is the website for NARAL. There is an interactive map, where you can click on your own state and find political information, abortion-care policies, family planning policies, and other important issues.

b. http://www.Guttmacher.org The Guttmacher Institute is a primary source for research and policy analysis on abortion in the United States. The United States abortion law is governed federally by the Roe Versus Wade Decision. However, states have adopted their own restrictions on abortion. Information on elective termination by state can be found on this website.

*Ms. Brown was working as a cashier at Walmart at the beginning of her pregnancy and had commercial insurance, but she left that job last month and has recently enrolled in a Medicaid managed care plan. Does this change her options on pregnancy termination?*

1. What is the federal law that dictates how federal dollars are spent on pregnancy termination services?

The Hyde Amendment (1976) bars the use of federal funds to pay for abortion except to save the life of the woman, or if the pregnancy arises from incest or rape. This has a major impact on women who are recipients of Medicaid and Medicare. In this case, Ms. Brown, would need to pay for her pregnancy termination. There are private funds (in some states) to assist women, but these funds are limited.

2. Would Ms. Brown's access to abortion be better if she had stayed on her commercial insurance plan?

Very few commercial insurance plans cover abortion services. Please see resources in #1 for state-specific information. There are location specific services that provide patient assistance funds for pregnancy termination.

3. As her mental health provider, how can you assist this patient in her desire for pregnancy termination?

Ms. Brown should have an assessment of her mood to determine is she has undertreated depression that may be impacting her current decision.

Scenario #1: You do an assessment with an EPDS and DSM V criteria and determine that Ms. Brown is euthymic. In the euthymic state, she has no mental or physical condition that impacts her ability to decide to terminate this pregnancy. You can reinforce that with this patient. In addition, if her termination provider wants communication about her mental health condition, you should provide that information.

Scenario #2: You do an assessment with an EPDS and DSM V criteria and determine that she is severely depressed. To determine if severe depression is impacting her decision for pregnancy termination, you would need to follow up

with a capacity assessment. If she has capacity, she can make the decision to follow through with pregnancy termination. However, as her psychiatrist, she should be followed closely post procedure for her depression and need for inpatient management.