A Determined Woman: Anxiety, Unresolved Mourning, and Capacity Assessment in Recurrent Pregnancy Loss

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CASE HISTORY

Presenting Problem

Mrs. N is a married, immigrant woman in her late thirties who is the mother of a six-year-old daughter. Mrs. N's gynecologist referred her to an outpatient clinic, staffed by psychiatric residents, for evaluation and management of anxiety during her latest of numerous pregnancy attempts.

Developmental History

Mrs. N grew up in a foreign country as an only child in a strict, orderly environment with an anxious mother. Both parents instilled the importance of high morals and family—and in particular, large families. This view accorded with the country's common cultural belief that motherhood was a woman's primary source of identity and responsibility. Women with many children were held in especially high esteem.

Mrs. N was an exceptionally driven and intelligent child with obsessive traits. She believed in always doing the right thing. She generally felt driven to perfection, and as an only child, she had a high desire to please her parents. She graduated from high school and college without difficulty, majoring in English, and developed a career as a journalist. She married in her early thirties to a man who had similarly strong beliefs regarding the importance of having a big family.

Obstetrical/Medical History

Both Mrs. N and her husband are carriers of an autosomal recessive disorder specific to their ethnic group. They consequently have a 25% risk that any child of theirs will be affected. Mrs. N had one natural, unassisted pregnancy. The daughter, conceiving shortly after her parents' marriage, is a carrier of the illness. Roughly a year after her birth, the family moved to the United States because Mr. N was relocated as part of his employment.

In the next five years, Mrs. N had multiple pregnancy losses, including elective and spontaneous abortions. After the last of those spontaneous abortions, she decided to begin in vitro fertilization (IVF) with preimplantation genetic diagnosis, which would enable her to know prior to pregnancy whether her child would be affected by the disorder.[1] After several failed cycles of in vitro fertilization, she succeeded in becoming pregnant with an unaffected embryo.

Past Psychiatric History

Mrs. N's prior psychiatric illness revolved around reproductive events. She suffered from moderate postpartum obsessive-compulsive disorder symptoms after the birth of her daughter. She describes both ego-dystonic obsessions of harming her daughter by shaking and fears of being alone with her daughter because of thoughts that she might harm her. She had compulsions of excessive hand washing and bottle washing that sometimes impeded her ability to feed her daughter. With the support from Mrs. N's family and friends, these symptoms resolved, without psychiatric treatment, during the first three months of her daughter's life. Mrs. N also found fulfillment through her career and cultural customs.

After the family moved to the United States, Mrs. N had difficulty obtaining her own employment and began staying at home with her daughter, who was then in the middle of her second year. It was at that time that Mrs. N and her husband began trying to have another child, only to experience recurrent pregnancy losses over the next several years. During that period, Mrs. N increasingly struggled to accept herself as a woman, wife, and mother. The upshot was an increased determination to have another child. Surprisingly, with each pregnancy loss she denied any sadness or grieving.

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Approximately three months after one of her lost pregnancies, Mrs. N began developing severe anxiety symptoms. She had catastrophic worry about rare, high-lethality health issues in her daughter, who was now five years old. For example, Mrs. N would be struck by the thought "What if she dies of cancer?" while her daughter was suffering from a benign respiratory illness. These thoughts would linger, and then Mrs. N would find herself struggling with sleep initiation for hours as she obsessed about her daughter and checked her multiple times through the night. She began repeating her postpartum behavior of hand washing but now also washed her daughter's bed linens and clothes repetitively to ensure that they were not contaminated.

The subject of Mrs. N's worries slowly began shifting toward her own health. For example, she became concerned about uneven breast tissue; worried about breast cancer, she could not be reassured until she was seen by her gynecologist. She would attempt to control her thoughts by repetitive breast self-exams several times per day. She conveyed a sense of feeling out of control regarding her symptoms. She also endorsed mild deficits in concentration; she denied other symptoms, however, such as low mood, anhedonia, appetite disturbance, hopelessness, suicidality, and fatigue.

Treatment Course

Mrs. N's gynecologist referred her to our outpatient resident clinic for psychiatric care. She rejected psychopharmacologic interventions because of the risk of congenital malformations in case she was able to become pregnant again. She was sequentially treated by two different resident psychiatrists. She was initially treated by a fourth-year resident, Dr. S, and then, after Dr. S graduated, by a third-year resident, Dr. L. Both therapists used mindfulness interventions, though Dr. S primarily focused on cognitive-behavioral therapy (CBT), and Dr. L focused on psychodynamic psychotherapy.

CBT/Mindfulness Course Without IVF

Dr. S's treatment began with the learning of defusion mindfulness techniques. Defusion is a strategy of separating or distancing from one's thoughts by allowing the thoughts to come and go rather than engaging in the thoughts.[2] Mrs. N was also encouraged to treat thoughts of having breast cancer as just thoughts without any power or influence over her behavior. Exposure and response prevention was also utilized in external and imaginal exposures, specifically for Mrs. N's fears of contamination and physical illness, respectively. Dr. S encouraged her to allow her daughter to attend play groups at graduated intervals with exposure to other children, and to resist the urge to immediately wash her daughter's clothes when she returned home. Through imaginal exposures of physical illnesses, Mrs. N became less overwhelmed by her thoughts of illness. She was also encouraged to gradually decrease engaging in safety "checking" behaviors—for example, breast self-exams, calling her physicians, and excessively washing clothes. Her compulsive behaviors and anxiety decreased throughout the first three months of treatment, as assessed through verbal self-report.

CBT/Mindfulness Course After IVF Was Initiated

Mrs. N's anxiety was in remission prior to starting a new cycle of IVF with preimplantation genetic diagnosis, a process that includes a complex series of steps and hormonal treatments: (1) controlled ovarian hyperstimulation (COH), (2) oocyte retrieval, (3) fertilization and culture of embryos, (4) assessment of embryo quality and genetic analysis by embryo biopsy, and (5) embryo transfer into the uterus. The COH stage includes induced menopause with gonadotropin-releasing hormone agonists (e.g., leuprolide), followed by daily injections of gonadotropins.[3]

Mrs. N's anxiety was elevated throughout the four months of this IVF cycle, with new-onset irritability and sleep maintenance difficulties. Particular peaks in anxiety were noted during the stages of COH and oocyte retrieval, and while she was awaiting the results of genetic analysis and embryo transfer. It was unclear whether the exacerbation in her anxiety was due more to hormonal factors or to situational factors, such as the bruising and pain of daily injections, or the stress of awaiting pregnancy results. She struggled with thoughts of developing ovarian cancer and breast cancer, with the consequence that she frequently telephoned the obstetrician on call. She again engaged in excessive breast self-exams. Previous mindfulness and behavioral interventions were utilized without significant benefit. At this point Dr. S noted a strong countertransference feeling of losing control of the therapy; she sought advice from her supervisor. What she learned was that, during this phase of the IVF treatment, Mrs. N's need for control was threatened and was a significant factor in the exacerbation of her anxiety. Dr. S then began to implement interventions that would help support Mrs. N's sense of control—for example, self-care and engaging in enjoyable activities.

Mrs. N was unable to become pregnant during that IVF cycle. To Dr. S's surprise, Mrs. N's symptoms of anxiety, irritability, and sleep disturbance diminished considerably, with little expression of sadness or mourning about the failed cycle of IVF. Mrs. N remained determined to get pregnant, however, despite some surfacing ambivalence about the process of IVF. Dr. S observed that the patient had difficulty discussing this ambivalence and would instead, at each session, ritualistically describe in detail the process of IVF. Notably, this point in the therapy coincided with Mrs. N's learning that Dr. S would be graduating and that a transition of care would occur. Dr. S herself felt exasperated after every session, and she was able to understand that her own frustration was connected with Mrs. N's response to the approaching termination of psychotherapy. Given Mrs. N's history of multiple losses, the reemergence of her symptoms and rigidity could well be connected to the prospective loss of Dr. S as her therapist.

Through supervision, Dr. S was able to engage the patient in collaborating around treatment goals during the last sessions,

taking into account that Mrs. N desired to continue treatment within the resident clinic. She expressed a goal of wanting to become pregnant again but felt that she was "too anxious" and not a "good enough" patient—which accounted, she felt, for her recurrent failures to become pregnant. She also felt that if she could discipline herself enough and stop being anxious, she would be able to become pregnant during another course of IVF treatment. Dr. S used CBT interventions to target, albeit without success, the harshness of the patient's comments toward herself. Dr. S began to wonder whether a different therapeutic approach—namely, psychodynamic psychotherapy—might be useful for treating Mrs. N's underlying obsessive character structure. In particular, Dr. S. thought that exploring Mrs. N's underlying desire for multiple children and her ambivalence regarding IVF might be necessary for her to better understand and reach her goals. Mrs. N held off on another cycle of IVF at this point.

Psychodynamic/Mindfulness Course Without IVF

Mrs. N was transferred to the care of Dr. L, but Mrs. N failed to start treatment for several weeks. When she did return, she had increased anxiety about having cancer and about her body being defective. Mrs. N noted that she missed her former therapist and that she was unsure what it would be like to begin treatment again. Dr. L initially used basic supportive interventions of empathic remarks and calls for association (encouragement of self-awareness [e.g., "What comes to mind?"]), to which Mrs. N responded with disdain. She asked instead for homework assignments and exercises to stop her anxious thoughts. Dr. L's response was to encourage mindfulness defusion techniques, which were partially effective in the first month of treatment. Dr. L had the strong feeling that she was not a good enough therapist during these initial sessions. She felt as though she was being graded and judged by Mrs. N. Dr. L also felt nervous about exploring Mrs. N's feelings around having more children. When Dr. L did attempt to explore that issue, Mrs. N made references to other people in her life who did not understand her. Dr. L sought supervision regarding her strong countertransference feelings. She began to understand her own feelings of insecurity, fear, and incompetence as reflecting some aspects of projective identification, thereby giving her a window into how fragile Mrs. N's sense of self was.

During the second month, the treatment began to focus on how Mrs. N defined herself. Mrs. N expressed that being a mother who bears children was central to her current identity. Given the loss of her career and cultural community, due in large part to immigration, she saw herself as simply a means of performing the function of having children. Dr. L's understanding of Mrs. N's problem led her to want to know more about Mrs. N's previous role in her country of origin. Dr. L thought that helping the patient with improved self-esteem and shame regulation, given her multiple losses, should be considered a crucial component of therapy.

Mrs. N began to understand that her anxiety could be reduced through the expression of genuine emotions and by coming to have a sense of compassion and hope for herself. Her anxiety gradually began to decrease in response to the empathy that Dr. L expressed for her multiple pregnancy losses. Mrs. N became open to exploring her feelings of disappointment and shame. She was able to discuss the origins of her desire to have a large family as stemming from her own family dynamics. She had felt isolated growing up as an only child and did not want the same for her daughter.

The therapy now focused on dynamic techniques of exploration (especially regarding the emotions of shame and anger) and on supportive interventions—which included supplying hope and optimism, and teaching self-care and meditation skills to cultivate self-compassion. Mrs. N was able to engage in more self-reflection during these five months of treatment in the absence of IVF, and she was able to imagine a satisfying life with her family.

Mrs. N's ambivalence regarding fertility treatment became a focus of treatment. Of particular note was her reproductive endocrinologist's concern that her history of severe anxiety was preventing her from being consistent in her decision for fertility treatment. Among other things, Mrs. N would schedule initial sessions with the reproductive endocrinologist and then cancel within the same week. The physician requested a consultation with Dr. L to assess Mrs. N's present capacity to consent to fertility treatment. Dr. L hypothesized that Mrs. N's difficulty in making a decision reflected her ambivalence rather than any diminished capacity. In the process of exploring the patient's ambivalence, it became clear to Dr. L that Mrs. N understood the risks and benefits of treatment but that she overestimated the risk of gynecological neoplasia with fertility drugs, which led her to cancel appointments. Another factor involved in her ambivalence was that she underestimated the risk of psychiatric exacerbation of her anxiety disorder. For instance, she would begin the process of initiating treatment without an appreciation of the risk of experiencing debilitating anxiety symptoms, and she would subsequently relapse with eventual cancellation of her fertility appointments. Through discussions with her reproductive endocrinologist and the continued exploration of her ambivalence with Dr. L, Mrs. N came to believe that the benefit of potentially becoming pregnant outweighed the risks for her. She was also able to communicate a clear and consistent choice that it was her desire to have a second child through IVF. Thus, it was determined that she had the capacity to proceed.

Psychodynamic/Mindfulness Course After IVF Was Initiated

Mrs. N's obsessive symptoms waxed and waned with less intensity than during her prior IVF treatment. Dr. L thought that her anxiety was less during this cycle because she not only utilized mindfulness skills learned in both courses of therapy but was more tolerant of the uncertainty of achieving pregnancy; she accepted her anxiety regarding the process of IVF as normal and brought compassion to her fears.

Mrs. N became pregnant, and the embryo screened negative for any major genetic abnormalities. She was ecstatic, and she wondered whether her capacity to become pregnant reflected, in part, her lower level of anxiety. Toward the end of her first trimester, however, her psychiatric symptoms worsened considerably, with several themes involved: miscarriage, food intake, and ego-dystonic thoughts of hurting her child once born. She had obsessive worries about having a miscarriage and imagined waking up in a pool of blood or having a traumatic loss of the pregnancy. She felt powerless to protect the pregnancy. She became concerned that her intake of ethnic breads and beverages could cause her to spontaneously abort, although these foods were taken without fears during her previous pregnancies. She had ego-dystonic thoughts of dropping or seeing her child, once born, decapitated. She found these thoughts distressing, and began struggling with insomnia, tension, irritability, and tearfulness.

Self-compassion and supportive techniques were utilized throughout this period, which lasted approximately six weeks. Mrs. N learned to treat her anxious thoughts about her child with kindness, reframed as affection and love toward her infant. These interventions helped decrease Mrs. N's symptoms to a mild level by the middle of her second trimester. She resisted, however, Dr. L's efforts to help her see her anxious thoughts as related to unresolved mourning and anger regarding pregnancy losses and identity loss. Mrs. N thus failed to address a psychological factor that was contributing to her continued cycle of anxiety around reproductive events.

Mrs. N's symptoms remained mild into her third trimester, and she decided to discontinue psychotherapy at that time. She also revealed plans to attempt to conceive a third child. Dr. L learned through outreach to her and her obstetrician that Mrs. N was adherent with all obstetrical care and was caring for her daughter and self appropriately. During outreach, Dr. L recommended that Mrs. N continue treatment because of concerns regarding postpartum anxiety, but she declined. She expressed that she was in a good place at this time in her life and that coming for therapy reminded her of the struggles she had experienced in her efforts to become pregnant.*

QUESTIONS TO THE CONSULTANTS

1. What are the features of obsessive-compulsive disorder (OCD) in relation to reproductive events, and does the available evidence indicate that psychiatric symptom reduction results in more positive pregnancy outcomes?
2. What are the psychological and biological factors that led Mrs. N's psychiatric symptoms to worsen during fertility treatments?
3. How did unresolved mourning contribute to this patient's presentation?
4. How would you describe this patient's personality structure, and what are the implications for using psychodynamic treatment to address personality pathology?
5. Mrs. N's psychiatric illness did not significantly interfere with her decision-making ability, but under what circumstances would one assess such a patient as lacking the capacity to consent for IVF, and under what circumstances would the patient be refused fertility treatment even if decision-making ability is not impaired?

*This composite case history was prepared by Osarumen Nicole Doghor, MD, and Cathryn Freid, PhD.

Florina Haimovici, MD

Perinatal OCD has been described as a specific subtype of OCD. A description by Abramowitz and Fairbrother[4(p 140)] of the clinical presentation includes the following signs and symptoms:

> 1) Onset (often rapid) or worsening during pregnancy or postpartum; 2) Obsessional content involving contamination OCD (particularly during pregnancy), illness, violence, harm, accidents or loss; 3) Avoidance of obsessional cues, sometimes including avoidance of the newborn; 4) Compulsive rituals may be overt (washing, checking) or covert (mental rituals, neutralizing); 5) Often associated with depressive symptoms; and 6) Not associated with postpartum psychosis.

Female reproductive events—including menarche, premenstruum, pregnancy, postpartum, and menopause—are viewed as periods of increased risk for the onset and worsening of OCD symptoms.[5] The diagnosis and treatment of OCD during and following pregnancy have especially important implications, as obsessions and compulsions during this stage frequently involve the infant and could thus negatively affect the development of mother-infant attachment. Several theories have been suggested regarding the relationship between OCD and reproductive events. It has been proposed that the rapid increase in oxytocin at the end of the pregnancy and during the postpartum period may exacerbate or trigger the onset of OCD. Another theory, based on the "serotonin hypothesis" for OCD, proposes that fluctuations in estrogen and progesterone during pregnancy and postpartum contribute to the serotonergic dysfunction related to OCD symptoms.[6] For Mrs. N, this theory sheds light on understanding the exacerbation of OCD symptoms during particular fertility-treatment stages. It is well understood that women with a history of postpartum depression or anxiety may be more sensitive to hormonal fluctuations, particularly hypoestrogenism during fertility treatment.[7] In women, the psychiatric side effects of fertility medications can include anxiety, sleep disturbances, mood lability, irritability, and cognitive deficits.[8] Infertile women pursuing infertility treatments present with higher scores of depression and anxiety when compared to the general population.[9] Research has shown that anxiety can fluctuate in women over the course of fertility treatments. During particular aspects of the cycle,

such as oocyte-retrieval day and pregnancy-testing day, scores of anxiety and depression are particularly elevated above pretreatment baseline.[10]

In regard to Mrs. N's thoughts about anxiety interfering with her ability to become pregnant, this question has been in debate in the field of reproductive psychiatry. The current data are inconclusive whether psychiatric factors are directly correlated with pregnancy outcomes. It is known, however, that biological dysfunction in the uterine environment by oxidative stress and inflammation can affect the ability to conceive,[11] and also that depressive and anxiety disorders can play a significant role in inflammation and immune regulation, potentially affecting pregnancy outcomes. In a 2015 meta-analysis of studies regarding the effectiveness of psychological treatment on pregnancy outcomes and symptom reduction, psychosocial interventions, particularly CBT, were associated with improved pregnancy rates.[11]

Mrs. N suffered multiple pregnancy losses. A grief reaction is common in women with infertility, and women who have experienced recurrent miscarriages can suffer from pathological grief and depression.[12] This case is complicated by Mrs. N's cultural belief that she needed to have multiple children and by her pursuit of fertility treatment to do so. She may have been struggling with the internalized stigma of not achieving the personal goal of bearing multiple children and also with the external stigma of not living up to the cultural and family ideals of having a large family.[13] One can hypothesize that during Mrs. N's childhood and adolescence, sociocultural values about the importance of parenthood and family were strongly emphasized and respected. Therefore, for a woman like Mrs. N, being a mother of a certain number of children is central to her identity. Her sense of loss of this identity led to feelings of defectiveness and incompetence, giving way to the common feeling among most women struggling with infertility: shame.[14]

Donna Mathias, MD

Obsessive character structures have been described as "obstinate, orderly, perfectionistic, . . . and inclined to intellectualism."[15(p 10)] From the description of Mrs. N, she does display characteristics of an obsessive-compulsive personality structure. Under conditions of a stressor and extreme demands, these personality characteristics may "congeal into symptomatic behavior that will then be ritualized."[15(p 10)] Hence, her personality structure made her more vulnerable to the development of obsessive-compulsive symptomatology as described in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).[16] Psychodynamic theorists understand OCD to involve some aspect of unresolved mourning or a failure to grieve, which may relate to the repetitive losses that Mrs. N experienced from the loss of her career, culture, and identity when she immigrated, as well as to the repetitive physical losses of pregnancy.[17]

One of the main aspects of the obsessive personality is the conflict between (1) obedience and defiance, and (2) fear and rage. For Mrs. N, her ambivalence about fertility treatments may also represent these conflicts. She described a cultural and personal desire to have a large family. She may have desired to stick to this "rule" out of obedience and fear regarding family pressure, marital pressure, and her own critical superego. Her defiance and rage may have been unconsciously displayed, however, by the obsessive content of her thoughts—that is, illness and aggression.

Most patients will have personality traits characteristic of different personality types, and this is true of Mrs. N. Her personality has strong obsessive traits, but themes of narcissism are also apparent. Mrs. N's identity appears to be tied strongly to her role as a mother. The narcissistic injury she endured with each pregnancy loss must have been quite disturbing for her, fueling her determination to have another child. Mrs. N may have experienced more shame and loss as her pregnancies were, in essence, extensions of herself. Her own insecurities of having a genetic disorder made her prone to view her pregnancy losses through the lens of being a "defective" woman.

Understanding Mrs. N's difficulty with mourning begins with her developmental history. She had to be the "perfect" child to her mother, who (as the mother of only one child) was unable to obtain the respect given to women in her culture who had multiple children. Mrs. N must have internalized her own mother's shame but could not access the sadness—which may have led to superstitious feelings about expressing sadness. That is, if Mrs. N felt sadness or mourned, she would not get pregnant. In addition, she may have felt that if she mourned, she would never stop and would relive the losses of her past.

Another layer of Mrs. N's difficulty with mourning is related to infertility, which has been referred to as a blank mourning: mourning for a wished-for experience rather than the loss of an object.[17] It makes the mourning experience more difficult, as there is no object to mourn, leaving the woman feeling empty, ashamed, and alone. This dynamic is evident in the case of Mrs. N. Although she was able to conceive with assisted reproduction, the years of recurrent pregnancy loss left her with a desire to fulfill a void she could not quite understand. This blank mourning, when unaddressed, can lead to pathological or unresolved mourning. The following signs are present in Mrs. N: refusing to talk about past losses; intrusive thoughts; psychosomatic symptoms; and illness anxiety. Studies have shown that patients with unresolved mourning after a loss have higher rates of anxiety—in particular, elements of a posttraumatic syndrome.[18] It is understood that many women who suffer from infertility, primary or secondary, have symptoms of posttraumatic stress disorder.[19]

This phenomenon explains the elevated anxiety that Mrs. N experienced during subsequent pregnancy attempts. She must have carried trauma and mourning from her past attempts. Galst[20] expands upon this phenomenon that occurs in infertile women during a subsequent pregnancy attempt.

The woman is conditioned to expect disappointment and loss. Self-protection is seen in the tendency to expect the worst outcome. This form of self-protection is created to decrease the woman's sense of disappointment by a failed IVF treatment or miscarriage. And once the woman is pregnant, uncertainty remains as to the ability to protect the pregnancy.

One important goal in Mrs. N's treatment would be to help her balance her desire for control and certainty with acceptance and hope. The desire for a child can be very strong, and when a woman has an equally strong desire for control, it can be problematic. The concept of hope is therefore too painful because disappointment may ensue. I have said to patients in similar circumstances, "If you cannot hold the hope, I will hold it for both of us." Once the patient is pregnant and has escalated fears of miscarriage, the therapist can hold the hope—hope for a successful pregnancy and hope for the ability to cope if the outcome is poor. It goes back to that sense of basic trust and also to the patient's attachment to the therapist. It would be very helpful to think of this patient in terms of her personality. A psychodynamic approach can provide benefit in providing a space for psychological flexibility.

Deborah Knudson-Gonzalez, MD

With regard to capacity, patients are presumed to be capable of making decisions about their care. We determine capacity through the process of informed consent. This process should include a discussion about the treatment proposed, the risks and benefits associated with that treatment, and the risks and benefits of treatment alternatives, including no treatment at all. Patients are deemed to be capable when able to understand and retain the information provided, rationally understand the risks described, and able to manipulate that information rationally prior to communicating a choice.[21] Capacity might also fluctuate. The patient might be able to make an informed choice at one point but, due to illness exacerbation, might lose that capacity at another time. The higher the risk of the treatment proposed, the higher the degree of scrutiny that should be exercised during the informed consent process.[21]

Given that Mrs. N received several infertility treatments, she presumably underwent capacity assessments on multiple occasions. She was capable of describing the IVF process in detail to her therapist—including risks and benefits associated with treatment. During her IVF treatment, however, her OCD symptoms waxed and waned, as did her ambivalence about undergoing repeated IVF treatments. When obsessive thoughts are experienced as ego-dystonic and irrational, those thoughts should not generally interfere with the capacity to make medical decisions.[22] Nevertheless, patients diagnosed with OCD might lose insight or develop irrational beliefs that rise to a delusional level. DSM-5 now includes a specifier of no insight/delusional belief, supporting this subtype. When these delusions are related to the medical treatment proposed, the capacity to consent should be questioned. Published studies on capacity and OCD are limited.[23] It is likely that, as we think further about treating psychosis in patients with OCD, data will emerge from studies employing the new criteria from DSM-5. To be considered, too, are the emerging data on potential deficits in executive function in patients with OCD.[24]

In this patient's case, one should consider whether her obsessive thoughts relating to themes of harm caused her to overestimate the risks that brief hormonal treatment would have on her health long term. If fears have not been overestimated, Mrs. N's choice to undergo repeated IVF cycles—despite long-term risks to her health, history of multiple losses, and exacerbation of anxiety symptoms during the IVF process and postpartum period—should prompt further exploration to ensure that her decision is congruent with her values. Also, during her treatment with Dr. S, she described details related to the process of IVF "ritualistically." This characterization provides an example of how OCD might interfere with capacity: Mrs. N appeared to compulsively discuss the IVF process without apparent appreciation on how the process might actually affect her. She also appeared to frequently schedule and cancel IVF appointments, raising questions about the stability of her choice over time. Appropriately, capacity was again assessed prior to her last IVF cycle.

Assessing the capacity to undergo assisted reproduction should not differ from capacity assessments for other medical interventions.[24] If this patient opts to undergo repeated IVF, she should be informed not only of the risks associated with that process but of the risks associated with exacerbating OCD during a future pregnancy and in the postpartum period, when OCD exacerbation appears to be higher.[25] Given her history, a discussion of how these symptoms might affect fetal development and her own stability should be included. The informed consent process should include a discussion about the likelihood of compulsive behaviors recurring if choosing to become pregnant again. If, at the time of pursuing IVF treatment, OCD symptoms are not interfering with her ability to make an informed choice, I see no need to question her capacity.

A separate question is whether the reproductive endocrinologist would agree to treat this patient if significant concerns arose for the safety of the future child. The American College of Obstetrics and Gynecology published a committee opinion in 2013 stating that "the well-being of the offspring is an overriding ethical concern that should be taken into account in determining whether to provide infertility services."[26(p 51)] The refusal of services "would have to raise child protection concerns and represent a very large deviation from a 'good enough' home."[26(p 52)] In this patient's case, despite her OCD worsening during pregnancy and her ambivalence and later rejection of therapy and medication management, she does not appear to have engaged in behaviors that would result in significant harm to child or self.

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