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Psychiatric emergencies in pregnancy and postpartum

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Abstract

The perinatal period is a vulnerable time for the acute onset and recurrence of psychiatric illness. Primary care providers are opportunely positioned to intervene for women who present with mood decompensation, excessive anxiety, or psychosis during the perinatal period. Due to increased screening efforts in obstetrical clinics and amount of contact during the perinatal period, obstetricians may be able to identify patients who need treatment before their symptoms become severe. In this article, we address imminent and emergent psychiatric symptoms in the perinatal period including management and risk reduction to help obstetrician/gynecologists treat and/or refer patients as clinically appropriate.

Keywords

psychiatric; emergencies; pregnancy; postpartum; depression; suicidality

Introduction

The perinatal period is a vulnerable time for the acute onset and recurrence of psychiatric illness. Approximately 1 in 13 women experience a new onset of a major depressive episode during pregnancy¹ and 1 in 7 experience an episode postpartum.² Among women with a pre-existing mood disorder, the rate of relapse postpartum is 30% for unipolar depression and 52% for bipolar depression or the recurrence of a manic episode.³ Similarly, antenatal and postnatal anxiety disorders (all anxiety subtypes) are diagnosed in 15.2% of women during pregnancy and 9.6% of women post-birth.⁴ During the first year after delivery, women with a psychiatric disorder are at the highest risk for psychiatric hospitalization⁵ and suicide is the leading cause of maternal death.^{6–8} Psychosis and suicidal ideation with onset during pregnancy and postpartum are psychiatric emergencies that require prompt intervention. Emergency room (ER) visits related to psychiatric illness have risen to one of every eight

visits in the past decade⁹ and, although investigations are limited, the prevalence and acuity of mental illness during the perinatal period contributes to the rising statistic. To prevent poor maternal and infant outcomes it is critical for clinicians to make the distinction between perinatal psychiatric symptoms that are appropriate for outpatient management and those that demand immediate intervention.

Perinatal worsening of mood and anxiety can progress rapidly and become an imminent risk to the patient and, in rare cases, her infant. Primary care providers, specifically obstetricians, are positioned to intervene for women who present with worsening or new onset mental illness. Although few patients have contact with a mental health provider (19%) prior to suicide, many (45%) have had contact with a primary care provider within one month of the attempt.¹⁰ Because obstetricians have frequent contact with perinatal patients and are integral to screening initiatives for perinatal depression, obstetricians may be able to identify patients who need treatment before their symptoms become severe. In this article, we address identification, risk reduction, and acute management of the common emergent perinatal psychiatric symptoms including 1) suicidality, 2) postpartum psychosis, 3) postpartum obsessive-compulsive disorder, and 4) agitation.

Suicidality

Suicide risk during the perinatal period is estimated to be 1.6 to 4.5 per 100,000 live births in the United States.¹¹ Global perinatal suicide rates similarly range between 1.27 and 3.7 in countries including the United Kingdom, Canada, and Sweden.^{12–14} Although suicide risk is high during the first postpartum year, studies often do not account for suicides beyond the first 6 months postpartum and suicide is underreported on death certificates; therefore, maternal suicide rates are likely to be higher.

Suicidal ideation, the thought to kill oneself, is a predictor of suicide and postpartum depression.¹⁵ Of women seeking obstetrical care, 2.7% endorse thoughts to end their lives.¹⁵ Suicidal ideation estimates are higher and range from 5–14% among perinatal women seeking mental health care.¹⁶ In a study of women with low-income in a university setting, women who experienced intimate partner violence had an increased risk of antenatal suicidal ideation with an OR of 9.37.¹⁷

A risk factor for perinatal suicidality includes a history of psychiatric illness. Women with a diagnosis of bipolar disorder have a higher risk for suicide and are more likely to die by suicide during pregnancy than women with unipolar depression.¹⁸ Suicide risk is also higher in women with a history of suicide attempts, abrupt discontinuation of psychotropic medications during pregnancy, sleep disturbances during the postpartum period, intimate partner violence, and stillbirth.^{7,8,19–22} Suicide prevention requires early screening, assessment, monitoring, and intervention of all patients during the perinatal period regardless of emotional affect and appearance.

The United States Preventive Services Task Force recommends depression screening for pregnant and postpartum women. The Edinburgh Perinatal Depression Scale (EPDS)²³ and the Patient Health Questionnaire – 9 (PHQ-9)²⁴ are commonly used self-report scales to

screen for depression during the perinatal period. The EPDS is an easy-to-administer 10-item, self-report scale that has been validated in 18 languages and translated to a total of 36 languages. Similarly the PHQ-9²⁴ is a quick, 9-item, self-report that is also validated in the perinatal population. One item on both EPDS and the PHQ-9 captures those patients with thoughts of suicide. Question 10 on the EPDS, states, “The thought of harming myself has occurred to me” and the patient is then asked to mark how often those thoughts have been experienced. Similarly, question 9 on the PHQ-9 is worded to determine whether the patient has “Thoughts that [she] would be better off dead or of hurting [herself] in some way.” The patient is asked to mark how frequently the symptoms occur. If a patient answers with an affirmative response for either question, a clinician must inquire about the frequency and intensity of the thoughts along with any potential methods or intent for self-harm.

Assessment of the patient’s basic self-care, interactions with infant/family, and treatment compliance is essential to gain insight into the patient’s functional capacity and suicide risk. Anhedonia (decreased motivation and reduced pleasure) and lack of self-care are risk factors for suicide and may present as a patient’s lack of interest in bonding with her infant, difficulty attending to daily hygiene, or neglecting medical needs.²⁵ Women with symptoms of self-neglect and lack of interest in their child must be monitored and evaluated for the onset of suicidal thoughts.

Cultural considerations are also important for assessing suicide risk. Among women screened for depression, the risk for suicide during the antepartum and postpartum periods was highest among younger, unpartnered women who were non-white, non-English speaking, publicly insured, and women with prior history of psychiatric diagnosis. Among non-English speaking patients, risk for suicidal ideation increased if these patients were partnered. In addition, an increased risk for suicidal ideation¹⁶ and suicide²⁶ was noted in communities that stigmatize unmarried pregnant women.

Because suicidal risk is elevated among women with bipolar disorder,²⁷ screening for a history of bipolar symptoms is necessary for risk assessment and treatment planning. The Mood Disorder Questionnaire (MDQ)²⁸ is a brief self-report, 17-item, screen that includes 13 bipolar disorder symptoms, time period of symptoms, and the degree of related impairment. Criteria for a positive screen include the following: 1) endorsement of seven symptoms, 2) presence of symptoms during the same time period and 3) moderate or serious impairment. Investigations of the MDQ in women with positive EPDS have shown that exclusion of the impairment criterion identifies 68% of postpartum women diagnosed with bipolar disorder by a structured diagnostic interview.²⁹

Assessment of suicide risk is necessary to determine whether a patient requires emergent hospitalization or can continue outpatient care. According to the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors,³⁰ a suicide risk assessment requires that the provider ask directly about: 1) the patient’s desire to live or die, 2) the specific thoughts about taking their life, 3) any plans they have to carry out the act, 4) access to means and, finally 5) the lethality of their intended means/plan. For patients who endorse thoughts of suicide or death, the clinician must ask about the frequency, intensity, and life stressors associated with the thoughts.^{30,31} Follow-up questions about preparations for death such as a creating a will, purchasing a

weapon/poison, stockpiling pills, or securing childcare for the children left behind will provide information about the patient's imminent risk.³¹ It is also critical to ask the patient if she can identify deterrents to attempting suicide such as spiritual beliefs, children, spouse, or parents, which may serve as protective factors. If the assessment reveals that a patient is a significant risk to herself due to endorsement of suicidal ideation, intent or plan to harm herself, and being unable to state reasons she would not commit suicide, an emergent psychiatric consultation is required for evaluation. In these instances, collateral information from the patient's significant other or family is also necessary to advise the patient's mental state and address concerns for suicide that may have been observed at home. A concern for imminent self-harm is an emergency and the disclosure of confidential information for the safety of the patient is warranted to prevent poor outcomes and supersedes rigid adherence to confidentiality regulations. According to the Health Insurance Portability and Accountability Act (HIPAA) of 1996,³² clinicians must disclose the minimum amount of information necessary to provide optimal care to the patient and may share patient information with anyone as necessary to prevent or lessen a serious or imminent threat to a person's health and safety.^{33,34} The patient's significant other, relative, or accessible collateral should be asked to remove any potential methods for suicide such as a weapon or collection of pills from the patient's home. Documentation of the disclosure, rationale, and details of the process in the medical record is a medicolegal necessity.

Patients who endorse suicidal ideation that is infrequent, deny a plan to act on their suicidal thoughts, and are able to name personal reasons for not committing suicide are appropriate to monitor monthly as an outpatient until psychiatric evaluation is available.

Pharmacotherapy or individual/ group psychotherapy (e.g., cognitive behavioral therapy, behavioral activation therapy, supportive therapy) are appropriate outpatient treatments. If a patient declines therapy and medication, monitoring the patient at regular intervals for worsening symptoms is advised.

Pharmacotherapy options for patients include antidepressants such as selective-serotonin reuptake inhibitors (e.g., sertraline, escitalopram), which are first-line for women who have symptoms of depression and have a negative screen on the MDQ. Mood stabilizing medications such as lithium, lamotrigine or atypical antipsychotics (e.g., aripiprazole, lurasidone) are standard of care for women who have bipolar disorder. Antidepressant monotherapy can exacerbate bipolar disorder type I, characterized by a history of at least one manic episode including symptoms of euphoria or extreme irritability and grandiosity, high energy, decreased need for sleep, increased goal-oriented activity, racing thoughts, and impulsive behavior. Women started on an antidepressant for unipolar depression should be closely monitored for transiently increased suicidal thoughts, agitation, or increased irritability which may be indicative of worsening bipolar symptoms.³⁵ Resuming prior effective medication regimens is appropriate for women with a history of mental illness. Prescribing medication during pregnancy and lactation requires a risk-benefit discussion with the patient that includes consideration of the risk of untreated illness versus the risk of the medication.³⁶ For patients at risk of harming themselves, the benefit of medication justifies the risk.

We recommend the following for suicidality identification, monitoring, and treatment:

1. Screen at every contact during the first year postpartum.
2. Screen pregnant and postpartum patients for depression (using EPDS or PHQ-9) and add the MDQ to screen for bipolar disorder.
3. Review item 10 on the EPDS and item 9 on the PHQ-9 for positive answers regarding thoughts of self-harm.
4. Ask patients directly about thoughts of suicide or self-harm for severity, frequency, and intent.
5. Request emergent psychiatric evaluation for patients who report suicidal ideation.
6. Contact the woman's significant other or preferred family member, ideally with the patient's permission, to complete a suicide risk assessment for patients who endorse suicidal ideation and to assist in removing any potential suicide methods from the home (i.e., gun, stockpiled pills).³⁷
7. Inform significant others of the potential risk for suicide and give instructions on what to do if risky behaviors develop. This is especially important for patients who have risk factors that include histories of mood or anxiety disorders, have a new onset of a mood or anxiety disorder, or endorse suicidal ideation, but who will be managed as an outpatient because she is not an imminent risk to herself or others.
8. Begin pharmacotherapy and monitor until further psychiatric assessment is obtained for patients with suicidal ideation who do not endorse a plan or intent and can identify protective factors against suicide.

Postpartum Psychosis

The incidence of postpartum psychosis is 1–2 per 1,000 births.^{38,39} Risk factors for postpartum psychosis include primiparity,^{40–42} advanced maternal age,⁴⁰ and occurrence of a mood disorder during the incident pregnancy itself. The greatest risk factors are a history of bipolar disorder and postpartum psychosis.^{43,44} A personal or family history of bipolar disorder substantially increases the risk of developing postpartum psychosis and women with a first-degree relative with postpartum psychosis have a 70% risk of onset.^{6,45,46} Most cases of postpartum psychosis present in those without a history of any psychiatric symptoms.¹⁴ Approximately 50–80% of patients who develop postpartum psychosis go on to develop manic or hypomanic episodes that are consistent with a bipolar spectrum illness.⁴⁷ Although rare, the risk of infanticide related to postpartum psychosis is about 4%.⁴⁸ Given that postpartum psychosis is a psychiatric emergency, early identification, immediate intervention, and appropriate treatment are critical to prevent maternal suicide and infanticide.

The typical onset of postpartum psychosis is between 3 and 10 days after birth.⁴² According to the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition*,⁴⁹ to meet diagnostic criteria, symptoms must occur within the first 4 weeks post-birth. The rapid hormonal shifts following delivery have been attributed to the illness onset.⁵⁰ Unlike

psychosis related to schizophrenia or other psychotic disorders, women with postpartum psychosis present with more disorganization, bizarre behavior, and non-auditory (i.e., visual, olfactory, or tactile) hallucinations.⁵¹ Patients have little to no insight into their symptoms, which are characterized by a drastic change from premorbid functioning. Some patients develop paranoid, grandiose, and bizarre delusions and, as a result, they are at risk for suicide and infanticide. Patients may also have altruistic delusions of committing suicide or killing their infant to save themselves and their infant from a “fate worse than death.”⁵² Significant changes in cognition postpartum including delirium-like confusion, derealization, or disorientation post-birth are hallmarks of postpartum psychosis.⁴⁷

Drug intoxication or withdrawal can mimic symptoms of postpartum psychosis. Use of or withdrawal from barbiturates, benzodiazepines, and alcohol may cause fluctuating levels of consciousness, anxiety, and hallucinations. Similarly, cocaine and cannabis use can mimic psychosis by causing an onset of paranoid symptoms. A urine or blood toxicology screen is necessary to rule out drug-induced psychosis.

Physical illnesses may also present with symptoms similar to postpartum psychosis. Evaluation requires assessment for febrile infections (e.g., endometritis), postpartum hemorrhage (e.g., Sheehan’s syndrome), and autoimmune disorders (e.g., autoimmune thyroiditis).⁵³ Late-onset urea cycle disorder, a rare metabolic disease associated with hyperammonemia and hyperglutaminemia, begins as early as 1 to 3 days postpartum with confusion, cognitive impairment, aggressive behavior and rapid progression to a coma.⁵⁴ A physical examination, head imaging, and complete laboratory work-up including a complete blood count, complete metabolic panel, thyroid stimulating hormone, and ammonia is recommended to assess for organic causes of postpartum psychosis. Patients with fluctuations in consciousness require a neurology consultation to assess for neurological abnormalities. A lumbar puncture, EEG, or thyroperoxidase antibodies may also be considered.

Patients with symptoms of postpartum psychosis require ongoing monitoring by a mental health clinician even after their symptoms resolve. Patients should be informed of the potential risk of having bipolar disorder and the associated symptoms that may develop. Clinicians must ask about suicidal ideation, thoughts of harming their infant, and obtain immediate psychiatric consultation or hospitalize the patient for safety if these symptoms are present. Patients must be educated on the importance of adequate sleep to support the remission of symptoms and to prevent relapse. Some mothers may need to forego breastfeeding overnight to reduce the risks of illness exacerbation or lack of symptom improvement due to interrupted sleep. Breastfeeding support by a partner or surrogate (i.e., postpartum night doula) to feed the infant a bottle of previously pumped breastmilk or formula during the night helps to prevent sleep disruption.

Management of Postpartum Psychosis

For women with a history of postpartum psychosis, prophylactic treatment with lithium immediately postpartum is the first-line agent.⁴⁷ Short-term use of benzodiazepines and/or atypical antipsychotics (i.e., lurasidone, aripiprazole) in addition to lithium have also been

used to promote sleep and to target psychosis.⁴³ For women with a history of postpartum psychosis only, Bergink et al. reported that these women did not relapse if they discontinued treatment during pregnancy and began prophylactic treatment with lithium postpartum.⁴³ Alternatively, 44% of those with a psychiatric history of mood episodes relapsed when a medication was discontinued during pregnancy and resumed immediately postpartum. For women with a prior history of psychosis, initiating the psychotropic medication regimen that has been most effective for the individual woman immediately after delivery is advisable.⁴⁵ Education about early signs and follow-up with the obstetrician, nurse, or psychiatrist within the first 2 weeks is appropriate for women at risk or with a history of postpartum psychosis.

Recommendations

1. Obtain a psychiatric consultation for any patient with suspected postpartum psychosis.
2. Hospitalize the patient for evaluation, safety assessment, and treatment.
3. Complete work-up for treatable physical illnesses.
4. Start lithium and add an atypical antipsychotic or benzodiazepine as needed for further reduction of psychotic symptoms. Continue treatment with lithium for 6–9 months.⁴⁷
5. Avoid use of antidepressants without a mood stabilizer.

Perinatal Obsessive-Compulsive Disorder

The prevalence of obsessive-compulsive disorder (OCD) has been estimated to be 2.1% in pregnancy and 2.4% postpartum according to a recent meta-analysis of seven studies of OCD in the perinatal period.⁵⁵ Obsessions are characterized as intrusive, inappropriate, repetitive, unwanted and uncontrollable thoughts or images and are experienced by most women early postpartum as well as during pregnancy. Maternal obsessions have been considered evolutionarily adaptive and protective to ensure the well-being of their offspring and may explain why they are prevalent during the postpartum period. The intrusive thoughts commonly pertain to worries about the well-being of the baby and concerns about inadvertently or purposely doing something to harm the baby (e.g., “what if I throw the baby down the stairs”). Data from three prospective investigations of healthy pregnant women found that all women who participated in the study had at least one intrusive thought related to harming her baby in the first postpartum month.^{56–58} Most often the obsessions resolve within the first several weeks postpartum but some women develop persistent, distressing, and impairing thoughts often accompanied by compulsive behaviors to mitigate or relieve the thoughts and distress. Compulsions may involve mothers repeatedly checking the infant to make sure he/she is breathing, frequent visits to the pediatrician for reassurance that their baby is normal, or avoidance of things that they fear could harm the baby. Perinatal women with obsessions and/or compulsions severe enough to impair function meet diagnostic criteria for obsessive-compulsive disorder according to Diagnostic Statistics Manual Fifth Edition (DSM-V) (Table 1).⁴⁹ Women with OCD symptoms postpartum may be unable to

effectively care for their child and early identification is necessary to promote mother-infant attachment.

Women are unlikely to report obsessional thoughts to family or medical professionals⁵⁹ because of fears that endorsement of thoughts or images to harm their children may result in losing custody of their child due to the concern that the thoughts represent psychosis. Screening for OCD is necessary to identify women who may be suffering from these symptoms. In a prospective cohort of women in an obstetrical setting, a study by Miller et al., 11% of women screened positive for OCD at 2 weeks postpartum and an additional 5.4% developed symptoms by 6 months postpartum.⁶⁰ The Perinatal Obsessive-Compulsive Scale (POCS) is the only self-report for OCD that has been validated in the perinatal population and is available in versions for prenatal and postpartum patients.⁶¹ It consists of 23 items divided between questions on thoughts and behaviors and is easy to administer in the office setting. A score of 9 has high specificity for OCD.

Patients who screen positive benefit from assessment by a mental health professional to evaluate whether the symptoms are better explained by postpartum psychosis or are comorbid with another psychiatric diagnosis. OCD affects as many as 57% of women with postpartum depression compared to 39% with non-postpartum depression.⁶² In addition, other anxiety disorders and bipolar disorder may be present. For patients who cannot readily be evaluated by a mental health professional, screening with the EPDS for depression and the MDQ for bipolar disorder will further inform the treatment plan. Before starting a treatment, it is necessary to consider that a psychotic patient who has thoughts of harming her child with a knife may in fact want to act on these thoughts due to a psychotic belief about the baby (i.e., that the baby is the devil). A patient with postpartum psychosis would require hospitalization to prevent harm to the infant related to delusional beliefs. On the other hand, a patient with OCD who has intrusive thoughts of harming her child with a knife would be distressed by the thought and not want to act on it because it would be inconsistent with the patient's desires and beliefs. Consequently, compared to delusions, women with obsessional thoughts may incorporate extreme avoidance behaviors to prevent harm. For example, a woman with OCD and thoughts of drowning her child might insist that her husband bathe the child so that there is no potential of her drowning the infant. Unlike postpartum psychosis, outpatient treatment is appropriate for women with perinatal OCD.

Treatment for OCD includes SSRIs, clomipramine (a tricyclic antidepressant), and/or cognitive behavioral therapy with adaptations to address the postpartum context.⁵⁹ If a psychotherapist is not available to provide exposure or cognitive behavioral therapy and the psychiatric evaluation is delayed or unavailable, a trial of an SSRI or clomipramine is reasonable to initiate as monotherapy as long as the patient has not scored positive on the MDQ. If the patient has had a previous trial of an SSRI with good response, that medication should be restarted. If there have been no previous trials, sertraline should be prescribed because it has been the most studied SSRI in pregnancy and lactation and has a favorable reproductive profile and minimal transfer in breastmilk. If the patient has a positive MDQ, an atypical antipsychotic (i.e., aripiprazole, lurasidone, ziprasidone) may address both the bipolar symptoms and prevent manic/hypomanic episodes. Risks and benefits of use of psychotropics during pregnancy and postpartum must be discussed with the patient. Mother

to Baby⁶³ and LACTMED⁶⁴ are additional resources to provide to the patient for further risk-benefit information (Table 2).

Agitation

During the perinatal period women may present for emergency evaluation for agitation, which is characterized by combative and aggressive behavior, physical restlessness, or extreme irritability. Similar to psychosis, agitation has many potential causes including psychiatric (i.e., new onset or exacerbation of mental illness), medication withdrawal, drug intoxication or withdrawal, delirium, or medical illness (i.e., hyperthyroidism). Determining the etiology of the agitation is the most important step to implement an effective treatment.

Abrupt discontinuation of psychotropic medications, drugs of abuse, and alcohol is a common occurrence during pregnancy due to concerns about fetal risk. Sudden cessation of antidepressants including selective serotonin reuptake inhibitors (SSRIs) (e.g., sertraline, escitalopram), serotonin/norepinephrine reuptake inhibitors (e.g., venlafaxine), and tricyclic antidepressants (i.e., amitriptyline, nortriptyline) is associated with nausea, dizziness, headache, lethargy as well as anxiety and agitation which begin within one week of discontinuing the medication and typically lasts less than one month.⁶⁵ Resuming psychotropic medication resolves the withdrawal symptoms and may prevent worsening mood or anxiety. A risk-benefit assessment is necessary prior to a patient resuming medication and patients who choose not to restart medication may obtain symptom relief from diphenhydramine and anti-muscarinic agents. Educating patients that the symptoms are self-limited and have a short-course is reassuring.

Cessation of alcohol consumption after sustained use results in several minor to severe physiologic symptoms including tachycardia, hypertension, seizures, hyperthermia, restlessness, tremor, hallucinations, and death.⁶⁶ The physiological stress of alcohol withdrawal has been associated with increased risk for preterm birth and low birth weight.⁶⁷ Detoxification is necessary to treat withdrawal and prevent adverse effects on the mother and fetus. Benzodiazepines are first-line for alcohol detoxification in non-pregnant patients and are not associated with major congenital malformations during pregnancy. Alternative pharmacotherapies for alcohol detoxification including anticonvulsants (i.e., gabapentin) have less known teratogenic effects. Similar to alcohol abuse, repeated opioid intoxication and withdrawal during pregnancy results in fetal distress and can cause pregnancy complications of placental insufficiency, preterm labor, and intrauterine growth restriction. Methadone and buprenorphine for opioid maintenance are appropriate treatments during the perinatal period. Buprenorphine is preferred given its more favorable reproductive outcomes including less risk of preterm birth and low birth weight, as well as, larger head circumference.⁶⁸ For each individual, the risk of medication exposure must be weighed against ongoing alcohol and opioid use. Treatment is justified when weighed against the alternative risk of ongoing intoxication and withdrawal.

Some agitated patients present with combative behavior. In such cases, a psychiatric consult should be obtained immediately. If a psychiatrist is unavailable, verbal de-escalation is necessary and is achieved by speaking in a calm and low voice while keeping a distance

from the patient. If verbal de-escalation fails, pharmacotherapy intervention may be required to calm the patient and complete the necessary work-up. There are three classes of medications commonly used to address agitation including 1) first-generation antipsychotics (i.e., haloperidol, perphenazine), 2) second generation antipsychotics (olanzapine, aripiprazole), and 3) benzodiazepines (i.e., lorazepam). When possible, the choice of medication should be best suited to the underlying cause of the agitation. For example, if a patient is agitated and it is obviously due to delusional thinking or hallucinations which are consistent with psychosis, then an antipsychotic will not only treat the agitation but the psychosis as well. If a patient is agitated due to excessive anxiety, a benzodiazepine is the most appropriate option to start. The aim of the medication is to calm the patient to allow for safety as well as adequate assessment and treatment. Medication is administered to achieve a calm and possibly drowsy state and also allow a medical and psychiatric evaluation. In some instances, agitated patients will agree to take the medication by mouth but medication can also be administered by intramuscular injection when necessary. Administration of an intramuscular dose requires the use of trained security to assist in restraining the patient to allow for the injection.

The choice of medication for a pregnant or postpartum patient requires consideration of the underlying etiology and the choice of a medication intervention that is both calming and therapeutic. Ideally the medication choice will also limit the number of medication exposures to the fetus or breastfed infant. For example, if a patient is taking olanzapine as part of her regimen, an additional dose of olanzapine may be effective to reduce agitation. Given the primary safety concerns for the mother and/or infant, few medications have an absolute contraindication for agitation management in pregnancy or for women who are breastfeeding. Valproic acid is contraindicated in pregnancy due to the well-established risk for neural tube defects and should not be used. Mood stabilizers such as lithium and lamotrigine are also not good options given that these medications do not resolve symptoms acutely.

When the cause of agitation is not evident clinicians prefer high-potency first-generation antipsychotics such as haloperidol (rated first line by 76%) given the much larger database with these medications according to the Expert Consensus Guidelines in 2005.⁶⁹ In most emergency situations, the benefits of preventing the patient from harming herself due to agitation outweigh the risks of medication exposure. Also, a one-time dose of an antipsychotic and/or benzodiazepine is generally considered low risk, as most studies evaluate prolonged use and, even in these, very few adverse effects and no long-term sequelae has been reported for typical (first-generation) or atypical antipsychotics.⁷⁰ For any treatment, the dose of medication must be considered in the context of the increased metabolism of many psychotropics during pregnancy. Medications metabolized by cytochrome P450 enzymes such as CYP3A4 (e.g., clonazepam, alprazolam, lurasidone, aripiprazole, quetiapine),⁷¹ glucuronidation (e.g., lorazepam),⁷² and CYP2D6 (e.g., risperidone)⁷³ are more rapidly metabolized during pregnancy and may require higher dosing to achieve an effect.

Conclusion

Obstetricians and gynecologists are opportunely positioned to diagnose and treat perinatal psychiatric disorders due to the frequency of visits during this high-risk time in a woman's life. Women are at increased risk of both relapse and the onset of the first episode of a psychiatric illness during pregnancy and the postpartum and distinguishing the need for emergent versus routine care is paramount to provide appropriate treatment. Screening tools are effective for identifying depression and bipolar disorder symptoms as well as suicidal ideation. Suicide risk assessment is necessary for patients that report suicidal thoughts to guide the appropriate level of care. Patients with psychosis must be differentiated from women with obsessive compulsive disorder and require a thorough lab and metabolic workup to rule out organic causes. Similarly, agitation may have many causes including psychiatric illness, antidepressant withdrawal, or drug intoxication or withdrawal. Pharmacotherapy and/or psychotherapy are standards of care for treatment of perinatal mood, anxiety, and drug and alcohol withdrawal symptom onset or worsening. Dosing of medication must include consideration of increased metabolic status in pregnancy of some commonly prescribed drugs which may therefore warrant an increased dose for emergency administered medications. Women with perinatal psychiatric emergencies require evaluation and treatment consistent with the standards of care for non-pregnant women that also considers their pregnancy or postpartum status.

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Table 1.

Criteria for Postpartum Obsessive-Compulsive Disorder adapted from Diagnostic Statistics Manual Fifth Edition⁴⁹

1.) Presence of obsessions, compulsions, or both
<ul style="list-style-type: none">• Obsessions are thoughts, images, or urges that are:<ul style="list-style-type: none">o Recurrent, persistent, intrusive, and unwantedo Cause marked anxiety or distress in most individualso An individual may attempt to ignore or suppress such thoughts, urges, or images or to neutralize them with another thought or action• Compulsions are behaviors or mental acts that:<ul style="list-style-type: none">o The individual feels driven to perform in response to the obsessionso Are intended to decrease the anxiety or prevent the undesired situation associated with the obsessionso Are excessive
2.) The obsessions or compulsions are time consuming (>1 hour/day), cause significant distress, or cause significant impairment in functioning socially, at work, at home, or other important areas
3.) The symptoms are not attributable to substance use, a medical condition, or another mental disorder

Table 2.

Differentiating Postpartum Intrusive Thoughts of Harm from Postpartum Psychosis

Postpartum OCD Intrusive thoughts are:	Postpartum Psychosis Intrusive thoughts are:
Are recognized as being misaligned with the patients moral beliefs, values, or desires by the patient	Delusional; are <i>not</i> regarded as being misaligned with the moral beliefs, values, or desires by the patient
Distressing, cause significant anxiety	Not concerning or distressing
Accompanied by compulsive behavior including avoidance to reduce the anxiety of the thought	Accompanied by other psychotic symptoms (i.e., hallucinations, disorganized behavior, cognitive dysfunction)