# Behavioral Emergencies

## Special Considerations in the Pregnant Patient

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**KEYWORDS**

• Psychiatric emergencies • Pregnancy • Psychotropics • Teratogenicity
• Depression • Bipolar disorder • Psychosis • Suicide

**KEY POINTS**

- The perinatal period is a time of psychiatric vulnerability. Up to 1 in 6 pregnant women experience major depressive disorder, and 1 in 4 pregnant women with bipolar disorder experience mood exacerbation.
- Untreated psychiatric illness in pregnancy puts the mother and child at considerable risks, and discontinuation of psychotropics during pregnancy increases the risk of relapse of psychiatric disorders.
- Mood stabilizers (valproate, carbamazepine and lithium) have well-recognized teratogenic risks. There is risk of neonatal toxicity and withdrawal with benzodiazepine use. The association of paroxetine and cardiac malformations is of concern but remains controversial.
- Women during late pregnancy are at risk of developing vena cava syndrome with the use of mechanical restraints for agitation. Suicidality in pregnant women is substantial and warrants adequate screening and assessment of suicide risk.
- All efforts should be made to prevent alcohol and opioid withdrawal syndromes during pregnancy given risk of harm to the fetus.

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## INTRODUCTION

It has been traditionally believed that pregnancy has a protective effect against mental illness and that gestation is a time of relative mental well-being. A body of literature over the past decades disproves this notion as a myth; the perinatal period is in fact a time of psychiatric vulnerability for many women, and presents its own unique challenges of management, given that the health of 2 lives is at stake. Mental disorders during pregnancy negatively affect maternal and neonatal outcomes. Management of psychiatric disorders in pregnancy therefore requires urgent and timely intervention. Psychiatric emergencies are clinical situations in which there is significant risk of harm to self or others in subjects with mental disorders, and these cases are likely to present in the emergency or acute inpatient setting for evaluation and management. Psychiatric emergencies in pregnant women constitutes the subject matter of this review. Although we base our discussion on the extensive literature that explores the management of psychiatric disorders during pregnancy, it is important to note that we are restricting ourselves to considerations that apply to behavioral emergencies, and this review is not intended to serve as an exhaustive resource for the general management of psychiatric disorders in peripartum.

## SEVERE MENTAL ILLNESS IN PREGNANCY

The prevalence of major depression in pregnant women ranges from 7% to 16%, and rates of depression in pregnancy appear to be comparable, or slightly lower, than in nonpregnant women.[1–3] The onset of many depressive episodes occurs for the first time during pregnancy,[4] and major depression also may be more undiagnosed in pregnant women.[5] A prior history of depression, perinatal or otherwise, is the biggest factor predictive of future risk.[6] Severe depression, especially if untreated, can proceed to outcomes such as psychosis, catatonia, and suicide. Screening all pregnant women for depression is recommended, and several tools are available to screen for depression in perinatal populations. These include instruments that were developed for generic depression screening, such as the Beck Depression Inventory, General Health Questionnaire, and the Hospital Anxiety and Depression Scale, as well as instruments that were specifically developed for use in perinatal women, such as the Edinburgh Postnatal Depression Scale (EPDS) and Postpartum Depression Screening Scale.[7] EPDS is self-report, 10-item scale that is convenient and widely used in the perinatal population.[8] Antidepressants and psychotherapy remain the first line of treatment.[9] Electroconvulsive therapy (ECT) should be considered for patients with psychotic symptoms, catatonia, suicidality, severe psychomotor retardation, and lack of response to multiple antidepressant trials.[9]

Symptomatic mood episodes are reported to occur in approximately 25% to 30% of women with bipolar disorder during pregnancy.[10,11] Patients with active mania in pregnancy present challenges in management. Given the teratogenic risks of mood stabilizers, antipsychotics are preferred agents for psychopharmacological treatment of mania. First-generation antipsychotics, particularly haloperidol, have a long tracking record of safety, and are commonly used.[12] Second-generation antipsychotics are also reasonable alternatives.[12] For patients not responding to antipsychotics, lithium and ECT are options to consider.[12] Adjunctive benzodiazepines can be helpful as well. Valproate and carbamazepine should be avoided unless clinical benefits outweigh the teratogenic risks. For patients with bipolar depression in pregnancy, lamotrigine and quetiapine are first-line medications[13]; lithium and ECT