

Psychiatric Emergencies in Pregnancy and the Postpartum Period

Case-Based Assessment and Management

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Disclosures

Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.

Objectives

- Recognize signs, symptoms and risk factors associated with psychiatric emergencies during pregnancy and postpartum
- Understand perinatal- specific considerations that affect emergency psychiatric care
- Explore strategies for effective collaboration within interdisciplinary teams, the perinatal patient and family members during a mental health crisis
- Learn about available resources and support services for perinatal mental health patients

Why is this important?

"During most episodes, participants **went to an emergency room or crisis center at least once, with a quarter of respondents going more than once**" [2]

"Experiences with inpatient hospitalization and crisis response teams **were almost always negative**" [1]

"Participants noted that police, emergency medical technicians, and emergency room clinicians had **limited knowledge** of postpartum care and **dismissed their concerns.**" [1]

"...the delays in referral, diagnosis, and treatment likely made my case longer and more severe, and they **risked my and my baby's safety**" [3]

Overview of Cases

CASE 1

Management of **Agitation** in Pregnancy

CASE 2

Assessing **Risk of Harm to Self and Others** in the Perinatal Population

CASE 3

Evaluation of **Psychosis** in a
Postpartum Patient

CASE 1 | Initial information

- 34 years old
- 30 weeks pregnant
- Brought into emergency department by police after aggressive behavior at a bus station

What do we need to do first?

Agitation Management

Definition: abnormal and excessive verbal or physical aggression, purposeless motor behaviors, heightened arousal and significant disruption of patient's functioning [1]

Prioritize assessment & make environment safe to prevent escalation and patient or staff injuries

Should be treated as an **obstetric emergency**

- Associated with preterm delivery, placental abnormalities, spontaneous abortion, fetal demise, and suicidality [2]

CASE 1 | Initial presentation

- Restless; intense staring
- Alert and oriented
- Declines to respond to assessment questions; wants to leave
- Pressured, loud speech; limited insight
- Declines labs and urine testing
- HR 108; otherwise reassuring vital signs

Address agitation early

- Plan ahead (acute care plan)
- Verbal de-escalation
- Reduce stimulation / adjust environment
- Meet basic needs
- Use supportive family or collateral when safe
- Offer oral medication before IM/IV when feasible

“Participants often felt that facilities were **“scary”** and **isolated** them from family, friends, and their infants”^[1]

Only use physical restraints as last resort

- Supine position can lead to inferior vena cava compression syndrome → Place in a left lateral decubitus position with vital sign & fetal monitoring [2, 3,4]

Agitation Management ^[3,4]

- Identify and treat the underlying cause
- Don't immediately assume psychiatric origin
- Rule out medical, substance-related, and obstetric conditions

Initial Triage

- Assess airway, breathing, circulation
- Vitals
- POC glucose

Rule Out Considerations

- Medication withdrawal or toxicity
- Substance intoxication or withdrawal
- Endocrine, metabolic or electrolyte abnormalities
- Infection
- Physical trauma
- Obstetric complications (ie amniotic fluid embolism, eclampsia/preeclampsia/HELLP, Placental abruption)

Medication for Agitation

Goal to limit medication exposures to fetus

- Monotherapy is favored at higher doses over using multiple agents [4]
- Choose medication based on underlying cause of agitation [5]
- When applicable, consider using patient's home medication [5]

First Generation Antipsychotics	Haloperidol
Second Generation Antipsychotics	Olanzapine, Quetiapine
Benzodiazepines	Lorazepam

CASE 1 | Collateral

- History of bipolar disorder
- Previously stable
- Stopped lithium 600 mg BID + olanzapine 15 mg QHS at 18 weeks gestation
- No known substance use
- Becomes increasingly agitated during collateral call

CASE 1 | Resolution

- Offered a dose of her previous home medication, PO olanzapine
- After giving the patient some space and allowing time for the PO medication to take effect, she agrees to provide labs and a urine sample and to engage in a psychiatric interview
- Ultimately, it was determined that the agitation was stemming from decompensation of her known bipolar disorder

Agitation- Perinatal Considerations

- Agitation should be treated as an **obstetric emergency**
- Don't immediately assume psychiatric origin; **Rule out medical, substance-related, and obstetric conditions**
- Involve **obstetric providers** early on, when possible
- Assess for any **recent medication discontinuations**
- Goal to **limit number of medication exposures** to fetus
- Place in a **left lateral decubitus position** if restraints are required

CASE 2 |

Initial information

- 27 years old
- 10 weeks postpartum with her first child
- Self presents to the emergency department
- Triage Note: suicidal and homicidal ideation
- Infant is at home with her partner

CASE 2 | Broader clinical picture

Patient reports:

- Chronic anxiety, worse postpartum
- **Wishes she could go to sleep and not wake up**
- **Thoughts of harming infant**
- Sleep-onset difficulty; 7-8 hours/night
- Low energy / appetite
- Denies depressed mood, anhedonia or hopelessness

Additional History

- Anxiety disorder, unspecified
- In weekly therapy
- No significant medical history

Suicide in the Perinatal Period

Suicide remains one of the **leading causes of pregnancy-associated mortality** [2]

"There seemed to be a lack of professional inquisitiveness to understand why a mother(-to-be) would consider suicide. Instead, all attention was directed towards the well-being of the baby, leading to multiple missed opportunities for timely care and support" [4]

Screening ≠ risk assessment ^[4,5,6]

Screening tools

- [Patient Health Questionnaire \(PHQ 9\)](#)
- [Edinburgh Pregnancy/Postnatal Depression Scale \(EPDS\)](#)
- [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#)

Clinical risk assessment

- Thoughts: passive vs active
- Intent
- Plan and access to means
- Preparatory behavior
- Past attempts / self-harm
- Psychiatric and substance-use history
- Acute psychosocial stressors
- Protective factors

Perinatal Suicide Risk Factors ^[3,8, 13]

- Personal or family history of mental health disorders
- Prior suicide attempt or ideation
- Comorbid substance use disorder
- Discontinuation of psychiatric medication during pregnancy
- Lack of social support
- Intimate partner problems or abuse history

CASE 2 | Suicide assessment

- Wishes to go to sleep and not wake up due to her anxiety
- Denies ever wanting to end her life or die
- No plan or intent
- Consistently future oriented and help seeking
- Multiple spontaneously identified protective factors

Additional History

- No history of psychiatric medications
- No substance-use history
- No family psychiatric history
- No prior hospitalization, self-harm, suicide attempt, or violence
- Denies IPV or trauma history
- No access to guns

Harm to infants | Assessment

- **Establish rapport**
- **Use non-judgmental language**
- **Provide psycho-education**
- **Ask every patient directly**

“Fear of child protective services involvement, fear of separation from the infant.... were generally considered “somewhat” important factors in deciding to seek treatment” [2]

“Some mothers have thoughts such as wishing their baby were dead or about harming their baby; has this happened to you?”



- Any plan, intent, preparation, or access to means?
- How do they feel about and respond to the thoughts?
- Any signs of psychosis?
- Additional risk factors?
- What does collateral say?

CASE 2 |

- Endorses intense fear daily that she will drown her 10-week-old child in the tub
- Insists she does not actually want to ever harm her child or do this

Intrusive thoughts of harm

- **Most women have at least one unwanted thought** related to harming her baby in the first postpartum month
- These obsessions resolved within the first several weeks postpartum & did not increase the risk of infant-harming behavior
- Often mistaken for homicidal ideation

[2, 3, 14]

Risk of Harm

OCD-related intrusive thoughts of infant harm, in the absence of other risk factors, are **not associated with an increased risk** of infant-directed aggression [14]

Active suicidality, psychosis, severe depression and substance use can **elevate risk** of maternal filicide [8, 9]

Risk of infanticide during an **untreated episode of postpartum psychosis** is estimated at **4%** [8, 10]

Thoughts of Harm to Infant

Postpartum Obsessions	Postpartum Psychosis
• Intrusive, unwanted, distressing • May engage in avoidance behaviors related to content of thought • May engage in compulsive behavior such as reassurance seeking or checking to ease distress/anxiety related to obsessions	• Associated with delusions or hallucinations • May be seen as an altruistic act • May feel compelled to act • Accompanied by other signs and symptoms of psychosis (i.e., disorganized behavior/thought process, impaired insight & reality testing)

[15,16]

CASE 2 | Additional information

- Highly distressed by the thoughts
- Avoids bath time to prevent feared harm, Partner provides all baths
- No psychotic symptoms on evaluation
- Collateral from partner + therapist supports without acute concerns
- No history of psychosis or mania
- No history of violence

Collateral

- **Very important aspect of a safety evaluation**
- Can help establish history and baseline, recent changes, medication adherence, substance exposure, and recent safety concerns
- Contact Options: Outpatient providers, family/friends, ED Referral Source, Police/EMS
- Disclose only what is necessary and permitted
- Document the disclosure, rationale, and process

Additional Safety Considerations

Intimate Partner Violence (IPV) [3, 8]

- Pregnancy is the 2nd most dangerous time in a violent relationship, and is a risk factor for dying by homicide
- Increased risk for suicide

Children in the home [8]

- Verifying location/safety of children
- Determine if referral to protective services is necessary

Social Determinants of Health [8]

- Childcare support
- Employment/maternity leave
- Medical care/ insurance
- Access to transportation, housing

CASE 2 | Disposition

- **Partial Hospitalization Program, ideally specialized in perinatal mental health**
- Coordinate with with Outpatient Team
- Stanley-Brown Patient Safety Plan [17]
- Psychoeducation
- Family/Friend Involvement
- Community Resources

"The simple lesson of my experience is that coordination between disparate parts of the mental health system is essential to avoid people falling through the cracks and ensuring the care they receive matches their needs."

CASE 3 |

Initial information

- 19 years old
- 2 weeks postpartum with first child
- Presents to the emergency department with her spouse due to insomnia and recent changes in behavior
- Infant with grandparents
- Breastfeeding

CASE 3 |

Patient reports:

- Anxiety, “great”, confusion
- Denies SI/HI or thoughts of harming child
- Denies hallucinations
- Song lyrics about how she is feeling are coincidentally playing on the radio
- Believes she does not need to eat or sleep as her baby is giving her the energy she needs

Spouse reports:

- dramatic change from baseline
- Nonsensical text messages
- Paranoia about visitors
- Talking about death / afterlife
- No food x 2 days
- ~2 hours sleep/night x 7 days

CASE 3 | Mental status

- Pressured speech
- Labile, euphoric / tearful affect
- Oddly related
- Tangential / intermittently disorganized
- Delusions
- Ideas of reference
- Responding to internal stimuli
- Limited insight / judgment

Postpartum Psychosis Work up [3]

Rule out medical, substance-related, and obstetric conditions

Test Considerations

- CMP
- magnesium
- phosphorus
- CBC
- LFTs
- TSH/T4 free
- vitamin B12
- Folate
- ANA
- Ammonia
- Ethanol
- UTOX
- UA
- RPR
- HIV
- Head imaging

Work up Considerations

- substance intoxication or withdrawal
- infection
- autoimmune process
- endocrine disorders
- eclampsia
- vitamin deficiency
- stroke
- urea cycle disorder
- sheehan's syndrome

CASE 3 |

Medical work up- negative

UTOX- negative

Ethanol- negative

Past medical history:

uncomplicated vaginal birth 2 weeks ago

Past psychiatric history:

Depressive episodes since age 18yo, last episode one year ago

One prior SSRI trial at age 18 which made her feel “too anxious”

No psychiatric medication but in weekly therapy

No known history of trauma

Denies substance use history

No history of suicide attempts, self harm, hospitalizations or violence

Past family psychiatric history

Father: Bipolar Disorder

Brother: alcohol use disorder

CASE 3 |

Most consistent with

Mania with psychotic features in the postpartum period

Postpartum psychosis = psychiatric emergency

Postpartum Psychosis (PPP)

- Incidence: 1–2 per 1,000 births
- Psychiatric emergency
- Increased risk of suicide and infanticide
- Personal or family history of bipolar disorder and/or postpartum psychosis increases risk
- About half of women who develop postpartum psychosis have no psychiatric history

[2, 4, 5, 6]

PPP Presentation

- Onset is usually rapid & within first 2 weeks PP
- No “classic” presentation & symptoms may wax and wane so obtain collateral

- Insomnia or decreased need for sleep
- Anxiety
- Mood fluctuations
- Restlessness
- Irritability
- Disorganized thoughts or behaviors
- Delusions
- Hallucinations
- Paranoia
- Impaired reality testing
- Delirium-like confusion
- Thoughts of harm to self or infant

[2, 3, 4]

PPP Acute treatment

- Recommend inpatient psychiatric care
- Lithium +/- Atypical antipsychotic & can also utilize benzodiazepines as needed for sleep/agitation
- Consider ECT
- Restore sleep

PPP Additional Care Considerations

- Ask about breastfeeding goals
- Provide access to pumping / lactation support when appropriate
- Plan infant visits and family involvement

"My one reservation about my treatment was the emphasis on "breast is best for baby". Expressing milk in the middle of a psychotic episode, at all hours of day and night, added unnecessary stress at a time when I desperately needed calm and rest."[3]

"About one-third of those who were breastfeeding or pumping at the time of hospital admission weren't given access to a breast pump during their hospitalization"[2]

"most participants did not have access to their infant during their hospitalization"[2]

PPP Additional Care Considerations

- Identify outpatient psychiatric follow-up
- Coordinate with OB / primary care / pediatric care as appropriate
- Provide psychoeducation for relapse prevention
- Connect patient to perinatal community resources

“Just over half of participants were not told about self-help or support groups and wanted more information to manage their PP”[2]

Perinatal Mental Health Resources

- **Massachusetts General Hospital Center for Women's Mental Health** — perinatal psychiatry information, research, and consultation

- **MotherToBaby** — website with evidence-based medication and exposure information

- **National Network of Perinatal Psychiatry Access Programs**

- **Postpartum Support International** — support groups, education, and provider resources/training

National Suicide & Crisis Hotline

- 988
- 24/7, free

National Maternal Mental Health Hotline

- 1-833-852-6262
- 24/7, free

National Domestic Violence Hotline:

- 1-800-799-SAFE (Voice) | 1-800-787-3224 (TTY)
- 24/7, free

References | Patient experiences

- [1] Vanderkruik R, Kobylski LA, Dunk MM, Arakelian MH, Gaw ML, Dineen H, Kanamori M, Freeman MP, Cohen LS. The lived experiences of individuals with postpartum psychosis: a qualitative analysis. *J Affect Disord*. 2024;348:367-377. doi:10.1016/j.jad.2023.12.069
- [2] Kobylski LA, Arakelian MH, Freeman MP, Gaw ML, Cohen LS, Vanderkruik R. Barriers to care and treatment experiences among individuals with postpartum psychosis. *Arch Womens Ment Health*. 2024;27:??-??. doi:10.1007/s00737-024-01447-z
- [3] Jones A. High as a kite: motherhood and psychosis. *Lancet Psychiatry*. 2025;12(10):734-735. doi:10.1016/S2215-0366(25)00236-6
- [4] De Backer K, Pali A, Challacombe FL, Hildersley R, Newburn M, Silverio SA, Sandall J, Howard LM, Easter A. Women's experiences of attempted suicide in the perinatal period (ASPEN-study): a qualitative study. *BMC Psychiatry*. 2024;24(1):255. doi:10.1186/s12888-024-05686-3

References | Case 1

- [1] Allen MH, Currier GW, Carpenter D, Ross R, Docherty JP. Guideline 2: Appropriate emergency interventions. *J Psychiatr Pract*. 2005;11(Suppl):29-31.
- [2] Aftab A, Shah AA. Behavioral emergencies: special considerations in the pregnant patient. *Psychiatr Clin North Am*. 2017;40(3):435-448.
- [3] Woo MY, Gantioque R. An obstetric and psychiatric emergency: managing acute agitation among pregnant patients in the emergency department. *Adv Emerg Nurs J*. 2023;45(4):301-310.
doi:10.1097/TME.0000000000000485
- [4] Gartenberg KL, Levine A, Petrie M. Emergency department management of acute agitation in the reproductive-age female and pregnancy. *World J Emerg Med*. 2024;15(2):83-90.
- [5] Rodriguez-Cabezas L, Clark C. Psychiatric emergencies in pregnancy and postpartum. *Clin Obstet Gynecol*. 2018;61(3):615-627.
doi:10.1097/GRF.0000000000000377. PMID:29794819; PMCID.

References | Case 2

- [1] Aftab A, Shah AA. Behavioral emergencies: special considerations in the pregnant patient. *Psychiatr Clin North Am*. 2017;40(3):435-448.
- [2]] Policy Center for Maternal Mental Health. Maternal suicide issue brief 2025. Published 2025. [Maternal Suicide Issue Brief 2025](#)
- [3] Rodriguez-Cabezas L, Clark C. Psychiatric emergencies in pregnancy and postpartum. *Clin Obstet Gynecol*. 2018;61(3):615-627. doi:10.1097/GRF.0000000000000377
- [4] Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry*. 1987;150:782-786.
- [5] Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16(9):606-613. doi:10.1046/j.1525-1497.2001.016009606.x
- [6] Posner K. Columbia-Suicide Severity Rating Scale (C-SSRS). PsycTESTS Dataset. Published 2007. doi:10.1037/t52667-000
- [7] American Psychiatric Association. Practice guideline for the assessment and treatment of patients with suicidal behaviors. *Am J Psychiatry*. 2003;160(11 Suppl):1-60.
- [8] Rork C. Assessing safety. In: Perinatal PCL Psychiatrists, eds. *Perinatal Mental Health Care Guide*. Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine; 2024:28-44.
- [9] Hatters Friedman S, Resnick PJ. Child murder by mothers: patterns and prevention. *World Psychiatry*. 2007;6(3):137-141.
- [10] Brockington I. Suicide and filicide in postpartum psychosis. *Arch Womens Ment Health*. 2017;20(1):63-69. doi:10.1007/s00737-016-0675-8
- [11] Luykx JJ, Di Florio A, Bergink V. Prevention of infanticide and suicide in the postpartum period—the importance of emergency care. *JAMA Psychiatry*. 2019;76(12):1221-1222. doi:10.1001/jamapsychiatry.2019.1929
- [12] Bergink V, Rasgon N, Wisner KL. Postpartum psychosis: madness, mania, and melancholia in motherhood. *Am J Psychiatry*. 2016;173(12):1179-1188. doi:10.1176/appi.ajp.2016.16040454
- [13] Maternal Mental Health Leadership Alliance. (2026, September). *Suicide and maternal mental health fact sheet*. <https://static1.squarespace.com/static/637b72cb2e3c555fa412eaf0/t/6aa190a94f719156e73f6c8a/1788973225992/Sep+2026+-+Suicide+and+Maternal+Mental+Health+Fact+Sheet.pdf>
- [14] Fairbrother N, Collardeau F, Woody SR, Wolfe DA, Fawcett JM. Postpartum Thoughts of Infant-Related Harm and Obsessive-Compulsive Disorder: Relation to Maternal Physical Aggression Toward the Infant. *J Clin Psychiatry*. 2022 Mar 1;83(2):21m14006. doi: 10.4088/JCP.21m14006. PMID: 35235718.
- [15] Toor R, Wiese M, Croicu C, Bhat A. Postpartum Psychosis: A Preventable Psychiatric Emergency. *Focus (Am Psychiatr Publ)*. 2024 Jan;22(1):44-52. doi: 10.1176/appi.focus.20230025. Epub 2024 Jan 12. PMID: 38694156; PMCID: PMC11058913.
- [16] Osborne LM. Recognizing and managing postpartum psychosis: a clinical guide for obstetric providers. *Obstet Gynecol Clin North Am*. 2018;45(3):455-468. doi:10.1016/j.ogc.2018.04.005
- [17] Stanley-Brown Safety Planning Intervention. Published February 1, 2022. Accessed June 29, 2024. [Stanley-Brown Safety Planning Intervention](#)

References | Case 3

- [2] Rodriguez-Cabezas L, Clark C. Psychiatric emergencies in pregnancy and postpartum. *Clin Obstet Gynecol*. 2018;61(3):615-627. doi:10.1097/GRF.0000000000000377
- [3] Toor R, Wiese M, Croicu C, Bhat A. Postpartum Psychosis: A Preventable Psychiatric Emergency. *Focus (Am Psychiatr Publ)*. 2024 Jan;22(1):44-52. doi: 10.1176/appi.focus.20230025. Epub 2024 Jan 12. PMID: 38694156; PMCID: PMC11058913.
- [4] Hendrick V, Mergler R. Postpartum psychosis: a primer. *The Carlat Hospital Psychiatry Report*. 2023.
- [5] Cohen LS, Arakelian M, Church TR, et al. The phenomenology of postpartum psychosis: preliminary findings from the MGH Postpartum Psychosis Project. *Mol Psychiatry*. 2024
- [6] Bergink V, Akbarian S, Byatt N, et al. Postpartum psychosis and bipolar disorder: review of neurobiology and expert consensus statement on classification. *Biol Psychiatry*. 2026;99(9):740-747.