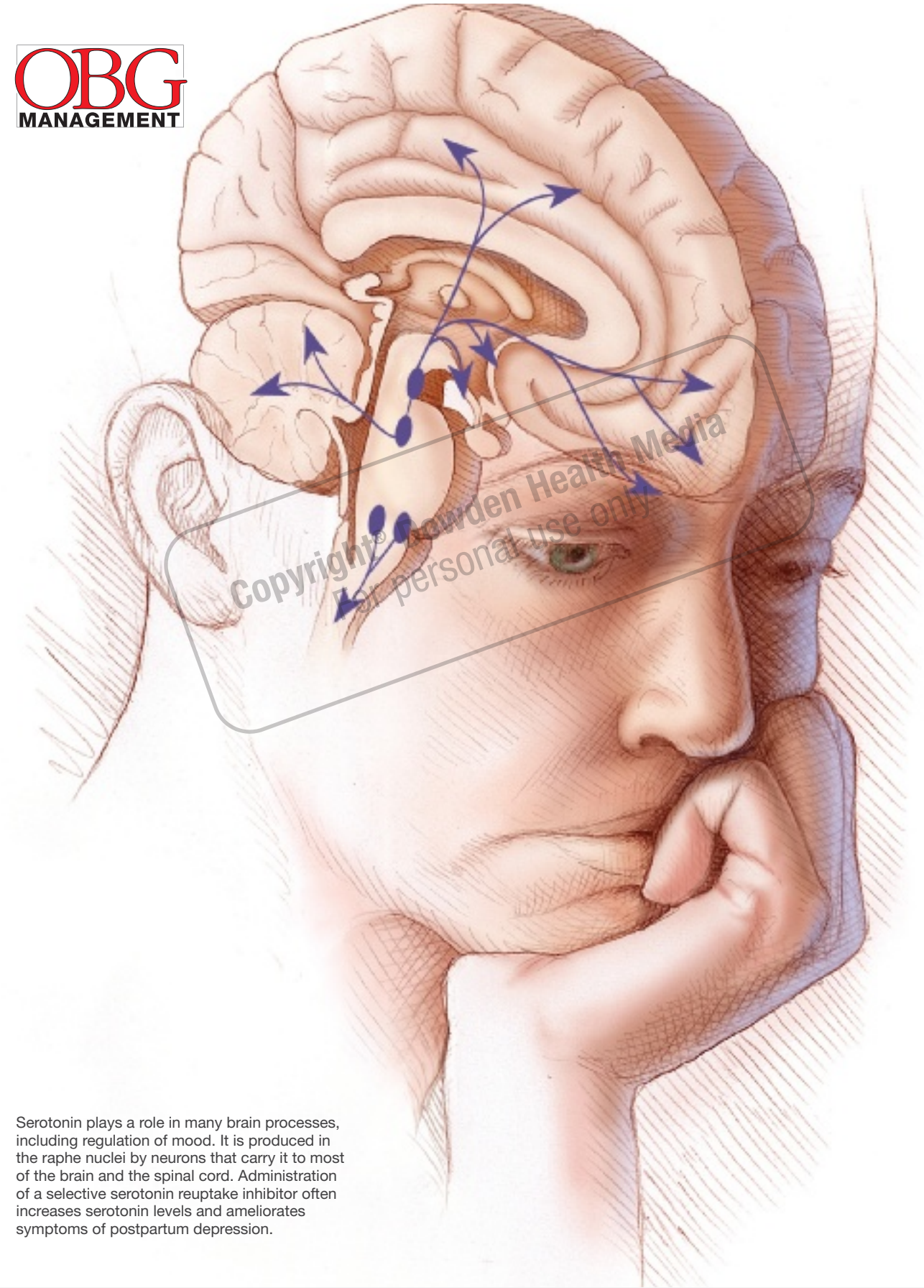
OBG MANAGEMENT



Serotonin plays a role in many brain processes, including regulation of mood. It is produced in the raphe nuclei by neurons that carry it to most of the brain and the spinal cord. Administration of a selective serotonin reuptake inhibitor often increases serotonin levels and ameliorates symptoms of postpartum depression.

LIFE ON CALL

Does your OB patient have a psychiatric complaint? And can you manage it?

Here's how to handle 5 challenges, including postpartum depression, an attempt to leave the hospital against advice, and denial of pregnancy

Susan Hatters Friedman, MD

Dr. Friedman is Senior Instructor, Departments of Psychiatry and Pediatrics, Case Western Reserve University School of Medicine, Cleveland, Ohio. She is on sabbatical at the Mason Clinic, Waitemata District Health Board, Auckland, New Zealand.

Jaina Amin, MD, BSN

Dr. Amin is affiliated with the Department of Psychiatry, Case Western Reserve University School of Medicine, Cleveland, Ohio.

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There's a full moon tonight—and you're the obstetrician on call. Not that you should expect any more funny business than usual. Despite stories of werewolves and other deviants coming out of the woodwork, there is no "full moon effect"—at least not one that can be documented. Nevertheless, chances are good that you will encounter at least one of the following psychiatric challenges as you end your day in the clinic and move on to an extended vigil:

- postpartum depression
- leaving against medical advice
- agitation
- antenatal illicit drug use
- denial or concealment of pregnancy.

In this article, we describe the management of these challenges and make recommendations to help increase your comfort level with patients who exhibit psychiatric problems. In some situations, our suggestions may help you manage the problem without a psychiatric consult.

Postpartum depression

CASE 1

Is it just the blues?

It is the end of your day in the clinic, and your last patient is a 30-year-old G3P3 who is 6 weeks postpartum. She describes repeated tearful episodes over the course of several weeks, decreased concentration, and poor appetite. She feels guilty because she is tired all the time and not bonding with her baby. She denies having suicidal or

IN THIS ARTICLE

TABLE 1 SIG: E CAPS—a mnemonic to assess for depression[1]

Decreased (sometimes increased) **S**leep
Decreased **I**nterests
Feelings of **G**uilt
Decreased **E**nergy
Decreased **C**oncentration
Decreased (sometimes increased) **A**ppetite
Psychomotor retardation, slowness
Suicidal thoughts, plans, or intent

homicidal thoughts, or any hallucinations. She had expected her energy to return to normal over the first few postpartum weeks, but it has not. She is worried because she will soon be returning to work as a medical resident.

Does this patient have postpartum depression? Or is it another condition with overlapping symptoms?

FAST TRACK

The differential diagnosis for altered mood in the postpartum period includes depression, baby blues, postpartum psychosis, and bipolar disorder

If a mother tells you that she is suicidal or having thoughts of harming her child or others, she should be sent immediately to the nearest emergency department for psychiatric evaluation. Short of such a dramatic situation, how do you know when you should manage a patient's depression on your own and when she should see a psychiatrist? Thorough assessment is the key.

Don't mistake transient feelings for depression

Transient feelings of sadness, bereavement, and grief are not the same as depression, which must last 2 weeks or longer to confirm the diagnosis.

A quick mnemonic for symptoms of depression is SIG: E CAPS (as if writing a prescription for energy capsules) (**TABLE 1**).[1] This mnemonic helps remind you to assess the patient's sleep, interest, guilt, energy, concentration, appetite, and psychomotor function, as well as identify any suicidal ideation.

It is important to assess a woman's sleep and appetite in addition to mood. However, differences may be difficult to ascertain due to normal changes in the postpartum period. One useful question is whether the mother is able to sleep when the baby sleeps. If she isn't, this wakefulness may be a symptom of depression.

The Edinburgh Postnatal Depression Scale is an easy, 10-question screening tool that is completed by the patient; it can be used both during pregnancy and postpartum. It is available on the Web at a number of sites, including www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf.

Differential diagnosis

Besides postpartum depression, the differential diagnosis for altered mood in the postpartum period includes several entities.

Baby blues generally occurs quite soon after birth and resolves within 2 weeks. It involves crying, emotional lability, and irritability.[2] It occurs in around 50% to 75% of new mothers (compared with postpartum depression, which affects 10% to 20%).[3–5]

Postpartum psychosis often involves the onset of psychotic symptoms within 1 week after delivery. The patient may exhibit both mood symptoms and psychosis. For example, she may believe that the baby is not hers or hear voices commanding her to kill the baby or warning her not to trust her healthcare providers.[6] Postpartum psychosis has a prevalence of about 0.2%.[3–6]

This psychosis can be organic in nature or can arise from a preexisting mood disorder or schizophrenia. Because treatment varies, depending on the cause, a thorough medical workup is needed.

Bipolar disorder may present as depression, but it also consists of manic periods of elevated, expansive, or irritable mood that last several days to weeks. Many symptoms appear to be the opposite of depression, such as increased energy and elevated self-esteem.[7,8]

It is important to consider bipolar disorder in the differential diagnosis. If a woman who has unrecognized bipolar disorder is given an antidepressant, a manic state could be precipitated. Women who have bipolar disorder require different drugs than women who have depression only, and they should be evaluated by a psychiatrist, at least initially.

Start treatment as soon as possible

Once you confirm that the patient has postpartum depression—and not another psychiatric disorder—prescribing an antidepressant may be the next step. Keep in mind that these drugs take several weeks before their benefits are felt. Therefore, it is best to start an antidepressant before depression becomes severe. The mother may also benefit from psychotherapy.

The selective serotonin reuptake inhibitor sertraline (Zoloft) is a reasonable first choice in pregnancy and lactation when the depression is of new onset.[9,10] Start it gradually (e.g., 25 mg for sertraline, which can cause nausea if it is initiated too rapidly) and titrate it over time, if necessary. When there is comorbid anxiety, it sometimes is helpful to prescribe low dosages of lorazepam (Ativan, Temesta) on an as-needed basis, while the patient is waiting for the antidepressant to "kick in." Also consider follow-up—do you plan to follow her frequently or refer her to psychiatry?

Remember to discuss the risks, benefits, side effects, and alternatives of antidepressant medication—and document that you have done so. In addition, discuss medication specifically in regard to lactation. Consultation with pediatrics is optimal.

Adjunctive or alternative options include psychotherapy, group therapy, and music therapy. Referral to a psychiatrist is warranted if the patient does not respond to the initial antidepressant agent.

Also be aware that untreated depression can become so severe that a woman can begin to experience psychosis, warranting rapid referral. Also refer any woman who reports a complex history of previous depression—unless the previous episode was easily controlled with a medicine safe for use during pregnancy and lactation.

If the patient is not lactating, a greater range of agents may be considered. (A full discussion of the risks and benefits of antidepressant use in pregnancy is outside the scope of this article. The interested reader is referred to an article on the subject by Wisner and colleagues.[11])

CASE 1 RESOLVED

A comprehensive discussion with the mother reveals that she is suffering from postpartum depression. No history of bipolar or psychotic symptoms is discovered. After discussing treatment options, you prescribe sertraline. Over the next 2 months, the patient's symptoms improve, and she bonds with her infant and successfully returns to work. She is also referred to a psychologist to work through some underlying issues.

Leaving against medical advice

CASE 2

Patient threatens to leave the hospital

At midnight, you are paged to attend to a 32-year-old G1P0 at 27 weeks' gestation who is threatening to leave against medical advice. She was admitted earlier in the day with uncontrolled gestational diabetes and is refusing her insulin.

How do you respond?

Use the relationship that you have established with this patient to the best of your ability. Make sure that you have explained fully, and in language she can easily comprehend, the reasons she needs to stay for treatment.

Don't overlook the obvious, either: Why does she want to leave? Sometimes the reason makes sense (e.g., one mother wanted to leave to protect her daughter from an abusive husband). Other reasons may be related to psychosis, addiction, lack of sleep in the hospital, or a desire to smoke, drink, or use drugs. Can you convince her to postpone her decision until morning, when her physician will be available?

It is important to document in the medical record your explanations and her reasoning. Can she coherently verbalize an understanding of the consequences of her decision to leave, including the risks and implications to herself and the fetus?[12] Can she describe alternatives and the reasoning against them?

If she is able to do these things, and you find her thought processing and reasoning to be lucid, then she may have the capacity to leave against medical advice. Keep in

FAST TRACK

Untreated depression can become so severe that a woman begins to experience psychosis or suicidality

TABLE 2 5 steps to sound management of a patient who wants to leave against medical advice

1. Ask the patient why she wants to leave *now*
2. Inform her of the risks to herself and to her fetus
3. Ask her to verbalize the risks to herself and to her fetus
4. Determine whether the patient's request is rational • If it is, call the hospital's attorney at once; forms may need to be signed • If it isn't, and she is not convinced to stay, complete an emergency detention form; in addition, you may need to contact psychiatry, security, and the hospital's attorney
5. Document the medical explanation and reasoning in the chart

FAST TRACK

If a patient is irrational, wants to leave the hospital, and lacks the capacity to make such a decision, you may need to contact the hospital's attorney and complete an emergency detention form

mind that rational persons do have the right, constitutionally, to refuse treatment, even if doing so will lead to morbidity. (A Jehovah's Witness who refuses treatment is the typical example.[12]) Contact the hospital's attorney—tonight—and document that you did so. The attorney may recommend that the patient sign a letter stating that she recognizes the maternal and fetal risks of leaving.

Sometimes a patient must be held against her will

Some mothers lack the capacity to refuse treatment. They may be unable to verbalize an understanding of the situation and its risks. Their reasoning may be abnormal, with disorganized or delusional thinking, or both. The patient may be tangential or talk "in circles" rather than answer your questions.

Try to ascertain whether mood symptoms are contributing to her irrational thinking. For example, is her rationale for going home—"just to be with my husband because I don't want to be alone"—due to her depression, despite the risk to herself and the fetus? Try to be flexible and creative. For example, you could call the husband and ask him to come to the hospital to sit with the patient.

Is the patient psychotic? For example, does she believe she has to leave now because the staff has been replaced by aliens who plan to kill her and her fetus? If so, you have the authority to continue her hospitalization—but contact the psychiatry department for medication recommendations. A urine toxicology screen would also be prudent.

If the patient is irrational and lacks the capacity to decide whether to stay or leave, document your conversation with her, as well as the reasoning behind your decision to intervene further. Other steps include:

- contacting the hospital's attorney
- completing an emergency detention form
- calling security
- ensuring that the patient's environment is safe for her and others (**TABLE 2**).[13]

If the patient is psychotic or delirious, look for organic causes and treat her to maintain her safety (*see Case 3*).

CASE 2 RESOLVED

After building some rapport with the patient, you ask why she wants to leave right now. During this conversation, the patient reveals that she has not slept in three nights, and says she believes that the insulin is keeping her up. You are able to assure her that this is not the case and offer her something to help her sleep. She decides not to leave against medical advice.

Unexplained agitation

CASE 3

Patient becomes abusive

At 1 AM, you are called to the seventh floor, where a 20-year-old G2P1 at 26 weeks' gestation is yelling at staff and hitting anyone who comes near. She was admitted earlier in the day for management of threatened abortion and a dilated cervix. She has no documented psychiatric history, but is flushed, disheveled, and hostile, accusing the staff of sabotaging her life, and is seen picking at imaginary things. You notify psychiatry, but no one is available.

What do you do?

Determining the origin of these symptoms will help determine the appropriate course of action. Among the possibilities are:

- drug intoxication or withdrawal
- delirium
- psychosis
- a chronic problem such as a personality disorder (**TABLE 3**).

TABLE 3 Some causes of agitation

Delirium
- fever, metabolic abnormality, or infection
- abrupt discontinuation of home narcotics/ illicit substances

Psychosis
- substance-induced (administration of narcotics, steroids, or illicit drugs)
- abrupt discontinuation of home narcotics/ illicit substances

Dementia
- HIV/AIDS encephalitis

Personality dysfunction
- poor coping skills exacerbated by the high stress of being hospitalized

Delirium is an acute disturbance of consciousness, with vacillating periods of clarity and confusion, often with agitation, and sometimes accompanied by visual hallucinations. Delirium has an organic rather than psychiatric cause; therefore, it is treated medically. Among the causes are fever, metabolic abnormality, and infection.

Psychosis means that a patient is out of touch with reality. A psychotic patient may experience delusions, auditory and visual hallucinations, and gross disorganization. Brief psychotic episodes usually last for 1 day to 1 month, with eventual recovery to premorbid functioning.[7]

Substances such as medications or illicit drugs also can induce psychosis. Major offenders include steroids and narcotic agents. Alternatively, sudden withdrawal of illicit substances (due to hospitalization) could manifest as delirium or psychosis.

Personality disorder. If the patient's behavior is not new but a long-term problem, she may have a chronic personality disorder rather than acute illness. Personality problems involve pervasive response patterns and dysfunctional coping patterns that affect daily life. For example, a patient who has borderline personality disorder may have emotional instability presenting as intense episodic dysphoria or irritability. Such patients have a hard time empathizing with others, poor impulse control, and a de-

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sire for instant gratification. They may also misinterpret the behavior of other people and take offense easily as a result. Lacking stress-management skills, they regress to unhealthy defense mechanisms such as acting out, complaining, passive aggressiveness, and splitting of the staff (thinking that people are all good or all bad).

Dementia may also be on the differential diagnosis, but this chronic condition is unlikely in such a young patient (unless she were in the late stages of HIV/AIDS, for example). Dementia has a gradual onset and is irreversible.

Workup for the agitated patient

Assess vital signs and basic laboratory studies, particularly a complete blood count, thyroid testing, metabolic screens, glucose, serum chemistry panel, and urine toxicology, to rule out causes of delirium and detect any substances the patient may have used. Also consider that the patient may have initiated a new medication recently.

Imaging of the brain or chest or electroencephalography may be necessary, such as in the setting of infection or concerns regarding seizure activity.

Gather collateral information about the patient from her relatives, friends, and the support staff. Search her chart for recent contacts. Did she have a visitor or phone call that may have upset her? Explore whether she is having problems with her partner or family and friends. Also confirm that her agitated behavior is an acute change.

Investigate the patient's paranoia. Why does she believe that the staff is against her? Does she believe they are trying to harm, kill, or poison her? Assess her reasoning to determine whether her behavior is psychotic or a personality problem.

Ask her about hallucinations, keeping in mind that hallucinations are different from illusions, in which a patient misinterprets what she sees. What are the voices saying to her?

Also ask about any suicidal or homicidal commands. If she acknowledges that she is hearing them, get a sitter for her immediately and make her environment safe so that she

TABLE 4 Commonly abused drugs and their potential effects

Drug	Withdrawal effects on mother	Drug effects on fetus or infant
Alcohol	Sweating, increased heart rate, hand tremor, nausea/vomiting, physical agitation, hallucination (tactile, visual, auditory), illusions, grand mal seizures[25]	Fetal alcohol syndrome. Withdrawal symptoms similar to those of the mother
Cocaine	Agitation, anxiety, anger, nausea/vomiting, muscle pain, disturbed sleep, depression, intense cravings for the drug, irritability[25]	Risk of abruptio placenta, small-for-gestational-age infant, microcephaly, congenital anomaly (cardiac and genitourinary abnormality, necrotizing enterocolitis), central nervous system stroke or hemorrhage. Withdrawal effects include hypertonia, jitteriness, and seizures.[26]
Crystal methamphetamine	Anxiety, psychotic reaction, intense hunger, irritability, restlessness, fatigue, depression, sleep disturbance, cravings[25]	Premature birth, abruptio placenta, small-for-gestational age, hypertonia, tremors, poor feeding, abnormal sleep patterns[26]
Marijuana	Irritability, anxiety, physical tension, decreased appetite and mood[25]	Irritability, increase in bodily motility, tremors, startles, poor habituation to visual stimuli, abnormal reflexes, symptoms similar to mild withdrawal[27]
Opioids (Heroin, methadone)	Dilated pupils, watery eyes, runny nose, diarrhea, nausea/vomiting, muscle cramps, piloerection, chills or profuse sweating, yawning, loss of appetite, tremor, jitteriness, panic, insomnia, stomach ache, irritability[26]	Risk of prematurity, small-for-gestational age, adult withdrawal symptoms, irritability, hypertonia, wakefulness, jitteriness, diarrhea, increased hiccups, yawning and sneezing, excessive sucking and seizures. Withdrawal effects occur earlier in heroin-exposed babies than in methadone-exposed infants.[26]

is unable to harm herself. Then contact the psychiatry department again.

How to intervene

Talk gently and quietly in an attempt to calm the situation. Try to make yourself "small": Stand back and stay at the patient's eye level, not in her personal space or towering over her.

Also, protect yourself. Don't challenge her complaints immediately or you will alienate her. Medically evaluate and treat the cause of her agitation, and, if medications are necessary for psychosis or sedation, contact psychiatry for assistance.

CASE 3 RESOLVED

The patient does not respond to your attempts to reason and refuses to allow the nurses to check her vital signs. Security is called to stand by while her vital signs are reassessed. The nurses inform you that the patient's family is in the waiting room. Though you find no documented history of substance use or abnormal labs, the family reports that the patient had a history of alcohol abuse but quit drinking about 3 days earlier. They also report that, before she quit, she drank approximately 25 oz of vodka and a sixpack of beer nightly. They deny knowledge of any other illicit drug use. Because her vital signs suggest alcohol withdrawal, you offer oral lorazepam and treat her according to the hospital's alcohol withdrawal protocol. She recovers without any further complications and is referred to the chemical dependency service for evaluation.

Drug abuse during pregnancy

CASE 4

Patient skips prenatal care

It is 2 AM, and you are about to get some rest when you are paged by the emergency room about a 26-year-old G5P4, who is in active labor with no dates. You check the database and discover that her previous pregnancies were complicated by chronic substance abuse.

How do you respond?

You might feel frustrated and angry with this patient. Considering that you have not

met her, these feelings would be based on previous contacts with patients who had a similar history. This is **countertransference**. We all experience it. It can be helpful or harmful, but you cannot control it unless you are aware of it. Pay attention to the anger, happiness, or pride that a patient triggers in you, and acknowledge that it is your issue.

Your frustration may also stem from personal feelings about mothers who repeatedly expose their fetuses to drugs and neglect prenatal care, as well as anxiety about what you are legally and ethically bound to do.

In *Ferguson v City of Charleston*, the Supreme Court found that drug testing of a pregnant woman for the purpose of criminal prosecution is a violation of Fourth Amendment rights.[14] However, there have been cases in which a state prosecuted a woman for using an illegal substance during pregnancy. These cases involved:

- child neglect[15]
- delivery of a stillborn fetus whose autopsy revealed traces of cocaine by-products[16]
- reckless endangerment after a newborn tested positive for cocaine.[17]

In 2006, a California appeals court determined that "the crime of reckless endangerment does not apply to a pregnant woman's conduct with respect to the child she is carrying."[18] Other states have their own reporting criteria, as well as criteria for prosecution. It is important to know the reporting criteria for the state in which you practice.

FAST TRACK

Among the criteria for substance dependence are tolerance to the drug, withdrawal when the drug is cut back or stopped, and continued use of the drug despite evidence of its dangers

What is drug abuse?

According to the 4th edition of the *Diagnostic and Statistical Manual of Mental Health Disorders*, it is a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" within a 12-month period, or persistently.[7] To meet criteria for substance dependence, in addition to the criteria just mentioned, the individual must be tolerant to the drug, experience withdrawal when the drug is cut back or stopped, continue to use the drug despite knowledge of its dangers, or all of the above. Mothers who match this description often lose custody of their child—sometimes to foster care, sometimes to other family members.[20,21]

Some states use positive serum and urine toxicology as evidence to remove a child from the mother's custody.[19]

It is important to attempt to build a doctor–patient relationship. You cannot solve the patient's substance dependence problem in one night, but you can refer her to drug treatment. A urine toxicology screen can help you and the pediatricians know what the patient has been exposed to (**TABLE 4**, page 51).

CASE 4 RESOLVED

After delivery, a test indicates that the newborn has been exposed to cocaine. The mother admits to cocaine use during pregnancy. She says she did not seek prenatal care because she was afraid of being prosecuted and sent to jail. A social work consult is requested, and the mother is referred to a substance abuse treatment program. State law requires the case to be reported to child protective services. Upon hospital discharge, the newborn is initially placed with the paternal grandmother.

Denial of pregnancy

CASE 5

Patient's labor takes her by surprise

The night is nearing its end, but it isn't over yet. At 5:30 AM, you are called to a precipitous delivery involving a 17-year-old who has had no prenatal care. She denies knowing that she was pregnant, and says she thought her labor pains were a bowel movement. Her parents were similarly unaware that their daughter was pregnant, and are threatening to disown her.

How do you defuse the situation?

In a study of women who denied or concealed pregnancy, patients presented to the hospital for various reasons.[22] For example, one woman went to the ER because she was seizing and her workup revealed that she had eclampsia. A number of women did not even recognize when they were in labor. The infants born to these women are at risk for a poor neonatal outcome.[21,22]

How can psychiatry help in such a case?

By determining whether the patient denied her pregnancy—even to herself—or actively concealed it from others. Obviously, these circumstances have differing implications.

Denial is not a simple entity. It may involve a psychotic schizophrenic woman who is out of touch with the reality of her pregnancy; a woman who "affectively" denies her pregnancy, keeping the significance of her condition from herself and behaving as though she is not gravid (perhaps because she plans to give the baby up for adoption); or a woman who has pervasive denial and does not know that she is pregnant.[22,23] In contrast, a woman who conceals her pregnancy is quite aware that she is gravid but consciously hides the gestation from others, begging the question of what she had planned for the future.[22]

Psychological issues abound, and may include a history of sexual and psychological trauma, an attempt to avoid religious prohibitions against unwed intercourse, anger at the father of the infant, and even homicidal urges toward the baby.[24] There may be more going on under the surface than "only" a failure to recognize the pregnancy, and the patient may need further mental health treatment.

Consider how well this young woman can be a mother. When she did not even recognize that she was pregnant for 9 months, how well will she be able to attend to her baby's needs? Psychiatry can evaluate the patient to help determine her capacity for parenting and whether child protective services should be alerted. Of additional concern is the distress of the patient's parents. Family support will be extremely important.

Be sure to conduct thorough contraceptive education and planning at the time of discharge because this patient is at risk for future denied or concealed pregnancies.[22]

CASE 5 RESOLVED

The patient is seen by psychiatry. She has no major mental illness, but her denial appears to be related to problems with her boyfriend, her attempts to be the perfect daughter, and fear of being disowned. After the initial shock, the patient's parents become more supportive and begin to bond with their new grandchild. The new mom is educated about birth control and agrees to follow up with a counselor and take parenting classes. The baby is discharged to his mother and grandparents.

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