Peripartum Agitation

Zoe Renner, MD & Laurel Pellegrino, MD

Peripartum Agitation

Peripartum Agitation Basics:

Definition: Combative and aggressive behavior, physical restlessness, or extreme irritability (1). Agitation in pregnancy is an **obstetric emergency** due to risk of harm to mother and/or baby/fetus.

Risks of untreated peripartum agitation: Preterm delivery, placental abnormalities, low birth weight, postnatal death, spontaneous abortion (3).

Determine the cause!

- Medical sources of agitation (2,3)
    - Delirium due to medical condition, amniotic or venous thromboembolism, pre-eclampsia/eclampsia, hyperthyroidism, trauma, infection, etc.
    - Substance Intoxication or Withdrawal
    - Pain
    - Traumatic Brain Injury (TBI)
- Psychiatric sources of agitation (2-4)
    - New onset vs exacerbation/decompensation of existing condition.
    - Abrupt discontinuation of psychotropic medications due to concern over fetal risk (1).
    - Post-partum psychosis
    - "Personality" characteristics, maladaptive coping patterns

Step 1: Verbal De-escalation & Behavioral Redirection

Verbal Strategies (2,3)

- Speak slowly in calm, low voice. Be concise.
    - Be present and genuine.
    - Convey empathy by listening, validating, and providing accurate reflections. *"It sounds like you are feeling overwhelmed for a lot of good reasons."*
    - Normalize emotions. *"I know you feel like ____ and that must be tough. Others in this predicament have also felt this way. In my experience, I have found that _____."*
- Identify wants/needs. *"What helps you at times like this?"*
- 'Agree' or 'Agree to Disagree.' Do not be provocative

Ensure safety of yourself, staff & scene (1)

- Ensure patient and the room are free of safety hazards/weapons.
- Remain at a safe distance from patient with clear exit from room.
- Alert appropriate security personnel and/or have mechanism for alerting additional staff/security.

Behavioral Strategies (2,3)

- Respect personal space
- Limit the number of people in the room. Use patient's preferred caregivers when possible.
- Keep the environment as "low stim" as possible
- Offer comfort items (warm blanket, food, etc.)
- Offer choices/options
- Pause if medically possible. *"Do you need to take a short break?"*
- Offer a PO medication *"I think you would benefit from medication" or "I think you need a medication."*

Step 2: Pharmacologic Intervention

Goal: Maintain safety of patient and providers during assessment and treatment

Choosing a medication:

- Never feel like you have to order a medication immediately. If unsure, go lay eyes on the patient.
- Choose medication based on most likely underlying cause of agitation when possible (ex. lorazepam for alcohol withdrawal, antipsychotic for psychosis, etc; 2,3)
- Limit number of medications. Give patients known medications first to limit exposures to fetus.
- Match IM/PO/IV medications.
- Consider onset of action
    - IV works the fastest: approximately 5-20 minutes.
    - PO generally takes at least 30 mins-1 hour.
- Choose a medication appropriate for the severity of agitation (3)
    - Mild: **PO meds**
        - Diphenhydramine 25 – 50 mg PO, IM (can worsen delirium)
    - Moderate: **Consider IV/IM**
        - Haloperidol 0.5 mg – 2 mg PO, IV, IM
        - Olanzapine 2.5 mg – 5 mg Rapidly dissolving, PO, IM (do not co-administer IM olanzapine and benzodiazepine; following IM olanzapine, wait at least one hour and monitor for respiratory depression prior to use of benzo)
        - Lorazepam 0.5 – 2 mg PO, IV, IM
    - Severe: **IV/IM**
        - Haloperidol +/- lorazepam +/- diphenhydramine

Administering medications:

- Offer PO first to honor autonomy.
- Use IM/IV only if refusal of PO, Danger to Self (DTS) and/or Danger to Others (DTOs).
- If does not have decisional capacity (ex. floridly delusional), okay to start with IV option.
- Start with PRN option. Recommend scheduling medications if persistent, regularly occurring agitation.
- Taper/Discontinue once agitation has resolved for a few days.
- Put in a not to exceed (NTE) in order.

Safety of Medications for Agitation in Pregnancy*

- Anti-psychotics
    - Most pregnancy data is on haloperidol, olanzapine, and quetiapine.
        - Haldol (1st gen) is less likely to have sedative or hypotensive effects than second gen (3) but more likely to have EPS.
    - One-time doses are generally low risk (1).
    - If frequent administration of anti-psychotics in 3rd trimester, newborns should be monitored for risk of neonatal EPS, sedation, breathing and feeding difficulties, increased/decreased muscle tone, agitation, tremor. These complications may resolve on their own or require additional hospitalization (7).
- Benzodiazepines
    - PO lorazepam has been safety administered during delivery of full-term infants, even at high doses. Use caution with IV lorazepam and in preemies (10).
    - If frequent administration during third trimester, monitor newborns for floppy baby or neonatal withdrawal syndrome (sedation, hypotonia, feeding difficulties).
- Contra-indicated: valproic acid (not generally used for acute agitation)
- Dosing: Medications metabolized by CYP P450 enzymes more rapidly metabolized during pregnancy and may require higher doses, including lorazepam, clonazepam, quetiapine.

**For more details about specific medications and effects during pregnancy, see table below.*

Step 3: Restraints as a last resort during pregnancy

Use as a **last resort** only if:

1. Imminent risk to mother, fetus/newborn, and/or staff
2. Failure of prior interventions/least restrictive options

DO: Use least restrictive options possible (fewer restraints the better). Continue frequent monitoring of patient/vital signs/fetal heart tones while in restraints. Ensure adequate comfort, hydration, nutrition, and medical stability throughout process. Limit/end restraints as much as possible.

DO NOT USE: abdominal restraints, restraints that increase risk of falling forward (wrist restraints behind the back), four-point restraints, restraints during labor & delivery, use out of convenience or punishment (5).

>20 weeks: Place pregnant patient partway to the left with support under the right hip – right hip should be 10-12 cm off the bed with supporting pillows/blankets. **Do not restrain in supine position or on right side** due to risk of inferior vena cava compression syndrome (hypotension, tachycardia, fetal distress due to compression vena cava, blocking flow of venous blood to the heart; 5).

Be mindful of implicit bias and thoughtful about escalation of interventions

Ethical Considerations & Decisional Capacity

Weigh **patient autonomy vs beneficence** to the birthing parent and baby.

Evaluate decisional capacity:

- Decisional capacity is evaluated on a moment-to-moment basis about each medical decision
- Patients have decisional capacity when they can:
    - Voice a clear and consistent **choice**
    - **Understand** the relevant medical information
    - **Appreciate** the situation and its consequences
    - Explain their **rationale**
- The stringency of this assessment depends on the risk-to-benefit ratio. A patient can **assent** to a life-saving procedure even if they do not have decisional capacity and therefore cannot complete full **informed consent**. This is an attempt to preserve patient autonomy.

If a patient **lacking decisional capacity** refuses treatment: (8,9)

- If possible, consult the hospital's clinical ethics team and legal counsel
- Determine whether the intervention is **medically necessary** (e.g. cesarean section for complete placenta previa) and whether it is **urgent/emergent**
- **Assisted decision-making:** If there is time, first attempt to restore capacity using verbal interventions, respectful persuasion, and pharmacologic interventions as necessary.
- **Surrogate decision-making:** If patient is still refusing, a legally designed surrogate or advance directives from the patient meet the **substituted judgment** standard.
- **Coerced clinical management:** If patient still cannot assent to medically necessary treatment, then proceeding with treatment can be ethically justified if nonintervention would cause more harm to the mother and/or baby. Continue to explain what is happening to the patient and attempt to minimize their stress/anxiety.

Peripartum Agitation Medications

Medication	Indications	Birthing parent Side Effects	Effects on Fetus	Starting Dose & Ranges	Onset of Action	Notes
Haloperidol (1st line if etiology of agitation unknown)	• Mod/Severe Agitation • Delirium/ Organic etiology • Primary Psych (ex. psychosis)	• EPS (higher risk) • Dystonia • Sedation • NMS • Anti-cholinergic Effects • QTc prolongation (worse with IV)	Risk of neonatal EPS for ongoing use; no data of increased risk from one time use. FDA warning (updated 2011) for EPS, sedation, breathing/ feeding difficulties, agitation, tremor, change in muscle tone; may resolve spontaneously or require additional hospital care.	• PO: 0.5-1 mg TID PRN • IV: 0.5 - 2 mg TID PRN • IM: 5 mg once time • Can increase to 4-20 mg/day • NTE: 20 mg/day	PO: 45 – 60 mins IV > IM: 15 – 30 mins	• Get EKG baseline to evaluate QTc. Continue to monitor with increased doses. • IV preferred over IM if IV available (IM higher risk of EPS) • IM: recommend giving with diphenhydramine 25 – 50 mg to prevent EPS
Olanzapine (alternative choice)	• Mod/Severe Agitation • Primary Psych • (ex. mood stabilization, psychosis)	• Sedation • Orthostatic hypotension • EPS • Metabolic syndrome		• PO: 2.5 – 5 mg PO or IM BID PRN • Can increase to 10-20 mg/day • NTE: 20 – 30 mg/day	PO: 30 mins – 1 hour IM: 15 – 30 minutes	• Get EKG baseline to evaluate QTc. Continue to monitor with increased doses. • Do not administer IM medication with benzodiazepine (risk of respiratory distress) • Highest placental transfer (72.1%)
Quetiapine (alternative choice)	• Primary psych (mood stabilization) • Delirium • Anxiety	• Sedation • Weight gain • Metabolic syndrome • Possible risk of increased gestational diabetes		• 25 – 100 mg PO • NTE: 300 mg daily for agitation		• Lowest possible placental transfer (3.7%)
Lorazepam (preferred benzo in pregnancy)	• Alcohol or Benzo withdrawal • Stimulant intoxication • AMS 2/2 NMS, serotonin syndrome, catatonia • Personality	• Sedation • Respiratory distress • Memory Impairment • Risk of falls/ • Incoordination • Tolerance • Dependence • Withdrawal	Exposure associated with “floppy baby” syndrome and neonatal withdrawal (requiring ICU admission); more likely from long term use	• 0.5 – 2 mg PO, IV, IM • up to 2-3 times daily • Increase as needed to 2-6 mg daily divided in doses • NTE: 10 mg/day in divided doses	PO: 15 – 30 mins IM, IV: rapid	• Black box warning: avoid use with opioids; abuse/misuse potential
Diphen-hydramine	• Mild agitation • Anxiety	• Sedation • Anti-cholinergic effects • GI distress • Impaired coordination	One case report of neonatal withdrawal symptoms (irritability, sedation, tremulous, diarrhea).	• 25 – 50 mg PO, IV, or IM • Q1-4 hours • NTE: 300 mg/day	PO: 15 – 20 mins IM, IV: rapid	• Dose dependent anti-cholinergic effect can make delirium worse

Peripartum Agitation References and Resources

1. Lisette, Rodriguez-Cabezas and Clark Crystal. Psychiatric Emergencies in Pregnancy and Post-Partum. Psychiatric emergencies in pregnancy and postpartum.pdf. *Clin Obstetrics gynecology Sept 2018.*
2. Wilson, Michael P, Kimberly Nordstrom, et al. Psychiatric Emergencies in Pregnant Women. http://dx.doi.org/10.1016/j.emc.2015.07.010. *Emergency Med Clin Elsevier Inc. 2015*
3. Niforatos, Joshua, Wanta, Jonathon, et al. How should I treat acute agitation in Pregnancy?. https://consultqd.clevelandclinic.org/how-should-i-treat-acute-agitation-in-pregnancy/
4. Aftab A, Shah AA., et al Behavioral emergencies: special considerations in the pregnant patient. *Psychiatry Clin North Am 2017; 40(3):435–448.*
5. Best Practices in the Use of Restraints with Pregnant Women and Girls Under Correctional Custody. https://www.ojp.gov/library/publications/best-practices-use-restraints-pregnant-women-and-girls-under-correctional. *Bureau of Justice Assistance. U.S. Department of Justice. 2014.*
6. Garriga, Marina, Pachiarotti, Isabella, et al. Assessment and management of agitation in psychiatry: Expert consensus. https://pubmed-ncbi-nlm-nih-gov.offcampus.lib.washington.edu/26912127/. World J Biology Psychiatry. 2016.
7. Yan, Jun. FDA extends Black-Box Warning to All Anti-psychotics. https://psychnews.psychiatryonline.org/doi/10.1176/pn.43.14.0001. Psychiatry News, American Psychiatric Association. Jul 18, 2008.
8. McCullough LB, Chervenak FA, Coverdale JH. Managing Care of an Intrapartum Patient with Agitation and Psychosis: Ethical and Legal Implications. AMA J Ethics. 2016 Mar 1;18(3):209-14. doi: 10.1001/journalofethics.2016.18.3.ecas2-1603. PMID: 27002991.
9. Babbitt KE, Bailey KJ, Coverdale JH, Chervenak FA, McCullough LB. Professionally responsible intrapartum management of patients with major mental disorders. Am J Obstet Gynecol. 2014 Jan;210(1):27-31. doi: 10.1016/j.ajog.2013.06.024. Epub 2013 Jun 18. PMID: 23791565.
10. Whitelaw AG, Cummings AJ, McFadyen IR. Effect of maternal lorazepam on the neonate. Br Med J (Clin Res Ed). 1981 Apr 4;282(6270):1106-8. doi: 10.1136/bmj.282.6270.1106. PMID: 6113019; PMCID: PMC1505046.
11. Black JR, Hovis E, Spada ML, Li L. CL Case Conference: Managing Substance Use and Agitation in Pregnancy. J Acad Consult Liaison Psychiatry. 2025 Feb 18:S2667-2960(25)00024-2. doi: 10.1016/j.jaclp.2025.02.002. Epub ahead of print. PMID: 39978638.