Treating psychosis in pregnant women: A measured approach

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The peak age of onset of schizophrenia coincides with the peak childbearing age of 25 to 35 years.[1] So it would not be unusual for your patient with schizophrenia to tell you she is trying to get pregnant, or thinks she might be pregnant. In these situations, you must carefully weigh the risks to the mother (eg, relapse, complications) and to the fetus (eg, possible miscarriage, teratogenesis) when deciding whether to continue or change her treatment regimen. When faced with making these decisions, keep the following factors in mind.

1. Most importantly: Do not make knee-jerk changes. Do not suddenly stop medications. Proceed in a thoughtful and measured way.

2. Discuss the risks with your patient. There is no such thing as a risk-free decision. There are potential risks from untreated psychosis as well as from medications. Mothers with untreated psychosis have an increased risk of suicide and violence, as well as poor self-care. Schizophrenia may be associated with an increased risk of poor birth outcomes, including preterm delivery, low birthweight, and neonatal complications.[2] Avoid making absolute statements about specific medications during pregnancy; there needs to be an individualized risk-benefit discussion for each patient, and for each medication.

3. Involve the patient's partner and family in treatment planning if possible. The patient's family can be important in promoting mental health during pregnancy and the postpartum. Educating the family as well as the patient regarding medications and the risks of untreated mental illness can go a long way toward compliance.

4. Do not rely on what pregnancy category a medication was. There are multiple dimensions to evaluate when considering the use of an antipsychotic agent during pregnancy. Does it increase the risk of miscarriage? Malformations? Preterm birth? Perinatal toxicity? Behavioral teratogenesis (neurodevelopmental sequelae)? Looking for a simple summary or single letter grade minimizes the understanding of the specific outcome of concern in the specific mother. Instead, look at the Pregnancy section under Use in Specific Populations on the medication's package insert (prescribing information), consult a web site such as MotherToBaby (mothertobaby.org/healthcare-professionals/), and/or search for the latest research on PubMed.

5. Collaborate with the patient's obstetrician or family medicine physician. Make sure that you are on the same page regarding treating the patient's psychosis. Other clinicians often will agree with your treatment plan because they understand the risks of untreated psychosis compared with other risks the patient is facing. However, if you don't communicate with your patient's other health care professionals, she might receive mixed messages.

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6. As for medication choice, pregnancy is the most important time to conduct a careful medication history to inform your choice of medication. Was Medication X ineffective, or did the patient not pick it up from the pharmacy? Did she really have a trial of 3 months, or did she only take it for a week before she decided to stop?

7. Determine which medication has worked for the patient in the past. If Medication Y worked before she was pregnant, it is likely to still work during pregnancy. If it is a relatively safe option, it may be the best choice.

8. Avoid multiple medication exposures wherever possible. If a patient is taking Medication Z, it is working, and she tells you she is 3 months pregnant, it is often better to continue it (assuming it is a relatively safe medication) than to switch to Medication A, which has slightly better "safety data." By switching to a different antipsychotic, you would be exposing the fetus to a second agent that may not even work for the mother.

9. Focus on treating the patient's present symptoms. Medication doses may need to change due to pregnancy-related changes in symptoms, drug distribution, and/or metabolism.

10. Remain vigilant for other risks. Keep in mind that pregnant women with psychosis often face risks other than psychiatric medications and psychosis. Comorbidities such as substance use disorders, obesity, and poor prenatal care must also be addressed.[3]

11. Follow your patient more closely during pregnancy. Pregnancy is an uncertain time for any new mother. Be sure to have an open line of communication with the patient, and be responsive to her concerns.

12. Provide psychoeducation about the postpartum period. Pregnancy is the time to educate your patient about the importance of sleep, warning signs of exacerbation of psychosis, and breastfeeding safety.

13. Be proactive with future female patients of childbearing age, regardless of whether they tell you they are sexually active. Women with psychosis have higher rates of unplanned pregnancy.[3,4] When initiating treatment of psychosis in a woman of childbearing age, rather than treating her with the newest available medication that does not yet have safety data in pregnancy, it is best to start with a medication already known to be relatively safe in pregnancy. This way, if she were to become pregnant, your treatment plan would already be safe and appropriate.

14. Consult a reproductive psychiatrist if needed.

Communicate with your patient's other health care professionals so she does not receive mixed messages about her care

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