Perinatal Anxiety

Anxiety in Pregnancy
Case Conference
Facilitator Guide

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Overview

Having anxious thoughts during pregnancy is a common phenomenon and typically requires no treatment beyond providing support. However, for some women, symptoms can become impairing enough to meet criteria for an anxiety disorder, which can have implications for both mother and baby. Anxiety disorders in the perinatal period are common and treatable. This module will focus on the clinical presentation of anxiety disorders in pregnancy and postpartum. These cases will highlight the challenge of differentiating between "normal" and pathologic anxiety and specific ways anxiety may manifest during the prenatal period, reviewing pharmacologic and nonpharmacologic treatment options and ways to discuss these with patients. These cases will also review the different psychosocial factors that can contribute to anxiety in pregnancy and reflect upon how anxiety can manifest itself with these factors in consideration. Lastly, this module will focus on an integrative approach to the treatment of anxiety and distress in pregnancy, encompassing biological, psychological, and social interventions.

Pre-session assignment

Before attending this session, please review the Perinatal Anxiety Disorders Self-Study guide.

Session

- **Review self-study materials (10 min)**
- **Apply knowledge to a new case (40 minutes)**
- **Wrap-up (10 minutes)**

Learning Objectives

By the end of this module, the learner will be able to:

1. Recognize the clinical presentations of generalized anxiety disorder, panic disorder, and insomnia in pregnancy, differentiating clinical anxiety disorders in pregnancy from "normal" anxiety/worry in pregnancy
2. Discuss how physiologic symptoms in pregnancy (such as shortness of breath or tachycardia) may be differentiated from anxiety or panic attacks
3. Identify psychosocial stressors and how they may affect pregnancy, comparing and contrasting pregnancy-related distress and anxiety disorders in the perinatal period
4. Describe treatment options including both pharmacologic and nonpharmacologic treatments for anxiety in pregnancy, encompassing biological, psychological, and social approaches

Case 1, Part 1: Serena

Serena is a 34-year-old woman, currently 16 weeks pregnant, presenting at the recommendation of her obstetrician, due to concerns about anxiety in pregnancy. She has been struggling with worry about her pregnancy over the past two months. She had a miscarriage five months ago and has been concerned about the viability of her current pregnancy. She notes that her heart pounds every time she goes to the bathroom because she fears seeing blood on her underwear. She thought these symptoms would go away once she finished her first trimester, but they have been getting worse instead of better. She is able to fall asleep at night, but has difficulty getting back to sleep once she wakes up at night because she cannot "turn off her thoughts." She spends a lot of time reading about pregnancy on the internet and finds that she worries often about developing complications such as gestational diabetes or pre-eclampsia. She is finding it difficult to concentrate at work due to her anxiety although others have not expressed concern about her work performance. Collateral from her obstetrician reveals that the patient calls the office several times each week with varying questions from ensuring that specific foods are "safe" for the fetus to inquiring about hospitals in a nearby city where she is planning an upcoming day trip. At her most recent appointment, she became tearful when she was told the fetus was measuring slightly large for dates, despite her doctor reassuring her that the pregnancy is proceeding normally.

She currently takes no psychiatric medications but reports that she was prescribed escitalopram by a mental health professional when she first started college. She was on it for at least two years and says that it was helpful for her. She is not sure if she is interested in medications now due to her concern for the effect on her pregnancy.

FACILITATOR PAUSES FOR DISCUSSION

1. Does Serena meet criteria for a psychiatric diagnosis, or would you consider her anxiety to be "normal" in the context of worry about pregnancy loss? What additional information would you need in order to make a diagnosis?
   Elicit the following:

- Possible diagnoses include generalized anxiety disorder (if symptoms present for greater than 6 months), adjustment disorder with anxiety, pregnancy-specific anxiety, or "normal" anxiety (if no significant distress or impairment is present)
- The presence of significant distress and impairment in multiple domains makes these symptoms clinically significant and worthy of treatment (anxiety with physical and emotional manifestations around going to the bathroom for fear of seeing blood on underwear, middle insomnia with anxious ruminations, difficulty concentrating at work).
- Evidence in favor of Generalized Anxiety Disorder
    a. Concern noted by another healthcare provider who is likely accustomed to seeing a wide range of patients with pregnancy-specific distress and "normal" anxiety
    b. History of escitalopram use with beneficial effects on anxiety (outside of the perinatal period)
    c. Anxiety symptoms present in multiple domains

2. What treatment options might you recommend for Serena?
   Elicit the following:

- Treatment options include psychotherapy, medications, and attention to self-care including exercise, adequate sleep/rest, healthful eating, mindfulness practice
- Biological: Medication options might include SSRI, SNRI, TCA, benzodiazepine, or other sleep aid [see Risk-Risk module to compare options]. Given her positive response to escitalopram previously, escitalopram may be a reasonable choice if she chooses to pursue medication treatment.

- Psychological: Psychotherapy options might include cognitive-behavioral therapy, interpersonal therapy, psychodynamic approaches, or group therapy modalities
- Psychological: Some data support the use of yoga or other mindfulness practice to address anxiety in pregnancy
- Social: Increase support, such as recommending new mother's groups, labor and delivery classes, etc.
- Stress management: In addition to prenatal yoga, can also consider progressive muscle relaxation or perinatal massage

3. What are the possible effects of untreated anxiety on Serena and her pregnancy?
Elicit the following:

- Possible increased risk for obstetrical complications: spontaneous miscarriage, preterm birth, low birth weight, hypertensive disorders of pregnancy
- Increased risk of postpartum depression
- Possible association with childhood anxiety, depression, developmental, or behavioral problems in offspring

4. What are the epidemiology and risk factors for perinatal anxiety? What sort of screening is recommended?
Elicit the following:

- Reported prevalence rates for anxiety disorders in pregnancy range from ~5%-40%, depending on methodology and which disorders are considered (including specific phobias, which may or may not be debilitating, may increase rates).
- It is unclear whether pregnancy itself increases the risk of onset of an anxiety disorder
- The most consistently reported risk factor for anxiety in pregnancy is a previous history of anxiety disorder
- Screening for perinatal anxiety disorders is important, as many women will not report symptoms unless asked. Possible screening tools include the Edinburgh Postnatal Depression Scale (despite the name, this scale is validated for use in pregnancy and contains a three-item anxiety subscale), the GAD-7, and several pregnancy-specific anxiety screening tools. See https://womensmentalhealth.org/posts/screening-for-peripartum-anxiety-disorders-what-are-the-best-screening-tools/ for more information.

Case 1, Part 2

Serena is now 20 weeks pregnant and is feeling relieved after her recent ultrasound which demonstrated normal fetal growth and development. She started escitalopram 10mg following the last visit and is tolerating it well. She wonders whether she should stop taking it as she is feeling much better and does not want to expose her pregnancy to a medication that is not needed. She continues to perform well at work.

FACILITATOR PAUSES FOR DISCUSSION

1. What would you recommend to Serena for follow-up monitoring, evaluation, and treatment?
Elicit the following:

- It is important to maintain follow-up, as symptoms often fluctuate over time, and she remains at risk for further anxiety symptoms as well as for postpartum depression.
- She should continue the medication at this time, as stopping medication now will likely increase her risk for recurrent symptoms, both during pregnancy and postpartum. The medication has likely contributed to her improvement in symptoms.
- Enlist social supports, both for support for Serena during this time but also in monitoring for symptom recurrence or worsening

Case 1, Part 3

Serena returns at 27 weeks, having some panic attacks related to becoming short of breath or feeling like she cannot swallow. She is very worried that her anxiety will harm her fetus or will cause her blood pressure to be elevated. She has been checking her BP repeatedly at home due to these fears and has also purchased a doppler to monitor fetal heart tones at home. She worries a lot before each OB visit, then feels relieved for several days afterward until anxiety escalates again. She will often call her OB in between visits to review her BP or fetal heart tones.

FACILITATOR PAUSES FOR DISCUSSION

1. How might the normal physiologic changes of pregnancy be contributing to her panic attacks?
   Elicit the following:
- Pregnancy may be associated with physiologic tachycardia, shortness of breath, nasal congestion, and other changes that can contribute to panic in individuals with heightened somatic sensitivity
- Psychoeducation regarding these normal changes in physiology can be helpful in some cases

2. What might you recommend for treatment at this time?
   Elicit the following:
- Treatment options could include increasing the dose of her SSRI, adding a benzodiazepine, or psychotherapy.
- Biological: Occasional use of low dose benzodiazepines for panic attacks in late pregnancy likely carries minimal risk for her fetus, but chronic daily use may contribute to tolerance and dependence, interfere with the effectiveness of cognitive behavioral therapy, and may lead to floppy baby syndrome or risk of neonatal benzodiazepine withdrawal symptoms.
- Psychological: Exposure-based cognitive behavioral therapies can be particularly effective for panic attacks and can be used in pregnancy (see Arch et. al., 2012).

Case 1, Part 4

Serena returns at 4 weeks postpartum, now reporting lots of anxiety related to the baby and his well-being rather than her own. She is breastfeeding and worries a lot about her milk supply and if her baby is getting what he needs, leading her to spend time on the internet to find ways to increase her milk supply. She is working with lactation support who has assured her that the baby is growing well and her supply is adequate. However, Serena still feels as if she is not producing enough milk and has thought about stopping entirely. She is setting an alarm and getting up multiple times at night to pump/feed. She notes she has a difficult time falling asleep when the baby is sleeping as "I know I will be up again soon to feed him all over again." Serena is not comfortable letting her partner or others take over care so she can sleep. She worries she is "not doing this motherhood thing right," and frequently questions her decisions as a parent.

FACILITATOR PAUSES FOR DISCUSSION

1. How can one differentiate Serena's anxiety about her baby from symptoms of perinatal OCD [See OCD module]?
   Elicit the following:
- Perinatal anxiety, specifically perinatal GAD, can be differentiated from OCD primarily by the nature of the anxious thoughts. OCD is characterized by intrusive, repetitive thoughts (obsessions) and/or ritualistic behaviors (compulsions) that are experienced as unwanted.

- With GAD, anxious thoughts are worries regarding real-life, routine matters that are approached with apprehension and thought distortions (such as catastrophizing and generalizing), and the thought content tends to shift over time.
- With OCD, thoughts are intrusive and unrelated to everyday concerns, mostly focused on disastrous outcomes such as harm coming to the infant, and obsessions tend to have stable content over time.
- Although Serena has anxious thoughts including a focus on her infant, the thought content of her worries shifts to also include her milk supply and baby getting adequate breast milk, difficulty allowing partner or others to take care of the baby while she sleeps, and negative self-appraisals (e.g, her abilities as a parent). She also does not attempt to ignore or suppress these thoughts or neutralize them with another action (compulsion).
- Serena does engage in behaviors that appear to be in response to her anxious thoughts (and may even be directed at reducing anxiety and distress), such as researching ways to increase milk supply, setting alarms, and getting up multiple times a night to pump/feed. However, these are not clearly repetitive nor do they appear to be performed in response to an obsession/according to rigidly applied rules. These behaviors may be in response to Serena's anxiety but are connected realistically with the content of her anxious thoughts.

2. How would you counsel Serena with regard to lactation?
Elicit the following:

- Reassure her that baby's normal weight gain indicates that her milk supply is adequate and that she is breastfeeding successfully
- Setting an alarm to get up at night to feed is not necessary if her baby is growing well and may be worsening her overall anxiety level, because sleep deprivation and fatigue may make it more difficult for her to cope during the day
- If she feels that continued breastfeeding is worsening her mental health, she may consider the pros and cons of supplementing or weaning.

3. Would you recommend medication to help her sleep? What factors might you consider?
Elicit the following:

- Most psychiatric medications are compatible with breastfeeding (including SSRIs, low doses of benzodiazepines, and most sleep aids).
- Sleep medication may be helpful if she has trouble sleeping even when her infant is sleeping or when others are caring for her infant; postpartum moms should aim for at least one stretch of 4-5 hours of uninterrupted sleep if at all possible.
- It may be helpful for her to use earplugs or sleep in a separate room from her infant if she has difficulty sleeping due to infant noises.
- Having another adult available to care for an infant is important if mom will be taking sedating medication (and also allows mom to benefit from the medication without being woken by the baby in a few hours!).
- If prescribing sedating medication, it is important to counsel parents about the risks of co-sleeping, as a parent sedated by medication is at greater risk to an infant.
- Parents may have to be creative in order to ensure sufficient sleep in the early postpartum period. Strategies may include taking shifts (one partner sleeps from 7 PM to midnight while the other cares for the infant, then the other partner is on duty from midnight to 5 AM), hiring a night nurse, asking a family member to spend the night periodically to help or taking naps during the day.
- It is important for mom to focus on baby care and rest and not to expect to complete projects or household tasks in the first several weeks postpartum

4. What else might you recommend?

- Social: Participating in a new mothers support group can help normalize worry about infant development and provide social support

Case 2, Part 1: KP

KP is a single, 31-year-old G1P0 woman, currently 16 weeks pregnant, who presents to her psychiatrist with concerns about her pregnancy. This is an unplanned but desired pregnancy. However, the patient notes increasing worries about the health of the pregnancy and whether or not she will be a good parent. She has had difficulty falling asleep and frequently wakes in the middle of the night when she makes lists of things needed to prepare for the baby. She has been told that she has "anxiety" by doctors in the past, but she has not taken medications in years, and she worries about doing so currently due to concern about possible effects on her pregnancy. She currently notes numerous psychosocial stressors, most notably her finances and relationship with her boyfriend. She works two part-time jobs to help make ends meet, and her expenses have increased with the current pregnancy. She is worried since she constantly works on her feet and is concerned that this could impact her pregnancy. Although she reports a good relationship with her boyfriend, they have only been together for 6 months. He initially encouraged her to terminate the pregnancy, though he later came around and has been more supportive. She reports that her mother and grandmother are emotionally supportive, but they are unable to provide any direct financial support at this time.

FACILITATOR PAUSES FOR DISCUSSION

1. What should we make of KP's distress? Does she meet criteria for an anxiety disorder? How much of her presentation is driven by pregnancy-specific psychosocial stressors?
   Elicit the following:

- Possible diagnoses include: *Pregnancy-specific anxiety, Generalized Anxiety Disorder*
  - Evidence in favor of generalized anxiety disorder
    - Past history of anxiety requiring medications (though we do not know if and what kind of anxiety disorder she had)
  - Evidence in favor of pregnancy-specific anxiety or distress
    - Concerns about preparedness, baby's health, and fitness to parent
    - No clear impairment in her level of functioning
    - Numerous social stressors
- Discuss the concept of pregnancy-specific anxiety (PSA): anxiety that is specific to concern about pregnancy, delivery, postpartum, and parenthood, and distinct from anxiety experienced at other times of life. It appears to be linked to state anxiety, but it arises out of the specific context of the perinatal period (a series of distinct transitions which can be experienced as stressful and overwhelming). The prevalence of pregnancy-specific anxiety is virtually equal to that of perinatal GAD, and the symptom severity and functional impairment are also equivalent. (Please refer to the self-study materials on PSA for a review of this concept.)

2. How might pregnancy-related life stressors relate to her risk of depression in the postpartum period?
   Elicit the following:

- Many women experience a wide variety of psychosocial stressors in pregnancy
  - These include: financial, partner-related, emotional, and traumatic
  - These stressors act as a robust independent risk factor for postpartum depression
  - However, women with numerous psychosocial stressors are less likely to seek treatment for postpartum depression

- Thus, screening for psychosocial stressors in the perinatal care setting has been suggested

3. Would you offer treatment to KP? If so, what interventions might be a good first step?
Elicit the following:

- The distress that she experiences is concerning enough to her that she is addressing it with her physician. Even if her symptom burden does not seem significant, if it is problematic to the patient, then offering treatment would be appropriate.
- Non-pharmacologic treatment options would be an excellent first step, including individual psychotherapy, stress management, and support for her psychosocial stressors
- Evidence-based psychotherapy modalities in the perinatal period include interpersonal psychotherapy, cognitive-behavioral therapy, and supportive psychotherapy.

4. If KP elects to do a course of interpersonal psychotherapy, what are the core elements that the psychotherapy would focus on?
Elicit the following:

- Focus on interpersonal dilemmas common to the perinatal period, including:
  - Interpersonal role disputes: conflicts with a significant other
  - Role transition: change in life status
  - Interpersonal deficits/coping skills: difficulty in coping with interpersonal conflicts
  - Grief

Case 1, Part 2

KP is now 27 weeks pregnant, and she continues to describe worsening anxiety. Although she notes being told her pregnancy has progressed without complications, she has missed her last prenatal appointment since she was unable to get time off from work. She notes waking twice now in the night with shortness of breath, palpitations, and feeling flushed, relieved by opening the window and sticking her head outside in the fresh air. She and her boyfriend have been arguing more of late, and he has seemed more detached from the pregnancy, preferring to go out with friends during a time when she feels they should be preparing the nursery. She once caught him texting another girl and when attempting to look at his phone, they began to fight, which ended with him punching a hole in the wall. She reports that he has not been violent and does not own any weapons, but she feels controlled and intimidated by him. Her mother has encouraged KP to be patient and give him time to come around and not to give up on the relationship just yet.

FACILITATOR PAUSES FOR DISCUSSION

1. At this point, have your thoughts changed on whether or not KP has pregnancy-specific anxiety or a perinatal anxiety disorder? Why or why not?
Elicit the following:

   - She is having anxiety symptoms that span more than one diagnostic domain (panic, generalized anxiety)
   - Discuss symptom overlap with PTSD:
     - Core clinical features of PTSD include the presence of a traumatic event, re-experiencing (reliving the traumatic event), emotional numbing, avoidance of thoughts, places, or persons associated with the event and hyperarousal
     - Assess for the above signs as well as a history of trauma
     - Of note, many disorders can present with perinatal insomnia (including PTSD, OCD, GAD, panic disorder)

- However, we cannot also discard the fact that her social stressors are continuing to exacerbate her anxiety, including work, financial stressors, and relationship stress.
- In particular, this situation raises concerns about intimate partner violence (IPV).

2. How might you advise her regarding the interpersonal conflict with the boyfriend?
Elicit the following:

- Intimate partner violence (IPV):
    - IPV: a pattern of assaultive and coercive behavior including physical injury, psychological abuse, sexual assault, progressive isolation, and intimidation.
    - She is at elevated risk of IPV; her partner has progressed from being emotionally unavailable to physically intimidating
    - Psychoeducation around IPV in the perinatal period:
        - Sequelae: emotional trauma, physical impairment, chronic health problems, death
        - Women who are pregnant and in abusive relationships are at an increased risk of being killed by their partners during the peripartum period
    - National and local resources for women in abusive relationships should be provided, such as printed take-home resource materials
    - Screen for IPV at each visit, in a private and safe setting
    - Inform patient of the confidentiality of the discussion, including state laws regarding disclosure and mandated reporting
    - Case management – identifying services (safe housing, insurance, food, transportation to appointments) for which she may be eligible

3. What are the potential complications if the situation with the boyfriend continues to worsen?
Elicit the following:

- Active IPV in pregnancy is associated with numerous negative outcomes, including:
    - Increased rates of depression and anxiety
    - Higher rates of suicide attempts
    - Decreased attachment with the baby
    - Lower rates of successful breastfeeding

References

American College of Obstetricians and Gynecologists: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Intimate-Partner-Violence

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Washington, DC, American Psychiatric Association, 2013

Arch JJ, Dimidjian S, Chessick C. Are exposure-based cognitive behavioral therapies safe during pregnancy?. Arch Womens Ment Health. 2012;15(6):445-57.

Bowen A, Baetz M, Schwartz L, Balbuena L, Muhajarine N. Antenatal group therapy improves worry and depression symptoms. Isr J Psychiatry Relat Sci. 2014;51(3):226-31.

Deligiannidis KM, Freeman MP. Complementary and alternative medicine therapies for perinatal depression. Best Pract Res Clin Obstet Gynaecol. 2014 Jan;28(1):85-95. doi: 10.1016/j.bpobgyn.2013.08.007. Epub 2013 Aug 26. PMID: 24041861; PMCID: PMC3992885.

Dominguez TP, Dunkel-Schetter C, Glynn LM, Hobel C, Sandman CA. Racial Differences in Birth Outcomes: The Role of General, Pregnancy, and Racism Stress. Health psychology : official journal of the Division of Health Psychology, American Psychological Association. 2008;27(2):194-203.

Dunkel Schetter C, Tanner L: Anxiety, depression and stress in pregnancy: implications for mothers, children, research, and practice. Curr Opin Psychiatry 25(2):141–148, 2012.

Freeman MP et al. Supportive psychotherapy for perinatal depression: preliminary data for adherence and response. Depress Anxiety 2010: 27 (1); 39-45.
Glasheen C, Richardson GA, Fabio A. A systematic review of the effects of postnatal maternal anxiety on children. Arch Womens Ment Health. 2010;13(1):61-74.

Goodman JH, Chenausky KL, Freeman MP. Anxiety disorders during pregnancy: a systematic review. J Clin Psychiatry. 2014;75(10):e1153-84.

Grote NK et al. A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. Psychiatr Serv 2009: 60 (3); 313-321.

Huizink AC, Mulder EJ, Robles de medina PG, Visser GH, Buitelaar JK. Is pregnancy anxiety a distinctive syndrome?. Early Hum Dev. 2004;79(2):81-91.

Kramer, M.S., Séguin, L., Lydon, J. and Goulet, L. (2000), Socio-economic disparities in pregnancy outcome: why do the poor fare so poorly?. Paediatric and Perinatal Epidemiology, 14: 194–210.

Loughnan SA, Wallace M, Joubert AE, Haskelberg H, Andrews G, Newby JM. A systematic review of psychological treatments for clinical anxiety during the perinatal period. Arch Womens Ment Health. 2018

Mclean MA, Cobham VE, Simcock G. Prenatal Maternal Distress: A Risk Factor for Child Anxiety?. Clin Child Fam Psychol Rev. 2018

Newham JJ, Wittkowski A, Hurley J, Aplin JD, Westwood M. Effects of antenatal yoga on maternal anxiety and depression: a randomized controlled trial. Depress Anxiety. 2014;31(8):631-40.

Nonacs, R. Screening For Peripartum Anxiety Disorders https://womensmentalhealth.org/posts/screening-for-peripartum-anxiety-disorders-what-are-the-best-screening-tools/. Accessed March 13, 2018.

Shear MK, Mammen O. Anxiety disorders in pregnant and postpartum women. Psychopharmacol Bull. 1995;31:693-703.

Stone SL et al. Stressful events during pregnancy and postpartum depressive symptoms. J Women's Health 2015; 24 (5): 384-393.

Stuart S et al. Psychological treatments for perinatal depression. Best Practice Research Clinical Obstetrics and Gynecol 2014; 28 (1): 61-70.

Thombre MK, Talge NM, Holzman C. Association between pre-pregnancy depression/anxiety symptoms and hypertensive disorders of pregnancy. J Womens Health (Larchmt). 2015;24(3):228-36.

Vignato J, Georges JM, Bush RA, Connelly CD: Post-traumatic stress disorder in the perinatal period: A concept analysis. J Clin Nurs 26(23-24):3859–3868, 2017

World Health Organization. Intimate partner violence during pregnancy. 2011 (WHO reference number: WHO/RHR/11.35)

Additional resources

Intimate Partner Violence National Resources

Hotlines

- National Domestic Violence Hotline
  1-800-799-SAFE (7233)
- Rape Abuse & Incest National Network (RAINN) Hotline
  1-800-656-HOPE (4673)

Web Sites

- Futures Without Violence (previously known as
  Family Violence Prevention Fund)
  www.futureswithoutviolence.org
- National Coalition Against Domestic Violence
  www.ncadv.org
- National Network to End Domestic Violence
  www.nnedv.org
- National Resource Center on Domestic Violence
  www.nrcdv.org
- Office on Violence Against Women
  (U.S. Department of Justice)
  www.usdoj.gov/ovw