Perinatal Anxiety

Anxiety in Pregnancy
Case Conference
Trainee Guide

Contributors
Kara Brown, MD
Melisa Olgun
Katie Thorsness, MD

Updated in 2022 by
Lucy Hutner, MD
Jasmine Saadatmand, MD

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.

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?

2. What treatment options might you recommend for Serena?

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

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

   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.

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

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.

1. How might the normal physiologic changes of pregnancy be contributing to her panic attacks?

2. What might you recommend for treatment at this time?

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.

1. How can one differentiate Serena's anxiety about her baby from symptoms of perinatal OCD [See OCD module]?

2. How would you counsel Serena with regard to lactation?

3. Would you recommend medication to help her sleep? What factors might you consider?

4. What else might you recommend?

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.

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?

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

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

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

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.

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?

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

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

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