Perinatal Anxiety Disorders

Self-Study

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Introduction

- During this period, it is common for women to experience increased worry, with major concerns including miscarriage, the baby's health, delivery, caring for the baby after discharge, and social stressors such as finances.
- Anxiety disorders differ from normative pregnancy-related worry by virtue of their intensity, persistence, and negative impact on a woman's functioning.
- Pregnancy-specific anxiety: 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.
- Generalized Anxiety Disorder (GAD) may include symptoms of persistent and excessive worries, feelings of tension, an inability to relax, and irritability. Often, these worries are focused on the baby or other children.
- Panic includes unpredictable moments of sudden and intense fear, accompanied by symptoms such as palpitations/tachycardia, dizziness/lightheadedness, shortness of breath, feelings of choking, nausea or abdominal distress, hot flushes or chills, paresthesias, diaphoresis, tremulousness, fear of losing control or going crazy, fear of dying, derealization, and depersonalization.
- Panic attacks may occur in the context of co-morbid psychiatric disorders or be diagnosed as a panic disorder if the woman experiences repeated panic attacks and develops major behavior changes (such as avoidance) and/or persistent anxiety and preoccupation by their potential recurrence.
- 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 should be provided with regards to this.
- Women with obsessional features (intrusive, unwanted thoughts or images) may worry excessively about causing accidental harm to their infant, leading to hypervigilance, infant avoidance, or frequent reassurance seeking from family and medical providers See OCD Module.

Epidemiology

- In general:
    - Approximately 30% of women will experience an anxiety disorder during their lifetime.
    - Compared with men, women are about twice as likely to suffer from an anxiety disorder.

- In the perinatal period:
    - Reported prevalence for anxiety disorders in pregnancy ranges from ~5%-40%, depending on methodology and which disorders are considered (including specific phobias increases these estimates)
    - Many studies suggest that the prevalence of anxiety symptoms may be higher during pregnancy than in the postpartum period.
- Perinatal anxiety is often comorbid with depressive symptoms (up to 80% comorbidity in some studies), so it is important to evaluate for both postpartum anxiety and postpartum depression. This comorbidity has been shown to manifest into more severe symptoms with poorer outcomes (both acute and long-term), is more difficult to treat, and increases the risk for suicide.
- Insomnia is a frequent companion to anxiety and is associated with more severe illness and increased risk of psychiatric decompensation.

Risk Factors

- The most consistently reported risk factor for anxiety in pregnancy is a previous history of anxiety disorder
- Other risk factors for perinatal anxiety include:
    - Stress during pregnancy, smoking, primiparity, negative childbirth experience, a previous stillbirth, an infant born ≤27 weeks gestation, infant admitted to the NICU, and a medically complicated pregnancy
        - Fairbrother, et al, found the relative risk of the onset of anxiety in pregnancy to be 5-7x greater for women experiencing a medically moderate or high-risk pregnancy compared to those experiencing a medically low-risk pregnancy
- Risk factors for comorbid postpartum depressive symptomatology and anxiety include: immigration within the past 5 years, vulnerable personality, childcare stress, and perceived stress. Conversely, higher levels of breastfeeding self-efficacy, maternal self-esteem, and partner support predicted a lower likelihood of comorbidity (Falah-Hassani 2016).

Risk of Untreated Anxiety

- Possible increased risk for obstetrical complications: preterm birth, low birth weight, hypertensive disorders of pregnancy.
- Anxiety in pregnancy has been found to be a strong predictor of postnatal depression (even after controlling for depression in pregnancy).
- Possible association with childhood anxiety, developmental, or behavioral problems in offspring.

Screening and Diagnosis

- Identification and treatment of anxiety disorders in pregnancy are especially important because of the potential impact of untreated anxiety disorders during pregnancy on maternal, obstetric, and fetal/child outcomes.
- The American College of Obstetricians and Gynecologists (ACOG) recommends screening for anxiety at least once during the perinatal period. ACOG cautions that screening alone is insufficient to improve clinical outcomes, instructing obstetric providers to initiate medication and/or refer patients to mental health treatment when indicated.
- The GAD-7 can be used as well as the Edinburgh Postnatal Depression Scale (EPDS).
- Although the EPDS is designed to detect depression, the following three items comprise an anxiety subscale that may help to also identify anxiety disorders:
    - I have blamed myself unnecessarily when things went wrong
    - I have felt scared or panicky for no good reason
    - I have been anxious or worried for no good reason

- Asking a mother if she is having intrusive or frightening thoughts or visions of harm befalling her baby, and inquiring whether she is able to sleep when her baby is sleeping are important additional questions to help identify anxiety in new mothers.

Treatment Interventions

- Non-pharmacological:
  - Psychotherapy
    - Psychotherapy is the first-line treatment of mild to moderate perinatal anxiety and is recommended in addition to medication for women with moderate to severe anxiety.
    - Cognitive behavioral therapy, interpersonal therapy, psychodynamic approaches, or group therapy modalities have all been identified as effective for perinatal anxiety.
    - Exposure-based cognitive behavioral therapies can be particularly effective for panic attacks and can be used in pregnancy.
  - Other
    - Some data support the use of yoga or other mindfulness practices to address anxiety in pregnancy.
    - Encouraging women to identify their support networks and decrease external stress are components of an optimal treatment plan.

- Pharmacological:
  - Selective serotonin reuptake inhibitors (SSRIs) are the first-line treatment for anxiety in pregnant and lactating women.
  - Side effects, reproductive safety, tolerability, and past response to medication should guide medication choice.
  - The goal of treatment is remission, as inadequate treatment exposes the fetus to adverse effects associated with both medication and maternal illness.
  - In order to limit the total number of fetal exposures, utilizing one antidepressant at a higher dose is preferable to prescribing multiple medications at lower doses.
  - Ideally, pregnant women should utilize the lowest effective dose of a single medication; however, dose requirements of certain medications may increase throughout gestation secondary to an induction of cytochrome enzymes.
  - See the Risk-Risk portion of the perinatal depression module for information re: SRI use.
  - Women with moderate to severe anxiety may require adjunctive medication to manage symptoms. Indications for the use of adjunctive medications include severe anxiety interfering with prenatal care, functioning, or sleep.
  - See the Risk-Risk portion of this anxiety module for information re: benzodiazepine use

- Insomnia
  - Insomnia is one of the most consistent risk factors for postpartum psychiatric decompensation and must be treated aggressively.
  - Creating a plan with patients and their families to promote consolidated sleep through assistance with nighttime feedings promotes optimal well-being of the mother-infant pair.
  - Clinicians prescribing medications for insomnia should instruct women to get help with overnight infant care in order to avoid both disrupted sleep and the potential for unintentional infant harm from maternal sedation.

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