Anxiety Disorders & Obsessive Compulsive Disorder in Pregnancy

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Learning Objectives:

- Recognize the clinical presentations of generalized anxiety disorder (GAD), panic disorder, and OCD in pregnancy
- Differentiate clinical anxiety disorders in pregnancy from "normal" anxiety/worry in pregnancy
- Differentiate between GAD and OCD
- Differentiate between OCD and Postpartum Psychosis
- Gain comfort with initiating treatment, avoiding treatment pitfalls, and knowing when to refer to a specialist

Outline:

- Introduction
- Epidemiology
- Screening
- Clinical Criteria w/ examples
- Treatment
- Risks

Introduction

20% of Pregnancies are affected by Anxiety Disorders

Anxiety Disorders are treatable and patients can improve dramatically

OCD often presents for the **first time** in the peripartum period

There is a huge opportunity to improve: Screening and Treatment

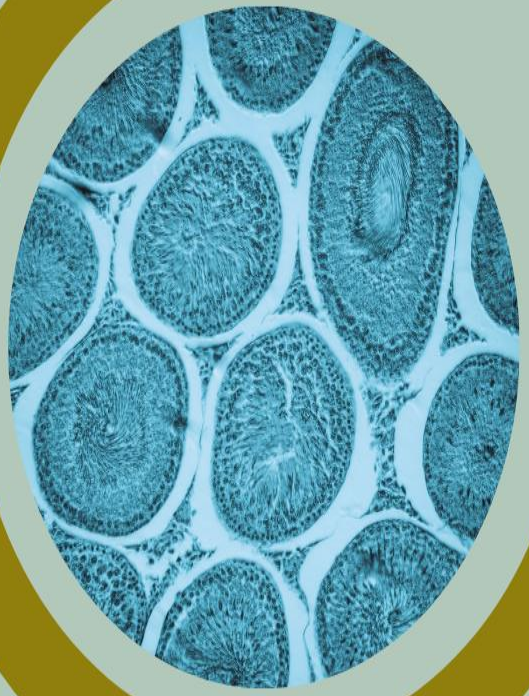
Epidemiology: Prevalence

	In Peripartum Period	In General Population (Lifetime)	Women in General Population (12 months)
Any anxiety disorder	20.7%	31.1%	23.4%
GAD	9%	5.7%	3.4%
Panic Disorder	1-2%	4.7%	3.8%
OCD	Pre: 0.2-7.8% Post: 2.3–16.9%	0.7 - 2.3%	1.8%

Epidemiology: Risk Factors for Anxiety

- Prior diagnosis of anxiety or depressive disorders (perinatal anxiety and depression are commonly comorbid)
- Family history of psychiatric disorders
- Multiparity
- Comorbid sleep disorder
- Comorbid mental health conditions
- Hyperemesis gravidarum, lower educational attainment, prior loss, pregnancy complications, prior trauma or adverse childhood events, poor social/partner support

Screening



- Because perinatal anxiety is often not discussed as its own phenomenon, it often goes underrecognized and underscreened
- EPDS, while good for depression, is not as helpful for identifying anxiety, though you can look at the subset of Questions #3-5 for a sense of elevated anxiety that requires further investigation
- PHQ-9 also does not identify anxiety

We can do better!

Screening Recommendation (NCRP Rec)

- OBs and other providers screen at least once during the perinatal period using a validated tool
  - Consider using the GAD-7 or, if in EMR, Perinatal Anxiety Screening Scale (PASS)
    - Preliminary validation shows that the PASS identifies 68% of women with diagnosable anxiety disorder. EPDS anxiety subscale only identified 36% (Somerville et al 2014)
  - For OCD: Perinatal Obsessive Compulsive Scale (POCS, hard to obtain) or the Obsessive-Compulsive Inventory –Revised (OCI-R, validated but less accurate in perinatal)
- A full assessment of emotional and mental well-being in the postpartum period regardless of prior assessment

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Generalized Anxiety Disorder scale (GAD-7)

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Diagnostic Criteria: Key features

- Excessive or uncontrolled worry
- Duration: >1 month during peripartum

GAD

Excessive worry present majority of days

Functional impairment

Worries about a variety of topics that are difficult to control

Feeling keyed-up, mind blanking

Panic Disorder

Recurrent, unexpected panic attacks

Persistent worry about additional panic attacks and their consequences

Panic attack: Abrupt surge of intense fear/discomfort, along with physical symptoms of tachycardia, dizziness, fear of dying

OCD

Presence of obsessions, compulsions or both

Recurrent/persistent thoughts, urges or images experiences as intrusive and unwanted

Compulsions are repetitive behaviors or mental acts that a patient is driven to perform in response to obsessions

OCD: More info

- Likely underdiagnosed
- Over 25% of people experience obsessive and compulsive symptoms that do not necessary meet diagnostic criteria for OCD but are clinically significant and impairing
- 70-100% of new mothers report intrusive thoughts of infant-related harm and 50% report intrusive thoughts of harming their infant on purpose
- Prevalence is higher during reproductive transitions: menarche, pregnancy, postpartum, and perimenopause
  - 13-22% of female patients with OCD attribute illness to menarche (Russell, Fawcett, and Mazmanian 2013)
  - Postpartum OCD historically estimated to be 2.3-9%, but recent new study using stringent criteria found 16.9%

GAD vs. OCD

The Nature of the Thoughts	
GAD	**OCD**
Anxious thoughts are worries related to real-life, routine matters that bring about apprehension and thought distortions. Thought content tends to shift over time.	Intrusive, repetitive thoughts and/or ritualistic behaviors that are experienced as unwanted.

"What if I have to have a C-section and I have a complication and then I can't work again and am a bad mother?"

"I keep seeing an image that I'm going to drop the baby down the stairs, so now I sit when I go down the stairs or I don't hold the baby at all"

Postpartum Psychosis vs. OCD

The Nature of the Thoughts	
Postpartum Psychosis	**OCD**
More of a manic state with severe and dangerous delusions. Can include confusion or appear similar to delirium. This is a psychiatric emergency due to risk of suicide/infanticide Delusional beliefs ego-syntonic: they are experienced without insight. Mothers likely need urgent hospitalization, and the baby needs to be in the care of someone else.	These thoughts are ego-dystonic: extreme distress is experienced with the thoughts. They are unwanted and do not make sense. It is not recommended to separate infants from their mothers but, instead, to pursue treatment and psychoeducation.

"I am on a special mission to save this baby, and the only option is for her to go to heaven and be protected by God"

"I keep having worries that she will roll over in her sleep, so I bought an Owlet, and I sleep beside her bed so I can check on her every few minutes"

Clinical Features

Perinatal GAD/Panic Disorder

Course

- Variable trajectory and onset/worsening

Prognosis without treatment associated with:

- Fewer perinatal visits and delayed initiation of care
- Prematurity
- Low birth weight
- Reduced head circumference
- Impaired bonding
- Long-lasting impact on children's cognition, social-emotional development and mental health

Perinatal OCD

Course:

- Often begins with intrusive thoughts and images (next slide)
- Symptoms are distressing and time consuming
- Insight is usually preserved
- Very often comorbid
- Onset can be abrupt or gradual

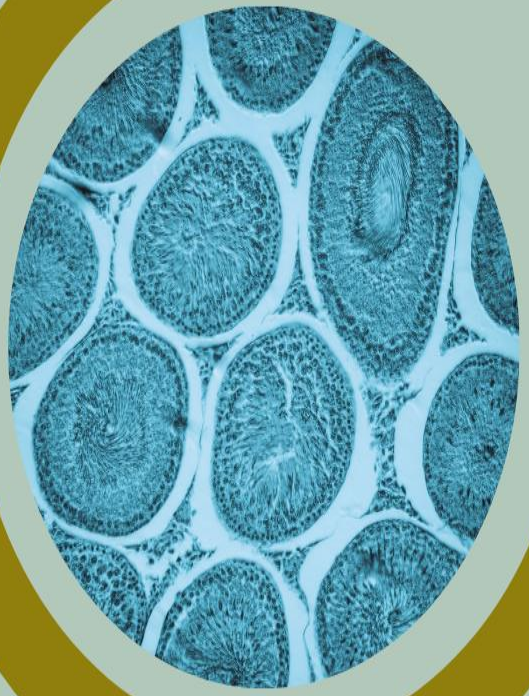
Prognosis without treatment associated with:

- Impaired mother-infant bonding
- Lower rates of breastfeeding
- Risk of not being as responsive to infant needs presumed to be due to fears from obsessions/compulsions or comorbid depression

Assessment

- Clinical Interview
- Scales (PASS, PCOS, OCR-I)
- Physical exam findings to evaluate medical causes of anxiety
- Basic labs (CBC, Chem Panel, TFTs, UA, Urine Tox)
    - Anemia, electrolyte abnormalities, infection, intoxication, and thyroid abnormalities can cause physiological mimics of anxiety (or complicate treatment)
- Extensive work-up only if clinically indicated: EEG, CT, Infectious work-up, extensive TFTs

Helpful Questions to Ask



- How much time in your day are you spending on these worries/thoughts?
- Do thoughts or images ever drop into your mind like a random “slide”? These are called intrusive thoughts and images, and many women experience them.
- Are you able to sleep when you get a chance, or do these thoughts keep you awake?
- Do you find yourself checking on the baby often and scrolling multiple online forums for answers?

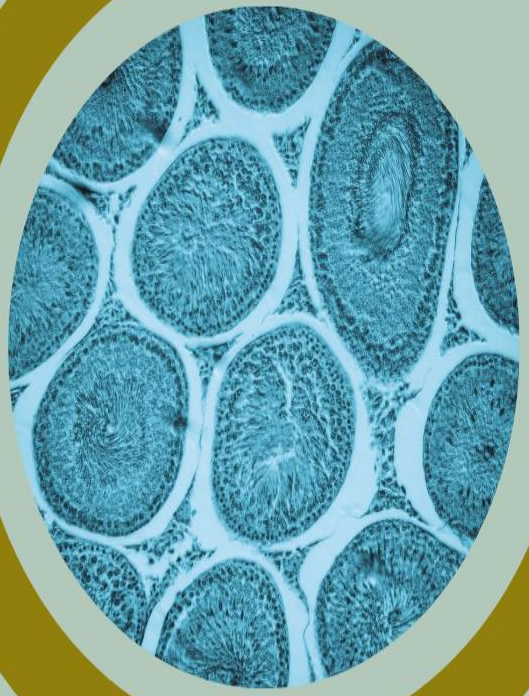
Differential Diagnosis for Anxiety/OCD

- Normal worry: Pregnancy is a huge transition, and some worrying is normal
  - Common worries: body image, health of baby, relationship, logistical issues like finances, mothering skills, breastfeeding
- Intrusive thoughts (isolated) that are not pathological
  - Ie. Flash thought of dropping baby down the stairs
  - These thoughts are recognized as irrational, fleeting, do not interfere with function
  - Fleeting intrusive thoughts of harm to baby occurs in approximately 50% of PP patients
- Depression
- Substance Use/Intoxication
- Trauma based disorder (PTSD)
  - Emotional numbing, avoidance of thoughts, places, or persons associated with the event and hyperarousal
- Postpartum Psychosis
  - Anxious thoughts and worries will reach levels of delusions. Insight is lost: patient agrees with delusional beliefs and may act based on delusions.

Physiological Symptoms: Mimics

- Physical symptoms may trigger feelings of anxiety/panic in some women
  - Normal physiology of pregnancy: elevated heart rate, shortness of breath
  - Thyroid dysfunction
  - Anemia
  - Preeclampsia
  - Pulmonary embolism
  - Cardiac arrhythmia
  - Asthma
  - Infection
  - Vitamin deficiencies
  - Autoimmune conditions

Pathophysiology: GAD



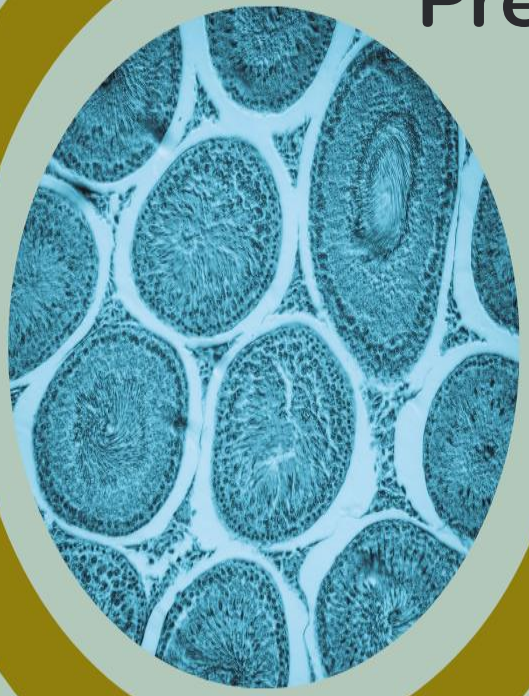
- Fundamentally thought to arise from underlying biological vulnerability paired with stressor/trauma
- Heritability: 30-50% (Genes not yet identified)
- Most anxiety symptoms mediated by the autonomic nervous system, neurotransmitters thought to be most involved are norepinephrine, serotonin, dopamine and GABA
- Changes in serum measurements of inflammation (i.e., cytokine levels) in the peripartum have been shown to be associated with perinatal anxiety

Pathophysiology: OCD

- Strong heritability: studies in general population have identified genetic factors such as serotonin transporter polymorphisms
- Other factors: immune, response to reproductive hormones, psychosocial precipitants
- Tendency towards perfectionism or hyper-responsibility; being responsible for a vulnerable infant can trigger concerns about keeping infant safe or being a good mother
- Sleep deprivation
- Coping with medical comorbidities

Pathophysiology: Psychosocial Precipitants in GAD

- Pregnancy complications
- Unexpected birth outcomes
- Previous traumatic events
- Transition in identity to motherhood
- Relationship stressors
- Low resources
- Poor employments/financial conditions
- Heavy family or household responsibilities
- Chronic stress from being a member of a discriminated against racial class



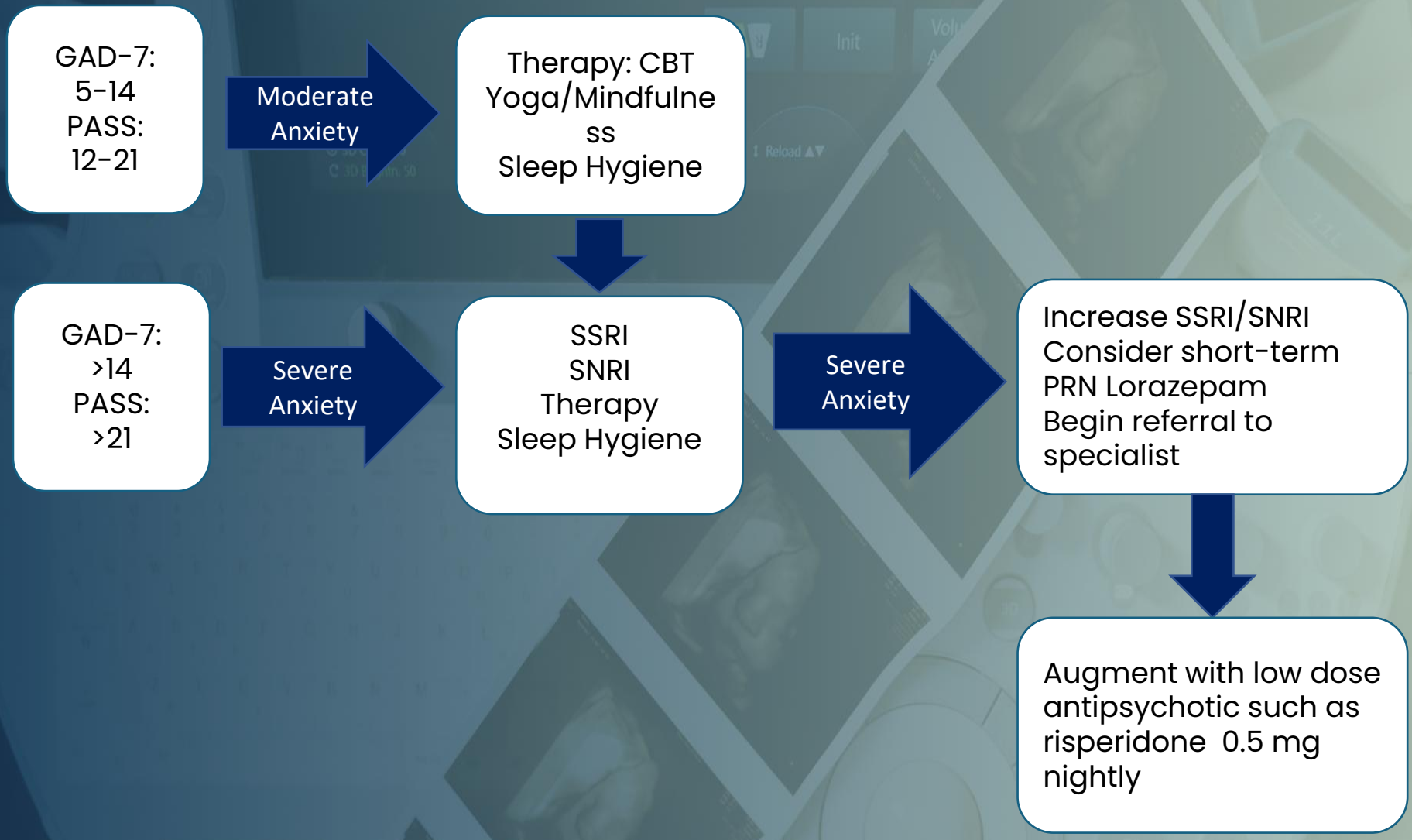
Pathophysiology: Psychosocial Precipitants in OCD

- Intense fear of harm coming to the baby
- Performing repetitive behaviors to protect the baby
- Sleep deprivation
- Coping with medical comorbidities

Risk Factors: Sleep (or lack thereof)

- Sleep deprivation, poor sleep quality, and insomnia confer risk for perinatal anxiety
- Sleep difficulties have been shown to be associated with a significant increase in suicidal ideation (EPDS question #10)
- Inquiring about sleep habits without assuming “it’s just pregnancy insomnia” is important, as there are treatment options:
  - Treatment of underlying illness
  - CBT for insomnia
  - Sleep aids like Doxylamine

Treatment: General Anxiety Disorder



Treatment: OCD

Concern for OCD with impairment

FDA approved meds:
- Fluoxetine
- Fluvoxamine
- Paroxetine
- Sertraline
- Clomipramine

- Higher medication doses often required for OCD

Therapy: Exposure & Response Prevention Therapy

Refractory

Increase SSRI

Short term benzodiazepines for acute anxiety

Low dose antipsychotics

Refer to specialist

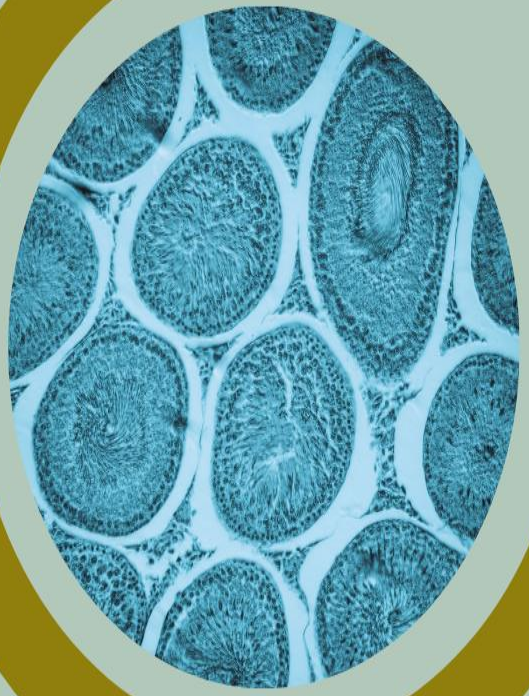
Dosages for common SSRIs

	Starting Dose (↓side effects)	Range often needed for GAD	Range often needed for OCD
Sertraline	25-50 mg	100-200 mg	200-400 mg
Fluoxetine	10 mg	20-80 mg	40-120 mg
Escitalopram	5-10 mg HS	20-40 mg	20-60 mg
Citalopram	10 mg	20-40 mg	20-80 mg
Fluvoxamine	50-100 mg HS	--------	100-300 mg

Choosing an SSRI/Insider Tips

- If patient has prior good response to a prior medication: go with that one!
- Sertraline and fluoxetine have a lot of “room” for increasing if there is concern for OCD
  - They can also be somewhat activating, so patient should take in the morning
- Escitalopram can, for some patients, be sedating, so check in with patient if it is causing drowsiness with morning dosing

Risk-risk Conversations



- As with all things in medicine, discussing the risks and benefits with patient allows them to make the best decisions for themselves
- For almost all SSRIs, especially sertraline, escitalopram, fluoxetine, and citalopram, the current data are reassuring from a safety perspective.
- Thorsness et al. provide a nice overview table of current knowledge related to antidepressants
- Consider risks of untreated anxiety: shorter length of gestation, small for gestational age, increased risk of hypertension and pre-eclampsia, risk of postpartum depression, etc

Benzodiazepines

- Often either under- or over-utilized
- Historically linked to cleft lip/palate, but more recent large studies do not show any association
- Some research has shown increased risk of malformations in first trimester for use of benzodiazepine and SSRI combined, but not for benzodiazepine alone
- Chronic benzodiazepine use in the third trimester associated with higher risk of small head circumference, NICU admission, and adverse delivery outcomes
- When deemed necessary and helpful (i.e., severe insomnia, severe breakthrough anxiety, major stressor), they should be prescribed sparingly and temporarily and coupled with psychotherapy
- Providing a small supply of medication with first prescription (e.g., 10 or fewer tablets) ensures that provider is contacted prior to chronic use
- Lorazepam preferred for lower abuse potential and shorter half-life

Benzodiazepines: Considerations

Risks	When balancing risks of benzodiazepines (sedation, neonatal respiratory suppression with high continuous doses), remember to balance it against the risk of untreated severe anxiety
Discontinuation	If benzodiazepines are not needed, taper slowly. Do not abruptly stop as this risks serious complications from withdrawal.
Changing benzos	Though lorazepam is preferred, do not switch in a patient who is already taking an effective benzodiazepine. This would be an additional exposure to the fetus.
Overnight care	Discuss a plan for infant care if patient is taking benzodiazepines for insomnia. The patient will need assistance as their alertness may be impaired.
Psychiatric consultation	Consider referral if benzodiazepines are required for more than just a brief, short term treatment.

Treatment: Considering Benzos

Presenting with severe anxiety or OCD

SSRI/SNRI Therapy
Sleep Hygiene (& non-pharm options)

Patient returns/messages that they cannot tolerate medication and/or cannot sleep

Risk-risk discussion about benzos with plan to use as bridge for sleep and starting meds

Prescribe a short course of lorazepam (ie. 5-10 tablets of 0.5 mg) nightly PRN while starting SSRI

As this point you have begun referral to psych, but can continue to utilize low dose lorazepam as needed with target for sleep and/or medication increases

Benzo: Algorithm to consider

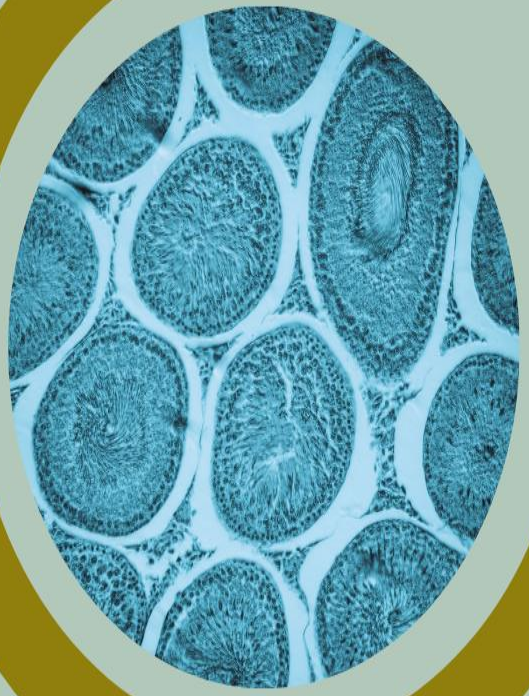
Severe illness with severe insomnia, acute event causing functional distress, and/or inability to overcome patient's medication anxiety

Start/increase SSRI
Prescribe short course of low- dose benzo
i.e., lorazepam 0.5 mg PRN hs or BID x 10-15 tablets
Begin referral to psych

32F G2P1011 at 9w3d

- Initial visit,
  - EPDS: 10
  - GAD-7: 14
- Reports history of anxiety and postpartum depression
- On Zoloft 50 mg from prior pregnancy
- Was doing OK with therapy until pregnancy

32F G2P1011 at 9w3d

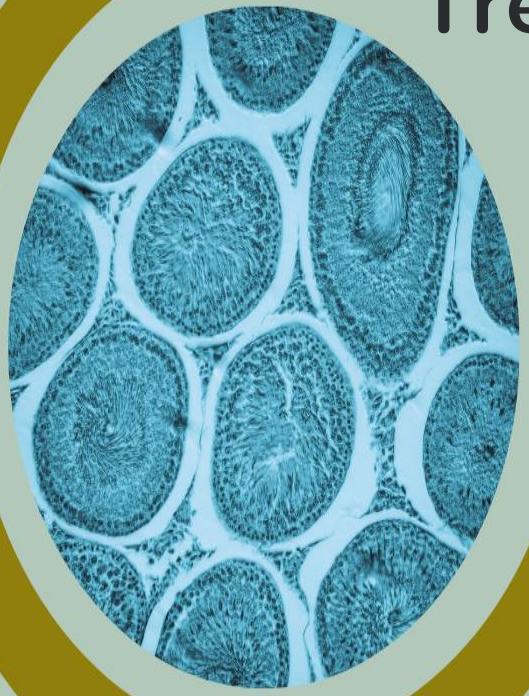


You do a RISK ASSESSMENT:

No history of suicide or suicidal thoughts. No thoughts now. No history of bipolar depression or manias.

Describes anxiety around miscarrying, dealing with work, concerns about losing her job and about her other child. These have caused her to have trouble falling asleep and staying asleep. Breathing exercises and therapy help but have become less effective.

32F G2P1011 at 9w3d: Treatment Decision



You, being the wise clinician that you are, decide to increase her Zoloft to 100 mg and have her return to clinic in 2-3 weeks

32F G2P1011 at 10w4d: EMR Message

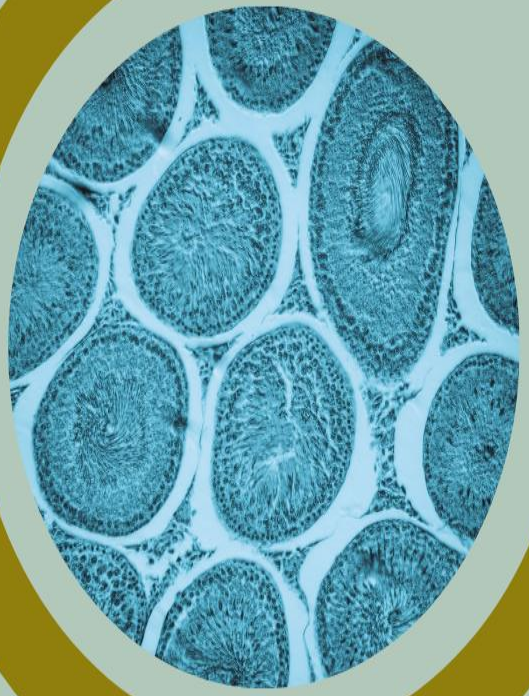
The patient messages you:

Dr. Smith,

I have not been able to sleep since I increased the Zoloft. I went up 3 days ago and feel more anxious now. I'm not sure I can continue like this. Before I was getting 5-6 hours, now I'm lucky if I get four and I'm exhausted. Unisom and Benadryl do nothing. I am safe, it's not that. Should I stop the medication?

What do you do?

32F G2P1011 at 10w4d: EMR Message



You reply:

Patient,

I'm so glad you reached out. It is not uncommon with SSRI increases to have some increased anxiety as your brain adjusts to it. This usually subsides after 3-5 days. As we discussed at our last visit, we sometimes use benzodiazepines such as Ativan when we are initiating/increasing treatment for severe anxiety. If you would like, I can prescribe a short course and we can get you in for follow-up in the next week.

The patient responds in agreement, asks appropriate questions about side effects of benzo (which you reiterate), and you write for lorazepam 0.5 mg x 7 tablets.

32F G2P1011 at 28w: Routine

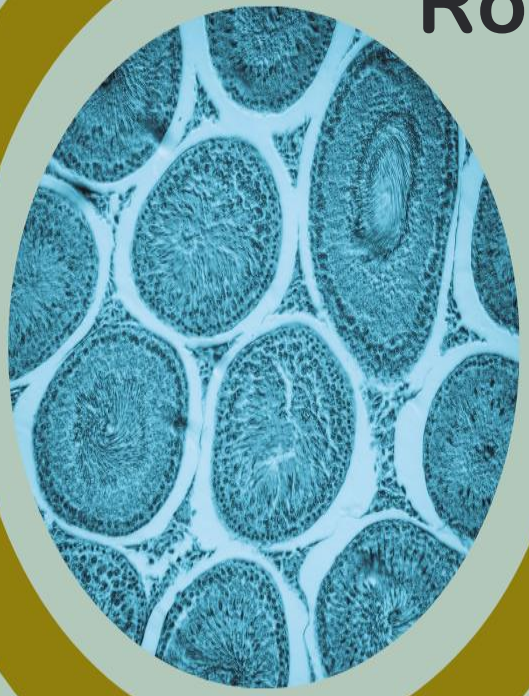
With a short course of benzos and reassurance, you were able to get the patient up to Zoloft 200 mg, which brought her symptoms back to pre-pregnancy levels.

She returns now at 28 weeks reporting some increased anxiety including more worries about work, delivery pain, postpartum depression.

EPDS: 7

GAD-7: 12

32F G2P1011 at 28w: Routine



You share with that patient that she is likely experiencing a resurgence of anxiety symptoms due to pregnancy changes leading to dilution of blood volume and changes in metabolism and excretion. For this you will plan to increase to Zoloft 250 mg.

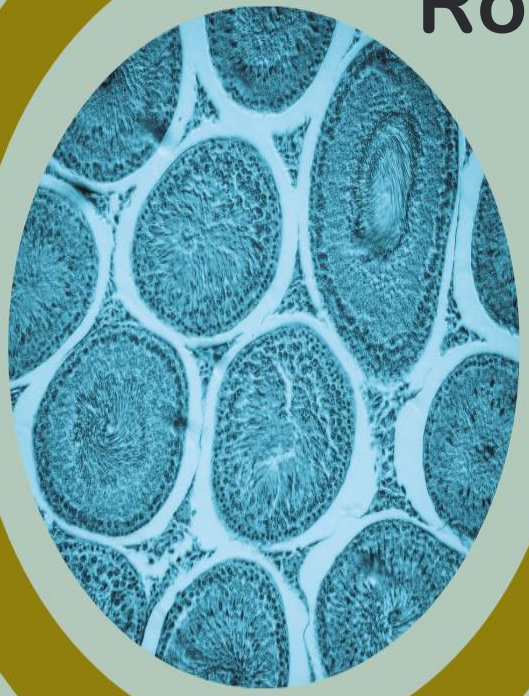
You also discuss that her anxiety places her at an increased risk of postpartum depression and you plan to follow her closely.

32F G2P1011 at 38w: Routine

The patient is on the waitlist for a Women's Mood Center in your area for soon after delivery. Today her GAD-7 is 10 and she reports that she is doing OK.

What are some quick preventative pointers that you can give her now?

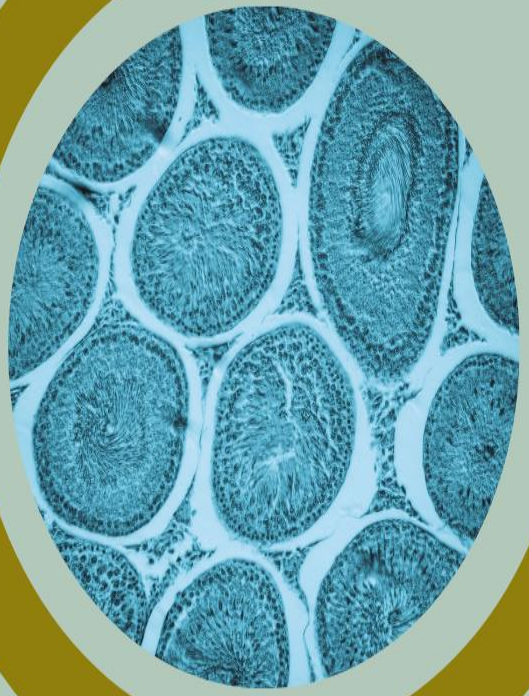
32F G2P1011 at 38w: Routine



Take a moment to ask/share the following:

1. Sleep – sleep is critical for healing for improving/preventing mental health deterioration.
    i. Ask: Have you considered sleeping arrangements? Who are the others that can help you protect sleep? The goal is 3-4 hours of uninterrupted sleep from the start. This may require a guest room, basement sleeping area, and/or creating a shift work schedule with another caregiver (spouse/family/friends/nanny).

Continued:

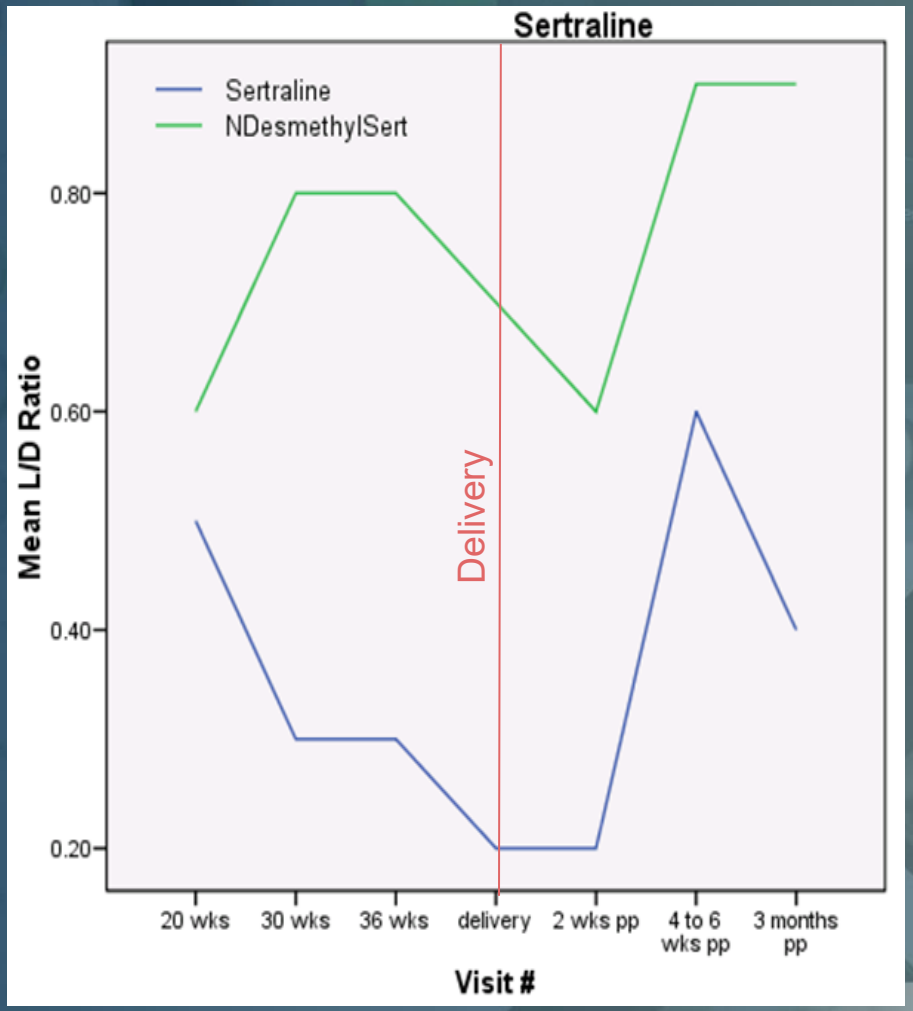


2. Anxious thoughts
    i. 100% of women will experience intrusive thoughts – ie. seemingly random thoughts of images that will pop into your mind and that are unnerving – if you have these and they become distressing, please reach out to us.
3. Postpartum Depression is common and treatable
    i. If you notice that your become more tearful, irritable, or have thoughts of self-doubt, you may be struggling with postpartum depression.
    ii. HHS Maternal Health Hotline:
        a. 1-833-9-HELP4MOMS (1-833-943-5746)

Treatment Pitfalls to Avoid: General

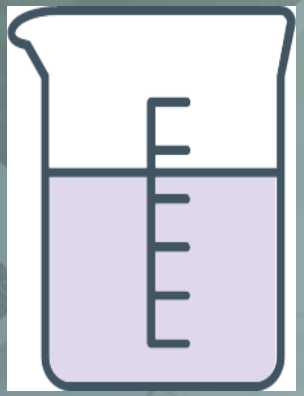
- Stopping treatment abruptly when patient becomes pregnant
- Not optimizing SSRI/SNRIs to target symptoms
  - Risks to fetus (pre-term birth, IUGR) are not dose dependent
  - Dose may need to be increased in the third trimester (next slide)
- Switching a patient's effective medication after she is pregnant:
  - Often patient will first see an OB at 8-10 weeks of pregnancy. By then, the fetus has already been exposed.
    - Evidence does not support switching from one SSRI to another if the initial medication is effective (i.e., If citalopram is working for the patient, there is no reason to switch her to sertraline)

Dose: why increases are necessary



Pre-pregnancy

Mid-trimester



Delivery

Sit DK et al, J Clin Psych 2008

Sit DK et al, J Clin Psychopharmacol 2010

Key Clinical Points

- A few concise questions can help to identify anxiety disorders
- OCD is often underrecognized and undertreated leading to poor outcomes
- Obsessive thoughts should be explored and not assumed to be a risk to the infant
- Scales can be very helpful for quick clinical assessment and can be done prior to evaluating a patient
- You can start treatment and then refer to specialists as needed

Key references

- The APA Textbook of Women's Reproductive Mental Health, eds. Hutner, Catapatno, Nagle-Yang, Williams, Osborne, forthcoming, APA Publishing:
  - Hutney, L, MacLean, J, Guerriei, G, Olgun, Melisa, Frew, J. Chapter 19: Anxiety Disorders and Insomnia in the Perinatal Period
  - Hudepohl, N, Leistikow, N, Levine, M, Osborne, L. Chapter 12: Obsessive-Compulsive Disorder
- Abramowitz JS, Schwartz SA, Moore KM, Luenzmann KR: Obsessive-compulsive symptoms in pregnancy and the puerperium: a review of the literature. J Anxiety Disord 17(4):461-478, 2003
- Bayrampour H, Vinturache H, Hetherington E, et al: Risk factors for antenatal anxiety: a systematic review of the literature. J Reprod Infant Psychol 36(5):476-503, 2018
- Challacombe FL, Salkovskis PM, Woolgar M, et al: Parenting and mother-infant interactions in the context of maternal postpartum obsessive-compulsive disorder: Effects of obsessional symptoms and mood. Infant Behav Dev 44:11-20, 2016
- Furtado M, Chow C, Owais S, et al: Risk factors of new onset anxiety and anxiety exacerbation in the perinatal period: a systematic review and meta-analysis. J Affect Disord 238:626–635, 2018
- Thorsness KR, Watson C, LaRusso EM. Perinatal anxiety: approach to diagnosis and management in the obstetric setting. Am J Obstet Gynecol. 2018 Oct;219(4):326-345. doi: 10.1016/j.ajog.2018.05.017. Epub 2018 May 24. PMID: 29803818.

Resources

- HHS Maternal Health Hotline:
  - 1-833-9-HELP4MOMS (1-833-943-5746)
- Psychology today (https://therapists.psychologytoday.com/rms/)
- American Psychological association (https://locator.apa.org)
- Postpartum support international (www.postpartum.net)
  - Online support groups
  - Support hotline (1-800-944-4773)
  - International therapist locator (https://postpartum.net/get-help/providerdirectory)
- MCPAP for Moms OB Toolkit: https://www.mcpapformoms.org/Toolkits/Toolkit.aspx
- ReproTox: https://www.reprotox.org/
- Mother To Baby: https://mothertobaby.org/fact-sheets/
- LactMed: www.lactmed.gov