Anxiety Disorders During and After Pregnancy

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Objectives

- Define anxiety and discuss the prevalence of anxiety disorders during pregnancy and postpartum
- Identify symptoms of anxiety in postpartum phase
- Identify screening tools to identify patients with anxiety
- Describe the process when a mother presents to clinic for anxiety
- Determine what is “normal” anxiety vs. clinically significant anxiety
- Discuss treatments available for anxiety
- Provide resources available for coping with anxiety
What do these women have in common?

“It was terrible, it was the exact opposite of what had happened when Apple was born. With her, I was on cloud nine. I couldn’t believe it wasn’t the same. I just thought it meant I was a terrible mother and a terrible person.”
Mental Health Diagnoses in Pregnancy and Postpartum

- Major Depressive Disorder (Perinatal and Postpartum)
- Anxiety Disorders
- Bipolar Disorder
- Substance Use Disorder
- Schizophrenia or Other Psychotic Disorders
- Adjustment Disorders with Anxiety and/or Depression
  - Common with social stressors and transitions in life
As a general rule, these diagnoses are the same as other psychiatric diagnoses, but the DSM-V has identified some particular specifiers relating some diagnoses to pregnancy and postpartum

For example, perinatal depression is an onset of depression that occurs during pregnancy or within the first 4 weeks postpartum.

DSM-V does not recognize “postpartum depression” as a diagnosis any longer, but rather that same criteria for a major depressive episode would be used for a diagnosis after 4 weeks postpartum.

Actually, the “postpartum” identifier is no longer present at all in the DSM-V.

Controversial

Postpartum Support International advocating for 6 month time period.
Anxiety Disorders – DSM-V

- Generalized Anxiety Disorder
- Panic Disorder
- Social Anxiety
- Agoraphobia
- Specific phobia
- *Posttraumatic Stress Disorder
- *Obsessive Compulsive Disorder

https://medskl.com/module/index/anxiety-disorders
Despite the diagnoses no longer having a postpartum identifier, there are specific signs and symptoms to watch for in postpartum women.
Anxiety

- Anxiety is diagnosed in:
  - 8.5% of postpartum women
- Significant predictor: maternal self report of anxiety or psychiatric history during antenatal phase
- Anxiety is highest during hospital stay but then sharply declines 2 weeks after delivery
  - If significant anxiety is still present at 2 weeks, levels remain fairly consistent at 2 months and 6 months
- Generalized anxiety disorder is the most common anxiety disorder in postpartum
Risk Factors for Anxiety in Postpartum Phase

- History of smoking
- Single mothers
- Young age
- Lower level of completed education
- Unplanned pregnancy
- Low self esteem
- High perceived stress
- Low marital satisfaction or low partner social support
- Low social support
- Presence of other mental health diagnoses, including depression
Common Symptoms of Anxiety in Pregnancy/Postpartum

- Low self-esteem, low self-efficacy
- Obsessions concerning contamination
- Fear of harm to the fetus
- Examples:
  - Contracting a serious illness
  - Doubts about the baby’s safety because of contamination
    - Sterilizing products aren’t working
  - Preparing the house, losing sleep over need to have house “perfect”
  - Seeking reassurance from friends, family members, and healthcare providers
Common Symptoms of Anxiety in Postpartum

- Difficulty bonding with baby
- Difficulty with breastfeeding – can exacerbate anxiety
  - Perinatal anxiety can also lead to breastfeeding difficulty due to increased demands and difficulty adapting to challenges
- Under involvement – avoidance in order to keep from acting on fears
- Overinvolvement – being overprotective in order to avoid fears
Isn’t some anxiety surrounding pregnancy “normal”? 

- YES!!!
- Major role transition
- Intrusive thoughts are common in pregnancy and postpartum
  - Vulnerable time because of inflated responsibility beliefs and overestimation of threat
  - Increased risk if a mother believes these thoughts increase the likelihood of the behavior occurring and exaggerate the consequences
Anxiety/Depression vs Baby Blues

- Baby Blues are common days after delivery lasting up to 2 weeks
  - Ups and downs in mood
  - Tearfulness for no reason
  - Feeling stressed and having doubts about ability to manage newborn

- Depression or anxiety lasts longer than 2 weeks
  - Low self esteem and guilt
  - Excessive worry
  - Frequent crying and cannot be consoled
  - Anger
  - Inability to sleep when has an opportunity
  - Blunted mood or not caring about comforting baby
  - Significant appetite changes
  - Hopelessness or thoughts of suicide
When Anxiety Goes Beyond “Normal”

- Difficult to determine when to treat due to this being a time of a lot of worry
- Recommend treatment when a female is very distressed and/or taking significant measures to alleviate the anxiety
  - Compulsions such as not leaving the house, avoiding the baby, cleaning, etc.
  - Increased anxiety over beliefs that automatic thoughts are indicating real desires (i.e. harm to the baby)
Process of Evaluating Anxiety in the Clinic

- Screening tools
- Diagnostic interview
- Rule out other medical diagnoses which could present as anxiety
  - Thyroid abnormalities
  - Low hemoglobin
- Develop a treatment plan including nonpharmacologic and/or pharmacologic options
  - Patient encouraged to be an active participant in developing treatment plan
Screening tools

- **Depression** – Edinburgh Postnatal Depression Scale, PHQ – 9
- **Anxiety** – Perinatal Anxiety Screening Scale (PASS), GAD-7

- These screening tools are available on the internet.
- Screening does not mean diagnosis.
- Need to keep other diagnoses in mind.
  - Depression and anxiety are often correlated
Perinatal Anxiety Screening Scale (PASS)

- Cut-off score of 26 is recommended to differentiate between high and low risk for presenting with an anxiety disorder
- PASS Screening Tool
Further evaluation is recommended when patient scores 10 or greater.
Special Considerations When Developing Treatment Plan

- Father and/or other caretakers should be involved in treatment if woman is comfortable with it.
- Family and friends are likely to have opinions – can be helpful or harmful.
- Pregnancy and delivery may be traumatic and cause other health problems.
- Sleep is often disrupted during this time.
- Some babies may go to the NICU – high levels of stress.
- Insurance concerns – Medicaid dropped after 60 days for many.
Nonpharmacologic Treatments for Anxiety

- Mindfulness
- Meditation
- Yoga
- Cognitive behavioral therapy (CBT)
  - Especially recommended for treatment of OCD, panic disorder, and specific phobia
  - No evidence supporting routine debriefing for women who perceived delivery as traumatic
    - Providing opportunities for women to discuss their experience may or may not be helpful
Pharmacologic Treatment of Anxiety

Exposure to Illness

Exposure to Medication
Pharmacologic Treatment for Anxiety

- Selective serotonin reuptake inhibitors (SSRI)
  - Most recent research does not indicate a need to choose one SSRI over another, but sertraline (Zoloft) is often chosen due to having the most information available on this medication
  - In breastfeeding, may choose SSRI with shorter half-life due to concerns about plasma levels in the infant
    - Longer half-life: citalopram, fluoxetine
Pharmacologic Treatment for Anxiety, cont.

- Benzodiazepines
  - Include medications such as lorazepam (Ativan), alprazolam (Xanax), or clonazepam (Klonopin)
  - Can cause some neonatal withdrawal including breathing difficulty, weakness, irritability, crying, sleep disturbance, tremors, jitteriness but not common at low doses
  - No association with maternal sedation response to medication
Resources - Websites

- FDA Drug Information: https://www.accessdata.fda.gov/scripts/cder/drugsatfda/
  - New guidelines regarding use in pregnancy and breastfeeding no longer use the letter categories
  - Now will have descriptive summaries, including use during pregnancy and lactation subsections

- Postpartum Support International (PSI) – training for professionals, screening tools, certifications, resources for patients
  - www.postpartum.net
Resources - Websites

- **Mother to Baby** – website to guide use of medications and dietary questions, includes patient handouts
  - [http://mothertobaby.org/](http://mothertobaby.org/)
- **LactMed** – National Institute of Health, used for medications and lactation
- **Massachusetts General Women’s Mental Health** – blog good for patients, easy to understand information for professionals
  - [https://womensmentalhealth.org/](https://womensmentalhealth.org/)
Resources - Apps

- Mindfulness apps
  - Calm
  - Headspace
  - Smiling Mind
Community Resources

- Nebraska Medicine Reproductive Psychiatry Clinic – (402) 552-6007
  - Target population: planning for conception, pregnant, or within 1 year postpartum
- Therapy resources ([www.psychologytoday.com](http://www.psychologytoday.com) or [www.nebraskamentalhealth.com/search](http://www.nebraskamentalhealth.com/search))
- Bethlehem House – residential facility providing parenting and prenatal care classes for women who are homeless, pregnant, and experiencing a crisis
- Mater Filius – housing, counseling, and medical care provided to women
- Women’s Center for Advancement – support for women and their families through various programs and services, 24 hour domestic abuse/sexual assault hotline, offers Spanish hotline
Community Resources

- Food Bank for the Heartland – food pantry, low income day care centers
- Heartland Hope Mission – food and clothing
- The Micah House – homeless shelter in Council Bluffs
- Open Door Mission, Siena-Francis House – homeless shelters in Omaha
- Salvation Army – residential and community support
- Restored Hope – transitional living program for homeless women and children (religious affiliation)
- Department of Health and Human Services – funding and oversight of behavioral health services, child welfare, Medicaid, etc.
- Nebraska Family Helpline – (888) 866-8660
- Heartland Family Services, Lutheran Family Services – low or no cost options for medication management and/or therapy
Case Study #1

- 32-year-old female from China
- Married with a 5-year-old son, full-time student in doctoral program
- Family history of OCD, depression
- No mental health history
- Referred from obstetrician for increased anxiety related to heartburn at 20 weeks pregnant
  - Made appointment for abortion
- Fixed beliefs vs. Obsessions
- Hospitalized for 10 days
- Started sertraline, quetiapine, and lorazepam
Case Study #2

- 41-year-old Caucasian female
- First pregnancy, unplanned
- Married, recently quit job to stay at home with child
- Presented at 2 months postpartum, breastfeeding
- Constant worry about daughter’s safety and how she may cause daughter harm
  - Unintentional harm vs. intentional harm
  - Recognizing automatic thoughts
  - Efforts to avoid harm including all organic diet, not leaving home due to fear of illness in public, avoidance of baby when home alone with her
- Started sertraline 50 mg daily x 1 week then increase to 100 mg daily
Questions?
References


