Perinatal anxiety: approach to diagnosis and management in the obstetric setting

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Anxiety is common in women during the perinatal period, manifests with various symptoms and severity, and is associated with significant maternal morbidity and adverse obstetric and neonatal outcomes. Given the intimate relationship and frequency of contact, the obstetric provider is positioned optimally to create a therapeutic alliance and to treat perinatal anxiety. Time constraints, absence of randomized controlled trials, mixed quality of data, and concern for potential adverse reproductive outcomes all limit the clinician's ability to initiate informed risk-benefit discussions. Clear understanding of the role of the obstetric provider in the identification, stabilization, and initiation of medication and/or referral to psychotherapy for women with perinatal anxiety disorders is critical to maternal and neonatal wellbeing. Informed by our clinical practice as perinatal psychiatric providers, we have provided a concise summary of current research on the approach to the treatment of perinatal anxiety disorders in the obstetric setting that includes psychotherapy and supportive interventions, primary and adjuvant psychiatric medication, and general prescribing pearls. Medications that we examined include antidepressants, benzodiazepines, sedative-hypnotics, antihistamines, quetiapine, buspirone, propranolol, and melatonin. Further research into management of perinatal anxiety, particularly psychopharmacologic management, is warranted.

Key words: antidepressant, anxiety, benzodiazepine, generalized anxiety disorder, lactation, panic disorder, pregnancy, selective-serotonin reuptake inhibitor

The perinatal period is a time of developmental transition for women that is characterized by significant physical and psychological change. During this period, women commonly experience pregnancy anxiety, a distinct feeling state comprised of negative emotions and worry related to pregnancy and becoming a mother.[1] Pregnancy anxiety often includes concerns about miscarriage, the baby's health, delivery, caring for the baby after discharge, and finances.[1-3] Pregnancy anxiety represents the interplay between a woman's emotions and the physiologic experience of her pregnancy and may impact up to 14.4% of pregnant women.[1,4]

Perinatal anxiety disorders differ from pregnancy anxiety by virtue of their intensity, persistence, and negative impact on a woman's functioning. Although frequently comorbid with depression, perinatal anxiety disorders are less studied, and prevalence estimates are inconclusive.[5] Available data suggest that 13−21% of pregnant women and that 11−17% of postpartum women experience clinically significant anxiety.[6,7] Perinatal mood and anxiety disorders are increased disproportionately among African American women compared with other racial groups in the United States[1,8-11] which may have etiologic importance for their increased risk of adverse obstetric and neonatal outcomes.[12]

In addition to race, socioeconomic status and personal and family psychiatric history are associated significantly with anxiety symptoms.[13] Other evidence suggests an association between anxiety and the following risk factors: primiparity, stress during pregnancy, decreased social support, medical complications, smoking, previous stillbirth, negative childbirth experience, prematurity, and neonatal intensive care unit admission.[1,14-18]

Maternal anxiety disorders are a significant source of maternal morbidity and are associated with suboptimal pregnancy, neonatal, and childhood outcomes.[19-24] Maternal stress and anxiety negatively impact mothers, contributing to sleep disruption, decreased physical activity, poor nutrition, substance use, fear of childbirth, and excessive use of prenatal services.[25-27] Untreated maternal anxiety is associated with increased risk of preterm birth,[19,28] low birthweight,[19,29,30] and preeclampsia.[27,31,32] Neonatal effects of untreated maternal anxiety may include elevated infant cortisol levels at birth, disrupted emotional regulation, negative behavioral reactivity, and impaired cognitive performance during infancy.[23,24,33] Fetal exposure to untreated maternal anxiety is associated with alterations in stress-regulatory systems and neurocognitive outcomes such as impaired attentional processing,[34] increased risk of childhood psychiatric disorders,[35] increased behavioral and emotional problems,[36] and decreased brain volumes in areas of the brain associated with learning, memory, social/emotional, and auditory language processing.[33,37,38]

Recognizing that the identification and treatment of perinatal anxiety disorders is crucial to improving maternal well-being and decreasing adverse pregnancy outcomes, the American Congress 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 and instructs obstetric providers to combine screening with appropriate follow-up evaluation and treatment

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interventions such as referral to psychotherapy, medication, and/or referral to mental health services when indicated.[39] In clinical practice, understanding the risk-benefit decision-making associated with the use of psychoactive medications may challenge obstetric providers who are tasked with managing multiple issues in the limited visit time allotted. This review will familiarize obstetric providers with the clinical considerations associated with the identification and treatment of anxiety disorders in pregnant and postpartum women, focusing on medication management, stabilization of acute symptoms, and the decision to involve psychiatry. The discussion is informed by our clinical observations and designed to highlight interventions appropriate to the obstetric setting.

Clinical Features and Diagnosis

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) defines fear as "the emotional response to real or perceived imminent threat" and anxiety as "anticipation of future threat."[7] Previous editions of the DSM grouped panic disorder, generalized anxiety disorder (GAD), obsessive compulsive disorder (OCD), and posttraumatic stress disorder (PTSD) together; however, the DSM-5 separated obsessive compulsive disorder and posttraumatic stress disorder into discrete sections closely related to the anxiety disorders.[7] Although it is important to recognize and treat obsessive compulsive disorder and posttraumatic stress disorder during the perinatal period, detailed descriptions of these conditions are beyond the scope of this review.

Common features of anxiety disorders include excessive fear, worry, and resulting impairment in behavior and psychosocial functioning. Anxiety disorders are frequently chronic, waxing and waning in response to external stressors. Maternal anxiety may include worries about fetal/infant health and wellbeing or manifest as physical concerns and frequent medical visits.[40] Providers mistakenly may attribute the physical symptoms of anxiety to the expected psychologic changes of pregnancy, which could complicate diagnosis. Medical conditions like thyroid dysfunction, anemia, and preeclampsia may also manifest as symptoms of anxiety, and evaluating for such conditions is recommended.[41]

Given the complexities of diagnosing anxiety in the obstetrics setting, we focus on GAD and panic because they are highly prevalent in the perinatal period. Table 1 provides diagnostic criteria for anxiety disorders.

GAD is characterized by persistent excessive worries in multiple domains. Worries are difficult to control and are associated with muscle tension, restlessness, irritability, fatigue, sleep disturbance, and poor concentration.[23] Prevalence data estimate a rate of 8.5% of GAD during pregnancy and 4.4−8.2% during the postpartum period,[41] which suggests that it may be more common in the perinatal period compared with the approximate 3% rates that have been observed in the general population.[7] The DSM-5 requires symptoms to be present for at least 6 months before diagnosing GAD.[7] Consideration of a diagnosis of adjustment disorder with anxiety, characterized by the same symptoms as GAD but precipitated by a stressful life event (eg, pregnancy/childbirth) and present for <6 months, may be more appropriate.[7]

Panic attacks present as unpredictable moments of sudden intense fear or discomfort accompanied by the symptoms outlined in Table 1. Women frequently interpret panic symptoms as indications of fetal distress.[41] Panic disorder is diagnosed if a woman experiences repeated attacks with subsequent major behavioral changes and/or preoccupation with potential recurrence.[7] Prevalence rates of panic disorder range from 1.3−2.0% during the perinatal period.[41] It is important to provide education to women that physiologic changes that are associated with pregnancy (like tachycardia, shortness of breath, and rhinitis) may precipitate panic attacks.

The perinatal period is a favorable time for providers to engage in anxiety screening and education, given the frequency of contact and likely maternal motivation for change.[42] Despite a lack of consensus on screening tools, a subscale of the Edinburgh Postpartum Depression Scale-3 (EPDS-3) is commonly used and has been validated in the diagnosis of anxiety disorders.[43] The EPDS-3 comprises the following 3 statements: (1) I have blamed myself unnecessarily when things went wrong; (2) I have felt scared or panicky for no good reason, and (3) I have been anxious or worried for no good reason.

Insomnia is a frequent companion to anxiety and is associated with more severe illness and increased risk of psychiatric decompensation. Women with obsessional features may worry excessively about causing accidental harm to their infant, leading to hypervigilance, infant avoidance, or frequent reassurance seeking from family and medical providers.[44] Asking a mother whether she is having intrusive or frightening thoughts/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 postpartum.[39] Such intrusive thoughts/visions, termed *obsessions*, may be present in anxiety and depressive disorders.

Providers must distinguish between anxiety-related obsessions and infanticidal ideation, which is a hallmark of perinatal psychosis. In anxiety-related obsessions, women are aware that the obsessions are illogical, are extremely distressed by their presence, and often expend great effort to avoid acting on them. In contrast, psychosis is characterized by poor insight and lack of distress associated with the thoughts, which indicates a belief that the actions may be reasonable. Postpartum psychosis, like suicidality, is an emergency that necessitates immediate psychiatric evaluation in a secure setting like the emergency department.[45,46] Obstetric practices that screen women for psychiatric conditions require clinic processes for accessing emergency resources, such as mental health crisis agencies or emergency departments, when emergencies are identified.[47]

Approach to Treatment

Obstetric providers play a critical role in the identification and treatment of perinatal anxiety. Screening for anxiety,