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Peripartum and Postpartum Anxiety

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Description of Peripartum and Postpartum Anxiety

Peripartum and postpartum anxiety (PPA) is not currently a standalone diagnosis in the *DSM-5* (American Psychiatric Association [APA], 2013). Common manifestations of PPA can include symptoms such as excessive worry related to one's child, difficulties with sleep or breathing, and repeated thoughts or images of bad things happening to one's child (UNC School of Medicine, 2015). Generalized anxiety disorder or adjustment disorder with anxiety may be appropriate diagnoses, depending on the specific circumstances (Ross & McLean, 2006). Due to shared risk factors, it is quite common for individuals diagnosed with anxiety disorders to also meet the criteria for major depressive disorder (APA, 2013). In fact, one study found that 20% of women who were diagnosed with postpartum depression had comorbid anxiety at two weeks postpartum (Miller, Hoxha, Wisner, & Gossett, 2015).

Approximately 10% of new parents (women and men) experience moderate levels of anxiety during and after pregnancy (Don, Chong, Biehle, Gordon, & Mickelson, 2014). Additionally, research has shown that approximately 7% of women screened positive for anxiety at 2 weeks postpartum, and that rate increased to 8% at 6 weeks postpartum (Miller et al., 2015).

Maternal separation anxiety (i.e., anxiety related to being separated from one's child short term) is often associated with feelings of worry, guilt, or sadness (Hock, McBride, & Gnezda, 1989), and it can be characterized by an overprotective style of parenting (Cooklin, Giallo, D'Esposito, Crawford, & Nicholson, 2013). High levels of separation anxiety can also make balancing various life roles and returning to work difficult for mothers (Cooklin, Rowe, & Fischer, 2012).

Obsessive-compulsive disorder (OCD) is characterized by recurrent thoughts and/or repetitive behaviors (APA, 2013), and at postpartum those thoughts often relate to the infant. In one study, approximately 11% of women screened positive for OCD at 2 and 6 weeks postpartum (Miller et al., 2013). Postpartum OCD also has been documented in new fathers (Abramowitz, Moore, Carmin, Wiegartz, & Purdon, 2001), but no estimates of prevalence are available. A small subset of women (approximately 4–5%) experienced the onset of OCD symptoms at postpartum, and up to half of women with preexisting OCD experienced an increase in symptoms at postpartum (Guglielmi et al., 2014).

Resources:

- Anxiety During Pregnancy and Postpartum: http://www.postpartum.net/learn-more/anxiety-during-pregnancy-postpartum/
- Men Also Get Postpartum Depression: http://www.webmd.com/depression/postpartum-depression/news/20080506/men-also-get-postpartum-depression
- Postpartum Anxiety More Common, Less Recognized than Postpartum Depression: http://news.psu.edu/story/269398/2013/03/20/research/postpartum-anxiety-more-common-less-recognized-postpartum
- Postpartum Obsessive-Compulsive Disorder: http://www.pregnancy-info.net/postpartum_obsessive_compulsive_disorder.html
- Symptoms of Postpartum Depression and Anxiety: http://postpartumprogress.org/2011/02/the-symptoms-of-postpartum-depression-anxiety/

- Tips for Postpartum Dads and Partners: http://www.postpartum.net/family/tips-for-postpartum-dads-and partners/

IDENTIFICATION/ ASSESSMENT STRATEGIES

There is limited information on the frequency of PPA screening among medical and/or counseling professionals. Further, no research is available regarding how often new mothers seek help for PPA. Nevertheless, women with depressive and anxiety disorders are more likely to identify that they experience barriers to seeking help (Alvidrez & Azocar, 1999). Pregnant women are more likely to seek out individual counseling if they have received similar help in the past (Goodman, 2009).

Medical and counseling professionals should be intentional in screening for risk factors and symptoms of PPA, ideally within 2-4 weeks postpartum (Brandes, Soares, & Cohen, 2004), if not before. Also important is that counselors rule out conditions that can mimic PPA (e.g., diseases and disorders such as thyroid dysfunction, anemia, side effects from medications, alcohol, or illegal drugs; Bennett & Indman, 2011; Brandes et al., 2004; Davis, 2014). Several empirically-supported risk factors for PPA include:

- **Previous *postpartum* depressive or anxiety disorders** in family or personal history;
- **General history of depressive or anxiety disorders** in family or personal history;
- **Mood reactions to hormonal changes** including heightened mood fluctuations throughout puberty, during menstrual cycles, or when using hormonal birth control methods;
- **Social factors** such as inadequate social support, interpersonal violence, financial stress/low socioeconomic status, high-stress parenting such as being a parent of multiples or being a teen parent, expectations related to the maternal role, and degree of importance placed on the maternal role versus employment;
- **Personality factors** including neuroticism (Cooklin et al., 2013b; Davis, 2014; Gee, 2008).

Additionally, other factors that are believed to play important roles in PPA but have not yet been studied include poor relationship satisfaction with one's OB/GYN and/or midwife provider, childbearing and infant complications, and perfectionism or high expectations (Davis, 2014).

Given the variation of risk factors and symptoms associated with PPA, screening tools can be helpful in assessing for PPA and more information about assessment measures and their authors and availability can be found in the *Resources* area below. The *Edinburgh Post Natal Depression Scale* was found to have a strong correlation with the *State-Trait Anxiety Inventory* and may be a good screening instrument for PPA (Stuart, Couser, Schilder, O'Hara, & Gorman, 1998). Additionally, the *State Trait Anxiety Inventory* can be used independently as a measure of anxiety, as can the *Maternal Separation Anxiety Scale.* The *Postpartum Distress Measure* can be useful in identifying negative thoughts and feelings associated with having a child. Finally, in terms of identifying OCD symptoms, the *Yale Brown Obsessive-Compulsive Scale and Checklist* offers a measure of the severity of general obsessive thoughts.

While there are no screening tools for obsessive thoughts specific to having a child, it may be helpful to specifically explore the obsessive thoughts that new mothers and fathers might have related to their infants. For example, OCD symptoms such as intrusive thoughts about harm coming to the infant can be common among new parents (Ross & McLean, 2006), and these should be differentiated from more pathological ways of thinking. A mother who identifies these kinds of thoughts as unreasonable, is bothered by the thoughts, and makes efforts not to act on them is at low risk of actually harming her child (Abramowitz, Schwartz, Moore, & Luenzmann, 2003). Counselors need to carefully screen for differences between these kinds of normal thoughts and those that might be indicators of more severe postpartum psychosis or severe major depression (Ross & McLean). Counselors should be aware of conducting a thorough screening – as needed- to determine if a referral for a higher level of care or a referral to child protective services is required.

Resources:

- Edinburgh Post Natal Depression Scale online: http://www.postpartumhealthalliance.org/screening-test
- State-Trait Anxiety Inventory: http://www.mindgarden.com/145-state-trait-anxiety-inventory-for-adults
- Maternal Separation Anxiety Scale: see Hock et al. (1989) reference
- Postpartum Distress Measure: http://postpartumstress.com/professional-development/assessments/

- Yale Brown Obsessive-Compulsive Scale and Checklist: https://psychology-tools.com/yale-brown-obsessive-compulsive-scale/

INTERVENTION STRATEGIES

Limited research exists regarding interventions specific to postpartum anxiety, but general anxiety research can inform counseling interventions for those struggling with PPA. Researchers have suggested that postpartum OCD should be treated as it would in anyone else who has OCD (Brandes et al., 2004). The majority of research suggests that some combination of cognitive behavioral therapy and psychoeducational approaches are the most effective in counseling those who have PPA (Aston, 2002; Austin et al., 2008; Cheng, Fowles, & Walker, 2006; Thomas, Komiti, & Judd, 2014).

Cognitive Behavioral Therapy (CBT)

CBT is widely used as a treatment approach for anxiety in general, but limited research is available regarding the use of CBT in relation to PPA. CBT has, however, been found to help lower the anxiety levels of pregnant women (Austin et al., 2008). Given the widespread effectiveness of CBT for treating anxiety in general and its effectiveness with pregnant women, counselors might consider using interventions grounded in CBT with new parents. For example, the use of self-monitoring or worry tracking might help new mothers become more aware of the frequency and types of thoughts they have, and then interventions could be implemented to challenge these distorted thoughts. CBT techniques involve teaching and practicing relaxation, and researchers have found relaxation techniques effective in reducing anxiety during pregnancy (Teixeira, Martin, Prendiville, & Glover, 2005).

Group Counseling

A psychoeducational group approach can help provide clients with information, which can normalize their experiences and help them understand what to expect with regard to their own transitions (e.g., physical, sexual, relationships) as well as what to expect in terms of their infants' development. Ideally, groups should be structured to allow opportunities to inform and challenge the participants while also facilitating opportunities for discussion of personal experiences (Aston, 2002).

Group counseling might also serve to prevent PPA in at-risk populations. One group of researchers targeted pregnant women who had a past history or current diagnosis of depression or anxiety. Their intervention consisted of a combination of psychoeducation, interpersonal therapy, and CBT and addressed content related to the parent-infant relationship. From pre- to post-group, participants experienced significant reductions in anxiety (Thomas et al., 2014).

Other Systemic and Preventative Approaches

CBT implemented in conjunction with childbirth education classes can be effective in decreasing obsessive thoughts post-partum (Timpano, Abramowitz, Mahaffey, Mitchell, & Schmidt, 2011). Timpano et al. (2011) constructed an intervention that focused specifically on psychoeducation about postpartum anxiety and cognitive restructuring and included techniques for modifying faulty thinking. Emphasis was also placed on the importance of controlling intrusive thoughts about the child.

Preventative approaches that are not empirically based, but are grounded in research and theory, also could help to decrease the potential for postpartum anxiety (Cheng et al., 2006). First, informational materials could be developed and provided to new mothers as early as possible, with content addressing common physical and psychological changes, infant care, relaxation techniques, time management strategies, and a list of counseling and health care resources. Counselors are encouraged to share those resources with the parenting partner as well. Finally, counselors might assess new mothers' social support—both from her partner (if applicable) as well as from family and friends. Related to social support, interventions might include referral to support groups, couples counseling, and information about respite care, depending on the identified needs.

Resources:

For Counselors

- Anxiety Disorders in Pregnancy and the Postpartum Period: http://cdn.intechopen.com/pdfs-wm/43758.pdf
- Beyond the Blues: Understanding and Treating Prenatal and Postpartum Depression and Anxiety: http://www.beyondtheblues.com/book/home.html
- I'm Listening: A Guide to Supporting Postpartum Families: http://www.amazon.com/Im-Listening-Supporting-Postpartum-Families/dp/0692305807/ref=sr_1_11?ie=UTF8&qid=1428709918&sr=8-11&keywords=postpartum+depression+support
- Massachusetts General Hospital Center for Women's Mental Health: http://womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders/
- Mood and Anxiety Disorders During Pregnancy and Postpartum: http://www.appi.org/home/search-results?FindMeThis=postpartum
- Postpartum Mood and Anxiety Disorders: A Clinician's Guide: http://www.jblearning.com/catalog/9780763716493/
- Postpartum Stress Center Professional Development: http://postpartumstress.com/professional-development/course-check-list-resources/
- Postpartum Support International PSI Certificate Trainings: http://www.postpartum.net/professionals/psi-certificate-training/
- Pregnancy and Postpartum Mood and Anxiety Disorders Video Training: http://www.pesi.com/ECommerce/ItemDetails.aspx?ResourceCode=RNV046870
- Psychiatric Illness in Women: Emerging Treatments and Research: http://www.appi.org/Book/Subscription/JournalSubscription/id-2212/Psychiatric_Illness_in_Women

For Clients

- Dropping the Baby and Other Scary Thoughts: Breaking the Cycle of Unwanted Thoughts in motherhood: http://postpartumstress.com/books/dropping-the-baby-and-other-scary-thoughts/
- Postpartum Stress Center: http://postpartumstress.com/
- Postpartum Support International: http://www.postpartum.net/
- Steps to Wellness: http://janehonikman.com/steps-to-wellness/
- The Pregnancy and Postpartum Anxiety Workbook: https://www.newharbinger.com/pregnancy-and-postpartum-anxiety-workbook
- When Words are Not Enough: The Women's Prescription for Depression and Anxiety: http://www.amazon.com/When-Words-Are-Not-Enough/dp/0553067133

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