Perinatal anxiety

A guide for health professionals

The term 'perinatal anxiety' refers to anxiety experienced at any time in the antenatal period or in the 12 months following the birth of a baby (postnatal period). Perinatal anxiety is common. However, it is often missed or misattributed to aspects of pregnancy (eg hormones) or having a baby (eg adjustment, sleep deprivation). In addition, high levels of stigma may prevent women seeking help.

Antenatal anxiety may occur in response to fears about aspects of the pregnancy (e.g. parenting role, miscarriage, congenital disorders), or as a continuation of a pre-pregnancy condition and/or comorbidly with depression. Higher levels of self-reported anxiety or anxiety disorder in pregnancy increase the risk of depression postnatally.

Anxiety disorders can have significant effects on the health and wellbeing not only of the mother, but also her partner and other children. The latest research also reveals that anxiety disorders can have a negative impact on the growth and development of the fetus/baby, so early detection and intervention is paramount.

Being aware of symptoms, referral pathways and effective treatments is critical for health professionals caring for women in the perinatal period.

Prevalence

Australian research indicates that around **1 in 5** women will experience anxiety in pregnancy or in the year following birth. It is common for women to experience depression and anxiety concurrently.

Causes

There is no single, definite cause of anxiety – rather it is likely to result from a combination of *biological* (eg personal/family history of depression), *psychological* (eg coping strategies, cognitive style) and *social factors* (eg access to support).

The combination of these risk factors may place a woman at increased risk of developing anxiety in the perinatal period. These risk factors are reflected in recommended psychosocial assessment scales/questions.

Symptoms

There are many types of anxiety disorder. While the symptoms of perinatal anxiety disorders differ, women who have an anxiety disorder may experience:

- anxiety or fear that interrupts thoughts and interferes with daily tasks
- panic attacks – outbursts of extreme fear and panic that are overwhelming and feel difficult to bring under control
- anxiety and worries that keep coming into the woman's mind and are difficult to stop or control
- constantly feeling irritable, restless or "on edge"
- having tense muscles, a "tight" chest and heart palpitations
- finding it difficult to relax and/or taking a long time to fall asleep at night
- anxiety or fear that stops the woman going out with her baby
- anxiety or fear that leads the woman to check on her baby constantly.

Screening and assessment

Women in the perinatal period should be routinely screened for possible symptoms of anxiety and assessed for psychosocial risk factors for mental health problems. The evidence supports the use of the following approaches.

Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a **screening tool** specifically designed to identify possible depression in the perinatal period. Comprising 10 questions, the screening tool asks the woman to choose from one of four responses that best describe how she has been feeling in the past 7 days. Some questions are specific to a woman's experience of anxiety (items 3, 4 and 5).

All women should be offered the EPDS at least four times in the perinatal period – as early as practical in pregnancy, once later in pregnancy, 6–12 weeks after the birth and again in the first postnatal year.

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Appropriate responses to EPDS scores are:

10 to 12 – offer repeat EPDS in 2-4 weeks as the woman's score may change subsequently

13 or more – offer further assessment as the woman may have major depression

Positive score on Question 10 – offer further mental health assessment as the woman is at risk of harming herself and/or her children.

When screening Aboriginal and Torres Strait Islander women or migrant and refugee women, language and cultural appropriateness of the tool are considerations.

Antenatal Risk Questionnaire

The Antenatal Risk Questionnaire (ANRQ) addresses key domains of psychosocial health that have been shown to be associated with increased risk of perinatal mental health morbidity (e.g. depressive or anxiety disorder) and less optimal mother-infant attachment. The ANRQ can be self-completed or administered by the health professional and can be used during pregnancy or postnatally.

The ANRQ has 12 scored items relating to the following risk domains:

- mental health history
- history of physical, sexual or emotional abuse or neglect
- level of practical support and emotional support from partner
- anxiety and perfectionism levels
- stressors/losses in the last year (e.g. bereavement, separation etc.).

Psychosocial risk factors should be assessed as early as practical in pregnancy and again 6–12 weeks after the birth.

When assessing psychosocial risk among Aboriginal and Torres Strait Islander women or migrant and refugee women, language and cultural appropriateness of the tool are considerations.

The ANRQ should only be used by appropriately trained staff with ongoing clinical supervision and, should be administered with a depression screening measure (e.g. EPDS), ideally towards the end of a visit. ANRQ responses should be discussed with the woman and a psychosocial care plan developed as appropriate.

The EPDS and ANRQ are screening tools only and further mental health assessment by a qualified health professional is required to provide a diagnosis.

Treatment and management

As with anxiety at other times of life, psychological and medical treatments are the basis of treatment and management in the perinatal period.

Psychological therapies

Psychological therapies are recommended for women with symptoms of perinatal anxiety. Psychological therapies target thoughts, feelings and behaviours and include cognitive-behavioural therapy (CBT), interpersonal therapy (IPT), and psychodynamic therapy. Psychotherapy involving the infant may improve mother-infant interaction and provide an opportunity to focus on the mother-infant relationship and maternal sensitivity.

The choice of therapy involves consideration of the woman's preferences, the severity of her anxiety, other psychological and physical conditions and her access to treatment. Psychological therapies should only be provided by registered health professionals with accredited training and experience.

Medication

Decision-making regarding medication is a collaborative process and is based on a woman's level of distress, the impact of her symptoms on her social, occupational and relationship functioning, and her ability to engage with structured psychological therapy.

The preferred antidepressants for use in the perinatal period are **selective serotonin reuptake inhibitors** (SSRIs) - these are also used for anxiety. Tricyclic antidepressants (TCAs) can also be considered, especially if they have been effective previously.

Benzodiazepines can be used for treating symptoms of anxiety while awaiting onset of action of an antidepressant in pregnant or postnatal women. Benzodiazepines should only be used for a short period (up to 3-4 weeks) as they are addictive. Long-acting benzodiazepines should be used with caution around the time of the birth.

Medications should only be prescribed after careful deliberation with the woman and her significant others when she is planning a pregnancy, is pregnant or breastfeeding. If symptoms are severe, involving a psychiatrist is advisable.

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Tips for providing support

Listen and reassure

- Encourage the woman to discuss any symptoms she may be experiencing.
- Assure the woman that anxiety can be treated and managed.

Provide information

- Refer all women to **Ready to COPE** – to receive ongoing information and support strategies throughout her pregnancy and/or the postnatal period.
- Provide the woman with quality information about anxiety - see COPE consumer fact sheet.
- Provide details of helplines if she is feeling distressed and needs support.
- Offer information to the woman's partner/others.

Direct to care and support

- Encourage the woman to consult with her general practitioner (GP) or other qualified health professional.
- Encourage the woman to identify and draw on possible supports and services that may be available to her for practical and/or emotional support.
- Remind the woman that she can go to her doctor or local hospital if she is at risk of harming herself or others.

This resource was developed from the *Mental Health in the Perinatal Period: Australian Clinical Practice Guideline* (2023). The Guideline can be downloaded from the COPE website at cope.org.au

Information for women and their families:

Ready to COPE Guide:

Women and their partners can receive free weekly information about emotional and mental health throughout the perinatal period, via the Ready to COPE Guide. Visit readytocope.org.au for more information.

Information:

Provide women with consumer fact sheets on anxiety in pregnancy and the postnatal period.

Telephone support:

To access a specialist counsellor, call the PANDA helpline on 1300 726 306 (Monday to Saturday 9.00am – 7.30pm AEST/AEDT)

Further mental health information:

To find out about other perinatal mental health treatment and support services, visit the eCOPE Directory

Further information for health professionals:

- **Edinburgh Postnatal Depression Scale (EPDS)**
- **Antenatal Risk Questionnaire (ANRQ)**

COPE
Centre of Perinatal Excellence

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