

# *Depression and Anxiety in OB/GYN:*

## *Depression:*

- [Major depression in women](#) is twice as common as in men - lifetime prevalence 21% for women. At age 10, the incidence difference begins to differ between the sexes, and peaks by mid to late adolescent.
- Women are more likely to have an increase in stressors prior to the depression diagnosis than men. [Anxiety, panic](#), somatic complaints, increased appetite, weight gain, guilt, and decreased [sexual desire](#) are more apt to be seen in women than men. Comorbid psychiatric disorders are more common. [Women attempt suicide](#) more often than men but men are more apt to be successful with the attempt.
- Why is depression more common in women than men? May be due to genetic transmission or difference in brain structure. [Depression is also associated with reproductive function](#). There are many psychosocial risk factors. Lack of work outside the home may be a risk factor, along with marital conflict (women three times more apt to be depressed in an unhealthy marriage than men) and the presence of young children in the home.
- [Depression and anxiety together](#) usually results in more treatment difficulties - often with the need for higher med dosing with longer duration of med use.
- Women with anxiety have much more [panic](#) and [phobia problems](#) than men. [Posttraumatic stress disorder in women](#) is more common along with a history of [sexual abuse in women with PTSD](#).
- Tricyclic antidepressants can have significant side effects once at therapeutic doses to treat depression. The lethal potential is greater than with the SSRI's as well.
- [Panic disorder in women](#) is associated with a more frequent relapse when the meds are discontinued. SSRI's are effective as this is most thought to be due to a serotonin deficiency. Starting at low dose and then titrating up to the mid or higher end of the dosing schedule for any given ssri is the recommended way to go. Beginning a benzodiazepine with the SSRI initially can be acceptable, but it is important to let the patient know that this is a temporary medication.
- Cognitive therapy is a valuable adjunct to medication use and should not be forgotten.
- [Premenstrual dysphoric disorder \(PMDD\)](#) - premenstrual and cyclical with mood symptoms (irritability is the hallmark), along with other typical depressive symptoms. [Women with postpartum depression](#), history of mood changes when on bcp's have a higher incidence of PMDD. The theory of this is that there is a decrease in serotonin function. There is also serotonergic dysregulation.
- [Treatment of PMDD](#) - one a day multivitamin plus calcium, diet modification with smaller and more frequent meals with higher carbohydrates and less fat, nsaid's can be effective for the dysmenorrhea, and consideration for SSRI medications. The SSRI's work "immediately" to treat the PMDD as they effect serotonin levels immediately. Some may already be on an SSRI and can "bump up" the dose for the one to two weeks of PMDD symptoms. The low dose of an SSRI may be all that is needed to treat the PMDD especially if there is no other comorbid condition such as anxiety or depression
- Postpartum depression (PPD) can also be well treated with SSRI's. Treatment for a minimum of one year is suggested. There can be an increase in conduct disorders and depression in children of women with untreated postpartum depression. Women with a previous history of PPD do better when given meds prophylactically shortly after the birth

- or even before birth (ssri's are category C, however -so one must weigh the risks and benefits) if the mother has a history of the depression beginning before the child is born. Minimal case reports of problems noted in babies breastfeeding whose mothers are on an SSRI medications.
- Depression during the perimenopause: commonly seen together. Early menopause is risk factor, as is surgical menopause.
  - [\*The Concise Guide to Women's Mental Health\*](#) is a book that can be obtained from the American Psychiatric Association to get additional advise in med prescribing in breastfeeding or pregnant women.
  - Major depression is multifactorial, prompted by both genetic and environmental factors.
  - First degree relatives of individuals with depression have a 25% risk of being affected, and female relatives may be at even higher risk
  - Families of affected individuals often include members with alcohol abuse and anxiety disorders (suggesting a link)
  - Each year 15-20% of adults in the US experience a major depression (over 50% do not seek help)
  - The incidence among women is twice that of men and peaks between 18-44 years of age (the childbearing years)
  - Women are at increased risk of mood disorders during periods of hormonal fluctuation
    - Premenstrual
    - postpartum
    - perimenopausal
  - Etiology is unknown
    - Deficiency/excess – estrogen, progesterone, prolactin, thyroxine, tryptophan, and others
    - Always need to consider and assess for medical conditions (thyroid, alcohol or drug use, ....) abuse (current/past physical/sexual/emotional)
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- Baby blues
    - 50-80% of women experience transient “baby blues” within the first two weeks following delivery
      - Most common perinatal mood disturbance
      - transient state of heightened emotional reactivity experienced by 50-80% of women during the first week after delivery
      - emotionally labile, insomnia, weepiness, anxiety, depression, poor concentration
      - transiently tearful, then happy, cycles
      - Begins 1-3 days after delivery, lasts hours to days, and is usually resolved by PP day 10
      - Factors include lack of sleep, anxiety of new responsibilities, fears of being less attractive
      - Managed with supportive therapy

- Postpartum depression
  - Symptoms are same as other depression
    - Hopelessness
    - Helplessness
    - Persistent sadness
    - Irritability
    - Low self esteem
    - Weight change
  - Symptoms must be present for most of the day, every day for at least 2 weeks
  - Begins within 4 weeks of delivery (DSM IV) (2 weeks to 6 months)
  - Develops in 10-15 % of PP women
  - Most common complication of childbirth
  - Associated with antenatal depression, young maternal age, single marital status, cigarette smoking or illegal drug use, hyperemesis gravidarum, high use of emergency services and sick leave during pregnancy
  - Up to 70% of pts with previous event with have a subsequent episode
  - Women with a previous episode and baby blues, have a 85% chance of developing PP depression
  - Without treatment, the natural course is one of gradual improvement in the 6 months after delivery
  - As the duration of depression increases however so do the number of sequelae and their severity
  - Treatment, (most authorities) includes an antidepressant, support therapy, supportive web pages may also help
  - If symptoms improve after a 6 week trial, then therapy should continue for 6 months
  - If the response is suboptimal or a relapse occurs, pts should be referred to a psychiatrist
  - Recurrence of depression develops in 50-85% of women with an initial PP depression some time after medication is stopped
  - 2 month old infants of mothers with depression had decreased cognitive ability and expressed more negative emotions during testing

- Postpartum psychosis
  - 0.1-0.2% of women experience postpartum psychosis usually within the first 4 weeks after delivery
    - Most severe mental disorder
    - Manifests within 2 weeks of delivery (95% of cases), commonly can occur within 72 hours of birth, and is usually evidence of a bipolar disorder
    - Affected women have signs of confusion and disorientation but may also have episodes of lucidity
    - Women with preexisting psychotic illness are at highest risk, as well as those with prior episodes of PP depression
    - 10-15 fold risk of recurrence
    - Many will develop relapsing, chronic psychotic illness
    - course is variable and depends of the type of underlying illness
    - requires hospitalization, pharmacological treatment and long term psychiatric care
    - psychotic women have delusion leading to thought of self-harm or harm to their infants
    - ECT may be helpful (can be used when pregnant as well)

## *Anxiety disorders*

- examples include panic attack, panic disorder, social phobia, specific phobia, OCD, PTSD, generalized anxiety disorder
- all are characterized by irrational fear, tension, and worry, accompanied by physiological changes such as trembling, nausea, hot or cold flashes, dizziness, dyspnea, insomnia, and frequent urination
- These disorders are treated with psychotherapy and medication, including selective serotonin-reuptake inhibitors, tricyclic antidepressants, monoamine oxidase inhibitors and others

### *Need to screen all women because*

Many are not able to recognize they are depressed

Believe her symptoms are normal

Fear being labeled a bad mother if she admits feelings

Feel she is going crazy, and her baby may be taken away

First screen should be at preconception visit, then during prenatal intake and subsequent visits, PP exam, “ill baby” visits, during 6 week PP visit

### Screening tools

#### 1. Edinburgh Postnatal depression scale (EPDS)

- Designed for home or outpatient use
  - Consists of 10 questions
  - Can be completed in 5 min
  - Reviews feeling of the previous 7 days
  - Scored 0-3 depending of symptom severity
- #### 2. The Mills depression and anxiety checklist
- #### 3. The center for epidemiological studies depression scale (CES-D)
- #### 4. Beck depression inventory

#### Depression in the GYN patient

- Common at about 12 % of population
- Higher rate in females
- Common in teens and often “blown off”
- Frequently present as “recurrent, chronic, non-specific” illness
- Abd pain, pelvic pain, headache, constipation, decreased libido, (male and female), wt changes, insomnia
- Always evaluate for abuse (especially with frequent visits and no pathology)

### Domestic violence:

- Experienced by 25-50% of women during their life
- It is estimated that 1 in 5 women who present to the ER had been injured by the partner
- Approximately 90% of domestic homicides there is a history of a police call for domestic violence within the year
- 10% of adolescents are battered by a partner
- 3 different types
  - physical
  - sexual abuse
  - emotional
- Recognition is the first step
- Discuss *SAFE*
- May need to involved police as indicated
- Make yourself aware of resources in your area and local laws

## TREATMENT

- Based on level of depression
- Mild or moderated depression, psychotherapy alone may be enough
- Moderate to severe cases, treatment may include counseling and antidepressant medication
- Most important step is identifying the problem or risk for problem
- ALWAYS ask questions about mental health
- Screening tool is indicated
  - Many OB/GYN feel under trained in this area and will not screen (TB, Mammo...)
- Appropriate referral
  - Supportive care
  - Group therapy
  - Physiologist
  - Psychiatrist
  - Mental health services in you community (insurances)
    - Multidisciplinary approach is best
  - Legal, moral, ethical guidelines
  - Medications
    - Know your comfort zone
    - SSRI
      - Effective
      - Well tolerated
      - Few adverse side effects (nausea, drowsiness, fatigue, decreased sex drive, headaches, weight gain/loss, agitation)
      - Few fetal affects (??? Mild respiratory distress, irritability, feeding problems, jitteriness)
      - Prozac
        - 20 mg qd x 30 days = \$70.00
      - Paxil
        - ACOG suggest not using
        - Poss increased risk of congenital heart malformations (consider fetal echo)
        - 20 mg qd x 30 days = \$85.00
      - Zoloft
        - 50 mg qhs x 30 days = \$75.00
      - Elavil
        - 75mg qd x 30 days \$12.00 (generic), \$38.00 (brand)

## ○ *Anxiety*

- Mild anxiety in life in normal
- When it effects daily life, unable to function, or effects those around the pt, consider intervention
- How anxiety in the mother may affect the pregnancy has been a topic of recent research, and several studies indicate that women who experience clinically significant anxiety symptoms during pregnancy are more likely to have preterm labor and low birthweight infants, as well as other complications, including pre-eclampsia. Thus it is crucial that women with anxiety disorders be monitored carefully during pregnancy, such that appropriate treatment may be administered should anxiety symptoms emerge during pregnancy.
- OCD
  - Group therapy
  - SSRI

## *Summary*

- Postpartum depression
  - Relatively common
  - May have long-term consequences for mother, infant and family
  - Is easily missed
  - Should be screened for
  - Can be treated successfully
- Postpartum psychosis
  - Rare event
  - Medical emergency
  - Begins soon after delivery, 3-14 days
  - Hospitalization and aggressive treatment
- Depression
  - Always consider abuse (physical, emotional, sexual)
  - Always consider abuse with certain conditions
    - Chronic pelvic pain
    - Dyspareunia
  - Always consider and assess for medical conditions (thyroid, neurological diseases.....)

Case Presentations:

1. 24 Y/O P 1001 S/P NSVD PPD # 6, C/O irritability, insomnia, poor feeding by baby
2. 38 Y/O P 2082 LMP 4 weeks ago, who presents with 20 year hx of dyspurnia, wt loss, OCD type symptoms
3. 53 Y/O P 3003 LMP 4 years ago, who presents with C/O vag dryness, decreased libido.