

MOTHERISK ROUNDS

Ruminative Worrying During Pregnancy: A Case Series

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Abstract

Background: Most women worry to some extent during pregnancy about exposure to agents that might harm their babies.

Cases: We describe three women who worried excessively throughout pregnancy about harming their babies because of exposure to agents including, but not limited to, psychotropic drugs. These women were extremely resistant to reassurances that their babies would not be adversely affected, and it is likely there are more women in the community who fit this profile. We have described a number of management strategies that we found effective in caring for these women during pregnancy.

Conclusion: A collaborative effort between caregivers in psychiatry and obstetrics, as well as other health professionals, is required to provide management for these women during pregnancy.

Résumé

Contexte : La plupart des femmes présentent au cours de la grossesse, dans une certaine mesure, des inquiétudes au sujet de l'exposition à des agents pouvant nuire au fœtus.

Cas : Nous avons décrit la situation de trois femmes qui ont présenté des inquiétudes excessives, tout au long de la grossesse, quant à la possibilité de porter tort à leur fœtus en raison d'une exposition à des agents, dont (entre autres) les psychotropes. Ces femmes se sont avérées extrêmement résistantes aux formules de réconfort affirmant que leur fœtus ne subirait pas de conséquences indésirables; de plus, il est probable qu'un nombre important de femmes correspondent à ce profil au sein de la communauté. Nous avons décrit un certain nombre de stratégies s'étant avérées efficaces pour la prise en charge de ces femmes au cours de la grossesse.

Key Words: pregnancy, teratogens, psychotropic drugs, management

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Conclusion : Un effort de collaboration entre les fournisseurs de soins en psychiatrie et en obstétrique, entre autres professionnels de la santé, s'avère requis pour assurer la prise en charge de ces femmes au cours de la grossesse.

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INTRODUCTION

Following the thalidomide tragedy, which alerted the world to the fact that taking a drug in pregnancy could adversely affect the fetus,¹ there has been great concern on the part of both prescribers and consumers about the potential teratogenicity of medications administered to pregnant women and women of childbearing age who may become pregnant. Furthermore, the recent emphasis on the “natural” approach to health care may have led expectant mothers to be hesitant to expose their unborn babies to agents that they perceive as “unnatural,” including “mood altering” drugs. This is particularly true in the case of psychotropic drug use, and causes some women to discontinue their medication abruptly upon becoming pregnant, sometimes with deleterious consequences.

This caution is often supported by their health care providers, who may not be aware of the extent of the patient's impairment and the degree to which untreated mental illness may adversely affect obstetrical outcome and infant well-being.² The majority of women do feel reassured by evidenced-based information received from a trusted health care provider, such as a teratology information specialist.³ However, the authors became aware that there is a subset of pregnant women who cannot stop worrying about their

babies' being exposed to agents they believe may be harmful, regardless of how many times they receive reassuring information; we classified them as ruminative worriers. The following is a description of three women who were characterized as ruminative worriers. The management strategies in each case were implemented by a psychiatry team with input from the woman's obstetrician and other health care providers as required.

THE CASES

Case 1

This 30-year-old primigravid woman was married and was employed as a magazine editor. Prior to becoming pregnant, she had no major medical problems other than depression and anxiety, for which she was undergoing treatment. She came to the attention of the Motherisk Program (a Teratogen Information Service)² at 12 weeks' gestation, at which time she was taking citalopram 10 mg daily and clonazepam 0.25 mg as needed. Because Motherisk counsellors have been trained to identify callers who appear to be ruminative worriers, she was flagged as such after calling frequently to repeatedly ask the same question about citalopram despite receiving reassuring information on each occasion that this medication was not teratogenic. According to the established protocol, contact with this woman was transferred to the assistant director of the program (AE). The woman admitted that she was also in contact on most days with her family physician, obstetrician, psychiatrist, and psychologist, but none of them were able to convince her that her worries were groundless. She also felt the need to check frequently on the Internet for information regarding other exposures during pregnancy and their effects on the unborn child. She realized on an intellectual level that many of her worries were irrational, but her ruminations were so pervasive that she was driven constantly to seek reassurance from each of the health professionals involved in her care. Not only did the information she received fail to alleviate her anxiety for more than a few hours, but she began to generalize her ruminative worries and think of new exposures that might potentially harm her baby.

For the most part, she complied with the recommendations she was given, and the remainder of the pregnancy was uneventful. The dose of citalopram was gradually increased to 40 mg per day and she used clonazepam 0.25 mg several times per week. As the citalopram dose was increased, she required less clonazepam and ultimately used it only occasionally (once every 2–3 weeks). Exercises to allay anxiety proved to be helpful for her. She expressed relief once a program of management was instituted, because it provided structure that she found effectively limited her anxiety, and her calls to Motherisk and to her care providers became

much less frequent. She delivered a normal healthy baby at term and had an uneventful postpartum period free of further ruminations.

Case 2

A 38-year-old primigravid married flight attendant had been taking fluoxetine 20 mg per day for two weeks, having previously taken venlafaxine. At six weeks' gestation, she presented to the emergency room on three consecutive nights with severe anxiety and panic attacks precipitated by a sense of guilt that she might have harmed her baby by taking a drug. In the emergency room she was noted to be severely anxious and tearful, and she reported that she had not eaten for two days. She was dehydrated and had lost five pounds over the preceding two weeks. She felt that she could not get through the pregnancy because she was consumed with guilt and worry that her use of medication had harmed her baby. She was considering terminating the pregnancy, although she was conflicted about this as well because she had always wanted to have a baby, and her age meant that her fertility was declining. She was hospitalized for three days, and during this time was prescribed clonazepam 0.5 mg when needed to alleviate her severe anxiety. The risks and benefits of both of these agents were reviewed carefully with her and she agreed to take the medication.

She continued to take the medication prescribed for her, and relied heavily on the support of her husband throughout pregnancy. Clonazepam therapy was continued at a dose of 0.5 mg when required for anxiety, and the dose of fluoxetine was increased to 40 mg per day with good effect. By mid-pregnancy, clonazepam was used very sparingly, and her contact for reassurance declined substantially. She delivered a healthy baby at term, and during the postpartum period was free of anxiety and panic attacks.

Case 3

A 29-year-old gravida 2, para 1, married woman with a three-year-old son, presented to The Women's Life Center in Los Angeles at six months' gestation. At that time she was taking fluoxetine 30 mg daily, which had been increased from 20 mg daily, and alprazolam 0.25 mg when required, having been treated for chronic depression with fluoxetine for the previous seven years. She had always been a healthy woman, but described herself as a chronic worrier. She worried particularly about health-related concerns and fears that were frequently precipitated by illnesses in friends and families. She had become alarmed and fearful after her pregnancy had been diagnosed because she had required the increase in the dose of fluoxetine and the addition of lorazepam to reduce her anxiety. She was afraid that taking lorazepam might harm her unborn child.

Despite detailed ultrasound examinations showing a healthy fetus, she became convinced that her medications

had harmed the fetus. She became so anxious that she was unable to eat or sleep or take care of her child. She had finally been persuaded to take fluoxetine 30 mg daily early in her pregnancy, as well as lorazepam 0.5 mg two to three times per week. She complied with the management strategies that were offered to her, and the frequency of her visits for reassurance decreased dramatically by the end of her pregnancy.

The patient delivered a healthy baby at term and had an uneventful postpartum period. She had no further symptoms and appeared to be free of the worrying that had plagued her throughout her pregnancy.

MANAGEMENT

Treatment modalities common to these three cases appear to have been effective in relieving the women of disturbing worries that adversely affected their pregnancies.

The strategies that appear to be effective in the treatment of this condition include the following:

1. Careful evaluation of the patient, addressing her current symptoms and psychiatric history, especially during prior pregnancies and postpartum periods if applicable.
2. Open discussion of the risks of untreated illness and of psychotropic treatment to both the pregnant woman and her fetus.
3. Assessment of current social supports, especially partner and close family members.
4. Assessment of the patient's past baseline temperament, especially any tendency to chronic anxiety/worrying/ catastrophic thinking, dysthymia, and dependency issues.
5. Evaluation of the patient in the presence of her partner when possible in order to allow the partner opportunities to add information, ask questions, and obtain information regarding management recommendations.
6. Discussion with the patient the management of her concerns throughout pregnancy, which must be very specific and include the following:
 - a. Assigning one individual on the care team to respond to her questions concerning exposures that she worries could harm the fetus. Other team members refer her to the assigned responder if she asks these questions.
 - b. Having the patient refrain from accessing the Internet or reading books or magazines that may exacerbate her fears.

- c. Setting a time limit for each contact with her primary care person to discuss a concern.

DISCUSSION

To our knowledge, this is the first time that the specific clinical picture of ruminative worrying in pregnancy has been reported. We conducted a literature search using MEDLINE, EMBASE, PubMed, and Web of Science databases of English-language publications from 1996 to the present, using the key words "pregnancy," "worrying," "anxiety," "drugs," and "exposures," and found no reference to this entity.

The women we describe here were not diagnosed as having an obsessive compulsive disorder (OCD) before or after pregnancy. We feel that the clinical picture described here is very different from OCD, as each woman described herself as having a pre-pregnancy personality that included being a worrier and generally anxious about health-related issues. They accepted these traits as part of their basic temperament and did not consider their pre-existing anxious temperaments as being unusual or troubled. Each woman was treated for depression and anxiety with pharmacotherapy, and each was on an appropriate dose of medication and functioning well prior to becoming pregnant, according to her attending physician.

Unlike the ego-dystonic bizarre obsessions that characterize patients with OCD,⁴ the worries that such women have stem from reality-based concerns. However, once they begin to ruminate about these concerns, their ruminations tend to persist and worsen, no matter how much reassuring information is given to them.⁵ Most often, these patients present with questions about the safety of psychotropic medications during pregnancy, but frequently their worries extend to become all-inclusive.

Interestingly, these worries did not extend to the delivery process or to the postpartum period. It appeared that by the time these women went into labour, their concerns about harming their babies from drug and other exposures had subsided. No special management was required during labour and delivery or in the postpartum period, and each of the women had an average length of labour and a vaginal delivery. We believe that the significant relief these women experienced from their constant worrying resulted from the effectiveness of our management strategies. However, because we did not follow other women who fit the same profile but did not receive our specific care, we have no way of knowing if this was actually the case.

Theories for the etiology of this condition include an exacerbation of the depressive disorder due to the increased levels in pregnancy of circulating prolactin, oxytocin, and cortisol, which could contribute to suppression of the stress

response during pregnancy.⁶ Another theory is that verbal worry about a stressor (in this case, pregnancy) leads to an incubation of intrusions, thus increasing ruminative activity in the woman.⁷

Regardless of the etiology, these women can consume an inordinate proportion of clinical care without feeling better, using up the limited resources of health care providers. Once these women have been identified, they require very careful structured management throughout their pregnancies, to ensure the best outcome possible for both mother and baby.

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Dr Vivien Burt is a consultant to Eli Lilly and GlaxoSmithKline and is on the speakers and advisory

boards of Eli Lilly, GlaxoSmithKline, Bristol-Myers Squibb, AstraZeneca, Pfizer, and Forest.

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