Pregnancy and OCD: The State of the Field and Future Directions

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Road Map

- Background information on pOCD
- Impact
- Dimensions of pOCD
- Differential Diagnoses
- UF Collaboration + Case Series
- Conclusions + Future Directions

pOCD Background Information & Treatment

Megan Barthle, M.S.

Key Terms

- **Postpartum OCD** occurs immediately after childbirth
- **Perinatal OCD** occurs during pregnancy
- Together, they are referred to as **pOCD**
- Pregnancy and postpartum periods are a time for increased onset or severity of OCD[1,2,3,4]

Measures

- Yale-Brown Obsessive Compulsive Scale (Y-BOCS)[5]
  - Gold Standard for OCD symptom severity measurement
  - Clinician interview
- Perinatal Obsessive-Compulsive Scale (POCS) [6]
  - Has separate items for perinatal and postpartum women
  - Self-Report Questionnaire
- UCLA Questionnaire
  - Designed based on clinical information
  - Psychometric properties unknown

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Prevalence

- OCD: 2-3% lifetime prevalence[7,8,9]
- pOCD:
  - 2.07% in pregnant women; 2.43% in postpartum women; 1.08% in general population[10]
  - Father prevalence is less known but documented[11,12]
- Females with OCD experience onset:
  - 40% during pregnancy[4]
  - 30% postpartum[1,13]

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Prevalence

- 90% of nonclinical individuals experience intrusive cognitions[14,15]
- 65% of new parents experience obsessional intrusive thoughts about their child[16]
- This is why psychoeducation is so important!!

Etiology

- pOCD has rapid onset[17]
- OCD and stressful situations[3]
  - Type of event rather than number is associated with onset of OCD.
  - In pOCD:
    - C-Section without labor
    - Pre-term birth (<34 weeks)
    - Post-term birth (>40 weeks)

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Etiology

- Serotonin/Hormone Changes[18]
  - Estrogen/Progesterone changes affect serotonin transmission, reuptake, and binding[19,20]
- Oxytocin[21,22,23]
  - Plays a role in late pregnancy and postpartum period
  - Higher levels correlated with OCD severity[24]
- No direct causal research and mixed results in available research for these theories
- Less is known about non-biological or other biological parent with pOCD

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Etiology

- Change in responsibility[17,25]
  - Sudden increase in responsibility for infant who is vulnerable and helpless
  - Misinterpretation of normal intrusive thoughts
  - Terrified that these thoughts mean s/he actually wants to hurt child.
  - Behavior patterns develop in response to thoughts
    - Avoidance
    - Checking
    - Reassurance seeking
- Can account for pOCD in partners

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Negative Outcomes

- Concerns for parents and family
  - Pre-term delivery
  - Miscarriage
  - Developmental delays/growth defects
  - Parent-infant bonding difficulty
  - Skewed distribution of childcare
  - Marriage/Relationship difficulty
  - Poor work performance/Loss of job

See: 10, 26,27 for Review

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Course of pOCD and Outcomes

- N=56 (women) with OCD compared to 156 matched patients without OCD
- Followed 1-3 month intervals through 52 weeks postpartum
- Measurements: YBOCS, Clniical Assessment, Medication Exposure Tracking
- Cesarean section and younger age was associated with higher OC symptoms in the postpartum period compared to those with vaginal deliveries
- Those without OCD had higher frequency fetal loss compared to those with OCD

(House, Tripathi, & Knight, 2016)

Treatment[27]

- Pharmacological[1,12,28,29]
  - Serotonin Reuptake Inhibitors (SRIs)
  - Typically 20-40% improvement [12]

- Therapy
  - CBT-E/RP
  - Typically 60-70% improvement[12]
  - Other therapies include ACT and Mindfulness techniques[30,31]

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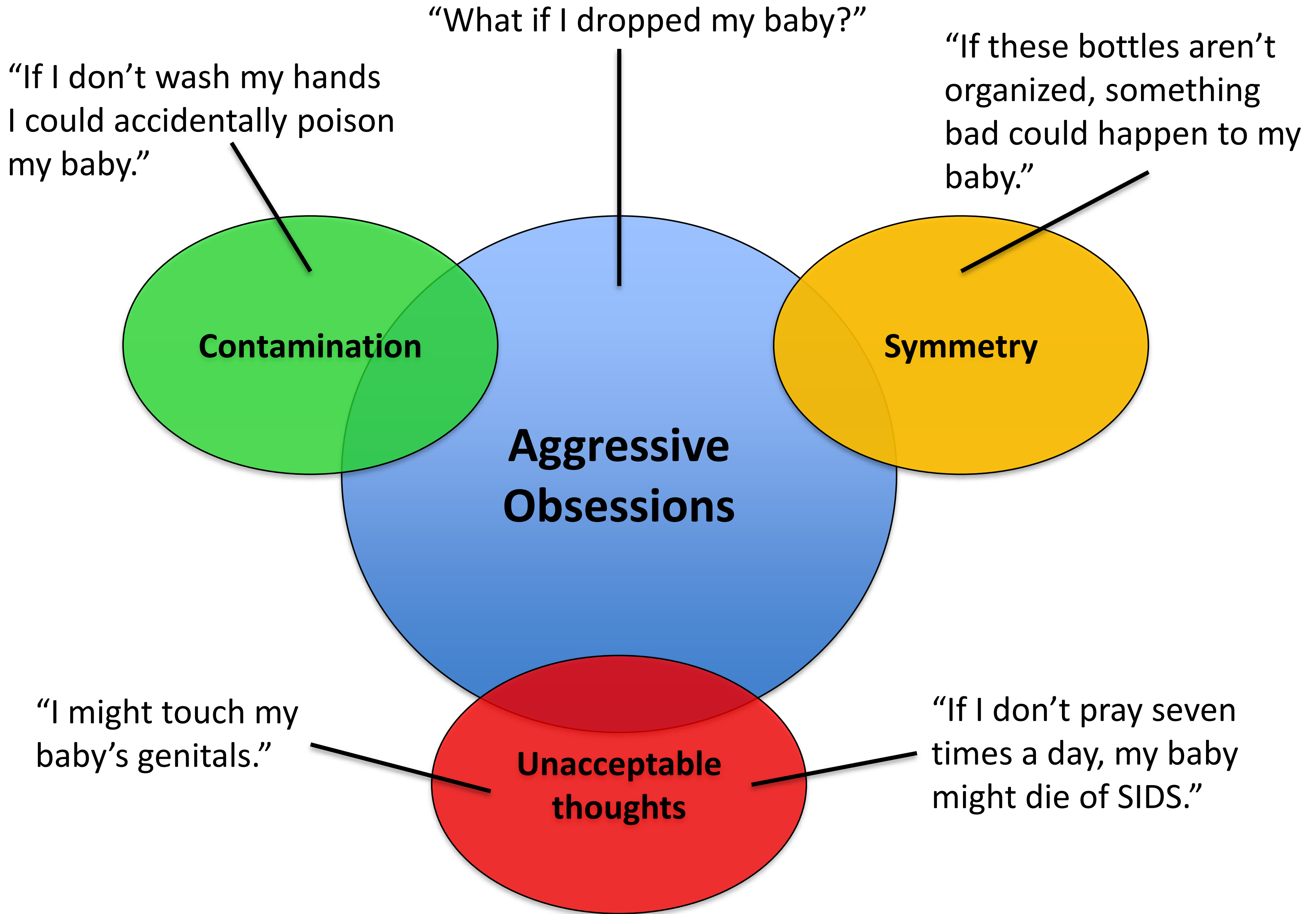
Dimensions of pOCD & Comorbidity

Danielle Cooke, BA/BS

Dimensionality and OCD

- Multidimensional and heterogeneous
- Dimensions[1,10]:
  - Contamination
    - Contamination obsessions, washing and cleaning compulsions
      - Two potential subtypes[5]
        - Individuals who report feeling discomfort or contamination without fears of harm
        - Individuals who report feeling discomfort or contamination with specific fears of harm
  - Responsibility for Harm
    - Obsessions about responsibility for harm, making mistakes, checking compulsions
  - Symmetry
    - Obsessions about order and symmetry, ordering and arranging compulsions
  - Unacceptable Thoughts
    - Obsessions concerning sex, religion, and violence


"What if I dropped my baby?"
"If I don't wash my hands I could accidentally poison my baby."
"If these bottles aren't organized, something bad could happen to my baby."
Contamination
Symmetry
Aggressive Obsessions
"I might touch my baby's genitals."
Unacceptable thoughts
"If I don't pray seven times a day, my baby might die of SIDS."

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pOCD by Dimension

- Intrusive thoughts concerning harm appear to be particularly common among women with POCD[2], with intrusive, recurrent thoughts about harming appearing in roughly 1 in every 15 childbearing females[6]
- Contamination and cleaning symptoms appears to be a common clinical presentation linked to pregnancy

	Zambaldi et al., 2009	Uguz et al., 2007	Timpano et al., 2011
	Thirty-six post-partum women who met the diagnostic criteria for OCD.	Study of twelve mothers in Turkey with pOCD	Thirty-three mothers in a control condition who reached mild, yet clinically significant levels of obsessive compulsive symptoms
Aggressive	77.8% (n=28)	33.3% (n=4)	80.0%
Contamination	77.8% (n=28)	75% (n=9)	64.0%
Symmetry	44.4% (n=16)	33.3% (n=4)	Not reported
Unacceptable Thoughts	Sexual Obsessions: 33.3% (n=12) Religious Obsessions: 41.7% (n=15)	Sexual Obsessions: 0% (n=0) Religious Obsessions: 16.7% (n=2)	Sexual Obsessions: 12.0% Violent Obsessions: 68.0%

Postpartum Compulsions

- Some evidence suggests that compulsions look different in pOCD with fewer **overt compulsions** (such as cleaning + organizing)
- **Covert behaviors** (such as praying, attempts at suppressing the thought, distraction) and **situational** avoidance (such as avoiding holding or bathing) appear to be more common.[4]

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Breakout!

- *The patient is presenting with obsessions regarding accidentally injuring her child. She has been reluctant to allow family members or friends to hold the baby for fear of them accidentally harming the child.*
- Turn to someone sitting next to you and discuss potential exposures to challenge this patient!
- **Challenge**: try to challenge the situational avoidance and covert behaviors!

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Potential Exposure Ideas (in SUDs)

The patient is presenting with obsessions regarding accidentally injuring her child. She has been reluctant to allow family members or friends to hold the baby for fear of them accidentally harming the child.

10 – repeating the thought out-loud "I could drop my baby."

30 – holding the baby while repeating a distressing thought such as "I could drop my baby/I might shake my baby."

40 – letting a family member hold the baby

50 – letting the therapist hold the baby

60 – Letting a stranger hold the baby

70 – Leaving the baby unsupervised with a family member

90 – playing "airplane" with the baby

100 – leave baby in therapy room by herself for 15 seconds

Differentiating: Postpartum Depression

- **Post-partum depression:**
  - Episode of major depression experienced in the post-partum period[9]
  - Estimated prevalence of 13%-19% of women in the first 6 months after delivery[9]
- **Similarities:**
  - Obsessions and depressive ruminations are each associated with negative affect[2]
  - Highly comorbid
    - 41%–57% of women with PPD experience obsessive-compulsive cognitions[12,6,15]
      - Of these women, the most commonly occurring thought concerned aggressive thoughts[6,15]
- **Differentiating**[2]**:**

Obsessions	**Depressive Ruminations**
Intrusive thoughts with fears of **specific** situations with specific **disastrous consequences with fixed subject matter and themes**	**General** sad, pessimistic thoughts concerning the world, self or future, with **shifting content**
Ex: “If I don’t wash my hands four times I could accidentally poison my baby.”	Ex: “ My child will never be able to love me”
Obsessional fears are usually **bizarre** and **senseless**	Usually concerns a real-life circumstance
Ex: “I might put my baby in the oven.”	Ex: “I am a worthless mother and spouse.”

Differentiating: Postpartum Psychosis

- **Post-partum psychosis:**
  - 0.1–0.2% of deliveries[11]
  - Not recognized in the DSM-5
  - " . . . an odd affect, withdrawn, distracted by auditory hallucinations, incompetent, confused, catatonic; or alternatively, elated, labile, rambling in speech, agitated or excessively active." [3]
- **Similarities:**
  - Both may involve ideas concerning harm to the child
  - **Differentiating:**

Postpartum OCD	Postpartum Psychosis
Ego-dystonic	Consistent with world-view
Ex. "I can't stop thinking about stabbing my baby, I am a terrible person."	Ex: "My baby is an imposter."
Preservation of rational judgement and reality testing	Hallucinations and delusions
Ex: "These thoughts are unreasonable, I don't have to do it."	Ex: "The government placed it with me in order to spy on me."
No increased risk of engaging in aggressive behavior	Increased risk of **engaging** in aggressive behavior
Ex: "These thoughts are unreasonable, I don't want to do them and I probably won't do them."	Ex: "I must abandon it to be free."

Conclusions and Future Directions

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Summary

- pOCD more prevalent than previously thought; occurs in both mothers and fathers
- Related to stressful events, hormonal changes, and/or increase in responsibility
- pOCD leads to dysfunction, distress, and increased risk for medical health problems
- pOCD can be treated with both therapy and medication
- Overlapping dimensions; aggressive and contamination dimensions occurring most frequently

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Considerations

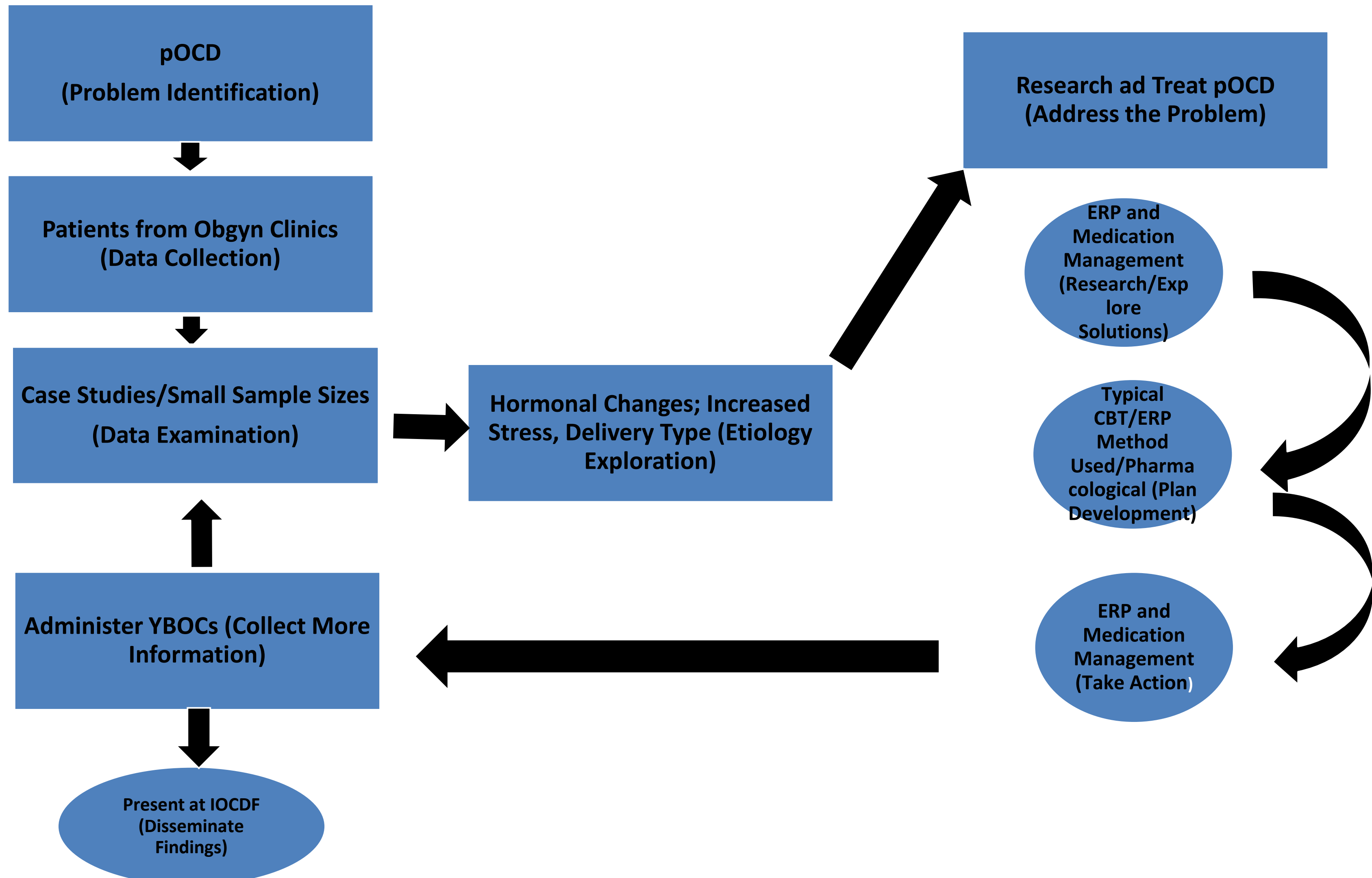
Risk Factors

- Pregnancy
- Past psychiatric history (particularly OCD)
- 1st pregnancy
- High Risk Pregnancy
- Delivery Type
- Increased Stress

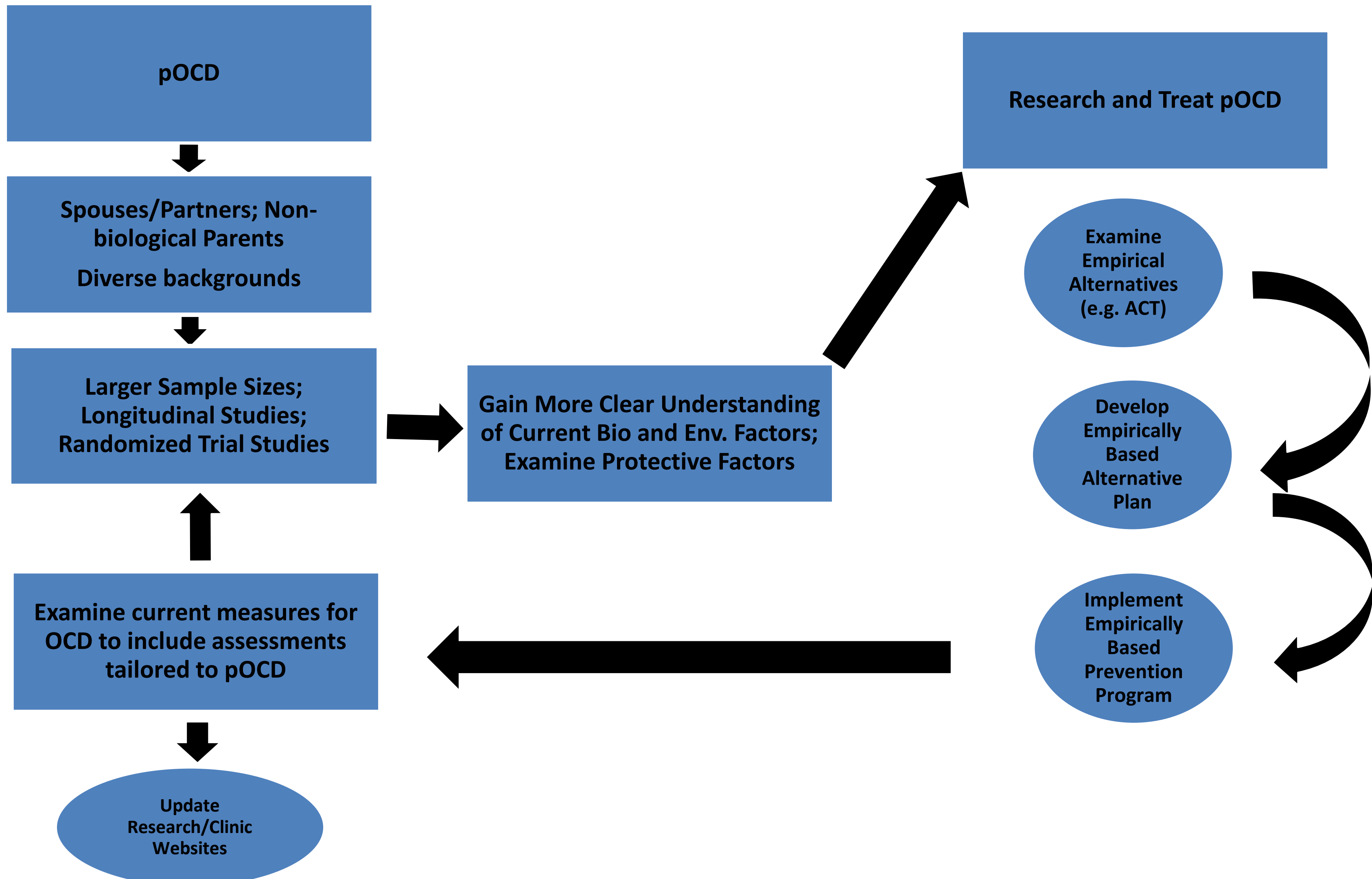
Protective Factors

- Early identification
- Early treatment using empirically based treatment
- Access to quality treatment
- Family and social support
- Good prenatal care

Future Directions



Future Directions Continued



Resources

- http://ocdla.com/perinatal-postpartum-ocd-test
- http://ocfjaxor.ipower.com/WordPress/wp-content/uploads/2010/06/5503JFP_AppliedEvidence3-upt2.pdf

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