Perinatal OCD

Carmen Croicu, MD
Psychiatry and Behavioral Sciences
University of Washington

May 5, 2021

General Disclosures

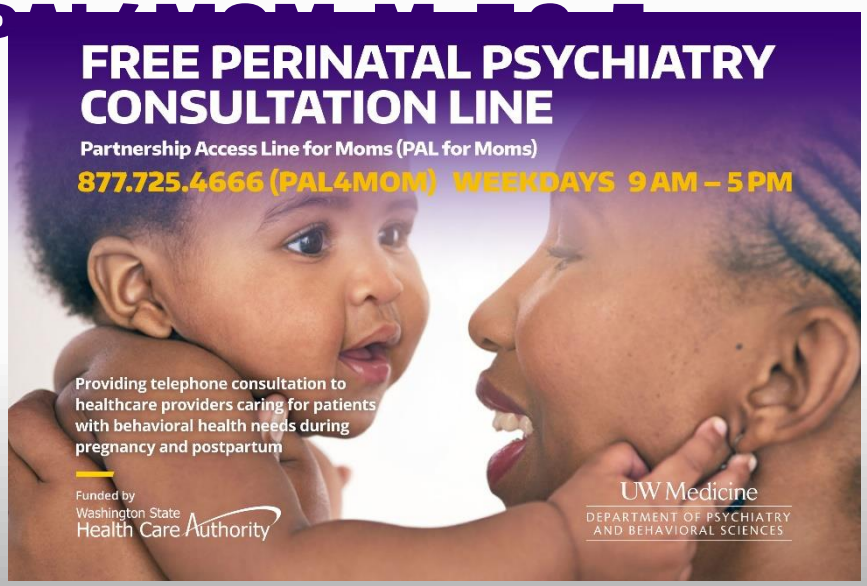
The UW Department of Psychiatry gratefully acknowledges receipt of philanthropic support for this activity – working to expand access to perinatal behavioral health services throughout Washington State.

Speaker Disclosures

- **PAL for Moms phone consultation line for providers**

  State of Washington Health Care Authority

  206-685-2924 or 1-877-P



Learning Objectives

- Describe clinical features and differential diagnosis of perinatal OCD
- Describe the evidence for a rational approach to the treatment of perinatal OCD
- Compare risks of untreated perinatal OCD with the risks of psychotropic medication use during pregnancy and lactation

Perinatal OCD –epidemiology

- Perinatal period is a vulnerable time for the onset or exacerbation of OCD

- Prevalence of 2% during pregnancy and 2.5% 12 months after delivery (meta-analysis of 19 retrospective studies)

- Women with a history of OCD or perinatal OCD are at risk for recurrence of OCD during postpartum period
  - rates of OCD exacerbation between 25% and 75%.

Sharma et al, 2018; Russell et al, 2013; Challacombe et al, 2016; Wisner et al, 1999

Risks factors for postpartum OCD

- Primiparity
- Early postpartum period (first 4 weeks)
- Major depressive disorder
- Obsessive compulsive personality disorder
- Avoidant personality disorder
- OCD related dysfunctional beliefs

Miller et al, 2013; Uguz et al., 2011

What are the risks of untreated perinatal OCD?

- **Adverse pregnancy outcomes**
  - **miscarriage, preterm delivery, low-birth weigh**
  - **preeclampsia, postpartum hemorrhage**
- **Impaired attachment and mother-infant bonding**
- **Reduced ability to care for the newborn**
- **Diminished quality of life**
- **Marriage/relationship difficulties**

Challacombe et al, 2016: Williams et al, 2018; Uguz et al, 2014; Gezginc et al, 2008

Unique features of perinata OCD

- Fetus or infant –related obsessional content (thoughts, images, and impulses)
- **Pregnancy**: gradual onset
  - contamination obsessions and cleaning rituals
  - fear of fetal death and repeated checking of fetal movements or repeated requests for ultrasounds

- **Postpartum**: rapid onset (within 4 weeks)
  - **frequent occurrence of intrusive thoughts and fears of harming the baby** (e.g. thoughts of drowning or misplacing the baby, images of smothering the infant)
  - avoidance behaviors (e.g. avoiding bathing or holding the baby), compulsive checking of infant
  - contamination obsessions (less)

Starcevic et al, 2020; Fairbrother et al, 2019; Bucholz et al, 2020

Case 1

- Jane is a 25-year-old, married woman with a four-month-old baby presents with severe anxiety. She is experiencing intrusive thoughts of harming her baby. She is reluctant to disclose details of her symptoms. She tells you that she is currently avoiding time with the baby.

- What are the challenges in the assessment and management of this woman presenting with intrusive thoughts of harming her child?
- How would you screen for OCD?

Exploring OCD symptoms and intrusive thoughts of harming the baby

- "Are you having any thoughts that keep bothering you that you would like to get rid of but cannot?"

- "Sometimes new mothers experience intrusive, unwanted thoughts that they might harm their baby, accidentally or deliberately. Many women experience these kinds of thoughts but are afraid to mention them. Tell me more about the kinds of thoughts like this that you've had".

- "What do you do when you have those thoughts?"
- "What does it mean to you to have these thoughts?"
- "What do you feel you want to do when you have these thoughts?"

Challacombe et al, 2019; **Brandes et al, 2006; Fairbrother et al, 2016**

Perinatal OCD: from screening to diagnosis

- Positive screening questions should be followed by psychiatric assessment and diagnostic evaluation (based on DSM-5 criteria for OCD)

- Screening for comorbid psychiatric disorders
  - 70% depressive disorder, 25% anxiety disorder

- **Other useful tools:**
  - Perinatal Obsessive-Compulsive Scale (POCS)
    - validated perinatal population, self-report questionnaire
    - 23 items, score >9 high specificity for OCD
  - **Yale-Brown Obsessive Compulsive Scale (Y-BOCS)**
    - gold standard for symptom severity measurement
    - interviewer-rated scale
    - ≥25-35% decrease in score = response to treatment
    - score ≤ 8 = remission of OCD

Yale-Brown obsessive-compulsive scale

Obsession rating scale

Item	None (0 points)	Mild (1 point)	Moderate (2 points)	Severe (3 points)	Extreme (4 points)
Time spent on obsessions	0 hrs/day	0-1 hrs/day	1-3 hrs/day	3-8 hrs/day	>8 hrs/day
Interference from obsessions	None	Mild	Manageable	Severe	Incapacitating
Distress from obsessions	None	Mild	Moderate	Severe	Disabling
Resistance to obsessions	Always resists	Much resistance	Some resistance	Often yields	Completely yields
Control over obsessions	Complete control	Much control	Moderate control	Little control	No control
Obsession subtotal (add items 1-5)	_____ +	_____ +	_____ +	_____ +	_____ =	_____

Compulsion rating scale

Item	None (0 points)	Mild (1 point)	Moderate (2 points)	Severe (3 points)	Extreme (4 points)
Time spent on compulsions	0 hrs/day	0-1 hrs/day	1-3 hrs/day	3-8 hrs/day	>8 hrs/day
Interference from compulsions	None	Mild	Manageable	Severe	Incapacitating
Distress from compulsions	None	Mild	Moderate	Severe	Disabling
Resistance to compulsions	Always resists	Much resistance	Some resistance	Often yields	Completely yields
Control over compulsions	Complete control	Much control	Moderate control	Little control	No control
Compulsion subtotal (add items 6-10)	_____ +	_____ +	_____ +	_____ +	_____ =	_____

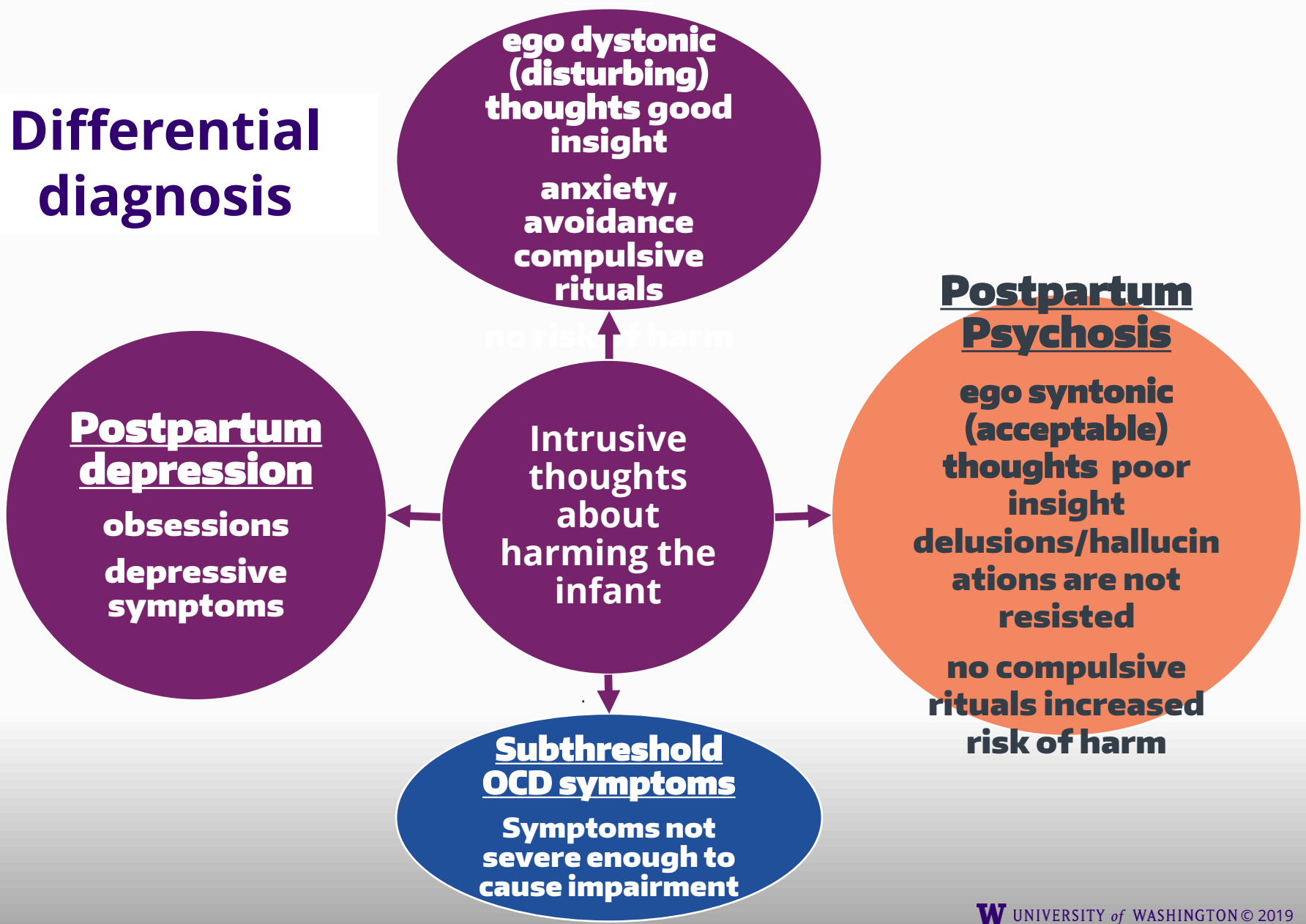
Total (add obsession and compulsion subtotals) _____

Range of OCD severity

0-7 points = Subclinical
8-15 points = Mild
16-23 points = Moderate
24-31 points = Severe
32-40 points = Extreme

Adapted with permission from Goodman, WK, Price, LH, Rasmussen, SA, et al, Arch Gen Psychiatry 1989; 46:106.

Differential diagnosis

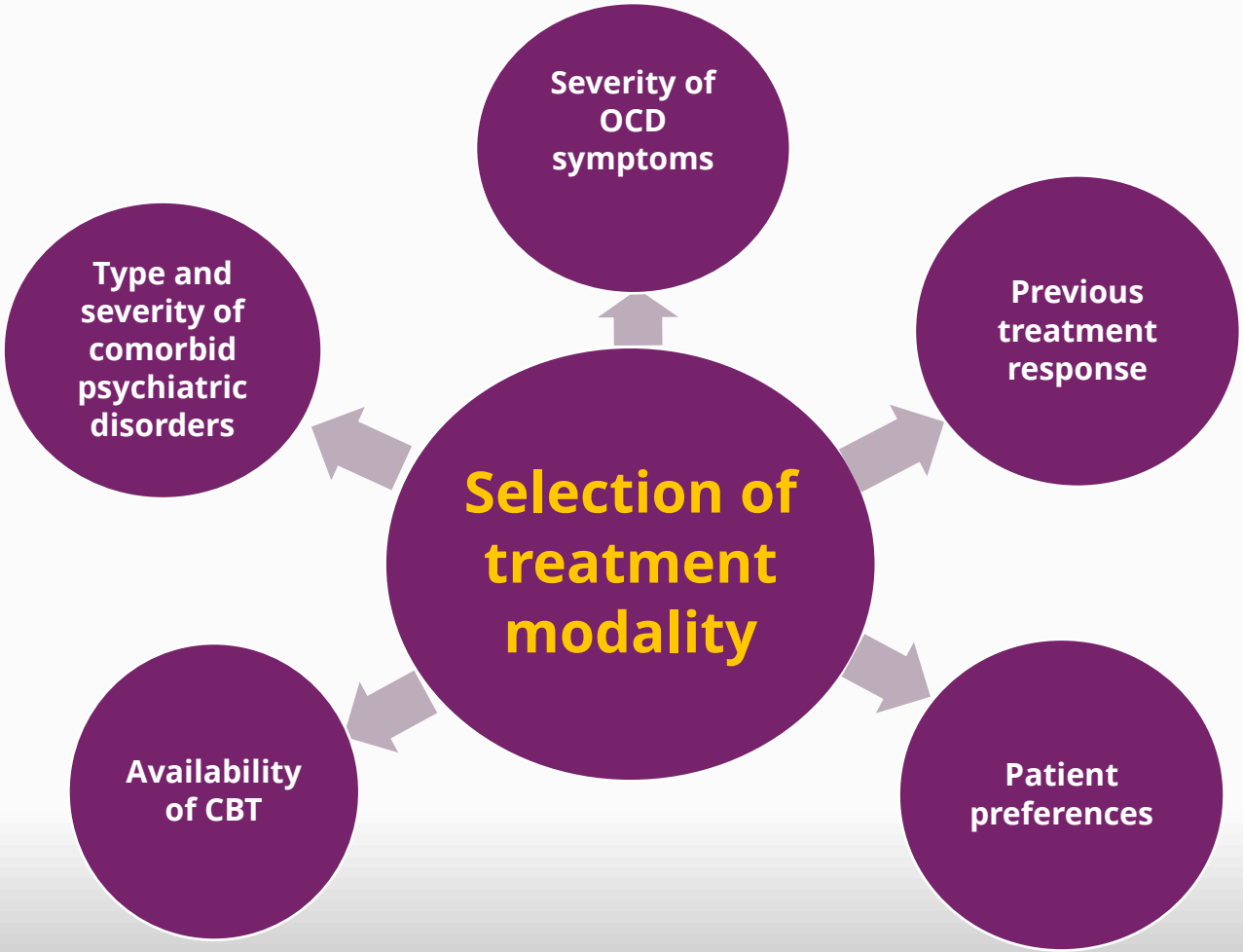


Case 2

Mary is a 30-year-old married, female at 9 weeks gestation who was diagnosed with OCD in her early 20s. She is doing well on Fluvoxamine 200 mg daily.

- Tried Sertraline and Fluoxetine in the past.
- Her obstetrician is concerned about safety of fluvoxamine during pregnancy.

Treatment perinatal OCD



Guidelines for management of perinatal OCD

- **First-line evidence-based therapies**
  - CBT, specifically exposure and response prevention (ERP)
  - SSRIs

Mild OCD	CBT/ERP
Moderate OCD	CBT/ERP or CBT/ERP + SSRI
Severe OCD	CBT/ERP + SSRI

- Consider CBT and/or SSRI for pregnant women with a history of peripartum OCD
- SSRIs: preferred when the severity of symptoms prevents the mother from engaging in CBT/ERP
- Other interventions: **psychoeducation** provided to mother and families

Non medication interventions

CBT with Exposure and Response Prevention (ERP)

- highly effective for OCD
- very small studies in perinatal OCD
- first-line treatment mild-moderate OCD
- CBT combined with SSRIs for moderate/severe symptoms

- Pilot RTC of time-intensive CBT trial at 6months postpartum (n=34)
  - CBT reduced OCD symptoms compared with treatment as usual (controlled effect size = 1.31 to 1.90)
  - mother–infant interactions were unchanged by treatment

Challacombe et al, 2017; Marchesi et al, 2016; Williams et al, 2018

Pharmacological treatment

SSRIs are 1st line treatment intervention for OCD

- no data suggesting one SSRI is superior to another
- higher dose than used for depression
- which SSRI to prescribe:
  - **Sertraline** in a drug naïve patient
  - SSRI that worked in the past

- **Fluvoxamine (Luvox)**
  - FDA approved SSRI for OCD, limited data
  - no major congenital malformations associated with exposure (n ~500)
  - low levels in breastmilk (dose <300mg/daily), diarrhea and vomiting in one infant but no other adverse effects in breast fed infants
  - typical dose: 200-300 mg/day

Raffi et al, 2019; Furu et al, 2015; Berard et al, 2017; LactMed

Pharmacological treatment

Clomipramine

Pregnancy

- less data and less well tolerated compared to SSRIs
- linked to an increased risk of major malformations
  - exposure (n>1600) associated with a modestly risk of severe malformations (odds ratio 1.4, 95% CI 1.1-1.7), including cardiovascular defects (odds ratio 1.6, 95% 1.1-2.4)
- more severe and prolonged neonatal adaptation syndrome
- no evidence adverse effects on neurocognitive development in children

Lactation

- limited data about risks in lactation
- no adverse effects in 4 infants and serum levels clomipramine and metabolites non-detectable or below the quantifiable limit

Uguz et al, 2015; Gentile et al, 2014; Horst et al, 2012; Wisner et al, 1995; Lactmed

Pharmacological treatment

Venlafaxine

- less evidence to support its use in perinatal OCD
- not associated with major congenital malformations

Augmentation with atypical antipsychotics (for treatment-resistant OCD)

- very limited data, no adequate data on safety of combination SSRI and antipsychotics during pregnancy

- **Quetiapine** augmentation following inadequate response to SSRI
  - 17 postpartum women, 11 with 60% mean reduction YBOCS score
  - average dose of response 100 mg/daily

Uguz et al, 2015; Misri et al, 2004

Strategies treatment-resistant OCD

- Address specific treatment for comorbid disorders
- Add CBT/ERP (if not already initiated) to SSRI
- Longer trial of SSRI, dose optimization, switch to new SSRI
- Augmentation of SSRI with atypical antipsychotics
- Consider psychiatric consultation

Managing COVID-19 concerns

- Provide psychoeducation with balanced information about the known risks and impact of COVID-19 on physical and mental health
- Highlight the need to follow valid recommendations for health behaviors
- Tell them to follow guidelines for social distancing, but not to isolate themselves more than necessary
- Recommend that they schedule additional sessions with you or that they reach out to a support group
- Remind patients that they have skills to manage uncertainty and anxiety

Take home points

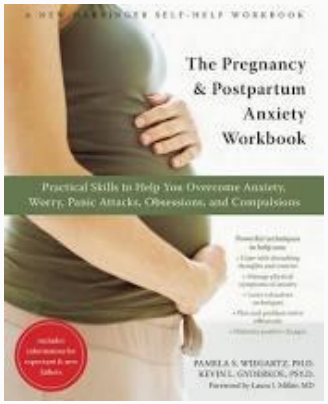
- Women are at risk of onset or recurrence of OCD in the perinatal period
- Consider screening for OCD in patients presenting with anxiety and depression
- Untreated OCD is associated with risks for the mother and the baby
- First-line evidence–based therapies for OCD
  - SSRIs=the most recommended drugs in the management of moderate-to-severe OCD
  - CBT/ERP

Questions/Contact Information

- **Feel free to contact me at: croicu@uw.edu**

Perinatal OCD resou

- Break Free from OCD: Overcoming Obsessive Compulsive Disorder with CBT Paperback – September 1, 2012 by Dr. Fiona Challacombe, Dr. Victoria Bream Oldfield, Professor Paul Salkovskis
- Treatments that Work Exposure and Response (Ritual) Prevention Therapy (2012) by Edna B. Foa, Elna Yadin, Tracey K. Lichner
- Royal College of Psychiatrists' page on Perinatal OCD https://www.rcpsych.ac.uk/mental-health/problems-disorders/perinatal-ocd
- International OCD Foundation https://iocdf.org/



International OCD Foundation
Resources. Research. Respect.

References for clinicians

- **Brok EC, Lok P, Oosterbaan DB, et al. Infant- related intrusive thoughts of harm in the postpartum period: a critical review. *J Clin Psychiatry*. 2017;78(8):e913–e923. https://doi.org/10.4088/JCP.16r11083**
- **Stein DJ, Costa DLC, Lochner C, et al. Obsessive-compulsive disorder. Nature Reviews 2019; 5:52; https://doi.org/10.1038/s41572-019-0102-3**
- **Fineberg NA, Van Ameringen M, Drummond L, et al. How to manage obsessive-compulsive disorder (OCD) under COVID-19: a clinician's guide from the International College of Obsessive-Compulsive Spectrum Disorders (ICOCS) and the Obsessive-Compulsive and Related Disorders Research Network (OCRN) of the European College of Neuropsychopharmacology. Comprehensive Psychiatry 2020; 100: 152174**
- **PALs for moms: Perinatal OCD care guide https://96fb3d3a-b240-4a2f-853e-a7afe8c43480.filesusr.com/ugd/5031c7_6b5b5045af0f4c0bacd1ba1b14effbc4.pdf**
- Russell EJ, Fawcett JM, Mazmanian D. Risk of obsessive-compulsive disorder in pregnant and postpartum women: a meta-analysis. J Clin Psychiatry. 2013 Apr;74(4):377-85
- Yakut E, Uguz F, Aydogan S, Bayman MG, Gezginc K. The course and clinical correlates of obsessive-compulsive disorder during the postpartum period: A naturalistic observational study. J Affect Disord. 2019 Jul 1;254:69-73
- Uguz F. Pharmacotherapy of obsessive-compulsive disorder during pregnancy: a clinical approach. Braz J Psychiatry. 2015 Oct-Dec;37(4):334-42. Review.
- Buchholz, JL, Hellberg, SN, & Abramowitz, JS. Phenomenology of perinatal obsessive-compulsive disorder. In Biomarkers of Postpartum Psychiatric Disorders. *Academic Press*. 2020; 79-93.
- Frías, Á, Palma, C, Barón, F, et al. Obsessive-compulsive disorder in the perinatal period: Epidemiology, phenomenology, pathogenesis, and treatment. *Anales De Psicología/Annals of Psychology*. 2015;31(1):1-7.
- Sharma, V, & Sommerdyk, C. Obsessive–compulsive disorder in the postpartum period: diagnosis, differential diagnosis and management. *Women's Health*. 2015;11(4):543-552.
- Challacombe, FL., Bavetta, M, DeGiorgio, S. Intrusive thoughts in perinatal obsessive-compulsive disorder. *BMJ*. 2019;367.
- Collardeau F, Corbyn B, Abramowitz J, et al. Maternal unwanted and intrusive thoughts of infant-related harm, obsessive-compulsive disorder and depression in the perinatal period: study protocol. *BMC psychiatry*. 2019;19(1):94.
- Marchesi C, Ossola P, Amerio A, et al. Clinical management of perinatal anxiety disorders: A systematic review. *Journal Affect Disord*. 2016;190:543-550.

References for clinicians

- Kaya V, Uguz F, Sahingoz M, Gezginc K. Pregnancy-onset obsessive-compulsive disorder: clinical features, comorbidity, and associated factors. Bull Clin Psychopharmacol. 2015;25:248–58.
- Lord C, Rieder A, Hall GBC, Soares CN, Steiner M. Piloting the perinatal obsessive-compulsive scale (POCS): development and validation. J Anxiety Disord. 2011;25:1079–84
- Challacombe FL, Salkovskis PM, Woolgar M, Wilkinson EL, Read J, Acheson R. Parenting and mother-infant interactions in the context of maternal postpartum obsessive compulsive disorder: effects of obsessional symptoms and mood. Inf Behav Dev. 2016;44:11–20.
- Fairbrother N, Thordarson DS, Challacobe FL & Sakaluk JK. Correlates and Predictors of New Mothers' Responses to Postpartum Thoughts of Accidental and Intentional Harm and Obsessive Compulsive Symptoms. Behav Cogn Psyhcother. 2018; 46; 437-453
- Fairbrother N et all. Obsessions and compulsions during pregnancy and the postpartum period : Oxford Handbook of Perinatal Psychology 2016
- Gentile S. Tricyclic antidepressants in pregnancy and puerperium. *Expert Opin Drug Saf*. 2014;13(2):207-225.
- Payne JL. Psychopharmacology in pregnancy and breastfeeding. *Psychiatric Clinics*. 2017;40(2): 217-238.
- Sharma V. Pharmacotherapy of postpartum obsessive-compulsive disorder: a systematic review. *Expert Rev Neurother*. 2018;18(12):925-931
- Gentile S. Tricyclic antidepressants in pregnancy and puerperium. Expert Opin Drug Saf. 2014;13:207-25.
- Wisner KL, Perel JM, Foglia JP. Serum clomipramine and metabolite levels in four nursing mother-infant pairs. J Clin Psychiatry. 1995;56:17–20.