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A Brief Overview of Post-Partum Obsessive Compulsive Disorder

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INTRODUCTION

General postpartum mood disorders, specifically depression and anxiety, have been well studied in the literature. However, there is limited data regarding the identification, diagnosis, and management of postpartum obsessive compulsive disorder (ppOCD). Women with this diagnosis are frequently undiagnosed or misdiagnosed and, regretfully, suffer with their symptomatology. The purpose of this review is to educate the clinician on the prevalence and signs and symptoms of ppOCD, and to offer recommendations regarding the pharmacologic and psychotherapeutic management of this disorder.

EPIDEMIOLOGY

Postpartum OCD is thought to occur in approximately 1-5% of all postpartum mothers. Pregnant and postpartum women are more likely to experience OCD compared to the general population [1-4]. Risk factors include a personal history of anxiety disorders and/or OCD, personal history of depression (El-Mallakh or a family history of anxiety or depression [5]. The onset of symptoms may occur rapidly, within a week of delivery. Interestingly, the focus of the obsessions and compulsions are similar between mothers. Aggressive obsessive thoughts involving the baby are significantly more common in groups of women with postpartum depression [4, 6]. Due to the disturbing obsessive thoughts that mothers have, many fear telling their physician or families for concern that their child will be taken from them, resulting in non-identification and non-treatment of their disorder.

SYMPTOMS

Examples of obsessions include

• Intrusive thoughts of stabbing, throwing, or suffocating the new born.

• Disturbing images of sexually abusing the new born.

• Fear of causing harm to the new born via exposure to germs.

• Fear of new born dying suddenly.

Examples of compulsions include

• Avoiding areas with sharp objects such as knives or scissors (fear of stabbing new born).

• Avoiding changing diapers or bathing the new born (fear of sexually abusing new born).

• Avoiding normal activities, leaving home (fear of germs, contamination).

• Repeatedly checking on new born to make sure he/she is alive (fear of death).

DIAGNOSIS

As part of a routine postpartum follow up exam, the Edinburgh Postnatal Depression Scale (EPDS) is recommended for evaluating women for postpartum depression. This scale includes 10 questions which are completed by the patient and scored by the provider. Within this scale, some questions (#4-6) focus on anxiety symptoms. If and when women have elevated scores on this section, it is worthwhile to further investigate for anxiety disorders, including ppOCD. Although there is no specific screening tool for ppOCD, the Florida Obsessive Compulsive Index (FOCI) is one example of a screening tool that can be given to the postpartum patient for completion. Scores of 8 or higher on this scale are highly suggestive of OCD. For providers that may not have access to the EPDS or FOCI, simply asking the woman if she finds herself having repetitive thoughts or avoiding certain things or behaviors may give the clinician additional information and evidence for a diagnosis of ppOCD. This should lead the clinician to further investigate the symptoms and determine whether they need additional evaluation by the clinician or referral to a psychiatrist.

The EPDS and FOCI may be found on-line

https://www2.aap.org/sections/scan/practicingsafety/Toolkit_Resources/.../EPDS.pdf

http://www.aafp.org/afp/2009/0801/afp20090801p239-s2.pdf

TREATMENT

Treatment modalities include both psychotherapeutic and pharmacologic. Involving the patient in this decision is paramount for successful intervention. Cognitive Behavioral Therapy (CBT) is the gold standard for treatment of OCD [7]. CBT for OCD treatment involves exposure and response prevention (ERP) [8]. Exposure involves patients with OCD confronting the fears that trigger their obsessive anxiety and distress, and response prevention involves reducing or refraining from engaging in compulsions which temporarily help to calm or neutralize the distress. By triggering the obsessive distress of the patients with OCD and refraining from responding or performing the compulsion, the patient habituates to the distress, with a measurable decrease in anxiety.

For women who have severe symptoms, the addition of pharmacologic treatment is frequently necessary in addition to CBT. Selective serotonin reuptake inhibitors (SSRIs) are the first line agents for treatment of ppOCD and have been shown to lead to significant improvement of OCD [9]. The dose should remain at the lowest effective dosage; however, it is important for the clinician to realize that frequently higher doses of medication are required for treatment of anxiety and OCD. There can be concern regarding initiating pharmacologic treatment in a lactating woman. In the lactating woman, SSRIs are felt to be safe for the breastfed new born. Minimal amounts of SSRIs are detectable in the breastmilk [10, 11]. A lactating woman should be encouraged to continue breastfeeding her newborn and should not stop breastfeeding due to medication exposure [12].

ppOCD can have negative outcomes in both mothers and children. Mothers with ppOCD have been shown to be less confident, less likely to breastfeed, report more marital distress, and have less social support than healthy peers [13]. Untreated ppOCD can result in negative outcomes in the offspring. OCD can significantly affect the provision of care and interfere with mother-infant bonding [4]. Children of mothers with OCD are more likely to be diagnosed with OCD, internalizing disorders, and depression [14]. Education of the clinician and the mothers regarding the signs and symptoms of ppOCD is of great importance in the successful treatment and remission of the mother and the wellbeing of the new born.

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