



Clinical Approach

Progressive Case Conference

Approach to the Peripartum Patient 2: Getting to the Diagnosis and Starting Treatment

Trainee Guide

Contributors

Neha Hudepohl, M.D.
Nicole Leistikow, M.D.
Jovana Martinovic, M.D.

Pre-Learning

Before you watch the case presentation videos and attend the classroom discussion, please review some basic concepts in the following resources:

- 1) Self-study on Psychopharmacology in Perinatal Period: Focus on Decision Making (PowerPoint)

- 2) Self-study on perinatal OCD

[General vs. Perinatal OCD, Part 1 of 3](#)

[General vs. Perinatal OCD, Part 2 of 3](#)

[General vs. Perinatal OCD, Part 3 of 3](#)

- 3) Self-study on polypharmacy in OCD

[Challenges of Polypharmacy in Perinatal OCD](#)

Additional Pre-Reading

- Anxiety Disorders (include Insomnia)
 - o Self-study Anxiety Disorders Overview
- Major Depressive Disorder
 - o Yonkers, Kimberly A., et al. "The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists." *General Hospital Psychiatry* 31.5 (2009): 403-413.
- Bipolar Disorder, Postpartum Psychosis
 - o Khan, S. J., Fersh, M. E., Ernst, C., Klipstein, K., Albertini, E. S., & Lusskin, S. I. (2016). Bipolar disorder in pregnancy and postpartum: principles of management. *Current psychiatry reports*, 18(2), 13.
 - o Bergink, V., Rasgon, N., & Wisner, K. L. (2016). Postpartum psychosis: madness, mania, and melancholia in motherhood. *American journal of psychiatry*, 173(12), 1179-1188.
- PTSD
 - o Watts, B. V., Schnurr, P. P., Mayo, L., et al. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 74, e541-550. doi:10.4088/JCP.12r08225
- Substance Use Disorders
 - o Heberlein A, Leggio L, Stichtenoth D, Thomas L. The Treatment of Alcohol and Opioid Dependence in Pregnant Women. 2012;25(6):559-564.



Overview

Obsessions can be a symptom of many different psychiatric diagnoses; distinguishing between obsessions, catastrophizing anxious thoughts, depressive ruminations and delusions can be challenging. Intrusive, unwanted thoughts of harm befalling the infant are common to the perinatal period, and can be significantly distressing and impairing when they rise to the level of a clinically significant illness. As many women can experience a sense of shame and guilt related to these thoughts, a standard psychiatric interview that does not specifically assess this spectrum of thought may miss the diagnosis, and lead to inadequate treatment and poor outcomes for the mother and the mother-infant dyad. Obsessive-compulsive disorder in the perinatal period can represent either new-onset disease or worsening of preexisting OCD symptoms, with some unique treatment considerations compared to other peripartum psychiatric disorders.

Session Overview

1. Video and group discussion – 4 parts

Learning Objectives:

1. Learners will be comfortable using specific interview techniques for women who demonstrate intrusive thoughts.
2. Learners will know how to distinguish among obsessions, catastrophizing anxious thoughts, depressive ruminations and delusions.
3. Learners will understand that obsessions can be a symptom of many different psychiatric diagnoses (rituals distinguish OCD from depression, impairment in reality testing distinguish OCD from psychosis).
4. Learners will demonstrate knowledge of evidence based treatment of peripartum intrusive thoughts, based on appropriate diagnosis.

Case Scenario

Ms. Jones is a 34YO G1P1001 woman referred by her OB for symptoms of anxiety and depression, 2 month postpartum with her first child. She has a history of anxiety starting her senior year of high school, treated with therapy, and one severe episode of major depressive disorder in college, which occurred in the setting of multiple stressors, including a failing grade, a 3-month period of daily marijuana use, and a romantic breakup. She took 15 Benadryl to overdose, but went to sleep, woke up the next day, and never told anyone. The episode resolved without treatment after six months. She reports a history of periodic flares of irritability and anxiety, often occurring the week prior to menses, and has never been hospitalized.

She presents today with 6 weeks of difficulty falling asleep and staying asleep, multiple anxious thoughts and worries about her health and the health of her baby, frequent tearfulness and feeling overwhelmed, poor appetite, poor concentration, and trouble completing her daily tasks, and she is “starting to feel hopeless, like things will never get better.” She has 12 weeks of leave from her job as a nursing assistant and feels like she will never be able to return to work in 6 weeks. Her partner works as a teacher and they are feeling financially stressed.

Family history is notable for untreated anxiety in her mother and bipolar illness treated with lithium in her maternal grandmother. She is married to her female partner, who is supportive but works long hours as a teacher and has a second job running an afterschool program. She does not smoke cigarettes, drink alcohol, or use any drugs, including marijuana, which she only used in college.

Case Part 1: Major Depressive Disorder

Background:

The provider asks about her symptoms of insomnia, poor concentration, low appetite, low motivation, and anxious thoughts, all of which she expands on in detail, including somatic symptoms of anxiety, such as nausea, diarrhea, and GERD. She feels very tired, but has great difficulty sleeping, even when the baby sleeps, and is breastfeeding every 2-3 hours at night.



The provider asks further about their feeding schedule and finds out that the partner has offered to do some night time feedings but has been rebuffed. The patient denies any active suicidal ideation.

Please review the video for this portion of the case conference prior to engaging in the following discussion.

[OCD Doctor-Patient Video Part 1](#)

- What is your differential diagnosis for the patient?
- What part of this patient's presentation leads you to choose this diagnosis?
- How would you educate this patient about this diagnosis?
- Are there other questions you would have wanted to ask? If so, what are they and why do you feel that they are important?
- What are your concerns about this patient's report of her sleep, and the impact this has on her clinical presentation?
- What does your treatment plan consist of?

Case Part 2: OCD

Background:

The provider asks for content of her anxious thoughts and she endorses worries about her physical health and whether or not something is wrong with her. When asked further about whether she does anything about these thoughts, she admits to spending hours on the internet late at night researching symptoms, and looking up various specialists. When asked about what other behaviors she might have developed to address the worries she is having, she reveals that she has a specific cleaning ritual for her baby bottles and pump that takes quite a lot of time and has to be started over if she misses any steps. She reveals fears that she might die and leave her baby without a mother.

Please review the video for this portion of the case conference prior to engaging in the following discussion.

[OCD Doctor-Patient Video Part 2](#)

- What is different about this interview compared to the first one? How did the interviewer ask questions in a different way?
- How do the patient's answers to these questions change your differential diagnosis?
- How would you describe the symptoms the patient is presenting in this scenario?



- Is your treatment plan any different after this interview?

Case Part 3: OCD with obsessions around the baby

Background:

The provider tells the patient that women sometimes have fears about their babies as part of their symptoms, and asks about whether any of her fears or rituals have to do with the baby. The patient reveals that she worries she might sexually harm the baby when she is changing the baby's diaper; as a result, she tries to wait as long as possible to change the baby, or has her partner change the baby and give her baths. She also doesn't like holding the baby unless her partner is around because she worries that she might do something harmful to the baby and so tries to keep her in her car seat or swinging chair most of the time. Provider screens further to rule out psychosis or concerns of safety.

Please review the video for this portion of the case conference prior to engaging in the following discussion.

[OCD Doctor-Patient Video Part 3](#)

- What is different about the patient's presentation in this scenario as compared to the first or second scenario?
- Are you concerned about safety in this patient? How might you assess that in further detail? How will this impact your disposition for the patient?
- How does this scenario change your differential diagnosis?
- How does this change your treatment plan?

Case Part 4: Patient and partner education

Please review the video for this portion of the case conference prior to engaging in the following discussion.

[OCD Doctor-Patient Video Part 4](#)

- Discuss different psychoeducation needs for patients and families based on the diagnosis and treatment plan.
- How will you educate patients and families about perceived safety risks?

Rapid Review



References

Abramowitz JS et al. Obsessional thoughts and compulsive behaviors in a sample of women with postpartum mood symptoms. *Arch Womens Ment Health*. 2010;13(6):523-30.

Benatti B et al. Which factors influence onset and latency to treatment in generalized anxiety disorder, panic disorder, and obsessive–compulsive disorder? *International Clinical Psychopharmacology*. 2016;31:347–352.

Hudak R, Wisner KL. Diagnosis and treatment of postpartum obsessions and compulsions that involve infant harm. *Am J Psychiatry* 2012; 169:360–363.

McGuinness M: OCD in the perinatal period: Is postpartum OCD (ppOCD) a distinct subtype? A review of the literature. *Behavioural and Cognitive Psychotherapy*. 2011;39:285-310.

Nolen-Hoeksema S. The role of rumination in depressive disorders and mixed anxiety/depressive symptoms. *Journal of Abnormal Psychology*. 2000;109(3):504-511.

Sharma V, Sommerdyk C. Obsessive–compulsive disorder in the postpartum period: diagnosis, differential diagnosis and management. *Womens Health* 2015; 11(4), 543–552.