



Obsessive Compulsive Disorder Media Conference *Facilitator's Guide*

Contributors

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Pre-Assessment Learning

- Marchesi et al. Clinical management of perinatal anxiety disorders: a systematic review. *J Affect Disord.* 2016 Jan 15;190:543-550.
- Statistical Snippets Videos, also found in the Perinatal Depressive Disorders Self-Study
<https://ncrptraining.org/learning-modules/f-perinatal-depression-v1/>
 - Study design: <https://www.youtube.com/watch?v=S3L0Pu7r4Xg>
 - Confounding: <https://www.youtube.com/watch?v=-VKX3RkB-ws>
 - Significance: <https://www.youtube.com/watch?v=engQWhXkkOE>
 - Risk: <https://www.youtube.com/watch?v=UD-xF8AX7mg>

Overview

Popular media frequently touches on issues germane to reproductive psychiatry and pregnancy, such as pregnancy weight gain, postpartum depression, stress in pregnancy, and breastfeeding. Well-known celebrities such as Gwyneth Paltrow and Chrissy Teigen have voiced their experiences with maternal mental health to millions of people worldwide. However, the tone of the messages arising from the media can be tinged with stigma. The ability to field patient questions arising from popular culture is an important professional skill for all psychiatrists. In particular, psychiatrists should be able to explain data and statistics cited in the lay media in an accurate, reassuring, and clinically relevant manner. Thus, the goal of the NCRP's media modules is to have psychiatrists and psychiatry trainees build communication skills that enable them to serve as knowledgeable and thoughtful representatives of reproductive psychiatry to a lay audience.

Each session consists of three parts: 1) reviewing and critiquing a piece from the popular media (such as from newspaper articles or social media); 2) appraising the comparable medical literature; and 3) role-playing a psychiatrist/patient interaction about how to communicate this topic to a lay audience.

The aim of reviewing the medical literature is to compare its findings with the information portrayed in the media. For the purposes of this exercise, the most relevant parts of medical literature are the abstract, the introduction, and the discussion. The aim is not to have an in-depth, "journal-club" analysis of the article (which is an important skill for residents to master elsewhere in their training), but rather to delineate in broad strokes the gaps between the information presented by the media portrayal and by the medical literature.

Sessions usually last 50 minutes, but can be modified, depending on the number of media items and articles selected. The media conference is tailored for PGY-4 psychiatry residents but can be modified for any group of psychiatric providers. A small group setting with time and space to work within break-out groups is recommended. After review of the media items and the medical literature, the group will divide up into small groups of 2-3 participants to role-play the clinical interaction.

Selection of Content

Content can either be selected in advance or selected at the time of the session. The faculty and resident group may pre-select a topic that is of particular interest to the group and distribute the media item and the article one to two weeks prior to the session. Alternatively, if there is a media item of particular interest to one or more of the trainees,



they can bring the item to the session and the relevant literature can be appraised in the session in real time by the faculty and trainees, using a laptop and projector.

The media conference presented here, as part of our “OCD Module,” focuses on diagnosis, treatment, and overall management of obsessive-compulsive disorder during pregnancy; topics more directly relevant to reproductive psychiatry are included in media conferences in other subject areas (including perinatal depression, etc.).

Session

- **Presentation of media items (10 minutes): Faculty and residents together will review the media item(s)**
- **Review of medical literature (10 minutes): Faculty and residents together will briefly assess the comparable medical literature**
- **Role-play with case example (15 minutes): Small groups of residents will role-play a psychiatrist/patient discussion**
- **Large group discussion (10 minutes)**
- **Wrap-up and Q+A**

Learning Objectives

1. Understand the power of the media to shape attitudes toward and concerns about pregnancy-related intrusive thoughts and OCD during pregnancy and in the post-partum period
2. Understand how the media differentiates between peripartum worries, intrusive thoughts, and OCD
3. Understand management and treatment recommendations for peripartum intrusive thoughts and peripartum OCD

Resources required

- A faculty moderator
- Samples from media (provided)
- Relevant article references (provided)
- Laptop (with internet access) and projector

Presentation of Media Items

<https://www.telegraph.co.uk/women/womens-health/9910244/Bryony-Gordon-OCD-takes-the-baby-blues-to-a-whole-new-level.html>

Critique of Media Coverage

- 1) What is the central claim of this media piece?

Facilitator elicits the following:

- “Pregnancy made me crazy, and it might make you crazy, too.”

- 2) How do these media pieces influence (and potentially bias) the lay reader?

Facilitator elicits the following:

- Pregnancy and OCD can make you “crazy”
- Having worries in pregnancy means you might get OCD
 - “Is it any surprise that a new mother might become obsessed with her baby’s breathing, or whether her breastmilk might do her newborn harm?”
- Antidepressants are bad in pregnancy
 - “At the beginning of pregnancy, addled by hormones and off my antidepressants, ...”
- OCD symptoms are amusing, and it is OK for partners to laugh them away
 - “Cheese...became the mortal enemy of myself and my unborn child...it had to be cordoned off in the fridge, and I could not eat anything that touched it in a shopping bag”



- o "...I became convinced that I had HIV, even going as far as calling up the Terrence Higgins Trust to talk a stranger through every single encounter I believed might have led to the illness...the poor chap on the other end of the phone, who actually did have HIV, clearly thought I was mad, and that's probably because I was."
- o "Hand-washing took place dozens and dozens of times a day; if I walked past dog feces in the street, I would have something approaching a panic attack ('Did I touch it?' I would ask my bemused boyfriend)
- Recommended treatments for perinatal OCD include low-dose antidepressants and CBT alone
 - o "It was suggested that I go back on low dose of antidepressants..."
 - o "But OCD can be treated with Cognitive Behavioral Therapy."
- The children of women with perinatal OCD can be easily removed from their mother's care
 - o "For new mothers who are taken surprise by OCD, there is a real fear that they are going mad and that their child might be taken away"
 - o The reality is that mothers do worry about this a great deal, and in fact when the provider does not understand the intrusive thoughts CPS can be called; but with adequate psychiatric diagnosis this would not happen

3) What are the scientific facts and statistics that the article uses to support its claims, and what are the potential problems we identify with those facts?

Facilitator elicits the following:

- Claim 1: Postpartum women are more likely to have OCD than women in the general population, and this "makes sense" because this period is characterized by major hormonal changes as well as significant worry
 - o While there is increasing evidence to suggest that there is increased prevalence of obsessions and compulsions in the postpartum period, we do not know for sure if there is increased prevalence of the disorder itself (i.e., by DSM-V criteria) in this period
 - o Obsessions and compulsions during pregnancy or postpartum may be subclinical (ie, occurring in otherwise healthy women), or may be a part of disorders other than OCD (anxiety, depression)
 - o While the difference between "normal" worries, subclinical symptoms, and frank obsessive-compulsive disorder in the perinatal period can be difficult to define, it is unclear if and how they are linked from a pathophysiological standpoint
 - o It is also still unclear what role hormones play in perinatal OCD
 - McGuinness et al. OCD in the perinatal period: is postpartum OCD (ppOCD) a distinct subtype? A review of the literature. *Behav Cogn Psychother*. 2011 May;39(3):285-310.
 - Uguz F, Akman C, Kaya N, Cilli AS. Postpartum-onset obsessive-compulsive disorder: incidence, clinical features, and related factors. *J Clin Psychiatry*. 2007 Jan;68(1):132–8.
 - Wisner K et al. Obsessions and compulsions in women with postpartum depression. *J Clin Psychiatry* 1999 Mar;60(3):176-80.
 - Miller ES, Hoxha D, Wisner KL, Gossett DR. Obsessions and Compulsions in Postpartum Women Without Obsessive Compulsive Disorder. *J Womens Health*. 2015 Jun 29;24(10):825– 30.
 - Abramowitz JS, Schwartz SA, Moore KM. Obsessional Thoughts in Postpartum Females and Their Partners: Content, Severity, and Relationship with Depression. *J Clin Psychol Med Settings*. 2003 Sep 1;10(3):157–64
 - Chaudron L and Nirodi N. The obsessive-compulsive spectrum in the perinatal period: a prospective pilot study. *Arch Womens Ment Health*. 2010 Oct; 13(5):403-410
- Claim 2: Pregnant or postpartum women with a history of OCD do not need treatment unless symptoms are severe, in which case they can be treated with low-dose antidepressants or CBT alone
 - o Women with prior histories of depression, anxiety disorders, or OCD should be identified as soon as possible during pregnancy and followed closely
 - Sharma V and Sommerdyk C. Obsessive-compulsive disorder in the postpartum period: diagnosis, differential diagnosis and management. *Womens Mental Health (Lond)*. 2015 Jul;11(4):543- 52.
 - o Pregnancy demands the minimum effective dose of as few medications as possible, but OCD in general requires higher doses, and perinatal OCD may need higher doses still due to the physiologic changes of pregnancy



- ☐ Uguz F. Pharmacotherapy of obsessive-compulsive disorder during pregnancy: a clinical approach. *Rev Bras Psiquiatr.* 2015 Oct- Dec;37(4):334-42.
 - o There are no controlled trials demonstrating the effectiveness of CBT alone in postpartum OCD, so combined therapy is the safest approach (though some patients may still refuse medications)
 - ☐ Sharma V and Sommerdyk C. Obsessive-compulsive disorder in the postpartum period: diagnosis, differential diagnosis and management. *Womens Mental Health (Lond).* 2015 Jul;11(4):543- 52.
- Claim 3: Perinatal OCD is dangerous, to the point that the children of women with OCD can be easily removed from their mother's care
 - o Perinatal OCD symptoms often revolve around concerns involving intentional or accidental harm to the baby, in the *absence* of actual intent to do so. These concerns are often experienced as intrusive, distressing and unwanted, and are considered “ego dystonic” in nature.
 - o Hospitalization, treatment over objection, and/or involvement of Child Protective Services (CPS) occur when the mother demonstrates behaviors that pose clear risk to her child (not simply expressing concerning thoughts)
 - o Psychoeducation (of the mother and family members/supports) is very important
 - Hudak R and Wisner K. Diagnosis and treatment of postpartum obsessions and compulsions that involve infant harm. *Am J Psychiatry.* 2012 Apr;169(4):360-3.

Appraisal of Scientific Literature

Marchesi et al. Clinical management of perinatal anxiety disorders: a systematic review. *J Affect Disord.* 2016 Jan 15;190:543-550.

1) What is the study design? What ‘level’ would this study design be? What are the strengths and limitations with this study design?

Facilitator elicits the following:

- Study design: systematic literature review
- Level of Evidence: III-IV
- Strengths:
 - o Systematic review
 - o Includes participants younger than 18 years old
 - o Includes OCD and anxiety disorders
 - o Examines pharmacologic interventions (including augmentation strategies) as well as non-pharmacologic interventions
 - o Organizes results into prenatal and postpartum
 - o Includes discussion about risks and safety of SSRI use in pregnancy
- Limitations:
 - o Only 18 studies identified
 - o Mostly case reports
 - o Few with $n > 25$
 - o Few studies outside of North America and Europe
 - o Conclusion is oddly worded (“CBT should be the first treatment offered to pregnant and breastfeeding women with anxiety disorders. However SSRIs can represent a first line treatment strategy, and not exclusively in cases where anxiety disorders are refractory to CBT”)

2) What are the central findings of this article?

Facilitator elicits the following:

- In the prenatal period, first-line treatment for OCD – particularly severe OCD -- consists of psychotherapy (CBT) and pharmacotherapy (SSRIs), as recent meta-analyses of SSRIs in pregnancy show a reassuring safety profile
- In the postpartum period, first-line treatment for OCD is similar to treatment for OCD in the general population (CBT and SSRIs), with Zoloft as the preferred SSRI (studies show low to undetectable levels in breastmilk)



Role Playing Exercise

Trainees should separate into groups of 2 or 3 with one trainee playing the role of the physician, one the patient, and others as observers or family members.

Sample clinical case:

Ms. B. is a 29yo woman, G1P0 at 30 weeks gestation, married for 3 years, working in software development, with a history of generalized anxiety disorder (GAD) and obsessive-compulsive disorder (OCD) diagnosed in adolescence for which she used to take paroxetine to good effect, who has discontinued paroxetine at the recommendation of her Ob Gyn because of pregnancy. She reports no history of suicide attempts or hospitalizations, and is presenting with two months of worsening anxiety and intrusive thoughts of harming her fetus.

Ms. B. says that her OCD used to be severe as an adolescent, and was mostly characterized by contamination-related intrusive thoughts, leading to recurrent washing of her hands to the point that they would become raw. She says that these symptoms improved dramatically after starting paroxetine, which was titrated to 50mg. She remained at this dose for many years until she found out she was pregnant. Out of concern for potential risks to her fetus, her Ob Gyn told her to stop the medication, which she did at 12 weeks gestation.

Ms. B. says that her anxiety increased, but that it was manageable until about two months ago. She started to develop intrusive thoughts again, this time about fears of contamination that could harm the baby. She stopped eating hot food at her job's cafeteria, and started eating only packaged foods that she could unwrap. She started to insist on eating packaged foods at home as well, to her husband's annoyance. She then started to have recurrent thoughts that her coworkers may have subclinical viral infections that she could catch, and after some time she stopped going to work and requested an early maternity leave. After being granted this, she started to develop intrusive thoughts of accidentally harming her baby, like falling down the stairs, and became even more worried that she could cause harm. At this point, her husband became concerned, and suggested that she see a psychiatrist. Ms. B. was in agreement, but was very concerned that she would be put back on an antidepressant for her symptoms. She denied depressed mood, elevated mood, decreased need for sleep, drug use, but said that she is quite distressed by her high levels of anxiety and the distressing nature of her intrusive thoughts.

Sample script for the physician:

"It is not uncommon to have intrusive thoughts during pregnancy, which is a time of heightened discomfort and concern. When these intrusive thoughts persist, they are called obsessions. When accompanied by repetitive behaviors that are done to relieve the distress caused by obsessions, these behaviors are called compulsions. The presence of obsessions, compulsions, or both, constitute a diagnosis of OCD, which it sounds like you have had before. Evidence shows that OCD during pregnancy can show up in a particular way, where the obsessions and compulsions often involve cleanliness or symmetry/exactness that can be paired with worries of intentionally or accidentally causing harm to the baby. It appears that you are experiencing these symptoms now, and it is clear that they are dramatically impacting your life, as well as that of your partner and potentially your baby. I am glad that you are seeking treatment, which is best done with both therapy and medications, especially in cases like yours where the symptoms are more severe."

Patient then asks a series of questions:

1) Do I have to take medications for my OCD?

- OCD is best treated with both medications and cognitive behavioral therapy, especially in cases where the symptoms are more severe. These recommendations also apply in the perinatal period. Recent research suggests that the safety profile of SSRIs during and after pregnancy is reassuring, though of course their use requires a careful and thoughtful discussion with the patient. In your case, in which the symptoms are severe, you would benefit most from both CBT and SSRI treatment.
- SSRI dosages may be higher in pregnancy, as the pregnant body metabolizes SSRIs and their active metabolites faster. However, after delivery it is most common to return to pre-pregnancy doses as the body returns to a pre-pregnancy hormonal state.

2) Will my baby be taken away if the symptoms come back after I give birth?

- The intrusive thoughts in perinatal OCD can be very disturbing, but they lack intentionality on the mother's part to harm her baby, as is the case for you. Providers familiar with OCD should be able to recognize this. However, if OCD symptoms are severe enough that the child has a high likelihood of being



harmed because the mother is so impaired, then it is important to find care for the child while the mother recovers. This can often be done with the help of the partner.

3) What are the chances OCD recurs during pregnancy or postpartum, in general? Could I have done anything to prevent this from happening?

- We do not know for sure if there is increased risk for the disorder itself to recur in pregnancy or postpartum, but we do know that the perinatal period is characterized by a higher rate of general worry, and also obsessions and compulsions. We recommend that pregnant women with a history of OCD, particularly severe OCD, be followed by a mental health provider during and after their pregnancy.

Wrap-up and Q+A

1) For the learner role-playing the physician: what was challenging about this interaction?

- Managing the patient's anxiety
- Explaining the nuances between worries, intrusive thoughts, and OCD
- Explaining that there may be a need for a higher level of care

2) For the learner role-playing the patient:

- Understanding the differences between worries, intrusive thoughts, and OCD
- Understanding the role for SSRI treatment in the peripartum period
- Hearing that a higher level of care could be needed



References

- Abramowitz JS, Schwartz SA, Moore KM. Obsessional Thoughts in Postpartum Females and Their Partners: Content, Severity, and Relationship with Depression. *J Clin Psychol Med Settings*. 2003 Sep 1;10(3):157–64
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