Obsessive Compulsive Disorder
Media Conference
Trainee Guide

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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?

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

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?

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?

2) What are the central findings of this article?

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?

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

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

Wrap-up and Q+A

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

2) For the learner role-playing the patient:

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