Obsessive Compulsive Disorder
Progressive Case Conference
Facilitator's Guide

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Pre-Assessment Learning
Before you watch the case presentation videos and attend the classroom discussion, please review some basic concepts of perinatal OCD in the following resources:

Abramowitz JS, Meltzer-Brody S, Leserman J, Killenberg S, Rinaldi K, Mahaffey BL, Pederson C: Obsessional thoughts and compulsive behaviors in a sample of women with postpartum mood symptoms. Arch Womens Ment Health 2010; 13:523-530

Sharma V & Sommerdyk C: Obsessive-compulsive disorder in the postpartum period: Diagnosis, differential diagnosis and management. Women's Health 2015; 11(4):543-552

Self-study on Perinatal OCD
General vs. Perinatal OCD Part 1 of 3: https://www.youtube.com/watch?v=shi7iodiEak
General vs. Perinatal OCD Part 2 of 3: https://www.youtube.com/watch?v=YmFZKW7mLC0
General vs. Perinatal OCD Part 3 of 3: https://www.youtube.com/watch?v=0sv-PjSAm_U

Self-study on polypharmacy in OCD
Challenges of Polypharmacy in Perinatal OCD: https://www.youtube.com/watch?v=ab0Dnn37oQc

Overview
Obsessive-compulsive disorder in the perinatal period can represent either new-onset disease or worsening of preexisting OCD symptoms. 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.

Session
- **Pre-assessment learning**
- **Video and group discussion – 4 parts**
- **Post-test**

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).

Background History

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, 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.

PLEASE NOTE PLACES IN THE VIDEO SCRIPT (PROVIDED SEPARATELY) TO PAUSE TAPE WITHIN EACH SCENE FOR DISCUSSION.

OCD Doctor-Patient Video Part 1: https://www.youtube.com/watch?v=qObxSf3PaQ8

FOR PART 1, PAUSE SCRIPT AFTER PATIENT SAYS: "YES, IT'S NEVER ENDING, IT FEELS LIKE I CAN NEVER KEEP UP WITH MAKING ENOUGH MILK. I'M PUMPING EVERY THREE HOURS"

1. What is your differential diagnosis for the patient?
   Facilitator elicits the following:
   - Criteria for MDD with DSM-5 specifier for peripartum onset
   - Mood disorders that could also be present
     - Bipolar disorder
     - Anxiety disorders

2. What part of this patient's presentation leads you to choose this diagnosis?
   Facilitator elicits the following:
   - Identify which symptoms are specific to MDD, including sleep changes, appetite and energy changes, guilt and worthlessness, thoughts of suicide or self-harm, impaired bonding with infant, concentration, memory and motivation impairments.
   - Identify what in the patient's presentation makes it "peripartum onset"

- Identify any other specifiers

3. How would you educate this patient about this diagnosis?
   Facilitator elicits the following:
   - Convey information about the illness including:
     - Risk factors
     - Prevalence of illness
     - Preventive factors
     - Treatment options
     - Impact of no treatment
     - Course of illness

4. Are there other questions you would have wanted to ask? If so, what are they and why do you feel that they are important?
   Facilitator elicits the following:
   - Assessment for anxiety and anxiety disorders
     - Specific questions about assessment of anxious/worry thoughts, intrusive thoughts, obsessions, other anxiety symptoms
   - Assessment for mood disorders
     - Specific questions about presence of irritability, manic or hypomanic symptoms

5. What are your concerns about this patient's report of her sleep, and the impact this has on her clinical presentation?
   Facilitator elicits the following:
   - Impact of sleep deprivation on mood and anxiety symptoms
   - Impact of intervention on sleep as treatment option
   - Asking partner to assist in night-time feedings for more uninterrupted sleep

6. What does your treatment plan consist of?
   Facilitator elicits the following
   - Start SSRI for MDD
     - Assess for breastfeeding status, especially in terms of medication
     - SSRI safety profile in pregnancy
       - Look at relative infant dosing (not clear how reliable this is)
       - Consider medications with lowest transmission through breastmilk (sertraline, paroxetine)
     - Informed consent process including risks and benefits of treatment and of no treatment
   - Sleep hygiene
     - Consider involving partner in treatment to take over nighttime feedings to allow for improved sleep
   - Referral for psychotherapy
     - Consider psychotherapy modalities that are effective for perinatal depression
       - Interpersonal therapy
       - CBT

RESUME VIDEO 1 AFTER ABOVE DISCUSSION

Case Part #2: OCD

Background

The provider asks for content of her anxious thoughts and she endorses worries about her physical health and whether 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: https://www.youtube.com/watch?v=vEpv0WtHVBw

FOR PART 2, PLEASE PAUSE VIDEO AFTER PATIENT SAYS, "PROBABLY ABOUT TWO HOURS TOTAL BETWEEN NIGHTTIME AND DURING THE DAY."

1. What is different about this interview compared to the first one? How did the interviewer ask questions in a different way?
   Facilitator elicits the following
   - Anxiety assessment
     - Unique peripartum symptoms include focus on infant
     - Compulsive behaviors around checking and cleaning
     - Worry symptoms and anxious rumination

2. How do the patient's answers to these questions change your differential diagnosis? What other conditions should you screen for?
   Facilitator elicits the following Include anxiety disorders and depressive disorders
     - Major Depressive Disorder
     - Generalized anxiety disorder
     - Obsessive-compulsive disorder
     - Unspecified anxiety

3. How would you describe the symptoms the patient is presenting in this scenario?
   Facilitator elicits the following
   - Worry and anxious rumination related to infant
   - Compulsive research, checking, cleaning behaviors
   - Catastrophic worry

4. Is your treatment plan any different after this interview?
   Facilitator elicits the following
   - How does the change in diagnosis affect treatment plan?
   - Different medications
     - SSRI
     - Atypical antipsychotic
   - Requirements for higher dosing in OCD as well as in pregnancy given metabolic changes and distribution volume in pregnancy
   - Exposure/response-prevention psychotherapy
   - Differing psychoeducation to patient/family

RESUME VIDEO 2 HERE

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: https://www.youtube.com/watch?v=W93cNFEdFdc

FOR PART 3, PLEASE PAUSE VIDEO AFTER PATIENT SAYS "IT'S HARD TO ENJOY BEING AROUND HIM, YOU KNOW, WHEN I CAN'T GET THESE IDEAS OUT OF MY HEAD."

1. What is different about the patient's presentation in this scenario as compared to the first or second scenario?
   Facilitator elicits the following
   - Intrusive nature of worry, ego-dystonic and distressing to the patient
   - Avoidance of infant related to intrusive thoughts
   - Harming infant thoughts

2. 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?
   Facilitator elicits the following
   - Assessment of harming infant thoughts
   - Risk factors for safety concern
     - Ego syntonic vs. dystonic
     - Insight
     - Distressing nature of intrusive thoughts
   - Recommendation for disposition
     - Why does this patient not require inpatient treatment
       - Ego dystonic thoughts of infant harm do not predict harm to child
       - Supportive partner
   - Risk of separation from infant
   - Possibility of mother-infant/dyadic treatment

3. How does this scenario change your differential diagnosis?
   Facilitator elicits the following
   - Perinatal OCD vs. delusional disorder
   - Differentiate from postpartum psychosis
     - Timing of onset
     - History of past bipolar disorder or family history
     - Clinical presentation as cognitive disorganization, delirium, and bizarre psychotic symptoms
   - Presence vs. absence of insight

4. How does this change your treatment plan?
   Facilitator elicits the following
   - Medication options
     - SSRI + atypical antipsychotic (if unsure of distinction from PPP, Lithium may be helpful)
     - Treatment of sleep
     - Mother-infant/dyadic treatment
     - Assess safety
     - Enlist partner support

RESUME VIDEO 3 HERE

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: https://www.youtube.com/watch?v=BO3gopDrS24

FOR PART 4, PLEASE PAUSE VIDEO AFER PATIENT'S PARTNER SAYS, "I GET TO THE POINT WHERE I WONDER IS SHE SAFE WITH THE BABY."

1. Discuss different psychoeducation needs for patients and families based on the diagnosis and treatment plan.
   Facilitator elicits the following
   - Education of family about treatment options
   - Discuss risks and benefits of hospitalization of patient
   - Use of medications in breastfeeding
   - Sleep hygiene
   - Partner/family support
   - Normalization of symptoms and patient experience

2. How will you educate patients and families about perceived safety risks?
   Facilitator elicits the following:
   - Using a supportive and non-pejorative tone
   - Review safety concerns
   - Discuss ways families and partners can aid in treatment
   - Discuss long-term outcomes

RESUME VIDEO 4 HERE

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.

McGuiness 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.