Does your patient have postpartum OCD?

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Childbirth is a trigger for first-onset or recurrence of various psychiatric disorders; however, research and clinical efforts have focused mainly on postpartum mood disorders. Unfortunately, there is little research on identifying and managing obsessive-compulsive disorder (OCD) in the postpartum period.

In one prospective study of 461 women who recently gave birth, researchers found the prevalence of OCD symptoms was 11% at 2 weeks postpartum.[1] Mothers with OCD may have time-consuming or functionally impairing obsessions and/or compulsions that can include:

- anticipatory anxiety of contamination (eg, germs, illness)
- thoughts of accidental or intentional harm to their infant
- compulsions comprised of cleaning and checking behaviors
- avoidance of situations
- thought suppression.

Because both clinicians and patients may not be aware of the effects of childbirth on women with OCD, postpartum OCD may go underdiagnosed or be misdiagnosed as major depressive disorder (MDD) or an anxiety disorder. Additionally, women with OCD who lack insight or have delusional beliefs might be misdiagnosed with postpartum psychosis.

Here I offer methods to help effectively identify OCD in postpartum women, and suggest how to implement an individualized treatment approach.

Keys to identification and diagnosis

Mothers who present with postpartum anxiety or depression may have obsessions and compulsions. It is important to specifically screen for these symptoms because some mothers may be reluctant to discuss the content of their thoughts or behaviors.

Screen women who present with postpartum anxiety or depression for obsessions and compulsions by using questions based on DSM-5 criteria,[2] such as:

- Do you have unpleasant thoughts, urges, or images that repeatedly enter your mind?
- Do you feel driven to perform certain behaviors or mental acts over and over again?

A validated scale, such as the Yale-Brown Obsessive Compulsive Scale (Y-BOCS),[3] can also be used to screen for obsessive/compulsive symptoms in these patients.

Evaluate women who endorse obsessions or compulsions for OCD. Women who meet diagnostic criteria for OCD should also be assessed for common psychiatric comorbidities, including MDD, anxiety disorders, or bipolar disorder. Obsessive-compulsive disorder with absent insight and delusional beliefs should be differentiated from postpartum

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psychosis, which is often a manifestation of bipolar disorder.

Treatment: What to consider

When selecting a treatment, consider factors such as symptom severity, psychiatric comorbidities, the patient's insight into her OCD symptoms, patient preference, and breastfeeding status. Cognitive-behavioral therapy with exposure response prevention is indicated for patients with mild to moderate OCD. Pharmacotherapy should be reserved for individuals with severe OCD. Selective serotonin reuptake inhibitors (SSRIs) are the mainstay pharmacologic treatment of postpartum OCD; however, there are currently no randomized controlled trials of SSRIs for women with postpartum OCD. Augmentation with quetiapine should be considered for women who have an inadequate response to SSRIs.

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