Obsessive-compulsive disorder in the postpartum period: Diagnosis, differential diagnosis and management

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Childbirth can trigger or exacerbate a variety of psychiatric disorders but the extant literature has focused primarily on mood disorders. Obsessive–compulsive disorder (OCD) after childbirth can occur alone or in combination with other psychiatric disorders such as major depressive disorder. Due to the general lack of awareness of the relationship between childbirth and OCD among clinicians as well as patients, the disorder may be underdiagnosed or misdiagnosed as major depressive disorder. This article describes the prevalence, clinical features, common psychiatric comorbidities, differential diagnosis and potential consequences of underdiagnosis or misdiagnosis. Using case vignettes strategies for its detection and clinical management are suggested. Finally, areas in need of further research are proposed.

Keywords: diagnosis • obsessive–compulsive disorder • postpartum • treatment

Clinical vignettes

‘Ms A’ is a 25-year-old married woman who is referred for a psychiatric assessment with a history of recurrent thoughts and images of stabbing her child since her first delivery 4 weeks earlier. She is afraid to be left alone with the baby and worries that she may accidentally harm the newborn. She has asked her husband to hide the kitchen knives and sharp objects. She is aware of the senseless nature of the thoughts and tries to avoid them but feels unable to do so. She finds the thoughts highly distressing but denies any current symptoms of depression. She had a major depressive episode 5 years ago that was treated with fluvoxamine 150 mg daily. Family history is positive for major depressive disorder.

However, over the next couple of weeks, she became increasingly convinced that her father had sexually abused the newborn. She reported the matter to child protection services who thoroughly investigated and concluded the allegations were false. Apart from having the delusional belief about sexual abuse there were no psychotic features. Also, there were no concomitant symptoms of depression or mania. She had been treated for obsessive–compulsive disorder with sertraline in the past but had stopped the medication in anticipation of pregnancy. There is no known family history of psychiatric illness.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) defines obsessive–compulsive disorder (OCD) as the presence of obsessions, compulsions or both that are time consuming (for example, take more than 1 h per day) or cause significant distress or impairment in social, occupational or other important areas of functioning [1] (see Box 1 for the diagnostic criteria and definitions of obsessions and compulsions). DSM-5 allows the specification of OCD along a spectrum with individuals at the severe end having absent insight or
delusional beliefs. Unlike the DSM-IV-TR [2], OCD has its own chapter (obsessive–compulsive and related disorders) in DSM-5 and is no longer considered an anxiety disorder.

OCD symptoms usually begin during childhood or adolescence but the average age at illness onset is 19.5 years [3]. OCD is more common among women, however, the gender difference in the prevalence of OCD is smaller compared with mood and anxiety disorders [3]. Gender differences also exist in the onset and course of OCD. For example, women are affected at a slightly higher rate than men in adulthood and women are also more likely to have symptoms in the cleaning dimension and greater comorbidity with eating and impulse-control disorders [4,5]. OCD tends to cluster during the childbearing years partly due to the triggering role of reproductive events especially menarche, the postpartum period [6] and after first pregnancy [7]. In a case-controlled study, birth of a live child was the only life event that was reported significantly more often by patients with OCD compared with control subjects [8].

The literature on the role of reproductive events on the course of psychiatric illness has focused primarily on maternity blues, postpartum depression and postpartum psychosis, however, there is increasing awareness that periods of hormonal change are also associated with the development or triggering of OCD. DSM-5 allows the use of the ‘with peripartum onset’ specifier to characterize episodes of major depressive disorder and bipolar disorder but there is acknowledgement in the text that “onset or exacerbation of OCD, as well as symptoms that can interfere with the mother–infant relationship (for example, aggressive obsessions leading to avoidance of the infant) have been reported in the postpartum period” [1]. Some authors question as to whether OCD is more common in the postpartum period compared with other times in a woman’s life; however, there is support for postpartum OCD’s unique diagnostic status due to its distinct symptom profile and illness course [9].

Due to the general lack of awareness among clinicians as well as patients of the relationship between OCD and childbirth the disorder may be underdiagnosed or misdiagnosed as major depressive disorder. This article discusses the prevalence, clinical features and common psychiatric comorbidities followed by a discussion of diagnostic considerations, differential diagnosis and consequences of underdiagnosis or misdiagnosis. Finally, the areas in need of further research are proposed.

Prevalence
Both syndromal and subsyndromal symptoms of OCD are common after childbirth. The prevalence estimates of postpartum OCD vary depending on the study population, screening/diagnostic instruments used and the duration of the postpartum period [10]. A meta-analysis of seven studies of OCD in postpartum (up to 12 months) women using structured diagnostic interviews reported a prevalence of 2.43% [11]. An exploratory analysis of regionally matched risk ratios revealed postpartum women to be at greater risk of experiencing OCD compared with the general female population.

A recent prospective cohort study of 461 women estimated the prevalence of obsessive–compulsive symptoms to be 11% at 2 weeks postpartum, and almost half of these women had persistence of symptoms at 6 months postpartum [12]. Two prospective studies

Box 1. DSM-5 diagnostic criteria for obsessive–compulsive disorder.

- Presence of obsessions, compulsions or both:
  - Obsessions are defined by:
    - Recurrent and persistent thoughts, urges or images that are experienced at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress
    - The individual attempts to ignore or suppress such thoughts, urges or images or to neutralize them with some other thought or action
    - Compulsions are defined by:
      - Repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly
      - The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive
  - The obsessions or compulsions are time consuming (e.g., take more than 1 h a day) or cause clinically significant distress or impairment in social, occupational or other important areas of functioning
  - The obsessive–compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition
  - The disturbance is not better explained by the symptoms of another mental disorder

- Onset or exacerbation of OCD, as well as symptoms that can interfere with the mother–infant relationship (for example, aggressive obsessions leading to avoidance of the infant) have been reported in the postpartum period [1]. Some authors question as to whether OCD is more common in the postpartum period compared with other times in a woman’s life; however, there is support for postpartum OCD’s unique diagnostic status due to its distinct symptom profile and illness course [9].

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demonstrated that 1.7–4.0% of women had first onset of OCD after childbirth. Women with a history of OCD or perinatal OCD are also at risk for recurrence of OCD in the postpartum period with studies reporting rates of recurrence of 25 to 75% after childbirth [10,13].

Clinical features & risk factors
The postpartum onset of OCD has generally been described as appearance of symptoms within 12–26 weeks postpartum [12,14,15], but some women have a rapid onset (within days) after delivery. Although the clinical presentation of postpartum OCD varies widely, obsessions often include concerns about intentionally or accidentally causing harm to the baby, worrying about the baby dying while asleep, worrying about being criticized and/or judged as a mother, cleanliness, symmetry/exactness or aggression [12,16–18]. Common compulsions include repetitive and ritualistic washing, checking, avoidance, concealment and seeking reassurance [8,15,18,19]. Obsessions are usually more frequent than compulsions [20]. A large number of women (45%) who have obsessions and compulsions at 2 weeks report persistence of symptoms at 6 months postpartum [12,15,20].

Postpartum OCD affects quality of life as mothers try to cope with significant levels of anxiety and feelings of guilt for having to spend large amounts of time dealing with obsessions and compulsions. Consequently, they may be less available to their children physically and emotionally [21]; however, the impact of postpartum OCD on the neurodevelopment of the child is unknown. The disorder also affects the relationships as family members may find it difficult to cope with the disorder for having to engage in compulsive rituals themselves or due to the need to provide constant reassurance.

Risk factors for postpartum OCD include primiparity, early postpartum period (first 4 weeks), personal history of depression, obsessive–compulsive personality disorder, avoidant personality disorder and the presence of OCD-related dysfunctional beliefs [10]. In one study OCD was more frequent in mothers with a personal history of previous psychiatric disorder, somatic disease (when psychiatric symptoms present as physical ailments) or obstetric complication in pregnancy or delivery [10]. Interestingly, women with postpartum OCD are more likely to have family histories of mood disorders and substance use disorders rather than OCD [15].

Comorbidities
Psychiatric comorbidity appears to be the rule rather than exception in women with postpartum OCD. Approximately 27.5% of women have an anxiety disorder and 70.6% of women have a comorbid depressive disorder [12]. Comorbidity with depression is associated with chronicity and a poor prognosis of the disorder [22]. In a small case series, approximately 20% of women had a comorbid diagnosis of bipolar disorder [15].

Diagnostic considerations
Identification of postpartum OCD and its differentiation from commonly occurring postpartum psychiatric disorders can be challenging for several reasons. First, OCD symptoms may not be recognized by women as being abnormal, or feelings of shame and guilt may prevent women from disclosing the symptoms to their families or their caregivers. Second, women with obsessive thoughts of harming the newborn may be reluctant to share these symptoms with caregivers for fear of being reported to the Child Protection Services, or having the children removed from their care. And third, due to the general lack of awareness of postpartum OCD, clinicians may fail to elicit information about obsessions and compulsions.

Due to their increased risk of developing OCD, women with prior histories of depression, anxiety disorders or OCD should be identified as soon as possible during pregnancy and followed closely in regards to emergence of obsessions or compulsions. Similarly, women with depression or anxiety disorders in the postpartum period should be screened for obsessive–compulsive symptoms. A couple of simple screening questions are: “do you have unpleasant thoughts, urges or images that repeatedly enter your mind?” and “do you feel driven to perform certain behaviors or mental acts over and over again?” [1]. Those who respond positively to one or both the questions should be assessed for OCD using the DSM-5 diagnostic criteria. The degree of insight into the beliefs that underlie the obsessions and compulsions should be evaluated. The DSM-5 differentiates between good/fair insight (recognizing the beliefs are definitely or probably not true, or showing doubt of their actuality), poor insight (thought that beliefs are likely true) or absent insight/delusional beliefs (thought that beliefs are definitely true) [1]). Due to their diagnostic and clinical implications, delusional beliefs accompanying OCD should be identified. For all women with postpartum OCD, especially, those with comorbid depression, or anxiety, the risk of self-harm should be assessed. Assessment should also include the impact of symptoms on the functioning and quality of life of patients and their close family members.

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is the most commonly used scale to evaluate
Box 2. Differential diagnosis of postpartum obsessive–compulsive disorder.

- Normal obsessions and compulsions in the postpartum period
- Generalized anxiety disorder
- Major depressive disorder with obsessions and compulsions
- Bipolar depression with obsessions and compulsions
- Postpartum psychosis

the severity of symptoms and to monitor response to treatment [23,24] however, it has not been validated in women with postpartum OCD. The Y-BOCS has 37 items that assess obsessive symptoms and 21 items that assess compulsive symptoms. Items are scored from 0 to 4 with 0 indicating no symptoms and 4 indicating severe symptoms. Thus the total score can range from 0 to 40. Scores of 1–7, 8–15, 16–23, 24–32 and 33–40 are considered subclinical, mild, moderate, severe and extremely severe symptoms, respectively. Response to treatment is usually defined as a 25–35% or greater decrease in a Y-BOCS score, and a score of 8 or less on the Y-BOCS indicates remission for OCD. This usually translates into full functionality, no or minimal anxiety [25] and depressive symptoms; thus, the individual no longer meets the diagnostic criteria for the disorder.

The Perinatal Obsessive Compulsive Scale (POCS) is the only scale that was developed and validated in women with perinatal OCD [26]. POCS is self-report questionnaire with a prenatal and a postpartum version. The postpartum version has 19 items on thoughts and 14 items on behaviors. Each symptom is assessed on a severity scale and an interference scale. The receiver operating characteristic analysis demonstrated that a score of 9 on the severity scale had a sensitivity of 64% and a specificity of 95% with an area under the curve of 0.183. In comparison, a score of 7 on the Y-BOCS had a sensitivity of 55% and a specificity of 90% with an area under the curve of 0.753.

The Edinburgh Postnatal Depression Scale [27] and the State-Trait Anxiety Inventory [28] can be used to identify and monitor the accompanying symptoms of depression and anxiety, respectively. Women with comorbid depression should be further evaluated to determine whether the depressive episode is related to major depressive disorder or bipolar disorder.

**Differential diagnosis**

Box 2 lists the differential diagnosis of postpartum OCD. Symptoms of OCD should be differentiated from normal thoughts that preoccupy parents about their child’s safety and are considered a ‘normal’ feature of parenthood, occurring in 34–65% of women after delivery [29]. Due to their adaptive nature, preoccupying thoughts about child safety may be helpful in protecting the infant from potential harm. These ‘normal’ preoccupying thoughts are usually temporary and do not interfere with normal daily functioning or appropriate childcare responsibilities. In contrast, the obsessions and compulsions of postpartum OCD are clearly maladaptive and time consuming, causing distress or functional impairment [1].

Postpartum OCD should be distinguished from other psychiatric disorders accompanying childbirth including anxiety, depression or psychosis. Due to the overlap of anxiety symptoms and avoidant behavior in the two disorders, postpartum OCD should be differentiated from generalized anxiety disorder (GAD). GAD is characterized by difficulty controlling apprehensive worry about events and circumstances (such as work or school performance) occurring more often than not over the course of 6 months [1]. The focus of the worry in GAD usually involves concerns related to day-to-day activities and routine life circumstances whereas the obsessions of OCD generally do not involve concerns about day-to-day activities [3]. While there are no studies on the topic, misdiagnosis of OCD as depression may not be uncommon. Obsessional thoughts about harming the infant are not unique to postpartum OCD and have been reported in over 57% of women with postpartum depression [17]. The ruminations in postpartum depression are usually mood-congruent and are not intrusive or distressing as in the case in postpartum OCD [29]. However, postpartum depression (major depressive disorder or bipolar disorder) can co-occur with OCD and should be diagnosed as a comorbid disorder. Use of screening instruments for postpartum depression like EPDS may be helpful in differentiating these disorders.

Postpartum OCD characterized by obsessive thoughts of harm to the infant should be carefully differentiated from postpartum psychosis. Women with postpartum OCD are generally aware of the unreasonable, unwanted and ego-dystonic nature of their thoughts and experience tremendous anxiety about having the obsessive symptoms. The differentiation of postpartum OCD characterized by absence of insight or delusional beliefs from other types of postpartum psychosis is particularly challenging [30]. Postpartum psychosis is usually considered a manifestation of bipolar disorder and is accompanied by symptoms of hyperactivity, decreased sleep requirement, flight of ideas, increased goal-directed activities, reckless behavior,
delusions and hallucinations [34]. Women with postpartum OCD are more likely to have a history of obsessions or compulsions prior to the development of delusional beliefs. A personal or a family history of bipolar disorder is more likely to be encountered in women with postpartum psychosis than postpartum OCD. Postpartum psychosis is a psychiatric emergency that typically requires treatment in an inpatient setting due to concerns regarding the safety of the mother and her newborn. Women with postpartum OCD, on the other hand, tend to take tremendous precautions to prevent doing harm to their infant [29].

**Treatment**

In general, treatment of postpartum OCD can be carried out in outpatient settings. Hospital treatment may be indicated for women who are at risk for suicide, are unable to provide adequate self-care, have a co-occurring psychiatric disorder that requires hospital treatment such as severe depression or bipolar disorder [32]. Pharmacological and psychotherapeutic treatments can be used on their own or in combination with women with postpartum OCD. Severity of the symptoms, as well as patient preference, should be taken into account when choosing a treatment modality. The literature on both treatment modalities is discussed below.

**Pharmacological treatment**

Surprisingly, there are no controlled trials of drugs in the acute or preventative treatment of postpartum OCD [33]. The selection of treatment modality should depend on the nature and severity of OCD symptoms, type and severity of comorbid psychiatric disorder, co-occurring medical conditions, availability of cognitive behavior therapy (CBT) and previous treatment response [34]. CBT is a good option for women who are breastfeeding, are not interested in drug treatment, and have both obsessions and compulsions [35].

Pharmacotherapy may be the preferred option for patients who have more severe obsessions, as is usually the case in postpartum OCD. Similar to the treatment of nonchildbirth-related OCD, selective serotonin reuptake inhibitors (SSRIs) are the pharmacological treatment of choice for most patients with postpartum OCD [34]. The extant literature on the pharmacotherapy of postpartum OCD includes only open-label studies. In one case series two of three patients treated with fluoxetine showed a positive response, defined as a 30% or greater decrease in the total Y-BOCS score [15]. In a case series by Sichel and colleagues, 15 patients treated with fluoxetine, clomipramine, desipramine or a combination of these drugs showed significant responsiveness to these SSRIs [20]. In each case, scores on the Clinical Global Improvement scale improved following 12 weeks of treatment and the improvement was maintained with continued treatment over a 1-year period.

Misri and Mills evaluated the effectiveness of quetiapine as an augmenting agent for SSRIs (paroxetine, fluoxetine and sertraline) and serotonin noradrenaline reuptake inhibitors (SNRIs: venlafaxine) in treatment-resistant postpartum OCD [36]. Treatment resistance was defined by Misri and Mills as no response to at least 8 weeks of SSR1 or SNRI monotherapy. Out of the 17 women treated with quetiapine, 14 completed the 12 weeks of treatment and three dropped out due to side effects, mainly sedation. The 11 women who responded to quetiapine augmentation had a mean reduction of 59.6% in the Y-BOCS scores with a mean dose of 112.5 mg daily. There are no data on the duration of treatment for women who have first onset of OCD in the postpartum period. For OCD in general, it is recommended that pharmacological treatment should be continued for 1–2 years before considering a gradual taper by decrements of 10%–25% every 1–2 months with close monitoring for symptom return or exacerbation [34].

Treatment of OCD with comorbid bipolar disorder is challenging due to the risk of induction of mania with the use of antidepressants [37,38]. Thus pharmacological treatment if indicated should be carried out with mood stabilizers alone or in combination with atypical antipsychotic drugs [38].

**Medications & breastfeeding**

Most antidepressants are excreted in low concentrations in breast milk and only a few reach the level considered unsafe for the infant (≥10% of the maternal weight-adjusted dose in breast milk) [39]. Nursing mothers should be informed that the infant will be exposed to medications and may have adverse events such as irritability, decreased feeding and sleep problems [40,41]. There is little evidence that there are any serious adverse effects in infants but long-term neurodevelopmental effects have not been adequately studied.

**Psychotherapeutic treatment**

**Cognitive behavior therapy**

Controlled trials support the effectiveness of CBT including exposure response prevention (ERP) in OCD [42,43], but there are no controlled studies of its use in women with postpartum OCD [44]. In ERP, patients are taught to confront feared situations and objects (for example, exposure) and to refrain from
performing rituals (i.e., response prevention) [34]. In one study, six cases of postpartum OCD were treated using CBT delivered over a 2-week period. All mothers improved on self-report and clinician-rated measures and the improvement was sustained at 3–5-month follow-up. The number of treatment sessions, their length and the duration of an adequate trial have not been established for postpartum OCD but in general 13–20 weekly sessions are recommended for most patients [45]. Successful CBT should be followed by monthly booster sessions for 3–6 months to sustain the improvement [34]. It is important to note that although psychotherapeutic treatment for depression, anxiety and OCD is generally the same, the focus of CBT will change in accordance with the nuances of the patients’ diagnoses.

Misri and colleagues studied the effect of addition of CBT to paroxetine in women with postpartum depression and comorbid anxiety disorders including OCD [46]. Both paroxetine monotherapy and combination therapy were effective in reducing depression and anxiety symptoms; however, there were no additional benefits from combining the two treatment modalities.

Psychoeducation
Psychoeducation should be an integral part of the treatment plan [23]. The focus of psychoeducation should be on imparting information about the disorder and psychiatric comorbidities, reducing feelings of blame and guilt, providing a rationale for treatment and promoting treatment adherence [32]. Incorporating a cognitive-behavioral prevention program into childbirth education classes also appears effective in reducing the obsessive–compulsive symptoms in the postpartum period [34,47]. Family members may also benefit from education about the disorder and its impact of family functioning.

Revisiting clinical vignettes
The clinical vignettes illustrate some of the challenges clinicians commonly face in diagnosing OCD and its differentiation from other postpartum psychiatric disorders. ‘Ms A’ was diagnosed with OCD with good to fair insight. Following a discussion of her diagnosis and treatment options, she agreed to a trial of fluvoxamine 150 mg daily. Due to a partial response after 4 weeks, the dose was optimized over a 4-week period to 300 mg. She noted an improvement in OCD symptoms as demonstrated by a reduction in the Y-BOCS score from 35 to 7 over a 3-month period.

‘Ms B’ was given the DSM-5 diagnosis of OCD with absent insight/delusional beliefs due to the history of obsessions and compulsions before she developed delusional beliefs. Moreover, the delusional beliefs were linked to her obsessive thoughts. The absence of symptoms such as hallucinations and formal thought disturbance ruled out a diagnosis of schizophrenia or schizoaffective disorder. The lack of accompanying mood changes and absence of features such as sleep loss, confusion and agitation ruled out a diagnosis of postpartum psychosis. Due to the onset of psychotic symptoms after delivery, a differential diagnosis of bipolar I disorder was considered; however, there were no current or past symptoms suggestive of mania or depression. She was treated successfully with sertraline 200 mg and risperidone 3 mg daily. Six months following initiation of treatment she realized that she had falsely accused her father and apologized to him for making false allegations.

Summary & recommendation
The traditional view that postpartum psychiatric disturbance includes only the baby blues, postpartum depression and puerperal psychosis ignores the clinical reality that childbirth can be associated with a wide range of psychiatric disorders including OCD. Despite the divergent findings of studies on the prevalence of postpartum OCD, childbirth can clearly trigger or exacerbate OCD. Women considered at risk for developing OCD should be informed of this risk and screened for obsessions and compulsions during and after pregnancy. Those with a positive screen should have a diagnostic evaluation performed to establish a diagnosis of OCD and any comorbid psychiatric disorder(s). Although the clinical presentation of postpartum OCD varies widely, a common theme of obsessions and compulsions revolves around causing harm to the newborn or about its safety. Obsessions appear to be more common than the compulsions. Despite its common occurrence OCD appears to be frequently underdiagnosed or misdiagnosed. Contributing factors to the underdiagnosis or misdiagnosis include a general lack of awareness of its existence among healthcare providers, patients and caregivers, frequent comorbidity with major depressive disorder and patients’ reluctance to seek professional help. Failure to diagnose the disorder correctly is associated with potentially serious consequences for the patient and her family. Clinical vigilance and detailed evaluation are essential to ensure that OCD is not missed, or misdiagnosed as another psychiatric disorder. In the absence of good quality data, treatment of postpartum OCD should follow the same guidelines as the treatment of nonpostpartum OCD. Factors such as severity of OCD symptoms, nature and severity of comorbid psychiatric disorder(s) if any, safety issues,
patient preference and compatibility with breastfeeding should guide the treatment choice. In general, patients with OCD require higher doses of SSRIs compared with the dose of antidepressants required to treat major depressive disorder. Before considering augmentation, it is important to ensure that patients receive an adequate therapeutic trial, both in terms of dose and duration, of an SSRI. Due to the high risk of recurrence, pregnant women with a history of postpartum OCD should be offered the prophylactic use of an antidepressant or a psychotherapeutic treatment such as CBT.

### Executive summary

#### Background
- The literature on the role of reproductive events on the course of psychiatric illness has focused primarily on maternity blues, postpartum depression and postpartum psychosis; however, there is increasing awareness that periods of hormonal change are also associated with the triggering or recurrence of obsessive–compulsive disorder (OCD).
- Due to the general lack of awareness among clinicians as well as patients of the relationship between OCD and childbirth the disorder may be underdiagnosed or misdiagnosed as major depressive disorder.

#### Prevalence
- Studies show a range from 1.7 to 4.0% of women having their first onset of OCD after childbirth.
- Women with a history of OCD or perinatal OCD are also at risk for recurrence of OCD in the postpartum period with studies reporting rates of recurrence of 25–75% after childbirth.

#### Clinical features & risk factors
- The postpartum onset of OCD has generally been described as appearance of symptoms within 12–26 weeks postpartum, but some women have a rapid onset (within days) after delivery.
- Risk factors for postpartum OCD include primiparity, early postpartum period, personal history of depression, obsessive–compulsive personality disorder, avoidant personality disorder and the presence of OCD-related dysfunctional beliefs.

#### Comorbidity
- Approximately 27.5% of women have an anxiety disorder and 70.6% of women have a comorbid depressive disorder.

#### Diagnostic considerations
- Diagnosis may be impacted by mothers’ reluctance to share obsessions and compulsions, and their lack of recognition between normal childcare preoccupations and obsessions.
- Use of a screening instrument, such as the Perinatal Obsessive Compulsive Scale, can be helpful for diagnosis.

#### Differential diagnosis
- For all women with postpartum OCD, especially those with comorbid depression, the risk of self-harm should be assessed.
- Due to the overlap of anxiety symptoms and avoidant behavior in the two disorders, postpartum OCD should be differentiated from generalized anxiety disorder.
- OCD can be accompanied by the absence of insights into the obsessive beliefs, and therefore it is important to differentiate it from postpartum psychosis.

#### Treatment
- Psychopharmacology and psychotherapy can both be useful in the treatment of postpartum OCD together or separately.
- Comorbidities should be considered when treating with medication, particularly mood disorders.
- Psychoeducation can benefit both the mother and family to impart information about the disorder and psychiatric comorbidities, reduce feelings of blame and guilt, provide rationale for treatment and promote treatment adherence.

#### Summary & recommendation
- Women considered at risk for developing OCD should be informed of this risk and screened for obsessions and compulsions during and after pregnancy.
- Treatment of postpartum OCD should follow the same guidelines as the treatment of nonpostpartum OCD.
- Breastfeeding is an important consideration in the treatment of postpartum OCD.
- Due to the high risk of recurrence, pregnant women with a history of postpartum OCD should be offered the prophylactic use of an antidepressant or a psychotherapeutic treatment such as CBT.

#### Future perspective
- Further studies are needed on the use of screening instruments designed specifically for use in women with postpartum OCD.
- Research to guide treatment of OCD with comorbid disorders in the postpartum period is urgently needed.
Future perspective

There is a surprising paucity of studies on the prevalence, clinical features, comorbid patterns, illness course, etiology, detection and treatment of postpartum OCD. Prevalence studies should focus on both syndromal as well as subsyndromal OCD at different time periods (e.g., 1 month, 3 months and 6 months). Rather than focusing on only postpartum OCD, studies of populations with common comorbid disorders (mood and anxiety) are urgently needed. There are no studies on the clinical correlates, comorbid patterns, family history and treatment response in early-onset (say with onset during the first 2–4 weeks after birth) versus late-onset postpartum OCD. This is an important area of inquiry because there is emerging evidence that early onset of psychiatric illness in some women may be a manifestation of bipolar disorder [48,49].

Further studies are needed on the use of screening instruments designed specifically for use in women with postpartum OCD. There are no controlled studies on the psychotherapeutic or pharmacological treatment of postpartum OCD occurring alone or in combination with postpartum depression. There is absolutely no guidance in the literature on the treatment of this disorder with comorbid bipolar disorder. And finally, the potent role of childbirth including primiparity needs to be elucidated for a better understanding of not only OCD but postpartum psychiatric disorders in general.

Financial & competing interests disclosure

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References

Papers of special note have been highlighted as:
• of interest; •• of considerable interest

• Discusses the relationship between female reproductive cycle and obsessive–compulsive disorder (OCD).
• Identifies the periods of increased risk for onset and exacerbation of OCD in women.

•• Provides an estimate of OCD prevalence in pregnant and postpartum women, and also identifies risk factors.
•• Identifies the prevalence and risk factors of postpartum OCD.


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Obsessive–compulsive disorder in the postpartum period: diagnosis, differential diagnosis & management  


• Discusses differential diagnosis and treatment of postpartum OCD.


• Identifies the practice guidelines for OCD.


• Provides treatment options for treatment-refractory OCD in the postpartum period.


• Discusses psychotherapeutic treatment options for OCD.


46. Misri S, Reehye P, Corral M, Milis L. The use of paroxetine and cognitive-behavioral therapy in postpartum depression...

