Perinatal OCD: a research and clinical update

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The Costs of perinatal mental health
:Maternal Mental Health Alliance & LSE
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• Taken together, perinatal depression, anxiety
  and psychosis carry a total long-term cost to
  society of about £8.1 billion for each one-year
  cohort of births in the UK. This is equivalent to
  a cost of just under £10,000 for every single
  birth in the country.
Costs of perinatal mental health

• The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child.

• Perinatal anxiety (when it exists alone and is not co-morbid with depression) costs about £35,000 per case, of which £21,000 relates to the mother and £14,000 to the child.
• About half of all cases of perinatal depression and anxiety go undetected and many of those which are detected fail to receive evidence-based forms of treatment.

• Specialist perinatal mental health services are needed for women with complex or severe conditions, but less than 15% of localities provide these at the full level recommended in national guidance and more than 40% provide no service at all.
Omitted costs from this analysis

• Impact on breastfeeding
• Decision to have another child
• Inappropriate costs (e.g. unnecessary hospitalisation)
Perinatal OCD: Scale of the problem

• OCD affects approximately 1.2% of people at any one time

• Pregnancy/childbirth consistently reported as onset event

• Median prevalence during pregnancy 1.4% (10 studies)

• Median prevalence postnatally 2.7% (6 studies)
Predictors of PN onset OCD

- Miscarriage (Geller, Klier et al. 2001) but possibly a transient effect (Janssen, Cuisinier et al. 1996).

- More common in first time mothers

- Pre-existing appraisals of thoughts (Abramowitz, Khandker et al. 2006; Abramowitz, Nelson et al. 2007)

- Some people better during pregnancy or recover during postpartum: Symptoms can wax and wane (Gossett et al, 2013)
The role of cognitive factors in the pathogenesis of obsessive–compulsive symptoms: A prospective study

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Shorter communication

New parenthood as a risk factor for the development of obsessional problems

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Postnatal Depression data... (Gavin et al, in press)

- of all cases of perinatal depression, only 40% are detected and diagnosed;
- of those recognised, only 60% receive any form of treatment;
- of those treated, only 40% are adequately treated; and
- of those adequately treated in real world primary care settings, only 30% achieve full recovery from their depression.
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...ONLY 3% RECOVER
Identification and help-seeking PNOCD

• All postnatal anxiety disorders under-diagnosed
  (Brockington, Macdonald et al. 2006; Battle, Zlotnick et al. 2006)

• Schofield, Battle et al. (2014) used notes to review symptoms in outpatient perinatal MH setting; assigned putative diagnosis
  – GAD 62.2% - 1.5% given diagnosis
  – OCD 30.2% – 3% given diagnosis

• 44% of anxious women (v 65% depression and 71% mixed anxiety depression) sought help (Woolhouse, Brown et al. 2009).
Identification and help-seeking PNOCD

• PND ‘trump’ diagnosis?

• Non-disclosure of obsessions?
  – Misunderstanding by professionals (Challacombe and Wroe 2013).
  – Minimised – “not busy enough”
  – Institutional safety-behaviours
  – Fear meaning of symptoms - shame
Treatment as usual for PNOCD

• All 34 mothers in contact with services by time baby 6m
  – Not all had a diagnosis of OCD

• All had been offered medication
  – 14 (41%) SSRIs; remainder tricyclics, beta blockers, dizepam
  – 15 (44%) declined or tried for short period
Treatment as usual II

• 32% either put on waitlist or accessed CBT
  – 5 had been offered CBT (rated as partly helpful or unhelpful; **helpful for 1**)
  – 5 on waiting list for CBT

• 3 had counselling; 1 on wait list for counselling

• 4 had other interventions
  – Mindfulness group
  – CBT group
  – OCD group
Effects of PNOCD: Parenting perceptions

• QOL impacted in OCD, particularly family

• Impact on relationships
  – Family accommodation rife (‘daily occurrence for 59% - Stewart et al, 2009)
  – Impact on couple relationships (Goodwin, Koenen et al. 2002; Subramaniam, Abdin et al. 2012)

• Risk and fear of risk
  – Primary & secondary risk (Veale et al, 2009)
Effects of PNOCD: Parenting behaviour

• OCD specific – washing, checking
• Avoidance prominent
  – Sources of threat – knives, contamination
  – Caregiving tasks – e.g nappy change
  – Child themselves

  – Sensitivity: “the mother's ability to perceive and to interpret accurately the signals and communications implicit in her infant's behavior, and given this understanding, to respond to them appropriately and promptly.”

  – Expressions of fear to and in front of child
Effects of PNOCD: Children

• **Short term:**
  – Temperament & attachment??? (Manassis, 1994; Warren, 2003)

• **Longer term:**
  • Subsequent mental health (OCD, anxiety, depression) (Nestadt et al, 2000, Black et al, 2003)
  • Competencies and difficulties (Challacombe & Salkovskis, 2009)
Study aims

Study 1
• Describe mother-infant interactions and parenting in clinical sample of mothers with 37 OCD v 37 controls

Study 2
• Determine if intensive CBT treatment helps with symptoms and interactions (17 CBT v 17 TAU)
• Assess attachment at 12 months in three groups (control, treated, untreated)
PNOCD symptom subtype

- 41% fears of deliberate harm
- 29% contamination
- 18% accidental harm
- 6% ordering/arranging
- 3% religious
- 3% checking
• 13/34 had new onset during pregnancy/postnatal period
• OCD mostly about baby or caregiving (29/34)
• Mean YBOCS score 24 (severe)
• Troubled by OCD 9.6 hours/day on average

• No difference in baby temperament compared with controls
• Depression in ‘severe’ range (DASS mean 24)
Key findings

• Fewer terminations in OCD group
• Fewer breastfeeding at 6m in OCD group
• Marital relationships, parenting self-efficacy, perceived social support all worse in OCD group.
• Enjoyment of everyday parenting tasks affected in OCD group.
Mother-infant interactions

• Sensitivity in interactions somewhat lower in OCD group
• Warmth somewhat lower

• Discernable, not radical effect on interactions
• May be due to depressive symptoms (significant in regression equation)
Intensive CBT

• 12 hours delivered in two weeks – 2 days in each week
• 1-3 one hour follow ups over the next 3 months
• Used Salkovskis (1985) model to develop individual formulation, cognitive techniques, behavioural experiments
Intensive CBT II

• Found to be equivalent to weekly CBT in symptom reduction (Oldfield, Salkovskis et al. 2011).

• Acceptable to participants (Bevan, Oldfield et al. 2010).

• CBT for PNOCD effective in case series (Challacombe & Salkovskis, 2011).

• May be good fit for parents of young babies
Formulation (after Salkovskis, 1985)

Situation: changing the baby’s nappy

“Image of touching baby’s genitals”

Anxious
Depressed
Angry

Avoid close contact
With baby

Check for signs of arousal

Self-criticism: I am not allowed to feel ok

I could be a paedophile (100% belief)

Ruminating – why these thoughts? something in my past history

Push thoughts away

Compare self with cases of paedophiles; child murders
• At 6m (baseline):
  – 9 (53%) cases were severe/extremely severe in CBT group with remainder moderate.
  – 10 (58%) in TAU group were severe

• At 12m (followup):
  – 70% of treated cases were recovered/mild illness versus 18.5% of TAU
12m OCD diagnosis

![Bar chart showing 12m OCD diagnosis for CBT and TAU. The chart indicates higher yes responses for TAU compared to CBT.](image)
• Interactions did not change over time or with treatment
• Attachment unaffected in clinical groups (70% secure)
• Relationships, self-efficacy still affected
Conclusions

• Although PNOCD is very distressing and time-consuming...
• It is treatable quickly and effectively by intensive CBT... which may be more accessible for mothers of young children
• Attachment is unaffected – the core pathology of OCD involves connection with the infant and a motivation to protect them
But..

• Lasting impact in terms of self-perceptions and interactions
  – Important time for identity

• Mood symptoms not entirely resolved by CBT
  – may therefore still impact on interactions
So…

• We need to make treatment even better
• We need to understand the issues related to the demands of the developing child (more autonomy, mixing with other children)
• Dads, Partners and family accommodation

• We need to help people as early as possible… or prevent the problem taking hold
Thank you!

- Participating mums and babies
- Prof Paul Salkovskis & Dr Matt Woolgar
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- Centre for Anxiety Disorders and Trauma, colleagues in SLAM and KHP
- OCD-UK, maternalocd.org

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