Perinatal OCD: a research and clinical update

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The Costs of perinatal mental health :Maternal Mental Health Alliance & LSE October 2014

- 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)

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Behaviour Research and Therapy 44 (2006) 1361–1374
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The role of cognitive factors in the pathogenesis of obsessive–compulsive symptoms: A prospective study

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Received 27 April 2005; received in revised form 9 August 2005; accepted 1 September 2005

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Behaviour Research and Therapy 45 (2007) 2155–2163
BEHAVIOUR RESEARCH AND THERAPY
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Shorter communication

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

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Received 11 March 2006; received in revised form 15 September 2006; accepted 26 September 2006

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

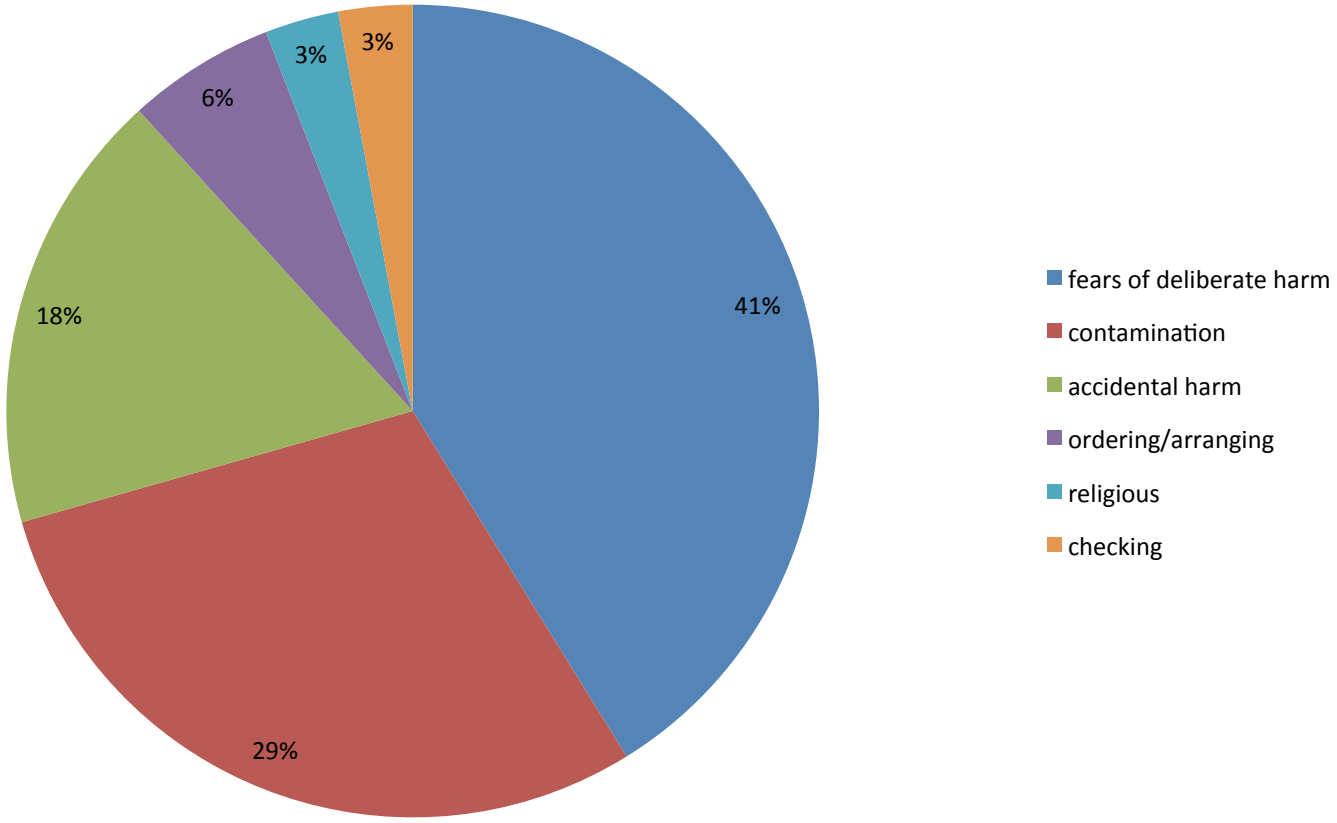
Study 1

- 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



- 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)

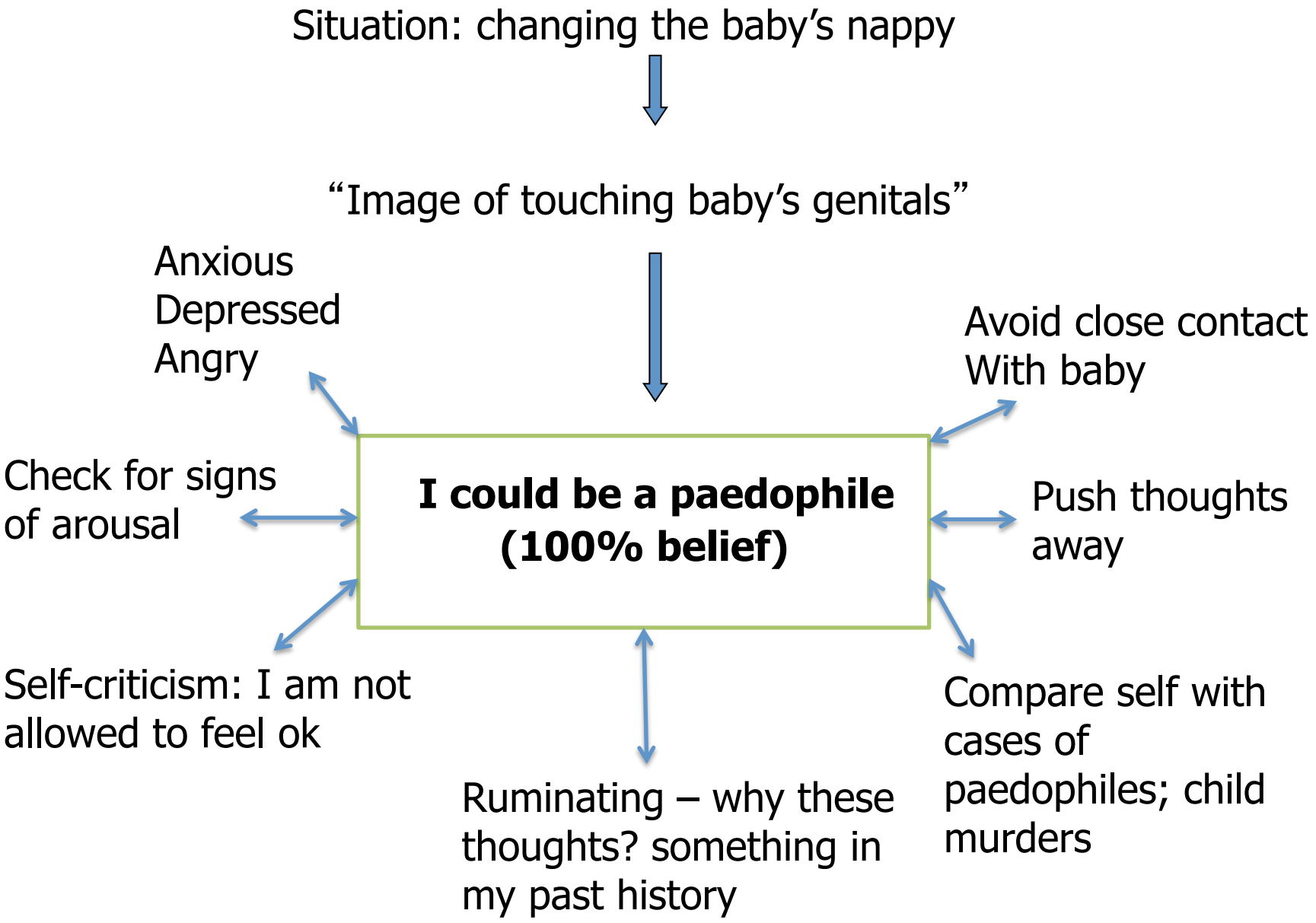
Intensive CBT

- 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)

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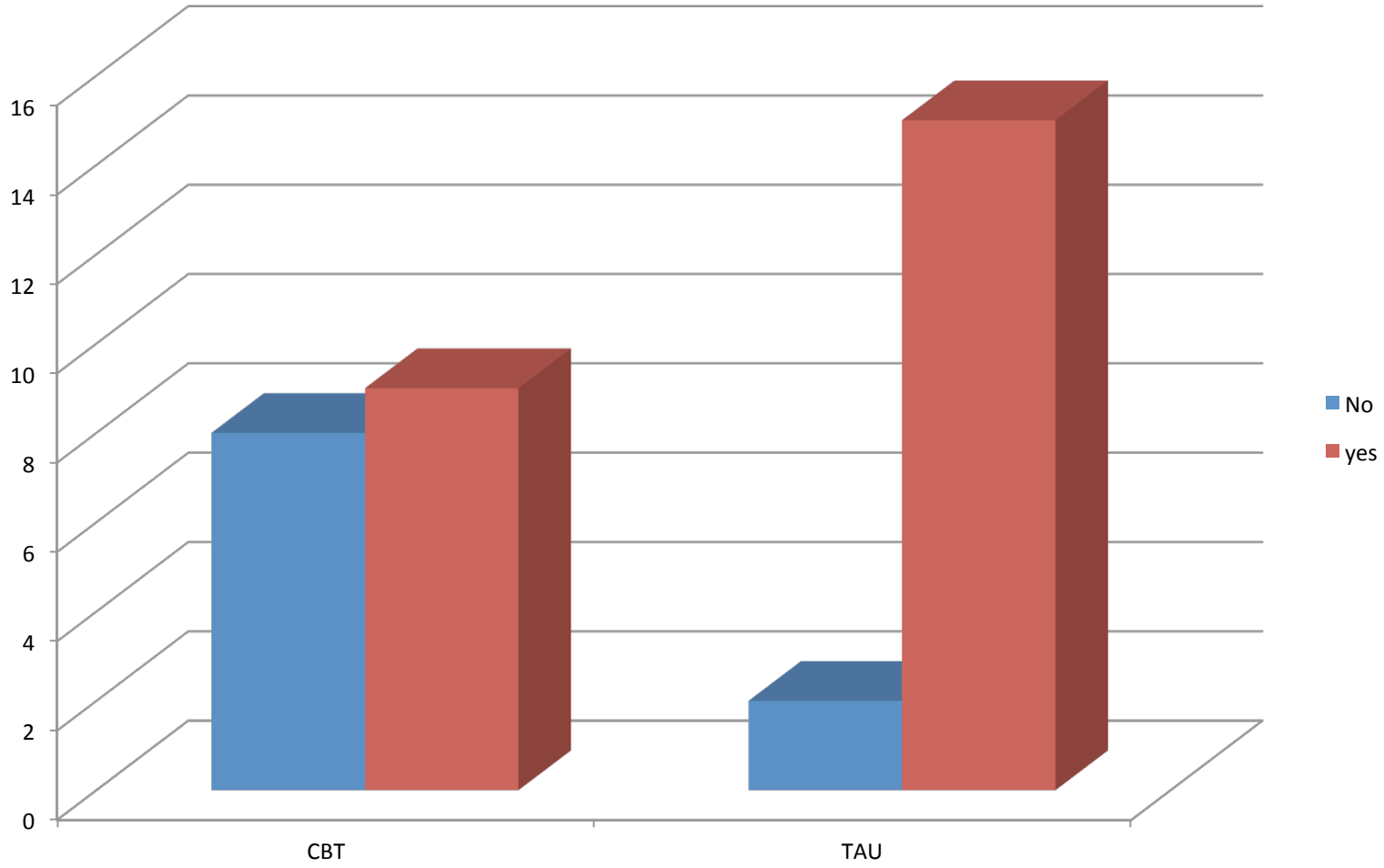
- At 6m (baseline):
  - 9 (53%) cases were severe/extremely severe in CBT group with remainder moderate.
  - 10 (58%) in TAU group were severe

- At 12m (followup):
  - **70%** of treated cases were recovered/mild illness versus **18.5%** of TAU

12m OCD diagnosis



- 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
- Small army of volunteers and RAs especially Esther Wilkinson
- Centre for Anxiety Disorders and Trauma, colleagues in SLAM and KHP
- OCD-UK, maternalocd.org

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