Obsessive-compulsive disorder in pregnant and postpartum patients

AUTHORS: Joanna V MacLean, MD, Lauren M Osborne, MD
SECTION EDITOR: Katharine A Phillips, MD
DEPUTY EDITOR: Michael Friedman, MD

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: **Oct 2023.**
This topic last updated: **Oct 25, 2023.**

INTRODUCTION

Obsessive-compulsive disorder (OCD) is characterized by recurrent intrusive thoughts, images, or urges (obsessions) that typically cause marked anxiety or distress, and by repetitive mental or behavioral acts (compulsions) that the individual feels driven to perform to suppress or neutralize the obsessions. OCD is often a disabling illness that is difficult to treat; partial responses to treatment are common as are subsequent relapses [1].

Perinatal OCD, which includes either new onset OCD or preexisting OCD that is exacerbated perinatally, has the potential for negative effects on obstetric and fetal outcomes, marital functioning, parenting, and quality of life [2,3].

This topic reviews OCD during pregnancy and in postpartum women. The presentation, assessment, and treatment of OCD outside this setting are discussed separately. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis" and "Obsessive-compulsive disorder in adults: Psychotherapy" and "Management of obsessive-compulsive disorder in adults".)

EPIDEMIOLOGY

Prevalence — Intrusive thoughts are common during the perinatal period. In a systematic review including 50 studies investigating characteristics of intrusive thoughts during pregnancy or postpartum periods, unwanted thoughts of accidental harm to the newborn were reported in up to 100 percent of new mothers, including those without psychiatric illness [4]. Additionally, in a prospective study, nearly 50 percent of individuals in the postpartum period reported unwanted thoughts of intentionally harming their infant [5].

However, not all individuals with intrusive thoughts meet diagnostic criteria for obsessive-compulsive disorder (OCD). For example, in a study of individuals in a perinatal day hospital [6], nearly 55 percent of individuals reported obsessions or compulsions, while only 4 percent met criteria for OCD. In some cases, these symptoms may be part of subsyndromal OCD or may be related to a comorbid anxiety or mood disorder.

The range of prevalence estimates of OCD during the perinatal period varies depending on the study population, screening, and diagnostic instruments used, and the duration of the postpartum period [2,7-9]. For example, in a prospective study including 763 pregnant females and new mothers, the prevalence of OCD was 8 percent prenatally and 17 percent postpartum. However, in a retrospective study including 334 individuals in a perinatal day hospital, the rate of perinatal OCD was 4 percent [6].

According to epidemiologic evidence, the prevalence of OCD is greater among pregnant and postpartum women compared with the estimated prevalence in the general population [10-14]. In one meta-analysis of 19 retrospective studies including 6922 participants, the prevalence of OCD among pregnant (12 studies) or postpartum (7 studies) women was greater than the estimated prevalence of OCD in 17,955 women drawn from the general population (2.1 and 2.4 versus 1.1 percent, respectively) [7].

Further research is needed to determine the significance of the difference in rates observed in pregnancy and postpartum, and whether OCD prevalence differs by trimester.

Comorbidity — In females with postpartum OCD, approximately 70.6 percent have a comorbid depressive disorder and 27.5 percent have an anxiety disorder. Comorbidity with depression is associated with chronicity and a poorer prognosis [15]. Prevalence of comorbid psychiatric disorders in adults with OCD is discussed elsewhere. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis", section on 'Epidemiology'.)

PATHOGENESIS

Genetic and environmental factors contribute to the etiology of obsessive-compulsive disorder (OCD). Studies specific to perinatal OCD are limited. However, by examining the biological systems that have been linked to general obsessions and compulsions and the overlap with those linked to perinatal mood and anxiety symptoms, one can generate hypotheses about the biological etiology of perinatal OCD. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis".)

Genetic factors — A family history of mood, anxiety, or substance use disorders, or a personal history of psychiatric disorders, may increase risk of OCD in the perinatal period [15]. While numerous genes have been studied in both OCD and perinatal mood and anxiety disorders, none have consistent evidence linking them to both types of disorders.

Neurotransmitters and reproductive hormones — Fluctuations in the levels of serotonin and gamma aminobutyric acid (GABA) may contribute to the development of perinatal OCD. These are potential areas of investigation for further research.

Specific theories include:

- **Serotonin hypothesis of OCD** – This theory proposes that fluctuations in estrogen and progesterone during pregnancy and postpartum affect serotonin levels in the brain and lead to symptoms of OCD. Preliminary evidence suggests that onset or worsening of OCD symptoms may be associated with the fluctuations that occur at specific points in the reproductive cycle [16,17].

- **Dysregulation of GABA** – Dysregulation of the GABA system may play a role in perinatal OCD. Individuals with OCD have altered levels of GABA in the anterior cingulate cortex [18] and the orbitofrontal cortex [19] compared with healthy individuals. Allopregnanolone, a progesterone metabolite that is a potent allosteric modulator of the GABA-A receptor, plays an important role in perinatal mood and anxiety disorders.

Psychological theory — Many new parents experience fleeting thoughts of harming their children. In individuals with OCD, these thoughts may be assigned a heightened level of meaning and responsibility. Compulsions, such as excessive checking on the infant may develop as an attempt to neutralize these unwanted intrusive thoughts.

This conceptualization suggests that treatment with cognitive-behavioral therapy should focus on helping the patient to understand and address maladaptive beliefs they have assigned to the intrusive thoughts [11,20]. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis", section on 'Clinical features'.)

CLINICAL FEATURES AND COURSE

Symptoms — Obsessive-compulsive disorder (OCD) is characterized by recurrent intrusive thoughts, images, or urges (obsessions) that typically cause marked anxiety or significant distress and/or by repetitive mental or behavioral acts such as checking, cleaning, or reassurance seeking (compulsions) that the individual feels driven to perform to suppress or neutralize the obsessions. The symptoms are time consuming and may affect overall functioning. Examples of obsessions and compulsions during pregnancy and the postpartum period are listed on the table (table 1) [11,14,16,21-30]. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis".)

Clinical manifestations of OCD tend to vary by perinatal stage. Symptoms that occur during the postpartum period tend to differ from those that occur during pregnancy or nonpregnant periods:

- During pregnancy, obsessions are often about fears of fetal death or contamination. The compensatory rituals may include compulsive checking on fetal well-being or compulsive cleaning or washing rituals.
- Postpartum obsessional thoughts often include mental images of harm coming to the child. Intrusive thoughts may include either inadvertent or deliberate harm to the infant. These may present as visually graphic and cause extreme distress. Examples include drowning the baby in a bathtub, throwing the baby out of a window, or crushing the baby's skull. Compensatory behaviors include avoiding contact with the baby.

In one analysis of 450 individuals with OCD reported in 14 studies, thoughts of aggression towards the infant were more prevalent in the postpartum period than during pregnancy (60 versus 15 percent), while obsessions involving contamination were more prevalent during pregnancy than postpartum (76 versus 58 percent) [31].

Clinical course during perinatal period — The course of perinatal OCD is variable. Most studies have been retrospective and show varying proportions of individuals worsening, improving, or staying the same [25,29,30,32].

Several studies suggest that for individuals with pre-existing OCD, the severity or course of their illness appears to be unaffected during the perinatal period [25,29,30,32-34]. In one prospective study, 56 women with pre-existing OCD were monitored at regular intervals throughout pregnancy and up to one year postpartum [33]. The severity of symptoms (measured at each visit using the Yale-Brown Obsessive Compulsive scale) did not change over the course of

pregnancy and postpartum. However, individuals with younger age and those who underwent cesarean section births did have more postpartum obsessive-compulsive symptoms.

Obstetrical outcomes — OCD appears to be associated with adverse obstetrical outcomes. As examples:

- In separate cohort studies in Sweden and British Columbia, pregnancy and neonatal outcomes of a total of 10,653 pregnancies in females with OCD, were compared with outcomes in over 2.9 million pregnant females without OCD [35]. The presence of OCD was associated with increased risk of adverse perinatal outcomes (eg, preterm birth, low birth weight, low Apgar score at five minutes, neonatal respiratory distress) in both cohorts. Furthermore, adverse pregnancy or delivery outcomes (eg, gestational diabetes, preeclampsia, placental abruption, induction of labor, elective or emergent cesarean delivery, postpartum hemorrhage) were reported in one cohort or the other. Among OCD participants in both cohorts, adverse outcomes were increased in those dispensed serotonin reuptake inhibitors (SRIs) compared with those not dispensed SRIs. The authors point out that confounding by indication may affect these results, as those women prescribed SRIs may be a group with greater symptom severity. Additionally, the fact that women with OCD not taking SRIs still had an increased risk of adverse outcomes suggests that risk is increased in the absence of SRI use. Based on current evidence, women with OCD taking clinically indicated medications should not be advised to discontinue pharmacologic treatment during the perinatal period.

- In a retrospective population-based study including 3365 births to women with OCD, women with OCD had a slightly increased risk of the following outcomes versus women without OCD [3]:

  - Gestational hypertension (adjusted odds ratio 1.5, 95% CI 1.14-1.98)
  - Preeclampsia (adjusted odds ratio 1.2, 95% CI 1.05-1.41)
  - Prelabor rupture of membranes (adjusted odds ratio 1.3, 95% CI 1.15-1.52)
  - Venous thromboembolism (adjusted odds ratio 1.6, 95% CI 1.02-2.37)
  - Preterm birth (adjusted odds ratio 1.31, 95% CI 1.17-1.46)

Risk of harm to the infant — Studies report that unwanted intrusive thoughts of infant-related harm do not predict harming behaviors toward the infant [4,5,36,37]. However, while there does not seem to be increased risk for intentional harm, there is potential for indirect harm as a result of the obsessions or compulsive behavior. Examples include avoidance and neglect of the infant, or inappropriate and excessive cleaning with harmful substances.

Perinatal OCD may be associated with impaired mother-infant relationships and impaired attachment patterns. Evidence is lacking concerning effect on infant development, but both anxiety and depression (whether experienced antenatally or postpartum) have been associated with negative effects on cognitive and emotional development in children [38]. (See 'Additional treatment for postpartum effects' below.)

For most mothers, including those with OCD, insight is preserved, and such thoughts are ego-dystonic and extremely distressing. This is contrasted with individuals with postpartum psychosis, who typically lack insight and whose thoughts are often ego-syntonic and, consequently, associated with an increased risk of aggressive behavior toward the infant. (See 'Differential diagnosis' below and "Postpartum psychosis: Epidemiology, clinical features, and diagnosis".)

SCREENING

Brief screening during prenatal and postpartum visits — Currently, there are no guidelines or standard of care regarding screening for obsessive-compulsive disorder (OCD) during the perinatal period. The United States Preventive Services Task Force recommends screening for depression, but not OCD, in both pregnancy and postpartum periods. We prefer that patients with a diagnosis of OCD continue to be managed by their psychiatric provider during pregnancy. For individuals without a preexisting diagnosis of OCD or in those that present with symptoms of OCD, we typically use a brief, one-question screening for OCD during the perinatal period.

Examples of such screening questions include:

- "It's not uncommon for new mothers to experience intrusive, unwanted thoughts that they might harm their baby. Have any such thoughts occurred to you?" [39].
- "Have you had any scary thoughts, for example, that you might accidentally harm the baby? Many women experience such thoughts but are afraid to mention them."

Any individual with a positive screen should be evaluated using an evidence-based screening instrument. (See 'For individuals with positive screen' below.)

For individuals with positive screen — For individuals who screen positive by the brief one-question screening or in those who present with symptoms of OCD, our preference for further screening is the Perinatal Obsessive-Compulsive Scale (POCS). This is a self-report scale developed specifically to assess the unique content of obsessions and compulsions during the

perinatal period, with separate context-specific versions for pregnancy and postpartum. It has been validated in comparison with the Yale-Brown Obsessive Compulsive Scale, the gold-standard clinician-administered diagnostic tool. The POCS is the only scale specific to obsessive and compulsive symptoms in the perinatal period [40]. Alternatives to the POCS include the Dimensional Obsessive-Compulsive Scale or the Obsessive-Compulsive Inventory-Revised; however, these are not specific to the perinatal period. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis".)

ASSESSMENT

For individuals without a prior diagnosis of obsessive-compulsive disorder (OCD) who screen positive (see 'For individuals with positive screen' above), or in those with new onset of OCD symptoms, we pursue further psychiatric assessment. We evaluate for the presence of further symptoms of OCD as well as diagnoses such as depression or generalized anxiety disorder. We use evidence-based tools such as the Edinburgh Postnatal Depression Scale, the Patient Health Questionnaire-9, the symptom checklist of Yale-Brown Obsessive Compulsive Scale, or the Generalized Anxiety Disorder-7 to screen for OCD symptoms, depression, or anxiety. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis", section on 'Assessment and diagnosis'.)

Individuals undergoing assessment for perinatal OCD should be asked specifically about thoughts of harming their baby, themselves, or others. Additionally, differentiation between postpartum psychosis and postpartum OCD is crucial in considering the level of risk to the baby or self. (See 'Differential diagnosis' below and 'Risk of harm to the infant' above.)

Whenever possible, assessment for OCD should include secondary sources of information, such as the patient's partner or a close family member. Women with OCD may be reluctant to disclose symptoms to a clinician due to stigma, shame, or fear that disclosure would lead to the forced separation from the baby.

DIAGNOSIS

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) diagnostic criteria for obsessive-compulsive disorder (OCD) are as follows [41]. A peripartum specifier for OCD is not included in the diagnostic criteria.

The DSM-5-TR diagnostic criteria for OCD are as follows:

- "A. Presence of obsessions, compulsions, or both:

  Obsessions as defined by (1) and (2):

  - 1. 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.

  - 2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (ie, by performing a compulsion).

  Compulsions as defined by (1) and (2):

  - 1. Repetitive behaviors (eg, hand washing, ordering, checking) or mental acts (eg, praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.

  - 2. 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.

- B. The obsessions or compulsions are time-consuming (eg, take more than one hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (eg, a drug of abuse, a medication) or another medical condition.

- D. The disturbance is not better explained by the symptoms of another mental disorder, for example:

  - Excessive worries, as in generalized anxiety disorder

  - Preoccupation with appearance, as in body dysmorphic disorder

  - Difficulty discarding or parting with possessions, as in hoarding disorder

  - Hair pulling, as in trichotillomania (hair-pulling disorder)

  - Skin picking, as in excoriation (skin-picking) disorder

  - Stereotypies, as in stereotypic movement disorder

- Ritualized eating behavior, as in eating disorders
- Preoccupation with substances or gambling, as in substance-related and addictive disorders
- Preoccupation with having an illness, as in illness anxiety disorder
- Sexual urges or fantasies, as in paraphilic disorders
- Impulses, as in disruptive, impulse-control, and conduct disorders
- Guilty ruminations, as in major depressive disorder
- Thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders
- Repetitive patterns of behavior, as in autism spectrum disorder”

(See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis", section on 'Assessment and diagnosis'.)

DIFFERENTIAL DIAGNOSIS

- **Subsyndromal obsessive-compulsive disorder (OCD) symptoms** – Many individuals with intrusive thoughts during pregnancy or postpartum periods do not meet diagnostic criteria for OCD. (See 'Diagnosis' above.)

  Differentiation between common intrusive thoughts and pathological thoughts is based on the frequency of the thoughts, the quality of the thoughts, how distressing they are, and their effect on parenting and functioning.

- **Postpartum psychosis** – Differentiating postpartum OCD from postpartum psychosis is an important clinical distinction. We establish the frequency of the thoughts, the quality of the thoughts, their effect on parenting and functioning, and the individual’s response to the thoughts in making this differentiation. For example, in an individual with frequent thoughts of dropping their child, a pathological response might be to avoid all contact with the child, whereas a more adaptive response would be to hold the child with the appropriate level of care and caution. In postpartum OCD, the thoughts are bothersome, usually resisted, and only rarely delusional in nature. In postpartum psychosis, the individual often lacks insight, and ideas are not subjectively resisted. Consequently it is

associated with an increased risk of aggressive behavior. (See "Postpartum psychosis: Epidemiology, clinical features, and diagnosis".)

- **Other psychiatric disorders** – In diagnosing OCD, other disorders with overlapping features should also be considered. These include anxiety disorders and mood disorders which are common in pregnancy and postpartum period and often comorbid with OCD, tic disorders, and obsessive-compulsive personality disorder. Further discussion of differentiating these disorders from OCD can be found elsewhere. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis", section on 'Differential diagnosis'.)

- **Other considerations** – There is evidence that some autoimmune conditions may present with obsessive-compulsive symptoms and should be considered via thorough medical history, physical examination, and laboratory studies when indicated. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis", section on 'Comorbidities'.)

TREATMENT

While the treatment of obsessive-compulsive disorder (OCD) in adults is based on established evidence, treatment of OCD in pregnant and postpartum individuals has additional risk factors to consider and little specific data available to inform treatment [42-46]. (See "Obsessive-compulsive disorder in adults: Psychotherapy" and "Management of obsessive-compulsive disorder in adults".)

Care setting — Most individuals with OCD in the perinatal period can be treated in the outpatient setting. If a patient is unable to care for themselves, or if there is significant risk of harm to self or others, including the infant, higher level of care such as partial or inpatient hospitalization is indicated. For example, inadequate oral intake for the child as a result of obsessional parental beliefs warrants further treatment and a higher level of care. Thoughts of harming the child should be carefully assessed as they may warrant a higher level of care. (See 'Risk of harm to the infant' above.)

Initial treatment for most patients

Cognitive-behavioral therapy — In most individuals, our preferred treatment modality for OCD during pregnancy and postpartum period is psychotherapy, particularly cognitive-behavioral therapy (CBT) incorporating exposure and response prevention. CBT is a well-established and effective treatment for OCD at all levels of symptom severity [47]. There is no

evidence to suggest that psychotherapeutic treatments would differ in peripartum individuals; however, most studies have not included them. The efficacy of CBT in the treatment of OCD in adult patients is discussed in detail separately. (See "Obsessive-compulsive disorder in adults: Psychotherapy", section on 'Efficacy'.)

Small trials and case reports have supported the use of CBT in the treatment of prenatal and postpartum OCD [44-46]. As an example, in a prospective trial, 34 individuals with postpartum OCD were randomly assigned to either time-intensive CBT for three months or treatment as usual [44]. At follow-up, individuals in the CBT treatment group had a greater reduction in symptoms of OCD as measured using the Yale-Brown Obsessive Compulsive Scale than those in the treatment as usual group (48 versus 13 percent).

A detailed discussion of CBT for individuals with OCD is found separately. (See "Obsessive-compulsive disorder in adults: Psychotherapy".)

Alternative initial treatment approaches

Pharmacologic management — In patients who cannot access or refuse psychotherapy, we use selective serotonin reuptake inhibitors (SSRIs) as the initial treatment. Additionally, in individuals with comorbid disorders such as depression, or in more severe cases of OCD that warrant more rapid improvement, we often use pharmacologic management along with CBT as the initial treatment. (See 'Role of pharmacotherapy' below.)

A decision to start medications in the perinatal period requires shared decision making, including a discussion of the potential risks of medication use versus the potential risks of untreated illness. (See 'Balancing the risks of treatment against the risks of untreated illness' below.)

A systematic review identified several case reports and case series that provided some support for the use of SSRIs (citalopram, sertraline, fluoxetine, fluvoxamine) in the treatment of perinatal OCD [46]. The authors concluded that CBT should be the first treatment offered but that SSRIs can represent an alternative first-line treatment strategy.

The specific choice of medication is discussed below. (See 'Choosing a medication' below.)

Other psychotherapies — In individuals for whom exposure and response prevention (ERP) is too distressing, we typically offer dialectical behavior therapy focusing on emotion regulation and distress tolerance. While there are no data to support this approach for perinatal OCD, we base this on clinical experience. We attempt to follow this with CBT that consists of ERP and cognitive therapy.

Limited data support the use of other forms of psychotherapy, such as progressive muscle relaxation, anxiety management training, or psychodynamic or eclectic psychotherapy for OCD [48,49]; these types of therapy are not considered the standard of care for OCD. (See "Obsessive-compulsive disorder in adults: Psychotherapy", section on 'Internet-delivered cognitive-behavioral therapy and other psychotherapies'.)

Role of pharmacotherapy

Indications — In individuals with severe symptoms or comorbid depression or anxiety, we initiate treatment with CBT and pharmacologic management with an SSRI simultaneously. In individuals with suboptimal response to CBT, we augment with pharmacologic treatment [50-52]. (See "Management of obsessive-compulsive disorder in adults".)

Studies assessing the effects of combined treatments have shown a trend towards increased efficacy over either treatment alone in more severe cases; however, interpretation of these findings is limited due to variability of study design [43,53].

Balancing the risks of treatment against the risks of untreated illness — We base the decision to prescribe medications for pregnant or nursing individuals by carefully weighing the potential risks of treatment versus the potential risks of untreated illness. These include:

- The severity and chronicity of the obsessions and compulsions, and the degree to which they impair patient and family functioning.
- The risks that untreated illness presents to the mother and baby (eg, avoidance of the baby, neglect, suicidality, or harm to the child).
- The risks of untreated psychiatric illness to child development (including increased risks of internalizing and behavioral disorders in the child [54-57]).
- The risks the medications present to the baby through exposure either in utero or during breastfeeding. (See "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding" and "Severe antenatal unipolar major depression: Choosing treatment" and "Antenatal use of antidepressants and the potential risk of teratogenicity and adverse pregnancy outcomes: Selective serotonin reuptake inhibitors".)

The decision to treat is made more difficult by the paucity of research on the efficacy of medications in pregnancy, the lack of sufficient providers trained in treating this unique population, and contradictory literature addressing the effects of psychotropic medication on fetal and child development. Nevertheless, the bulk of studies that appropriately control for

confounding variables support the compatibility of most antidepressants with both pregnancy and breastfeeding.

We emphasize educating individuals and their support person(s) about the potential risks of pharmacologic management while helping them come to an informed decision.

Choosing a medication — Our preferred first-line medication treatment for OCD during pregnancy or the postpartum period is an SSRI. These agents are effective in reducing OCD (as well as depressive and anxiety) symptoms in nonpregnant patients and are likely to be effective in the perinatal period as well. (See "Management of obsessive-compulsive disorder in adults".)

SSRIs are generally compatible with pregnancy and breastfeeding. However, we weigh the potential effects of medications crossing the placenta and the infant blood brain barrier in pregnant individuals and their presence in breast milk of postpartum individuals. Discussion of the use of SSRIs in pregnancy and postpartum period can be found elsewhere.

- (See "Antenatal use of antidepressants and the potential risk of teratogenicity and adverse pregnancy outcomes: Selective serotonin reuptake inhibitors".)
- (See "Antenatal exposure to selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs): Neonatal outcomes".)
- (See "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding".)

The evidence for pharmacologic treatment of OCD perinatally is based on small studies or case reports, and further studies are needed [46].

- **Pregnancy** – For women during pregnancy or the postpartum period with new-onset symptoms, we often choose sertraline as the first-choice medication. All SSRIs are low-risk in pregnancy, and our preference when initiating a medication in pregnancy is to choose a medication that can be used in breastfeeding as well. Sertraline has the most evidence concerning low passage into the breast milk. However, the differences between sertraline and other SSRIs are not great, and it is important also to consider prior response to medications. For example, if a patient has already responded well to another SSRI during a previous episode, it makes sense to consider restarting that medication; most antidepressants have relative infant doses less than 2 percent of the weight-adjusted maternal dose, and efficacy of the medication for an individual patient should be a key factor in decision-making [58].

  - (See "Antenatal use of antidepressants and the potential risk of teratogenicity and adverse pregnancy outcomes: Selective serotonin reuptake inhibitors", section on

'Citalopram'.)

- (See "Antenatal use of antidepressants and the potential risk of teratogenicity and adverse pregnancy outcomes: Selective serotonin reuptake inhibitors", section on 'Sertraline'.)

Pregnancy outcomes observed for each SSRI are comparable, except for a small increase in congenital malformations with paroxetine [59-61]. However, study findings are inconsistent [62,63]. Use of SSRIs during pregnancy is discussed elsewhere. (See "Antenatal use of antidepressants and the potential risk of teratogenicity and adverse pregnancy outcomes: Selective serotonin reuptake inhibitors".)

- **Breastfeeding individuals** – As in pregnancy, we often use sertraline as the first-choice medication for treatment of OCD during the postpartum period for individuals who have never previously taken an SSRI and are breastfeeding. Clinical studies in breastfeeding individuals taking sertraline, fluvoxamine, or paroxetine suggest that the transfer of these medications into human milk is low and uptake by the infant is even lower [64]. For women who have previously responded to other agents, the individual history of response should rule the choice, as risks are comparable and low for all SSRIs. (See "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding", section on 'Antidepressants'.)

Side effect management and dosing considerations in pregnancy — Due to physiologic changes that occur during pregnancy (for example, increased glomerular filtration rate, increased volume of distribution, and changes in enzymatic activity), individuals will often require a higher than usual dose to achieve an effect. Serum concentrations of medications may decrease across pregnancy, for some medications by as much as 40 to 50 percent. For many this may mean that dose increases may be needed as the pregnancy progresses [65].

As an example, in a pregnant individual with clinically significant new-onset OCD that warrants treatment, we start sertraline at 50 mg daily for one week. We increase the dose by 50 mg weekly or every other week to a maximum of 200 mg per day, if needed, while following up with the individual weekly to every two weeks. In individuals with inadequate response to 200 mg per day after two to four weeks at that dose, we often increase by 25 to 50 mg weekly to a total dose of 300 to 400 mg per day. In the early postpartum period, a time of high risk for depressive and anxiety symptoms, it is appropriate to continue the pregnancy dose unless the patient reports excessive side effects; the dose can be lowered thereafter according to clinical evaluation of both symptoms and side effects. This same strategy applies to any SSRI a patient may be taking during pregnancy. As an example, if a pregnant individual was taking citalopram 20 mg per day and had recurrence or significant exacerbation of symptoms, it would be

appropriate to continue titration as needed to achieve adequate response, even above 40 mg per day, if the patient is tolerating the medication.

In some cases, at the beginning of treatment and prior to antidepressants having the time to take effect, individuals treated with SSRI medications may occasionally experience irritability or worsening anxiety. When severe anxiety threatens discontinuation of treatment, we use a low dose of lorazepam (eg, 0.5 mg up to twice daily) to treat early symptoms. Other options include hydroxyzine (eg, 25 mg orally twice daily), an antihistamine with anxiolytic effects, which we use in individuals with a history of substance use disorder. In individuals whose obsessions border on overvalued ideas or delusional thinking, we often use the second-generation antipsychotic quetiapine. However, data are lacking on the relative efficacy of SSRI monotherapy versus SSRI augmentation with a second-generation antipsychotic for OCD with poor insight (overvalued ideation) or absent insight (delusional OCD beliefs). (See "Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding" and "Severe antenatal unipolar major depression: Choosing treatment".)

Individuals refractory to combined treatment — For individuals who are unresponsive to the initial combination of psychotherapy and pharmacologic management we choose the next treatment as follows:

- **Individuals with no response to treatment** – In these individuals, we typically taper off the initial SSRI while titrating a second SSRI. As an example, in an individual with no response to initial combination of CBT with sertraline, we would taper sertraline over 7 to 10 days while titrating another SSRI at the same time.

- **In individuals with a partial response to treatment** – In individuals with a partial response to the combination of CBT with an SSRI, we often augment with an antipsychotic agent.

  Our first-line choice is often quetiapine, an antipsychotic agent with a low burden of side effects and helpful properties for a number of symptoms (sleep difficulty, depressive symptoms) that may accompany OCD, thus allowing us to use an augmenting agent that may serve more than one purpose and allowing us to minimize the risk of multiple medication exposures to the fetus. Quetiapine also has low passage into the breast milk due to high molecular weight. We typically begin quetiapine at 25 mg daily and titrate by 25 mg weekly to 100 to 150 mg daily, depending on response and the type of symptoms (eg, lower doses when soporific side effects are primarily desired). (See "Second-generation antipsychotic medications: Pharmacology, administration, and side effects".)

One uncontrolled study examined quetiapine augmentation following an inadequate response to an SSRI in 17 postpartum women with OCD. After 12 weeks of treatment, 11 of the 17 women experienced a 50 percent or greater reduction in symptoms [66]. (See "Second-generation antipsychotic medications: Pharmacology, administration, and side effects" and "Schizophrenia in adults: Maintenance therapy and side effect management".)

Other atypical antipsychotics can be used as well; there is little evidence on augmentation strategies in the perinatal period, but risperidone and aripiprazole have the strongest evidence in nonperinatal populations [67]. When using aripiprazole, it is important to monitor effects on breastfeeding, as some evidence indicates that it may have effects on milk supply [68]. Newer antipsychotics, about which we have little data on pregnancy use, should be avoided.

Another augmenting strategy, when possible, is more intensive CBT with ERP (ie, more days a week and/or more hours per day). Given the lack of access to trained ERP therapists, this is often not a realistic strategy.

- **Individuals refractory to multiple treatments** – Additional strategies such as switching to clomipramine or to a different SSRI, or augmenting with lamotrigine or memantine (as advised for general OCD [69]) can also be tried, although there is little evidence to support either efficacy or safety in the perinatal population. The goal of all pharmacotherapeutic treatment in pregnancy should be to minimize the number of exposures to the fetus. Each medication, and the psychiatric illness itself, are considered exposures. Given this, and the pharmacokinetic and pharmacodynamic changes of pregnancy, it is prudent always to maximize doses of one medication before adding a second. Transcranial magnetic stimulation is compatible with pregnancy, and preliminary evidence indicates some efficacy for perinatal depression [70] and for OCD outside of the perinatal period [71], although its efficacy for perinatal OCD is unknown.

  For patients with severe illness who do not respond to the above approaches, deep brain stimulation (DBS) is a neurosurgical treatment involving implantation of electrodes that send electrical impulses to various targets. While small, randomized trials suggest that DBS may reduce symptoms of OCD, further studies are needed. The risks and efficacy in the perinatal period are unknown. There is no literature supporting the use of DBS in pregnancy. (See "Deep brain stimulation for treatment of obsessive-compulsive disorder".)

Additional treatment for postpartum effects — Clinical experts have suggested the use of dyadic therapy or infant massage as adjunctive treatment when OCD interferes with attachment and bonding between the mother and child [72,73]. Dyadic work can help the mother through

instruction, demonstration play, and supervision to create positive interactions with the baby, recognizing and responding to his or her emotions in an accepting environment.

PROGNOSIS

Obsessive-compulsive disorder (OCD) tends to have a chronic course (although treatment is often effective). Perinatal OCD is associated with impaired mother-infant relationships and may be associated with impaired attachment patterns and neurodevelopment of infants in extreme cases.

There are limited studies that have looked specifically at the prognosis of perinatal OCD. In individuals with pre-existing OCD, the presence of comorbid major depressive disorder and/or another anxiety disorder is associated with a more chronic course of illness and poorer outcomes [15,74].

One study comparing postpartum mothers with OCD and their infants to control dyads showed that mothers with OCD were less confident, had lower rates of breastfeeding, were less sensitive to infant needs, had less vocalization with their baby, and reported increased marital distress and less social support than peers [75]. According to an earlier study, mothers with OCD perceive the quality of their parenting to be affected, such as the ability to enjoy and have fun with their child [76]. Some of these interactions can also be attributed to comorbid postpartum depression. Dysfunction in early mother-infant interactions is important, as it may be one mechanism by which vulnerabilities for child difficulties can be transmitted.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Obsessive-compulsive disorder and related disorders" and "Society guideline links: Postpartum care".)

SUMMARY AND RECOMMENDATIONS

- **Epidemiology** – The range of prevalence estimates of obsessive-compulsive disorder (OCD) during pregnancy and postpartum varies depending on the study population, screening or diagnostic methods and criteria used. According to epidemiologic evidence, the prevalence of OCD is greater among pregnant and postpartum women compared with the estimated prevalence in the general population. (See 'Epidemiology' above.)

- **Clinical features and course**

  - **Symptoms** – OCD in the perinatal period is characterized by recurrent intrusive thoughts, images, or urges that cause marked anxiety or distress and/or by repetitive mental or behavioral acts that the individual feels driven to perform to suppress the obsessions. The symptoms are time consuming, may cause significant distress, or lead to impairment in social, occupational, or other important areas of functioning. (See 'Symptoms' above.)

  - **Course** – The course of OCD in pregnancy and postpartum periods is variable. Retrospective studies show varying proportions of individuals worsening, improving, or staying the same. (See 'Clinical course during perinatal period' above.)

  - **Obstetrical outcomes** – OCD may be associated with a slightly increased risk of gestational hypertension, preeclampsia, premature rupture of membranes, venous thromboembolism, and preterm birth. (See 'Obstetrical outcomes' above.)

  - **Risk of harm to infant** – Studies report that intrusive thoughts of infant-related harm do not predict harming behaviors toward the infant. (See 'Risk of harm to the infant' above.)

    While there does not seem to be increased risk for intentional harm, harm may occur due to infant neglect or other behaviors. In instances where the clinician has concerns about patient or child safety, it is necessary to involve higher levels of care or social agencies.

- **Screening and assessment** – There are no guidelines or standard of care regarding screening for OCD during the perinatal period. We screen individuals without a preexisting diagnosis of OCD with a brief one-question screening tool. (See 'Screening' above and 'Assessment' above.)

  We complete a psychiatric assessment for the diagnosis of OCD and other comorbid disorders such as depression, anxiety, and postpartum psychosis in all individuals who screen positive for OCD. Diagnostic criteria for the diagnosis of OCD are provided above. (See 'Diagnosis' above.)

- **Diagnostic differentiation** – Differentiating postpartum OCD from postpartum psychosis is an important clinical distinction. In postpartum psychosis, in contrast to OCD, the individual often lacks insight, and the ideas are not subjectively resisted. Mothers with

postpartum psychosis are at greater risk for harm to themselves and their child than those with OCD. (See 'Differential diagnosis' above.)

- **Treatment** – For most individuals with OCD in pregnancy or the postpartum period, we suggest cognitive-behavioral therapy (CBT) (**Grade 2C**). Pharmacologic management is a reasonable alternative for individuals who refuse psychotherapy, or when psychotherapy is unavailable. (See 'Initial treatment for most patients' above.)

  For patients with more severe symptomatology (eg, functional decline or requiring more immediate symptomatic relief), or in those with comorbid depression or anxiety, we suggest initiating treatment with both CBT and pharmacologic management with a selective serotonin reuptake inhibitor rather than using either treatment alone (**Grade 2C**). (See 'Role of pharmacotherapy' above.)

  For individuals who are unresponsive to the initial combination of psychotherapy and pharmacologic management we choose to either switch medications or augment depending on response to initial medication. More intensive CBT can also be considered. (See 'Individuals refractory to combined treatment' above.)

  Medication treatment during pregnancy may require higher dosing, as physiologic changes of pregnancy result in decreased serum levels. (See 'Side effect management and dosing considerations in pregnancy' above.)

Topic 504 Version 34.0

→