Cognitive Behavioral Treatment of Postpartum Onset Obsessive-Compulsive Disorder with Aggressive Obsessions

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Overview

- Review of diagnostic criteria for OCD
- Describe unique characteristics of OCD with postpartum onset
- Review CBT for OCD
- Describe a case of OCD with postpartum onset and the course of CBT treatment
Cognitive Behavioral Treatment of Postpartum Onset

Obsessive Compulsive Disorder With Aggressive Obsessions

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Background

- Lifetime prevalence of OCD is 2.5%
- 4th most prevalent psychiatric disorder
- Increased risk of OCD onset and exacerbation during pregnancy and postpartum
- OCD symptoms prior to pregnancy predict increased risk of pregnancy-related OCD
Background

- OCD can interfere significantly with mother’s ability to care for and bond with her child.
- Without treatment, symptoms are likely to persist for an extended period (e.g., Uguz et al., 2008).
OCD Diagnostic Criteria

A. Either obsessions or compulsions:

- **Obsessions as defined by 1, 2, 3, and 4**
  - 1) recurrent and persistent thoughts, impulses, or images that are...experienced as intrusive and inappropriate and that cause marked anxiety or distress
  - 2) the thoughts, impulses, or images are not simply excessive worries about real-life problems
  - 3) the person attempts to ignore or suppress such thoughts, impulses, or images or to neutralize them with some other thought or action
  - 4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)
OCD Diagnostic Criteria

- **Compulsions as defined by 1 and 2**
  - 1) repetitive behaviors or mental acts that the person feels driven to performing response to an obsession, or according to rules that must be rigidly applied.
  - 2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, they are either not connected in a realistic way with what they are designed to neutralize or prevent or a clearly excessive
OCD Diagnostic Criteria

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable

C. The obsessions or compulsions cause marked distress, are time consuming, or significantly interfere with the person’s normal routine or life functioning

D. If another Axis I condition is present, the content of the disorder is not restricted to it.

E. Not due to direct physiological effects of substance or general medical condition.
# Common Obsessions and Compulsions

<table>
<thead>
<tr>
<th>OBSESSIONS</th>
<th>COMPULSIONS</th>
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<tbody>
<tr>
<td>Contamination</td>
<td>Handwashing</td>
</tr>
<tr>
<td>Aggression</td>
<td>Reassurance Seeking</td>
</tr>
<tr>
<td>Exactness</td>
<td>Ordering, Counting</td>
</tr>
<tr>
<td>Symmetry</td>
<td>Ordering, Counting</td>
</tr>
<tr>
<td>Scrupulosity</td>
<td>Praying, “Undoing”</td>
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</table>
Aggressive Obsessions

- More commonly reported in postpartum OCD than when OCD onset is not associated with pregnancy (Uguz et al., 2007)
- Tend to focus on thoughts or images of accidental and purposeful harm including dropping, stabbing, strangling, or drowning the baby.
Aggressive Obsessions

- Although highly disturbing, aggressive obsessions do not predict increased risk of committing harm (Abramowitz et al., 2003)
- Postpartum psychosis is associated with increased risk of child harm.
- Differentiation from psychotic spectrum disorders:
  - In OCD, symptoms are distressing, ego-dystonic
  - In OCD, insight into the irrationality of thoughts and behaviors
Postpartum OCD

- Commonly occurs within 6 weeks of delivery
- Often rapid onset
- Obsessions, rather than compulsions, tend to predominate (e.g., Sichel et al., 1993)
- Avoidance of feared objects (e.g., knives) or situations (e.g., being alone with baby) may be more evident than compulsions
Treatment

- OCD Expert Consensus Guidelines recommend EX/RP as the first-line treatment in most cases due to relative superiority to pharmacological therapy.
- Concerns of taking psychotropic medications while breastfeeding also support CBT approach.
Randomized, Placebo-Controlled Trial of Exposure and Ritual Prevention, Clomipramine, and Their Combination in the Treatment of Obsessive-Compulsive Disorder


a Linear mixed-effects model analyses.
Case study: “Sara”

- 29 year old, Caucasian, married women
- Thoughts of harming 5-month old son
- Had been prescribed sertraline (150mg) 3 weeks prior to presentation at the clinic
- Motivated to pursue CBT; desired greater symptom reduction, more active role in treatment, and to discontinue psychototropic medications
Presenting Complaints

- Intrusive, repetitive, and distressing thoughts and images of strangling and drowning her 5-month old son “Justin”
- Obsessions most frequent when home alone, particularly when putting to sleep or bathing him
Compulsions and avoidance

- “undoing” ritual (kiss baby; think loving thoughts)
- Reassurance seeking
- Avoidance of bathing son, being alone with him
- Symptoms were highly distressing and significantly impaired ability to care for her son
History

- Master’s degree; working part-time
- Good relationship with husband of 2-years who was a full-time professional
- Denied history of significant trauma
- Good relationship with family of origin, good support from friends
History

- History of OCD symptoms dating to childhood; no previous treatment
- Past symptoms: excessive hand-washing, avoidance of stepping on lines/cracks, aggressive thoughts of harming her dog
- In past, symptoms has been mildly impairing, discontinued over time
History

- Sought treatment at this time due to notable distress and interference
  - Difficulty eating, sleeping, caring for her son
- First consulted psychiatrist; was prescribed sertaline and referred to the CBT clinic
Assessment

- Anxiety Disorders Interview Schedule (ADIS-IV); 90 minute semistructured interview
  - Confirmed diagnosis of OCD
  - No other anxiety, mood, or personality disorders
- Obsessive-Compulsive Inventory-Revised
- Yale-Brown OCD Scale
  - Assess distress, frequency of symptoms, interference, and resistance
  - Above clinical cut-off for both scales
  - Indicated moderate severity of symptoms
Assessment

- **Beck Depression Inventory:**
  - Score = 23; moderate depressive symptoms
  - Did not meet criteria for depressive disorder
  - Items endorsed related to guilt, self-criticism, and appeared to be secondary to OCD

- Good insight, highly motivated
Case conceptualization: Cognitive Factors

- Obsessive Beliefs Questionnaire (OBQ-44) score of 221; above mean for OCD patients
- Score of 71 (12-84 scale) on subscale assessing importance/control of thoughts
- Examples:
  - “Having a bad thought is morally no different than doing a bad deed.”
  - “If I have aggressive thoughts or impulses about my loved ones, this means I may secretly want to hurt them.”
  - “I should be able to rid my mind of unwanted thoughts.”
Case Conceptualization: Behavioral Factors

- Anxiety and fear in response to obsessions
- Compulsions and avoidance perpetuated by negative reinforcement (temporary reduction in anxiety)
Exposure and Response Prevention

• Goals
  ◦ 1) reduce association between feared thoughts and situations and anxiety
  ◦ 2) extinguish the association between compulsive/avoidant behaviors and anxiety reduction.

Obsessions ➔ Anxiety ➔ Compulsions
Course of Treatment

- Eight 75-90 minute sessions over 3 months
  - 5 weekly sessions, 3 sessions every 3 weeks
- Weekly rather than intensive treatment because
  - Functioning reasonably well at time of presentation
  - Deriving benefit from SSRI treatment
  - Anxiety most strongly triggered by being home alone with son, so weekly sessions allowed for practice of home-based exposures
Course of Treatment

- Treatment focused on:
  a) Psychoeducation regarding factors that contribute to the development and maintenance of OCD
  b) Cognitive restructuring focused on faulty assumptions relevant to OCD
  c) Exposure and Response Prevention (EX/RP)
Initial Session: Psychoeducation

- Describe treatment: progressively challenging exposures to feared thoughts and situations
  - Goals: Reducing associations of 1) obsessions with anxiety and 2) compulsions/avoidance with anxiety reduction
- OCD as self-perpetuating
  - Compulsions are negatively reinforcing
Initial Session: Psychoeducation

- OCD vulnerability: belief that all thoughts are highly meaningful, should be easily controlled, and must be controlled to prevent negative consequences
- Pregnancy and postpartum are vulnerable periods; symptoms commonly focus on child
Initial Session: Cognitive Aspect

- Common cognitive errors described and alternatives suggested.
  - Thought: “I should be able to rid my mind of unwanted thoughts”
  - New thought: “I cannot control all of my thoughts, but I can control my actions”

- Very receptive; hadn’t considered that her thoughts may be inaccurate
## Initial Session: EX/RP Hierarchy

### Table 1
Sara’s Initial Hierarchy of Feared Situations

<table>
<thead>
<tr>
<th>SUDS</th>
<th>Scenario</th>
</tr>
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<tbody>
<tr>
<td>100</td>
<td>While home alone, hold baby with hand on his throat while listening to a tape of the therapist describing strangling the baby</td>
</tr>
<tr>
<td>95</td>
<td>While home alone, but in a different room than the baby, listen to a tape of therapist describing strangling the baby</td>
</tr>
<tr>
<td>90</td>
<td>Hold hand on baby’s throat while home alone with him</td>
</tr>
<tr>
<td>85</td>
<td>Hold hand on baby’s throat while husband is in another room</td>
</tr>
<tr>
<td>60</td>
<td>Hold hand on baby’s throat with husband or therapist present</td>
</tr>
<tr>
<td>50</td>
<td>Place baby in crib to sleep and remain in the room while home alone</td>
</tr>
<tr>
<td>40</td>
<td>Bathe baby while home alone</td>
</tr>
<tr>
<td>30</td>
<td>Put baby in the crib while husband is home</td>
</tr>
<tr>
<td>20</td>
<td>Bathe baby while husband is home</td>
</tr>
</tbody>
</table>

Note: SUDS = subjective units of distress.
Second session

- EX/RP initiated using Sara’s hierarchy
- Starting with relatively easy exposure
- Cradled Justin while placing hand on his chest and refraining from ritualizing (including mental rituals)
- This evoked moderate anxiety (SUDs = 60)
- Continued with encouragement; after 35 minutes, anxiety decreased substantially (SUDs = 30).
- Exposure was repeated.
- Assigned homework: bathe Justin daily while husband not home. No engaging in avoidance or ritualizing. Record anxiety at beginning and end each time.
- Briefly reviewed common cognitive errors
Continued Treatment

- Completed daily bathing; reported significant anxiety habituation within trials and across trials
- Continued to progress up hierarchy
- Gained confidence in completing tasks
- Items initially rated as highly distressing were only moderately distressing when completed
- Demonstrated increasing awareness of cognitions and ability to challenge faulty assumptions
- Reductions in avoidance, frequency and intensity of obsessions, and impairment in daily life
Continued Treatment

- By session 6, Sara was completing exposures from the top of her hierarchy
  - In-session: Sara would hold Justin with her hands on his throat while the therapist described aloud how it would feel to strangle him
  - Home practice: Sara completed similar exposure using audiotape from session
Note

- Therapists may be reluctant to engage in the most highly challenging exposures due to their own fears.
- Important for such exposures to be completed; purposeful avoidance of certain thoughts or images implies to the client that these are dangerous and should be avoided.
Concluding Treatment

- 8 therapy sessions over 3 months.
- After 5 weekly sessions, experienced minimal impairment, and requested greater time between sessions to allow more time to practice exposures and to reduce medical costs.
- In consultation with psychiatrist, discontinued sertraline.
Follow-up Assessment

- ADIS-IV; No longer met criteria for OCD
- OCI-R: 27 to 9; below clinical cut-off
- Y-BOCs: 22 to 6; below clinical cut-off
- OBQ-44: 221 to 106, similar to non-anxious controls
- BDI-II: 23 to 5 (treatment did not specifically address depressive symptoms)
Complicating Factors

- In many ways, ideal candidate for CBT; highly motivated, understood rationale, good adherence
- Justin sometimes fussy or fidgety; exposures ended early were repeated ASAP to prevent unintentional negative reinforcement of avoidance
- Verbal accounts of harming Justin were audiotaped and Sara listened on headphones as Justin grew older
Treatment Implications

• Features common to postpartum OCD:
  ◦ Aggressive obsessions
  ◦ Cognitive errors
  ◦ History of symptoms
Conclusions

- Highly treatable, largely undiagnosed and misunderstood
- Reluctance to disclose symptoms
- Highly comorbid with postpartum depression
- Differentiating from psychosis is key
- New parenthood can be vulnerable period for men as well as women

(Fairbrother & Abramowitz, 2007)
Reference