Disturbo Ossessivo-Compulsivo perinatale

Carlo Marchesi

Università degli Studi di Parma
Dipartimento di Medicina e Chirurgia
Sezione di Psichiatria

carlo.marchesi@unipr.it

Disturbo Ossessivo-Compulsivo

DOC

DOC di Personalità

Disturbi dello Spettro OC

periodo perinatale

Disturbo Ossessivo-Compulsivo (DSM 5)

Ossessioni

1. pensieri, impulsi o immagini, ricorrenti o persistenti, che vengono esperiti come intrusivi e non voluti e che nella maggior parte degli individui causano intensa ansia e disagio;
2. il soggetto tenta di ignorare o di sopprimere questi pensieri o impulsi o di neutralizzarli con qualche altro pensiero o azione (compulsione);
3. *(il soggetto le riconosce come prodotto della sua mente) (DSM-IV);*

Compulsioni

1. Comportamenti ripetitivi o atti mentali (pregare, contare, ripetere parole) messi in atto in risposta ad una ossessione, o eseguiti rigidamente in accordo a certe regole;
2. hanno lo scopo di prevenire o ridurre l'ansia o il disagio o di prevenire qualche situazione temuta; non sono connesse in modo realistico a ciò che dovrebbero prevenire o sono chiaramente eccessivi;

Sono causa di un marcato disagio, costituiscono una notevole perdita di tempo (più di un'ora/die), o interferiscono significativamente con la normale attività del soggetto

Disturbo Ossessivo-Compulsivo di Personalità (DSM 5)

Un quadro pervasivo di preoccupazione per l'ordine, perfezionismo, e controllo mentale e interpersonale, a spese di flessibilità, apertura ed efficienza, che compare entro la prima età adulta ed è presente in una varietà di contesti, come indicato da quattro (o più) dei seguenti elementi:

1) attenzione per i dettagli, le regole, le liste, l'ordine, l'organizzazione o gli schemi, al punto che va perduto lo scopo principale dell'attività;
2) mostra un perfezionismo che interferisce con il completamento dei compiti;
3) eccessiva dedizione al lavoro e alla produttività, fino all'esclusione delle attività di svago e delle amicizie;
4) esageratamente coscienzioso, scrupoloso, inflessibile in tema di moralità, etica o valori;
5) è incapace di gettare via oggetti consumati o di nessun valore, anche quando non hanno alcun significato affettivo
6) è riluttante a delegare compiti o a lavorare con altri, a meno che non si sottomettano esattamente al suo modo di fare le cose
7) adotta una modalità di spesa improntata all'avarizia, sia per sé che per gli altri; il denaro è visto come qualcosa da accumulare in vista di catastrofi future
8) manifesta rigidità e testardaggine.

Disturbi dello Spettro Ossessivo

1. Disturbo da dimorfismo corporeo
2. Disturbo da accumulo
3. Tricotillomania
4. Disturbo da escoriazione
5. DOC indotto da sostanze/farmaci
6. DOC da condizione medica (PANDAS, corea di Sydenham)
7. Altri specifici DOC
8. DOC non specificato

DOC

Approccio classico

- ansia è la componente centrale

↓

Classificato tra i Disturbi d'Ansia fino al DSM-IV

Ma il ruolo dell'ansia nella formazione dei sintomi è lungi dall'essere chiarita

DOC

Thought-Action-Fusion

pensare un evento negativo:

- lo possa far accadere
- equivale, in senso etico, a compierlo

(Amir et al. *Behav Res Ther 2001; 39: 765-776*)

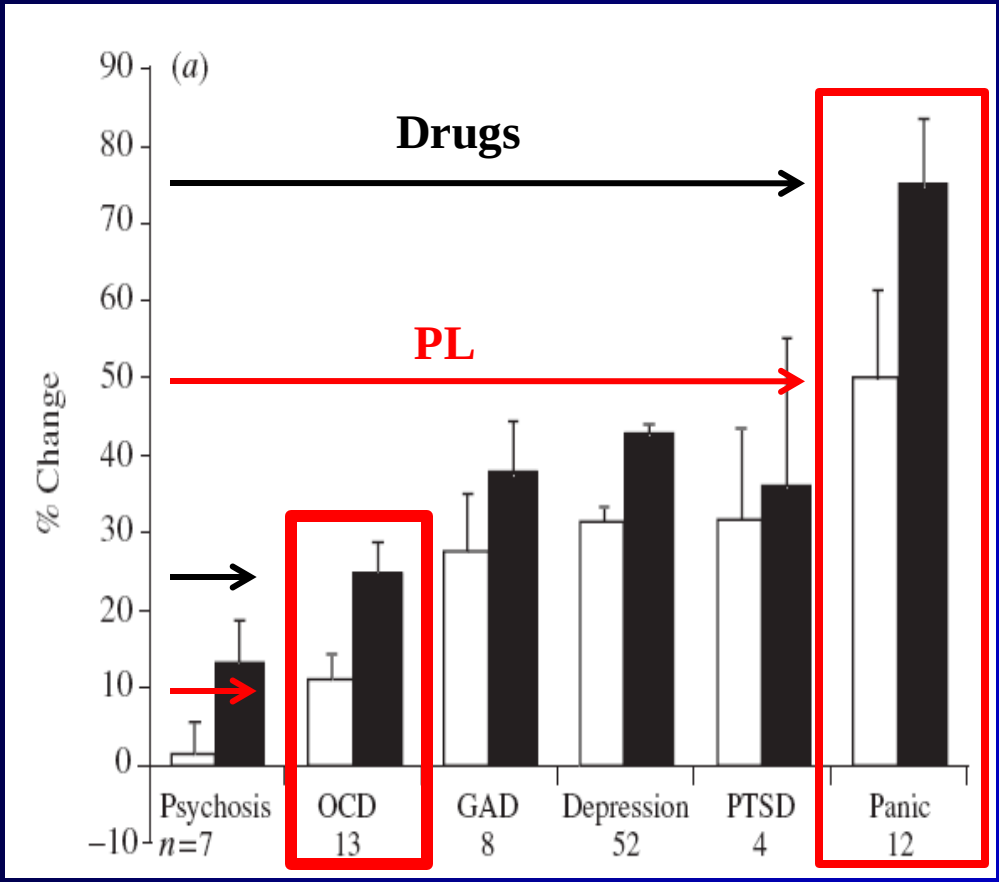
DOC
Caratteristiche cognitive

- attenzione e vigilanza:
  - aumentate per parole a contenuto di “contaminazione”;
  - ricordano maggiormente le parole a contenuto negativo e le dimenticato più difficilmente;
- incapacità di inibire o spostare l’attenzione da pensieri o azioni che creano disagio ad altri più piacevoli;
- alterazioni delle strategie organizzative
- rallentamento psicomotorio, conseguente al deficit delle strategie esecutive e dell’attenzione e al dubbio nelle decisioni.

(Chamberlain et al, *Neurosci Biobehav Rev 2005; 29: 399-419;* Aouizerate et al. *Prog Neurobiol 2004; 72: 195-221)*

Magnitude of placebo response and drug–placebo differences across psychiatric disorders

Psychological Medicine, 2005, **35**, 743–749



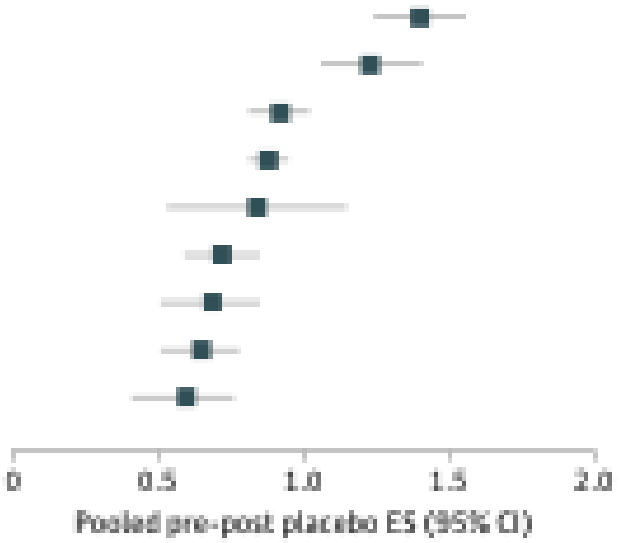
Differential Outcomes of Placebo Treatment Across 9 Psychiatric Disorders A Systematic Review and Meta-Analysis

Bschor et al, *JAMA Psychiatry 2024; 81: 757-768*

Figure 1. Random-Effects Meta-Analysis Estimates of Pooled Pre-Post Placebo Effect Sizes

Diagnosis	Study participants, No.	Q	I^2, %	ES (95% CI)
MDD	1598	47.9	81	1.40 (1.24-1.56)
GAD	1457	61.4	85	1.23 (1.06-1.41)
Panic disorder	1307	20.8	57	0.92 (0.81-1.02)
ADHD	1189	7.3	0	0.88 (0.81-0.95)
PTSD	655	99.8	91	0.84 (0.53-1.15)
Social phobia	1180	34.7	74	0.72 (0.59-0.85)
Mania	967	53.1	83	0.68 (0.51-0.85)
OCD	819	29.6	70	0.65 (0.51-0.78)
Schizophrenia	888	50.0	82	0.59 (0.41-0.76)

Heterogeneity: $\chi^2_8 = 88.50$ ($P < .01$)



DOC

1. Prevalenza un anno: 1.1-1.8%
2. Età media di esordio: ~ 20 anni (25% età ≤14 anni)
3. Rapporto maschi-femmine: 1-1.5
4. Sottotipi: contaminazione/lavaggio; controllo; accumulo; simmetria/ordine;
5. Decorso: tendenzialmente cronico con fluttuazione di intensità dei sintomi (alcuni persistono anche dopo un trattamento efficace)
6. Richiedono più spesso un trattamento medico (20% dei pazienti a visita dermatologica);

(Jenike, *Lancet 2004;350:259-256*; Aouizerate et al. *Prog Neurobiol 2004; 72: 195-221*
Chamberlain et al, *Neurosci Biobehav Rev 2005; 29: 399-419)*

Duration of Untreated Illness in Patients with Obsessive–Compulsive Disorder and Its Impact on Long-Term Outcome: A Systematic Review

Perris et al, *J Pers Med 2023;13:1453-1463*

The DUI ranged from 7.0±8.5 to 20.9±11.2 years.

longer DUI → greater symptom severity
lower level of treatment response

DOC: opzioni terapeutiche

	SRI	CBT	SRI+CBT
More severe disorder	+++	0	+++
More severe depression	+++	0	+++
More severe anxiety	+++	0	+++
Patient cooperation	+	+++	+++
Need to perform “homeworks”	0	++	++
Persistence of effect after stopping treatment	0	+	+
Used by experienced therapist	0	+	+
Side effects	++	0	++
Non-response to a previous treatment	+	+	++

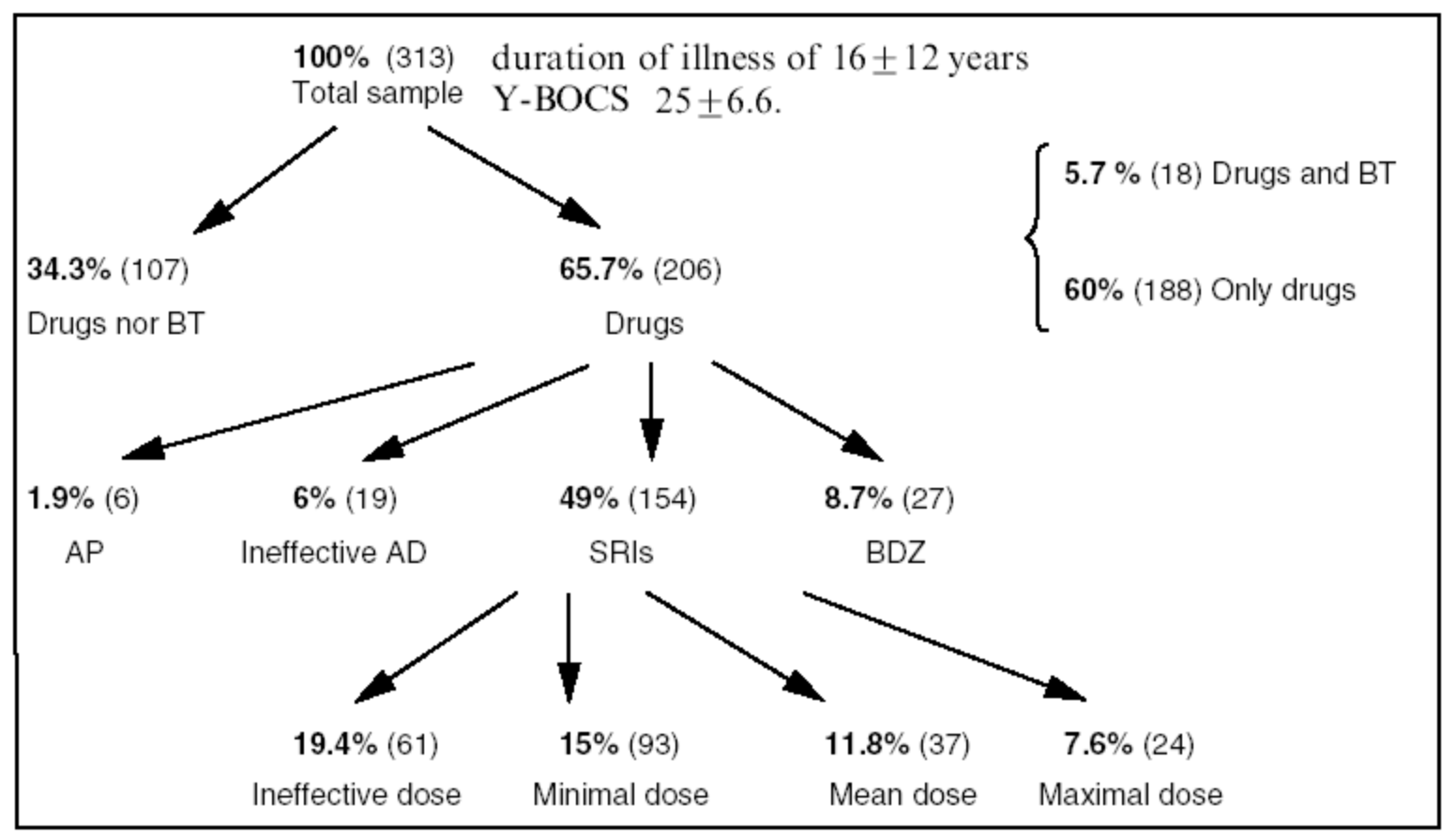
APA guideline, 2007

International Clinical Psychopharmacology 2002, **17**:109–114

The adequacy of pharmacotherapy in outpatients with obsessive–compulsive disorder

D. Denys, H. van Megen and H. Westenberg

Department of Psychiatry, University Medical Center, Utrecht, The Netherlands



Adequacy of treatment in outpatients with obsessive-compulsive disorder

Cohen et al, *Comp Psychiatry 2025;136: 152546*

673 patients, 60% female, age 37±13 yrs, YBOCS 27±6

33% no medication
9% medication not recommended
4% BDZ
33% SSRI low to medium dose
8% SSRI high dose

3.6% BDZ

Psychotherapy
14 % none
51 % at least one CBT trial
29 % Exposure Response Prevention
4.9 % others

Adequate pharmacotherapy
(1st line drug, 1 SSRI at max dose, ≥ 2SSRIs)
increased by
- illness duration
- previous psychotherapy

Periodo Perinatale

The effect of maternal concerns about childbirth and postpartum period on obsessive and compulsive behaviors related to baby care

Menekşe et al, *Biomedica 2024; 44: 379-390*

Variables	1	2
1. Age	-	
2. OCB-PPBC	**-0.129***	-
3. Concerns about the baby	-0.120	**0.359****
4. Concerns about labor	**-0.156***	**0.359****
5. Concerns about postpartum breastfeeding	-0.078	**0.368****
6. Concerns about inadequate baby care after birth	**-0.155***	**0.360****
7. Concerns about postpartum social life	0.015	**0.256****
8. Concerns about baby and women health after childbirth	-0.065	**0.368****
9. Concerns of not getting support from spouse after delivery	-0.076	**0.255****
10. Concerns before labor	-0.077	**0.376****
11. Concerns about health personnel's behavior during delivery	-0.108	**0.269****
12. Concerns about cesarean section	-0.076	**0.223****
13. FCPPS	-0.119	**0.429****

OCB-PPBC: Obsessive and Compulsive Behaviors-Postpartum Period Baby Care; FCPPS: Fear of Childbirth and Postpartum Period Scale. * $p < 0.05$ ** $p < 0.01$

DOC perinatale

Punti in discussione

1. Maggior frequenza nel periodo perinatale ?
2. Maggior frequenza in gravidanza o nel postpartum ?
3. Maggior frequenza per esordio o peggioramento ?
4. Ha caratteristiche sintomatologiche differenti ?
5. Ne sono affette solo le madri ?

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Risk of Obsessive-Compulsive Disorder in Pregnant and Postpartum Women: a Meta-Analysis

Russell et al, *J Clin Psychiatry 2013; 74: 377-385*

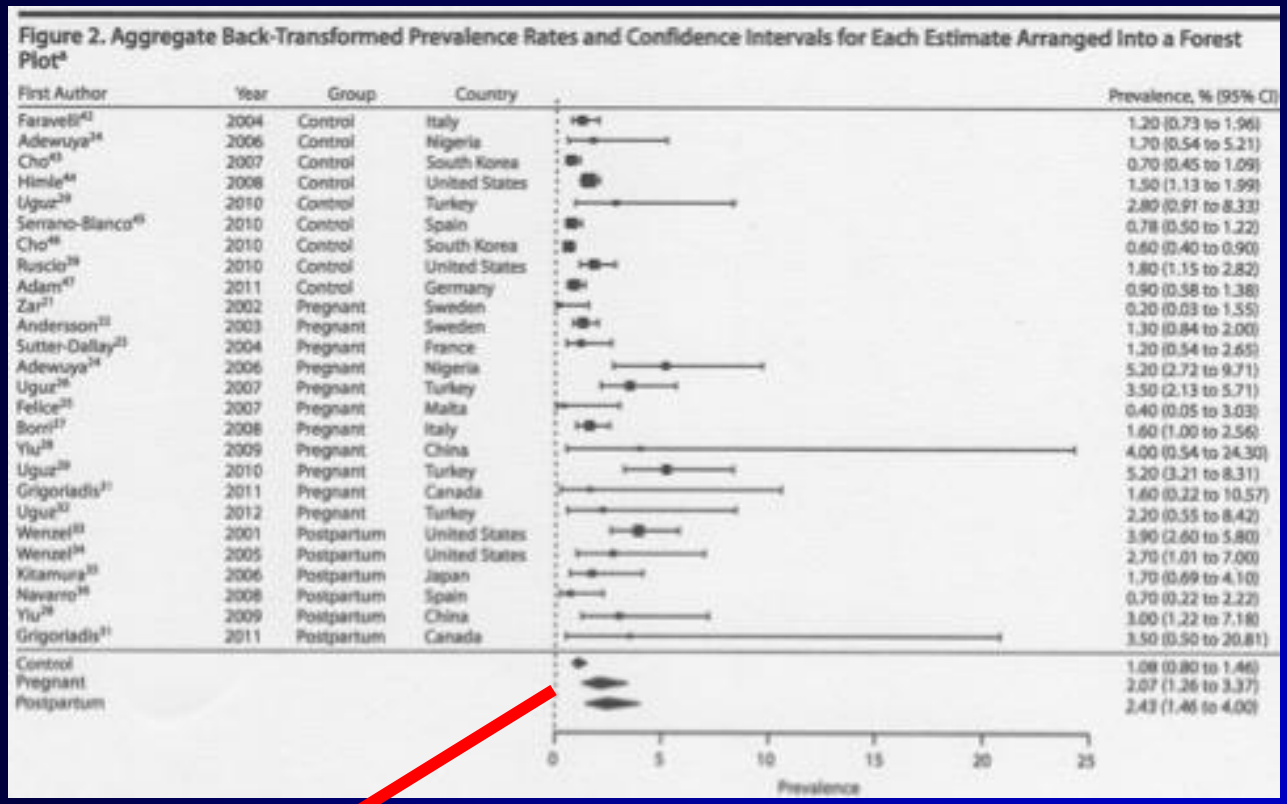


Figure 2. Aggregate Back-Transformed Prevalence Rates and Confidence Intervals for Each Estimate Arranged Into a Forest Plot[a]

First Author	Year	Group	Country	Prevalence, % (95% CI)
Faravelli[42]	2004	Control	Italy	1.20 (0.73 to 1.96)
Adewuya[34]	2006	Control	Nigeria	1.70 (0.54 to 5.21)
Cho[43]	2007	Control	South Korea	0.70 (0.45 to 1.09)
Himle[44]	2008	Control	United States	1.50 (1.13 to 1.99)
Uguz[29]	2010	Control	Turkey	2.80 (0.91 to 8.33)
Serrano-Blanco[45]	2010	Control	Spain	0.78 (0.50 to 1.22)
Cho[46]	2010	Control	South Korea	0.60 (0.40 to 0.90)
Ruscio[39]	2010	Control	United States	1.80 (1.15 to 2.82)
Adam[47]	2011	Control	Germany	0.90 (0.58 to 1.38)
Zar[21]	2002	Pregnant	Sweden	0.20 (0.03 to 1.55)
Andersson[33]	2003	Pregnant	Sweden	1.30 (0.84 to 2.00)
Sutter-Dallay[23]	2004	Pregnant	France	1.20 (0.54 to 2.65)
Adewuya[24]	2006	Pregnant	Nigeria	5.20 (2.72 to 9.71)
Uguz[26]	2007	Pregnant	Turkey	3.50 (2.13 to 5.71)
Felice[25]	2007	Pregnant	Malta	0.40 (0.05 to 3.03)
Bonri[27]	2008	Pregnant	Italy	1.60 (1.00 to 2.56)
Yiu[28]	2009	Pregnant	China	4.00 (0.54 to 24.30)
Uguz[29]	2010	Pregnant	Turkey	5.20 (3.21 to 8.31)
Grigoriadis[31]	2011	Pregnant	Canada	1.60 (0.22 to 10.57)
Uguz[32]	2012	Pregnant	Turkey	2.20 (0.55 to 8.42)
Wenzel[33]	2001	Postpartum	United States	3.90 (2.60 to 5.80)
Wenzel[34]	2005	Postpartum	United States	2.70 (1.01 to 7.00)
Kitamura[35]	2006	Postpartum	Japan	1.70 (0.69 to 4.10)
Navarro[36]	2008	Postpartum	Spain	0.70 (0.22 to 2.22)
Yiu[28]	2009	Postpartum	China	3.00 (1.22 to 7.18)
Grigoriadis[31]	2011	Postpartum	Canada	3.50 (0.50 to 20.81)
Control				1.08 (0.80 to 1.46)
Pregnant				2.07 (1.26 to 3.37)
Postpartum				2.43 (1.46 to 4.00)

0 5 10 15 20 25

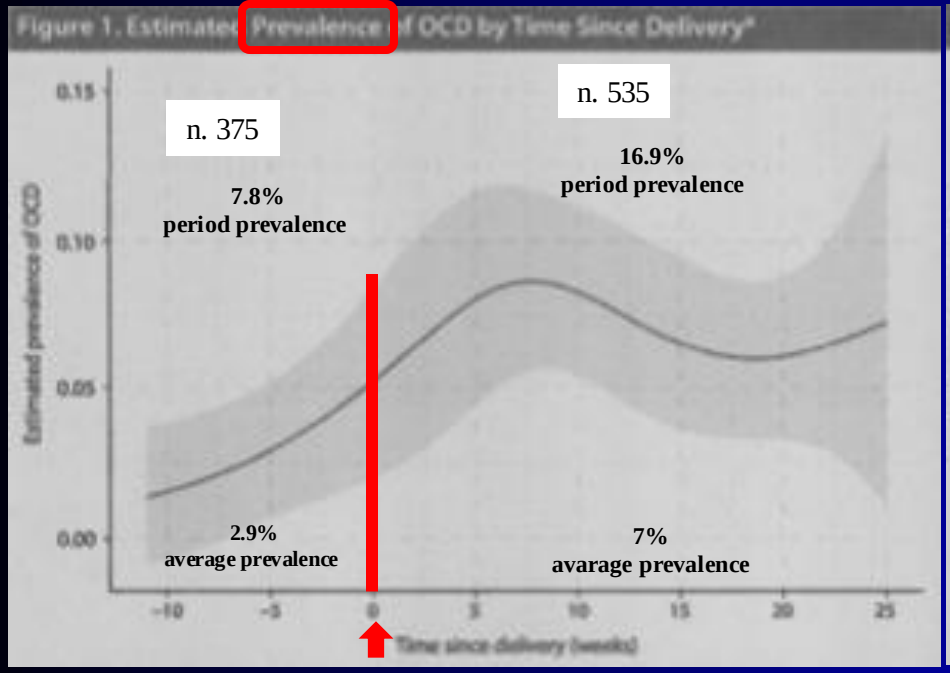
Prevalence

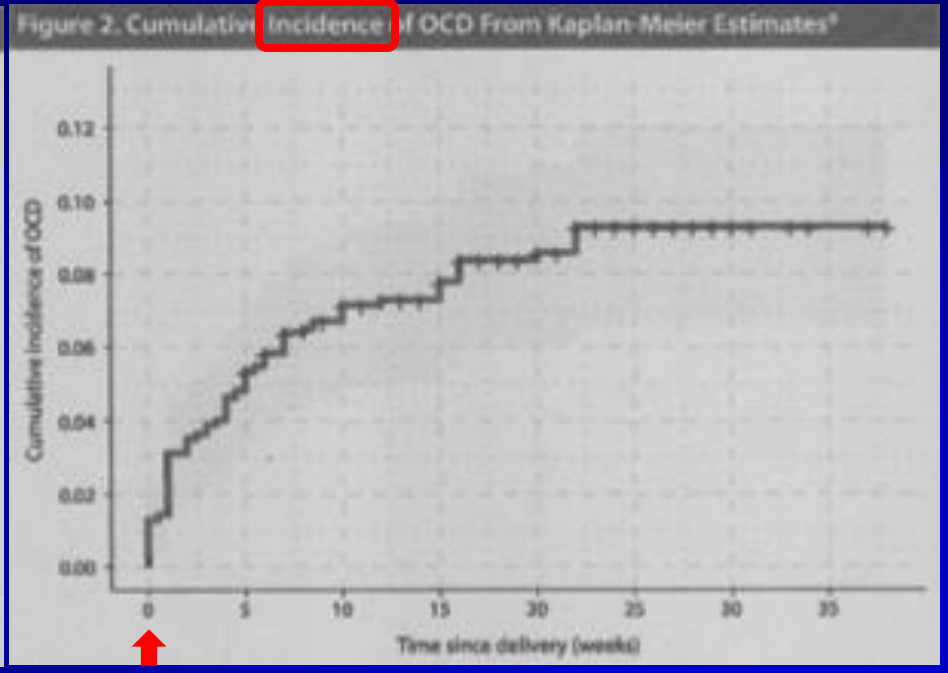
Prevalence %	
Control	1.08 (95% CI 0.80-1.46)
Pregnancy	2.07 (95% CI 1.26-3.37)
Postpartum	2.43 (95% CI 1.46-4.00)

Risk ratio	
Perinatal	1.79 (95% CI 1.39-2.29)
Pregnancy	1.45 (95% CI 1.07-1.96)
Postpartum	2.38 (95% CI 1.70-3.33)

High Prevalence and Incidence of Obsessive-Compulsive Disorder Among Women Across Pregnancy and the Postpartum

Fairbrother et al, *J Clin Psychiatry 2021; 82: 20m13398*





Obsessive-Compulsive and Related Disorder Symptoms in the Perinatal Period: Prevalence and Associations with Postpartum Functioning

Miller et al, *Arch Womens Ment Health 2022; 25: 771–780*

OCRD; e.g., hoarding disorder, body dysmorphic disorder (BDD), trichotillomania, excoriation disorder

clinical interview during
- pregnancy: 28-32 weeks gestation, n 276
- postpartum: 6-8 weeks, n 221

BDD and OCD symptoms were the most prevalent:

- pregnancy, 14.9% (n 41) BDD and 6.2% (n 17) OCD symptoms;
- postpartum, 11.8% (n 26) BDD and 14% (n 31) OCD symptoms.

Poorer postpartum functioning was associated with elevated OCRD symptoms in pregnancy and postpartum.

Analysis of the Characteristics and Influencing Factors of Perinatal Obsessive-Compulsive Symptoms in Elderly Parturients

Wang J, Jia F. *Br J Hosp Med. nov 2024*

122 women
age 35 years or older
no prior history of mental illness
37 (30%) OCD

1° figlio
età media 33 anni

Table 4. Logistic regression analysis of perinatal obsessive-compulsive symptoms in elderly parturients.

Factor	β	SE	Ward χ^2	p	OR	95% CI
History of pregnancy	0.599	0.236	6.450	0.008	1.821	1.147~2.892
Pregnancy complications	0.512	0.154	11.063	<0.001	1.669	1.234~2.257
Fetal health condition	0.562	0.175	10.310	<0.001	1.754	1.245~2.472
SAS	0.637	0.295	4.664	0.027	1.891	1.061~3.371
EPDS	0.512	0.212	5.838	0.012	1.669	1.102~2.529
SOC-13	0.242	0.089	7.403	0.002	1.274	1.070~1.517

Note: SAS is self-rating anxiety scale, EPDS is edinburgh postpartum depression scale, SOC-13 ability to cope with stress and promote health

Prenatal, Perinatal, and Postnatal Risk Factors in Obsessive–Compulsive Disorder

Vasconcelos et al, *Biol Psychiatry 2007; 61: 301-307*

Table 3. Univariate Analysis of Environmental Risk Factors Comparing the Obsessive–Compulsive Disorder (OCD) with the Control Groups

Environmental Variable	*OCD *n* (%)	Control *n* (%)	*p*
Prenatal Period			
Difficulty conceiving	4 (6.1)	0 (0)	.053
Special medication or procedure to conceive	5 (7.6)	0 (0)	.025
Maternal history of medical problems	4 (6.2)	0 (0)	.051
Excessive weight gain during pregnancy	20 (30.3)	3 (4.5)	<.001
Edema of the hands, feet, or face during pregnancy	18 (26.9)	3 (4.7)	.001
Premature amniorrhexis (rupture of membranes)	6 (9.2)	0 (0)	.013
Hyperemesis gravidarum	32 (51.6)	7 (11.5)	<.001
Medication during pregnancy	42 (66.7)	16 (28.6)	<.001
Other problems during pregnancy (see text)	24 (35.3)	3 (4.3)	<.001
Perinatal Period			
Hospital delivery	64 (94.1)	56 (80)	
Home delivery	4 (5.9)	14 (20)	.014
Normal delivery	37 (54.4)	54 (77.1)	
Cesarean section	31 (45.6)	16 (22.9)	.005
Protracted labor	17 (37.8)	4 (6.0)	<.001
Nuchal cord entanglement	6 (10.2)	1 (1.5)	.05
Postnatal Period			
Incubator required	13 (21.3)	4 (5.9)	.01
Other postnatal problems	21 (34.4)	5 (7.1)	<.001
Delayed bladder control	5 (8.1)	0 (0)	.026

* high socio-economic status and education level

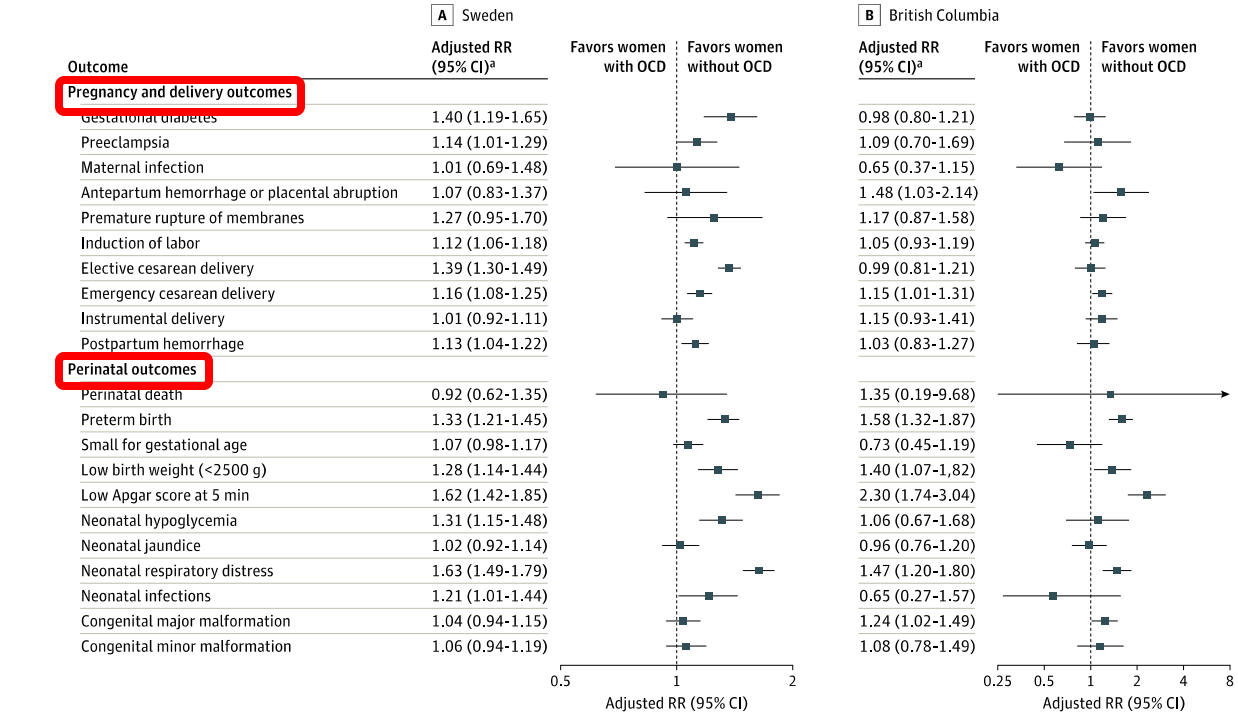
Pregnancy, Delivery, and Neonatal Outcomes Associated With Maternal Obsessive-Compulsive Disorder

Two Cohort Studies in Sweden and British Columbia, Canada

Fernandez de la Cruz et al, *JAMA Psychiatry Open 2023; 6: e2318212*

Characteristic	No. (%)			
	Sweden (N = 2 145 660)		British Columbia, Canada (N = 824 100)	
	Mothers without OCD (n = 2 137 348)	Mothers with OCD (n = 8312)	Mothers without OCD (n = 821 759)	Mothers with OCD (n = 2341)
Psychiatric comorbidities[e]				
Any psychiatric disorder	151 141 (7.1)	6009 (72.3)	57 531 (7.0)	1184 (50.6)
Bipolar and psychotic disorders	13 751 (0.6)	980 (11.8)	7612 (0.9)	269 (11.5)
Mood and anxiety disorders	147 225 (6.9)	5940 (71.5)	54 923 (6.7)	1155 (49.3)

Figure. Adjusted Risk Ratios (RRs) of Pregnancy, Delivery, and Neonatal Outcomes Among Mothers With or Without Obsessive-Compulsive Disorder in Sweden (1999-2019) and British Columbia, Canada (2000-2019)



[a] Risk ratios adjusted for age at delivery, parity, place of birth, educational level, cohabitation with a partner, body mass index, prepregnancy diabetes, smoking during pregnancy, and year of delivery.

DOC perinatale

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Female Reproductive Cycle and Obsessive-Compulsive Disorder

Labad et al, *J Clin Psychiatry 2005; 66: 428-435*

Table 2. Onset of Obsessive-Compulsive Disorder at Reproductive Events

Reproductive Event	N/N	%
Menarche (within the following 12 months)	10/46	22
Pregnancy		
All patients	1/46	2
Patients with children[a]	1/17	6
Postpartum		
All patients	3/46	7
Patients with children[a]	3/17	18
Menopause		
All patients	1/46	2
Postmenopausal patients[b]	1/11	9

[a]Patients who delivered at least 1 live-born child.
[b]Patients with natural menopause (N – 9) or surgical menopause (N – 2) following a hysterectomy with removal of both ovaries.

Table 4. Results of Stepwise Logistic Regression for Premenstrual and Postpartum Exacerbations of Obsessive-Compulsive Disorder (OCD) and Their Association With Premenstrual Symptoms

	Model 1 Premenstrual Worsening of OCD[a]			Model 2 Onset or Worsening of OCD at Postpartum[a]		
Covariate	OR	95% CI	p	OR	95% CI	p
Number of premenstrual mood symptoms[b]	5.1	1.6 to 16.1	.006	2.7	1.1 to 6.8	.039
Premenstrual worsening of OCD[b]	NA	NA	NA	NS	NS	NS

Female Reproductive Cycle and Obsessive-Compulsive Disorder

Labad et al, *J Clin Psychiatry 2005; 66: 428-435*

Table 3. Worsening of Preexisting Obsessive-Compulsive Disorder (OCD) at Reproductive Events

Reproductive Event	N/N[a]	%
Premenstruum	9/45	20
Abortion or miscarriage	0/6	0
Pregnancy	1/12	8
Postpartum	6/12	50
Perimenopause/menopause	1/12	8

[a]Sample sizes are compounded by the number of patients with preexisting OCD at each reproductive event.

Perinatal Timing of Obssessive-Compulsive Disorder Onset

Fairbrother et al, *J Clin Psychiatry 2024; 85: 24m15266*

69 women with perinatal OCD		
Perinatal period		
• Pregnancy	12	17.4
• Postpartum	57	82.6
Multiparas	**34**	
Nonperinatal	8	23.5
First perinatal	9	26.5
Subsequent perinatal	17	50.0

OCD Symptom Change			
	Increase	No change	Decrease
Pregnancy	35%	55%	10%
Postpartum	77%	6%	17%

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Distinct correlates of hoarding and cleaning symptom dimensions in relation to onset of obsessive–compulsive disorder at menarche or the perinatal period

Labad et al *Arch Womens Ment Health 2010; 13: 75-81*

Abstract

- 90 female outpatients with OCD
- to assess the relationship between different symptom dimensions and the onset of OCD at menarche or during perinatal period.

Patients with

- ***hoarding symptoms*** were more likely to report OCD onset at ***menarche*** (OR = 4.1, p = 0.034);
- ***contamination/cleaning symptoms*** were more likely to report the onset of their disorder during ***pregnancy or postpartum*** (OR=9.3, p=0.048).

Onset and Exacerbation of Obsessive-Compulsive Disorder in Pregnancy and the Postpartum Period

Forray et al, *J Clin Psychiatry 2010; 71: 1061-1068*

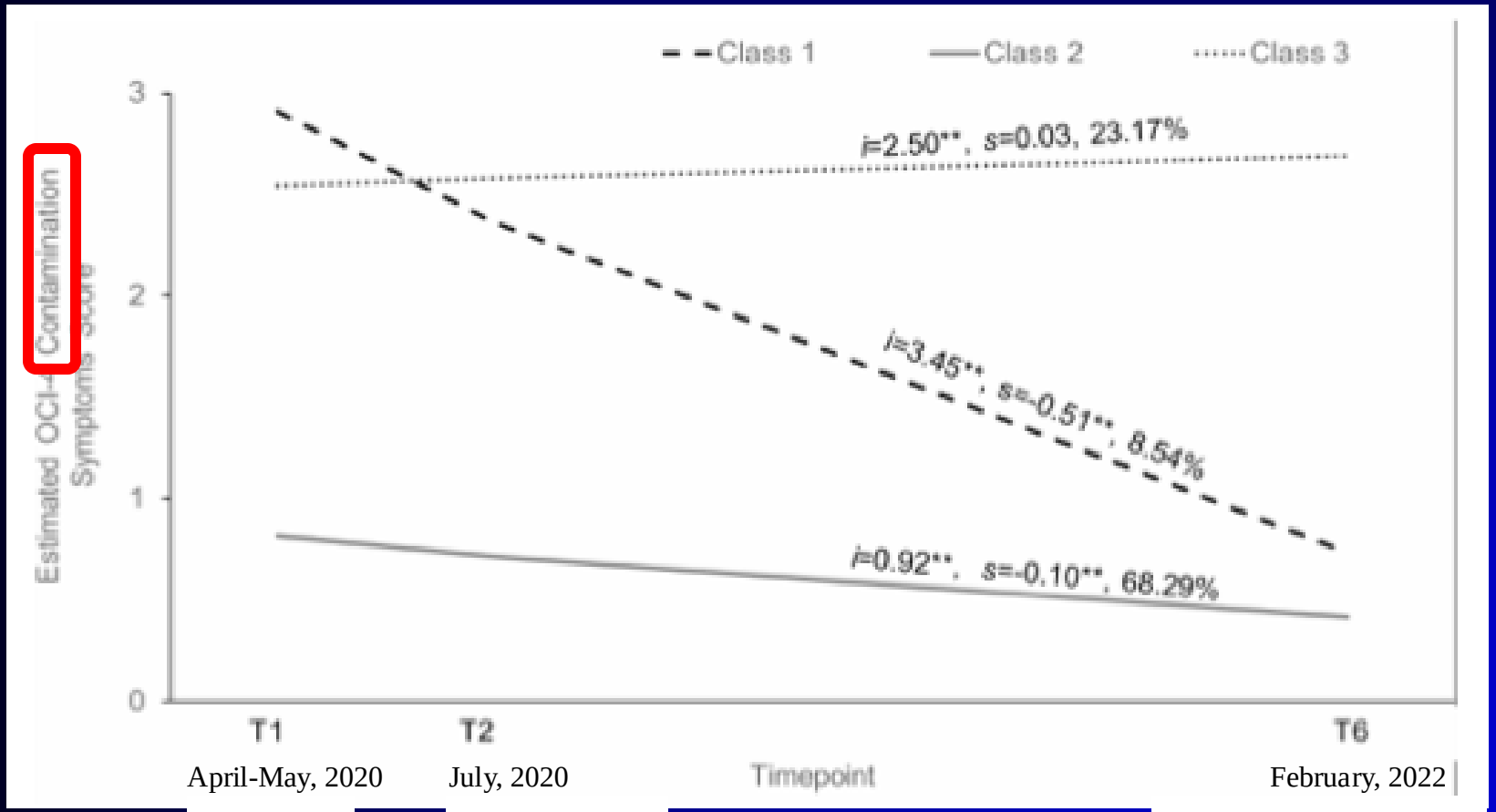
Table 3. OCD Symptoms Most Frequently Reported by Women in the Ever Pregnant and Never Pregnant Groups

Symptom, n (%)	Never Pregnant Group (n=48)	Ever Pregnant Group: All Pregnant Women (n=77)[a]	Ever Pregnant Group: Perinatal-Related OCD Onset (n=24)	Ever Pregnant Group: Nonperinatal-Related OCD Onset (n=53)[b]
Aggressive	18 (37.5)	22 (28.6)	5 (20.8)	17 (32.1)
Contamination	23 (47.9)	35 (45.5)	16 (66.7)[c]	19 (35.9)[c]
Sexual	7 (14.6)	4 (5.2)	1 (4.2)	3 (5.7)
Hoarding/saving	6 (12.5)	5 (6.5)	0 (0)	5 (9.4)
Religious/scrupulosity	8 (16.7)[c]	3 (3.9)[c]	1 (4.2)	2 (3.8)
Symmetry/exactness	13 (27.1)	17 (22.1)	6 (25.0)	11 (20.8)
Somatic/illness	4 (8.3)	5 (6.5)	2 (8.3)	3 (5.7)
Miscellaneous obsessions	15 (31.3)	23 (29.9)	6 (25.0)	17 (32.1)
Cleaning/washing	23 (47.9)	45 (58.4)	17 (10.8)	28 (52.8)
Checking	27 (56.3)	38 (49.4)	12 (50.0)	26 (49.1)
Repeating	18 (37.5)	24 (31.2)	8 (33.3)	16 (30.2)
Counting	11 (22.9)	12 (15.6)	1 (4.2)	11 (20.8)
Ordering/arranging	3 (6.3)[d]	17 (22.1)[d]	6 (25.0)	11 (20.8)
Collecting	8 (16.7)	5 (6.5)	0 (0)	5 (9.4)
Miscellaneous compulsions	16 (33.3)[c]	11 (14.3)[c]	2 (8.3)	9 (17.0)
Worry—aggression or harm to babies	NA	16 (20.8)	6 (25.0)	10 (18.9)
Total, mean ± SD	4.2 ± 2.0	3.7 ± 1.4	3.7 ± 1.3	3.6 ± 1.5

[c] $P = .01$.
[d] $P = .02$.

Obsessive-compulsive symptom trajectories from pregnancy through the postpartum: examining longitudinal course and risk factors during the COVID-19 pandemic

Levison et al, *Arch Women Mental Health october 2024*



April-May, 2020

25±8 *wks*

July, 2020

39% after birth

February, 2022

18±2 *mts postpartum*

OCD in the Perinatal Period: Is Postpartum OCD a Distinct Subtype? A Review of the Literature

McGuinness et al, *Behav Cogn Psychother 2011; 39: 285-310*

Conclusion

- The concept of ppOCD as a specific subtype has not been robustly demonstrated.
- The evidence that OCD in the postpartum period presents a distinctive clinical picture with specific symptomatology and course is more compelling.

DOC perinatale

Punti in discussione

1. Maggior frequenza nel periodo perinatale ?
2. Maggior frequenza in gravidanza o nel postpartum ?
3. Maggior frequenza per peggioramento o per esordio ?
4. Ha caratteristiche sintomatologiche differenti ?
5. Ne sono affette solo le madri ?

Acute Onset of Obsessive-Compulsive Disorder in Males Following Childbirth

Abramowitz et al, *Psychosomatics 2001; 42: 429-431*

- The authors present four cases of males with OCD onset that coincide with a spouse's pregnancy or delivery.
- The rapid onset and content of obsessions and compulsions are remarkably similar to those reported in previous studies of postpartum OCD in females.

Obsessive-compulsive disorder in fathers during pregnancy and postpartum

Coelho et al, *Rev Bras Psiquiatr 2014; 36: 271-273*

Table 1 Adjusted relative risks (RR) and 95% confidence intervals (95%CI) for the concordance of obsessive-compulsive disorder (OCD) in mothers and fathers during pregnancy and postpartum period

	Adjusted RR*	95%CI
Maternal and paternal OCD concordance during pregnancy	6.13	1.77-21.20
Maternal and paternal OCD concordance in the postpartum period	5.89	1.22-28.42

* Adjusted for age, social class, living with partner, parity, and mood episodes in mothers and fathers.

Obsessive compulsive-disorder and reproductive life events

Paul et al, *Asian J Psychiatry 2020; 52: 102124*

Sociodemographic and clinical characteristics and symptom profile of OCD in women (N = 92) and men (N = 58) with OCD.

Variable	Female OCD patients (N = 92) Mean ± SD / N (%)	Male OCD patients (N = 58) Mean ± SD / N (%)	t /X^2	P
Age (years)	37.06 ± 7.42	36.17 ± 6.21	0.758	0.449
Age of onset of OCD	27.25 ± 8.36	23.94 ± 7.92	2.403	0.018
Duration of illness (years)	9.84 ± 8.76	12.20 ± 6.98	−1.756	0.085
Age at first consultation for OCD (years)	31.97 ± 7.18	29.68 ± 7.20	1.905	0.059
Duration of untreated illness (years)	4.74 ± 6.65	5.87 ± 6.06	−1.049	0.296
YBOCS score (obsessions)	10.29 ± 4.59	9.86 ± 4.56	0.587	0.558
YBOCS score (compulsions)	8.78 ± 5.20	7.67 ± 5.09	1.283	0.202
YBOCS score total	18.91 ± 9.17	17.33 ± 8.99	1.038	0.301
Obsessions				
Contamination	71(77)	20(35)	27.17	< .001
Somatic	10(11)	11(19)	1.936	.164
Aggression	27(29)	25(43)	2.971	.084
Sexual	11(12)	18(31)	8.302	.003
Religious	17(18)	17(29)	2.581	.122
Hoarding	5(5)	3(5)	.004	.944
Pathological doubt	43(47)	33(57)	1.468	.225
Need for symmetry	32(35)	16(28)	.846	.357
Miscellaneous	26(28)	18(31)	.132	.716
Compulsions				
Washing	70(76)	22(38)	21.838	< .001
Checking	43(47)	23(40)	.724	.394
Repeating	24(26)	20(34)	1.209	.271
Counting	8(9)	6(10)	.114	.735
Collecting	3(3)	1(2)	.323	.569
Ordering/arranging	25(27)	15(26)	.031	.859
Miscellaneous compulsions	50(54)	38(66)	1.830	.176
Any Comorbid condition	31(34)	18 (31)	.206	0.650
Major depressive disorder (current)	14 (15)	6 (10)	.842	0.359
Dysthymia (current)	10 (11)	2 (3)	–	0.127
Panic disorder (current)	3 (3)	1 (2)	–	1.000
Agoraphobia (current)	3 (3)	1 (2)	–	1.000
Social phobia (current)	2 (2)	2 (2)	–	0.646
GAD (current)	5 (6)	3 (5)	–	1.000

Fathers' Experience of Perinatal Obsessive–Compulsive Symptoms: A Systematic Literature Review

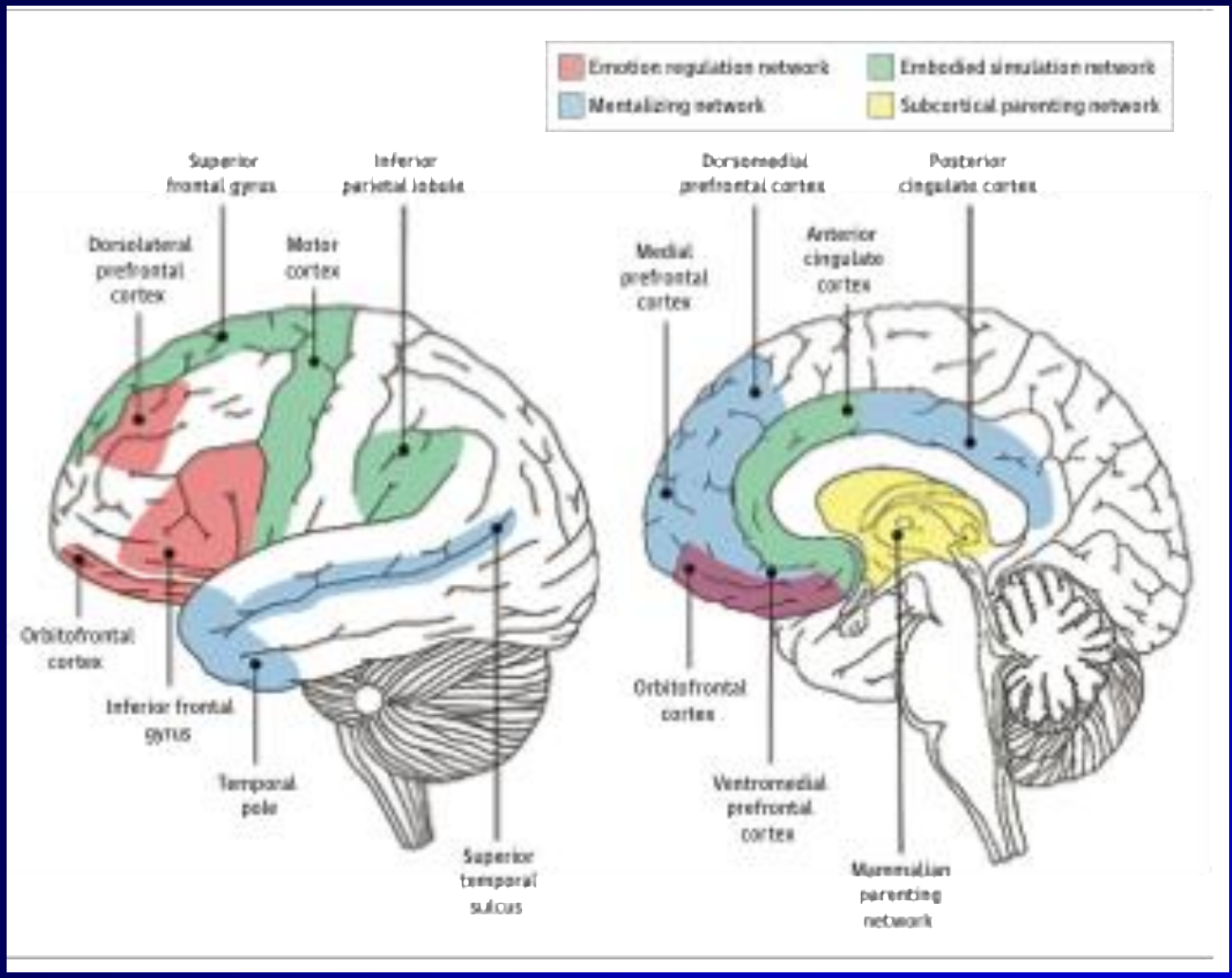
Walker et al, *Clin Child Fam Psychol Rev 2021; 24: 529-541*

- intrusive, ego-dystonic thoughts relating to their baby ranging from 57.7% to 88.1%; commonly reported: their ***baby suffocating, dying from SIDS, or being harmed in an accident***
- Clinical OCD 3.4% during the ***prenatal*** and 1.8% during the postnatal period
- no significant difference in the frequency of any of the common categories of obsessions or compulsions between mothers and fathers;
- ***mothers*** were ***more distressed*** by their intrusive thoughts than fathers.

How the Paternal Brain Is Wired by Pregnancy

Bottemanne and Joly, *JAMA Psychiatry 2024; november 13*

These changes have been associated with greater activation in emotion processing networks in fathers toward their own infant interactions, compared with childless men.



Consensus recommendations for the assessment and treatment of perinatal obsessive–compulsive disorder (OCD): A Delphi study

Mulcahy et al, *Archives of Women's Mental Health 2023; 26: 389–399*

Table 4 Statements with large differences (≥ 30%) in endorsement between panels

Statement	Endorsement level by Professionals Expert Panel (%)	Endorsement level by Consumers Panel (%)	Difference (%)
Clinicians should determine whether any taboo thoughts present are experienced as ego-syntonic (consistent with the parent's beliefs, desires and wishes) or ego-dystonic (inconsistent with the parent's beliefs, desires and wishes and therefore experienced as senseless, unwanted and intrusive)	100	64.3	35.7
Individuals experiencing pnOCD should be offered mother-infant therapy, or peer support/interpersonal therapy groups, as an adjunct therapy to evidenced-based treatment	40	78.6	38.6
Parents should have the option to speak to someone who has had lived experience of perinatal OCD.[a]	8.3	90	81.7
Assessments for pnOCD should include questions regarding significant others' beliefs about mental health in the perinatal period.[a]	25	80	55
Documentation of specific PnOCD symptoms should be kept confidential and only shared with those clinicians who are pnOCD specialists to prevent stigma and overprotective treatment.[a]	8.3	50	41.7

Endorsement is based on the percentage of 'essential' or 'important' ratings

[a]Statement added from participant suggestions

Buon lavoro

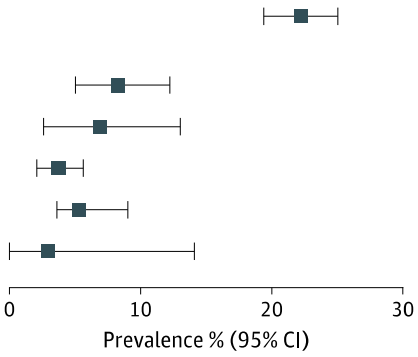
Prevalence of Perinatal Anxiety and Related Disorders in Low- and Middle-Income Countries

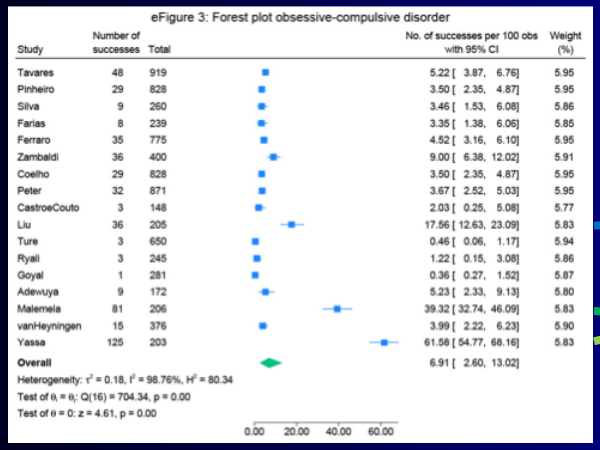
A Systematic Review and Meta-Analysis

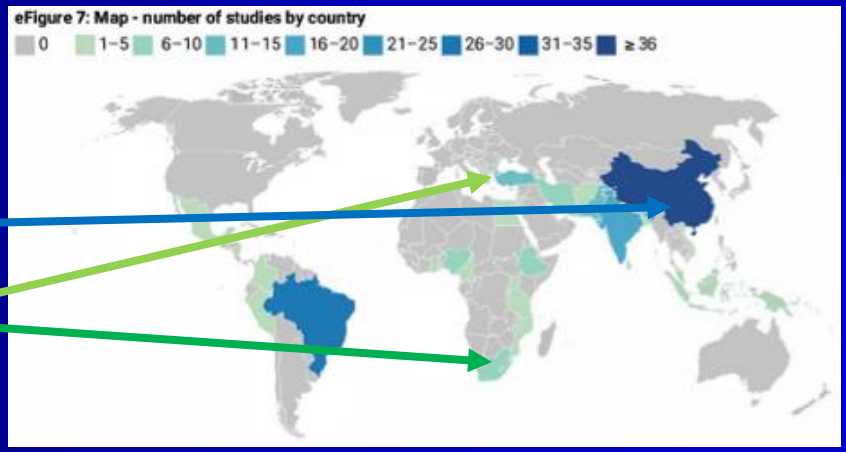
Mitchell et al, *JAMA Network Open 2023; 6: e2343711*

2. Prevalence of Anxiety and Related Disorders in Low- and Middle-Income Countries

Type of disorder	No. of studies	Total No. of participants	No. of participants with outcome	Prevalence % (95% CI)	I^2, %	τ^2
Generalized anxiety disorder and anxiety not specified	184	173 553	32 276	22.2 (19.4-25.0)	99.5	0.23
Posttraumatic stress disorder	33	22 452	3581	8.3 (5.0-12.2)	98.9	0.14
Obsessive-compulsive disorder	17	7606	502	6.9 (2.6-13.0)	98.8	0.18
Panic disorder	13	5728	209	3.7 (2.1-5.6)	91.1	0.03
Social anxiety disorder	6	2504	134	5.3 (2.6-9.0)	90.0	0.03
Adjustment disorder	2	475	16	2.9 (0.0-14.1)	95.3	0.09







DOC
Comorbilità life-time

1. Depressione Maggiore: 67%
2. Fobia semplice 22%
3. Fobia Sociale 18%
4. Disturbo di Panico 12%
5. DCA 17%
6. Abuso o dipendenza da alcool 14%

(Aouizerate et al. *Prog Neurobiol 2004; 72: 195-221*)

Trattamento del DOC

Expert Consensus Guidelines *J Clin Psychiatry 1997; 58 (suppl 4)*

	Adult OCD	
	Milder	More Severe
First line	CBT first	CBT+SRI SRI first
Second line	CBT+SRI SRI first	CBT first

YBOCS: 0-7 sub-clinico
8-15 lieve
16-23 moderato
24-31 grave
32-40 gravissimo

Trattamento farmacologico del DOC

Durata del trattamento

Expert Consensus Guidelines *J Clin Psychiatry 1997; 58 (suppl 4)*

	Visit schedule for first 3–6 months after acute treatment[42]	When to consider medication taper[43]	How to discontinue medications[44]	Long-term prophylactic maintenance medication[45]
Recommendations	Monthly visits	Not before 1–2 years	Gradual* with monthly follow-up	After 2–4 severe relapses After 3–4 mild-to-moderate relapses

Dose → la stessa della fase acuta

(Finenberg and Gale, *Int J Neuropsychopharmacol 2005; 8: 107-129*)

Adequacy of Pharmacotherapy Among Medicaid-Enrolled Patients Newly Diagnosed with Obsessive-Compulsive Disorder

Hankin et al, *CSN Spectr 2009: 14: 695*--703

TABLE 2.
Psychotropic Medications Received by Patients Following Index OCD Diagnosis

Received First-line Pharmacotherapy (N=588) **70%**	***% (N)****
Clomipramine	10.9% (64)
Citalopram	13.6% (80)
Escitalopram	10.4% (61)
Fluoxetine	23.3% (137)
Fluvoxamine	24.1% (142)
Paroxetine	27.9% (164)
Sertraline	23.5% (138)
Did Not Receive First-line Pharmacotherapy (N=255) **30%**	
Received no psychotropic	37.6% (96)
SNRI	7.8% (20)
Venlafaxine	7.4% (19)
Duloxetine	0.4% (1)
Other Antidepressants	22.0% (56)
Antipsychotics	39.6% (101)
Mood stabilizers	12.2% (31)
Anxiolytics, Sedatives, or Hypnotics	41.6% (106)
CNS Stimulants	2.0% (5)
Antimanic	5.1% (13)

58% adeguato (dose minima e durata 8 settimane)

TABLE 3.
Differences Across Studies in Definitions of Effective Pharmacotherapy and Percentage of Patients Receiving Minimally Effective Pharmacotherapy

		Citalopram	*Clomipramine*	*Escitalopram*	*Fluoxetine*	*Fluvoxamine*	*Paroxetine*	*Sertraline*
Koran* (2000)*	Effective Dose (mg/d)	N/A	150	N/A	20	100	40	50
	43% Received Minimally Effective Drug Treatment							
Denys' (2002)[9]	Effective Dose (mg/day)	20	100	N/A	40	100	40	50
	30% Received Minimally Effective Drug Treatment							
Blanco' (2006)[10]	Effective Dose (mg/day)	60	225	N/A	60	250	60	200
	39% Received Minimally Effective Drug Treatment							
Hankin* (2009)	Effective Dose (mg/day)	20	100	10	20	100	40	50
	38% Received Minimally Effective Drug Treatment							

Psicoterapia (≥ 1 seduta) 31% in terapia farmacologica 1ª linea
34% in terapia farmacologica non 1ªlinea