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# Cognitive Behavioral Treatment of Postpartum Onset

## Obsessive Compulsive Disorder With Aggressive Obsessions

Lisa M. Christian

*Ohio State University*

Eric A. Storch

*University of South Florida*

This case study describes the application of cognitive behavioral therapy (CBT) for obsessive compulsive disorder (OCD) with postpartum onset. Sara, a 29-year-old woman, presented with aggressive obsessions of strangling and drowning her 5-month-old son. When she presented at the clinic, Sara had recently begun pharmacological treatment and was highly motivated to supplement this treatment with CBT. She showed marked improvement over the course of 8 CBT sessions using exposure and ritual prevention. This case study highlights cognitive and behavioral risk factors for OCD with postpartum onset, key considerations in differential diagnosis, and the utility of CBT for OCD with this population.

**Keywords:** *postpartum; obsessive compulsive disorder; cognitive behavioral therapy; exposure and ritual prevention*

### 1 Theoretical and Research Basis

The lifetime prevalence of obsessive compulsive disorder (OCD) is estimated to be 2.5%, making it the fourth most prevalent psychiatric disorder (Karno, Goldin, Sorenson, & Burnam, 1988; Stein, 2002). When considering specific etiological factors, there is increased risk of OCD onset and exacerbation during pregnancy and postpartum (Altemus, 2001; Diaz, Grush, Sichel, & Cohen, 1997; Williams & Koran, 1997). Although no epidemiological studies to date have examined prevalence rates of OCD in the perinatal period, retrospective studies suggest that pregnancy and childbirth are the most frequent life events to trigger OCD onset or exacerbation (Buttolph & Holland, 1990; Neziroglu, Anemone, & Yaryura-Tobias, 1998). Symptoms of OCD prior to pregnancy predict increased risk of pregnancy-related OCD (Maina, Albert, Bogetto, Vaschetto, & Ravizza, 1999).

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In the postpartum period, OCD can interfere significantly with a mother's ability to care for and bond with her child due to anxiety-driven rituals and avoidance (Abramowitz, Schwartz, Moore, & Luenzmann, 2003). Without treatment, symptoms of postpartum OCD are likely to persist for an extended period of time. For example, among 9 women diagnosed with postpartum OCD who did not receive any pharmacological or psychotherapeutic treatment, 8 continued to meet criteria for OCD at 1-year follow-up (Uguz, Kaya, Sahingoz, & Cilli, 2008). Moreover, at follow-up, 7 women exhibited equivalent or increased symptomology as compared to baseline. These data highlight the importance of proper diagnosis and treatment of OCD during pregnancy and postpartum.

Characterized by persistent intrusive thoughts and/or repetitive behaviors, OCD causes significant distress and interferes with functioning (American Psychiatric Association [APA], 2000). Symptoms can take a variety of forms. Obsessions commonly focus on contamination, aggression, exactness, symmetry, and scrupulosity. Common compulsions include handwashing, reassurance seeking, ordering, and mental rituals (e.g., praying, counting). Aggressive obsessions are more commonly reported in postpartum OCD than when OCD onset is not associated with pregnancy (e.g., Buttolph & Holland, 1990; Maina et al., 1999; Uguz, Akman, Kaya, & Cilli, 2007; Williams & Koran, 1997). In postpartum, aggressive obsessions tend to focus on thoughts and images of accidental and purposeful harm including dropping, stabbing, strangling, or drowning the baby. Prevalence of obsessions which focus on the child in the postpartum period supports the contention that symptoms are strongly influenced by situational and cognitive factors.

Importantly, although they may be highly disturbing, aggressive obsessions do not predict increased risk of committing harm (Abramowitz, Schwartz, Moore, et al., 2003). By nature, symptoms of OCD are ego-dystonic (Abramowitz, Schwartz, Moore, et al., 2003), and patients with OCD have insight into the irrationality of their thoughts and behaviors (APA, 2000). These features differentiate OCD from psychotic spectrum disorders; characterized by thoughts of ego-syntonic nature and typically marked by lack of insight, postpartum psychosis involving thoughts of harming a child is associated with increased risk of committing such acts (Spinelli, 2004). Thus, differential diagnosis is critical.

Postpartum OCD commonly occurs within 6 weeks of delivery and is frequently characterized by rapid onset (Grigoriadis & Romans, 2006). Available evidence suggests that obsessions, rather than compulsions, tend to predominate in OCD with pregnancy or postpartum onset (Sichel, Cohen, Dimmock, & Rosenbaum, 1993). Avoidance of feared objects (e.g., knives) or situations (e.g., being alone with the baby) may be more evident and impairing than compulsions.

Pharmacological treatment, namely serotonin reuptake inhibitors (SRIs) and cognitive behavioral therapy (CBT) utilizing exposure and ritual prevention (EX/RP) are both effective treatments for OCD. The OCD Expert Consensus Guidelines recommend EX/RP as the first-line treatment in most cases given its superiority to pharmacological therapy (March, Frances, Carpenter, & Kahn, 1997). Among the studies which have directly compared the effectiveness of different treatment modalities, results have favored EX/RP or combined approaches. For example, Foa and colleagues (2005) reported that EX/RP and EX/RP in combination with an SRI (clomipramine) produced comparable results which were superior to clomipramine alone. Specifically, among treatment completers, 86% responded to EX/RP, 79% responded to EX/RP in combination with clomipramine, and 48% responded

to clomipramine alone. In addition, EX/RP has proven to be an effective supplemental treatment for individuals who have not achieved adequate symptom reduction from pharmacotherapy alone (Simpson et al., 2008).

Due to their unique health concerns, CBT is especially appropriate for postpartum women. Although there have been no studies examining CBT for OCD specifically with postpartum onset, there is no theoretical basis for predicting that treatment response would differ between those with postpartum OCD and those with onset that is not pregnancy related. Moreover, importantly, all SRIs are excreted into breastmilk, and there is insufficient evidence to determine whether the amounts transferred to the infant have meaningful effects on health or development (Hallberg & Sjöblom, 2005). Thus, although pharmacological treatment is implicated in cases in which benefits clearly outweigh potential risks, given its relative safety and demonstrated efficacy, CBT alone is an excellent first-line treatment for postpartum OCD.

In sum, pregnancy and childbirth are associated with increased vulnerability for OCD. Postpartum OCD is commonly characterized by aggressive thoughts of harming the newborn child. These symptoms can be quite debilitating and persist if untreated. The current case study describes a course of CBT for postpartum OCD. This case highlights cognitive and behavioral risk factors for OCD with postpartum onset, key considerations in differential diagnosis, and the utility of CBT for augmenting pharmacological treatment.

## 2 Case Presentation

Sara (pseudonym), a 29-year-old White married woman presented with symptoms of OCD that focused on thoughts of harming her 5-month-old son. Sara had been prescribed sertraline (150 mg) three weeks prior to her presentation to the clinic. Despite some benefit from pharmacological treatment, she was highly motivated to pursue CBT because she desired a more active role in her treatment and preferred to discontinue psychotropic medications in the near future, in part due to adverse side effects including digestive problems.

## 3 Presenting Complaints

Sara reported intrusive, repetitive, and distressing thoughts and images of strangling and drowning her 5-month-old son, Justin. These obsessions occurred most frequently when she was home alone with Justin, particularly when bathing him or putting him to sleep in his crib. Sara's typical obsessional scenario involved images of strangling or drowning Justin, her husband running into the room to try to stop her, and subsequently, being arrested, jailed, and having her husband divorce her. At times, the obsessions would also involve Justin's funeral including images of his coffin as well as friends and relatives crying and saying horrible things about Sara. In other scenarios, Justin would survive the murder attempt and Sara would be jailed for life.

In response to her obsessions, Sara frequently engaged in an "undoing" ritual involving kissing the baby and thinking loving thoughts. In addition, she often asked her husband for reassurance that she would not harm the baby. Sara demonstrated significant avoidance of

bathing her son and being alone with him, particularly when he was sleeping because she perceived him to be more vulnerable. Her symptoms were highly distressing to her and significantly impaired her ability to care for her son.

## 4 History

On presentation, Sara had a master's degree and was working part-time outside home. She reported a good relationship with her husband of two years who was employed full-time in a professional setting. She denied a history of significant trauma. She had a positive relationship with her family of origin and adequate support from friends, including other mothers with whom she interacted for regular play groups.

Sara had a history of OCD symptoms dating to childhood but had never sought pharmacological or psychotherapeutic treatment. In the past, she experienced excessive hand-washing, avoidance of stepping on cracks/lines, and aggressive thoughts of harming her dog. Generally, her symptoms had been minimally impairing and had tended to discontinue over time. Sara sought treatment at the present time due to notable distress and interference. Approximately 3 weeks prior to her presentation at the clinic, her aggressive thoughts and related anxiety resulted in difficulty eating, sleeping, and caring for her son.

On seeking treatment, Sara first consulted a therapist whom she had seen previously for couples' counseling. She was referred by this clinician to a psychiatrist who had Sara involuntarily hospitalized because she was deemed to be a threat to her son. This measure was taken despite Sara's willingness to be admitted voluntarily. Sara was discharged within 24 hr of her admission after being prescribed sertraline (150 mg) and being referred for outpatient services at our clinic. She found her brief involuntary admission upsetting because she believed that it was evidence that she may, in fact, be a threat to her son as she feared.

## 5 Assessment

An experienced clinician administered a 90-min semistructured diagnostic interview, the Anxiety Disorders Interview Schedule for *DSM-IV* (ADIS-IV; Di Nardo, Brown, & Barlow, 1994), which confirmed a diagnosis of OCD. Sara did not meet diagnostic criteria for any other anxiety, mood, or personality disorder. Diagnoses were confirmed by a second clinician based on a discussion of clinical materials and results from clinical measures.

Questionnaire measures assessing anxiety and mood were also administered. Her score of 27 on the Obsessive Compulsive Inventory–Revised was above a cut-off which typically distinguishes those with OCD from control subjects (OCI-R; Foa et al., 2002). Severity of OCD symptoms was assessed using the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989). Her total score of 22 indicated moderate severity of symptoms. Data from questionnaire measures were consistent with information gathered during the clinical interview.

Sara also completed the Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996). Her score of 23 indicated moderate depressive symptoms. She did not meet diagnostic criteria for major depressive disorder; in particular, she denied persistent sadness or

loss of interest in usual activities. The items which she highly endorsed related to feelings of guilt and self-criticism. Her depressive symptoms appeared to be secondary to OCD. Based on the severity of her symptoms, good insight, and high level of motivation, it was determined that Sara was a good candidate for weekly CBT for OCD.

## 6 Case Conceptualization

Sara exhibited thinking patterns and behaviors which fit well with a cognitive-behavioral conceptualization of OCD. In terms of cognitive factors, Sara endorsed many faulty beliefs which perpetuated her symptoms. She completed the Obsessive Belief Questionnaire (OBQ-44), which assesses the strength of relevant beliefs (OCCWG, 2005). At the beginning of therapy, Sara scored 221 points on this measure, which is above the mean reported in a sample of OCD patients. She scored exceedingly high on a subscale assessing importance/control of thoughts (71 points on a scale of 12-84). Examples of items which Sara strongly endorsed included, "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"; and "I should be able to rid my mind of unwanted thoughts." During therapy, cognitive techniques were used to address faulty assumptions, particularly beliefs reflecting thought-action fusion.

In terms of behavioral factors, Sara experienced considerable anxiety and fear in response to intrusive thoughts and images. As described above, faulty beliefs contributed to this heightened fear response. In addition, compulsions and avoidance were perpetuated by negative reinforcement; Sara experienced temporary anxiety reduction after engaging in these behaviors. Thus, EX/RP was used to (a) reduce the association between feared thoughts/situations and anxiety and (b) extinguish the association between compulsive/avoidant behaviors and anxiety reduction.

## 7 Course of Treatment and Assessment of Progress

Treatment involved eight 75-90 min sessions over the course of 3 months. The first 5 sessions were weekly, whereas the final 3 sessions were scheduled at 3 week intervals. Weekly sessions were chosen rather than intensive (i.e., daily) treatment because Sara was functioning reasonably well in her daily life at the time of her presentation at the clinic, presumably due to benefit from SRI treatment. In addition, her anxiety was most strongly triggered by being home alone with her son while completing daily activities. Thus, weekly sessions allowed for greater time to practice home-based assignments repeatedly between sessions. Treatment focused on (a) psychoeducation regarding factors which contribute to development and maintenance of OCD, (b) cognitive restructuring focused on faulty assumptions relevant to OCD, and (c) EX/RP.

During the initial session, psychoeducation focused on the cognitive-behavioral conceptualization of OCD. Sara was informed that treatment would involve progressively challenging exposures to feared thoughts and images, with the goal of decreasing associations of (a) obsessions with increased anxiety and (b) compulsions/avoidance with anxiety

reduction. Sara was encouraged to understand that OCD is self-perpetuating because avoidance and rituals are negatively reinforcing; these behaviors temporarily reduce anxiety and are therefore likely to be repeated. However, this prevents the individual from learning that anxiety will reduce over time without avoidance or rituals. Thus, EX/RP is focused on breaking this cycle of anxiety, ritualizing/avoidance, and temporary anxiety reduction.

It was explained to Sara that it is common for people to occasionally have passing thoughts that are disturbing or distressing; however, a key feature of those who are vulnerable to developing OCD is that they are likely to believe that such thoughts are meaningful and must be controlled to prevent negative consequences. Sara was informed that therapy would address these types of beliefs which are believed to contribute to vulnerability to OCD. She was also informed that it is common for symptoms of OCD to develop during pregnancy and postpartum, particularly among women with a history of OCD symptoms prior to pregnancy. Moreover, it was related to Sara that because many of her present concerns and daily activities focused on childcare, it was understandable that her current pattern of OCD symptoms related to her son's welfare.

Next, consistent with contemporary cognitive approaches in OCD treatment (e.g., Freeston, Rhéaume, & LaDouceur, 1996; Salkovskis, 1985, 1989), common cognitive errors were described, and alternative beliefs were suggested. For example, as alternative to the belief, "I should be able to rid my mind of unwanted thoughts," Sara was encouraged to remind herself, "I cannot control my thoughts, but I can control my actions." As noted, Sara strongly endorsed numerous faulty beliefs reflecting thought-action fusion and assumptions that one can and should control thoughts. She was quite receptive to the cognitive aspect of treatment; she related that she had never considered that certain beliefs which she held strongly may not be accurate. She also reported that challenging such beliefs reduced her anxiety and made her feel hopeful about treatment.

Finally, Sara and her therapist constructed a hierarchy of feared thoughts and situations. Sara was asked to rate different scenarios on a scale of 0 to 100 in terms of subjective units of distress (SUDS), with 100 being the most anxiety and distress imaginable. Sara's initial hierarchy is presented in Table 1.

During the second session, EX/RP was initiated using Sara's hierarchy to select a relatively nonchallenging exposure. For her first exposure exercise, Sara cradled Justin while placing her hand on his upper chest and refraining from ritualizing. This evoked a moderately high level of anxiety (SUDS = 60). Sara appeared distressed and reported fearing that she would lose control of her hand and begin choking Justin. She continued the exposure with encouragement, and after 35 min her anxiety had decreased substantially (SUDS = 30). This exposure was repeated in session. For homework, Sara was assigned to bathe Justin daily while her husband was not home. The importance of not engaging in avoidance (e.g., avoiding washing Justin's throat) or ritualistic behaviors (e.g., kissing Justin after having a distressing thought) was emphasized. A relatively easy exposure was selected for this initial homework so that Sara could gain a sense of mastery and accomplishment by successfully completing her first assignment.

At the following session, Sara reported that she had bathed Justin daily as agreed. She reported significant anxiety habituation both within trials and across trials. As therapy continued, Sara progressed to more difficult exposures. Sara gained confidence as she learned

**Table 1**  
**Sara's Initial Hierarchy of Feared Situations**

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

Note: SUDS = subjective units of distress.

that she could complete these exposures without losing control or inflicting harm as she feared. Thus, as expected, items initially rated as highly distressing were experienced as only moderately distressing by the time they were selected as exposures. Over the course of therapy, Sara also demonstrated increasing awareness of her own cognitions and improved ability to challenge faulty assumptions. As treatment progressed, she reported reductions in avoidance, frequency and intensity of obsessions, and impairment in daily life.

By Session 6, Sara was completing exposures from the top of her initial hierarchy. Specifically, in-session exposures involved having Sara hold Justin with her hands on his throat while the therapist described aloud how it would feel to strangle him and what the repercussions would be. For home practice, Sara completed this exposure using an audio-tape of the therapist describing the feared behavior in detail. Although Sara had initially rated this scenario as very highly distressing (SUDS = 100), these exposures elicited a peak SUDS rating of 80 when they were addressed at this point in treatment. In addition, habituation to these exposures occurred more quickly than Sara had anticipated.

It should be noted that therapists may be reluctant to engage in the most highly challenging exposures due to their own fears. It is important for such exposures to be completed because purposely avoiding certain thoughts or scenarios may imply to the client that these situations are dangerous and should be avoided. Thus, the therapist serves as an important model of how to approach thoughts and situations that were previously avoided.

Sara completed eight therapy sessions over 3 months. As described earlier, she completed these sessions over a relatively long period of time due to the fact that she was functioning relatively well at intake and gained great benefit from completing daily home-based exposures. In addition, after 5 weekly sessions, Sara was experiencing minimal impairment and requested greater time between subsequent sessions so that she could continue therapy over a longer time period without excessive medical costs.

At the conclusion of eight sessions, Sara repeated a semistructured diagnostic interview (ADIS-IV) and questionnaire measures of mood and anxiety. The clinical interview confirmed that she no longer met diagnostic criteria for OCD, which was consistent with Sara's



anecdotal account. Questionnaire measures were consistent in indicating significant reductions in symptom presence and severity. Specifically, her score on the OCI-R had decreased from 27 to 9, which is below a cut-off for significant symptoms. Similarly, her Y-BOCS total score had reduced from 22 to 6 and thus was no longer in the clinically significant range. Her score on the OBQ-44, which assesses cognitive biases which may contribute to OCD onset and/or maintenance, reduced from 221 to 106, which is similar to the mean in nonanxious controls.

Notably, although treatment did not specifically address depressive symptoms, her score on the BDI-II reduced from 23 to 5, indicating no/mild depressive symptoms at the conclusion of treatment. This improvement suggests that her depressive symptoms were secondary to OCD as hypothesized at the beginning of treatment.

## 8 Complicating Factors

In many ways, Sara was an ideal candidate for CBT for OCD; she was highly motivated, understood the rationale for treatment, and adhered well to at-home exposure assignments. Designing exposures involving her son presented some challenges. First, although Justin was generally very cooperative, extended exposures in which Sara held him while he was awake were difficult because he became fussy and fidgety when held in one position. Therefore, special effort was made to ensure that when an exposure was ended prematurely, it was repeated as soon as possible so that avoidance of feared scenarios would not be reinforced unintentionally. In addition, as her son grew older, Sara and her therapist chose to alter the format of exposures involving verbal accounts of harming her son. Rather than having the therapist describe this aloud or playing audiotapes which Justin could hear, Sara listened to audiotapes while wearing headphones. In this way, exposures were completed without concern of her son hearing or understanding the content of the exposure.

## 9 Follow-Up

Twelve weeks after termination of therapy, Sara experienced a relapse which was triggered when she read a magazine article about a man who had “snapped” and drowned his two children. She reported that she had been relatively asymptomatic prior to this. In consultation with her psychiatrist, she had discontinued sertraline shortly after termination of psychotherapy. To address her symptom recurrence, Sara resumed sertraline (150 mg) and reinitiated seven 30-60 min CBT booster sessions. Her symptom severity and impairment was notably milder than at initial onset; although she was distressed by her symptoms, Sara continued to care for her son without assistance or disruption of their daily routine.

Demonstrating the maintenance of previous treatment gains, Sara resumed practice of exposures that were initially at the top of her hierarchy. In addition, exposures to reading articles similar to the one which triggered relapse were added to the treatment plan. Resumption of regular home exposure practice was emphasized and relapse prevention strategies were reviewed. These included discussing how to apply cognitive and behavioral

strategies when potential triggers are encountered, being aware of and addressing even subtle avoidance, continuing occasional exposure practice after symptom remission, and occasionally reviewing common cognitive errors. After four weekly sessions, Sara endorsed minimal avoidance and distress. She completed an additional three follow-up sessions at 3-week intervals thereafter to ensure that gains were maintained.

## 11 Treatment Implications of the Case

This case illustrates features common to OCD with postpartum onset. First, as in Sara's case, OCD with postpartum onset tends to be characterized by aggressive obsessions of harming the child. In addition, cognitive errors are common among those with a vulnerability to developing OCD. As in this case, beliefs reflecting thought–action fusion and exaggerated sense of control over one's thoughts may be particularly evident in cases of aggressive obsessions. Sara's course illustrates that a history of OCD symptoms prior to pregnancy is an important risk factor for postpartum OCD. Finally, Sara's case demonstrates how postpartum OCD can interfere with a mother's ability to care for and bond with her child.

This case highlights the utility of CBT for postpartum OCD. Because she desired rapid symptom reduction, Sara's preference was a combined treatment approach involving both CBT and pharmacotherapy. As described previously, the OCD Expert Consensus Guidelines indicate that CBT alone or with an SRI is the preferred first-line approach. Given these recommendations, CBT alone may be particularly appropriate for women with concerns about taking psychotropic medications while pregnant or breastfeeding. However, combined psychotherapy and pharmacotherapy may be indicated if immediate symptom reduction is a priority.

Sara's symptom relapse at 12 weeks following treatment emphasizes the importance of identifying potential triggers for relapse and preparing for these through relevant exposures and relapse prevention strategies (e.g., planning how cognitive and behavioral techniques will be used when faced with a trigger). Her case also demonstrates that prior CBT can result in reduced symptom severity and more rapid treatment response if recurrence does occur.

## 12 Recommendations to Clinicians and Students

Though highly treatable, postpartum OCD remains largely undiagnosed and misunderstood (i.e., mistaken for postpartum psychosis or depression). Importantly, symptoms of postpartum OCD frequently focus on thoughts of harming one's child. Therefore, women are unlikely to spontaneously report symptoms due to shame and fear of legal repercussions (e.g., being involuntarily hospitalized). For these reasons, it is critical for clinicians to inquire about potential symptoms when appropriate.

Although the temporal relationship has not been elucidated, OCD is highly comorbid with postpartum depression (Humenik & Fingerhut, 2007). For example, in a study of

mothers of young children, 41% of those with postpartum depression reported occurrence of aggressive thoughts whereas only 7% of those without postpartum depression reported such thoughts (Jennings, Ross, Pepper, & Elmore, 1999). Importantly, postpartum depression is commonly assessed in clinical settings. The routine identification of those with postpartum depression provides the opportunity for targeted assessment of potential OCD among this higher-risk group.

Differentiating postpartum OCD from postpartum psychosis is an important diagnostic issue. Although both may be characterized by thoughts of harming one's child, the key distinguishing feature is that OCD-related thoughts are ego-dystonic whereas thoughts accompanying postpartum psychosis are ego-syntonic (Abramowitz, Schwartz, Moore, et al., 2003). Due to the ego-dystonic nature of their symptoms, women with OCD exhibit significant distress and avoidance. In contrast to postpartum psychosis, in the case of OCD, the presence of distressing thoughts does not increase the likelihood of acting on them. Therefore, thorough assessment of factors which differentiate OCD from psychosis, including insight, motivation for treatment, and distress, is critical.

Finally, although the majority of research on postpartum OCD has focused on mothers, emerging evidence indicates that new parenthood is a period of vulnerability for men as well as women (Abramowitz, Moore, Carmin, Wiegartz, & Purdon, 2001; Abramowitz, Schwartz, & Moore, 2003). Indeed, although neuroendocrine factors specific to pregnancy affect only women, cognitive and situational risk factors associated with new parenthood affect fathers as well as mothers (Fairbrother & Abramowitz, 2007). Therefore, healthcare providers should extend their awareness of potential postpartum psychopathology to spouses and partners as well as mothers.

## References

- Abramowitz, J. S., Moore, K. M., Carmin, K., Wiegartz, P., & Purdon, C. (2001). Obsessive-compulsive disorder in males following childbirth. *Psychosomatics*, *42*, 429-431.
- Abramowitz, J. S., Schwartz, S. A., & Moore, K. M. (2003). Obsessional thoughts in postpartum females and their partners: Content, severity and relationship with depression. *Journal of Clinical Psychology in Medical Settings*, *10*, 157-164.
- Abramowitz, J. S., Schwartz, S. A., Moore, K. M., & Luenzmann, K. R. (2003). Obsessive-compulsive symptoms in pregnancy and the puerperium: A review of the literature. *Journal of Anxiety Disorders*, *17*, 461-478.
- Altemus, M. (2001). Obsessive-compulsive disorder during pregnancy and postpartum. In K. Yonkers & B. Little (Eds.), *Management of psychiatric disorders in pregnancy* (pp. 149-163). London: Oxford University Press.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- Beck, A. T., Steer, R., & Brown, G. K. (1996). *Beck Depression Inventory (BDI-II)*. San Antonio, TX: Psychological Corporation.
- Buttolph, M. L., & Holland, A. D. (1990). Obsessive-compulsive disorder in pregnancy and childbirth. In M. A. Jenike, L. Baer, & W. E. Minichiello (Eds.), *Obsessive-compulsive disorder: Theory and management*. Chicago: Year Book Medical.
- Diaz, S. F., Grush, L. R., Sichel, D. A., & Cohen, L. S. (1997). Obsessive-compulsive disorder in pregnancy and the puerperium. In M. T. Pato & G. Steketee (Eds.), *OCD across the life cycle* (pp. 97-112). Washington, DC: American Psychiatric Association Press.

- Di Nardo, P. A., Brown, T. A., & Barlow, D. H. (1994). *Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV)*. San Antonio, TX: Psychological Corporation.
- Fairbrother, N., & Abramowitz, J. S. (2007). New parenthood as a risk factor for the development of obsessional problems. *Behavior Research and Therapy*, *45*, 2155-2163.
- Foa, E. B., Huppert, J. D., Leiberg, S., Langner, R., Kichic, R., Hajcak, G., et al. (2002). The Obsessive-Compulsive Inventory: Development and validation of a short version. *Psychological Assessment*, *14*, 485-496.
- Foa, E. B., Liebowitz, M. R., Kozak, M. J., Davies, S., Campeas, R., Franklin, M. E., et al. (2005). Randomized, placebo-controlled trial of exposure and ritual prevention, clomipramine, and their combination in the treatment of obsessive-compulsive disorder. *American Journal of Psychiatry*, *162*, 151-161.
- Freeston, M. H., Rhéaume, J., & LaDouceur, R. (1996). Correcting faulty appraisals of obsessional thoughts. *Behaviour Research and Therapy*, *34*, 433-446.
- Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C. L., et al. (1989). The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Archives of General Psychiatry*, *46*, 1006-1111.
- Grigoriadis, S., & Romans, S. (2006). Postpartum psychiatric disorders: What do we know and where do we go? *Current Psychiatry Reviews*, *2*, 151-158.
- Hallberg, P., & Sjöblom, V. (2005). The use of selective serotonin reuptake inhibitors during pregnancy and breast-feeding: A review and clinical aspects. *Journal of Clinical Psychopharmacology*, *25*(1), 59-73.
- Humenik, A., & Fingerhut, R. (2007). A pilot study assessing the relationship between child harming thoughts and postpartum depression. *Journal of Clinical Psychology in Medical Settings*, *14*, 360-366.
- Jennings, K. D., Ross, S., Pepper, S., & Elmore, M. (1999). Thoughts of harming infants in depressed and non-depressed mothers. *Journal of Affective Disorders*, *54*, 21-28.
- Karno, M., Goldin, J. M., Sorenson, S. B., & Burnam, M. A. (1988). The epidemiology of obsessive-compulsive disorder in five US communities. *Archives of General Psychiatry*, *45*, 1094-1099.
- Maina, G., Albert, U., Bogetto, F., Vaschetto, P., & Ravizza, L. (1999). Recent life events and obsessive-compulsive disorder (OCD): The role of pregnancy/delivery. *Psychiatry Research*, *89*(1), 49-58.
- March, J. S., Frances, A., Carpenter, D., & Kahn, D. (1997). The Expert Consensus Guideline series: Treatment of obsessive compulsive disorder. *Journal of Clinical Psychiatry*, *58* (Suppl. 4), 65-72.
- Neziroglu, F., Anemone, R., & Yaryura-Tobias, J. A. (1998). Onset of obsessive-compulsive disorder in pregnancy. *American Journal of Psychiatry*, *149*, 947-950.
- Obsessive Compulsive Cognitions Working Group. (2005). Psychometric validation of the obsessive belief questionnaire and interpretation of intrusions inventory—Part 2: Factor analyses and testing of a brief version. *Behaviour Research and Therapy*, *43*, 1527-1542.
- Salkovskis, P. M. (1985). Obsessional compulsive problems: A cognitive-behavioral analysis. *Behaviour Research and Therapy*, *23*, 571-583.
- Salkovskis, P. M. (1989). Cognitive-behavioural factors and the persistence of intrusive thoughts in obsessional problems. *Behaviour Research and Therapy*, *27*, 677-682.
- Sichel, D. A., Cohen, L. S., Dimmock, J. A., & Rosenbaum, J. F. (1993). Postpartum obsessive-compulsive disorder: A case series. *Journal of Clinical Psychiatry*, *54*, 156-159.
- Simpson, H. B., Foa, E. B., Liebowitz, M. R., Ledley, D. R., Huppert, J. D., Cahill, S., et al. (2008). A randomized, controlled trial of cognitive-behavioral therapy for augmenting pharmacotherapy in obsessive-compulsive disorder. *American Journal of Psychiatry*, *165*, 621-630.
- Spinelli, M. G. (2004). Maternal infanticide associated with mental illness: Prevention and the promise of saved lives. *American Journal of Psychiatry*, *161*, 1548-1557.
- Stein, D. J. (2002). Obsessive-compulsive disorder. *Lancet*, *360*, 397-405.
- Uguz, F., Akman, C., Kaya, N., & Cilli, A. S. (2007). Postpartum-onset obsessive-compulsive disorder: Incidence, clinical features, and related factors. *Journal of Clinical Psychiatry*, *68*, 132-138.
- Uguz, F., Kaya, N., Sahingoz, M., & Cilli, A. S. (2008). One year follow-up of postpartum-onset obsessive-compulsive disorder: A case series. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, *32*, 1091-1092.
- Williams, K. E., & Koran, L. M. (1997). Obsessive compulsive disorder in pregnancy, the puerperium, and the premenstruum. *Journal of Clinical Psychiatry*, *58*, 330-334.

**Lisa M. Christian**, PhD, received her doctorate in clinical psychology from the Ohio State University. She is currently an assistant professor at the Ohio State University with joint appointments in the Department of Psychiatry and the Institute for Behavioral Medicine Research. Her research examines effects of psychosocial stress during pregnancy and postpartum on maternal and fetal/infant health with an emphasis on immune function.

**Eric A. Storch**, PhD, is an associate professor of clinical psychology in the Departments of Pediatrics and Psychiatry at the University of South Florida. He has received funding from the National Institutes of Health and multiple foundations for his work on child and adult OCD. He has published more than 140 peer-reviewed articles and is the lead editor of the *Handbook of Child and Adolescent Obsessive-Compulsive Disorder*.