

## **‘Consider the relationship between obsessive-compulsive disorder and childbearing and how the condition might affect early parenting’**

*“I have never experienced such terror, a terror which became part of my daily life for twenty-six years. At its worst, it constantly told me I could harm my four beautiful little girls. How cruel perinatal OCD is. Those haunting memories will never leave me but because of effective CBT my OCD has gone and I am free of this debilitating disorder”*

– Diana Wilson, Maternal OCD Co-Founder (used with permission)

Obsessive-compulsive disorder (OCD) during the perinatal period is an extremely debilitating yet relatively unknown phenomenon affecting up to 9% of mothers every year. As emphasized above, it can have a profound impact on quality of life, with severe psychological distress and physical burden affecting the critical early days of parenthood. Despite this, recognition and early treatment can significantly reverse these symptoms and restore psychological well-being, enabling mothers to fulfil their parenting responsibilities. In this essay I will consider how OCD is related to childbearing, its recognition and management by clinicians, and lastly the impact this condition can have on the parents, many of whom suffer compromises in their parenting abilities as they struggle with this disease<sup>1,2</sup>.

### **OCD and the Perinatal Period**

OCD is a common anxiety disorder characterised by obsessions or compulsions (frequently both)<sup>3</sup> and affects around 1.2% of the general population every year<sup>4</sup>. Obsessions are defined as repetitive and intrusive thoughts or images<sup>5,6</sup> which may be violent, sexual or blasphemous in nature but also includes feelings of continuous self-doubt, indecision or extreme levels of perfectionism<sup>7</sup>. Obsessions often induce feelings of anxiety, guilt and distress which precipitates the onset of compulsions: repetitive behavioural or mental acts utilised to temporarily relieve this distress<sup>5,6</sup>. Compulsive behaviours include thinking ‘neutralising’ thoughts repetitively, ritualistic behaviours, continuous checking, reassurance seeking and total avoidance of activities, objects or places associated with the obsession<sup>6</sup>. OCD is therefore extremely debilitating, causing psychological distress, reduced quality of life and ability to carry out normal daily tasks, sometimes resulting in loss of employment, independence and vulnerability to anxiety disorders and depression<sup>8,9</sup>.

When OCD occurs during or immediately after a pregnancy it is known as perinatal OCD, and there is much debate as to whether this is a separate condition due to the similarity and specificity of perinatal OCD symptoms, setting them aside from a typical OCD diagnosis. In ladies, OCD first presents during the early 20's and frequently coincides with pregnancy, which is a common trigger for development of OCD symptoms<sup>4</sup>. OCD following delivery (postnatal OCD) is more common and onset is often rapid, usually appearing between the second and third weeks of the puerperium (sometimes as early as day two). The puerperium is associated with increased susceptibility to psychiatric illness and therefore predisposition to exacerbations of pre-existing OCD or spontaneous onset is at an increased risk<sup>1</sup>. Retrospective studies have clearly shown childbirth to be a major precipitating event in the development of new onset obsessions and compulsions. *Maina et al.* found in their 1999 study that 24% of their female subjects reported childbirth as the sole life event precipitating OCD while *Epperson et al.* found in 1995 that 73% of their female cohort experienced symptom exacerbation during pregnancy. Although these studies are retrospective (and thus limited by recall bias) they clearly highlight the link between OCD and the perinatal period as well as the need for more studies investigating the prevalence of postnatal OCD within the general population<sup>10,11</sup>.

Perinatal OCD is poorly recognised, despite postpartum mood and anxiety disorders being extremely common, affecting approximately 10-30% of new mothers. Studies showing postnatal OCD prevalence are limited and suggest between 2 and 9% of women satisfy the DSM-IV criteria for OCD in the postpartum period (from 2 to 26 weeks), considerably higher than the prevalence of typical OCD in the background population<sup>12,13</sup>. Furthermore, postnatal OCD may be the extreme end of a normal spectrum of obsessions and compulsions commonly experienced by new parents as evidenced by *Abramowitz et al.* who showed 69% and 58% of new mothers and fathers respectively reported intrusive thoughts of harm towards their newborn baby. This suggests symptoms of OCD may be a normal occurrence in healthy men and women, highlighting the need for more screening and awareness of the prevalence and morbidity of perinatal OCD and its milder subclinical forms<sup>12,10</sup>.

The obsessions experienced during perinatal OCD are distinctive from typical OCD and are more commonly associated with violence and aggression towards the infant, especially in women with psychiatric co-morbidity such as depression<sup>13</sup>. During pregnancy, obsessions are often due to fear of contaminating the foetus with toxic substances whilst postnatally, anxiety is induced by intrusive thoughts of harming the baby, either through direct acts of violence (e.g. stabbing or dropping the infant), contamination, or negligence (e.g. leaving the baby in the bath). Evidence has also shown that intrusive thoughts of harm towards the newborn is exceedingly common among new parents as demonstrated by *Jennings et al.*, who showed intrusive obsessive thoughts were present in

6.5% of postpartum women without a psychiatric diagnosis<sup>9</sup>, further suggesting intrusive thoughts may be considered a normal part of early parenthood. Compulsions are less frequent in perinatal OCD and persist for a shorter duration. Avoidance behaviours appear to be the most common; *Sichel et al.* found patients responded to unwanted thoughts of violence towards the infant by evading activities associated with the thought, for example avoiding bathing the child or using sharp implements such as knives. Other studies have also shown ritualistic checking to be common in postnatal OCD patients, usually regarding the safety of the infant<sup>10</sup>. Follow up also revealed these compulsive behaviours were absent 12 months after delivery, a phenomenon not normally seen in typical OCD patients who normally develop their compulsions gradually over time after the initial obsessions have started<sup>11,14</sup>.

### Perinatal OCD and Psychiatric Co-morbidity

OCD is often not an illness in isolation, with other psychiatric comorbidities such as depression, anxiety and more rarely psychosis co-existing, adding further burden to the mother. *Yaryura-Tobias et al.* found in their 1996 study that 42.2% of women had an additional psychiatric diagnosis to their postnatal OCD, the majority of which were major mood disorders such as postnatal depression. At present it is unknown whether there is a causal link between postnatal OCD and postnatal depression; the obsessions experienced in postnatal OCD are very upsetting and continuous uncontrollable distress could lead to depressive symptoms that are commonly seen in typical OCD. Conversely, women with postnatal depression are more likely to experience distressing thoughts of loss or aggression towards the infant, which may predispose to obsessions consistent with postnatal OCD<sup>10</sup>. This may also explain why violent and aggressive obsessions are more common in women with postnatal depression<sup>15,16</sup>.

More rarely women with postnatal depression may develop psychotic features and it is extremely important for clinicians to accurately differentiate between the features of postnatal OCD and those of postpartum psychosis. Although postnatal OCD often involves thoughts of harm to the infant, these thoughts are associated with feelings of guilt and compulsive behaviours afterwards and lack psychotic features such as delusional thinking and loss of touch with reality. It is important to note that women with postnatal OCD do not act upon their thoughts which contrasts to psychosis where thoughts of violence are associated with delusional beliefs and hallucinations without insight into their inappropriate nature and lack 'neutralising' compulsive acts<sup>10,14</sup>.

## Perinatal OCD in Men

Perinatal OCD is not limited to motherhood, fathers also experience onset of OCD symptoms following the birth of their first baby. As previously mentioned, OCD symptoms appear extremely common in new fathers as demonstrated by *Abramowitz et al.* who found 58% of 40 new fathers surveyed had intrusive thoughts of harm, either via a violent act towards the child or towards the mother during the pregnancy<sup>14</sup>. The content of the obsessions does not appear to significantly differ between the sexes; four case studies also presented by *Abramowitz et al.* showed rapid onset and intrusive thoughts of violence and aggression were common to all four fathers, coinciding with the recent birth of their first child. Perinatal OCD in men is poorly recognised warranting further study into its prevalence, studies of which are distinctly lacking. Failure to identify male perinatal OCD from lack of awareness by health care professionals and concealment by the patient results in prolonged distress and misdiagnosis, resulting in inappropriate treatment and prolonged distress, highlighting the importance for clinicians to consider both parents when assessing postnatal welfare<sup>13,17</sup>.

## Causes of Perinatal OCD

The cause of OCD during the perinatal period is unknown, however there are several theories as to its origins suggesting a multifactorial aetiology. These theories should account for the key features which differentiate perinatal OCD from typical OCD, namely aggression predominant obsessions, rapid symptom onset following birth and symptom development in both parents.

*Fairbrother et al.* suggest a cognitive-behavioural approach; they hypothesise that the highly anticipated birth stimulates rapid and overwhelming feelings of responsibility to prevent harm, an experience exacerbated by the loss of input from healthcare professionals and concurrent increasing demands on their own duties of care. Such tremendous feelings of responsibility are then met with an overestimated perception of risk to the newborn and thus excessive precautions are undertaken. Unwanted intrusive thoughts that are normally disregarded in healthy parents are heightened and are met with guilt, fear and distress that both provokes further attacks of unwanted thoughts as well as a cascade of compulsive safety-seeking behaviours in an effort to reduce this sense of heightened risk. This may account for the rapid onset of symptoms commonly seen in postnatal OCD, as well as the development in new fathers<sup>14</sup>.

Hormone and neurotransmitter dysregulation forms the basis of biological mechanisms that may contribute towards perinatal OCD, however lack explanation for perinatal OCD in men. During the puerperium there is a sudden drop in oestrogen and progesterone, both of which appear to regulate serotonin activity, affecting its re-uptake and transmission. Serotonin dysregulation may contribute to development of obsessions and compulsions and the rapid onset of postnatal OCD symptoms could be a result of sudden dysregulation from the loss of these pregnancy hormones<sup>10</sup>. Oxytocin may also be responsible; it is commonly raised in the CSF of untreated OCD patients and oxytocin concentrations rise preceding delivery to facilitate uterine contraction, perhaps accounting for sudden onset of OCD immediately after birth<sup>10</sup>.

Evolutionary theories highlight the benefits of postnatal OCD to the newborn and a possible genetic predisposition to its development. Heightened awareness to threats and overzealous attempts to avoid harm are both beneficial to ensuring the infant's physical survival and confers a survival advantage when environmental conditions were less favourable. This may also explain why symptoms of OCD are extremely common within healthy parent populations. In addition to the evolutionary ideation, the obstetric history of the patient's mother may also predispose environmental susceptibility to postnatal OCD. A background of hyperemesis gravidarum, prolonged labour, prematurity and neonatal jaundice appears to be more common in postnatal OCD populations compared to controls and is associated with raised serum cortisol, suggesting altered reactivity to stressors<sup>13</sup>.

### Investigating and Managing of Perinatal OCD

The NICE guidelines for antenatal and postnatal mental health recommended screening for depression and use of the 2-item General Anxiety Disorder scale (GAD-2) to identify women with mental health difficulties. Clinical suspicion warrants further investigation and referral to perinatal mental health services as well as the charity Maternal OCD, which provides valuable support and advisory services for both clinicians and patients. Further assessment in primary care often involves the Patient Health Questionnaire (PHQ-9) or Edinburgh Postnatal Depression scale for suspected depression or the GAD-7 for anxiety<sup>18</sup>. Although effective at identifying mental health concerns, these screening tools lack specificity for OCD symptoms and may inadvertently aid the clinician in misdiagnosing depression or anxiety. Furthermore, NICE guidelines do not have specific recommendations for treating perinatal OCD with only general anxiety disorders catered for, advocating facilitated self-help methods such as cognitive behavioural therapy (CBT) for a 2-3 month period as the first-line treatment with SSRI's for more severe or unresponsive cases<sup>18</sup>. Diagnosis and treatment is thus limited at present due to the unspecific nature of the guidelines and poor identification of symptoms suggestive of OCD.

The importance of differentiating between depression/anxiety and OCD is critical because of differences in their management. The CBT regime used for OCD is distinct from that of other anxiety disorders while the dose of SSRI required in OCD is higher than in postnatal depression or anxiety. Accurate diagnosis and treatment is therefore fundamental to achieving effective outcomes when managing perinatal OCD<sup>19</sup>. A solution to this is the use of the Psychiatric Diagnostic Screening Questionnaire, a more useful diagnostic measure due to its inclusion of OCD specific screening questions. Shame and guilt associated with obsessions means concealment of intrusive thoughts is common therefore direct questioning is essential to eliciting symptoms and accurately diagnosing perinatal OCD, especially when other anxiety or mood disorders are being considered. The quick screening questions used to identify depression lack an OCD equivalent at present, a development needed if perinatal OCD is to be identified and managed appropriately<sup>4,19</sup>.

### The Impact of Perinatal OCD on Parenting

*“OCD came into my life and stole time and enjoyment from me and my daughter - we were both very lucky that I got the right treatment and I went on to be the mummy I wanted to be and my daughter got the mummy she deserved. However hours and days were surrendered to obsessive thoughts and compulsions and feeling utter exhaustion and guilt - this meant I could only exist hour by hour and could not fully experience motherhood. We will never get the early months experiences back however I now embrace every moment more so than ever before”*

- Maria Bavetta, Maternal OCD Co-Founder (used with permission)

The consequences of prolonged psychological distress coupled with the use of compulsive behaviours will rapidly begin to impact parenting ability, initially through limited time spent with the infant but also through reduced social and occupational functioning as well a marked decline in quality of life. Such repercussions warrant rapid identification and management of affected families so that the long-term repercussions can be effectively minimised, susceptibility to other psychiatric co-morbidities reduced and to allow the parenting experience be achieved to its greatest potential<sup>21</sup>.

In the mother, untreated OCD is likely to continue. Persistence of symptoms such as distressing intrusive thoughts, avoidance behaviours and concealment will severely impact on the women's enjoyment of motherhood and prolonged distress may confer heightened vulnerability to mood and anxiety disorders<sup>21</sup>. Gezginc *et al.* were the first to show impaired quality life as a direct consequence of perinatal OCD in women and suggest it may also contribute to other mental health conditions such as mood disorders<sup>20</sup>. Less time spent bonding and interacting with the infant is inevitable for most due to preoccupation with carrying out compulsive tasks in response to distressing

obsessions, for example, fear of dropping the infant precludes avoidance of picking up or holding the child. Similarly a contamination obsession may prevent the mother from allowing her and the infant to interact with other parents and children, limiting social interaction for the child and isolating the mother from a supportive network of other parents. Mothers may avoid being in the same room as the child when carrying out compulsive behaviours, further limiting child-parent interactions.

Persistence of symptoms as the child ages is also possible, with further distress endured by the mother as the developing infant becomes more independent and parental control wanes regarding the child's activities and behaviour. As a result, maternal bonding is hindered, the infant's emotional and physical needs may be left unfulfilled and enjoyment of parenting is continually affected, adding more to the distress experienced by the mother and contributing further to the long-term consequences on the infant, the results of which are unknown<sup>21</sup>.

Although fathers are likely to experience the same challenges to parenting as a mother with perinatal OCD, paternal OCD appears to differ which may limit its impact on parenting ability. Studies show fathers experiencing perinatal OCD are less upset by intrusive thoughts and are less susceptible to distress and depressive episodes. A lower perceived sense of responsibility towards the infant (compared to the mother) and less time spent with the infant may be responsible for the milder symptoms seen in new fathers<sup>22</sup>. Thoughts of intentional harm and contamination are also less common in fathers that may limit the extent to which compulsions impact on daily functioning and thus parenting ability<sup>14</sup>. Paternal OCD may also affect relationships with the other primary caregivers, (e.g. the mother), especially if he is a key source for support and care of the new child; *Abramowitz et al.* described a father who left the family home due to symptom severity and relationship breakdown as well as impaired ability to carry out tasks at work<sup>17</sup>. Despite much speculation on the likely effects of paternal OCD, conclusive data is extremely limited warranting further investigation into this area. Nevertheless, paternal OCD should be considered just as seriously as maternal so to minimise morbidity and maximise parental enjoyment and stability.

Research involving the relationship between perinatal OCD and the infant is limited, the majority of studies focus on postnatal depression. *Uguz et al.* found in their 2015 study a statistically significant link between lower birth weight and gestational age at delivery in OCD mothers compared to controls, mirroring other specific anxiety disorders such as panic disorder. The cause for this association is unknown however premature birth and low birth weights are linked to poorer neurodevelopmental, mortality and morbidity outcomes as evidenced in other anxiety disorders<sup>23</sup>. *Manassis et al.* showed in their 1994 study high levels of insecurity in the infants of anxious mothers when compared to controls<sup>24</sup> while *Black et al.* found in their 2003 study children born to OCD parents were more likely to experience social withdrawal, anxiety and depression as well as somatic

disturbances such as headaches and difficulty sleeping. Their study also showed expected higher rates of unemployment and lower incomes in the affected parent highlighting the impact OCD has on day to day functioning<sup>25</sup>. These factors will all contribute to increasing demands on the infants primary care-givers and thus will challenge their parenting ability. Further studies are required to investigate whether reversal of symptoms before, during or after pregnancy in a patient with perinatal OCD can improve outcomes in the infant, which would prioritise earlier screening, diagnosis and management in order to reverse adverse outcomes associated with an OCD diagnosis, both to the parents and their offspring.

### **Conclusion**

In summary this essay has explored the relationship between OCD and new parents with an insight into the devastating experiences many parents endure trying to keep their obsessions at bay. OCD is a common and treatable condition yet has the power to steal critical bonding experiences from families whilst surrendering social, psychological, occupational and physical well-being in the process. Lack of awareness and little research precipitates unknown numbers of parents who may be suffering in silence, despite there being effective treatments readily available. More understanding and awareness is urgently required to identify at risk parents and manage them effectively so to improve their quality of life, enable fulfilment of their parenting role and minimise future repercussions bestowed on the child.

By David Rook

Final Year Medical Student

Barts and The London School of Medicine and Dentistry

Word Count: 2986 (excluding quotations, headings and titles)

## References

1. Forray A, Focseneanu M, Pittman B, et al. Onset and Exacerbation of Obsessive-Compulsive Disorder in Pregnancy and the Postpartum Period. *Journal of Clinical Psychiatry* [online], 2010; 71(8):1061-1068. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204467/> [Accessed: 08/08/15]
2. OCD-UK. Prenatal and Postnatal OCD [online]; 2015. Available at: <http://www.ocduk.org/prenatal-postnatal-ocd> [Accessed: 13/08/15]
3. National Institute of Clinical Excellence. Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder [online]; 2005. Available at: <https://www.nice.org.uk/guidance/CG31/chapter/1-Guidance> [Accessed: 08/08/15]
4. Challacombe F L, Wroe A L. A hidden problem: consequences of misdiagnosis of perinatal obsessive-compulsive disorder. *British Journal of General Practice* [online]. 2013; 63: 275-276
5. Seibell P J, Hollander E. Management of Obsessive-Compulsive Disorder. F1000 Prime Reports [online]. 2014 6:68 10.12703/P6-68. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4126524/> [Accessed: 13/08/15]
6. NHS Choices. Obsessive compulsive disorder (OCD) [online]; 2015. Available at: <http://www.nhs.uk/conditions/Obsessive-compulsive-disorder/Pages/Introduction.aspx> [Accessed: 13/08/15]
7. Royal College of Psychiatrists. Obsessive-Compulsive Disorder Leaflet [online]; 2015. Available at: <http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/obsessivecompulsivedisorder.aspx> [Accessed: 13/08/15]
8. OCD-UK. Social and economic impact of OCD [online]; 2015. Available at: <http://www.ocduk.org/ocd-social-economic-impact> [Accessed: 14/08/15]
9. OCD-UK. Related disorders [online]; 2015. Available at: <http://www.ocduk.org/related-disorders> [Accessed: 14/08/15]
10. Abramowitz J S, Schwartz S A, Moore K A, et al. Obsessive-compulsive symptoms in pregnancy and the puerperium: a review of the literature. *Journal of Anxiety Disorders* [online]. 17(2003):461-478. [Accessed: 14/08/15]
11. Brandes M, Soares C N, Cohen L S. Postpartum onset obsessive-compulsive disorder: diagnosis and management. *Archives of Women's Mental Health* [online]; (2004)7:99-110. [Accessed: 14/08/15]
12. Zambaldi C F, Cantilino A, Montenegro A C, et al. Postpartum obsessive-compulsive disorder: prevalence and clinical characteristics. *Comprehensive psychiatry* [online]. 50(2009):503-509. Accessed: 14/08/15].
13. Speisman B B, Storch E A, Abramowitz J S. Postpartum Obsessive-Compulsive Disorder. *Journal of Obstetric, Gynaecologic & Neonatal Nursing* [online]. 40(2011):680-690. [Accessed: 14/08/15]
14. Fairbrother N, Abramowitz J S. New parenthood as a risk factor for the development of obsession problems. *Behaviour Research and Therapy* [online]. 45(2007)2155-2163
15. Wisner K L, Peindl K S, Gigliotti T, et al. Obsessions and compulsions in women with

- postpartum depression. *Journal of Clinical Psychiatry* [online]. 1999; 60(3):176-80. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/10192593> [Accessed: 15/08/15].
16. Jennings K D, Ross S, Popper S, et al. Thoughts of harming infants in depressed and nondepressed mothers. *Journal of Affective Disorders* [online]. 1999; 54(1-2):21-8. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/?term=Jennings%2C+Ross%2C+Pepper%2C+%26+El+more%2C+1999> [Accessed: 15/08/15]
  17. Abramowitz J, Moore K, Carmin C, et al. Acute Onset of Obsessive-Compulsive Disorder in Males Following Childbirth. *Psychosomatics* [online]. 2001; September-October 42:5
  18. National Institute for Health and Care Excellence. Antenatal and postnatal mental health: clinical management and service guidance [online]. 2014. Available at:
  19. Abramowitz J S, Meltzer-Brody S, Leserman J, et al. Obsessional thoughts and compulsive behaviors in a sample of women with postpartum mood symptoms. *Womens Mental Health* [online]. 2010; 13:523-530. Available at:
  20. Gezginc K, Uguz F, Karatayli S, et al. The impact of obsessive-compulsive disorder in pregnancy on quality of life. *Journal of Psychiatry in Clinical Practice* [online]. 2008; 12(2):134-137. Available at: <http://informahealthcare.com/doi/full/10.1080/13651500701777363>
  21. Challacombe F L, Salkovskis P M. Intensive cognitive-behavioural treatment for women with postnatal obsessive-compulsive disorder: A consecutive case series. *Behaviour Research and Therapy* [online]. 49 (2011):422-426.
  22. Abramowitz J, Schwartz S A, Moore K M. Obsessional thoughts in postpartum females and their partners: content, severity, and relationship with depression. *Journal of Clinical Psychology in Medical Settings* [online]. 2003; 10(3):157-164
  23. Uguz F, Yuksel G, Karsidag C, et al. Birth weight and gestational age in newborns exposed to maternal obsessive-compulsive disorder. *Psychiatry Research* [online]. 2015; 226(2015):396-398. Available at: <http://www.sciencedirect.com/science/article/pii/S016517811500027X#> [Accessed: 26/08/15]
  24. Manassis K, Bradley S, Goldberg S, et al. Attachment in mothers with anxiety disorders and their children. *Journal of the American Academy of Child and Adolescent Psychiatry* [online]. 1994; 33(8):1106-13. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/7982861> [Accessed: 25/08/15]
  25. Black D W, Gaffney G R, Schlosser S, et al. Children of parents with obsessive compulsive disorder – a 2-year follow-up study. *Acta Psychiatrica Scandinavica* [online]. 2003;107:305-313. Available at: <http://onlinelibrary.wiley.com/doi/10.1034/j.1600-0447.2003.02182.x/pdf> [Accessed: 26/08/15]

All quotes are courtesy of Maria Bavetta, Co-Founder of the charity Maternal OCD.