

OCD in the perinatal period: detection and assessment - what are the risks of missed diagnosis?

"I was unknowingly experiencing perinatal obsessive compulsive disorder. I was having the most intensely graphic, unwanted, recurring intrusive thoughts about harming my newborn son and, as lovely as I'm sure you all are, you were the last people I wanted to tell about it. I was worried that if I did, you'd begin the proceedings to have my son taken out of my care." - Benfield (2018, p.700)

Intro

During the perinatal period depression and anxiety disorders occur at a significant rate (Brand & Brennan, 2009). The majority of academic focus has been placed on depression, despite anxiety being the most common psychiatric disorder in adults (Kessler et al., 2005). Anxiety disorders include obsessive-compulsive disorder (OCD) which is more prevalent within the perinatal period than within the general population (Ross and McLean, 2006). However, perinatal OCD is under researched and therefore frequently misunderstood, meaning that diagnoses are often missed by health care professionals (Brand & Brennan, 2009). This is complicated further by many mothers remaining secretive due to fears of stigma; as reflected in the British journal of midwifery 'mother's voice' narrative of Benfield (2018), who reflects upon her experience of perinatal OCD. Furthermore, without a diagnosis many women suffer in silence, which poses risks to themselves and their child. This essay considers perinatal OCD and the issues in diagnosis and assessment, alongside exploring the risks of a missed diagnosis.

Perinatal Obsessive-Compulsive Disorder

OCD is an anxiety disorder affecting approximately 1-2% of the general population (Torres et al., 2006). OCD is characterised by obsessions, compulsions and anxiety (Challacombe et al., 2010). Obsessions are unwanted recurrent intrusive thoughts, images, urges or doubts. To mediate the distress of these intrusive thoughts, or to prevent these fears from occurring, individuals carry out compulsions. Compulsions include: rituals, checking, seeking reassurance, correcting obsessional thoughts and avoiding behaviours. Alongside anxiety, individuals may experience fear, depression, guilt and disgust. These feelings may momentarily be relieved by compulsive behaviours however, this is often short lived due to the recurrence of intrusive thoughts. This perpetuates a vicious cycle of obsessions and compulsions that can seriously impede on the individual's quality of life.

OCD affects 2% of women during pregnancy and 2-3% of women within their first year post-partum (Russell et al., 2013). Pre-existing OCD may be exacerbated during pregnancy, or the perinatal period may trigger OCD onset. For women with pre-existing OCD, pregnancy heightens symptoms in around a third of patients, but will often have no impact and may even improve symptoms (Guglielmi et al., 2014). New onset OCD is most prevalent in, but not exclusive to, first time mothers. If occurring after the first pregnancy, perinatal OCD is likely to reoccur in subsequent pregnancies (Guglielmi et al., 2014). Onset may be rapid with OCD developing over days or weeks, or the onset may be more gradual (Challacombe et al., 2010).

There are many biological and environmental factors that predispose to perinatal OCD and there are currently three theoretical frameworks (sociobiological, neuroendocrine, and cognitive-behavioural) that aim to explain disease pathogenesis (Frias et al., 2015). Hormones are frequently considered to be a significant contributory factor, as the serotonin system is heavily involved in OCD but is also affected by gonadal steroids (Stein et al., 1993). Yet the prevalence of perinatal OCD in fathers highlights the involvement of social, and cognitive-behavioural factors (Abramowitz et al., 2006).

The symptoms of perinatal OCD are often specific and focused on the child. Mothers often fear accidentally being harmful to or causing harm to their child, but they are not at risk to their baby. Mothers frequently appreciate that their intrusive thoughts are excessive and can care for their child sufficiently (Challacombe et al., 2010). However, the distress caused may have significant implications on the mother's health and therefore her child's. It may impact the mother's confidence, on her relationships and her quality of life, as mothers with perinatal OCD often become sleep deprived and experience depressive thoughts (Fairbrother et al., 2018).

Assessment and detection

Current screening for perinatal OCD is limited due to a lack of rigorous studies and research in the condition. However, recommendations include clinicians partaking in clinical interviews with mothers and assessing potential intrusive thoughts as part of prenatal and postpartum care. Screening questions from the Psychiatric Diagnostic Screening Questionnaire have been shown to be effective (Challacombe & Wroe, 2013). This screening should occur periodically during the first six months' post partum, with more frequent questioning in patients with a history of OCD (Stein, 2018). Women who screen positively for potential OCD should then receive a thorough psychiatric assessment where a diagnosis based on the International Classification of Diseases (ICD) criteria may arise. If perinatal OCD is suspected, then clinicians should follow the NICE management guidelines. Here it is essential to rule out potential differential diagnoses, such as postpartum depression and postpartum psychosis, as inappropriate treatment or a missed diagnosis may have significant negative impacts on both the mother and her child.

The degree of risk varies greatly between psychiatric diagnoses as mothers with postpartum psychosis, unlike in OCD, may act upon delusional thoughts of harming her child (Stein, 2018). Subsequently, clinicians must be skilled in differentiating between diagnoses of intrusive thoughts and delusions to ensure adequate risk assessments occur. Likewise, conditions may co-exist, such as perinatal OCD alongside postpartum depression. Adequate diagnosis is essential here as depressive symptoms may slow down the resolution of OCD symptoms thus masking the condition and the developing harms (Collardeu et al., 2019).

Challenges in detecting perinatal OCD

Diagnosis of perinatal OCD is clouded further by the prevalence of intrusive thoughts, such as harming the child via contamination, being seen not only in OCD patients, but by the majority of the general population (Barrett & Wroe, 2016). These figures have been found to be up to 91% of mothers and 88% of fathers (Abramowitz et al., 2006), the majority also reported pursuing strategies of self-reassurance and even avoidance to help control these thoughts (Larsen et al., 2006). This is thought to have an evolutionary origin as these thoughts

encourage parents to be more diligent in preventing and protecting their child from harm (Frias et al., 2015). However, in perinatal OCD, this adaptive trait has hypertrophied beyond the clinical threshold to become a harmful behaviour.

It may be difficult to differentiate between what is expected anxiety and what is pathological in the context of pregnancy. Consequently, the detection and help-seeking for all perinatal problems, particularly for anxiety disorders, is relatively low (Challacombe & Wroe, 2013). There are longstanding cultural perceptions of motherhood as being selfless and nurturing and this idealism is frequently absorbed into the internalised expectations of the mother (Woodward, 1997). The realities of the struggles of motherhood often lead mother to feel inadequate, which may be accentuated when a background of mental health concerns are present (McGuinness, 2011). Many mothers feel shameful for struggling due to fears of being deemed unable to cope, or being harmful to their child. Likewise, mothers may fear stigma or that they may be separated from their child upon the development of intrusive thoughts surrounding their child. This may lead to secrecy and increased difficulty for health care practitioners in reaching a diagnosis of perinatal OCD (Stein, 2018).

The risks of undiagnosed perinatal OCD

The potential risks to the mother

OCD arising during pregnancy is frequently associated with intrusive fears of accidentally harming the baby by contamination and related compulsions such as excessive washing. Likewise, the mother may minimise child handling and avoid outdoor activities due to these fears of contamination. Furthermore, fears of deliberately harming the child are most prevalent in OCD arising shortly post-partum. Here, mothers may avoid contact with their child and essential tasks such as bathing and nappy changing (Challacombe & Wroe, 2013). These thoughts may cause a significant degree of distress for mothers and may dominate their care giving activities; while reducing the degree of mother-child interaction, which is essential for child development. Consequently, peripartum OCD is considered to have a significant negative impact on the mother's quality of life, her capacity to complete parental tasks and may also extend to impede on her relationships with her partner and perceived social support (Benfield, 2018).

Yet these unwanted harm-related thoughts surrounding the child are actually a common and normative postpartum experience in all women. The key distinguishing feature between normative intrusive thoughts and perinatal OCD is how the mother then interprets those thoughts, with compulsions being characteristic of OCD (Collardeu et al., 2019). Likewise, it is essential that mothers with perinatal OCD are managed appropriately. While women may experience intrusions related to harming their child, they will not act upon these thoughts in such a way. Inappropriate classification of mothers as being 'at high risk' of harming their child may result in severe restrictions in contact and inappropriate proceedings of child protection services. Such situations have been documented as being severely damaging to both mother and child, as resultant OCD exacerbation may occur (Challacombe & Wroe, 2013). Instead, management of cognitive behavioural therapies and potentially pharmacological treatment should ensue (Frias et al., 2015). However, while this has been shown to significantly reduce perinatal psychopathology, the short term relapse rates are significant (Christian & Storch, 2009), thus diligent monitoring and support are required to

ensure the mother maintains an adequate quality of life and a secure relationship with her child.

The potential risks to the mother-child relationship and attachment

In instances of significantly reduced mother-child interactions due to perinatal OCD, the child may develop insecure attachment. Insecure attachment is a term coined as part of Bowlby's Attachment theory (1969). This theory describes a biological instinct that seeks proximity to an attachment figure (carer) when threat is perceived, or discomfort is experienced. This attachment is essential for the child to develop while remaining in a protected environment.

Attachment disorder is defined by the International Classification of Diseases 10th edition (ICD-10) as a disorder of social functioning that arises in childhood and adolescence (1993). While attachment disorder is considered to be rare, Skovgaard (2010) found the estimated prevalence to be 0.9% in infants aged 18 months. The disorder is associated with developmental delays that may present as social withdrawal, disruptive behaviour and difficulty in establishing social relationships (Harding, 2015). Likewise, attachment disorder or insecure attachment is associated with a higher prevalence of anxiety, depression, phobias and aggressive behaviour.

Fortunately, many of these issues are preventable with early identification and treatment of perinatal OCD (DeOliveira, 2017). However, diagnosis during pregnancy may be essential as Favez et al. (2012) reported that family interactions during pregnancy were strongly associated with the future child's emotional development. Likewise, Breaux et al. (2016) state that parental psychopathology is predictive of behaviour problems that may arise in the child by the time they reach preschool age.

The potential risks to the child's cognitive development

The intellectual development of a child may not only be impeded by perinatal OCD, but by any degree of maternal stress, anxiety or depression (Brand & Brennan, 2009). This is highlighted by the work of Sohr-Preston and Scaramella (2006) illustrating many potential pathways to offspring cognitive dysfunction and the associated biological and social risk factors. These developmental delays include reduced motor and reduced mental skills in children aged 8 months who were born to mothers self-reporting high levels of perinatal hassle and anxiety.

Likewise, Niederhofer and Reiter (2004) found that maternal stress was negatively correlated with the school performance of children aged 6 years. This highlights the significant impact perinatal OCD and associated anxiety disorders can have on the development of the growing child. Furthermore, Laplante et al. (2004) found that exposure to naturally occurring stressors accounted for a 11.4% variance in the child's mental skills, a 12.1% variance in the child's motor skills and a 17.3% variance in the child's receptive language abilities. These developmental delays appeared to be greater in mothers experiencing significant stress during the first two trimesters of pregnancy. Furthermore, the study found that maternal stress had a larger impact on child development than the variable of birth weight, revealing how crucial maternal well being is for the healthy development of the child.

The potential risks to the child's behaviour and psychopathology

There is a plethora of environmental factors that have been shown to enhance the risk of childhood aggressive behaviour. One of these factors is maternal distress during pregnancy, which may be resultant from perinatal OCD (Jaffee et al., 2012). Prenatal maternal anxiety has been associated with conduct disorders across a range of studies looking at children across a spectrum of ages (Zohsel et al., 2013). Likewise, maternal depression, which often co-exists with perinatal OCD, is associated with an increased risk of the child being involved in violence and criminal activity in adolescence. According to Glover (2011), this may be due to fetal programming, where the fetus adapts in utero to the anticipated postnatal environment, as developing higher levels of aggression in anticipation of stressful environments may have had evolutionary benefits.

However, the work of Zohsel et al. (2013) found this relationship between perinatal stress and childhood conduct disorders to be limited, except in a subgroup of children carrying the DRD4 7r allele, thus suggesting a more genetic aetiology, as opposed to childhood developmental issues arising predominantly due to environmental stressors. Nevertheless, the work of the O'Conner et al. (2002) found the relationship between stress and anxiety during pregnancy and behavioral and emotional problems in young children to be significant. Furthermore, Van den Berg et al. (2005) found that antenatal maternal anxiety was associated with attention deficit hyperactivity disorder (ADHD) and anxiety symptoms in the child, explaining up to 22% of the variance in these symptoms. This is especially significant as OCD is an anxiety disorder and so much of the distress caused by perinatal OCD may have similar implications to the distress caused by generalized anxiety and stress in pregnancy.

Conclusion

Perinatal OCD is associated with a reduced quality of life in the mother while the children of women with perinatal OCD experience higher rates of language, social, and emotional delays (McKee et al., 2006). Failure to diagnose and treat perinatal OCD is likely to result in persistence of these issues and may even result in the development of chronic or more severe OCD (Challacombe & Wroe, 2013). Misdiagnosis of perinatal OCD, especially as post partum psychosis, may result in inappropriate and ineffective treatment that is potentially damaging for both mother and child. It is therefore crucial that health care professionals in obstetrics and primary care are able to identify the symptoms of perinatal OCD, to appropriately refer the patient, to allow the commencement of treatment.

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