

Obsessions, compulsions, and intrusive thoughts in the perinatal period

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Abstract

Perinatal intrusive thoughts, obsessions, and compulsions are often neglected or misidentified, compared to postpartum depression and anxiety. These symptoms have a unique presentation and progression during the perinatal period. Both mothers and fathers of newborns may experience intrusive thoughts particularly in the early postpartum phase. New mothers may feel guilty and ashamed about having such thoughts especially if they are related to intentions of harm to their baby. While many have intrusive thoughts alone, some mothers may develop a perinatal

obsessive compulsive disorder (OCD). The detrimental effects of perinatal obsessions and compulsions may extend beyond the mother's quality of life and functioning, also affecting mother-infant bonding and consequently the infant's development. Clinicians need to assess these thoughts sensitively and provide multidisciplinary care that takes into account the mother, the infant and the family.

Key words: perinatal, intrusive thoughts, obsessions, harm to infant, perinatal OCD, mother- infant bonding

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Postpartum depression and less commonly postpartum anxiety are the two perinatal mental health conditions that have got the most attention from clinicians and researchers. However, women who struggle with intrusive thoughts and obsessions during pregnancy and postpartum may often be overlooked or labeled as having postpartum depression. Abramowitz et al., studying a sample of 300 mothers and partners found that 65% of the subjects reported the presence of obsessive intrusive thoughts (1). In a prospective study, Fairbrother et al., reported that in their sample of almost all new mothers, 70-100% reported unwanted, intrusive thoughts about harm befalling their children while as many as 50% of new mothers were plagued by intrusive thoughts about harming their infant on purpose (2). A more recent study by Paul et al., reported that postpartum onset and worsening of obsessive compulsive disorder (OCD) were reported among 14% and 11% of women, respectively, in their sample of 150 patients (3). Russel et al., in their meta-analysis, reported the prevalence of OCD among postnatal women to be higher (2.43%) when compared to that of the general population (1.08%) and pregnant women (2.07%) (4). Both pregnant and postpartum women were found to be at a greater risk of experiencing OCD as compared to the general population by an aggregate risk ratio of 1.79 (4).

Phenomenology

Perinatal OCD is a complex and multifaceted condition with a range of symptoms and risk factors. It presents

with a unique symptomatology and course (1, 2, 5). Considering the evolutionary perspective, the high prevalence of perinatal OCD may have had adaptive value in the past. It may have served as an alert system for mothers to potential dangers that their child could have been exposed to in unsafe living conditions compared to the current times (6). The symptom profile of perinatal OCD also differs based on when the onset occurs. Women who develop OCD during pregnancy tend to exhibit contamination obsessions, and cleaning rituals, while those who develop OCD after childbirth often experience distressing and unwelcome intrusive thoughts about harming their infant (7).

In a 2006 study, Abramowitz et al., found that most new parents reported some distressing intrusive thoughts regarding their newborns. The content of these intrusions resembled clinical obsessions in that they focused on misfortune but were described as senseless and incongruent with the person's belief system (8). The seven most common obsessions found among these women include obsessions of suffocation/sudden infant death syndrome (SIDS), accidents, intentional harm, losing the infant, illness, sexual thoughts and contamination. Furthermore, women reporting more than one intrusive thought were found to be using one or more ritualistic or neutralizing strategies in response to these disturbing intrusions (8). The most commonly used compulsions include: seeking reassurance from oneself, checking behaviors, inserting positive thoughts, engaging in distracting behaviors, religious or prayer

rituals, cognitive distractions, seeking social support, interacting with the baby, and avoiding triggers (1, 9). Oftentimes, these parents avoid high places, sharp objects, holding the baby near stairs and in severe cases even being left alone with the baby (8). In keeping with these findings, Sharma et al., described that OCD symptoms in postpartum women commonly include concerns about harming the baby, fear of the baby dying, and worries about being judged as a mother (5). Postpartum OCD can have a negative impact on the functioning and quality of life of mothers who experience significant levels of anxiety and guilt. Mothers may find it challenging to bond with their infants as they spend a considerable amount of time coping with their obsessions (5, 10, 11). Furthermore, unwanted intrusive thoughts may trigger distress leading to depression in some postpartum women. Conversely, symptoms of OCD may be preceded by depressive symptoms (9).

In their 2021 study, Ratzoni et al., discussed the postnatal onset of a particular dimension of OCD symptoms which focuses on close interpersonal relationships (12). Using the parent-infant version of Parent-Child-Related Obsessive-Compulsive Symptoms Inventory, they concluded that mothers who experience symptoms of Parent-Infant Relationship Obsessive-Compulsive Disorder (PI-ROCD) at four months postpartum exhibited poor maternal-infant bonding. Changes in maternal behaviour (less praising / more criticism of the infant) serve as a mediator for the predictive relationship between PI-ROCD symptoms at 4 months postpartum and infants displaying avoidance of social engagement behaviors at ten months old. In addition to impacting the mother's quality of life, perinatal OCD can also have a negative effect on the mother-infant bonding process and consequently on the infant's socioemotional development. Given the extensive consequences of perinatal OCD on both mother, foetus and infant, it is crucial to prioritize early screening and management (12).

Obsessive compulsive symptoms in fathers

An often-overlooked aspect of perinatal mental health welfare is the father's mental health. Abramowitz and colleagues reported that over 50% of fathers in their sample experienced unwanted intrusive thoughts during the perinatal period (1, 8).

Neurobiological theories suggest that hormonal changes during late pregnancy and delivery trigger postpartum obsessional symptoms in women, however, the fact that fathers also experience similar intrusive phenomena, despite not undergoing hormonal changes, indicates the importance of investigating environmental factors in the development of postpartum obsessions (1). Fathers of newborns commonly have intrusive, senseless, and unacceptable thoughts related to infants including those related to suffocation, accidents, and contamination. The

authors suggested that stress, high standards of conduct, and sensitivity to external threat cues might increase the vulnerability to intrusive thoughts in parents during this period (8,13). While it is suggested mothers were more distressed by these intrusive thoughts than fathers, which may be attributed to the mothers spending more time with their infants, it is possible that fathers cope with uncontrollable unwanted thoughts by suppressing or even hiding them (13).

Risk factors for the development of obsessions, compulsions and intrusive thoughts in the perinatal period

The risk factors for peripartum obsessive-compulsive disorder include primiparity, the early postpartum period (first 4 weeks), obstetric complications, history of previous psychiatric disorder, postpartum blues, depression and anxiety disorders, obsessive-compulsive personality disorder, avoidant personality disorder, presence of OCD-related dysfunctional beliefs, insufficient social/emotional support and family histories of mood and substance use disorders (14, 15).

Management

When interviewing a mother with postpartum OCD, it is useful to ask about intrusive thoughts and symptoms in an empathic way and recognize that having any mental health problem can be associated with stigma, guilt and shame. It is crucial that we approach the exploration of what those thoughts signify for them and their coping mechanisms, with sensitivity (5,10).

Other diagnoses to consider are post-traumatic stress disorder (PTSD), tokophobia, and generalized anxiety disorder (GAD). While the history of a traumatic childbirth or previous threatening or traumatic life experience is characteristic of postpartum PTSD, tokophobia is an ego-syntonic fear of pregnancy or childbirth and GAD is characterized by difficulty controlling apprehensive worry about events and circumstances (14). Parents experiencing perinatal OCD typically have insight into the irrational, intrusive, and ego-dystonic nature of their thoughts, which is different from those who have postpartum psychosis (5, 10, 13). However, mothers with bipolar disorder and psychosis may also have intrusive thoughts.

Screening tools

The assessment of postpartum intrusive thoughts is a critical area of study in the field of maternal mental health. The Postpartum Thoughts and Behaviors Checklist (PTBC) developed by Abramowitz et al., (2003) evaluates the content of postpartum intrusive thoughts and neutralizing strategies (1). This semi-structured interview assesses the normality of the experience of

intrusive thoughts, a checklist of intrusive thoughts and neutralizing strategies used to manage unwanted infant-related thoughts.

The Postpartum Intrusions Interview was designed to assess the nature of maternal thoughts related to harm towards the newborn, as well as the emotional and behavioral responses to such thoughts, and the degree of functional impairment they cause (2). The interview is divided into three sections: accidental harm, intentional harm, and natural history of the thoughts.

The Postpartum Obsessive-Compulsive Scale (POCS) assesses the presence, time of onset, severity, interference, distress, resistance, and control of specific undesirable or troubling thoughts and behaviors (15). The instrument consists of three sections: thoughts, behaviors, and interference with different aspects of participants' lives. The severity and interference questions from both thoughts and behaviors sections are used to calculate the severity scores, which range from zero to 40.

These instruments provide a comprehensive evaluation of postpartum intrusive thoughts. While they are not meant to establish a diagnosis, they serve as an indicator for targeted help and support.

Treatment

It is important to balance the potential risks of treatment with the risks associated with untreated illness, while treating perinatal mental illnesses. The selection of treatment modality should depend on the nature and severity of OCD symptoms, type and severity of comorbid psychiatric disorder, co-occurring medical conditions, availability of cognitive behavior therapy (CBT), and previous treatment response (5). Fairbrother et al., hypothesized a cognitive behavioral model of perinatal OCD in both parents (16). The perinatal period is characterized by sudden and significant responsibility for a vulnerable infant. This responsibility may lead to misinterpretation of normally occurring intrusive thoughts related to the infant as highly significant and threatening. Over time, behavioral patterns such as checking on the baby, avoiding the child, or attempting to suppress thoughts can contribute to the maintenance of obsessional distress (2,8). Hence, CBT techniques, including psychoeducation, cognitive therapy, exposure, and response prevention, can be effective and be considered as first line treatment in managing perinatal OCD. These techniques can help individuals modify their misinterpretations of normal intrusive thoughts during the postpartum period and eliminate avoidance, concealment, and other safety-seeking behaviors (13, 16). In spite of limited evidence, selective serotonin reuptake inhibitors (SSRIs) continue to be the first line treatment strategy for treatment of moderate to severe peripartum OCD (5, 11). Most antidepressants are excreted in low

concentrations in breast milk and therefore are considered safe in prescribing in women who wish to continue breastfeeding (5).

Although rTMS has demonstrated efficacy in reducing symptoms among persons with OCD in general, there is limited evidence of its effectiveness in women with perinatal OCD, and the total number of pregnancies exposed to TMS is still relatively small (17). However, it could be considered a viable treatment option during the postpartum period, considering its safety profile. In-patient care may also be required if the mother presents with a risk for self-harm and/or harm to the infant. Usually, mothers with postpartum OCD are very apprehensive about harming the baby and take extreme care not to do so (5). On the other hand, they may completely avoid childcare and even being around the infant. In-patient care in a mother-baby unit (MBU) can be offered to assess and improve mother infant bonding and treat mother infant relationship disorders (18).

Women with mental disorders face various psychosocial difficulties that can negatively impact their attachment with their child, potentially leading to neglect and increased risk of psychopathology in the child. Antenatal stress and anxiety have also been linked to behavioral and emotional problems in the child (14). According to a 2020 review by Newton K et al., the initial year after childbirth presents a crucial window of opportunity for implementing interventions that can safeguard and enhance the mental health of an infant. Video Feedback interventions and guided interactions between mother and infant have been shown to improve mother-infant bonding (19). Psychoeducation should be an integral part of the treatment plan to reduce feelings of blame and guilt and to promote treatment adherence. Accommodation which consists of changes in family members' behavior to prevent or reduce patients' obsessive-compulsive disorder rituals or distress also needs to be handled (20).

To conclude, obsessions and compulsions in the perinatal period need to be recognised and handled with sensitivity and care using a multidisciplinary approach that supports the mother, the infant and the family.

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