

## **Perinatal Obsessive Compulsive Disorder**

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## Perinatal Obsessive Compulsive Disorder by Andy Young

Obsessive compulsive disorder (OCD) is a fairly common mental health problem that can affect men and women at any time of life (Young 2019). It is called perinatal OCD when a woman develops OCD during pregnancy or after birth—the perinatal period. Perinatal OCD affects at least 2 in every 100 women (Marchesi et al. 2016).

Perinatal OCD has three main parts:

1. Obsessions—frequent unpleasant thoughts, images, urges, or doubts.
2. Anxiety—distress caused by these unpleasant thoughts.
3. Compulsions—behaviours (e.g., excessive hand-washing) or mental acts (e.g., counting) that the person keeps repeating to try to reduce anxiety or prevent bad things from happening.

In perinatal OCD, symptoms are often, but not always, focused on the baby (Fairbrother 2008). These may be:

- Intense fear that the baby will be contaminated with germs, dirt, or poison and will die as a result. The mother may go to great lengths to prevent contamination by excessive hand-washing or sterilising, or not using public nappy-changing facilities.
- Thoughts or images (pictures in the mind) of the baby coming to harm, e.g., cot death (SIDS). The mother finds herself repeatedly checking on the baby's breathing during the night.
- Thoughts or images of harming the baby, either accidentally or deliberately. Sometimes these thoughts can be sexual or violent. Women often feel deeply distressed and ashamed by these thoughts. Research shows that people with OCD do not become violent or act on these thoughts. But, as a result of them, a mother may start to avoid sharp objects, like kitchen knives, or situations such as nappy-changing (Fairbrother and Woody 2008).
- Worrying too much about doing things or not doing things in a particular way, e.g., not sterilising the baby's feeding bottles correctly.
- Asking for reassurance from others again and again, e.g., about whether something is clean enough.

It is very common for a mother to have occasional unpleasant thoughts about her baby being harmed. These can be frightening for anyone, but for someone with perinatal OCD, these thoughts occur so often and are so upsetting that it becomes difficult to perform everyday tasks. Such thoughts can also cause a woman to think she is a bad mother and make her feel depressed, which is not only difficult for the mother but also hard for a supportive partner or a family member to deal with. Supporting a woman with perinatal OCD can be stressful, especially for someone who is already the main carer for a baby and other children. It is important that carers look after themselves as well, and doulas should be mindful of this.

### What Does It Feel Like to Have Perinatal OCD?

Having a baby brings many changes, which can be stressful. Many pregnant women and new mothers have a normal (and probably helpful) rise in obsessive or compulsive-like symptoms. Most mothers feel that having a baby is a huge

responsibility, and it is normal for a woman to worry about her child's well-being and want to protect her baby.

However, someone with perinatal OCD may be more careful about avoiding risks in pregnancy and following childbirth. They may worry if they have normal but unexpected thoughts about their baby being harmed. Many mothers have these but do not find them to be a problem. For some, these normal worries can trigger or worsen symptoms of OCD, and the symptoms can interfere with life and daily living. Typically, they will usually bother a woman for at least an hour a day and, often, much more than that. Those with perinatal OCD may feel anxious, fearful, guilty, disgusted, or depressed about their condition.

A woman with perinatal OCD will often realise that her symptoms are unreasonable or excessive, although this can be harder to see if a woman is very anxious. She may worry that her symptoms mean that she is going mad or that she is a bad mother. Consequently, this can make her feel embarrassed and ashamed.

Women with perinatal OCD will feel they need to do certain things (compulsions) to reduce their anxiety or prevent what they fear from happening. They will feel better in the short term if they carry out compulsive behaviour—but this doesn't help for long.

Perinatal OCD compulsions may include:

*Rituals*—e.g., washing, cleaning, or sterilising repetitively and excessively. This can take up so much time that it prevents a mother from doing other things she needs to do.

*Checking*—e.g., repeatedly checking baby throughout the night to ensure that he/she is breathing.

*Seeking reassurance*—repeatedly asking others to tell them that everything is all right.

*Correcting obsessional thoughts*—by counting, praying, or saying a special word repeatedly. This may feel as though it prevents bad things from happening. It can also be a way of trying to get rid of unpleasant thoughts or pictures in the mind.

*Avoiding feared situations or activities*—someone with OCD will often avoid things that may trigger obsessions or compulsions. For example, a woman with perinatal OCD may avoid nappy-changing, or hide all the knives. She may not want to attend mother and baby groups, and some women even avoid spending time alone with their baby.

## Treatment

Perinatal OCD is very treatable, though evidence for the treatment of perinatal OCD comes from small-scale research studies and so is limited (NICE 2005). The two main treatments for perinatal OCD are:

1. Cognitive Behavioural Therapy (CBT)—a talking therapy (Challacombe et al. 2017)
2. Antidepressant medication—a woman can use these medications even when she is pregnant or breastfeeding (McAllister-Williams et al. 2017).

The GP or psychiatrist can discuss the risks and benefits of medication in the individual case. CBT and medication can be used alone or together. Research shows that their effectiveness is similar (Russell, Fawcett, and Mazmanian 2013). It is recommended that women in the perinatal period be assessed within two weeks and receive therapy within four weeks of assessment. For more severe perinatal OCD which has not responded to treatment by the GP and psychological therapy services, a woman may be referred to a specialist perinatal service. Midwives, obstetricians, health visitors, and other professionals can also refer. Sometimes a woman with very severe perinatal OCD may need a hospital admission, which should be to a specialist mother and baby unit where women can be admitted with their babies (NICE 2014).

### What Can a Doula Do to Help?

A Doula can do many things to help a woman with perinatal OCD and her partner/family. These encompass practical support, emotional support, recovery-focused support, awareness and understanding of OCD, and communication. It is fundamental to give a woman the chance to openly discuss her feelings about the illness and its impact on her pregnancy, baby, and other family members. Additionally, some women might ask for support in relation to their spiritual needs, with a doula empowering them to make choices and decisions in relation to childbirth and parenting that align with their personal beliefs and culture. The subject of spirituality is sometimes overlooked or glossed over in mental health, but there is growing evidence that it can contribute to personal capital (optimism, self-efficacy and self-monitoring) and resilience, with practitioners other than the midwife being well located to address spirituality needs (Barber 2013).

### Practical Support

Encourage time for exercise and rest. OCD can be mentally exhausting, on top of the demands of being a mother. Help to organise her social diary, spacing out visits so they are not too tiring. When she has OCD-free moments, use these as beacons of hope and praise her. If a mum feels worthless or that she can't do anything to help herself, work with her to build back up her self-esteem. Practical support might include helping to draw up a contingency plan for emergency mental health or childcare, or acknowledging ethnic minority women's experiences of perinatal mental health conditions and signposting a mother to appropriate services (Watson et al. 2019).

### Emotional Support

People need different types of support at different times. Find out from the woman or her family what helps her, in terms of positive coping and self-compassion. For example, some people like affection at times of stress, whereas others prefer to be left alone until they feel calmer. Perinatal OCD can make a mother question her parenting ability, so encourage and remind her of what she is doing well. Emphasise the positives and help her to feel that she is doing the best she can. Delivering this type of support to women and families requires tact, sensitivity, emotional intelligence, and a sound understanding of compassion.

## Recovery-focused Support

Keep track of changes in symptoms and behaviour and the impact these have on daily activities. Note concerns and questions that have cropped up since your last visit, for example, any problems with medication. Try to notice when a woman seems to be avoiding something because of her thoughts, but don't criticise her for not trying. Instead, help her control her own recovery. Find local support groups that she can go to, either by herself, with her partner, or with you. Support her to challenge her thoughts and beliefs and see OCD thoughts for what they are—limiting and unreasonable. Above all, give the woman hope, remind her that she can recover, and help her access and read some success stories. Peer support can be very powerful in connecting women with others who have had similar experiences and survived/flourished.

## Awareness and Understanding of OCD

Be empathic and find out as much as you can about OCD and how treatment works. Understand how OCD can affect a mother and the process of getting better. A woman with perinatal OCD may seem to be very rigid or stuck in unhelpful ways of thinking and doing things. This is common and can feel overwhelming. Developing awareness and understanding can help doulas support women to make changes and get through the process of recovery. It can also help them better understand the beliefs and behaviour, which may seem to be quite irrational. Remember, perinatal OCD and postnatal depression are different. Having OCD can mean that a woman finds it difficult to be intimate with loved ones, but the partner should not take this personally or as a sign that she does not care. In this type of situation, a doula might usefully offer reassurance to both the woman and her family.

## Communication

Keep listening and talking. It can be frustrating to see somebody who is in the grip of OCD, but any frustration should be attributed to the OCD rather than the person who has it. Having some conversations that are not about symptoms/mental illness can also be helpful. Some women find it helpful to choose a simple word they can say to a friend or family member as a prompt to change the subject. Also, promoting effective communication between a woman with perinatal OCD, her partner/carer, doctor, midwife, and the other professionals in her care is vitally important. This can take time and effort, but sensitive doulas can be a valuable conduit for therapeutic communication and help resolve any misunderstanding and tension among the clinical team, the woman with perinatal OCD, and her family.

## Conclusion

For about a third of women who already have OCD, pregnancy and childbirth can make their condition worse. For some women, pregnancy and birth have no impact or can even improve symptoms. Someone experiencing OCD for the first time in pregnancy may find that it gets better soon after giving birth. However, it can continue and keep coming back later in life if a woman does not get timely help or receive the right treatment. If perinatal OCD starts after the baby is born, it may

happen very suddenly days or weeks after giving birth. For some women, the onset is more gradual. Women who have OCD in their first pregnancy are more likely to have it again in their second pregnancy (Guglielmi et al. 2014). Recently, it has been suggested that the doula role can “revitalise” midwifery, but for this to happen services must be prepared to innovate and work differently (Krapf 2019). Certainly this is true in relation to mental health and women with perinatal OCD. It is imperative that midwives and doulas work together to develop their potential to work inter-professionally with a range of professionals who may provide support to pregnant women, new mothers, and their families.

#### References:

- Barber, C. 2013. “Spirituality and Mental Health: Applications for Healthcare Assistants.” *Brit J Healthcare Assistants* 7(2): 64–68.
- Challacombe, F, et al. 2017. “A pilot randomised controlled trial of time-intensive cognitive-behaviour therapy for postpartum obsessive-compulsive disorder. Effects on maternal symptoms, mother-infant interactions, and attachment.” *Psychol Med* 47(8): 1478–88.
- Fairbrother, N, and SR Woody. 2018. “New Mothers’ Thoughts of Harm Related to the Newborn.” *Arch Womens Ment Health* 11(3): 221–29.
- Russell, EJ, JM Fawcett, and D Mazmanian. 2013. “Risk of Obsessive-compulsive Disorder in Pregnant and Postpartum Women: A Meta-analysis.” *J Clin Psychiat* 7(4): 377–85.
- Marchesi, C, et al. 2016. “Clinical Management of Perinatal Anxiety Disorders. A Systematic Review.” *J Affective Disorders* 190: 543–50.
- Krapf, J. 2019. “Re-imagining the Doula’s role.” *Midwifery Today* 130: 51–55.
- McAllister-Williams, RH, et al. 2017. “British Association for Psychopharmacology Consensus Guidance on the Use of Psychotropic Medication Preconception, in Pregnancy and Postpartum.” *J Psycopharmacol* 31(5): 519–52.
- National Institute for Health and Care Excellence (NICE) Clinical guideline 192. 2014. “Antenatal and postnatal mental health: clinical management and service guidance.” Updated April 2018. [nice.org.uk/guidance/cg192](https://www.nice.org.uk/guidance/cg192).
- National Institute for Health and Care Excellence (NICE) Clinical guideline 31. 2005. “Obsessive compulsive disorder and body dysmorphic disorder: treatment.” Updated April 2018. [www.nice.org.uk/guidance/cg31](https://www.nice.org.uk/guidance/cg31).
- Watson, H, et al. 2019. “A systematic review of ethnic minority women’s experiences of perinatal mental health conditions and services in Europe.” *PLOS One* 14(1): e0210587. [doi.org/10.1371/journal.pone.0210587](https://doi.org/10.1371/journal.pone.0210587).
- Young, A. 2019. “Assessing and Treating Obsessive Compulsive Disorder in Practice.” *Practice Nursing* 30(4): 178–81.

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