

# Beyond the Blues: Postpartum OCD

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In recent years we have seen an increased focus on mental health during pregnancy and the postpartum period. One reason for this focus is a number of highly publicized cases in which parents suffering from postpartum depression or psychosis end up actually harming their children. Another important reason for turning attention toward these problems is that we are learning how maternal (mental) health can negatively affect the mother-infant bond and the child's development. When the mother is emotionally unhealthy during pregnancy and the postpartum the risks of problems such as low birth weight, attention deficit disorder, and soothing difficulties are increased. But whereas postpartum depression and psychosis typically grab the headlines, we are now learning that anxiety disorders, especially obsessive-compulsive disorder (OCD), are also experienced by many new and expecting mothers. Moreover, perinatal (meaning "around the time of childbirth") OCD and other anxiety disorders can also result in the types of adverse consequences mentioned above. When the potential negative effects of postpartum OCD are considered along with the fact that this problem is under-recognized by patients and professionals alike, it is easy to see the importance of learning more about this condition and how it can be managed most effectively. My research group at the Mayo Clinic, and now at the University of North Carolina, has conducted several studies on postpartum OCD, and has treated many individuals with this problem. The goal of this article is to discuss (a) what we currently know about postpartum OCD, (b) what the potential causes are, and (c) what are the effective treatments.

## What do we know about postpartum OCD?

Although there are no large studies on the overall incidence of OCD in the postpartum, we know from several small studies that a greater than expected percentage of women with OCD attribute the onset or worsening of their symptoms to pregnancy or the postpartum. In fact, among female OCD patients who have given birth, pregnancy and childbirth are the most commonly cited "triggers" of OCD onset. Still, research suggests that postpartum OCD is fairly rare, probably affecting between 1% and 3% of childbearing women.

In contrast to non-postpartum OCD, the postpartum variant typically comes on rapidly, sometimes within a week of giving birth. Research also indicates that postpartum OCD most often involves scary obsessions related to harm befalling the newborn infant (in contrast to obsessions having to do with contamination, paperwork mistakes, order and symmetry, and hoarding). In some instances, sufferers report obsessions having to do with accidental harm, while in others the obsessions involve unwanted thoughts or ideas of intentionally harming the newborn. Some examples of the kinds of postpartum obsessions encountered in our clinic are as follows:

- The idea that the baby could die in her sleep (S.I.D.S)
- The thought of dropping the baby from a high place
- The thought of putting the baby in the microwave
- An image of the baby dead

- Thoughts of the baby choking and not being able to save him
- Unwanted impulses to shake the baby to see what would happen
- Thoughts of yelling at the baby
- Thoughts of poking the baby in the soft spot in her head (fontanel)
- Thought of stabbing the baby
- Thoughts of drowning the baby during a bath

Compulsive rituals among mothers with postpartum OCD often include checking on the baby, for example, during the night to make sure that the baby is still alive. New parents with OCD also report mental compulsions such as praying over and over to prevent disastrous outcomes. Finally, many postpartum OCD sufferers engage in compulsive reassurance-seeking, including looking their symptoms up on the internet and asking others if it's "normal" to have bad thoughts about the baby. Avoidance is also a problem. I have worked with many new mothers who are afraid to be left alone with their newborns for fear that they might act on their unwanted thoughts about harm.

But interestingly, our research indicates that up to 80% of all new mothers (even those *without* clinical OCD symptoms) report nasty, senseless, unacceptable, unwanted thoughts that are similar to those described by mothers with postpartum OCD (see above). Let me say that again: most new parents experience unwanted negative thoughts about their infants- the same kinds of thoughts that mothers with postpartum OCD experience. I'll return to this later because this significant finding has important implications for how we understand postpartum OCD.

### **What about postpartum psychosis?**

Many women suffering from postpartum OCD worry that they might act on their harm-related thoughts, or that their thoughts mean they are unfit to be parents. "What if I drown my children like that woman on the news did?" "What kind of a parent thinks about such terrible things? Surely, I am losing my mind!" What drives these fears is a lack of understanding of the differences between postpartum OCD and postpartum psychosis.

Let me explain. First, both OCD and psychosis can involve strange, bizarre, and violent thoughts. But the similarities stop there. In postpartum OCD, the sufferer is terrified of committing harm; so much so that it scares her to even *think* about harming the infant. Women with postpartum OCD *resist* their obsessional thoughts; meaning that they try to dismiss the obsessions, or neutralize them with some other thought or behavior. The thoughts seem as if they are against every moral fiber of their being. Consequently, the risk of someone with postpartum OCD acting on their violent obsessions is extremely low (one can never say with absolute certainty that the chances are 0%, but in this case, it's pretty close).

In contrast, women with postpartum psychosis tend to experience their violent thoughts much differently. The violent thoughts might be perceived as consistent with the person's world view. Hence, such women don't try to fight these thoughts. The thoughts are usually part of *delusions*; lines of thinking in which the person holds strongly to bizarre beliefs such as the idea that someone (or the government) is after them, or that they have magical powers that other people don't have. So, thoughts to harm the baby might be perceived as "a good idea." Because people with psychotic

disorders sometimes act in accord with their delusions, postpartum psychosis poses very serious risks and often requires hospitalization to ensure the safety of the mother than infant.

### **Postpartum OCD in *fathers*?**

My colleagues and I have found in a number of studies that new *fathers* are also vulnerable to OCD symptoms. First, over two-thirds of the healthy new fathers we studied reported unwanted, scary, negative thoughts about their newborn just like mothers did. Furthermore, we have seen a number of new dads with clinically severe OCD symptoms that reportedly started soon after the baby was born. So, postpartum OCD does not appear to be only for new mothers! Why might fathers get “postpartum” OCD symptoms? My colleagues and I have developed a theory, which we describe below.

### **What causes postpartum OCD?**

Two main explanations for postpartum OCD have been described in the research literature. I will review them only briefly here since neither is definitive. First, let’s consider the biological model. Because pregnancy and the postpartum are biological events that involve fluctuations in hormones, some experts believe it is these hormonal fluctuations that give rise to postpartum OCD. In particular, levels of progesterone and oxytocin—two hormones that are involved in the termination of pregnancy—are in flux during this time period. Research has linked oxytocin, in particular, with serotonin, a neurotransmitter believed to play a role in OCD. Thus, it is thought that imbalances of oxytocin can change levels of serotonin in postpartum mothers, possibly leading to OCD.

While the biological model is interesting, it remains speculative since it has not been well tested. One difficulty I have with this model is that it doesn’t explain why the obsessions in postpartum OCD tend to revolve around harm coming to the newborn baby, as opposed to concerning contamination, order, or hoarding, or other common symptom themes in OCD. It also does not explain why almost all new mothers have unwanted infant-related thoughts, but only some develop clinical levels of OCD. But my most serious criticism of the biological approach to postpartum OCD is that it cannot explain how postpartum OCD can occur in new *fathers* (who do not experience the same hormonal fluctuation as do childbearing women). For these reasons, I believe we need to look beyond purely biological explanations for postpartum OCD.

My colleague Dr. Nichole Fairbrother and I have recently developed a psychological model of postpartum OCD. It begins with our finding that most new parents (mothers and fathers) experience unwanted infant-related thoughts (perhaps such thoughts have evolutionary significance). That is, we consider such thoughts as a completely normal and harmless part of early parenthood. The trouble begins, however, when a new parent mistakenly *misinterprets* these normal thoughts as indicating something very significant and threatening. For example, if a new mother misinterprets her violent thoughts as meaning that she is likely to kill her baby, or a new father who interprets his images of the baby dying as meaning that deep down he *wants* the baby to die. Why might someone misinterpret intrusive senseless thoughts as very significant? We think it has to do with the rapid increase in responsibility—which certainly is the case when one becomes a parent and gains the responsibility of caring for a helpless infant.

When normally occurring postpartum thoughts are misconstrued as dangerous or very significant, it leads the person with such thoughts to become anxiety and fearful. Moreover, it leads to behaviors such as avoidance of the baby, seeking reassurance, and excessive ritualistic checking or praying. All of these behaviors are consistent with feeling threatened by upsetting thoughts about one's child. Because these avoidance and ritualistic strategies seem to work (that is, no harm is committed), the new parent keeps on believing that the strategies have prevented catastrophe (when in fact, the thoughts are meaningless). Therefore, the strategy becomes a compulsive behavior, and the fear of acting on the unwanted obsessional thought remains intact (it is never disproven). Furthermore, when the new mother or father keeps their negative thoughts to themselves ("they would put me in the hospital if I told them about the thoughts I was having"), it further prevents them from learning that such thoughts are normal occurrences (other have them too).

### **Treatment of postpartum OCD**

As with OCD that occurs outside of the perinatal period, postpartum OCD responds to medications using serotonin reuptake inhibitors, and to cognitive-behavioral therapy (CBT). Serotonin reuptake inhibitors are effective treatments for OCD, yet their risks to the unborn and breast-feeding child are not well known. Many experts believe that these medicines are probably not dangerous, but it is important to discuss the possible risks with your doctor on an individual basis.

A safer, yet more challenging treatment approach is CBT. Demonstrated to be more effective than medications for non-postpartum OCD, CBT for postpartum OCD symptoms involves four components. The first component is assessment, in which the therapist learns about the specifics of the obsessional thoughts, interpretations of the thoughts, situations that trigger the thoughts, and how the person responds to the obsessions (avoidance, compulsive behavior). The second component involves education about the normalcy of negative thoughts around the time of childbirth. That is, we teach the patient about how virtually everyone has such thoughts, but the problem is in how the thoughts are misinterpreted in ways that bring on anxiety. The third treatment component is cognitive therapy, in which specific misinterpretations of intrusive thoughts are identified and challenged. For example, the patient is helped to look at evidence for and against her or his ideas that violent thoughts will lead to acting violently against one's will. Finally, the fourth component of CBT is exposure and response prevention (ERP). During ERP, the patient is helped to confront situations and thoughts that evoke distress, which simultaneously refraining from compulsive behaviors. For example, a new mother with fears of bathing her newborn son because of obsessional thoughts of drowning would practice giving the baby a bath to find out that she is not likely to commit any harm. ERP takes the wind out of the sails of obsessional fears because it allows the person to see that what they were afraid of is much less likely that had been thought.

### **Some final thoughts**

Let me end with some final words for people who might be suffering silently with postpartum OCD or obsessions. First, if you are *afraid* of your thoughts, or so fearful of acting on postpartum obsessions that you are avoiding situations (or trying to avoid certain thoughts), the chances are very good that you have postpartum OCD and *not* psychosis. Therefore, your risk of acting

violently is extremely low. Second, it is important to tell someone about your obsessional thoughts so that you can get help. Bring this article to your physician or mental health professional and explain what you are experiencing so that you can get help. Finally, having a new baby should be a happy time of life (although it is stressful, too). Effective treatments for postpartum OCD and anxiety are available and you (and your newborn) deserve to have the opportunity to receive the benefits of effective interventions. Don't be afraid to speak up and ask for help.

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