

Obsessive-Compulsive Disorder in Pregnancy and Postpartum: The Possible Etiologic Role and Implications of Obsessive-Compulsive Personality Disorder

To the Editor: We read with interest a recent publication by Fairbrother and colleagues.¹ The authors assessed the prevalence and incidence of maternal obsessive-compulsive disorder (OCD) between the third trimester of pregnancy and 6 months postpartum in 763 pregnant women. Weighted prenatal and postnatal prevalence of 7.8% and 16.9% was calculated. Point prevalence gradually increased over the course of pregnancy and postpartum, with a peak of 9% about 8 weeks postpartum.¹ Previous data from the literature indicate a prevalence of around 2% during pregnancy and 2.38% in the postpartum vs 1% in the general female population.²

Several studies provide evidence supporting more frequent OCD symptoms in the perinatal period, but a clear analysis of risk factors and reasons is still lacking.² Obsessive-compulsive personality disorder (OCPD) is among the risk factors for the development of OCD.^{3,4} OCPD is marked by an excessive obsession with rules, lists, schedules, and order; a need for perfectionism that interferes with efficiency and the ability to complete tasks; a devotion to productivity that hinders interpersonal relationships and leisure time; rigidity and jealousy on matters of morality and ethics; an inability to delegate responsibilities or work to others; restricted functioning in interpersonal relationships; restricted expression of emotion and affect; and a need for control over one's environment and self.³ It has a prevalence of 2.1%–7.9% in the general population, with a peak of 8.7% in the clinical population.

We analyzed 215 pregnant women with the Structured Clinical Interview for DSM-5 Axis I and II Disorders. Thirty-one of them had OCPD (14.41%), while 3 showed the onset of OCD (1.4%). With regard to their reproductive health, women with OCPD showed more voluntary termination of pregnancy (16.1% vs 11.9%, $P = \text{NS}$); more complications during pregnancy, labor, and delivery (77.8% vs 12.5%, $P < .0001$), including emergency cesarean sections (19.4% vs 6.25%, $P = \text{NS}$); and used more contraceptive pills (61.3% vs 32.2%, $P = .008$).

A possible gap in the explanation of a high prevalence of OCD in the perinatal period might be accounted for by a significantly

higher prevalence of acknowledged risk factors like OCPD.^{3,4} The extent of OCPD detected in our sample could justify epidemiologic data underlined by Fairbrother et al, while clinical implications highlighted in women affected by OCPD (eg, significantly higher prevalence of voluntary termination of pregnancy and complications during pregnancy and delivery) emphasize the need for early detection and treatment to prevent adverse outcomes in mother and child.

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High Prevalence of Perinatal-Occurring Obsessive-Compulsive Disorder: Reply to Di Giacomo et al

To the Editor: We welcome the opportunity to reply to the letter submitted by Dr di Giacomo and colleagues.¹ We appreciate their interesting discussion of the potential role of obsessive-compulsive personality disorder (OCPD) in perinatal obsessive-compulsive disorder (OCD) generally, and in relation to our findings in particular. They hypothesize that the very high prevalence of OCD found in our own research,² and (although to a lesser degree) found more generally in the perinatal literature, may be attributable to increased symptoms of OCPD perinatally.

Although Dr di Giacomo and colleagues report a high prevalence of OCPD among pregnant women in their own research, and we agree that the possibility of OCPD being responsible for higher estimates of OCD prevalence and incidence is an interesting hypothesis, and one that merits further investigation, it is nevertheless unclear to us what would make OCPD the primary explanatory factor rather than one among many. We would like to highlight some of the other factors that may explain an increased incidence and prevalence of OCD in the perinatal period as was the case in our study.

Specifically, there are a number of other risk factors for OCD that may also contribute to the increased prevalence and incidence of OCD observed in general in the perinatal period, not only in our own research. For example, during the perinatal period, individuals experience many hormonal changes, which have been hypothesized to contribute to postpartum depression³ and other physiological and psychological changes.⁴ It is possible those hormonal changes contribute to both the emergence and resolution of some obsessions and compulsions in the first months of the infant's life. Furthermore, increased stress and the establishment of a new attachment relationship may also heighten existing anxieties present for new mothers (eg, responsibility for harming the infant accidentally or intentionally) and lead to frequent unwanted, intrusive thoughts about those real-life worries. Those unwanted, intrusive thoughts about real-life worries can now be considered obsessions under *DSM-5* diagnostic criteria, which would not have been true when using the *DSM-IV*.

Additionally, because OCPD is a personality disorder, it implies the presence of personality traits that are stable and long held and were present before the perinatal period. *DSM-5* diagnostic criteria suggest individuals suffering from OCPD have an extreme need for control, perfectionism, and order that can result in rigid beliefs and interpersonal style.⁵ Again, due to the nature of personality disorders, OCPD symptoms are likely to be stable and persistent over time rather than fluctuate in association with the underlying level of anxiety (as would be true for OCD). Thus, birthing individuals for whom a focus on order and cleanliness emerges during the perinatal period only are unlikely to show the stable and persistent personality traits present in OCPD.

With respect to our own recent research² in which we observed particularly high estimates of perinatal OCD prevalence and incidence, our perception is that other explanations are more probable than OCPD. Specifically, our sample is largely representative of the population of birthing women in Vancouver, British Columbia, Canada. In addition to proportional recruitment by health authority, we also adjusted for differences in key characteristics (ie, mode of delivery, maternal age, parity, delivery hospital) between the population and the sample via sample

weighting. Given the effort we made to ensure a representative sample of the selected geographical region, we find it unlikely that birthing people in Vancouver, Canada, evidence higher prevalence of OCPD compared with other locations.

What we believe are likely to be the most significant contributors to the difference in prevalence and incidence found by our team and those reported in other publications are as follows:

1. In this study, we employed *DSM-5* diagnostic criteria. Several requirements for a diagnosis of OCD from the *DSM-IV* have been dropped in the *DSM-5*.^{6,7} Namely, it is no longer necessary that unwanted, intrusive thoughts, images, and impulses cause emotional distress, be inappropriate in content, or exclude real-life worries. In addition, it is no longer necessary that obsessions and compulsions be recognized as excessive or unreasonable by the person experiencing them. While research investigating the epidemiologic implications of these changes in diagnostic criteria has yet to be published, we suspect that they will contribute to significantly higher prevalence and incidence estimates of OCD.
2. We were meticulous in our inclusion of perinatal-specific intrusions into OCD assessments. This is distinct from what others have done. To our knowledge, only 1 previous study has incorporated perinatal-specific OC symptoms into OCD diagnostic assessments,⁸ and in that study, the focus on these symptoms was significantly less intense than in our study.
3. We also went to significant lengths to normalize postpartum harm thoughts for our participants. It is possible that participants in our study felt safer to disclose their infant-related harming obsessions because of the lengths to which we went to reassure them that their disclosures were safe.

We look forward to seeing more work in this area. We welcome work on the interplay between OCPD and OCD. Additionally, and of critical importance, are studies comparing OCD prevalence differences based on *DSM-IV* versus *DSM-5* criteria. These data appear currently lacking, and this makes it difficult to ascertain how much the differences may have contributed to our elevated rates.

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