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POSTPARTUM OBSESSIVE-COMPULSIVE DISORDER: PREVALENCE, SYMPTOMS, OUTCOMES, AND TREATMENT APPROACHES: A COMPREHENSIVE REVIEW

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ABSTRACT

Introduction: Postpartum obsessive-compulsive disorder (PP-OCD) is a mental health condition that affects new mothers during a time of biological and emotional vulnerability. Characterized by intrusive obsessions, frequently involving fears of harming the infant, and accompanying compulsions such as checking or avoidance, PP-OCD can significantly impair maternal functioning. This review aims to synthesize current research regarding the prevalence, symptom profile, risk and protective factors, consequences, and treatment approaches for PP-OCD to improve diagnosis and intervention strategies.
Description of the state of knowledge: Prevalence estimates of PP-OCD vary widely, from 1.7% to 16.9%, depending on diagnostic criteria and methodology. Obsessions typically involve harm-related intrusive thoughts, while traditional OCD features like contamination concerns are less common. Risk factors include poor sleep, prior mental illness, high neuroticism, and maladaptive cognitive interpretations. Protective traits such as resilience and hyperthymic temperament may buffer risk. There is no evidence linking PP-OCD to actual infant harm. Treatments effective in general OCD, such as CBT with ERP and SSRIs, are applicable, though specific postpartum research is still limited. Preventive CBT-based interventions show emerging promise.
Conclusions: PP-OCD is a significant but underdiagnosed condition that impacts maternal well-being and can influence the bond between the infant and the mother. Increased awareness among healthcare providers and the public is essential, as misdiagnosing can lead to inappropriate care. Targeted screening, evidence-based treatments, and preventive strategies are crucial.

KEYWORDS

Obsessive-Compulsive Disorder, Postpartum Period, Anxiety, Cognitive-Behavioural Therapy, Maternal Health, Obsessive-Compulsive Related Disorders

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1. Introduction

Obsessive-compulsive disorder (OCD) is a mental health condition that is characterized by the presence of obsessions and/or compulsions. Obsessions are repetitive, persistent and intrusive thoughts, images, urges or impulses, often triggering intense anxiety. Compulsions are repetitive behaviours or mental acts that the individual feels the urge to perform as a response to an obsession according to rigid rules, or to achieve a sense of 'completeness' [1].

The postpartum period is a time of heightened vulnerability to mental health disorders due to biological, psychological, and social changes. Around 8.5% of postpartum mothers experience one or more anxiety disorders. Rates for specific disorders range from a.03% for specific phobias to 3.5% for GAD [2].

This review aims at examining existing research concerning postpartum OCD. Obsessive-compulsive disorder has historically been considered part of the anxiety disorder spectrum [3], however now it is no longer classified within anxiety disorders but instead falls under the separate "obsessive-compulsive and related disorders" category in the DSM-5 [4]. Anxiety and OCD do share some overlapping features [5], and for this reason, anxiety in the postpartum period will occasionally be discussed in this review, as long as it is relevant to contextualizing postpartum OCD.

Understanding the specific manifestations, prevalence, and implications of OCD during the postpartum period is essential for improving diagnosis, intervention, and providing support for affected individuals.

2. State of knowledge

2.1. Prevalence of symptoms and diagnosis

Obsessive-compulsive symptoms are relatively common in the postpartum period, even when they do not meet the full diagnostic criteria for OCD. In a prospective cohort from 2015 where 461 women were screened for OCD, 11.2% were diagnosed with OCD, while 37.5% reported experiencing subclinical obsessions or compulsions. This subclinical OCD was associated with an increased rate of depression (24%) and state-trait anxiety (8%) compared with women who did not endorse experiencing any obsessions or compulsions [6].

A 2017 review further highlighted the prevalence of intrusive thoughts, reporting that harming intrusions occur in up to 100% of women, regardless of whether they have a psychiatric diagnosis. Stress and cognitive misinterpretation were identified as key factors influencing both the presence and severity of these intrusive thoughts [7].

However, prevalence of OCD is likely higher in the perinatal period than in the general population [8]. According to a very recent meta-analysis and systematic review, overall prevalence of this disorder in the postpartum period is 6.2 % [9]. It is a lot higher than as indicated by a meta-analysis from 2019, which reported a prevalence of OCD of 1.7 % postpartum. [10]. A meta-analysis from 2016 stated that the prevalence of PP-OCD is 2.43% [2], which is consistent with an older meta-analysis from 2013 [11].

However, a quite recent article from 2019 that carefully characterized women using DSM-5 as diagnostic criteria (a lot of research used DSM-IV) found a period prevalence of OCD 16.9% in the postpartum, suggesting that perinatal OCD may in fact be present even more frequently than previously believed if more up-to-date diagnostic criteria are applied [12].

A study exploring prevalence of all clinically significant obsessive-compulsive related disorders (OCRD) symptoms in the postpartum period found that the most common clinically significant psychopathology symptoms in the postpartum period, apart from obsessive-compulsive symptoms (14%), were body dysmorphic disorder symptoms (11, 8%).

An important finding of the study is also the fact that in the postpartum period, the onset of clinically significant OCRD symptoms was more likely to emerge from pre-existing subthreshold symptoms than to appear de novo in individuals with no prior symptoms. Obsessive-compulsive symptoms had the highest out of all OCRD percentage of cases (71%) exacerbated from non-clinical significance in pregnancy to clinical significance postpartum [13].

Differences in diagnostic criteria, assessment timing, and methodology likely account for wide-ranging estimates (1.7% to 16.9%).

2.2. The specific content of obsessive and compulsive symptoms in the postpartum period

2.2.1. Obsessions in PP-OCD

PP-OCD significantly more often than non PP-OCD shows presence of aggressive obsessions, with the majority centering around harming the infant. The topic of obsessions in the postpartum period is also accidental harm to the infant and losing the infant. What's more, frequency of contamination concerns in PP-OCD is significantly lower, so is a need for symmetry/exactness and hoarding/saving obsessions. If present, contamination or sexual obsessions are often found to relate to the infant [14].

2.2.2. Compulsions in PP-OCD

Compared to OCD in pregnancy and OCD in non-pregnant, non-postpartum women, PP-OCD was characterized by significantly lower frequencies of washing/cleaning and several other compulsions. In addition to using checking and some other rituals, a proportion of these women reassure themselves or seek reassurance from others; they may also avoid various situations or objects related to aggressive obsessions and obsessions about accidental harm to the infant. The rates of avoidance are reported to be significant [14].

2.3. Risk and protective factors for postpartum OCD

2.3.1. Correlated factors

A study from 2020 found that participants with mid-pregnancy insomnia had significantly higher levels of perinatal anxiety and postpartum OCD symptoms than participants with normal mid-pregnancy sleep. OCD symptoms affected more women after delivery than before (6.4% vs. 3.8%) [15]. Since 45.7% of expectant mothers experienced poor sleep quality [16], these findings seem to be notable.

According to a very recent study, there is a substantial comorbidity of postpartum OCD with depression symptoms. Women who are high on neuroticism and anxiety sensitivity are more prone to OCD symptoms [17].

Additionally, another study found that a history of depression, anxiety, insomnia, obsessive compulsive, and avoidant personality disorder or presenting inappropriate interpretation of infant related intrusive thoughts are particularly at risk of developing OCD in the postpartum period [18].

2.3.2. Protective factors

In a study from 2019 data were collected from 37 postpartum women diagnosed with OCD. Assessments were conducted on the first day after delivery and again at 6–8 weeks postpartum. The results suggest that patients diagnosed with OCD who have hyperthymic affective temperament character and a decrease in symptoms following a previous childbirth experienced a significant alleviation in the severity of obsessive-compulsive symptoms during the postpartum period [19].

A different study found that resilience also shows to be significantly protective [17].

2.4. Outcomes of the postpartum OCD

2.4.1. Development of the child

A longitudinal study from 2022 used data involving 674 mothers and 442 fathers who completed self-report questionnaires at multiple time points. The aim was to examine the relationship between parental postpartum obsessive-compulsive symptoms, the quality of the parent–child relationship, and child development up to 24 months. The study found no direct negative impact of postpartum OCD symptoms on children's cognitive, motor, language, or social-emotional development [20].

2.4.2. Mother-child relationship

In a study from 2016, maternal postpartum OCD was found to affect experiences of parenting and mother-infant interactions. two groups were examined, mothers with and without OCD. While obsessions and compulsions were reported in both groups, they did not cause interference in the control group. Mothers with OCD were troubled by their symptoms for a mean of 9.6 hours/day. Mothers with OCD were less confident, reported more marital distress and less social support than healthy peers and were less likely to be breastfeeding. Infant temperament ratings did not differ. Mothers with OCD were rated as less sensitive in interactions than the comparison group, partly attributable to levels of concurrent depression. although this may not be driven directly by OCD symptoms [21].

A recent population-based study among Israeli women indicates that maternal postpartum obsessive-compulsive symptoms are associated with poorer mother–child relationship 4 months after delivery. It has to be noted that this study focused on a specific subtype of postpartum OCD—parent–child relationship OCD.

High comorbidity with depression and anxiety, along with generally mild symptoms in the sample, may also account for the findings. It's unclear whether postpartum OCD impacts the parent–child relationship directly or whether avoidance behavior is a key factor [22].

2.4.3. Aggressive behaviour towards the child

Given the distressing nature of intrusive thoughts in PP-OCD, concerns about the potential for actual harm are common. However, a study from 2022 found no evidence that the occurrence of either unwanted intrusive thoughts of intentional, infant-related harm or OCD is associated with an increased risk of infant harm. The prevalence of child abuse of infants in this sample (2.9%) is even lower than reported in others (4%–9%). The findings offer important and reassuring evidence that new mothers' unwanted intrusive thoughts about aggression are not linked to an increased risk of actual physical violence [23].

2.5. Management

2.5.1. Psychotherapy and CBT-based interventions

Research shows that exposure and response prevention (ERP) is the leading evidence-based psychotherapeutic treatment for OCD. When combined with cognitive therapy targeting OCD-specific challenges—such as distress tolerance, maladaptive beliefs, and treatment adherence—it may enhance outcomes and reduce dropout rates [24]. However, there hasn't been much research done on postpartum women.

Evidence of CBT being efficacious for the postpartum period specifically is largely limited to small-sample trials or case studies [25-27]. A randomized controlled trial from 2017 showed that intensive CBT (iCBT) is an effective intervention for postpartum OCD. Sensitive parenting interactions are affected by the presence of postpartum OCD and this is not improved by successful treatment of OCD symptoms. However, the overall attachment bond appears to be unaffected [28]. According to a review by Hudepohl et al (2022), treatment guidelines from the general population can be applied in perinatal OCD, with 13–20 weekly sessions followed by a 3–6-month period of booster sessions [8].

Preventive interventions targeting postpartum obsessive-compulsive symptoms (OCS) are gaining attention as a means to reduce onset in at-risk populations. Some research has begun to explore the feasibility and effectiveness of such programs, both in-person and online. A randomized controlled trial from 2011 examined a cognitive-behavioral prevention program in women with a risk factor for postpartum OCS, which was incorporated into traditional childbirth education classes. The group that received the prevention program was associated with significantly lower levels of obsessions and compulsions compared to the control group [29]. A recent open trial from 2025 evaluated the CB-based program—an internet-delivered intervention aimed at preventing postpartum anxiety and OCD—in a small group of at-risk pregnant women. The program consists of seven 30-minute interactive modules. Results indicated that such an intervention is feasible and associated with reduced risk factors for postpartum anxiety [30].

2.5.2. Pharmacotherapy

SSRIs are the first-line pharmacological treatment for OCD due to their proven effectiveness and tolerability. OCD treatment typically requires higher doses and longer duration than depression. Clomipramine may be slightly more effective but is usually reserved for second-line use due to its side effect profile. If monotherapy is insufficient, augmentation with low-dose antipsychotics like risperidone or psychotherapy is well-supported [31].

While this pharmacological approach represents the standard treatment for OCD in the general population, a growing body of research has begun to explore its applicability and safety in the postpartum period. The available few open-label trials during the perinatal period suggest that efficaciousness in the postpartum period is consistent with that from the general population [25][32].

SSRIs are generally regarded as safe in breastfeeding, but sertraline and paroxetine are found in lower concentrations in breast milk than fluoxetine and citalopram [33].

When considering treatment, clinicians should balance the risks of medication against those of untreated OCD, which can include disrupted mother-infant bonding, reduced functioning, and greater caregiving strain on family members [34].

2.6. Awareness of postpartum anxiety and postpartum OCD

While postpartum depression is widely acknowledged, postpartum anxiety continues to be largely overlooked—both by those experiencing it and by healthcare providers.

A study with 218 women who were planning to become pregnant, pregnant, or recently postpartum showed that they were less familiar with postpartum anxiety than postpartum depression and had limited familiarity with CBT. Women also reported low screening rates for PPA and low perceived treatment seeking for women with PPA and PPD. Study with 290 women revealed that recently postpartum women recognized fewer symptoms and recommended treatment less often for PPA than PPD and had limited CBT knowledge [35].

Not only patients affected by anxiety and OCD show limited knowledge in terms of both recognition and coping strategies. Almost 70% of healthcare practitioners are not able to accurately identify OCS within the case, according to a study from 2019. Furthermore, the suggested clinical management in more than a half of cases included not even a neutral, but a contraindicated strategy, likely to aggravate postpartum OCS. Getting educated in the matter appears to be key in the choice of intervention. Accurate recognition of OCS is associated with the selection of fewer contraindicated management strategies. The study shows that while mental health practitioners scored much better than average, some aspects like years of experience in clinical practice or perinatal environment were not significantly associated with identifying the OCS [36].

3. Conclusions

Postpartum obsessive-compulsive disorder (PP-OCD) is a significant and often underrecognized mental health condition that affects a notable proportion of new mothers. Current evidence suggests that while many women experience intrusive thoughts during the postpartum period, a substantial subset meets diagnostic criteria for OCD, with prevalence estimates ranging from 2% to 17%, depending on methodology and diagnostic criteria used.

PP-OCD is uniquely characterized by a higher frequency of intrusive aggressive obsessions, often centered around infant harm, and relatively lower rates of traditional OCD features such as contamination and symmetry concerns. These obsessions are commonly accompanied by compulsive behaviors such as checking, reassurance seeking, and avoidance, all of which can significantly disrupt maternal functioning.

Risk factors for PP-OCD include a personal or family history of mental illness (especially anxiety, depression, or OCD), poor sleep quality, heightened neuroticism, and cognitive misinterpretations of intrusive thoughts. Conversely, resilience and certain temperament traits (e.g., hyperthymic affectivity) may offer protection. Importantly, many women who develop PP-OCD in the postpartum period had subthreshold symptoms prior to childbirth.

While postpartum OCD symptoms do not appear to negatively affect infant development directly, they can impair maternal confidence and sensitivity in the mother-infant relationship, particularly when comorbid depression is present. Encouragingly, despite the disturbing nature of some intrusive thoughts, there is no evidence that these translate into increased risks of harm to the child.

Treatment for PP-OCD is aligned with general OCD protocols, with cognitive behavioral therapy (CBT), especially exposure and response prevention (ERP), being the gold standard. Pharmacological interventions, particularly SSRIs, are generally effective and safe during the postpartum period, including breastfeeding. However, evidence specifically about the postpartum population is limited, and larger clinical trials are needed. Preventive interventions, including CBT-based psychoeducation during pregnancy, show promise in reducing symptom onset and severity.

Despite increasing research attention, public and professional awareness of postpartum OCD remains limited. Many women and healthcare providers are more familiar with postpartum depression than with postpartum anxiety or OCD. This gap often leads to underdiagnosis or inappropriate clinical responses, underscoring the need for improved screening tools, training, and public education.

Disclosure

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