P.4.e.006 Perinatal Obsessive–Compulsive Scale (POCS): preliminary data

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Piloting the Perinatal Obsessive-Compulsive Scale (POCS): Development and validation

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A B S T R A C T
Onset/worsening of obsessive-compulsive disorder (OCD) during the perinatal period are frequently seen clinically. No specific tool assessing the unique content, context, severity, and onset of perinatal OCD exists. A self-report scale of perinatal obsessions and compulsions, the Perinatal Obsessive-Compulsive Scale (POCS), was developed and validated. A total of 162 women (67 pregnant, 95 postpartum) participated in this pilot study. They completed the POCS as well as the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS). The POCS has good construct validity, reflected by representative items, high internal consistency, good concurrent validity and discriminative capacity. The most common obsessions were fear of having an unhealthy baby at birth, contamination, the baby being taken away, and infant death. Behavioral compulsions such as repeating rituals, asking for reassurance, checking, and cleaning mirrored these obsessions. The POCS helps clinicians detect perinatal OCD while giving perinatal women an opportunity to openly discuss social sensitive issues.

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1. Introduction

Reproductive events in a woman's life, especially during the perinatal period can increase risk of developing or worsening of psychiatric conditions, such as depression and anxiety (Bennett, Einarson, Taddio, Koren, & Einarson, 2004; Brandes, Soares, & Cohen, 2004; Pigott, 2003; Ross & McLean, 2006). Perinatal anxiety is likely underestimated during this period since many of the symptoms can be incorrectly attributed to being pregnant or postpartum. Furthermore, most diagnostic instruments are not sex- and context-specific, leading to further underestimation (Coates, Schaefer, & Alexander, 2004; Lonstein, 2007; Pigott, 2003).

Obsessive-compulsive disorder (OCD) has a 2% lifetime prevalence (Ruscio, Stein, Chiu, & Kessler, 2010; Sasson et al., 1997). Recent evidence from two prospective studies has demonstrated that prevalence of OCD symptoms during the postpartum period was found to be 4% and 9%, respectively, suggesting that women are at an increased risk of OCD onset/worsening postnatally (Uguz, Akman, Kaya, & Cilli, 2007; Zambaldi et al., 2009). Moreover, studies indicate that up to 50% of women suffering from OCD recall the onset/worsening of their symptoms during the perinatal period, especially postpartum (Labad et al., 2005; Maina, Albert, Bogetto, Vaschetti, & Ravizza, 1999; Vulink, Denys, Bus, & Westenberg, 2006; Williams & Koran, 1997).

As one of the most severe anxiety disorders, OCD is characterized by intrusive and inappropriate recurrent thoughts, impulses or images (obsessions) with or without repetitive behaviors and/or mental rituals (compulsions). Perinatal obsessions and compulsions are very specific in content and are frequently directed towards the baby's health and well-being and the baby's environment. These symptoms create immense distress and impair not only one's social, occupational and personal life, but may also affect the ability of the mother to care for her baby, disrupting the mother-infant bonding process (Brandes et al., 2004; Hertzman, 1999; Pigott, 2003). Pregnant women report symptoms that are primarily focused on the fear of having an unhealthy baby and the fear of inadequacy as a mother. New mothers appear to have more aggressive obsessions involving fear of harming their baby accidentally or intentionally, fear of their baby being contaminated, and fear of infant death, among others (Abramowitz, Schwartz, Moore, & Luenzmann, 2003; Brockington, Macdonald, & Wainscott, 2006; Fairbrother & Woody, 2008; Leckman et al., 1999; Maina et al., 1999; Schel, Cohen, Dimmock, & Rosenbaum, 1993; Schel, Cohen, Rosenbaum, & Driscoll, 1993; Zambaldi et al., 2009). These baby-focused preoccupations/worries are not necessarily exclusive to postpartum-related OCD. They can be seen in healthy new parents at a subclinical level, peaking in the immediate postpartum period (Abramowitz, Nelson, Rygwall, & Khandker, 2007; Fairbrother &...
Woody, 2008; Leckman et al., 1999), as well as in women suffering from postpartum depression (Jennings, Ross, Popper, & Elmone, 1999; Wisner, Peindl, Gigiotti, & Hanusa, 1999) and could be argued from an evolutionary perspective as adaptive for survival of the species. Furthermore, these intrusive thoughts should be differentiated from the delusions or psychotic features observed in patients who have developed postpartum psychosis (Abramowitz et al., 2003; Brandes et al., 2004; Fairbrother & Abramowitz, 2007). Thoughts associated with perinatal OCD are disturbing or frightening, but quite often women with OCD will avoid situations related to these obsessions due to their fear of acting on them. In contrast, new mothers suffering from postpartum psychosis may experience an impulse to act on their disturbing thoughts, which poses a greater risk of actually harming their babies.

While there are several existing scales to measure OCD symptoms and severity, their appropriateness for new mothers has not been established. Currently, there is no specific tool available to assess OCD during the perinatal period. Therefore, the present study was to develop a paper-and-pencil, self-report scale to assess the unique content, context, severity and onset of obsessions and compulsions during the perinatal period and examine its psychometric properties.

2. Methods

2.1. Subjects

Pregnant or postpartum women (n = 162) were recruited through the Women’s Health Concerns Clinic (WHCC) and the Ultrasound Department at St. Joseph’s Healthcare Hamilton, Ontario, Canada (see Table 1). The WHCC is an outpatient psychiatric facility associated with McMaster University that provides clinical services to women with mental disorders related to their reproductive cycle.

Inclusion criteria required the participant to be either pregnant or within the first year postpartum. Women with a current primary diagnosis of OCD, depression, or anxiety as assessed by the Composite International Diagnostic Interview for Women (CIDI-VENUS; Martini, Wittchen, Soares, Ried, & Steiner, 2009) and healthy volunteers were recruited. Women with premature and/or otherwise unhealthy babies, as well as women with major physical conditions, current or history of psychotic disorder, alcohol and/or substance abuse disorders were excluded. Potential control subjects were also excluded if they had a current or past history of psychiatric disorders. This study was approved by the Research Ethics Board of St. Joseph’s Healthcare Hamilton.

Following consent, all women completed the prenatal or the postnatal version of the Perinatal Obsessive-Compulsive Scale (POCS) depending on their current state (pregnant or postpartum) and the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) checklist and severity scales.

2.2. Scales

2.2.1. Perinatal Obsessive-Compulsive Scale (POCS)

A self-report questionnaire was developed with a context-specific version for pregnant and postpartum women. Women were asked to mark the presence or absence, as well as time of onset, of specific undesirable or troubling thoughts and behaviors. To obtain good content validity, representative thoughts and behaviors were derived from a systematic review of the literature and the clinical experience of experts in the field. The prenatal version consists of 7 pregnancy and infant-related thoughts and 9 behaviors. The postpartum version includes 19 thoughts and 14 behaviors. Women were asked to answer the question: “Have you ever worried or had thoughts about,” while thinking of the following sample items: “Being criticized and/or judged as a mother; Baby being contaminated; Accidentally harming your baby; Baby unwell at birth or having an unhealthy baby; and Your baby being harmed or dying in an accident.” Regarding the behaviors, the question was: “Have you ever engaged in the following behaviors” and sample items were: “Repeatedly washing and cleaning your baby’s environment; Repeatedly checking the baby while she/he is asleep; Repeatedly checking that you did not make a mistake (for example verifying that your baby drank enough); and Repeatedly asking for reassurance.”

The POCS has 2 scales: a severity scale and an interference scale. To assess symptom severity, questions similar to those in the Y-BOCSs were used to rate the amount of time spent, interference, distress, resistance and control of the disclosed thoughts and behaviors (severity scale: 10 questions with scores ranging from 0 to 4, with higher scores indicating greater symptom severity). Information was also collected about how much the reported symptoms interfere with different aspects of participants’ lives (interference scale: 12 questions with scores ranging from 0 to 4, total scores ranging from 0 to 48, with higher scores indicating greater symptom severity).

2.2.2. Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

The Y-BOCS interview is considered the gold standard for OCD symptom severity assessment due to its strong psychometric properties, high internal consistency, good inter-rater reliability, and construct validity (Abramowitz & Deacon, 2006; Goodman, Price, Rasmussen, Mazure, Delgado et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann et al., 1989; Woody, Steketee, & Chambliss, 1995). The self-report paper-and-pencil version of the Y-BOCS is very similar to the interview, with a list of symptoms and a severity scale for both obsessions and compulsions. The self-report Y-BOCS is a time-saving and less expensive substitute for the Y-BOCS interview. It has demonstrated excellent internal consistency, test–retest reliability, strong discriminant and convergent validity with the interview (Steketee, Frost, & Bogart, 1996).

2.3. Statistical analysis

Descriptive statistics (i.e., frequencies, means, and standard deviations) were calculated on the POCS severity and interference scores and on the Y-BOCS checklist and severity scales. Cronbach-alphas were used to establish internal consistency for the POCS severity and interference scales and for the Y-BOCS. Exploratory factorial analyses were performed on the two new scales (POCS severity and interference scales) to see if they were composed of only one component and if so, if it was explaining the majority of the variance. The Bland–Altman accord was also performed between the POCS and Y-BOCS severity scales as a measure of concurrent validity. To study the discriminative capacity of our new scales we used a mixed-model ANOVA (between factors: state and clinical

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Obstetric and psychiatric characteristics.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total sample</td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>30.7 ± 5.0</td>
</tr>
<tr>
<td>Weeks gestation/postpartum</td>
<td>28 ± 8</td>
</tr>
<tr>
<td>Current diagnosis group [n (%)]</td>
<td></td>
</tr>
<tr>
<td>OCD</td>
<td>49 (30%)</td>
</tr>
<tr>
<td>Depression</td>
<td>48 (30%)</td>
</tr>
<tr>
<td>Anxiety (GAD and Panic)</td>
<td>18 (11%)</td>
</tr>
<tr>
<td>Control</td>
<td>47 (29%)</td>
</tr>
</tbody>
</table>
group) with a repeated measure on the 2 questionnaires (POCS and Y-BOCS).

A receiver operating characteristic (ROC) curve analysis and Youden indices were performed to establish sensitivity and specificity of the POCS and the Y-BOCS in this particular population. Sensitivity would thus refer to number of OCD patients who are correctly classified with a given score on the severity scale. Specificity would refer to the number of controls who are also correctly classified with the same score on the severity scale. Also, we report the area under the ROC curve (AUC) as an indication of the ability to discriminate between those with and without clinically significant OCD symptoms. There is no standard for interpreting significance of the AUC statistics but it has been suggested that values between 0.70 and 0.90 describe a useful screening scale, and a value of 0.90 and above indicates a highly accurate screening scale with a near perfect discriminative capacity (Swets, 1988).

3. Results

3.1. Descriptive data

3.1.1. Symptoms checklists

Overall, a greater number of symptoms was endorsed on the POCS than the Y-BOCS. Pregnant women with OCD reported on average 25% more symptoms on the POCS checklist, whereas postpartum mothers with OCD reported on average 8% more symptoms using the POCS as compared to the Y-BOCS checklist. Moreover, for both groups of women, no perinatal specific symptoms were disclosed on any of the open-ended questions of the Y-BOCS checklist. Pregnant women with OCD reported thoughts concerning being criticized and/or judged as a mother, about their baby being unwell at birth, contaminated, or having an unhealthy baby, as well as certain aggressive, violent thoughts. Nearly all postpartum women suffering from OCD reported worrying excessively about being criticized and/or judged as a mother. They also reported worrying about their baby dying while asleep, their baby being harmed or dying in an accident, and fear of someone taking their baby. Both pregnant and postpartum women with OCD reported the need to repeatedly ask for reassurance, repeatedly check that they had not made mistakes, and repeatedly check their newborn when applicable. All women with OCD endorsed at least one thought and one behavior from the checklist, and a significant proportion of pregnant and postpartum women not suffering from OCD reported at least one distressing thought as well. Tables 2 and 3 show the proportion of pregnant (Table 2) and postpartum (Table 3) women who reported thoughts and behaviors on the POCS per diagnostic group.

On the Y-BOCS checklist, both pregnant and postpartum women reported contamination and aggressive obsessions and pathological doubt, mirroring the POCS findings. Again, concordant with the POCS-reported behavioral symptoms, the more frequently endorsed compulsions reported on the Y-BOCS were from the mental and miscellaneous categories, mostly of repeatedly asking for reassurance, and urges to tell, ask, and confess. While many pregnant women reported checking and cleaning compulsions, postpartum women reported more checking, cleaning and washing compulsions and ordering, and repeating rituals than pregnant women overall.

3.1.2. Symptom severity and interference scales

Women suffering from OCD scored higher than women not suffering from OCD on both the POCS severity and interference scales and the Y-BOCS severity scales. On average the women scored higher on the POCS severity scale compared to the Y-BOCS severity scale. Higher scores on the POCS severity scale can be explained in part by higher ratings on the distress rating sub-scales (see Table 4).

3.1.3. Onset of perinatal thoughts and behavior

For each endorsed symptom, participants were asked to report when the symptom started through open-ended questioning (e.g., When did it start?). Symptom onset responses were clustered by trimester for the pregnant women and onset during pregnancy at birth, or during the first 3–6 months for the postpartum mothers. Most pregnant women were able to identify the onset of their symptoms as it related to an event during pregnancy, with 67% of the women dating the onset back to the first trimester. The majority of postpartum women (70%) dated the onset back to right at the time of their baby’s birth.

3.2. Psychometric properties of the severity scales

3.2.1. Reliability and internal consistency

The POCS and Y-BOCS both had excellent Cronbach-alphas. The POCS severity scale Cronbach-alphas were 0.95 for the whole sample, 0.94 for the pregnant women group, and 0.95 for the postpartum group. The POCS interference scale Cronbach-alphas were 0.92 for the whole sample, 0.93 for the pregnant women group, and 0.92 for the postpartum group. The Y-BOCS severity scale Cronbach-alphas were 0.97 for the whole sample, 0.98 for the pregnant women group, and 0.97 for the postpartum group.
Table 3
Proportion of postpartum subjects who reported thoughts and behaviors on the POCS per diagnostic group.

<table>
<thead>
<tr>
<th>POCS thoughts</th>
<th>OCD n = 31</th>
<th>Dep n = 25</th>
<th>Anx n = 7</th>
<th>Ctrl n = 32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being criticized and/or judged as a mother?</td>
<td>27</td>
<td>19</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Shaking your baby?</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Screaming at your baby?</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Your baby being contaminated (e.g., by germs)?</td>
<td>12</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Harming your baby during bath time?</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Somebody taking your baby away?</td>
<td>18</td>
<td>4</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Dropping your baby?</td>
<td>14</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Your baby dying in her/his sleep?</td>
<td>24</td>
<td>10</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Your baby being harmed or dying in an accident?</td>
<td>17</td>
<td>9</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Harming your baby while he/she is asleep?</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Your baby acquiring a head injury?</td>
<td>11</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Your baby bleeding?</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Throwing your baby?</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Accidentally harming with a sharp object/knife?</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Having inappropriate sexual contact with your baby?</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Someone else having inappropriate sexual contact with your baby?</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Your baby being spiritually possessed (e.g., by a negative force)?</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Postpartum POCS behaviors

<table>
<thead>
<tr>
<th>POCS behaviors</th>
<th>OCD n = 31</th>
<th>Dep n = 25</th>
<th>Anx n = 7</th>
<th>Ctrl n = 32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeatedly washing or cleaning your hands?</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Strong urge to count or add?</td>
<td>10</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Making sure that you are not alone with your baby?</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Repeatedly checking the door, locks, or oven, etc.?</td>
<td>15</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Repeatedly lining up and/or putting things in order?</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Repeatedly checking that you did not make a mistake (for example verifying that your baby drank enough)?</td>
<td>15</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Collecting useless items (not including hobbies)</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Repeatedly asking for reinsurance?</td>
<td>20</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Avoiding your baby?</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Repeatedly washing and cleaning your baby’s environment?</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Repeatedly washing and cleaning your newborn?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Repeatedly checking the baby while she/he is asleep?</td>
<td>19</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Perform a combination of behaviors to prevent something bad from happening or to reduce your feelings of anxiety (routines, mental rituals, superstitious rituals, etc.)</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2.2. Factor structure

Based on the scree-plot, the factor analysis revealed only one component. This component explains 68% of the variance for the POCS severity scale and 57% for the POCS interference scale.

3.2.3. Concurrent validity

The Bland–Altman analysis of concordance revealed that for the whole sample the correlation between the POCS and Y-BOCS severity scale was $r = 0.81, p < 0.0001$. The mean score difference was 3.44 ($SD = 5.98$) more points on the POCS compared to the Y-BOCS severity score and was significantly different from zero. The Bland–Altman limits were 15.16 to –8.28. The analysis was repeated for each of the woman’s current state. For the pregnant group the correlation between the POCS and Y-BOCS severity scale was $r = 0.80, p < 0.0001$. The mean score difference was of 4.14 ($SD = 6.11$) more points on the POCS score compared to the Y-BOCS severity score, significantly different from zero, with Bland–Altman limits of 16.11 to –7.84. For the postpartum group, the correlation between POCS and Y-BOCS severity scale was $r = 0.82, p < 0.0001$. The mean score difference was 2.94 ($SD = 5.86$) more points on the POCS score compared to the Y-BOCS severity score, significantly different from zero and the Bland–Altman limits were 14.42 to –8.55.

The mixed model ANOVA revealed neither a triple or a double significant interaction demonstrating that the increase was neither dependant on the grouping nor on the current state of the women but inherent to the measures itself (POCS and Y-BOCS severity scales).

3.2.4. Sensitivity and specificity

The ROC curve analysis demonstrated that the discriminator score based on the Younden index on the POCS severity scale was 9 with sensitivity of 62% and a specificity of 92% with an area under the curve of 0.813, on the POPS interference scale was 5.5 with sensitivity of 64% and a specificity of 94% with an area under the curve of 0.813, and on the Y-BOCS was 7, corresponding to a sensitivity of 55% and a specificity of 90%, with an area under the curve of 0.753.

4. Discussion

In this pilot study we developed a paper-and-pencil, self-report scale assessing the unique content, context, severity, and onset of obsessions and compulsions during the perinatal period. The POCS appears to be a useful screening tool with good construct validity reflected by good psychometric properties (representative items,
high internal consistency, good concurrent validity, and discriminative capacity). Overall, women suffering from OCD during the perinatal period endorsed more symptoms and of greater severity on the POCS than on the Y-BOCS. Moreover, we observed that women do not utilize the option to report specific perinatal symptoms under the ‘other’ option when using the Y-BOCS.

ROC curve analyses from this pilot study suggest that if the Y-BOCS severity scale was to be used as a diagnostic tool in a perinatal population, the severity rating would become clinically significant at a lower threshold than in a non-perinatal OCD population (5.5 instead of 7). In contrast, since perinatal women scored higher on the POCS, the clinical threshold for the POCS severity scale may be higher (9 instead of 7). At this point, we suggest that these scales be used with caution and not be used as a diagnostic tool. Until the clinical threshold can be established in a larger sample, we encourage conservative interpretation when using the Y-BOCS in a perinatal population and less conservative interpretation when using the POCS.

Our recruitment strategy and inclusion criteria allowed for the collection of a relatively large sample of perinatal women suffering from OCD. However, this sample is not representative of the general population, and a study of women attending primary obstetric and gynecological care would be needed to establish more accurate estimates of the POCS’ discriminatory capacities.

The focus of the thoughts of nearly all the women was a fear of being criticized or judged as a mother with the thoughts of women suffered from OCD being centered around the baby’s well-being. Fear of having an unwell baby at birth and fear of contamination characterized pregnant women with OCD, and fear of baby death or the baby being taken away characterized postpartum mothers with OCD. Repeating rituals, asking for reassurance, checking and cleaning rituals mirrored these thoughts. The onset of OCD symptomatology tends to occur early in pregnancy or soon after birth.

This pilot study has its limitations, and some of them will be addressed in the larger validation study currently in progress. The POCS will be tested against other OCD scales to further investigate its validity; a retest phase has been added to assess test–retest reliability; checklist items have been revisited based on the current findings and now consist of a shorter, more targeted list of symptoms; and fathers have been added to the investigation. Nonetheless, these pilot data provide new evidence regarding the presentation of symptoms in pregnant and postpartum women. This allows for targeted clinical intervention and early screening, and provides an opportunity for open-dialogue between patients and their health care providers.

5. Conclusions

The POCS appears to be a specific and sensitive tool with good discriminant capacity based on the Yonidel indices and ROC AUC values. A large proportion of healthy perinatal women as well as women suffering from depression and anxiety disclosed a variety of thoughts and behaviors on the POCS checklist. This finding supports the hypothesis that worries resembling OCD symptoms during the perinatal period, such as intrusive thoughts related to the baby’s well-being and safety, are frequently reported by healthy postpartum (Abramowitz et al., 2007; Fairbrother & Woody, 2008; Leckman et al., 1999) as well as depressed postpartum women (Jennings et al., 1999; Wisner et al., 1999), and may even be universal and adaptive in nature. However, the severity and interference ratings on the POCS scale do discriminate between women who suffer from OCD and those who do not, as the depressed and healthy controls have subclinical–threshold scores.

Current findings support the good construct validity of the POCS. It is a new instrument that is easy and quick, requiring less than 5 min to complete and score. Based on our results, a score higher than 9 on the POCS does not guarantee that the pregnant or postpartum woman suffers from OCD but should prompt diagnostic assessment and discussion with the mother as well as the other support providers. It is hoped that the POCS will increase awareness and detection of perinatal OCD and help clinicians to better describe, understand, diagnose, and treat this population.

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