Peter J Lawrence, Michelle G Craske, Claire Kempton, Anne Stewart and Alan Stein

Intrusive thoughts and images of intentional harm to infants in the context of maternal postnatal depression, anxiety, and OCD

PJ Lawrence, D Clin Psych, research training fellow and clinical psychologist, Anxiety and Depression in Young People Clinical Research Unit, School of Psychology & Clinical Language Sciences, University of Reading, Reading, UK; honorary clinical psychologist, Department of Psychiatry, University of Oxford, Oxford, UK; lecturer, Academic Unit of Psychology, University of Southampton, Southampton, UK. **MG Craske**, PhD, distinguished professor and vice chair, Department of Psychology, University of California, Los Angeles (UCLA), CA, US. **C Kempton**, M App Sci, senior psychological therapist, Department of Psychiatry, University of Oxford, Oxford, UK. **A Stewart**, FRCPsych, consultant child and adolescent psychiatrist, Boundary Brook House, Oxford Health NHS Foundation Trust, Oxford, UK; senior clinical lecturer, Department of Psychiatry, University of Oxford, Oxford, UK. **A Stein**, FRCPsych, professor of child and adolescent psychiatry, Department of Psychiatry, University of Oxford, Oxford, UK; honorary consultant child and adolescent psychiatrist, Oxford Health NHS Foundation Trust, Oxford, UK.

Address for correspondence

Pete J Lawrence, AnDY Clinical Research Unit, PCLS, Whiteknights Campus, Reading RG6 6AL, UK.

E-mail: p.j.p.lawrence@reading.ac.uk

Submitted: 6 January 2017; **Editor's response:** 8 February 2017; **final acceptance:** 16 February 2017.

DOI: https://doi.org/10.3399/bjgp17X692105

INTRODUCTION

Intrusive thoughts are key features of depression, anxiety, and obsessive-compulsive disorder (OCD).[1] Such thoughts are also common in the general population, where their content is the same as found in those with a psychiatric disorder. Intrusive thoughts comprise unwanted negative thoughts and images that frequently intrude, are difficult to dismiss, and, when dismissed, recur. Furthermore, they lead to a narrowed focus of attention that, in turn, can impair a person's ability to respond to the external world. They can play an important role in maintaining the disorders in which they occur.[2]

One form of intrusive thoughts that is particularly distressing in the postnatal period is of intentionally harming one's infant (Box 1). Such thoughts and images have been reported to occur in very nearly half of parents of infants in the general population.[3] Although such intrusions are not in themselves indicative of risk, they are likely to be of particular significance when they occur as part of depression, anxiety disorders, or OCD, where they are often associated with great distress and shame. Although much of the research in this area has been with mothers, these intrusive thoughts also frequently occur in fathers.[4]

SHOULD I ENQUIRE ABOUT INTRUSIVE THOUGHTS?

A common concern of clinicians is that, by enquiring about thoughts related to sensitive and undesirable behaviours (for example, suicidal thoughts), they might in some way contribute to the likelihood of a patient acting on such thoughts. However, as with suicidal thoughts, there is no evidence that clinicians increase this likelihood of acting on thoughts of harming an infant by enquiring about such thoughts. Rather, patients often feel relieved at being able to talk about these thoughts.

Parents very rarely spontaneously volunteer having intrusive thoughts of harming their baby, even when answering questions concerning their depression, anxiety disorder, or OCD. This can be because of a feeling of shame and a fear that the baby may be removed from them by statutory services. However, mothers can be helped to understand that such intrusions are common, and by themselves they signify nothing sinister.

HOW DO I ASSESS THEM?

These intrusive thoughts need to be carefully assessed, by a GP, health visitor, or mental health professional, to distinguish them from those that should, in fact, trigger child protection and safeguarding proceedings.

The assessment is likely to reveal that the thoughts are intrusive, ego-dystonic (that is, they are inconsistent with the mother's view of herself), inconsistent with the mother's behaviour, and cause the mother distress and dismay. There is no intention to act on them or a history of harming the baby; as such, the mother poses no risk of harm to her infant.

The content of intrusions is such that patients are often unwilling to disclose them. Disclosure of intrusive thoughts is more likely within a trusting relationship, possibly one developed via continuity of

Box 1. Specific content of intrusive thoughts of intentionally harming one's infant

- Shaking the baby.
- Hitting the baby too hard during winding.
- Throwing the baby to the ground or against a wall.
- Puncturing the infant's fontanelle.
- Drowning the baby in the bath.
- Smothering the baby, for example, with a baby's milk bottle or pillow.
- Releasing the baby in a pram from the top of a hill/into traffic.

Box 2. Features to assess

- Is the mother indifferent to the intrusive thoughts?
- Is the mother emotionally unaffected by the thoughts?
- Does the mother try to trigger the thoughts?
- Does the mother decline help to manage the thoughts?
- Does the mother intend to act out the thoughts?
- Has the mother ever intentionally harmed her baby?
- Negative answers to these questions are entirely consistent with a very *low risk* of a mother deliberately harming her infant. Conversely, an affirmative answer to the first four points does not necessarily indicate that a mother *will* harm her infant. Rather, *the overall clinical picture* from answers to all of these questions is the more informative indicator. However, if the mother acknowledges intention to act out the thoughts or has a history of previously harming her baby, the risk needs to be taken seriously.
- Unlike in puerperal psychosis, intrusive thoughts of intentional harm to the infant are ego-dystonic. That is, they are experienced as unacceptable and inconsistent with a person's sense of self.
- The content of intrusions is important only so far as secondary risks might arise. For example, if a mother fears smothering the baby using the baby's milk bottle, she might refuse to feed the baby.

Box 3. Normalising intrusive thoughts for concerned parents

- Intrusive thoughts or images of causing harm to one's infant are common in the general population.
- Experiencing the intrusive thoughts makes them no more likely to harm their infant intentionally than any other parent is to harm their own infant intentionally.
- There is no need to avoid triggers or situations that give rise to the intrusive thoughts or images. Avoiding them actually tends to increase the frequency of the thoughts and/or images.

care. Even so, on a first meeting, we have found that enquiry can be fruitful. We have also found that, directly before enquiring about intrusive thoughts of harm, it can help to build a parent's trust by explaining to them that negative intrusive thoughts of all kinds — for example, violent thoughts — are common and that we, as mental health professionals, also experience them. Following such explanation and disclosure, patients have been able to reveal, often with great relief, that they have, indeed, experienced just such thoughts. Assessing features of mothers' emotions and behaviours associated with these thoughts (Box 2) has shown us that mothers almost invariably find the intrusions to be repugnant and distressing, that they have done nothing consistent with the intrusions, and have no intention to do anything consistent with the intrusions.

IS FURTHER GUIDANCE AVAILABLE?

There is an increasing recognition of the importance of identifying and treating postnatal depression and anxiety as well as OCD (for example, The National Institute for Health and Care Excellence guidelines for perinatal mental health).[5] The issue of screening for intrusive thoughts of harm to the baby or managing them, however, is not mentioned in these guidelines or any other standard information, and neither is such enquiry included in the screening instruments. The only easily available information of which we are aware that mentions this issue is a leaflet produced by the Royal College of Psychiatrists for families (http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postnataldepression.aspx) and the OCD-UK website (http://www.ocduk.org/prenatal-postnatal-ocd). Box 3 contains important advice that can be given, confidently, to parents reporting intrusive thoughts of intentionally harming their infants.

CONCLUSION

Postnatal depression occurs in the UK in approximately 10–12% of mothers, and anxiety and OCD are also common in the postpartum period. Intrusive thoughts of harming one's baby are common among clinical and non-clinical samples alike. However, they may become more distressing and harder to cope with in mothers who are suffering from mental health problems. Such thoughts can be elicited through careful and sensitive questioning (especially emphasising to parents that these are common and do not mean that they will act on them). Once parents are able to acknowledge and talk about these thoughts and appreciate that experiencing them is very common, they often diminish in significance and frequency. Where they persist, treatment for intrusive thoughts is available using standard cognitive behavioural techniques.[5]

Funding

The Wellcome Trust provided funding for this work (grant number 090139).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

Acknowledgements

We are grateful to Charlotte Granger, Peter Cooper, Lynne Murray, and Louise Dalton for their help with this work.

Discuss this article

Contribute and read comments about this article: **bjgp.org/letters**

REFERENCES

1. Harvey A, Watkins E, Mansell W, Shafran R. *Cognitive behavioural processes across psychological disorders: a transdiagnostic approach to research and treatment.* Oxford: Oxford University Press, 2004.
2. Clark DA, de Silva P. The nature of depressive and anxious, intrusive thoughts: distinct or uniform phenomena? *Behav Res Ther* 1985; **23(4):** 383–393.
3. Fairbrother N, Woody SR. New mothers' thoughts of harm related to the newborn. *Arch Women's Ment Health* 2008; **11(3):** 221–229.
4. Abramowitz JS, Khandker M, Nelson CA, *et al.* The role of cognitive factors in the pathogenesis of obsessive-compulsive symptoms: a prospective study. *Behav Res Ther* 2006; **44(9):** 1361–1374.
5. National Institute for Health and Care Excellence. *Antenatal and postnatal mental health: clinical management and service guidance. CG192.* London: NICE, 2015. http://www.nice.org.uk/guidance/cg192/evidence (accessed 7 Jul 2017).