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Obsessive–compulsive disorder and child safeguarding

REFRESHMENT

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SUMMARY

Obsessive–compulsive disorder (OCD) is a common psychiatric condition and many patients have childcare responsibilities. A small proportion have aggressive and sexual thoughts about their children. There is little risk that they will act on these thoughts, but primary healthcare and social care professionals are often unaware of this and instigate unnecessary and potentially harmful child safeguarding processes. Psychiatrists have an essential role in educating and liaising with other professionals to prevent these inappropriate interventions.

DECLARATION OF INTEREST

None.

KEYWORDS

Obsessive-compulsive disorder; phenomenology; psychiatry and law.

Obsessive–compulsive disorder (OCD) is a heterogeneous condition, commonly presenting as obsessive thoughts related to contamination and doubts. Many people with OCD present in adulthood, when they are responsible for looking after children. About 20–30% people with OCD reports sexual and aggressive thoughts as their primary problems. Usually these thoughts directed towards themselves, and/or family members including children (Moulding 2014). As with other psychiatric disorders, OCD can also affect the patient's ability to look after their children. This brief article discusses child safeguarding considerations in clinical assessments of patients with OCD.

Proportionate interventions

Protecting the child

People with severe OCD can become so preoccupied with their obsessions or compulsions that they ignore or do not adequately care for their children. Sometimes, their children become the target of the compulsive behaviour. For example, one mother with OCD was so worried about infection that she did not let her 6-year-old son go to school or play with other children and she bathed him three times a day. In this case, it would be appropriate to assess (with family involvement) the impact of the mother's OCD on the boy and to consider formal child safeguarding procedures to ensure his well-being. Appropriate support to ensure the child's well-being would include early help and, occasionally, the involvement of specialist services (in England, for example, a 'child in need' referral to the local authority's Children's Social Care Services). Rarely, if the parent is uncooperative and there are serious concerns about the child's well-being, then referral for child protection can be considered.

Supporting the adult

If a parent or carer with OCD presents with aggressive and sexual thoughts, images or impulses involving children but there are no other concerns (such as comorbid psychiatric illness, doubts about the patient's psychopathology or inadequate childcare), then referral for child safeguarding is usually not appropriate (Box 1). Such obsessions are more commonly reported by mothers during the perinatal period but can also be experienced by the fathers. Unfortunately, patients are usually reluctant to seek help and even when they do they may not be correctly diagnosed (Glazier 2013). Even worse, sometimes these patients are deemed to pose serious risks to children. Such patients have even been deemed to pose a serious risk to their children (National Institute for Health and Care Excellence 2005), and some have been unnecessarily referred and their children subjected to safeguarding procedures. Cases have also been reported in the literature and media, generally with worse outcomes for both patients and children (Challacombe 2013; Morgan 2016). The usual reasons for

BOX 1 Potential harm to the patient of an inappropriate safeguarding referral

- Worsening of OCD symptoms by 'confirming' the patient's fear that they are a risk to their children
- Disengagement from mental health services
- Stigma and shame associated with aggressive and sexual thoughts

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BOX 2 The role of psychiatrists in assessment and referral for child safeguarding

- Develop trusting relationships and reassure patients about the risks so that they are unlikely to act on their thoughts
- Clarify the diagnosis and do a comprehensive risk assessment
- Liaise with other professionals, including social workers, to develop a management plan informed by the risk assessment
- Provide a constructive professional challenge to the other agencies involved in the safeguarding process

referral are clinicians' lack of awareness about OCD, inability to do a proper risk assessment before referral or a risk-averse attitude (Booth 2014).

Treatment for obsessive symptoms involves exposure to the feared situation. For example, treatment for a father demonstrating significant avoidance behaviour because of his sexual obsessive thoughts towards his infant might include changing the child's nappy. The psychiatrist should explain the treatment rationale to social services and other involved agencies.

Referral

Referral for child safeguarding should not be made without a thorough risk assessment by an experienced clinician, preferably a psychiatrist. In cases of uncertainty, another clinician with specific expertise in OCD assessment and management should be consulted. The psychiatrist's role is important, especially in guiding the other professionals (Box 2).

In typical cases of OCD, the obsessive thoughts are ego-dystonic: the patient is distressed by the thoughts and does not intend to act on them. They are usually afraid of acting on them and take precautions to prevent it; for example, an individual with thoughts of harming a child might remove knives or sharp objects from the house; one with sexual thoughts towards children might avoid contact with them. Therefore, the risk that someone with OCD will act on their obsessions seems likely to be much lower than that for general population; there is no published evidence to contradict this (Veale 2009; Booth 2014). A similar analogy would be the risk of a person who has a fear of heights falling to their death from a tall building.

Conclusions

Primary and social care professionals still lack awareness about OCD. Hence, psychiatrists have a responsibility to work closely with these agencies and with the families of patients with OCD to increase awareness and thereby prevent the unnecessary harm and distress caused by inappropriate child safeguarding referrals.

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