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The Puerperal Obsessions- That Wax And Wane

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ABSTRACT

We report an exacerbation of obsessive compulsion disorder in an Indian woman, which developed within a week following a delivery of a female baby from Victoria hospital, Bengaluru. She was maintaining well with no immediate post partum complications, she had similar episode of Obsessive compulsive disorder in second trimester of pregnancy three years back for which no treatment was sought. The following case report describes the prevalence, clinical features, differential diagnosis; management and discussion by comparing similar studies on obsessive compulsive disorder, finally areas of need of further research are proposed.

Key words: obsessions, puerperium, episodic nature.

INTRODUCTION

Obsessive compulsive disorder is an anxiety disorder characterized by obsessions and compulsions. Obsession is recurrent and persistent thoughts, impulses, or images that are experienced, at some time during a disturbance, as intrusive and inappropriate and that cause marked anxiety or distress. Compulsions are repetitive behavior or mental acts that a person feels driven to perform in response to an obsession, or rules that must be applied rigidly. The person recognize that the obsessions or compulsions are excessive or unreasonable, cause marked distress, are time consuming significantly interfere with persons normal routine occupational functioning, or usual social activities and relationship. [1]

Prevalence

A meta-analysis of seven studies of OCD in puerperium (up to 12 months) women using structured diagnostic interviews reported a prevalence of 2.43%. [2] An exploratory analysis of regionally matched risk ratios revealed postpartum women are at greater risk of experiencing OCD compared with the general female population. A recent prospective cohort study of 461 women estimated the prevalence of obsessive–compulsive symptoms to be 11% at 2 weeks postpartum, and almost half of these women had persistence of symptoms at 6 months postpartum. [3] Two prospective studies demonstrated that 1.7–4.0% of women had first onset of OCD after childbirth. Women with a history of OCD or perinatal OCD are also at risk for recurrence of OCD in the postpartum period with studies reporting rates of recurrence of 25 to 75% after childbirth. [4]

Biological theories of postpartum OCD point to dysregulation or dysfunction in various neurotransmitters or hormones including serotonin, estrogen, progesterone, and oxytocin. The serotonin hypothesis suggest that dysregulation of this neurotransmitter may play a role in development of OCD. [5]

CASE PRESENTATION

A 22 year old female, illiterate, homemaker, comes from low socioeconomic status brought by husband with 6 years history of obsessive thoughts, with clear consciousness and disturbed

biosocio-occupational functioning. The patient was treated at a private facility with no improvement in the symptoms when she reported to us.

On admission the patient reported of repetitive thoughts of killing herself which were her own thoughts, distressful, ego-dystonic and out of her control. Despite the resistance offered by the patient, these thoughts continued to persist to the extent that the patient had given up and decided to end her life. She was preoccupied with distressing thoughts on existence of god which occurred most of the day and on a daily basis. She described the thoughts as bad thoughts and blasphemous. She was aware that the thoughts were hers and were senseless and this made her made even more fearful. On average she spent 4 to 6 hours daily ruminating over these irrational thoughts. Patient also complaints of hearing of voices mood congruent commenting type auditory hallucinations telling her she is not worthy have to die, She even reported that there was no hope for the future.

Past history: Three years back patient had similar compulsions of blasphemous thoughts and images of abusing God and throwing footwear at God during second trimester of pregnancy. These thoughts persisted for a period of 1 year and resolved without treatment. The symptoms reduced when she conceived her third child. No history of head injury, loss of consciousness, seizures, fever.

Family history: no family history of psychiatric disorder

On examination there was no pallor, icterus, clubbing, cyanosis or pedal edema.

Patient's height was 152 cms with a weight of 49 kgs, and a BMI of 21.21kg/m2.

MSE: patient was found to be restless while sitting, she was repeating herself many times, she appears anxious during the interview. She reported distressing thoughts and third person auditory hallucinations disturbances were seen mood congruent cognitive test were normal. Insight was poor, personal judgement was impaired.

Routine investigations were done and were found to be within normal limits.

YBOCS scale was administered and the patient scored 23 with predominant obsessions.

Differential diagnosis

1. Obsessive compulsive disorder with mixed obsessional thoughts and acts
2. Mental and behavioural disorders associated with the puerperium not elsewhere classified

Treatment

The patient was started on medication fluvoxamine and clonazepam and the dosage titrated according to response. Her progress was consistently monitored during her stay in the hospital. Patient required higher dosages and augmentation with risperidone along with consistent psychoeducation and insight building. Successive CBT was planned and initiated to maintain and sustain improvement. Patient showed significant improvement in symptoms during her stay in the hospital.

DISCUSSION

Both syndromal and sub-syndromal symptoms of OCD are common after childbirth. The prevalence estimates of postpartum OCD vary depending on the study population, screening /diagnostic instruments used and the duration of the postpartum period. [6] A recent prospective cohort study of 461women estimated the prevalence of obsessive compulsive symptoms to be 11% at 2 weeks postpartum, and almost half of these women had persistence of symptoms at 6 months postpartum. [3] A meta-analysis of seven studies in post partum upto 12 months women using structured diagnostic interview reported a prevalence of 2.43%. Postpartum OCD, affects quality of life as mothers try to cope with significant levels of anxiety and feelings of guilt for having to spend large amount of time dealing with obsessions and compulsions. [2] Obsessive compulsive symptoms are common in

women who experience postpartum onset depression .When comparing women with and without postpartum depression; both groups have high but not statistically different rates of obsessive compulsive symptoms 57% and 39% respectively by Wisner, Pendi, Giglotti & Hanusa 1999.

Women who exhibit obsessive compulsive symptoms and postpartum depression have significantly higher number of obsessions and significantly more aggression obsessions than women who don't have depression or have non postpartum onset depression by Jennings, Ross, Pepper, & Elmore, 1999; Wisner et al.,1999.

Approximately 4% women with postpartum depression and aggressive obsession avoid being alone with babies for fear of acting on their aggressions by Jennings et al 2000. [7]

A study on OCD in pregnant women during third trimester of pregnancy by Faruk Uguz et al.,in 2007 revealed prevalence rate of OCD to be 3.5% among the women in third trimester of pregnancy. The study also observed that most obsessions were contaminations (80%) and symmetry (60%), were as most common compulsions were cleaning or washing (86.7%) and checking (60%). [8]

In a study done by Epperson et al., 25 out of 34 women with pre-existing OCD reported worsening of symptoms in early post partum. Another study done by Williams and Koran et al., seven out of twenty four (29%) patient who completed full term pregnancy reported worsening of their pre-existing OCD during puerperium. So to reiterate women with pre-existing OCD often experience worsening of their symptoms during puerperium. [9]

The delusion regarding the infant, in post partum psychosis has to be differentiated from intrusive thoughts of harming the baby in post partum OCD. The patient with post partum OCD often presents with ego-dystonic thoughts, patients are irritable, frightened and disturbed by the thoughts whereas in post partum psychosis, the delusion are ego-syntonic and no such distress is seen in regard to their thoughts and also in post partum psychosis the patients experience impulses to act on their delusions and therefore one can accept and risk of actually harming the infant.

Special about Case

Blasphemy and blasphemous themes on the post-partum spectrum, though rare are not non-existent. But it is quite rare to see patients were the OCD symptoms seem to improve in pregnancy, worsen after child birth and in this case, on one occasion even spontaneously resolved. This though can be attributed to the hormonal variation post-partum, still emphasizes the unpredictable pattern, theme and course of post- partum OCD.

Course is waxing and waning type

Clinical implications:

1. Research is needed to address efficacy of psychosocial and psychopharmacological intervention for postpartum OCD.

2 further studies needed on use of screening instruments, designed specifically for use in women with postpartum OCD.

CONCLUSION

Post partum psychiatric conditions can be associated with exacerbation of OCD also. Women with risk factors develop OCD should be informed of the risk and screened for obsession and compulsion during pregnancy. [10]

Post partum OCD is understudied and additional casual pathways through which OCD develops and co occurrence of perinatal depression remains largely unknown. Advance in empirical research on post partum OCD are essential for development of prevention and treatment, giving empirical knowledge regarding OCD in post partum to medical staff may be useful. [11]

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