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Postpartum of a Triplet Pregnancy: Risk Factor for Resistant Obsessive Compulsive Disorder: A Clinical Case

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Abstract **Case Report**

The postpartum period is a time conducive to the worsening of obsessive-compulsive disorders (OCD), particularly impulse phobias during postpartum, which are anxieties related to the fear of harming the baby. The individual acknowledges the unreasonable nature of their thoughts. Estimates of the prevalence of perinatal OCD vary significantly. OCD after childbirth can occur alone or in conjunction with other psychiatric disorders such as major depressive disorder. Due to the general lack of awareness of the relationship between childbirth and OCD, the disorder may be underdiagnosed or misdiagnosed as major depressive disorder. The evaluation of a postpartum woman requires sensitive communication and careful risk assessment. This article describes the case of a patient who developed OCD with impulse phobias complicated by a major depressive episode following the birth of her triplets. The specific challenges related to the management and treatment of OCD and particularly impulse phobias during the perinatal period are discussed.

Keywords: Obsessive-Compulsive Disorder, Impulse Phobias, Major Depressive Episode, Management.

INTRODUCTION

For most expectant parents, pregnancy and the postpartum period are marked by excitement, wonder, anticipation, and joy. However, for some, this period is characterized by the onset (or intensification) of severe emotional distress. While much attention has been given to symptoms of depression and psychosis that occur during the perinatal period, much less attention has been paid to perinatal anxiety and OCD, which, although no longer officially classified as an anxiety disorder, is clearly closely related. Recent evidence suggests that women are actually at increased risk of developing OCD during pregnancy and the postpartum period, with meta-analytic results indicating rates of 207% and 243% respectively compared to 108% in the general population.

Several studies provide evidence of an increased risk of developing and exacerbating OCD during the postpartum period, with symptoms generally starting 4 weeks after childbirth. Multiple pregnancies, classified as high medical risk, have been found to be a risk factor for the subsequent development of OCD. Impulse phobias in the postpartum period include the fear of uncontrollable urges leading to violent acts towards the child. The mother must struggle against obsessive fears of violent acts that could endanger the child's life.

The interest of our work is to highlight the particularity of postpartum OCD with impulse phobias and the challenges of its management.

PATIENT AND OBSERVATION

The patient, Mrs. H.M., a 40-year-old civil servant, married, and mother of 4 children (one daughter and triplet daughters), presented in January 2021 for treatment of mood sadness, anhedonia, insomnia, impulse phobias, and suicidal ideation evolving since 2016, coinciding with the postpartum period.

Her history includes a severe melancholic depressive episode in 2011 following a professional conflict, treated with Olanzapine 25mg/day and Escitalopram 20mg/day, with complete remission in 2012. She also has a sister and a maternal aunt followed for OCD. Her childhood and adolescence were marked

by conflictual relationships with her authoritarian mother.

Symptoms began in 2016, coinciding with the birth of her triplets, with initial symptoms of insomnia, irritability, anorexia, crying spells, refusal to breastfeed or care for her daughters, leading to her first consultation three weeks after childbirth. A diagnosis of OCD complicated by a major depressive episode was made, and she was prescribed Sertraline 50mg/day, which she adhered to well but without clinical improvement.

Despite strong family support, her condition worsened, with increasing obsessive fears of harming her children and suicidal thoughts, slightly relieved initially by prayer. She neglected her personal care and her children. Due to her worsening condition, her daughters were cared for by her mother and paternal grandmother. She consulted several psychiatrists, underwent various treatments (Fluoxetine 20mg/day, Olanzapine 25mg/day + Anafranil 75mg/day, Escitalopram 20mg/day + Nozinan 100mg/day), each for 6-8 weeks without satisfactory improvement, leading her to stop treatment.

In 2020, her condition worsened, with increased sadness, anhedonia, and suicidal ideation without a specific plan, leading to her consultation in January 2021. Psychiatric assessment revealed a distressed, slow-moving patient with a hesitant gait, hypomobile facial expressions (melancholic omega sign), fixed and distant gaze, neglected grooming, crying in the waiting room and during the interview, but with easy and productive contact. Basic psychic activities were preserved, her voice was monotone, and her thoughts were dominated by obsessive fears of harming her children, significant anxiety, and refusal to be alone with them. She also reported guilt and self-deprecation, believing herself to be a bad mother and wife, with suicidal ideation.

Given this presentation, a diagnosis of OCD complicated by severe major depressive episode was made, with a Y-BOCS score of 20 at admission. Laboratory tests, including CBC, electrolytes, liver, lipid, renal, thyroid function, and vitamin D levels, were unremarkable except for low vitamin D. She was prescribed Sertraline 100mg/day, Anafranil 150mg/day, Risperidone 1mg, and tapering Prazepam over 4 weeks with vitamin D supplementation. Clinical improvement was marked by restored sleep, absence of suicidal ideation, disappearance of impulsive obsessions, reduced anxiety, improved mood and affect, and resumption of self-care, work, and contact with her children. One year later, she fully returned to her premorbid state, with gradual tapering of medication and eventual discontinuation of Risperidone and Anafranil. She remains stable on Sertraline 100mg/day.

DISCUSSION

The perinatal period increases the risk of onset or exacerbation of OCD, particularly during the puerperium. Studies in this area are primarily retrospective and indicate a trend towards worsening OCD after childbirth. A systematic review found that 243% of women experienced OCD within 12 months postpartum. Retrospective studies showed that 7% of women developed the disorder postpartum and 50% experienced symptom worsening.

The perinatal period is also a time of increased vulnerability to depression, with approximately 12% of pregnant and new mothers globally experiencing perinatal depression, and 9-4% experiencing clinical levels of comorbid depression.

The etiology of postpartum OCD is largely unknown, likely involving a complex interaction of biological and environmental factors. However, several factors appear to play a role in maintaining postpartum OCD, including:

- Increased responsibility: Pregnancy and childbirth evoke a sudden increase in the sense of responsibility to prevent harm.
- Overestimation of threat
- Misinterpretation and excessive importance of intrusive thoughts: New parents may incorrectly interpret normal intrusive thoughts as highly significant.

Few studies have evaluated the role of multiple pregnancies in postpartum OCD or its exacerbation. Our patient's experience aligns with literature indicating a 5.17-fold higher risk of first-time anxiety disorder diagnosis in women with high-risk pregnancies, such as multiple pregnancies, with OCD being one of the most common psychiatric disorders in these cases.

Clinical observations suggest that postpartum obsessive intrusions can be transient or persistent and may lead to actions designed to prevent disastrous outcomes. These include intrusive and distressing thoughts about harming the infant, and phobic avoidance of situations and stimuli triggering such obsessions.

Untreated OCD can have serious consequences, including impaired mother-child bonding, reduced quality of life, impaired ability to care for the newborn, and poor social functioning, as seen in our patient. Despite these distressing symptoms, women often hesitate to seek professional help due to shame, guilt, and embarrassment. Studies show that patients with OCD tend to delay psychiatric treatment, prolonging the illness and functional impairment.

Cognitive-behavioral therapy (CBT) is recommended for most individuals with OCD during pregnancy or the postpartum period. Pharmacological management is a reasonable alternative for those who

refuse psychotherapy or where it is unavailable, as in our patient's case.

Approximately 40% of OCD patients do not achieve adequate response to SSRIs. Pharmacological strategies for SSRI-resistant OCD include longer SSRI trials, switching to another medication like a serotonin-norepinephrine reuptake inhibitor (SNRI), or augmentation with another medication. Despite extensive literature on the role of neuroleptics in managing OCD, only one study specifically addresses postpartum OCD.

First-line choices often include quetiapine, an antipsychotic with a low side effect profile and useful properties for multiple symptoms (sleep difficulties, depressive symptoms) accompanying OCD, allowing for single-agent use to minimize fetal exposure risk. Quetiapine's high molecular weight limits its transfer into breast milk. Typical starting doses are 25mg/day, titrated to 100-150mg/day based on response and symptom type.

Other atypical antipsychotics can be used, though evidence on augmentation strategies during the perinatal period is limited. Risperidone and aripiprazole have the strongest evidence in non-perinatal populations. Our patient was prescribed risperidone as she had surpassed the immediate postpartum period at the initial consultation.

CONCLUSION

Women are at risk for the onset or recurrence of OCD during the postpartum period. OCD symptoms can be highly distressing and interfere with the mother's ability to provide optimal care for the newborn. Due to the lack of systematic screening for obsessions and compulsions, underdiagnosis or misdiagnosis of OCD is common in the postpartum period.

SSRIs are the most recommended medications for managing moderate to severe OCD. CBT is indicated in conjunction with pharmacotherapy. Antipsychotics may be indicated as adjunctive treatment with antidepressants in SSRI-resistant OCD.

BIBLIOGRAPHIE

1. Riquin, E., Faure, K., Legras, M., Chocard, A. S., Gillard, P., Descamps, P., & Duverger, P. (2015). Troubles psychiques de la grossesse et du post-partum. *La Revue du praticien*, *65*(5), 701-708.
2. Russell, E. J., Fawcett, J. M., & Mazmanian, D. (2013). Risk of obsessive-compulsive disorder in pregnant and postpartum women: a meta-analysis. *The Journal of clinical psychiatry*, *74*(4), 18438. doi: 10.4088/JCP.12r07917. PMID: 23656845.
3. Fairbrother, N., Challacombe, F. L., EA, F. C. R., & Truong, T. T. (2021). Perinatal and postpartum obsessive-compulsive disorder. *Complexities in Obsessive Compulsive and Related Disorders: Advances in Conceptualization and Treatment*, 249.
4. Sharma, V. (2018). Pharmacotherapy of postpartum obsessive–compulsive disorder: a systematic review. *Expert review of Neurotherapeutics*, *18*(12), 925-931.
5. Yakut, E., Uguz, F., Aydogan, S., Bayman, M. G., & Gezginc, K. (2019). The course and clinical correlates of obsessive-compulsive disorder during the postpartum period: a naturalistic observational study. *Journal of Affective Disorders*, *254*, 69-73.
6. Collardeau, F., Corbyn, B., Abramowitz, J., Janssen, P. A., Woody, S., & Fairbrother, N. (2019). Maternal unwanted and intrusive thoughts of infant-related harm, obsessive-compulsive disorder and depression in the perinatal period: study protocol. *BMC psychiatry*, *19*, 1-15.
7. Buchholz, J. L., Hellberg, S. N., & Abramowitz, J. S. (2020). Phenomenology of perinatal obsessive–compulsive disorder. In *Biomarkers of postpartum psychiatric disorders* (pp. 79-93). Academic Press.
8. Nestour, A. L., & Guettier, B. (2009). Phobies d'impulsion en post-partum: syndrome d'alarme ou processus défensif dynamique?. *Enfances & Psy*, (3), 092-106.
9. Blakey, S. M., & Abramowitz, J. S. (2017). Postpartum obsessive-compulsive disorder. *The Wiley handbook of obsessive compulsive disorders*, *1*, 511-526.
10. Sharma, V., & Sommerdyk, C. (2015). Obsessive–compulsive disorder in the postpartum period: diagnosis, differential diagnosis and management. *Women's Health*, *11*(4), 543-552.
11. MacLean, J. V., & Osborne, L. M. (2021). Obsessive-compulsive disorder in pregnant and postpartum patients. *UpToDate. Retrieved March*, *26*, 2023.
12. Thamby, A., & Jaisoorya, T. S. (2019). Antipsychotic augmentation in the treatment of obsessive-compulsive disorder. *Indian journal of psychiatry*, *61*(Suppl 1), S51-S57.