Postpartum Obsessive-compulsive Disorder in a Nigerian Woman: a Case Report and Literature Review

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We report an obsessive-compulsive disorder in a Nigerian woman, which developed 3 months following delivery of a live baby. A 30-year-old woman who delivered a live female baby at a maternity centre was brought to the teaching hospital with vaginal bleeding owing to a retained placenta. She was transfused with 3 pints of blood after placenta evacuation and discharged 3 weeks later, with a packed cell volume of 32%. She had no prior history of psychopathology at discharge but presented at 3 months post-delivery with an obsessive-compulsive disorder. The relevant literature was reviewed. Obsessive-compulsive disorder should be screened for in pregnancy and the postpartum period, because just as in the West it is not rare in this environment. Increased awareness can help prevent or reduce the disability associated with this disorder.

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Introduction

Obsessive-compulsive disorder (OCD) is characterised by obsessions (recurrent, intrusive, and disturbing ideas, thoughts, impulses, or images) as well as compulsions (repetitive behaviours, or mental acts performed according to certain rules or in a stereotyped fashion, designed to reduce discomfort), and may be severe enough to be time-consuming or cause-marked distress or significant functional impairment[1]. The individual who suffers from OCD becomes trapped in a pattern of repetitive thoughts and behaviours that are senseless and distressing, but extremely difficult to overcome. This makes it a potentially disabling condition affecting a person's capacity to function at school, at work, and even at home[2].

There are numerous reports on the association between OCD and pregnancy. Some reports describe OCD during pregnancy[3,4], while others report its occurrence in the postpartum period[5-7]. Earlier literature indicated that pregnancy and the postpartum period was known to influence many psychiatric disorders, such as the affective disorders, psychotic disorders, and anxiety disorders[8-10].

Pregnancy and the postpartum period are reported to be stressful to some women, which may be a risk factor that precipitates or exacerbates OCD[3,11]. The symptoms of OCD in the postpartum period may start within the first 3 weeks of delivery[6]. To our knowledge, postpartum OCD, though common, has not been reported in Nigeria and there are only few reports from sub-Saharan Africa.

Case Report

A 30-year-old primiparous woman was referred for psychiatric assessment from the postnatal clinic on account of 3-month history of worrying and distressing thoughts, undue fearfulness, and fear of knives. The symptoms started about 4 weeks post-delivery after she was discharged from the teaching hospital. She was preoccupied with distressing thoughts on the existence of 'God' which occurred most of the day and on a daily basis. She became fearful at the site of a knife, because she was afraid of injuring herself or her 3-month-old baby. She described the thoughts as 'bad thoughts and blasphemous'. She was aware that the thoughts were not only hers but also senseless, and this made her even more fearful. She avoided going to the kitchen or any other place she could encounter a knife; on average she

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spent 4 to 6 hours daily ruminating over these irrational thoughts. Efforts to resist or ignore the thoughts proved abortive and she said that it took her much longer to do simple basic tasks at home and at work. She acknowledged feeling sad about her present condition but denied losing interest in otherwise usual pleasurable activities, nor did she have any suicidal ideation.

She denied any past or familial history of mental illness, or having any such intrusive thoughts prior to or during the pregnancy. She has a supportive husband and reported no history of abuse, or a history suggestive of an infection or head injury. The patient claimed she had her antenatal care at a primary healthcare centre other than the maternity centre to which she was referred. The antepartum period was uneventful and the pregnancy was carried to term.

She had a spontaneous vertex delivery of a live female baby at a maternity centre and 1 week later she was referred to an obstetrician following a postpartum haemorrhage. She had retained placental products which were removed by suction evacuation and transfused with 3 pints of whole blood. She responded well and was discharged. A month after discharge, she presented to the General Outpatient Department and was started on amitriptyline (a tricyclic antidepressant) 50 mg daily by her family physician, but over the next 2 months there was no improvement in her behavioural symptoms. In the teaching hospital where she was referred, she was diagnosed to have postpartum OCD; she scored 28 on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS; 13 and 15 on the Obsession and Compulsion subscales of Y-BOCS). She was commenced on paroxetine (a selective serotonin reuptake inhibitor [SSRI]) based on availability; the starting dose was 20 mg daily which was gradually increased to 40 mg daily over 8 weeks. She was also given behavioural therapy in the form of thought stopping by a simple technique of wearing a rubber band around the wrist, which she asked to snap in a mild-to-moderate manner, whenever she had her abnormal thoughts.

After about 7 weeks of treatment, she reported a significant improvement, and only has abnormal thoughts once in a while and was able to use the kitchen without any fear and was also able to return to work.

Discussion

OCD may not be recognised or misdiagnosed in many cases. Because of its protean forms, OCD is often not recognised or is misdiagnosed, which also applies to the postpartum form of this disorder[12]. Its estimated prevalence in pregnancy or the postpartum period ranges from 3% to 40%[3,13-17]. This is higher than in the general population[18,19]. However, one prospective study of OCD in pregnancy noted a prevalence of 1.2%, which was similar to that in the general population[20].

The phenomenology of postpartum OCD is directed or related to the fetus or the newborn[11,21], of which the situation was similar to the case described in this report. At presentation she harboured thoughts of harming her baby with a knife. Such ruminations are highly intrusive and disturbing and in severe cases may lead to abandonment or neglect of the baby, out of fear of hurting the baby.

The role of stress and major life events in the pathogenesis of OCD is well-documented; pregnancy and childbirth being not just stressful periods but major life events[11]. Neziroglu et al[3] reported a 52% prevalence of OCD in primigravid women, although it is well-reported in multiparous women too. Difficult delivery, problems before conceiving or pre-existing anxiety disorder, and unsupportive spouse or family are also linked to the occurrence or precipitation of OCD during the postpartum period[15].

Prospective studies have shown that a prenatal anxiety disorder is a strong risk factor for developing postnatal depression[22] and this in turn causes poorer obstetric outcomes and an array of behavioural problems in exposed infants[23]. Other problems include disturbance in mother-infant interaction leading to the neglect of the newborn and associated failure-to-thrive or even infanticide[24]. Like other psychiatric disorders during pregnancy and postpartum periods, profound changes in hormones such as oestrogens and progesterone may be responsible for the development of OCD during these periods[25]. Such hormones disrupt the activity of serotonin, a neurotransmitter implicated in the development of OCD and may explain the effectiveness of drugs acting on serotonin reuptake. The uses of SSRI drugs as well as behavioural therapy or cognitive-behavioural therapy are effective treatments of postpartum OCD.

Although many psychiatric disorders like depression and psychosis have been studied and recognised in pregnant women and during the postpartum period, there has been less focus on OCD in this very special population. There is evidence that some women suffer from new-onset OCD or that it exacerbates during pregnancy or during the postpartum period. The condition could be deleterious to

the fetus, mother, or the family at large. Effective treatments are available and it is important for healthcare providers to recognise the condition and institute appropriate treatment. An epidemiological study in this part of the world is necessary to explore the prevalence and pattern of OCD in this special population and to identify transcultural variations, if any.

Declaration

No conflicts of interest were declared by the authors.

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