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Peripartum-onset of obsessive-compulsive disorder in women with bipolar disorder – A case series

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ABSTRACT

Both pregnancy and the postpartum period are times of high risk for the occurrence of obsessive-compulsive disorder (OCD). We describe first onset of OCD during or after pregnancy in three women with bipolar II disorder. Two cases had pre-existing diagnosis of bipolar II disorder, and one woman with recurrent major depressive disorder had simultaneous onset of hypomania and obsessive compulsive symptoms in the postpartum period. Clinical challenges in the identification and management of bipolar disorder and comorbid OCD in the peripartum period are discussed.

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1. Introduction

Both pregnancy and the postpartum period are associated with the onset or recurrence of a variety of psychiatric disorders in women (Abramowitz, Schwartz, Moore, & Luenzmann, 2003; Chaudron & Nirodi, 2010). Research focus so far has been on mood disorders but there is emerging evidence that the peripartum period is also a time of increased risk for the occurrence of obsessive-compulsive symptoms, and obsessive-compulsive disorder (OCD). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) allows the use of the 'with peripartum onset' specifier to characterize episodes of major depressive disorder and bipolar disorder. However, there is acknowledgement in the text that "onset or exacerbation of OCD, as well as symptoms that can interfere with the mother-infant relationship (e.g., aggressive obsessions leading to avoidance of the infant) have been reported in the postpartum period" (American Psychiatric Association, 2013).

Pregnant and postpartum women are more likely to experience OCD compared to the general population. A meta-analysis estimated the prevalence of OCD during and after pregnancy to be greater than the estimated prevalence in the general population (2.07 and 2.43 versus 1.08 percent respectively) (Russell, Fawcett, & Mazmanian, 2013). Compared to OCD in men, women are also more likely to have symptoms in the cleaning dimension and greater comorbidity with eating- and impulse-control disorders (Castle, Deale, & Marks, 1995; Mathis et al., 2011; Pigott, 1999). Women are also more likely to have higher depression and anxiety scores (Torresan et al. 2009). The clinical presentation of OCD in pregnant and postpartum women is characterized by obsessions concerning contamination, or aggression toward the child, compulsive cleaning, avoidance of the child, or excessive checking on the child (Russell et al., 2013). The OCD can occur alone but is usually accompanied by depressive symptoms or major depressive disorder in the peripartum period (El-Mallakh & Hollifield, 2008).

Untreated OCD has long-term effects on both mothers and their children. Mothers are unable to enjoy their time with their children, and have high levels of concern about the impact of their anxiety disorder on their parenting ability (Challacombe & Salkovskis, 2009). Children of women with OCD have been found to suffer more from a range of internalizing disorders, including broadly defined OCD compared with controls (Challacombe & Salkovskis, 2009, 2011).

OCD is a common comorbid disorder in patients with bipolar disorder (Amerio, Odone, Liapis, & Ghaemi, 2014). In the National Comorbidity Survey Replication (NCS-R) an estimated 26% of respondents with bipolar I disorder and 22% with bipolar II disorder had a lifetime diagnosis of OCD (Merikangas et al., 2007). The NCS-R also provided data on the temporal association of the two disorders with OCD developing first in 37% of patients, mood episodes developing first in 52% of patients, and both disorders

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developing in the same year in 11% of patients (Ruscio, Stein, Chiu, & Kessler, 2010).

There are no data on the peripartum onset of OCD in women with bipolar II disorder. We present three such cases – two women with bipolar II disorder who had first-onset of OCD during pregnancy, and one woman with recurrent major depressive disorder who had simultaneous onset of OCD and hypomania in the postpartum period. Clinical challenges in the identification and diagnosis of peripartum OCD in women with bipolar disorder are discussed. We also make suggestions for pharmacological management of OCD and bipolar disorder in peripartum period.

2. Case vignettes

At our perinatal clinic we provide consultations and follow-up to approximately 400 women annually. Women are referred by obstetricians, family physicians, midwives, nurse practitioners, and public health nurses. With the use of a detailed questionnaire we routinely obtain information about the role of reproductive events in the onset and exacerbation of psychiatric disorders, psychiatric comorbidities, family history of psychiatric illness, and past treatments. We also try to gather collateral information from family members. Patients referred during pregnancy are routinely seen prior to, and immediately after delivery in order to identify emerging symptoms of psychiatric disorders.

Table 1 describes the clinical characteristics of the three women who had first-onset of OCD during, or after pregnancy. These women met the DSM-5 criteria for both bipolar II disorder and OCD.

2.1. Case 1

A 32-year old woman with a history of bipolar II disorder, panic disorder and polysubstance use disorder was first assessed at our clinic during the early part of her first pregnancy. She had just been discharged from a psychiatric hospital after spending 8 weeks for treatment of depression and posttraumatic stress disorder Upon finding out about the pregnancy she decided to taper off her medications including desvenlafaxine 100 mg, trazodone 100 mg, lamotrigine 50 mg and cyproheptadine 4 mg daily. She did not have any symptoms of depression, hypomania or anxiety during the rest of pregnancy but during the third trimester she began to take frequent showers, and started spending a lot of time cleaning her house. Previously she did not have any interest in housekeeping. This change in her behavior was noted by her mother who was residing with her at that time. There were no accompanying hypomanic or depressive symptoms and she reported her mood as being quite stable. Due to the clear history of mood instability following the use of antidepressants she was not interested in retrying desvenlafaxine or trazodone but agreed to a trial of quetiapine 25 mg daily. The OCD symptoms resolved within a month as evidenced by a drop in the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (Goodman, Price, & Rasmussen, et al., 1989) score from 21 (moderate) to 5 (sub-clinical) in one month. There were no recurrences of OCD or mood episodes in the postpartum period. She has remained symptom free for approximately 18 months and continues to take quetiapine 50 mg daily.

2.2. Case 2

A 28-year old married woman who had received regular follow-up care at our clinic since she was first diagnosed with bipolar II disorder 11 years earlier. She had first onset of depression and hypomania within one year of menarche. Family history was positive for bipolar II disorder and OCD in first-degree relatives.

Table 1
Demographic and clinical characteristics.

Case number	Age (years)	Parity status	Time of onset of OCD[a]	OCD symptoms	Time of onset of BD[b]	Other comorbid psychiatric disorders	Family history of psychiatric illness	Medications
1	32	Primi[c]	Third trimester	Washing/cleaning compulsions	Menarche (14 years)	PD[d], SUD[e]	BD, MDD[f], SUD	Quetiapine 50 mg
2	29	Primi[c]	Third trimester	Intrusive thoughts and images	Menarche (15 years)	PD[d]	BD OCD	Quetiapine 375 mg and lamotrigine 150 mg
3	37	Multi	Postpartum	Washing/cleaning/ checking compulsions	Postpartum (first week after delivery)	None	BD	Quetiapine 100 mg and clonazepam 0.5 od prn

[a] Obsessive Compulsive Disorder;
[b] Bipolar disorder;
[c] Primiparous;
[d] Panic disorder;
[e] Substance use disorder;
[f] Major depressive disorder

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