CLINICAL CASE

EXISTENTIAL OBSESSIONS: A CASE REPORT OF A POSTPARTUM OBSESSIVE COMPULSIVE DISORDER

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ABSTRACT

Existential obsessions (EO) are an uncommon type of obsessive thought, also described as philosophical or ruminative obsessions. In Obsessive Compulsive Disorder (OCD) with postpartum onset, the clinical picture frequently counts with intrusive thoughts about infant harm and compulsions of verification. We report an unusual case of a patient with postpartum onset OCD, who presented with EO. The case highlights the importance of actively exploring the symptomatology, for an accurate differential diagnosis. In particular, in the postpartum period, a correct psychiatric diagnosis has significant therapeutic and prognostic implications.

Key words. Obsessive Compulsive Disorder | Postpartum | Existential Obsessions | Psychopathology

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RESUMEN

Las obsesiones existenciales (OE) son un tipo poco común de pensamiento obsesivo, también descrito como obsesiones filosóficas o reflexivas. En el Trastorno Obsesivo-Compulsivo (TOC) con inicio en el posparto, el cuadro clínico frecuentemente presenta pensamientos intrusivos sobre el daño infantil y compulsiones de verificación. Presentamos un caso inusual de una paciente con TOC de inicio posparto, que presentaba OE. El caso destaca la importancia de explorar activamente la sintomatología, para un diagnóstico diferencial acertado. En particular, en el posparto, un diagnóstico psiquiátrico correcto tiene importantes implicaciones terapéuticas y pronósticas.

Palabras clave. Trastorno obsesivo compulsivo | Posparto | Obsesiones existenciales | Psicopatología

INTRODUCTION

OCD is characterized by recurrent obsessions (intrusive, unwanted, and uncontrollable thoughts/images) and compulsively repeated behaviours/rituals. It is a common psychiatric entity (average prevalence of 0.5-3%)[1-3]. The diagnosis is frequently delayed, mainly due to patient's shame about core symptoms[4]. Besides, the sudden onset is possible, mostly after a stressful event or during pregnancy and/or postpartum period[5]. The main psychopathological features reported on postpartum-onset OCD are intrusive thoughts about infant harm and verification compulsions[6,7]. Although perinatal period is an high-risk time for OCD onset, the postpartum incidence is not well studied, ranging from 4% to 11%[7-8].

In a phenomenological perspective, the concept of doubt has been regarded as a core characteristic of OCD[9,10]. Historically, Du Salle nominated OCD as *Folie du Doute*. William James referred to "questioning mania" and Janet expressed a "lack of certainty" in OCD patients. Some authors have inclusively advocated an association between the severity of doubt and a poor prognosis[10-12]. If doubt is a core characteristic of obsessive thought's form, it is also part of its content in EO. EO are intrusive thoughts about questions which cannot be possibly answered, due to its metaphysical nature[10,11]. These questions are purely philosophical, involving the meaning or reality of life, the existence of the universe or even one's own existence. The patient cannot stop trying to solve the issues, formulating sequential hypotheses in his/her mind, and endlessly searching for answers. This mental activity can take hours, and usually leads to extreme anxious and depressed states. This rare kind of OCD is called by some authors as purely obsessive OCD[9,11]. It is often misdiagnosed as depressive or generalized anxiety disorders, mainly due the fact EO are not predictive of any certain compulsive behaviour. However, the truth is EO frequently lead to internal compulsions, provoking ritualized thoughts, which phenomenologically are compulsions, more difficult to identify, and often underdiagnosed[11-13].

We report an unusual case of postpartum onset OCD with EO.

CASE REPORT

A 25-year-old woman, born in Cape Verde, living in Portugal for several years, presented to the Emergency Department (ED) with sadness and anxiety started in the previous week. She was a married woman, who lived with her husband, her six-year-old son and a 4-week-old newborn daughter. She had a high school academic degree, and worked as an hotel maid. She had no previous follow-up in Psychiatry, although she referred aggressive obsessive ideas

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after the birth of her first child, for a short period of time, and with spontaneous remission without medical/psychological intervention. She had no relevant personal and familiar pathological history. She did not take any usual medication or psychoactive substances. Her daughter's delivery had been uneventful, and the new-born was healthy. She was referred by her General Practitioner, whom she had visited that morning. She complained about *anxiety, fear of being alone* (*sic*), and *a big confusion in my head* (*sic*). In this context, she described permanent existential questions, as *What am I doing here? Why is there life and death?... or why is there this or that...simple things?* (*sic*). She claimed to spend a lot of time trying to solve these issues. Was very distressed and anxious about these thoughts, feeling unable to properly take care of her daughter, feeling sad, with frequent crying, feeling uncomfortable and strange: *I don't know why I think about this, I never thought about these issues before... "*(*sic*). Her mental state examination (MSE) at the ED was described as: orientated at time, space and person; sustained attention; syntonic contact, proper posture; mostly provoked and hypophonic speech, but coherent; ruminative thinking; depressed mood with emotional lability; preserved insight. She was referred to a Psychiatry consultation, with a working diagnosis of postpartum depressive episode (PPD), and was medicated with sertraline 50 mg/day.

She returned to the ED ten days later, due to lack of improvement. She described worsening of anxiety, initial and terminal insomnia, and more intense *weird thoughts* (*sic*), exemplifying: *Why am I like this? Why people exist? Why God created people?* (*sic*). Consequently, she felt *confused* (*sic*), she feared the thoughts would never end, and expressed she couldn't live in that way, although she had not an active suicidal ideation or plan. The MSE was similar to the previous one. The working diagnosis of PPD was maintained, and sertraline was increased to 100 mg/day.

At the first Psychiatry consultation, three weeks later, she showed slight improvements in mood and anxiety, although she maintained the described existential worries, with an important functional impact. Given her more stable affective state, it was possible to better explore the phenomenology of the existential obsessive thoughts. In fact, they had an intrusive character, appearing for the first time a few days after delivery. Its content was not related to any subject of interest to the patient, although, as soon as they emerged, they came with an intense need of solving them and of clarifying the doubt. Their impossible resolution caused great distress to the patient. The feelings of sadness, worthlessness, inability to care of the new-born and anxiety arose secondarily to the obsessions. She spent a lot of time trying to mentally solve the doubts, formulating other thoughts, creating internal compulsive phenomena.

The diagnosis was changed to OCD with postpartum onset. Sertraline was titrated until 200 mg/day and adjuvanted with an antipsychotic (olanzapine until 5mg at bedtime). With these pharmacological regimen, the clinical picture progressively improved in the next two months. There was a significant decrease in the obsessive thoughts' frequency, and, knowing their nature, the patient was capable to integrate some psychoeducational strategies provided to deal with them. Her mood became euthymic, and her ability to take care of her baby was restored after five months from initial evaluation.

DISCUSSION

The case highlights the importance of a rigorous research on the psychopathology that underlies a clinical picture, and the significance of the distinction between primary and secondary psychopathological phenomena. In this patient, the altered affective dimension, initially ascertained, was secondary to the egodystonia of the OCD symptoms. This scrutiny had crucial practical implications. The simple fact the patient understood the nature of her symptoms was, in itself, a factor of relief and good adherence to the therapeutic project.

A diagnosis of PPD, firstly raised, requires monitoring for maniac symptoms, since it is significantly predictive of bipolar disorder (BD)[7,14-15]. On the contrary, the treatment of postpartum OCD demands the titration of high doses of SSRI's, which can be assertively done if the clinician is free from the thought of a possible BD. Another important diagnostic distinction is from postpartum psychosis (PPP). Like PPD, PPP is also highly predictive of BD[7,16]. The differentiation between PPP and postpartum OCD has also an important behavioural predictive value: in OCD there is fear and doubt in relation to acting on the baby, in PPP stepping to act is a real possibility[16-18]. In prognostic terms, although these three diagnoses have a favourable resolution, PPD and PPP require closer long-term monitoring, due to the probability of BD development[17,18]

Finally, the psychoeducational/psychotherapeutic strategies to OCD are quite different from those to depression and psychosis. The right diagnosis is fundamental to this approach.

CONCLUSION AND RECOMMENDATIONS

The article describes a case of postpartum OCD with EO. The case is unusual, both because of its postpartum onset as because of the presented symptomatology. It highlights the heterogeneity of OCD obsessive content, and the possibility of atypical presentations. In the postpartum period there are two potentially serious conditions to be taken into account:

PPD and PPP (both predictive of BD). An accurate diagnosis has important therapeutic and prognostic implications.

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