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LETTERS TO THE EDITORS

Cognitive-behavioral therapy as an effective, safe, and acceptable intervention for OCD during pregnancy

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We read with great interest Uguz's[1] review of pharmacotherapy of obsessive-compulsive disorder (OCD) during pregnancy. Given the relative frequency with which OCD, as well as other psychiatric disorders, present during pregnancy, establishing evidence-based therapies that are safe and acceptable is of critical importance.

Within the strengths of this article (e.g., clinical relevance to a vulnerable population), there was limited mention of cognitive-behavioral psychotherapeutic interventions for OCD during pregnancy. This is of particular concern for two reasons. First, cognitive-behavioral therapy (CBT) with exposure and response prevention is the single most effective intervention available for adults with OCD, demonstrating superiority as a monotherapy both to serotonin reuptake inhibitor (SRI) medications and to other forms of psychotherapy in terms of response rates and degree of improvement.[2] Based on the strength of this evidence, CBT is recommended as a first-line intervention for those with OCD regardless of pregnancy. As an augmentation approach to SRIs, CBT has demonstrated greater reduction in OCD symptoms than risperidone, which did not differ from placebo.[3] Preliminary efficacy data, similar in quality to that for SRIs during pregnancy, supports this approach in working with women in the postpartum period.[4] Given the similarity of content, onset, and development patterns of OCD in pregnancy and the postpartum, these results should be extrapolatable.

Second, the side effect profile of many medications, especially antipsychotics (i.e., weight gain, increased appetite), makes their use a last resort in this population, and some women may find pharmacotherapy an undesirable treatment approach. More concerning are the effects of SRIs on fetal development as discussed by Uguz,[1] including increasing evidence of the role of fluoxetine and paroxetine in fetal defects and high risk of poor neonatal adaptation syndrome, whereas for other SRIs, the data on this possible linkage are few and inconsistent. The effects of antipsychotics on the developing fetus remain unexplored and not adequately evaluated at this time to recommend use. As reviewed above, cognitive-behavioral interventions have demonstrated sound efficacy across numerous studies for reducing obsessive-compulsive symptoms in adults, with a negligible side effect profile and no theoretical reason why it might impact the developing fetus. Thus, clinicians should base treatment decisions on a complete assessment of all available therapies; when data are limited for OCD during pregnancy, extrapolating from the treatment literature more broadly may be appropriate to achieve the most effective and safe treatment of the affected individual and developing fetus, since pregnancy does not appear to be related to poor response to CBT.[5]

In short, caution should be used in incorporating conclusions from this report into clinical practice, given the strength of the current literature supporting pharmacotherapy during pregnancy (relative to CBT) and the associated side effect profile. Behavioral interventions are an important treatment component for this population, and the psychiatric care of pregnant women should be multidisciplinary, involving physicians, psychologists, and other allied health professionals. Collectively, the limited available data on pharmacological and behavioral interventions highlight the need for further clinical trials investigating potentially viable therapies that are safe, effective, and acceptable.

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Disclosure

The authors report no conflicts of interest.

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