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Jan Fawcett, MD
Editor
PSYCHIATRIC ANNALS
Cognitive-Behavioral Therapy for Obsessive-Compulsive Disorder in Pregnancy

Dawn L. Flosnik, MD; and Eindra Khin Khin, MD

PRESENTATION

A 31-year-old, married, employed white woman was referred by her obstetrician to a specialty perinatal psychiatric disorders clinic for anxiety, noted during the 27th week of her first pregnancy.

Despite never having been diagnosed with a psychiatric disorder, the patient described experiencing frequent violent and intrusive thoughts for several years. For example, when riding in an elevator with a pleasant colleague, she kept thinking he was going to push her into the doors. In addition, at work, even when the restroom was not crowded, she often waited for a particular stall because the others “felt wrong” somehow. She found this behavior “ridiculous” as her pregnancy continued, when she was using the restroom several times a day.

Another quality she found odd was her intense need to use white instead of more readily available yellow paper for writing assignments. She would “waste time” at work looking for white paper. If she could not find it or had to write on yellow paper, she became agitated and anxious. Finally, she found it very difficult to change her daily walking route; even the thought of changing routes provoked great anxiety. Overall, the patient found her obsessions and compulsions terribly abnormal, shaming, and embarrassing. She had rarely spoken about them with anyone.

No depressive, manic, or psychotic symptoms were elicited. The patient also denied specific phobias, somatic concerns, or overt suicidal/homicidal thoughts. She did not use tobacco, alcohol, or illicit drugs. Her only medications were an omega-3 free fatty acid supplement and prenatal vitamins. She denied any significant family psychiatric history.

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TREATMENT

The patient was treated by the clinician who evaluated her. The clinician first reviewed the criteria from the DSM-IV TR with the patient and initiated a discussion of the pathophysiology and phenomenology of OCD. The patient was given an explanation that obsessions (or “fears”), like superstitions, are shaming and hidden, and that compulsions are actions meant to neutralize the obsessions. She experienced relief from learning that she had a real diagnosis and that others suffer similar symptoms.

The clinician then linked her over-developed need to be perfect and her under-developed capacity for spontaneity to the OC symptoms and enlisted her in cognitive-behavioral therapy (CBT). She was told that therapy would focus on behavioral change first, with the ultimate goal being a change in cognition.

Therapy began with a discussion of anxiety as involving a flood of neural catecholamines, which stresses the brain. The brain does not want to “waste” precious energy on sustaining this anxiety. Therefore, to habituate to this anxiety, one must sit with the anxiety. It will go away. This concept was explained in real-world examples: If a person is in a room with a bad smell for a length of time, that person’s brain will ultimately stop “paying attention” to the smell after awhile.

Besides the idea of habituation, therapy involved discussing obsessions and compulsions as being habits — bad habits — that must be changed. Over time, as the patient practiced sitting with her anxiety, she would learn to tolerate uncomfortable emotions. Eventually, the therapist predicted her anxiety would decrease and the changes would be integrated as new, healthier habits. This process was analogous to regular exercise. Someone who starts exercising after not being active will experience sore muscles. As a body gets used to new routines, exercising gets easier.

To employ these concepts, the patient learned she would have to resist the impulse to give into her obsessions. She and the therapist decided to start by working with the obsessions or compulsions that bothered her least, as these would likely be the easiest to treat. She was least bothered by the need to use the same bathroom stall; her first therapy homework was to use a different stall every day, i.e., to adopt a new “habit.” If she experienced anxiety initially when trying a stall, something which the therapist predicted would be highly likely, she was to endure it and know that she would habituate and that the anxiety would eventually go away.

Another concept, “collaborative empiricism,” was introduced early in the therapy. The patient described cognitive schema reflexively characterizing aspects of her world as “gross, bad, and wrong,” (to be avoided) or “clean, good, and right” (to strive for). The therapist challenged her to “look for the evidence” supporting these statements. If things are either good or bad, what really makes them so? For example, wearing jeans to the office is wrong, but only because it is disrespectful, not gross or bad.

The patient was guided to go through her obsessions and compulsions systematically and look for evidence justifying her automatic classifications. She naturally found very little evidence supporting the idea that one stall or one color of writing paper is good and another is bad. Through habituation, habit modifications, collaborative empiricism, and behavioral change, her obsessive thoughts changed to thoughts that nothing is inherently “right” or “wrong.” As expected, cognitive change followed behavioral change and explicit attention to modifying the underlying schema.

It was important that the therapist articulated realistic expectations for the treatment. The patient tracked her anxiety in a notebook when working through her obsessions and compulsions, rating her anxieties before and after making behavioral changes on a scale of 1 (minimal) to 10 (severe). The therapist explained that it would be unrealistic to expect all anxiety to go away with the behavioral change, but the patient could expect that anxiety would improve from a score of 8 to a score of 3 or so. The patient agreed this degree of change would improve her quality of life. Her Edinburgh Postnatal Depression Scale score decreased from 17 to 10 after 6 months of psychotherapy. Similarly, her WHO Index of Well-Being score improved from 10 to 19 in the same time period.

Treatment also included sertraline 37.5 mg taken orally each morning. The use of antidepressants or any medication in pregnancy and postpartum involves simultaneously weighing risks and benefits to mother and to fetus or child. These calculations rely on animal studies.
and epidemiological data, rather than placebo-controlled human trials. Nevertheless, the data are relatively reassuring about the generally low risk of selective serotonin reuptake inhibitors (SSRIs) in pregnancy. They also suggest that maternal stress may lead to preterm delivery, low birth weight, and developmental delays in an infant.\(^1\)\(^2\)

The patient suspended therapy for a month at the time of delivery. Upon her return, she brought the baby to her sessions and appeared to be enjoying motherhood. She had continued to do CBT homework, on her own and without prompting. For example, when taking her daily walks with the baby, she changed the route. In one of her final sessions, she reported, “You’d be so happy with me! I used yellow paper the other day to take notes on something I’m working on. And I was okay with it!”

**DISCUSSION**

OCD is characterized by the experience of intrusive and inappropriate recurrent thoughts, impulses or images (obsessions) that may or may not be accompanied by repetitive behaviors and/or mental rituals (compulsions). The overall lifetime prevalence of OCD in the general population is estimated to be 1% to 2%\(^3\)\(^4\). Of note, in a recent small pilot study, 29% of pregnant women in the sample met criteria for OCD based on the Structured Clinical Interview for DSM-IV (SCID), suggesting that the prevalence of this disorder in pregnancy may be more common than generally thought.\(^5\)

Additionally, OCD is known to occur in women during the postpartum period, ranging in incidence from 13% to 39%.\(^6\)\(^7\)

A clinical study investigating postpartum OCD employed CBT intensively delivered during a 2-week period in a series of six cases. In this study, all mothers reported significant benefits in terms of their own OCD symptoms and in parenting in general. Improvements on both self-report and clinician-rated measures were sustained at 3- to 5-month follow-up.\(^8\)

Another recent study showed that the incorporation of a CBT-based prevention program for pregnant women with obsessive-compulsive symptoms into childbirth education classes significantly decreased the women’s levels of obsessions and compulsions in the postpartum period compared with those of the control group.\(^9\) With the patient discussed in this case, the implementation of treatment during her pregnancy allowed her to gain the skills to manage her symptoms, skills she could employ on her own during the postpartum period.

Despite the generally low risk associated with the use of SSRIs in pregnancy, many patients still shy away from treatment with psychotropic medications. CBT has been shown to be both efficacious and effective in the treatment of OCD,\(^10\) making it a valuable alternative to psychopharmacological interventions in pregnancy.

**REFERENCES**


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