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A pilot randomized controlled trial of time-intensive Cognitive Behaviour Therapy for postpartum OCD: effects on maternal symptoms, mother-infant interactions and attachment

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Abstract

Background: There is increasing recognition that perinatal anxiety disorders are both common and potentially serious for mother and child. OCD can be triggered or exacerbated in the postpartum, with mothers reporting significant effects on parenting tasks. However, there is little evidence concerning their effective treatment or the impact of successful treatment on parenting.

Methods: 34 mothers with OCD and a baby of 6 months old were randomized into either time-intensive cognitive behaviour therapy (iCBT) or treatment as usual (TAU). iCBT took place after randomization at 6 months postpartum and was completed by 9 months. Maternal symptomatology, sensitivity in mother-infant interactions and parenting were assessed at baseline and reassessed at 12 months postpartum. At 12 months attachment was also assessed using Ainsworth's Strange Situation Procedure. A healthy control group of mothers and infants (n=37) underwent the same assessments as a benchmark.

Results: iCBT was successful in ameliorating maternal symptoms of OCD (controlled ES=1.31-1.90). However, mother-infant interactions were unchanged by treatment and remained less sensitive in both OCD groups than a healthy control group. The distribution of attachment categories was similar across both clinical groups and healthy controls with approximately 72% classified as secure in each group.

Conclusions: iCBT is an effective intervention for postpartum OCD. Sensitive parenting interactions are affected by the presence of postpartum OCD and this is not improved by

successful treatment of OCD symptoms. However, the overall attachment bond appears to be unaffected. Longitudinal studies are needed to explore the impact of postpartum OCD as the child develops.

Key words: Postpartum, obsessive-compulsive disorder, randomized controlled trial, cognitive behaviour therapy, mother-infant interactions, attachment

Introduction

Anxiety is a common source of perinatal psychiatric morbidity and may be particularly prevalent in the postpartum period (Stuart et al., 1998; Paul et al., 2013). In addition to increased general anxiety, specific anxiety disorders also appear to be very common in the postpartum (Wenzel, Haugen et al. 2005) and they are also frequently co-morbid with depression (Heron et al., 2004; Miller et al., 2006). However, anxiety disorders can be overshadowed by the presence of depression and can therefore remain undiagnosed (Matthey et al., 2003; Austin et al., 2010) or can be misdiagnosed as depression or psychosis (Challacombe and Wroe, 2013). The relatively raised prevalence and diagnostic overshadowing are important as there are well defined and supported treatments for specific anxiety disorders which may as a result not be accessible or promoted in the perinatal period. Untreated anxiety can have negative and long term consequences for mother and child (Glasheen et al., 2010; O'Donnell et al., 2014).

Obsessive-compulsive disorder (OCD) is a well-defined anxiety disorder that has been increasingly identified as being triggered or exacerbated in the perinatal period (Neziroglu et al., 1992; Williams and Koran, 1997; Maina et al., 1999). Accruing evidence suggests that this is a particularly common problem in the postpartum, with estimates of prevalence ranging from 0.7-11.1% with a median of 2.7% (Wenzel et al., 2005; Kitamura et al., 2006; Navarro et al., 2008; Zambaldi et al., 2009; Miller et al., 2013). This compares with 1.2% in the general population (Torres et al., 2006). Although OCD and depression are distinct disorders, they can be comorbid or features of each can co-occur and interact in the

perinatal period (Challacombe et al., 2016; Miller, Hoxha, Wisner, & Gossett, 2015), as at other times (Torres et al., 2006).

There is abundant evidence that OCD can be a very debilitating disorder. It is known to significantly affect quality of life for the individual and those around them (Bobes et al., 2001; Olatunji et al., 2007; Albert et al., 2010; Subramaniam et al., 2012). Families often become involved in compulsive rituals and avoidance or significantly adapt family life to the demands of the disorder (Stewart et al., 2008). Quality of life appears to be affected by OCD during pregnancy (Gezginc, Uguz et al. 2008). In the postpartum, sensitive mother-infant interactions and parenting are compromised, which may be driven by associated depressive symptoms (Challacombe et al., 2016). However, it remains unclear whether successful treatment can ameliorate this impact or if, as in the case of depression, more targeted treatments are required (Milgrom et al., 2006; Gunlicks and Weissman, 2008). There is no specific evidence on attachment in perinatal OCD and conflicting evidence that attachment is affected by maternal anxiety disorders (Manassis et al., 1994; Warren et al., 2003).

Cognitive behaviour therapy (CBT) has become one of the main lines of treatment for OCD. It has been shown to be effective in a number of studies (Nakatani et al., 2005; Simpson et al., 2013, Olatunji et al., 2013; Ost et al., 2015) with a recent meta-analysis estimating post treatment effect sizes of 1.39 (Hedges g) and at follow up of 0.4 (Hedges g) (Olatunji et al., 2013) and 1.31 in a second meta-analysis (Ost et al., 2015). Mean refusal and dropout rates for CBT for OCD are 15% (Ost et al., 2015). There is little evidence beyond case studies and

series as to its application in perinatal populations, which may affect case management (Marchesi et al., 2016). Case literature indicates that CBT is a potentially useful and acceptable treatment for perinatal OCD, for women who may also prefer not to take medication whilst pregnant or breastfeeding (Christian and Storch, 2009; Challacombe and Salkovskis, 2011). Modifications such as delivering the treatment intensively (i.e. over a shorter time-frame) may be particularly useful in enhancing access to treatment for women with young children. In the UK comparable results were found between weekly and intensively delivered treatment (Oldfield et al., 2011). This implies that recovery could be facilitated within a shorter time, thereby minimizing any impact on parenting and the mother-infant relationship.

One study (Challacombe and Salkovskis, 2011) reported on a consecutive series of six women treated with intensively delivered CBT (comprising twelve hours over two weeks), delivered in the participants home where possible (in 4/6 cases). All women showed some improvement with an average reduction on the YBOCS of 19 points after two weeks which was maintained at 1-3 month follow up. The intensive and predominantly home-based CBT was rated by mothers as highly acceptable and helpful for parenting, although objective parenting data was not collected.

The primary questions addressed in the current study were whether intensive CBT was effective compared with treatment as usual and secondly, whether any improvement in symptoms was associated with differences in parenting variables including mother-infant

interactions, attachment and related measures such as parenting self-efficacy.

Method

The study was approved by the Lewisham Research Ethics Committee (08/H0810/18).

Participants

34 mothers with OCD with a baby of less than six months old were recruited from a range of sources as a sample of convenience. The study was advertised via UK based OCD service user networks and parenting websites as well as within local clinical services. Exclusion criteria were: OCD not the primary diagnosis, psychosis, alcohol or substance abuse, twins, refusal to be videotaped. 6 mothers were excluded from the study after an initial telephone screening interview (twins (n=1); refusal to be taped, could not attend for treatment (n=5)). A healthy comparison group of 37 mothers was recruited from community antenatal clinics, fully described in (Challacombe et al., 2016), who were assessed using the same procedures.

Measures

Structured clinical interview for DSM-IV (SCID-IV, First, Spitzer et al. 1995). This semi-structured interview is used to establish DSM-IV diagnoses (APA, 1994). The SCID has been shown to have acceptable reliability (Segal, Hersen et al. 1994). Most major categories have kappas of 0.6 or above (Williams, Gibbon et al. 1992).

Yale-Brown Obsessive-Compulsive Scale (YBOCS; Goodman et al., 1989).

The YBOCS is a clinician administered interview to establish OCD symptom severity over the preceding week. Convergent validity of the measure with other clinician rated measures

such as the CGI are reasonable (r=0.74). Inter-rater reliability correlations have been reported as r=0.86-0.97 for individual items and r=0.98 for total scores (Goodman et al., 1989, Woody et al., 1995).

Obsessive Compulsive Inventory-Revised (OCI; Foa et al., 1998). This is a 42–item self-report inventory concerning symptoms of OCD composed of seven subscales (washing, checking, doubting, ordering, obsessing, hoarding and mental neutralising. The internal consistency for the full scale is high (0.86-0.95), whilst it is satisfactory for the subscales (>0.7, apart from neutralising). The OCI has good test-retest reliability for total scores, and satisfactory reliability for subscale scores. The OCI also shows good discriminative validity and is reliable to measure change in symptoms over time (Abramowitz et al., 2005). The distress scale only was used for this study.

Depression, Anxiety and Stress Scale (DASS; Lovibond and Lovibond, 1995). The DASS is a 42-item self-report questionnaire designed to measure states of depression, anxiety and tension/stress. It has been widely used in perinatal populations. Internal consistency for each scale was Depression 0.91; Anxiety 0.84, Stress 0.9, and the three factors have been found to be distinct (Lovibond and Lovibond 1995).

Social Support Questionnaire (PSSS; Marshall and Barnett, 1993). This is an 11-item self-report measure assessing the sharing of concerns, intimacy, opportunity for nurturance, reassurance of worth and assistance or guidance. Items are scored from 1 (‘none of the time’) to 6 (‘all of the time’) according to the respondent’s experiences over the past month, and a total score is then calculated. Cronbach's alpha was reported as .91. Test-retest correlation over 4 months is .68. It was found to correlate with depression ($r = -0.38$, $p <$

.001), anxiety (r = -.23, p < .001) and physical health as measured by physical symptoms (r = -.20, p < .001).

Golombok-Rust Inventory of Marital Satisfaction (GRIMS; (Rust et al., 1986). The GRIMS is a 28 item self-report questionnaire assessing the quality of a respondent's intimate relationship (i.e. a marriage or similar partnership). Items are scored on a four-point Likert scale ranging from 'strongly agree' (0) to 'strongly disagree' (3). Items are summed to obtain a total score, from which a satisfaction banding is then derived. Alphas of 0.86 in community and 0.89 in clinical groups have been reported and mean differences have distinguished groups seeking treatment for relationship and sexual difficulties (Rust et al., 1990).

Maternal Self-Efficacy Scale (Pederson et al., 1989)

This scale contains 16 items rated on 7-point scales that pertain to mothers' perceptions of their competence on basic skills required in caring for an infant, with higher scores reflecting greater feelings of efficacy. The scale has shown robust test–retest reliability and moderate to high internal consistency (Pedersen et al., 1989). Internal reliability (Cronbach's alpha) of the scale was 0.91 antenatally and 0.78 at both 1 and 3 months postpartum (Porter and Hsu, 2003).

Bates Infant Temperament Questionnaire (ITQ; Bates et al., 1979). This parent-report measure consists of 24 items, each requiring the mother to rate her baby on a 1-7 scale for each characteristic described. Four factors emerge from the questionnaire: 'infant difficultness', 'unadaptability' (how much the infant dislikes new experience, somewhat akin to behavioral inhibition), 'dullness' (how much or little the infant responds positively to stimuli) and 'unpredictable' (how much the infant is able to get into a routine). Internal

consistency for subscales ranges from alphas of 0.39 for the dull subscale to 0.79 for infant difficultness. Test-retest reliability for subscales ranges from 0.47 unpredictable subscale to 0.70 for infant difficultness. Moderate correlations have been reported between independent observation of fussiness (0.22) and soothability (0.18) and ITQ infant difficultness (Bates et al., 1979).

Data Analytic Strategy

The clinician rated YBOCS was the primary outcome measure in terms of differences in maternal symptoms. The secondary measure of maternal improvement was the self-report OCI. The self-efficacy scale, GRIMS and DASS scales were tertiary measures. The Ainsworth sensitivity scale was the primary outcome measure for mother-infant interactions, with the SSP as a further primary measure of the relationship. Secondary measures were the Ainsworth cooperation-intrusiveness scale, maternal warmth, vocalisations and overconscientious behaviours.

Analyses were 'intention to treat' and outcome data was available for all participants. ANOVAs, t-tests, Fisher's exact test were used as appropriate. Where repeated measures were reported, an allowance was made for serial dependency when the Epsilon coefficient was found to be significant. In such instances, the Greenhouse-Geisser probabilities and degrees of freedom are reported. For missing questionnaire items, if the subscale consisted of at least 8 items, up to two missing items were permitted for data imputation based on participants mean scores. <1% of data was missing for each questionnaire across all participants. Data analysis was carried out using IBM SPSS version 21.

Participant characteristics

The three groups did not significantly differ in terms of mean age (iCBT:32.4 v TAU:32.7 v HC:34.6); ethnicity (iCBT:82% v TAU:88% v HC:84% white); education (iCBT:65% v TAU:70% v HC:95% to degree level or above); with a partner (iCBT:100% v HC:100% v TAU:98%); parity (iCBT: 65% v TAU:59% v HC:51% first time parents) and child gender (iCBT:53% vTAU:47% v HC:51% male); all $p>0.8$. Baseline clinical characteristics of the two OCD groups are presented in Table 1 below. All five mothers reporting current MDD had a history of depression prior to this pregnancy; three had experienced previous postnatal depression (1/2 in iCBT group and 2/3 in TAU group). All mothers considered OCD to be their primary problem.

Table 1 about here

The TAU group was significantly higher in dimensionally measured anxiety on the DASS scale. Otherwise the two clinical groups were well matched. In the healthy control group the mean (sd) DASS anxiety scale was 1.24 (1.79) and depression was 1.78 (2.8). In addition, in the control group one woman had a specific phobia and one person had GAD.

Procedure

At the initial contact the study rationale and procedure was explained. If this was acceptable the diagnosis of DSM-IV OCD was then confirmed using the SCID and other exclusion criteria were disconfirmed. Baseline assessments took place in the participant's home when their baby was six months old (+/- two weeks). This comprised a clinical interview including demographics, symptoms, and parenting variables. Dyads were videotaped in three 'everyday' interactions. These were (i) a solid feed, (ii) a nappy change

and (iii) play (firstly without any toys and then with toys provided by the researcher). Up to 8 minutes of tape were rated in each situation. At twelve months, dyads were filmed in a feed, nappy change and then freeplay followed by a set sequence of toys (shape sorter, stacking rings, soft horse puppet, hammerballs) with 3 minutes of play recorded for each.

Ratings of maternal sensitivity and cooperativeness/intrusiveness were made on a 1-9 scale used Ainsworth's definitions and descriptions (Ainsworth, unpublished scales). Maternal warmth during interactions was rated using a 1-9 scale. Maternal vocalizations to the infant were time-sampled every 15 seconds. A novel code of 'overconscientiousness' was devised to capture observable rituals or excessive behaviours designed to prevent harm e.g. excessive use of wipes. This was rated globally as present/absent. Interactions were coded by a graduate psychologist (EW) trained in the coding system and blind to the mother's clinical status. A second rater (FC) coded 10 randomly selected tapes of mothers. Intraclass correlations were: 0.93 for sensitivity; 0.71 for cooperation; 0.81 for warmth. Percentage agreement for vocalizations was 94% and for over-conscientiousness was 90%.

Questionnaires were completed prior to the assessment. Mothers were given £30 for each completed assessment as a token of thanks for their time. A further similar home-based assessment took place when the baby was twelve months old. After this, mothers were then invited to come to the research centre to complete the Strange Situation Procedure (SSP, Ainsworth et al., 1978), which consists of eight episodes, including two brief separations from and reunions with the mother. Attachment group classification was assigned using the traditional ABC criteria, based primarily on the infant's reactions to the

mother's return (Ainsworth et al., 1978), with the tape then rated in its entirety for disorganised (D) behaviour which potentially yields a further insecure category. The first author has been trained to reliability in administration and coding of this measure.

A random sequence of the two treatment categories was generated in blocks of 6 using www.randomization.com. A person unconnected with the study sealed cards with each category in numbered individual envelopes. The researchers and participant were blind to group allocation until the envelope was opened at the end of the baseline assessment. The outcome/twelve month assessment was conducted by a researcher who was blind to group allocation and was not in any way involved in the therapy (JR, RA). Video coding of interactions was conducted by a further researcher blind to group (EW). Following the outcome assessment mothers in the TAU group were offered iCBT.

Time-intensive CBT (iCBT)

Participants received twelve hours of face to face individual cognitive behaviour therapy (iCBT), typically delivered in four sessions of three hours, with the sessions taking place over a two-week period. Up to three follow up sessions of one hour were offered at monthly intervals, with participants taking these up as they preferred.

iCBT was predominantly delivered by the first author who is a qualified clinician, who received ongoing supervision in cognitive behaviour therapy for OCD for the duration of the study. During the course of the research, three of the thirty-one cases seen for iCBT were treated by two other qualified CBT and experienced therapists specializing in OCD and

familiar with the design and protocol of the study. Two of these were in the iCBT group and one was in the TAU group and seen as a crossover case after the outcome assessment. One mother in the iCBT group did not complete treatment but did complete assessments and was included in all analyses.

Treatment as usual (TAU)

Between 6m and 12m postpartum in the TAU group, 6/16 (37.5%) women received some CBT, 5 of whom described it as 'helpful' or 'partly helpful'. A further three had received other psychological input (a mindfulness group for one mother and general counseling for two mothers). 8 mothers in the CBT group and 10 in the TAU group were on psychotropic medication of various types between 6 and 12 months postpartum. 2 TAU mothers received no specific treatment during this period.

Medication use

Medication use was not an exclusion criterion. 7/17 (41%) mothers in the iCBT group were on medication (SNRI (2); SSRI (4); SSRI + antipsychotic augmentation (2)) compared to 11/17 (64%) in the TAU group (SSRI-11; SSRI + antipsychotic augmentation (1)). All medications were at stable dose for two months prior to, and throughout the six months' study period.

Results

Maternal symptomatology

Table 2 about here

In order to test the effect of treatment on YBOCS scores a mixed model ANOVA with time as the repeated factor and group as the between group factor was conducted.

A significant main effect was found for time ($F_{[1,31]}$=58.4, p<0.001), but not group ($F_{[1,31]}$=2.37, p=0.13). Results indicated a significant group by time interaction ($F_{[1,31]}$=16.2, p<0.0001). The mean YBOCS reduction in the CBT group was 48.4% (sd = 25.2) and in the TAU group was 12.8% (sd= 22.6), which represented a significant difference ($t_{[31]}$=4.27, p<0.0001). This represents a between-subjects effect size of Cohen's d=1.32 (adjusted according to Cohen, 1988) using 12 month YBOCS total scores and pooled pre-treatment standard deviations. According to the criteria of Tolin et al (Tolin, Abramowitz et al. 2005), a 30% change on the YBOCS is considered clinically meaningful. This occurred in 12/17 of the CBT group and 3/16 of the TAU group, which represented a significant difference (Fisher's exact test, p=0.005). The mean percentage OCI improvement in the CBT group was 54.45% (35.62) and in the TAU group was 14.77% (23.37) which was significant ($t_{[32]}$ =3.84, p=0.001). This represents an effect size of Cohen's d=1.90 using end OCI total scores and pooled pre-treatment standard deviations.

Change in general anxiety using the anxiety subscale of the DASS was analysed using repeated measures ANOVA and there was a main effect of time ($F_{[1,32]=}$19.4, p<0.0001) and group ($F_{[1,32]}$ =8.53, p=0.006) reflecting the initial difference in scores, but no significant time by group interaction ($F_{[1,32]=}$0.53, p=0.47). Similar results were found for changes in the DASS depression subscale with a main effect for time ($F_{[1,32]=}$23.54, p<0.0001) but not of group ($F_{[1,32]=}$2.15, p=0.15) and no interaction ($F_{[1,32]=}$1.54, p=0.22). Therefore treatment did not have a statistically significant effect on the change in general anxiety and depression scores.

Change in the self-efficacy questionnaire was examined using repeated measures ANOVA but no main effect was found for time ($F_{[1,32]}$ =1.38, p=0.25) or group ($F_{[1,32]}$ =0.67, p=0.42) and there was no interaction ($F_{[1,32]}$ =0.48, p=0.49). Similarly there was no main effect of time on the GRIMS marital satisfaction measure ($F_{[1,32]}$ =1.03, p=0.32), no main effect of group ($F_{[1,32]}$ =0.16, p=0.69) and no time by group interaction ($F_{[1,32]}$ =1.64, p=0.21).

Mother-infant interactions

Video data was available for 16 mothers in each clinical group and all 37 control mothers.

Table 3 about here

In order to examine the impact of treatment on interactions an omnibus ANOVA (2x2x3 mixed model) was used to examine differences in Ainsworth Scale scores (sensitivity and cooperation-interference) over time, between the two clinical groups and over different parenting tasks. There was a third order interaction between time, scale and task ($F_{[2,60]}$ = 5.541, p=0.006) indicating that the tasks at different infant ages elicited different levels of sensitivity and cooperation/intrusiveness. There were no other third order interactions and there was not a fourth order interaction, indicating that treatment group membership had no effect at either timepoint on sensitivity or cooperation/interference in any task. A similar pattern was found for maternal warmth.

Overconscientious behaviour was identified at very similar rates at twelve months in the clinical groups: 10/17 of mothers in the CBT group and 8/16 in the TAU group (Fisher's exact=0.732). However, this was twice as common as in the control group 7/37.

One-way ANOVAs carried out as simple main effects were significant for comparisons of 12 month sensitivity ($F_{[2,69]}$ =5.694, p=0.005), cooperation ($F_{[2,69]}$ =4.221, p=0.019), warmth ($F_{[2,69]}$ =5.379, p=0.007) and overconscientiousness ratings (Chi-square=0.001). Post-hoc test revealed that healthy controls differed from both OCD groups at 12m, and the OCD groups did not differ in each case.

Vocalizations during nappy change differed between the healthy control and TAU group at 6m and 12m ($p<0.05$). The clinical groups did not differ at 12m ($F_{[2,69]}$ =2.16, p=0.123) in terms of maternal vocalisations during nappy change.

There were no between group differences in the infant temperament scale (ITQ) at 6 or 12 months.

Both six month and twelve month interaction data indicated differences between mothers with and without OCD in terms of sensitivity and psychopathology. The correlation matrix below indicates relationships between the continuous variables at twelve months.

Table 4 about here

In light of the strong effects for sensitivity and for mood reported in table 4 a hierarchical regression analysis was performed to examine the contribution of anxiety, depression and obsessional distress and diagnostic status to sensitivity scores at twelve months for the whole sample. Three variables were entered into the model, DASS anxiety, DASS depression and OCI total scores in two blocks. Twelve month scores were entered as block one and six

month scores were entered as block two. Twelve-month sensitivity score was the dependent variable.

Table 5 about here

This analysis indicated that only the twelve month OCD diagnosis was significant over and above the other variables in the first block. Both regression models were significant indicating an effect of 'maternal distress' on sensitivity (twelve months: $F_{[4,66]}$ =2.753, p=0.035, and six plus twelve months: $F_{[8,66]}$ =2.870, p=0.009). The twelve month variables accounted for 9% of the variance (adjusted R^2), rising to 17.6% (adjusted R^2) with the addition of the six month scores which was significant (R^2 change = 0.127, $F_{[4,62]}$ =2.702, p=0.038).

The finding suggests that having a diagnosis of postpartum OCD, even if it is not current is an important predictor of current sensitivity in interactions.

Attachment

The groups did not differ in terms of the distribution of attachment categories with 23/32 (71.8%) classified as secure in the control group, against 10/14 (71.4%) in each of the iCBT and TAU groups. 3/32 (9.4%) were avoidant in the control group versus 3/14 (21.4%)in both clinical groups. 4/32 (12.5%) were anxious-resistant in the control group against 1/14 (7%) in iCBT and 0/14 in TAU. 2 (6.3%) were disorganized in the control group against 0 in iCBT and 1 in TAU.

Discussion

This study indicates that intensive CBT is an effective treatment for postpartum OCD, with a

controlled effect size on the primary measure, the YBOCS (1.32) similar to that of a recent meta-analysis of CBT for OCD against waitlist controls (1.31; (Ost et al., 2015). The low dropout rate suggests that iCBT was particularly acceptable to mothers who may show a preference for psychological treatments over medication (Arch, 2013, Pearlstein et al., 2006). However, iCBT did not fully ameliorate depressive and general anxiety symptoms which changed to some degree in both treated and untreated groups. Marital satisfaction and self-efficacy remained unchanged and remained lower than in the control group. Furthermore treatment status was not associated with changes in mother-infant interactions, consistent with findings in postpartum depression (Milgrom et al., 2006; Gunlicks and Weissman, 2008). Analysis of this sample at six months indicated that depression was associated with less sensitive interactions (Challacombe et al., 2016). At twelve months depression was no longer an independent predictor of sensitivity and diagnosis of OCD at six and twelve months became significant. The regression was significant and a composite factor of maternal distress may have led to less sensitive interactions. This mirrors the findings of Tietz et al (2014) that maternal depression and avoidance affected bonding rather than anxiety disorders per se. Additional treatment targeted on residual symptoms of depression and anxiety, marital relationships and/or targeted on mother infant interactions may therefore be warranted. In tandem with this finding, 'overconscientious' interactions were more prominent at twelve months in the clinical groups, suggesting that the developing infant may be presenting different challenges for mothers with OCD. Longer-term longitudinal research is required to examine this possibility.

Attachment was unaffected by postpartum OCD in this sample, as was the case with a previous study of mothers with panic disorder which also found differences in sensitivity (Warren et al, 2003). The current study differed from the findings of Manassis et al (1994) whose sample included three women with OCD, but primarily consisted of women with panic disorder. The children in that study had a wide age range (18-59 months) necessitating the use of two parallel coding systems which may have affected reliability. Alternatively, the difference could be due to potentially longer exposure to aspects of maternal anxiety that limited family functioning and had a greater effect as the infant developed. Previous research has found that sensitivity only explains some of the variance in predicting attachment categories (De Wolff and van Ijzendoorn 1997). Therefore, although maternal sensitivity was compromised, either it may not be the primary mechanism for developing secure attachment, or it may not have been compromised enough to make a difference. Alternatively, or in addition, there may be buffering effect from other aspects of the mother-infant relationship. If OCD is a problem (for many, if not all sufferers) of inflated responsibility and over-care, it is consistent with this that whilst aspects of the symptoms may interfere with the ability to be sensitive, the underlying affective bond remains intact. That is, whilst mothers with OCD may be afraid of their own symptoms or hyper alert to signs of threat to their infant, their experience of the infant themselves is not threatening or disconcerting (Hesse & Main, 2006). Sensitivity in this sample was 'inconsistent' rather than 'insensitive'; at the times when mothers are sensitively attuned, the infants are likely to be comforted and reassured.

Limitations of the study were a small and largely self-identified sample. It would not have been ethical to preclude mothers in the comparison group from receiving treatment which included some sessions of CBT. However, the effect size for iCBT in comparison to TAU was large. About half of the sample was on medication which may have affected outcomes. Mothers in this study were on a wide range of medications, some reluctantly due to concerns about the impact on breastmilk. The role of concurrent medication use should also be investigated in order to determine the most effective management of postpartum OCD for mothers and infants.

Just over a third of mothers in this study had OCD with onset related to this pregnancy, and these mothers with less longstanding problems may have benefitted more from treatment. Similarly, concurrent or historical postnatal depression may have affected key outcomes. Future research with larger samples could examine the challenges presented by particular subtypes of OCD for parenting and allow better examination of predictors of treatment response as well as longer term follow up. In terms of feasibility, it was clear that intensive treatment of this kind was particularly acceptable, and has the advantage of being rapidly deliverable. This may be especially important as there is evidence of both onset and worsening of OCD during the perinatal period leading to concerns about the mothers' ability to cope. Comparison of iCBT with regular (non-intensive) CBT for OCD should now be carried out.

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Declaration of interest

None

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Table 1: Baseline maternal clinical characteristics of the two OCD groups

Variable	**iCBT N=17**	**Treatment as usual/wait list N=17**	
OCPD diagnosis at 6m	1	2	Fisher's exact =1.00
Age of first OCD interference	26.82 (9.96)	24.18 (6.20)	$t_{[32]}$ =-0.93, p=0.36
New diagnosis of OCD related to this child	9	4	Fisher's exact =0.16
OCD related to ideas of deliberate harm	8	6	
OCD related to contamination	3	7	
OCD not directly related to the infant	4	1	Fisher's exact =0.34
OCI total score	53.88 (23.11)	61.82 (27.95)	$t_{[32]}$ =-0.90, p=0.37
YBOCS total score	24.82 (5.19)	24.47 (5.81)	$t_{[32]}$ =-0.19, p=0.85
Time troubled by OCD daily (hours)	9.53 (8.30)	9.69 (7.44)	$t_{[32]}$ =-0.06, p=0.95
Current comorbid diagnoses:			
Major Depressive disorder	2	3	
Panic disorder	0	2	
GAD	1	3	
Social Phobia	1	1	
DASS anxiety	10.88 (7.43)	17.35 (10.31)	$t_{[32]}$ = -2.10, p=0.04*
DASS depression	17.00 (11.26)	20.59 (16.02)	$t_{[28.7]}$ =-0.76, p=0.45

OCPD: Obsessive-compulsive personality disorder; YBOCS: Yale-Brown Obsessive-compulsive scale; OCI: Obsessive compulsive Inventory; RAS: Responsibility Attitudes Scale; DASS: Depression, Anxiety & Stress Scale; *p<0.05

Table 2: Mean (sd) OCI and YBOCS scores at 6m and 12m in CBT and TAU groups

Variable		**iCBT N=17**	**TAU N=16**
YBOCS	6 month	24.82 (5.20)	24.47 (5.81)
	12 month	13.71 (8.95)	20.88 (6.34)
OCI	6 month	53.88 (23.11)	61.82 (27.95)
	12 month	26.18 (23.80)	52.23 (30.96)

Table 3: Mean interaction (sd) ratings at 6 and 12 months in the three groups across the three tasks

Variable	iCBT group N=16		TAU group N=16		Control group N=37	
	6m	*12m*	*6m*	*12m*	*6m*	*12m*
Ainsworth sensitivity (1-9)	5.12 (1.68)	5.41 (1.52)	4.98 (1.67)	5.25 (1.79)	6.24 (1.51)	6.60 (1.51)
Ainsworth cooperation-interference (1-9)	5.24 (1.49)	5.59 (1.01)	5.12 (1.43)	5.38 (1.30)	6.13 (1.49)	6.44 (1.56)
Maternal warmth (1-9)	5.31 (1.54)	5.43 (1.45)	5.35 (1.47)	5.60 (1.58)	6.55 (1.17)	6.58 (1.21)
Maternal vocalizations during nappy change (% of total interaction)	83.84 (17.81)	88.18 (23.88)	86.65 (12.42)	79.88 (24.89)	95.06 (7.00)	92.08 (15.07)
Overconscientiousness Dichotomous – n did occur (%)	7 (41%)	10 (58.8%)	8 (50%)	9 (56.2%)	13 (35%)	7 (18.9%)
Dyadic synchrony (1-5)	2.91 (0.90)	3.01 (0.86)	2.92 (0.73)	3.02 (0.95)	3.48 (0.83)	3.59 (0.80)

Table 4. Correlation matrix for sensitivity and maternal mood variables at 6m and 12m

		6m			12m			6m
		OCI N=71	**ANX N=71**	**DEP N=71**	**OCI N=71**	**ANX N=71**	**DEP N=71**	**SENS N=68**
6m	**OCI**	**1**						
	ANX	**.670******	**1**					
	DEP	**.586******	**.815****	**1**				
12m	**OCI**	**.840******	**.614******	**.529******	**1**			
	ANX	**.470******	**.611******	**.534*******	**.608******	**1**		
	DEP	**.409******	**.486******	**.670******	**.590******	**.738******	**1**	
6m	**SENS**	**-.376*****	**-.378*****	**-.493******	**-.400****	**-.233**	**-.297***	**1**
12m	**SENS N=70**	**-.362*****	**-.384*****	**-.421*****	**-.387******	**-.303***	**-.301***	**.782****

OCI = OCI total score; ANX=DASS anxiety; DEP=DASS depression; SENS = sensitivity; Pearson correlations: *p<0.05; **p<0.01, ***p<0.005, ****p<0.0001

Table 5: Regression table for maternal sensitivity at twelve months

		B	Std. Error	Beta	t	p
1	**Constant**	**6.502**	**0.255**		**25.468**	**<0.0001**
	12m OCD diagnosis	**0.197**	**0.599**	**0.054**	**0.329**	**0.749**
	12m OCI	**-0.019**	**0.011**	**-0.305**	**-1.704**	**0.093**
	12m Anxiety	**-0.028**	**0.039**	**-0.126**	**-0.707**	**0.482**
	12m Depression	**-0.005**	**0.030**	**-0.030**	**-1.704**	**0.866**
2	**Constant**	**7.617**	**0.519**		**14.666**	**<0.0001**
	12m OCD diagnosis	**1.406**	**0.693**	**0.388**	**2.030**	**0.047***
	12m OCI	**-0.034**	**0.017**	**-0.536**	**-1.967**	**0.054**
	12m Anxiety	**-0.045**	**0.044**	**-0.205**	**-1.039**	**0.303**
	12m Depression	**-0.005**	**0.040**	**0.178**	**0.764**	**0.448**
	6m OCD diagnosis	**-0.866**	**0.391**	**-0.510**	**-2.213**	**0.031***
	6m OCI	**0.020**	**0.016**	**0.376**	**1.287**	**0.203**
	6m Anxiety	**0.024**	**0.048**	**0.130**	**0.506**	**0.614**
	6m Depression	**-0.046**	**0.036**	**-0.346**	**-1.276**	**0.207**

*$p<0.05$