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Overcoming the Horrors of Perinatal Obsessive-Compulsive Disorder:

Stories of Lived Experience and Recovery

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Abstract

Perinatal populations are vulnerable to the development and exacerbation of obsessive-compulsive disorder (OCD). Perinatal OCD can be highly debilitating and interfere with the experience of motherhood if left untreated. Despite this, research investigating treatment and recovery experience remains sparse. This study explored the lived experience of perinatal OCD and recovery to gain an understanding of the treatments and strategies that can facilitate recovery.

Data was collected from a secondary source 'The OCD Stories' podcast. Podcast transcripts were analysed using interpretative phenomenological analysis to enable rich and nuanced insights into lived experience. The first research objective explored how mothers experienced perinatal OCD, and the meaning that was assigned to these experiences. The overarching theme 'Stuck in a horror story' illustrated the terrifying, tormenting, and destructive nature of perinatal OCD. The second research objective explored the experience of treatment and recovery. The overarching theme 'An arduous but worthwhile road to recovery' identified the multiple recovery strategies that were used to overcome the disorder and challenges that were experienced along the way.

The final overarching theme 'Words of Hope' illuminated that hope is central to recovery. Overall, these findings demonstrated that recovery from perinatal OCD is possible. These findings add to small body of literature on perinatal OCD and emphasise the importance of early identification and treatment within clinical settings.

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Chapter 1: Introduction

This project explored women's lived experience of perinatal obsessive-compulsive disorder (OCD) and recovery. In this chapter, I engage with the literature on perinatal OCD, by outlining current research and the rational for the present study.

This chapter is divided into three parts. The first part examines OCD in the context of general population, by focusing on prevalence, factors that are linked to onset, and current treatment options. Section two then develops the discussion of the literature by focusing on what is known about perinatal OCD; firstly, considering the medical and clinical literature in relation to treatment and aetiology, and then considering qualitative research focusing women's personal experience. Section three reveals a current gap in the literature regarding recovery experiences, thus providing space for this study.

Defining OCD

Obsessions and compulsions were initially conceptualised from a religious perspective and later morphed into a psychiatric condition. Later, in 1906, Freud conceptualised OCD as 'obsessional neuroses' that were the result of unconscious and repressed desires that were considered taboo in society. Such early psychoanalytic theories proposed that obsessional thoughts would arise when the ego attempted to suppress disturbing thoughts or experiences (Meehan et al., 2022). Subsequently, OCD became framed as a cognitive condition, entering the entering the Third Edition (DSM-III) published by the American Psychiatric Association in 1980 as an anxiety disorder based on commonalities amongst the disorders, including escapist or avoidant behaviour.

Obsessive compulsive disorder (OCD) is now classified under 'Obsessive-Compulsive and Related Disorders' in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (5th ed.; DSM-5; American Psychiatric Association, 2013). Prior to the release of the DSM-5, the categorisation of OCD was widely debated. This was due to emerging research indicating that OCD was closely related to trichotillomania, body dysmorphia disorder (BDD), hoarding disorder and skin

picking disorder (Abramowitz & Jacoby, 2014). It was proposed that these disorders be grouped together based on their shared clinical features, including obsessions/preoccupations, repetitive behaviours, brain circuitry and neurotransmitter abnormalities and diagnostic specifiers. In 2010, prior to the publishing of DSM-5, 176 experts were surveyed to determine whether the disorder should be moved out of the anxiety disorders section; 60% of respondents supported this change (Pittenger & Phillips, 2017). Consequently, OCD was removed from the anxiety disorder section and a new chapter was added under the heading of 'Obsessive-Compulsive and Related Disorders' (OCRD). The grouping of disorders under this category is recent, however, similarities between BDD and OCD were identified in the early 1900's (Phillips et al., 2007).

OCD, trichotillomania, BDD and skin picking disorders have been clustered together based on their shared characteristics, however, these disorders are presumed to be distinct from one another. For example, OCD and OCRDs share underlying constructs such as impulsivity or compulsivity, however, there are many important differences in the psychopathology and treatment of these disorders (Abramowitz & Jacoby, 2014). This new categorisation has raised concerns regarding the accuracy of diagnosis and treatment for OCD and the related disorders. Clustering these disorders within the same chapter in the DSM-5 could result in clinicians giving a blanket diagnosis of OCD based on the presence of repetitive or compulsive behaviour, which in turn would lead to ineffective therapeutic interventions (Abramowitz & Jacoby, 2014). Despite these concerns, the re-classification in the DSM-5 is largely regarded as positive because OCD and OCRD differ from other anxiety disorders in terms of illness course, comorbidity, cognitive processing, and genetic risk factors and treatment (Pittenger & Phillips, 2017).

OCD is a chronic psychiatric condition marked by the presence of obsessions and/or compulsions. Obsessions and compulsions occur with regularity in the general population (Rachman & de Silva, 1978). However, many individuals do not meet the DSM-5 criteria of clinical distress and impairment (Angst et al., 2004). Obsessive-compulsive symptoms (OC symptoms) exist on a

continuum ranging from clinical to subclinical severity. OC symptoms differ from commonly occurring intrusive thoughts because they cause some distress or impact on functioning, whereas commonly occurring intrusive thoughts do not (Angst et al., 2004). To meet the current diagnostic criteria, obsessions and/or compulsions must consume more than one hour daily and cause the individual daily distress or impairment (American Psychological Association, 2013).

The DSM-5 states that obsessions are characterised by persistent and recurrent intrusive thoughts, images, impulses, or physical sensations. Intrusions are ego-dystonic; the individual perceives them as incongruent with their sense of self. This internal conflict causes uncomfortable emotions such as anxiety, doubt, fear, guilt, and disgust. Individuals with OCD perform physical and/or mental compulsions to reduce the discomfort induced by the obsessions. Some compulsions may be overt, (e.g., touching or checking items a specific number of times, cleaning, counting or reassurance seeking) whereas some compulsions may include be covert (e.g., praying silently, mental checking or replacing thoughts). When the individual performs the compulsion, they feel temporary relief from the anxiety. This sense of relief reinforces the belief that compulsions can restore emotional safety. Thus, the individual is more inclined to repeat the compulsive behaviour next time they experience an intrusive thought. This serves to further perpetuate the cycle, until the obsessions and compulsions become more ingrained and time-consuming. Individuals with OCD may hold differing levels of insight into the excessive or unreasonable nature of their thoughts and behaviour. While many individuals are aware that these compulsions and repetitive behaviours are irrational, they cannot resist engaging in them (American Psychological Association, 2013).

OCD is characterised by heterogeneous presentation that falls into several subtypes; these are characterised by specific obsessions and compulsions. Subtypes include contamination obsessions, sexual obsessions, violent obsessions, religious/moral obsessions, identity obsessions and existential obsessions. Contamination obsessions are marked by a fear of touching perceived contaminants, such as body fluids or bacteria. The individual with contamination obsessions may

respond to this anxiety by washing their hands excessively, sterilising objects or avoiding crowded spaces (Guazzini et al., 2022). Sexual obsessions are characterised by a fear of committing a sexually aggressive act or being attracted to a family member or child; mental compulsions may include replacing unacceptable thoughts with something deemed more appropriate (Williams & Wetterneck, 2019). Common harm obsessions include fears of committing a violent act, for example, stabbing or killing someone. The individual engaging in overt compulsions may hide knives or razor blades out of fear. Convert compulsions may include checking their previous thoughts and behaviours, to determine whether they are or capable or hurting anyone (Williams et al., 2013). Finally, religious obsessions involve excessive concerns about acting immorally or committing sin. To neutralise blasphemous thoughts, individuals might perform religious rituals or seek reassurance from spiritual leaders (Williams et al., 2013). Typically speaking, obsessions and compulsions become more frequent over time, regardless of their subtype (Pereira et al., 2006). Specific factors including disease prognosis, prevalence and sex differences can shape the experience of OCD; these are discussed in the section below.

Prevalence, Onset, and Disease Course of OCD in the General Population

The prevalence rates of OCD have been retrieved using the fully structured World Health Organization World Mental Health Survey version of the Composite International Diagnostic Interview. Global prevalence rates are estimated to be 2-3% of the global population, with 1% of the population having the disorder within a 12-month period (Kessler et al., 2005). The onset of the disorder is often gradual, with an average of seven years between onset the symptoms and a full diagnostic criterion being met (Thompson et al., 2020). The average onset of illness occurs at age 19 and is uncommon after the age of 30 (Mental Health Foundation, 2022). In Aotearoa, the 12-month prevalence of OCD is estimated to be 1% of the population (Wells, 2006). These prevalence rates were determined by the Te Rau Hinengaro – New Zealand Mental Health Survey conducted in 2004; this survey was based off the Composite International Diagnostic Interview (CIDI 3.0). Although this instrument has excellent validity and reliability (Kessler & Ustun, 2004), it lacks cultural specificity.

For example, the instrument relied on Western conceptualisations of mental health and neglected the inclusion of Māori or Pasifika beliefs. This is problematic because differences in cultural expressions of mental illness could contribute to insensitivity of the survey instrument and underreported prevalence rates (Butler et al., 2007). A further limitation is the amount of time that has passed since the survey was conducted in 2003. It is possible that the prevalence rate of OCD is higher now, given that the proportion of New Zealanders with high levels of mental distress is trending upwards annually (Wilson & Nicolson, 2020).

Research indicates that the course of OCD is chronic, with an average illness duration of 10 years or longer (Maina et al., 2001). The remission rates of OCD are just over 50%, however, more than a third of individuals seeking treatment may experience unremitting or worsening symptoms that span across decades (Sharma et al., 2014). Relapse is common considering the chronic course of OCD, with recovery occurring in only one-fifth of adult cases (Maina et al., 2001). Factors such as early onset, the presence of co-morbidities, longer illness duration and a family history of illness can lead to a greater rate of re-occurrence. Relapses have been associated with functional impairment, distress and a decreased response to treatment that was previously effective (Maina et al., 2001).

Approximately 90% of individuals who meet the diagnostic criteria of OCD also meet the criteria for another psychiatric disorder (Pereira et al., 2006). The most common co-morbid disorders are anxiety disorders (32%), mood disorders (54%), personality disorders (35%), substance abuse disorders, and impulse control disorders (Sharma et al., 2021). OCD onset differs between sexes (Torresan et al., 2013). Research has indicated that males demonstrate a more chronic and severe pattern of symptoms, with onset occurring more frequently in childhood (Torresan et al., 2013). Female prevalence is higher during adolescence and adulthood, with an 'acute' onset and an episodic course of illness (Torres et al., 2006; as cited in Torresan et al., 2013). Women represent slightly more than half of all adults with OCD in community samples (Fawcett et al., 2020), whereas this number is more equally distributed amongst clinical samples (Torres at al., 2006). The disorder is

highly debilitating for both sexes, with most individuals experiencing symptoms within the severe range (Kessler et al., 2005). The severity and intensity of OCD may fluctuate over developmental phases. For instance, obsessions related to death and loss are more common during childhood, whereas sexual obsessions are more typical during adolescence (Stavropoulos et al., 2017). The literature suggests that women are more likely to experience contamination obsessions and compulsions, whereas men are more likely to experience sexual obsessions (Mathis et al., 2011). This indicates that gender role norms or specific biological factors may play a role in the presentation of OCD.

While the exact causes of OCD remain unknown, several biological theories are widely accepted. A range of factors including genetics, neurotransmitters and hormones have been associated with the development of the disorder. Genetic studies have firmly established that OCD has a heritable component, with twin studies estimating heritability to be around 40% in the general population (Browne et al., 2014). Several candidate genes involved in serotonin regulation and the glutamatergic system have been identified, however they have not reached genome-wide significance (Robbins et al., 2019). Some studies have identified lower dopaminergic receptor binding levels in specific brain regions (Denys et al., 2004) and increased oxytocin plasma in OCD patients compared with non-OCD controls (Marazziti et al., 2015; Marazziti et al., 2023). While these studies have found correlations between hormone or neurotransmitter function and OCD, they do not imply a causal pathway (Mulcahy, 2021).

Meanwhile, research has focused on the cognitive and behavioural factors that interact to drive obsessions and compulsions. Behavioural psychologists state that obsessions are developed though classical conditioning and maintained by operant conditioning (Law & Boisseau, 2019). The theory posits that the disorder arises from a learned association between specific stimuli and anxiety-provoking thoughts (classical conditioning). Performing compulsions leads to a temporary decrease in distress, this is maintained through a schedule of negative reinforcement (operant

conditioning). Repeated pairings of the obsession (and corresponding distress) with the avoidance behaviours leads to the strengthening of learnt associations, thereby increasing the intensity of OCD symptoms overtime (Mowrer, 1960). While this model was highly informative for developing the first empirically supported psychological treatments for OCD, it was critiqued for its inability to explain the entire phenomenology. Salkovskis (1985), a cognitive psychologist, argued that behavioural theories did not shed light into the nature and development of obsessional thoughts and beliefs. Specifically, this model did not cater for the cognitive aspects of OCD, including the interpretation of thoughts, appraisal processes and maladaptive beliefs that perpetuate the disorder. These limitations led psychologists to consider cognitive explanations of OCD, which are widely used in clinical practise today.

Salkovskis (1985) cognitive model of OCD proposes that maladaptive appraisals play a significant role in the aetiology and maintenance of the disorder. According to this model, distress arises when a person misappraises an unwanted thought as threatening. Cognitive theorists have identified three domains of obsessive beliefs that form the basis for negative appraisals (Obsessive Compulsive Cognitions Working Group, 2005). The first domain relates to the tendency for people to overestimate the probability of disastrous outcomes occurring; this is accompanied by the belief that they are personally responsible for preventing the feared event from happening. The second domain involves the belief that intrusive thoughts carry meaning and significance, and therefore, must be controlled. The third domain relates to the belief that imperfection and uncertainty are intolerable.

Another cognitive process, thought-action fusion (TAF) is also central to the theories of OCD. TAF is the belief that thinking about committing an immoral action is morally equivalent to carrying out that action (Shafran & Rachman, 2004). A cognitive error associated with TAF is the belief that thinking about an intrusion increases the probability of it occurring (Shafran & Rachman, 2004). These maladaptive beliefs about cognition lead to a cycle of repetitive negative thinking, worry and rumination (Salkovskis, 1985).

In recent years, researchers have developed these cognitive bias arguments by examining the role of metacognition in OCD (Rees & Anderson, 2013). Individuals with OCD hold metacognitive beliefs regarding; (a) the importance and meaning of thoughts; (b) the need to control these thoughts, and; (c) the need to perform compulsions to prevent danger. Like the cognitive model of OCD, the metacognitive model is based on the notion that individuals become trapped in a pattern of emotional distress; this is known as the cognitive attentional syndrome (CAS). The CAS is characterised by excessive verbal thinking, worry and rumination which is accompanied by an attentional- threat bias (ATB). According to this model, intrusive thoughts activate metacognitive processing which accesses knowledge about the intrusion (Wells, 2006).

Emerging research from community and clinical samples suggests that metacognitive beliefs may contribute to the development of obsessions and compulsions, however the small number of existing studies have used a range of assessment tools which make them difficult to compare. Solem et al. (2009) investigated the role of metacognitions and OC symptoms in community control (n = 269) and clinical samples (n = 57) using the Beliefs About Rituals Inventory (BARI) and The Thought-Fusion Instrument (TFI). The study found that metacognitive domains of thought fusion beliefs were positively correlated with OC symptoms. Specifically, beliefs regarding the importance of thoughts and controlling them predicted greater OCD symptom severity. The study also found that the clinical sample reported more severe OC symptoms and scored higher on the metacognitive constructs compared to the community sample.

To further research on the relationship between metacognitive beliefs and OC symptoms, Kim et al. (2021) examined the metacognitive beliefs of patients with OC symptoms (n = 144), compared with non-OCD controls (n= 232). Metacognitive beliefs were measured using the Metacognitions Questionnaire (MCQ) and OC symptom severity was measured using the Yale-Brown Obsessive-Compulsive Scale (YBOCS) and the Obsessive–Compulsive Inventory-Revised-Korean (OCI-R-K). The findings demonstrated that patients with OC symptoms scored significantly higher (p <

0.001) on all five dimensions of the MCQ, compared with non-OCD patients. While the MCQ is a reliable and valid measure of metacognitions, it is not specific to OCD beliefs. It was difficult to compare this study to Solem et al. (2009) and Kim et al. (2021), due to variation in definitions and assessments of metacognitions. For example, Solem et al. (2009) had focused on two domains of metacognitions regarding the significance and importance of thoughts, while Kim et al. (2021) had focused on the five domains of metacognitions that are central to psychopathology. Consequently, it was challenging to draw generalisations about what metacognitive belief domains influence OC symptoms.

The empirical OCD literature is complicated due to the various theoretical models of OCD and their emphasis on different belief domains (Solem at al., 2009). Although both models have empirical support, only one study has investigated the relative contributions of both models in the prediction of OC symptom dimensions. Nance et al. (2018) measured the metacognitions and OCD symptoms of undergraduate students (*n* = 110) using the DOCS, Depression Anxiety Stress Scale (DASS), Obsessive beliefs Questionnaire and the Metacognitions Questionnaire (MCQ). The study found that obsessive beliefs regarding the importance of thoughts and the need to control them were correlated with OC symptom dimension of unacceptable thoughts. Both metacognitive and cognitive beliefs predicted the OC symptom subscale related to responsibility of harm. Additionally, metacognitions were significant predictors of OC symptoms related to unacceptable thoughts and symmetry, thus concluding that both models account for many aspects of OC symptomology. One benefit of this study by Nance et al. (2018) was the use of both the MQB and the Obsessive Beliefs Questionnaire (OBQ). The OBQ measures three domains of obsessive beliefs and thus is more appropriately suited to measuring OCD-related metacognitions.

A limitation of the study by Nance et al. (2018) was the use of a community sample, rather than a clinical sample. Since the aim of the study was to test the metacognitive and cognitive model of OCD, a clinical sample with OCD would have been appropriate to include, especially since Solem

et al. (2009) and Kim et al. (2021) noted differences in the symptomology experienced by clinical and non-clinical samples. Further limitations include the recruitment of participants who were taking SSRI's, which have been reported to reduce maladaptive metacognitions and thought-action fusion (Solem et al. 2009). In all three studies causal relationships were found, suggesting that metacognitive beliefs may cause OC symptoms to develop, but these findings do not rule out the possibility that experiencing OC symptoms leads to the development of OCD-related metacognitions. Prospective studies are therefore needed to test the direction of causation.

Summary

Cognition and metacognition are complex and not easily quantifiable or reducible to simple measurements. Research to date has heavily relied on the use of theoretical studies and survey tools to collect data on metacognitions rather than employing qualitative methods to explore lived experience. Thus, the cognitive and metacognitive processes that underpin OCD remain understudied. Given these limitations, qualitative research designs would allow for more nuanced accounts of how these two processes occur and are experienced. Treatment practices also give insights into the understanding of the causal mechanisms of OCD.

Treatment of OCD

Selective Serotonin Reuptake Inhibitors

Selective serotonin reuptake inhibitors (SSRIs) are considered the gold standard treatments for OCD (Abramowitz & Jacoby, 2014). As mentioned earlier, the biological model of OCD suggests that changes in serotonin regulation may contribute to the development of the disorder. Selective serotonin reuptake inhibitors (SSRIs) are recommended for the treatment of OCD because they work to inhibit the reabsorption of serotonin into neurons, thus increasing the availability of serotonin in the brain. SSRIs are recommended as a first-line pharmacological option for the treatment of OCD, with more than 20 blinded placebo-controlled studies demonstrating their efficacy (Pittenger & Bloch, 2014).

The systemic review conducted by Pittenger and Bloch (2014) examined the efficacy of numerous pharmacological medications for the treatment of OCD. Medication efficacy was tested using The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS). The YBOCS is considered the gold standard for evaluating OC symptoms and severity within the literature and clinical settings (Chaudron & Nirodi, 2010; Foa et al., 2005). The study found that all SSRI's (fluvoxamine, sertraline, fluoxetine, citalopram, and escitalopram) decreased the YBOCS mean score by 3.4 -18.5 points. Thus, most of the studies demonstrated pre-post-test reductions of 25-35%; this is considered a treatment response as defined by the CGI Improvement scale (Lewin et al., 2011; Tolin et al., 2005). Despite the proven efficacy of SSRIs and clomipramine in OCD, around 40% -60% of patients show no improvement or only partial symptom improvement. While SSRI's can be an effective method of treatment, relapse is common after discontinuation of use (Fineberg et al., 2019).

Only one qualitative study has examined the treatment experience of SSRI using semi-structured interviews (Pedley et al. 2019). While participants noted that medication had improved their symptoms of anxiety, they held reservations regarding the adequacy of medication as a standalone treatment. Some participants had viewed medication as inferior to CBT treatment because it did not treat the underlying cause of the disorder. Thus, psychological therapy was deemed a more effective form of treatment. Further qualitative research is needed to yield additional insight on SSRI use as a standalone treatment and in conjunction with other treatments.

Cognitive-Behavioural Therapy and Exposure Response Prevention

Cognitive-Behavioural Therapy (CBT) and Exposure Response Prevention (ERP) are also recommended as a first-line treatment of OCD. As discussed earlier, behavioural theories of OCD suggest that the disorder develops through classical conditioning and is sustained through operant conditioning, whereas cognitive theories suggest that maladaptive appraisals contribute to the development of the disorder (Barrera & Norton, 2011). CBT and ERP therapy are typically recommended for individuals with mild to moderate symptoms of OCD.

CBT and ERP were developed to target the cognitive and behavioural features of OCD. This type of therapy is delivered by a therapist and involves a combination of psychoeducation and exposure exercises. The aim of ERP is to help the patient learn to tolerate anxiety and uncertainty without engaging in their compulsive behaviours (Hezel & Simpson, 2019). During therapy, a patient is gradually exposed to situations or objects that trigger their obsessions. For example, a person with contamination OCD may be gradually exposed to real or hypothetical situations involving germs or dirt. During exposure, they must refrain from engaging in their compulsive cleaning behaviours. The patient gradually learns to tolerate the anxiety that is triggered by specific situations and resist the urge to perform compulsions. Drawing on the behavioural model of OCD, ERP weakens the conditioned response, eventually leading to extinction (Hezel & Simpson, 2019).

Numerous randomised clinical trials support the efficacy of ERP for the treatment of OCD (Cottraux et al., 2001; Foa et al., 2005). In a double-blind, randomised control trial, Foa et al. (2005) found that ERP as a standalone treatment, and ERP combined with SSRIs, were more effective than SSRIs as a standalone treatment for OCD in adults. Treatment outcomes were measured using the YBOCS. Despite compelling evidence supporting the use of ERP therapy for the treatment of OCD, 50% of patients do not report improvement during treatment, with 25-30% dropping out prematurely (Hazel & Simpson, 2019). Research demonstrates that lower symptom severity predicts greater symptom improvement following treatment. Additionally, greater insight and self-awareness predicts a better treatment response (Hezel & Simpson, 2019). Other factors, such as therapists providing reassurance or treating the peripheral symptoms instead of the core obsession can hinder the patients progress and increase the chance of relapse (Gilihan et al., 2012). Therapists may also fail to identify mental compulsions due to their unobservable nature. This can lead to reassurance rituals that perpetuate obsessions and ultimately exacerbate symptoms (Gilihan et al., 2012).

There is very limited qualitative literature examining the lived experience of CBT treatment and recovery within the general population. Murphy and Delcourt (2014) used interpretative

phenomenological analysis (IPA) to explore accounts of CBT and ERP treatment. Prior to starting treatment, the participants reported being torn between maintaining their attachment to the familiar aspects of OCD and letting go of these behaviours. Forming a strong therapeutic alliance was deemed vital for overcoming OCD; these interactions provided validation, hope, and relief, which ultimately contributed to self-acceptance. Participants noted the importance of exploring the psychological origins of the disorder. This insight helped them to transform the meaning of their OCD experience, which contributed to improved self-esteem. Similar findings were reported by Bevan et al. (2010), who used a comparative qualitative analysis to explore the delivery of CBT in the treatment of OCD. The participants in this study noted the importance of the therapeutic alliance for successful treatment outcomes. Positive interactions provided benefits such as feeling supported, understood, and gaining a different perspective on the disorder.

Acceptance Commitment Therapy

Research has suggested that acceptance commitment therapy (ACT) may be beneficial as an alternative or complimentary treatment of OCD. Developed by Hayes (1980), ACT is a form of cognitive behavioural therapy that is focused on enhancing psychological flexibility and distress tolerance. ACT employs various mindfulness techniques to help individuals stay present and fully engaged with their experiences. The second component of ACT involves identifying personal values and goals and taking committed actions towards these.

Few studies that have investigated the treatment effects of ACT on OCD. The most substantial study in this small literature is the randomised control trial of Zemestani et al. (2022), which included 40 adults with OCD diagnosis. Individuals were assigned to three conditions: 12 weeks of ERP + SSRI treatment, 12 weeks of ACT + ERP treatment, and continued SSRI only. The results found significant reductions in OCD symptom severity in both ACT+SSRI and ERP+SSRI conditions at posttreatment, these reductions were significantly greater than the SSRI only group. These findings suggest that ACT may an effective treatment option for OCD patients who are already

taking SSRIs. Another study by Dehlin et al. (2013) included five participants who were treated with ACT using a multiple baseline design. The results found a reduction in compulsions, and improvements in avoided valued activities. These studies suggest that ACT may be beneficial as an OCD treatment, however, further research is needed to explore the effectiveness of ACT as a standalone treatment and how this compares with other first-line treatments.

The Role of Metacognition in Treatment

Wells (2006) metacognitive model of OCD argues that metacognitions must change for treatment to be effective. A growing body of literature has investigated the impact of various interventions on metacognitions as a potential mechanism of change in OCD outcomes. While research is limited, several studies have found significant changes in metacognitive beliefs following ERP therapy. For example, Solem et al. (2010) investigated the impact of ERP on metacognition and OC symptoms. The sample included 83 patients with a clinical diagnosis of OCD. The metacognitions and OC symptoms were assessed using the YBOCS, the Metacognitions Questionnaire (MCQ-30) and the Obsessive Beliefs Questionnaire (OBQ-44) before treatment, post treatment and at 12 months follow-up. The study found that metacognitive beliefs regarding responsibility and perfectionism significantly decreased following ERP treatment, and this was found to mediate reductions in OCD symptoms. Changes in metacognitions explained 22% of the variance in symptoms at post-treatment when pre-treatment symptoms and changes in mood were controlled for.

An alternative approach to focusing on cognitions is Metacognitive Therapy (MCT). MCT aims to modify dysfunctional beliefs and thought processes as a potential mechanism of change in the treatment of OCD. This was investigated by Hansmeier et al. (2021), who split OCD patients into two groups; 12 patients received MCT, and 12 patients received ERP. The results demonstrated that metacognition scores significantly decreased pre-post treatment, this was observed across both treatment groups. Patients who received MCT yielded lower scores in thought fusion beliefs, compared to those who had received ERP. Although MCT was a mechanism for change in TAF, it did

not predict treatment outcome, and symptom reduction was not clinically significant. Further research is needed to investigate the effectiveness of MCT and how certain metacognitive subdimensions change in the long term as OC symptoms are treated and vice versa.

Research has investigated the effect of pharmacological treatment on metacognition and OC symptoms (Kim et al., 2021). OCD patients were prescribed various psychiatric medications (SSRIs, benzodiazepines, and atypical antipsychotics) over a three-month period. Of the 144 patients, 48 patients demonstrated a ≥35% reduction in symptoms and were classified as treatment responders. The remaining participants were classified as non-responders. In the responder's group, there was a significant decrease in the subscale of negative beliefs after three months of pharmacological treatment. While these findings suggest metacognition may play a crucial role in the pathophysiology of OCD, there were several limitations noted. Firstly, the control group were prescribed varying pharmacological treatments that may have affected OC symptom severity. Secondly, the study used the MCQ to measure metacognition but did not include any OCD-specific measures.

Summary

In conclusion, the gold standard of treatment is a combination of SSRI's, CBT and ERP for individuals with moderate to severe symptoms and co-morbid disorders. For individuals with mild-moderate symptoms, CBT and ERP are recommended over SSRI's (Fineberg et al., 2019). However, variations may be required for individuals who don't respond to specific interventions, or for those who do not feel comfortable taking medication. New developments indicate that MCT and ACT may be beneficial when used in conjunction with existing treatments (Kim et al. 2021; Zemestani et al., 2022). These findings suggest that the use of multiple interventions, rather than a singular approach, may be more effective for treating OCD.

OCD Remission and Recovery

The notion of 'recovery' is broadly captured in the literature as ongoing symptom remission and a return to pre-morbid functioning (Andreasen et al., 2005). Specific to the OCD literature and clinical settings, remission is largely defined as a score of ≤12 on the Y-BOCS (Lewin et al., 2011). Current research on OCD has largely focused on response to treatment as opposed to long-term recovery (Burchi et al., 2018). Randomised control trials have mainly examined the efficacy of CBT and SSRI treatment over a mean duration of 12 weeks (Pizarro et al., 2014; Öst et al., 2015). These studies, designed to investigate short-term improvements, use treatment response to measure efficacy rather than long-term recovery. While these studies demonstrate a short-term improvement in symptoms, they may be limited in predicting the potential for long-term symptom remission (Burchi et al., 2018).

Research on symptom reduction is important, however it overlooks the broader and more holistic aspects of recovery, including self-determination, meaning, empowerment and connectedness (Piat et al., 2022). While limited, prospective studies have shown that a substantial number of patients with OCD (32%- 70%) have achieved remission 1-5 years post-treatment (Sharma et al., 2014). Other longitudinal studies suggest more a favourable prognosis of OCD, where recovery can be considered a realistic goal (Burchi et al., 2018).

More research demonstrating recovery as one of the possible outcomes for OCD is needed. This is important considering that individuals with OCD tend to perceive their condition as permanent and are pessimistic about their illness remitting, even with treatment (Pedley, 2019). These perceptions of illness permanency have also been echoed by the family members of individuals with OCD (Pedley et al., 2017). Considering the known efficacy of treatments such as SSRIs, CBT and ERP, these pessimistic views may be unwarranted. Future research exploring the experience of treatment and recovery would be particularly helpful for countering the pessimistic illness perceptions held by OCD sufferers. This, in turn, would enhance engagement their

engagement with treatment. Further, exploring the lived experience of recovery would enable individuals to conceptualise recovery more broadly and holistically, by shedding light on the most meaningful indicators of recovery within the context of their lives; this would extend beyond the limited focus of symptom remission found in the current literature.

Summary

The literature demonstrates that OCD is chronic and debilitating disorder that affects around 1% of Aotearoa's population. While the exact determinants of OCD remain unknown, the disorder is believed to be caused by a range of biological factors including genetics, neurotransmitters, and hormones. Other behavioural and cognitive factors are thought to underlie the disorder, including the misappraisal of intrusive thoughts and maladaptive beliefs regarding the significance of them. A combination of ERP and SSRI treatment are considered the gold standard of treatment for OCD, however there is limited research examining the efficacy of treatment from a qualitative perspective; this insight would be valuable for medical professionals and therapists who are delivering interventions. Finally, research on OCD recovery has mainly focused on symptom remission over a short-term period. Given the debilitating and chronic nature of OCD, research on the lived experience of recovery is needed for reframing illness beliefs. This information provides the foundations for understanding the literature specific to perinatal OCD, which is the focus of the next section.

Perinatal OCD

Perinatal OCD occurs as a specific life event and therefore has distinctive features. In this section, I consider how researchers have defined perinatal OCD, and consider some of the biological, social, and cognitive factors associated with the condition. Lastly, I review the current treatment options available for perinatal OCD.

Defining Perinatal OCD

The term perinatal OCD has been used to describe obsessive and compulsive symptoms occurring in pregnancy or postpartum, or the exacerbation of symptoms in the prenatal or postnatal period (Abramowitz et al., 2003). However, there is no established definition of perinatal OCD in the literature. For this thesis, I chose to define this period as OCD onset from the time of conception to 12 months following childbirth. This period was chosen to align with other researchers who have defined perinatal OCD by this timeline, to ensure that these findings can be more easily compared with their studies (Timpano et al. 2011; Mulcahy, 2021).

Historically speaking, postnatal depression has been the focus of research into maternal mental health, despite the high prevalence of anxiety disorders (Higgins et al., 2018). Perinatal OCD has only been mentioned in the literature over the past 20 years. Prior to this, it was only discussed as a manifestation of OCD occurring during pregnancy and the post-natal period. Literature dated between the years of 1980 – 2000 has largely investigated the factors related to the onset and exacerbation of OCS and OCD during pregnancy. More recently, literature has focused on the prevalence, aetiology, diagnosis, and management of the disorder.

The clinical description of perinatal OCD presentation includes the following signs and symptoms: (a), the onset of symptoms during pregnancy or the postpartum; (b), obsessional content related to accidents, illness, harm or contamination; (c), avoidant behaviour; (d) compulsive rituals; (e) co-morbidity with depressive symptoms and (f) no association with psychotic delusions (Abramowitz., 2008). It has been argued that perinatal OCD should be considered a distinct subtype of OCD, due to the specific expressions of the disorder (McGuinness et al., 2011). Symptoms of perinatal OCD are similar to typical OCD; however, it is widely debated whether this is a separate condition (Rook, 2017). The obsessions that occur in perinatal OCD are distinctive from typical OCD and often focus on aggression or violence towards the infant (Rook, 2017).

The characteristics of obsessions and compulsions in this population appear to be shaped by the perinatal period. During pregnancy, common obsessions involve fears of contaminating the foetus, while postnatal obsessions typically involve thoughts of harming the baby through direct acts of violence or negligence (Hudepohl et al., 2022). Common intrusive thoughts may include for example, infant suffocation, inappropriate touching, contamination, or intentional harm. Individuals with postpartum OCD believe that the recurrence of these thoughts will lead them to act on them. This leads to compulsive behaviour that manifests as checking the infant's safety repetitively, or avoiding situations that elicit fears, such as changing, bathing, feeding, or holding the baby. These actions negatively reinforce the parent's preoccupation with the intrusions and become conditioned stimuli for the re-occurrence of the thoughts and strengthen the learnt associations (Mowrer, 1960). While there is evidence to suggest that the postpartum period illustrates a distinctive clinical picture, the criteria has not been robustly demonstrated (McGuiness et al., 2011).

Prevalence Rates of OCD in the Perinatal Population

Early research on the global prevalence of perinatal OCD has produced mixed findings. The diverse findings are likely due to the retrospective self-reporting of perinatal OCD, different psychometric tools for measuring the psychiatric condition, and the absence of non-childbearing women as a comparator group (Mulcahy, 2021). More recent estimates suggest prevalence rates of OCD in pregnancy that range from 0.2% to 29% (Zar et al. 2002; Chaudron & Nirodi, 2010), with most studies reporting prevalence estimates from 1-2% (Russell et al., 2013). Prevalence rates of OCD are the highest in the postpartum period, with reports ranging from 2.4% to 6.1% (Fairbrother et al., 2016). Group differences have been found throughout the postpartum period, with increased prevalence rates of 6.6% for new parents, compared to prevalence rates of 1.8% for those with more than one child (Uguz et., 2007). Further, post-partum onset of OCD is more likely to occur in women than men (Torresan et al., 2013). Research has indicated that the risk of OCD onset is 50-79% higher during the perinatal period, compared to the general female population (Russell et al., 2013). Many women with pre-existing OCD report that their symptoms are exacerbated during the postpartum

period with rates as high as 73% (Fairbrother et al., 2016; Miller & O'Hara, 2020). In Aotearoa, it is estimated that roughly 1500 women experience perinatal OC symptoms each year, however it is not clear how Perinatal Anxiety and Depression Aotearoa (2023) have derived these figures.

Regular intrusive thoughts differ from clinical obsessions based on of the distress and impairment they cause on daily basis (Fairbrother & Abramowitz, 2007). As mentioned earlier, women may experience OCS that are distressing but do not meet the diagnostic criteria. While the research findings vary, the prevalence of subclinical OCS appears to be greater among the perinatal population, compared with the general population (Chaudron & Nirodi, 2010; Wenzel et al., 2005). One study found that 5.4% of women in a community sample reported subclinical OCS symptoms at 8 weeks postpartum (Wenzel et al., 2005), whereas another study by Chaudron and Nirodi (2010) found that 31% of women reported scores 8 or higher on the Y-BOCS at 1-month postpartum, suggesting the presence of subclinical obsessions and compulsions. The varied findings may be explained by the different sampling methodologies. Chaudron and Nirodi (2010) used a convenience method and had a high dropout rate, resulting in a small sample (*N* = 24), some of whom already had children. Overall, the research findings suggest that prevalence rates of subclinical OCD and non-subclinical OCS are highest in the postpartum period, specifically 1-3 months following birth.

Identification of Perinatal OCD

As it currently stands, there is limited research on treatment of OCD specific to the perinatal period. Consequently, there are no clear guidelines for treatment, other than those that are recommended for the treatment of OCD in the general population. While numerous randomised-controlled trials support the efficacy of CBT with ERP in the general population, evidence specific to the perinatal period has been limited to observational trials with few participants and no comparator groups (Challacombe & Salkovskis, 2011; Christian & Storch., 2009; Timpano et al., 2011).

While post-natal screening for depression and anxiety is becoming more commonplace, screening for post-natal OCD is rare (Chaudron & Nirodi, 2010). Many women may experience obsessions or compulsions in the perinatal period without meeting the diagnostic criteria. It is well documented that intrusive thoughts are more frequent in early postpartum but tend to decrease one – three months later (Chaudron & Nirodi, 2010). Thus, it is likely that some of the symptoms in early postpartum represent a normal phenomenon instead of underlying psychopathology, which could implicate and interfere with OCD screening accuracy (Collardeau et al., 2019; Fairbrother et al., 2021).

Measures that comprehensively assess the presence, frequency, and severity of OC symptoms are lacking despite the high prevalence in the perinatal population (Pereira et al., 2022). While perinatal OCD resembles OCD at other stages of the lifespan, there are some distinct clinical features. If clinicians do not account for these nuances when evaluating patients, they will miss indications of OCD, and attribute symptoms to other disorders, such as mood or anxiety disorders (Challacombe & Wroe., 2013). For example, OCD is commonly misdiagnosed as generalised anxiety disorder (GAD) or post-natal depression due to overlapping symptoms (Chaudron & Nirodi., 2010). Both disorders are characterised by worry and rumination which are also present in OCD. However, the differences lie in the content of thoughts. With GAD and depression, distress tends to focus on real life events that shift over time. Whereas with OCD, thoughts and ruminations usually centre around irrational and nonsensical themes that do not shift over time (Abramowitz et al., 2010).

Research has documented cases of medical professionals misdiagnosing postnatal OCD as psychosis (Challacombe & Wroe., 2013). Both disorders typically occur within two-four weeks following birth; however, they are very different in their clinician presentation. Postpartum psychosis is a severe disorder that occurs in approximately 1 in 1000 live births and is characterised by the presence of delusions or hallucinations that cannot be distinguished from reality (Sharma et al., 2021). In contrast to postpartum OCD, the thoughts of infant harm are ego-syntonic and

associated with psychotic beliefs. Unlike OCD, the thoughts are not resisted by the individual and not experienced as intrusive to one's sense of self (Sharma et al., 2021). Women with postpartum psychosis almost always require impatient hospitalisation, alternative care arrangements and the involvement of social services to protect the child. In contrast, women with perinatal OCD seldom require the involvement of social services or separation from their babies (Hudepohl et al., 2022). Thus, it is essential for health care professionals to be able to identify the nuances of post-natal OCD, because there are critical differences in how the disorder is treated.

Obsessive-compulsive disorder is commonly accessed using self-report questionnaires and diagnostic interviews. The most widely used scale in the literature, the Y-BOCS, includes two subscales that measure obsessions and compulsions separately. Recently, the Perinatal Obsessive-Compulsive Scale (POCS) was developed to assess perinatal OCD. Research by Lord et al. (2011) found that the POCS had high internal consistency and construct validity. Although promising, the POCS is not yet a widely used scale among clinicians (Chaudron & Nirodi, 2010). Amongst the general population, another popular assessment tool is the Dimensional Obsessive-Compulsive Scale (DOCS). The DOCS is a 20-item self-report measure that is used to assess the severity of OC symptoms on four common subscales: (a) germs and contamination; (b) responsibility of harm; (c) unacceptable thoughts and (d) symmetry and completeness (Abramowitz et al., 2010). The DOCS subscales have demonstrated excellent reliability in clinical samples (a= .87 - .96) and strong construct validity (Abramowitz et al., 2010; Thibodeau et al., 2015).

While these measures have been identified as accurate screening tools for OCD in the general population, current literature is too week to support the accuracy of these tools for the perinatal population (Chaudron & Nirodi, 2010). For a screening tool to be implemented, it must be deemed 'sufficiently accurate' (Cohen et al., 2016). Although many studies have evaluated the accuracy of various OCD screening tools, very few have employed high-quality methodology (Chaudron & Nirodi, 2010). To date, only the POCS and Y-BOCS are recommended as potential

screening tools for the perinatal population. In a recent study, Chaudron and Nirodi (2010) found that the DOCS met the criteria of a 'sufficiently accurate' measure during the postpartum period when compared with the EPDS, a tool used to measure depressed mood during the perinatal period. While the study provides strong evidence for the accuracy of DOCS in assessing perinatal OCD, it would have been more beneficial to compare the DOCS with another tool designed to measure OCD to determine accuracy, because the EPDS is not specific to OCD symptoms. Further studies are needed on the use of screening instruments that are specifically designed to measure postpartum OCD (Pereira, 2022).

Biological and Environmental Theories of Perinatal OCD

While the exact aetiology of perinatal OCD is not fully understood, it is believed to be caused by a combination of biological and environmental factors (Vasconcelos et al. 2007). A wide body of literature suggests that hormonal changes during pregnancy and the postpartum period may contribute to the development of OCD (Karpinski et al., 2017). The literature states that hormonal changes during the female reproduction cycle, for example, menstruation, pregnancy, and menopause, may exacerbate or contribute to the onset of OCD (Guglielmi et al., 2014). Other factors that may also contribute to OCD onset include caesarean delivery, or a lower maternal age (Mulcahy, 2021).

In the perinatal population, the regulation of OCD symptoms is believed to be mediated by several neurotransmitter systems including the dopaminergic, serotonergic, and glutamatergic systems (Karpinski et al., 2017). The pathophysiology of OCD is believed to be caused by low levels of serotonin and increased levels of dopamine. Following birth, serotonin levels decrease due to an increase in ovarian steroids that bind to oestrogen and progesterone receptors (Brok et al., 2017). However, existing literature provides only lacking evidence to substantiate the role of gonadal steroids in OCD pathology (Karpinski et al., 2017). No studies to date have measured OCD symptoms and hormone levels concurrently (Karpinski et al., 2017).

Growing evidence suggests that the neurotransmission of glutamate, the primary neurotransmitter within the cortical-striatal-thalamocortical (CSTC) circuitry, is disrupted in OCD. Chakrabarty et al. (2005) and Bhattacharyya et al. (2009) found that OCD patients had higher levels of glutamate in their cerebrospinal fluid compared with psychiatrically normal controls. This evidence indicates that increased levels of glutamate and glutaminergic signalling can lead to OCD development. Other findings suggest that oxytocin may have a role in the pathophysiology of OCD. The hormone oxytocin is thought to encourage mother-infant bonding and increase the mother's sensitivity to threat cues (Brok et al., 2017). Thus, it has been suggested that increased oxytocin levels may be associated with OCD presentation or the worsening of OC symptoms (Leckman et al., 1994; Marazziti, 2023). While some studies have found elevated levels of oxytocin in cerebrospinal fluid, no correlation has been established (Leckman et al., 1994; Marazziti et al., 2015). Further, these findings have not been replicated (den Boer & Westenberg, 1992) making it difficult to make sound conclusions about the relationship between oxytocin and OCD.

Due to the heterogeneous nature of OCD, many experts believe that its aetiology may be attributed to a range of factors and their interactions. These include environmental, genetic, hormonal and immunological factors (Brandes et al., 2004). Some studies report that the mode of delivery and obstetric complications may increase risk, however, these findings are not consistent (Brander et al., 2016; Miller et al., 2015; Vasconcelos et al., 2007). Other findings suggest that a family history of OCD increases risk (Labad et al., 2005), as does the presence of dysfunctional beliefs or avoidant tendencies (Fairbrother & Abramowitz, 2007; Uguz et al., 2007).

Research has identified that sleep deprivation may contribute to the development of perinatal OCD. Recent studies suggest that OCD may be associated with shorter sleep duration (Hudepohl et al., 2022) and increased rates of delayed sleep disorder in the general population (Nota et al., 2015). Insomnia and sleep disturbance is common in pregnancy (Chaudhry & Susser, 2018), while the postpartum period is marked by a change in the circadian cycle (Mulcahy, 2021). Two

prospective studies have investigated the relationship between self-reported sleep difficulties during pregnancy and postpartum OC symptoms. Fairbrother et al. (2018) found that maternal sleep difficulties and fatigue were correlated with postpartum OCD symptoms, including more frequent obsessions, increased distress, and perceived impairment in parenting abilities. Similarly, Osnes et al. (2020) found that women who reported insomnia at 17 weeks gestation reported more obsessions and compulsions at eight weeks postpartum, compared with women who did not report insomnia in the second trimester.

Cognitive Theories of Perinatal OCD

Intrusive thoughts and compulsive behaviours similar to those that characterise OCD are common amongst all new parents, including fathers (Abramowitz et al., 2003; Fairbrother & Abramowitz, 2007; Miller & O'Hara, 2020; Zambaldi et al., 2009). In the study of Abramowitz et al. (2006), 91% of mothers and 88% of fathers reported disturbing intrusive thoughts about their newborn. Another study by Kim et al. (2013) found that both mothers and fathers experienced substantial preoccupations and thoughts of their infants during the first few months of life. Preoccupations included concerns related to their infant's safety, their adequacy as parents, and the potential for harm. These concerns prompted behaviours such as checking on and interacting with the newborn more frequently. The study found that these preoccupations and corresponding behaviours had significantly decreased by the third month postpartum. Conversely, positive thoughts regarding parenting and their infants increased during this period. This may explain that why symptoms of OCD are extremely common within non-OCD parent populations.

It has also been proposed that postnatal OCD may sit at the extreme end of what is considered a normal spectrum of OCS that are experienced by new parents. Evolutionary theories suggest that OCD symptoms are common in new parents because they are beneficial to the newborn (Gonda et al., 2008). Parents are biologically wired to protect their children from danger. Hypervigilance and overly cautious efforts to avoid harm are advantageous to the infant's survival,

especially when environmental conditions are less favorable. Fairbrother et al. (2007) suggest that the highly anticipated birth comes with rapid and overwhelming feelings of responsibility to prevent harm and keep the newborn safe. Immense feelings of responsibility are met with an overestimated perception of risk to the newborn, resulting in excessive precautions been taken.

Evolutionary theories have led to perinatal OCD being conceptualised as an overactivation of the maternal caregiving system (Leckman et al., 2022). Fairbrother and Abramowitz (2007) argue that problems only arise when new mothers or fathers interpret their intrusive thoughts of harm as catastrophic by overestimating both their responsibility for preventing harm and the probability of harm to the infant. As discussed in the cognitive model of OCD, faulty belief systems play a role in the development of the disorder. These beliefs include an inflated sense of responsibility for preventing the feared outcome, and the tendency to believe that having a thought increases the likelihood of it occurring. Intrusive thoughts are met with guilt, shame, fear, and distress that provokes further unwanted thoughts and compulsive safety-seeking behaviours. This theory may account for the rapid onset of symptoms following birth that are commonly seen in postnatal OCD and provide insight as to how the experience of intrusions and maladaptive cognitive appraisals may develop into obsessional problems. These obsessional issues may not only be linked to hard-wired evolutionary instincts to protect their babies, but may also intersect with social expectations, as outlined below.

Social Pressures of Motherhood

The transition into motherhood presents many challenges as women adjust to the psychological, physical, and social changes that influence themselves and their families (Levesque et al., 2020). It is important to consider the discourses surrounding motherhood when exploring the perinatal experience, because these discourses impose the expectation of particular societal roles. Women who deviate from these standards may be subject to blame and criticism. Responsibility and blame are often attributed to the individual rather than considering the broader social, economic,

and cultural factors that shape women's experiences of motherhood. This, in turn, shapes the focus of research into maternal mental health.

In 1956, Winnicott conceptualised the notion of 'primary material preoccupations.' He described the perinatal period as dissociative state of hyperactivity that developed towards the end of pregnancy and continued in the weeks following birth. The purpose of this hyper aroused state was to enable the mother to anticipate the needs of the infant. Winnicott (1956, p. 91) stated that this period was "almost an illness that a mother must experience and recover from, in order to create and sustain an environment that can meet the physical and psychological needs of the infant." During this period of maternal pre-occupation, the mother and baby were not considered separate entities, but rather a 'mother-baby-unit' (Winnicott, 1965). This conceptualisation has been critiqued for pathologising women and generating a limited and idealised portrayal of motherhood (McBride, 2018). It also approaches mothering as an individual problem, in which women are viewed as solely responsible for parenting. Further, it generates the notion that a women must abandon herself to be a 'good mother' (Plaza, 1982; as cited in Kaplan, 1992).

Many pressures can arise from the 'good mother' ideology that is pervasive throughout society (Williamson et al., 2023). This ideology suggests that women are good mothers if they adhere to the beliefs of the dominant parenting discourse. The modern conceptualisation of 'intensive mothering' characterises mothers as expert caregivers, who are nurturing and readily available to care for their children, regardless of their own circumstances (Goodwin & Huppatz, 2010). Women should sacrifice their physical and mental self to their children and be exceptional in their chosen career (Williamson et al., 2023). This set of social beliefs implies that women should put their children above everything else, which creates an unrealistic and unattainable pressure for women who already have other roles in their life, alongside being a mother (Goodwin & Huppatz, 2010).

Good mother notions present a set of standards that women should be held too; suggesting that mothers are ‘good’ if their beliefs and actions align with this discourse, or ‘bad’ if they do not meet these standards (Lanctot & Turcotte, 2017). ‘Good’ mothering is often met with praise and positive feedback, thus reinforcing the ideology and the predominance of motherhood as part of one’s identity (Turner & Norwood, 2013). Conversely, women who do not adhere to these standards encounter judgement, negative evaluation, and mum shaming (Orton-Johnson, 2017). Dissonance may arise when women are unable to live up to these expectations. This dissonance can be accompanied by feelings of shame and guilt, which can negatively impact the new mother and her identity (Williamson et al., 2023).

The ‘good mother’ narrative is harmful because motherhood is not devoid of feelings of hostility, resentment, or destructive impulses (Meehan et al., 2021). Being a mother requires managing tensions between maintaining an autonomous identity and the responsibility of motherhood. Issues arise when a mother becomes anxious about her unloving thoughts and emotions, which can be a consequence of the unrealistic social expectations that she feels she must live up to (Williamson et al., 2023). Further complicating this issue is the juxtaposition between the romanticised expectation of an ideal motherhood and the reality of becoming a mother (Boyd & Gannon, 2019; Laney at al., 2015). Powerful discourses are embedded and reinforced until they shape the way people perceive motherhood (Laney et al., 2015).

The Psychological Impacts of Perinatal OCD

It is widely recognised that maternal mental illness has negative impacts on the mother and her child. There is little research investigating risks of untreated perinatal OCD. However, anxiety and mood disorders have been associated with substantial risk, including deficits in cognitive and emotional development of the child and relapse of illness for the mother (Hoffman et al., 2017). Research has found that women with perinatal OCD report greater distress and decreased quality of life compared with non-OCD controls (Challacombe et al., 2016; Miller & O’Hara, 2020).

The quality of interactions between a mother and infant are important because they affect the infants cognitive and social development during the first years of life (Challacombe et al., 2016). Postpartum OCD has the potential to affect mother-infant interactions and can also influence broader vulnerability factors for difficulties later in life, including attachment security (Tietz et al., 2014). Challacombe et al. (2016) found that mothers with OCD experienced troubling symptoms for an average of 9.6 hours per day. It also found that mothers were less sensitive when interacting with their infant when compared with non-OCD controls. Similarly, participants Meehan et al. (2021) reported that OCD affected their parenting abilities and limited their ability to enjoy time with their child. While this study used eight different survey measures and an observational component to videotape the mother performing parenting tasks, it did not capture the lived experience of parenting with OCD. It is evident that perinatal OCD has the potential to significantly disrupt a mother's parenting experience and the developing mother-infant bond (Challacombe et al., 2016). This in turn may contribute to social-emotional, behavioural or neurodevelopmental issues in childhood or later life.

Treatment of Perinatal OCD

There is limited research on the treatment of OCD specific to the perinatal context. Most treatment guidelines recommend the use of existing interventions for adult OCD (Hudak & Wisner, 2012). As discussed earlier, CBT and ERP are considered first-line treatments (Abramowitz & Jacoby, 2014). Few studies have investigated the impact of CBT on perinatal OCD symptoms. Christian and Storch (2009) conducted a single case treatment that included eight sessions of CBT delivered over a three-month period. The findings reported a decrease in YBOCS score from 22 to 6, and a significant reduction in thoughts of deliberate harm. Despite these improvements, relapse occurred three months later, necessitating further treatment. In another study by Challacombe and Salkovskis (2011), six participants were treated with CBT over an intense two-week period. Participants reported significant benefits regarding their OC symptoms and general parenting experiences. These self-reported and clinician-rated measures were sustained at 3-5 months follow-up. The use of only

one intervention is a limitation of the study, considering that research indicates that multiple treatments need to be combined for effective outcomes.

The efficacy of SSRIs in the treatment of OCD in the general population has been well established and are commonly recommended as a treatment option, as discussed previously (Fisher & Wells, 2004; Nakatani et al., 2005). However, there is few studies investigating the safety and efficacy of medication for this population group. The systematic review conducted by Sharma (2018) reported that the literature on SSRI treatment is limited to one randomised control trial, one case series, two open-label trials and six case reports. Thus, current findings on the pharmacological treatment of postpartum OCD are limited to 76 women, most of whom had co-morbid psychiatric disorders. The overall findings of these studies report that SSRI treatment led to a reduction in OCS. For example, the RCT conducted by Misri et al. (2004) reported that 80% of participants had obtained symptom remission following 12 weeks of treatment with paroxetine. However, 31 out of 32 participants in the study had comorbid anxiety disorders, thus limiting the conclusions that may be drawn about the pharmacological treatment of OCD specifically.

Review of the Perinatal OCD Literature

In this current section, I review the literature specific to the experience of perinatal OCD. The literature presented here focuses on studies that highlight misdiagnosis, diagnostic delays, reluctance to treatment and the psychological impacts of the disorder. Next, I examine what happens following diagnosis, by focusing on uncertainty around medication use and its side effects. This is followed by the experience of professional treatment and recovery.

The Experience of Perinatal OCD

To date, the literature on people's experience of perinatal OCD has largely focused on symptomology using interviews and survey methods. There are few studies that have investigated the lived experience of mothers with this condition. Of these studies, different methods of data collection have been used, including psychoanalytic interviews (Meehan et al., 2021) and blog posts

(Beck, 2022). Women in these studies experienced a difficult road to motherhood that was plagued by distrust for their own body and fears of killing the baby, with one expectant fearing that she would not carry her baby to full term (Meehan et al. 2021). There was a sense of relief each time a new foetal milestone was reached, but this relief was short-lived. Another woman recalled a vicious cycle of engaging in cleaning rituals that she deemed crucial for the survival of her baby. These rituals included cleaning the walls and doors until their hands bled (Beck, 2022).

In the study of Meehan et al. (2021), the participants reported fears of harm continued after giving birth. The women in these studies described feeling elated when their infant was born, however this was quickly followed by a huge sense of responsibility to keep the infant alive. The vulnerability and defencelessness of their new-borns frightened them. The participants in this study also described experiencing great conflict between their role as the baby's protector, while also viewing themselves as the aggressor. This conflict manifested as the desire to protect their baby, while fearing that they would harm or kill the baby. These women described their intrusive thoughts as a 'beast', 'demon' and a 'bully', with one woman labelling herself a 'murderous paedophile who just wants to hurt people' (p. 168). Some woman reported fearing that having destructive thoughts would somehow damage their baby, while others believed that having these thoughts made them an evil and immoral person.

Doubt has been described as a hallmark feature of OCD (Nestadt et al., 2016). Individuals with OCD experience a pathological excess of doubt that manifests as a lack of confidence in their memory, perception, intuition, and attention, making it difficult to trust their internal experiences (Nestadt et al., 2016). For example, a woman interviewed in Meehan et al. (2021) reported feeling that intrusive thoughts had infiltrated her mind and created an environment of doubt. This sense of doubt pervaded the core of her being, making her question if she really loved her child or not.

Women from the studies reported feeling tortured by their obsessional thoughts and paralysed with fear. While many mothers recognised that their fears were irrational, they could not

stop replaying them, with one describing them as an 'unwanted stranger invading her mind' (Beck, 2022, p. 277). One mother recalled repetitive thoughts of throwing her infant through the window when he cried, while another mother visualised herself drowning her baby in the bath. They described these experiences as 'a special type of hell' that drove them to perform compulsions in efforts to keep the infant safe (Beck, 2022, p. 277). Common compulsions included setting alarms to wake up and check that the baby was still breathing, washing baby bottles until their hands bled, and avoiding activities such as bathing and checking the internet for stories about mothers who harmed their children and making comparisons with their own behaviour (Meehan et al., 2021). Women recalled feeling exhausted and debilitated by the constant cycle of obsessions and compulsions (Beck, 2022; Meehan et al., 2021).

Some women in the studies reported feeling a sense of loss from not enjoying pregnancy or early motherhood, due to the exhausting cycle of OCD. For example, Beck et al. (2022) reported how one mother stated that OCD had robbed her of her pregnancy. She explained not being able to buy any clothes for her baby or take photos of her pregnancy due to fears she would miscarry or give birth to a stillborn (Beck et al., 2022). Similarly, a participant in the study of Meehan et al. (2021) reported feeling as though they had missed out on the good parts of motherhood, because they were always 'in their head' (p. 169). While another woman mentioned that it was easier to forget this period of her life. The participants noted a stark contrast between what they hoped parenthood would be like and what they actually experienced, with one woman noting that she felt a sense of anger and frustration about the impact of motherhood on her mental health (Meehan et al., 2021). Although Meehan et al. (2021) and Beck et al. (2022) had a different lens of analysis, there were many similarities in participant experiences. Both studies were comprised of fifty participants in total from predominantly Western countries including United Kingdom, United States, Australia, and South Africa and therefore they reflect only small sample of the overall population who experience perinatal OCD. Consequently, they cannot be deemed exhaustive or conclusive.

Experience of Treatment and Care

Little is known about the mental health care experiences of women with perinatal OCD. The few studies that investigated treatment and care experiences have used singular case studies or personal narratives. A systematic review, conducted by Burton et al. (2022) included a broad inclusion criterion: any quantitative or qualitative study including information about the treatment experience for women with OCD, in any language, in any country using any study design. The review yielded 18 studies. This included fourteen case studies, three personal narratives and one qualitative interview study. The systematic review reported that all 18 eligible studies did not meet the assessment tool of Murad et al. (2018) designed to evaluate the methodological quality of case studies and personal narratives. For example, many of the case studies included in the systemic view were missing patient perspectives on the treatment that they had received, which can devalue the lived experience voice. Further, only one study contained direct quotes from their participant (Gershkovich, 2019). It has been argued that direct quotations can clearly illustrate the participants perspective in their own words. Not only does this deepen the meaning of the text, but it also helps to serve the readers assessment of the accuracy of the analysis, thus can be understood as a validation process (Corden & Sainsbury, 2006). Other limitations include a lack of OCD assessment across eight studies, and a poor description of treatment across three studies, thus highlighting significant research gaps in the field. Findings from the systemic review are included in the following section.

Barriers to Treatment

Several women in the review reported multiple barriers to diagnosis and treatment. Some of the barriers to diagnosis and care stemmed from personal apprehensions, where participants did not feel comfortable confiding in their maternity care professional (Benfield, 2018; Burton, 2020; Gershkovich, 2019; Puryear & Treece, 2020). While intrusive thoughts are a common postpartum experience, women felt like a ‘bad mother’ for experiencing them due to the associated stigma; this acted as a barrier to seeking help (Meehan et al., 2021). Additionally, many new mothers feared that

their infants would be removed from their care if they disclosed their thoughts to a professional (Benfield, 2018; Burton, 2020; Gershkovich, 2019). The deep-seated fears held by participants were not unfounded, with one mother being inaccurately diagnosed with psychosis and involuntarily hospitalised (Christian and Storch, 2009), while two other participants were reported to social services without their knowledge (Challacombe, 2014). Another woman was told that she needed to fight off her thoughts or she would be hospitalised (Challacombe, 2014). This was detrimental for the women who already feared she was a risk to her child. Misdiagnosis had further reinforced and strengthened their maladaptive beliefs, exacerbating their symptoms.

Misdiagnosis can also increase secondary care risks, where the mother avoids essential care-giving due to belief they present a risk to the baby's safety (Challacombe & Wroe, 2013). These research findings highlight a need for health care professionals to be able to distinguish between ego-dystonic harm obsessions that occur in OCD, and infanticidal ideation that can occur in depression or psychosis (Abramowitz et al., 2003). This is important considering that there have been no documented cases of women with perinatal OCD causing harm to their infants within the literature (Ross & McLean, 2006).

A lack of knowledge amongst health care professionals was identified as a treatment barrier by women with OCD across four studies (Benfield, 2018; Challacombe, 2014; Christian & Storch, 2009; Gershkovich, 2019). One woman expressed how health care professionals failed to identify her OCD symptoms for two years after her son's birth (Benfield, 2018). Women also reported being told by health care professionals that 'everyone feels like this' after birth and that 'everyone has OCD' and they 'should get on with it' (Challacombe, 2014, p. 10). Many women felt unsupported by health care professionals, who trivialised and minimised their symptoms (Meehan et al., 2021; Challacombe, 2014).

Women also felt afraid to confide in family members. Participants expressed concerns about being perceived and judge as 'crazy' or 'an evil monster' by their family (Blakey & Abramowitz, 2017,

p. 111; Gershkovich, 2019). Another woman expressed a fear of being perceived as bad mother and felt she needed to 'act like a new mom, who had it all together' (Meehan et al., 2021, p. 166). These findings reflect the pressures of the 'good mother' ideology that prevails throughout society. Another Chinese woman feared that she would bring disgrace to her family if she was deemed mentally unstable, highlighting the cultural perceptions that may impede disclosure (Fang et al., 2018). In many cases, fears of judgement led to the concealment of obsessional thoughts and behaviours, ultimately impeding access to accurate diagnosis and treatment (Burton et al., 2022).

Medication

Research on the use of medication suggests that careful consideration must be taken when weighing up the risks of treatment compared to the risks of no-treatment (Hudepohl et al., 2022). As discussed earlier there is currently little research on the treatment of perinatal OCD. The foetal risks associated with psychotropic medication have been extensively studied during pregnancy, and while they are deemed relatively safe, they do carry risk (Creeley & Denton, 2019). Across the literature, women reported concerns about taking medication while pregnant or breastfeeding (Blakey & Abramowitz, 2017; Chelmow & Halfin, 1997; Gershkovich, 2019). Several women explained that they felt conflicted between keeping the baby healthy and keeping themselves healthy (Burton et al., 2022). While they were concerned about the impact that their poor mental health could have on their babies, they were also concerned about the unknown risks associated taking anti-depressants (Lynch et al., 2018). Women from six studies decided to stop taking their anti-depressants during pregnancy to minimise harm to their infants, which for some meant that their OCD symptoms worsened during this time (Burton, 2020; Berez, 1996; Challacombe, 2014; Viveiros & Darling, 2019; Fang et al., 2018; Kalra et al., 2005).

Four participants decided not to start anti-depressants while breast feeding due to similar concerns (Beraz, 1996; Blakey & Abramowitz, 2017; Chelmow & Halflin, 1997; Gershkovich, 2019). There were a few cases however, where participants decided to take medication due to the

acknowledgement that it would help them be a better mother (Chelmow & Halfin, 1997). Two women who made this decision reported a relief in OCD symptoms and an improved perinatal experience (Burton, 2020). These findings highlight the importance of providing women with clear information and resources that include the risk and benefits of treatment to ensure they make informed choices (Berez, 1996; Burt & Rudolph, 2000; Burton et al., 2022). When considering the use of psychotic medications during the perinatal period, the individual should also account for the risks of untreated illness (Creeley & Denton, 2019). Depression and anxiety in pregnancy has been associated with infant respiratory distress, low birth weight, and preeclampsia (Chen et al., 2010; Cripe et al., 2011; Ding et al., 2014; Mulder et al., 2002). Further, postpartum depression has been associated with infant attachment issues, behavioural problems, and neurocognitive delays (Avan et al., 2010; Campbell et al., 2004; Stein et al., 2014). While the impact of OCD on a developing foetus is currently unknown, one recent study found that exposure to maternal OCD was associated with a lower birth weight and lower gestational age in new-borns (Uguz et al., 2015).

Therapy

The most beneficial forms of therapy reported by women in qualitative studies focused on OCD experience were psychoeducation, CBT and ERP therapy. This was not surprising considering CBT with ERP was identified as a first-line approach in the wider literature (Abramowitz & Jacoby 2014). Research suggests that CBT is a safe and effective psychological intervention for OCD in the postpartum period (Fang et al., 2018). CBT's approach includes three components: (a) psychoeducation regarding typical OCD symptoms; (b) challenging irrational thoughts related to the infant or parenting and (c) exposure to anxiety provoking situations, such as changing the infant's nappy, without engaging in compulsions. Participants across multiple studies have noted that psychoeducation was the most beneficial when presented within the context of perinatal experience and perinatal OCD (Gershkovich, 2019; Hudak & Wisner, 2012; Puryear &Treece, 2020).

In the study by Challacombe (2014), a participant had previously declined CBT because she believed that exposure response therapy would put her baby at risk. While many participants were initially anxious to start therapy, this concern was relieved with psychoeducation. Psychoeducation was described as helpful in eight studies (Burton et al., 2022). Many women attributed symptom improvement to psychoeducation, particularly to the realisation that their intrusive thoughts did not reflect their desires, values, or actions (Fang et al., 2018). Another woman expressed that she had never considered that the beliefs she held so strongly may be inaccurate. She challenged these beliefs and found that her anxiety lessened (Christian & Storch, 2009). Successful therapeutic interventions were attributed to a strong therapeutic alliance between the woman and their clinician, where an ongoing state of meaning-making took place (Meehan et al., 2021).

The normalisation of intrusive thoughts was also particularly helpful for women in the study of Burton et al. (2022); two women reported feeling relieved knowing that intrusive thoughts were a common experience for new mothers and did not mean that they were bad people. Normalisation was helpful when it was received from both health care professionals and family members (Gershkovich, 2019). The taboo nature of intrusive thoughts made it challenging for women to disclose what they were thinking, but normalisation helped to break down barriers which prevented women from seeking help (Puryear & Treece, 2020). Additionally, some women found reframing their perspective of intrusive thoughts to be helpful. Instead of questioning their thoughts of intentional harm, they regarded them as protective impulses that were an extension of maternal vigilance and care (Murray & Finn, 2011). The findings of these studies suggest that CBT with ERP is a powerful treatment for perinatal OCD. However, it was not clear whether the women in these studies had used CBT as an isolated approach, or if they had combined it with other interventions, such as medication or ACT. Further research is needed to determine whether CBT with ERP is sufficient as a standalone treatment for perinatal OCD.

Women in the study of Beck et al. (2022) noted several other strategies that were beneficial for recovery. Some women found comfort in online community groups or reading the blog posts of other women who had experienced OCD. This helped them to realise that they were not alone, and that recovery was possible. Other tools that helped them recover included yoga and mindfulness and learning to be more compassionate towards themselves. As a final part of the healing process, women wanted to share their experiences with others who were facing similar obstacles that inhibited the joys of motherhood.

Considering the highly debilitating nature of perinatal OCD, there is a need for an in-depth exploration of women's recovery experiences. This data can provide an indication of what therapies and techniques are beneficial to recovery; this is informative for the individual and for professional practise. Further, the exploration of recovery from a phenomenological perspective is empowering for mothers who suffer from OCD, this is particularly important given that maternal mental health is often stigmatised, leaving women afraid and ashamed to voice their experience, especially if it does not fit the dominant discourse of 'motherhood'. Silent voices can leave these notions unchallenged.

Summary

Despite the high prevalence of perinatal OCD and its detrimental impact on mothers' wellbeing, there is limited research on the topic of treatment and recovery. Cognitive research indicates that intrusive thoughts are common to all new parents; this stems from an evolutionary drive to protect the infant, however these intrusions become pronounced in OCD due to faulty misappraisals. This is compounded by societal expectations and pressures associated with the 'good mother' ideology, which can act as a barrier to treatment. This section revealed that OCD was experienced as tormenting, consuming, and paralysing, however these studies are few and have mainly relied on thematic analysis rather than employing analysis that deeply engage with experience. In the absence of treatment guidelines tailored specifically to perinatal OCD, recommendations follow those that have been established for the general population. Existing

qualitative literature has indicated that CBT with ERP is a promising and safe treatment option. The use of SSRIs may also be beneficial; however, the risks and benefits need to be carefully considered. While these studies indicate that these treatment options may be efficacious, it is not clear if they are sufficient as standalone treatments, and their long-term impacts on recovery remain unknown.

Rationale for The Current Study

There is strong evidence to suggest that the perinatal population are vulnerable to the development and exacerbation of OCD symptoms. The comprehensive literature review above shows how OCD symptoms can compromise the experience of motherhood if left untreated. Consequently, the lived experience of perinatal OCD and the underlying mechanisms of recovery are of important to understand. Despite this, the literature pertaining to experience and recovery is sparse. In light of these gaps, this research aims to understand better the nature of experience from the woman's perspective, as well as their expertise on treatments strategies and tools that can aid recovery.

To the best of my knowledge, only Beck et al. (2022) has explored perinatal OCD recovery. The study highlighted that recovery was possible and entirely worthwhile, albeit a slow and difficult process. While the study touched on various treatments that were used in journey to recovery, it did not explore the lived experience of treatment. This type of research is important because it foregrounds listening to women's stories and is better placed to illuminate the nuances and complexities of treatment. Hence, the present study aims to contribute to this nascent literature by generating novel insights into treatment and recovery through the analysis of mothers' accounts, who have experienced and recovered from perinatal OCD. The primary research aims for the present study are outlined below.

Research Objectives

The current thesis aims to meet the following objectives:

1. Gain a greater understanding of the lived experience of women with perinatal OCD

2. Identify how this experience affected their wellbeing/mental health and experience of pregnancy and motherhood

3. Gain a greater understanding of the lived recovery experience

4. Identify the strategies, techniques and behaviours that aided recovery

It seeks to address these objectives by answering the stated research questions below.

Research Question

- What is the lived experience of women with perinatal OCD?
- What is the lived experience of recovery for women who have overcome perinatal OCD?
- What are the therapeutic tools and interventions that contributed to recovery?

Chapter 2: Methodology and Methods

This chapter begins with an overview of the qualitative methodology used in the present study. First, I outline the core principals of interpretative phenomenological analysis (IPA) and provide a rationale for how this methodology aligns with the research aims, followed by a description of the procedure that was used to collect data. I will then discuss the ethical considerations of the project and critically reflect on my position as a researcher. Lastly, I describe the data analysis and quality assurance procedures that were undertaken throughout the study.

The Rationale for a Qualitative Approach of Inquiry

Qualitative research sets out to investigate and understand the subjective reality of the human experience (Masoodi, 2007). Qualitative researchers are interested in understanding how different contexts and social interactions shape individual perception. Qualitative research is an umbrella term that is used to describe a range of methods and approaches to inquiry. For example, phenomenological research, a type of qualitative inquiry, sets out to explore the lived experience of individuals. This type of research provides insight into how the individual makes sense of phenomena and assigns meaning to their experience (Rahman, 2016). Hence, qualitative methodology is more appropriate for investigating internal experiences that cannot be easily observed or obtained through numerical data (Rahman, 2016). Considering the current research aims, qualitative methodologies were deemed more suitable to investigate and understand the complex phenomena of illness experience and recovery; this is important considering that existing literature has mostly employed quantitative methods that only seek to describe phenomena. Contrary to quantitative methodology, this project does not seek to generate causal relationships or make generalisations (Noon, 2018). While this project will describe commonalities found in individuals who experience perinatal OCD, it will also highlight individual differences.

Interpretative Phenomenological Analysis (IPA)

IPA is a qualitative approach that aims to explore how individuals make sense of their experiences and generate meaning from them (Smith & Osborn, 2008). IPA researchers attempt to understand what an experience is like from the perspective of the participant. This is achieved through two complimentary commitments of IPA – 'giving voice' and 'making sense' (Smith & Osborn, 2008). The concept of giving voice refers to the opportunity for participants to describe their experiences and feelings in their own words (Noon, 2018). The concept of sense making is concerned with how participants interpret their experiences, and what these subjective interpretations reveal about the phenomenon under investigation. These in-depth explorations of personal accounts can uncover both similarities and differences in experience, thus providing insight into the nature of the phenomena (Smith et al., 2009). The main theoretical underpinnings of IPA are idiography, phenomenology and hermeneutics; these will be described in the following section.

Phenomenology

Initially developed by Husserl (1900), phenomenology is the study of consciousness, perception and lived experience. From this perspective, humans are viewed as interpretative beings, who are constantly interpreting and making sense of their experiences (Smith & Shinebourne, 2012). Thus, individual perception is not a passive reflection of objective reality. Instead, it is actively construed and shaped by embodied experiences as they appear to consciousness (Tuohy et al., 2013). Thus, phenomenology aims to produce an account of consciousness from the perspective of the individual. These aspects of consciousness include the meaning of experience, the significance of objects, nature, time, and the (Langdridge, 2007).

Phenomenologists endeavour to understand the inner worlds of individuals through their thoughts, feelings, and memories. They recognise these inner experiences are influenced by the broader environment in which they occur. IPA is committed to exploring how the historical, environmental, cultural, and social context of a participant's life may shape their experience

(Eatough & Smith, 2008). Thus, interpretations go beyond mere description; the researcher aims to provide a comprehensive account of what it means to have such experiences, within their specific context (Noon, 2018). The objective of the researcher is to attain an 'insider perspective'; this can be described as gaining an understanding of what it is like to walk in the participants shoes (Smith et al., 2009).

Hermeneutics

In a broad sense, hermeneutics describes the interpretation of meanings (George, 2021). To gain an 'insider perspective', IPA researchers engage in double hermeneutics (Smith, 2004). This is described as a dual interpretation process; as the participant interprets their experience, the researcher makes sense of the meaning that they assign these experiences (Peat et al., 2018). The researcher plays a crucial role in the analysis and interpretation of the individual's experience, by reading between the lines for deeper meaning (Charlick et al., 2016).

Whilst interpreting the data, the researcher formulates critical questions that enhance the depth of the analysis (Peat et al., 2019). Interpretations are therefore restricted by both the respondent's capacity to articulate their inner experiences and the investigator's ability to explore them (Noon, 2018). While the researcher should work reflexively to manage their personal biases, IPA acknowledges that it is impossible for researchers to discard their preconceptions, opinions, and beliefs completely (Noon, 2018). It also recognises that it is not possible to fully access the inner world of another. Therefore, the objective is to obtain an account as 'close' to the respondent's view as is possible (Larkin et al., 2006). Rather than assuming an objective approach, IPA argues that researcher knowledge is valuable and essential to phenomenological research. This process of double hermeneutics can be described as 'a fusion of horizons' between the participant and the researcher, where new meanings are generated from the merging of perspectives (Gardamer, 1976; as cited in Lopez & Willis, 2004)

Idiography

Idiography is a method of inquiry that is concerned with the study of the individual and subjective phenomena (Moses & Knutsen, 2012). The research process of IPA enables an in-depth examination of lived experience that is unique to the participant and their context (Noon, 2018). The individual is seen as a unique agent with a unique life history. From this standpoint, individual perspectives are viewed as being shaped by prior knowledge, beliefs and life experiences; these properties set them apart from other individuals (Smith et al., 2009). The researcher seeks to understand as much as possible about each individual case before moving on to the next (Cassidy et al., 2011).

Since IPA studies usually focus on more than one participant, the researcher must construct a narrative that enables the reader to identify key similarities amongst the participants, while also allowing the reader to appreciate the idiosyncrasies that emerge (Eatough et al., 2017). Thus, the goal is to produce an analysis that addresses both convergence and distinctiveness amongst participants experiences (Noon et al., 2018).

Strengths and Limitations of IPA for the Current Study

IPA is an inductive research method that has several strengths. First, it is a data driven and flexible approach. Secondly, IPA advocates for a participant-centred approach in theory development. Inductive reasoning enables the researcher to gther a set of observations and then form conclusions about the patterns of convergence and divergence in the data (Noon et al., 2018). Further, it can provide novel insight on specific phenomena and fuel further exploration. There is currently limited qualitative literature on the topic of perinatal OCD. Thus, the strengths mentioned above were a significant driver for selecting IPA as a methodology. Further, this methodology provided women with a platform to share their personal experiences and opinions that may not have been heard. IPA's idiographic commitment complimented the sensitive nature of perinatal OCD, by ensuring that narratives and themes remain personalised (Noon, 2018).

Another strength of IPA is the priority it places on subjective experience within its broader context. This subjective and contextual lens was fitting for the present study, given its commitment to exploring the recovery experience. There is a clear distinction between 'personal recovery' and 'clinical recovery' in the literature (Gilburt et al., 2013). Qualitatively speaking, mental health recovery is defined as "a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness" (Anthony, 1993, p.12). This definition illustrates recovery as a subjective experience that is related to personal processes including connectedness, hope, identity, meaning, and empowerment. In contrast, clinical recovery is associated with symptom remission, or a return to a pre-illness state (Davidson et al., 2020). IPA was deemed the most appropriate methodology because of its ability to provide more insightful, nuanced, and contextualised interpretations (Smith & Osborn, 2008). Specifically, it enabled the exploration of the environmental, sociocultural, and ideological that contribute to mental health recovery. Applying this methodology ensured that recovery was not presented in a narrow, deficit-focused, or stigmatising manner.

IPA relies on language as a necessary tool to capture participant experience (Noon, 2018). The dataset in the present study consisted of highly articulate women. The women described their experiences using expressive and detailed language, which enabled the researcher to collect nuanced accounts. However, IPA's reliance on language was also considered to be a limitation. Relying solely on language to access individual experience can be problematic, as it may overlook those who are unable to articulate their experiences. For example, researchers may exclude individuals with speech difficulties or language barriers, because such challenges can impede the exploration of the persons inner world (Noon, 2018). Thus, IPA may be seen as elitist, by only providing access to participants who can articulately and fluently describe their experiences, and dismissing those who cannot (Tuffour, 2017).

Positioning

Interpretivist research assumes that the researcher takes a central role in the interpretation and discovery of situated knowledge (Cohen et al., 2007). The researcher is assumed to have a

position that influences the interpretations they make (Bukamal, 2022). A researcher is considered an 'insider' when they share particular attributes with the participants they are studying, and an 'outsider' when they do not (Clarke & Braun, 2013). There are several benefits and disadvantages of being aligned with these positions, therefore, the costs and benefits need to be weighed carefully. It has been argued that only the insider understands the 'subtleties, nuances, and sometimes significance of what takes place' (Walker et al., 2006, p. 335). However, being an insider can raise issues of undue influence on the researcher's perspective (Dwyer & Buckle, 2009). For example, it is possible that the researcher may make assumptions of similarity and thus fail to explain the participants individual experience fully. In another scenario, the researchers' perceptions may be coloured by their own experiences, and he/she may have difficulty separating this from that of the participants. On the other hand, being an outsider does not mean that the researcher is immune to the influence of personal perspective (Dwyer & Buckle, 2009). To overcome these obstacles, Dwyer and Buckle (2009) recommend that the researcher engages in an ongoing practice of reflection and pays close attention to their personal biases and perspectives. Regardless of the insider or outsider perspective, the researcher should remain open, honest, authentic, interested, and committed to accurately presenting the participant's experience.

My Positioning

Throughout this project, I have been uncertain with my positioning as an insider or an outsider. I have experienced two episodes of harm OCD in my lifetime - this occurred between the ages of 22-23 and 30-32. Both episodes were triggered by grief experiences. The first episode was left untreated and seemed to dissipate over time. The second episode was worse and required clinical intervention. Fortunately, I have been in remission for more than two years. This experience has inspired me to help others with OCD by becoming a registered psychologist. It is important to note that I have not experienced perinatal OCD or given birth. Consequently, I consider myself both an insider and an outsider in relation to this research, and therefore occupy 'the space between'. This concept was developed by Dwyer and Buckle (2009) who propose that researchers can never

really position themselves entirely on one side of the insider/outsider binary. I was motivated to complete this project because I have experienced the debilitating side of OCD and I have compassion and empathy for others who face similar challenges. Further, I consider myself a feminist and was determined to shine light on this important topic from a strengths-based perspective, by illuminating recovery in a holistic and empowering manner.

Both the context of the research and my positionality influenced certain methodological decisions. Initially, I was going to recruit participants for the project and conduct 1:1 interviews. However, after reflecting on my own experience of OCD, I recalled how difficult it was for me to talk about my own experience, despite identifying as 'recovered'. This was largely due to the fear of being labelled as 'crazy' or perceived differently. It has been suggested that a secondary analysis may be of benefit in situations where the topic of discussion is a sensitive one (Fielding, 2004). Considering the nature of my chosen project, my supervisor and I decided it was best to use data that already exists. As a result, I searched for data from women who have voluntarily and actively chosen to speak publicly about their experience; this meant that I was not putting additional people at risk. Where I found such talk, was in a podcast series about OCD.

Podcast as a Secondary Data Source

Developments in technology have enabled innovative methods of collecting qualitative data (Riley & LaMarre, 2022), including digital technologies, such as podcasts. This study explores women's experiences of perinatal OCD through interviews published on 'The OCD Stories' podcast channel. There are several advantages of using podcasts as a medium for data. Podcasts have become more widely used for research and education, due to them being readily available and convenient. There is evidence to suggest that podcasts have advanced to a 'second wave' educational tool that can help academia disseminate research findings (DeMarco, 2022), but they can also be used to create data. IPA research pays close attention to the way participants describe their experience through language (Noon, 2018). Podcasts enable the capture nuances in voice, emotion, and tone. These nuances, including intonation, cadence, silences, and pauses can also

convey deeper meaning and enhance the depth of analysis. Further, podcasts may help researchers connect with the broader community (Harter, 2019). This is certainly the case in the current project, as I was able to hear from women around the world.

The literature examining podcast data as a method in qualitative data is practically non-existent at this current time. It can be assumed that this method of data collection carries similar advantages and limitations and of other secondary data sources. A specific limitation of employing podcasts as a data collection method is the absence of standardised methods to evaluate the quality of the podcast (DeMarco, 2022). A key advantage of using 'The OCD stories' podcast data was the expertise held by the podcast host. Stuart Ralph, a registered psychotherapist, has interviewed hundreds of people on his podcast series in relation to OCD. Stuarts interviews are guided by compassion, empathy, and professionalism. He provides a safe and non-judgemental environment where podcast guests feel encouraged to share their stories. He also uses interview techniques such as open-ended questions to encourage further elaboration. These factors served as quality criteria when determining whether the data was suitable for the research aims.

There are also disadvantages of using a secondary data source. Podcasts, for example, are often edited by the podcast host. The process of editing is subjective, where the host decides what information to include and discard, based on assumptions of what people want to hear (Cheng & Phillips, 2014). As a result, researchers who use second hand data are not privy to the whole data set. This limitation was considered when assessing the quality of the dataset and determining whether it had the potential to answer the questions in this project. This assessment concluded that the data had adequate depth to answer the topics of inquiry, because it included highly intimate accounts of illness and recovery.

Data Collection

Purpose sampling is a common technique in qualitative research because it enables the researcher to identify and select individuals who have experience with a phenomenon of interest

(Charlick et al. 2016). The podcast data were sourced through 'The OCD Stories' podcast channel hosted on Spotify. A short list of episodes was made for podcasts blurbs that mentioned the keywords 'pregnancy,' 'post-natal' and 'recovery'. This short list contained 10 episodes. A specific inclusion and exclusion criteria were established prior to data collection. Firstly, the experience of obsessive-compulsive disorder during the perinatal period needed to be the primary topic for the podcast. Guest speakers who described their subjective OCD symptoms were considered, including those without a clinical diagnosis. The second criteria related to recovery. Speakers who self-identified as being in the recovery phase of perinatal OCD were included; the notion of recovery was subjectively defined by the podcast guests on their own terms. Ten podcasts met the criteria stated above and were deemed suitable for secondary analysis, with one being removed after transcription.

There is no set rule for sample size in qualitative research, however IPA recommendations include a purposive, homogenous sample (Noon, 2018). Suggested sample sizes range from 3-10 to ensure idiographic commitments are upheld (Smith et al., 2009). Although this project used interviews from a secondary data source, these guidelines were considered when determining the amount of data to be included. Further, the data selection process was guided by the concept of information power, rather than setting a numerical goal (Malterud et al., 2016). In this instance, information power related to the quality of the interview dialogue between the podcast host and the guest speaker. The conversations were very focused due to the expertise held by the podcast hold. Many of the participants were able to articulate their experiences very well, and thus provided adequate information that could contribute to the goals of the project. Of the 320 episodes, 10 were dedicated to perinatal OCD. Of the 10 episodes, one dataset was eliminated during the analysis phase. As discussed earlier, IPA's reliance on language and articulation can be a limitation of the method. The researcher was unable to accurately interpret this account because the transcript was lacking both depth and detail. For this specific dataset, a different methodology might have been

more appropriate to use. The remaining nine podcasts addressed the breadth of perinatal OCD and recovery, with talk time ranging between 45 – 90 minutes.

Sample demographics are presented in Table 1 below. The names of podcast guests have been replaced with a pseudonym. In addition to OCD, several podcast guests discussed co-morbid disorders including anxiety, depression, post-traumatic stress disorder (PTSD) and complex trauma; these co-morbidities are noted in the background information section.

Table 1

Participant Demographics.

Podcast	Pseudonym	Background
1	Ivy	American mother of one, married, trained as an OCD psychologist. Had history of generalised anxiety and social anxiety during adolescence but no diagnosis. Experienced onset of post-natal OCD following birth received diagnosis. Identifies as in recovery after using medication, CBT and ERP.
2	Olivia	American mother of one, married. Anxiety, depression and complex trauma throughout childhood, OCD throughout adolescence, received OCD diagnosis in early adulthood. OCD symptoms were exacerbated following birth. Identifies as being in recovery after using medication, CBT and ERP and group therapy.
3	Mia	British mother of one, divorced. History of OCD throughout childhood/adolescence, undiagnosed. Experienced exacerbation of OCD following birth and received diagnosis. Identifies as being in recovery after using medication, CBT and ERP.
4	Jane	American mother of three, married. History of OCD, through adolescence, undiagnosed. Experienced exacerbated OCD during first pregnancy after a traumatic event. Received a diagnosis for OCD, depression and PTSD. Identifies as being in recovery following medication, CBT and ERP. Also used creative writing as a recovery strategy. Did not experience perinatal OCD in subsequent pregnancies.

5	Emma	British mother of two, married. History of anxiety during childhood/adolescence, undiagnosed. Experienced onset of OCD symptoms following the birth of both children. Identifies as being in recovery after using medication, CBT, ACT and group therapy.
6	Amelia	American mother of three, married. History of anxiety and OCD in childhood/adolescence, undiagnosed. Experienced exacerbated OCD symptoms with all pregnancies. Identifies as being in recovery after using medication, CBT and ERP and group therapy.
7	Sophia	American mother of three, married. History of anxiety through childhood, undiagnosed. Experienced symptoms of OCD in adulthood but was diagnosed with depression. OCD symptoms were exacerbated following birth, received diagnosis. Identifies as being in recovery after using medication, CBT and ERP, and community groups.
8	Grace	American mother of two, married. History of OCD throughout childhood/adolescence, undiagnosed and manageable. Experienced exacerbated symptoms following the birth of both children. Identifies as being in recovery after using medication, CBT and ERP.
9	Audrey	British mother of one, married. Had history of anxiety as a child, received depression and anxiety diagnosis in adulthood. Experienced onset of perinatal OCD with first child following birth, received diagnosis. In hindsight, had manageable OCD symptoms most of childhood/adolescence. Identifies as in recovery after using medication, CBT and ERP. Other strategies for recovery included creative writing and self-compassion exercises.

Ethical Approval Process

The first draft of the Ethics Application was submitted to the Massey University Human Ethics Committee on 08/11/2022. The ethical considerations of this project were guided by two key policies: The Massey University Code of Ethical Conduct for Research and Teaching involving Human

Participants (Massey University, 2017) and The Ethics guidelines for Internet-mediated Research (2021). A full ethics approval was granted on 28/03/2023 by the Human Ethics Committee once revisions had been made. A summarisation of the main ethical considerations of this study are included below.

Ethical Considerations

The ethical standards regarding the use of 'publicly available data' as empirical research are widely debated (Markham & Buchanan, 2015). Some scholars argue that consent should be waived when individuals have knowingly published content within a public domain. In response to this, Boyd (2008) argues that privacy is about the individual's sense of control over the context it is shared in, and with whom. It was particularly challenging to negotiate these blurred boundaries within the context of a publicity available podcast. It can be argued that this information was specifically intended for a large public audience, due to being readily available on global streaming platforms including Spotify, iTunes and Google Play. Conversely, the guests of the podcasts may have only intended for this information to be available on the podcast, and control over privacy is lost when various contexts are collapsed into one (Marwick & Boyd, 2010). Instead, Highfield and Leaver (2016) contend that researchers should evaluate the potential to cause harm, rather than focusing on public or private binaries. Further, ethics should be embedded into the research methods and be frequently reviewed during data collection, analysis, and dissemination (Markham et al., 2018). It is anticipated that this project has minimal potential to cause harm, due to the guests having already shared their story in a public sphere. There was also a small risk that individuals may be identifiable from the data set, thus generating a threat to anonymity, confidentiality, and privacy (The British Psychological Society, 2021).

In consideration of the above, I decided to inform the guests that I was planning to use their data for the project and provide them with the opportunity to opt out if preferred. I found the guests information on 'The OCD Stories' website. The website contains a comprehensive list of all

the podcast episodes that have aired. Many of the participants contact details were publicly listed under their individual episode. The email outlined my research and my intention for using their data. I reassured the guests that I would protect their privacy to the best of my ability by anonymising their data and removing all identifiable information. I noted that I would, however, include direct verbatim quotes that could lead to the identification of their podcast episode and consequently, their identity. I received extremely positive replies from each guest. Many of them were enthusiastic for their experience to be used in this way, to help generate awareness and knowledge regarding perinatal OCD, as this had been their initial reason for participating on the podcast.

Other ethical concerns included the decision of whether to publish the podcast name. Publishing the name of the podcast has the potential to compromise the anonymity of the individuals or have a negative effect on the online community. Based on the Ethics Guidelines for Internet-mediated Research (2021), I decided to discuss the potential risks with Stuart Ralph, the owner of the podcast, to determine whether the name of the podcast would be published or anonymised in the research project. The podcast owner welcomed the publishing of the podcast name 'The OCD Stories' in the present study, suggesting that the risk of harm would not be any greater than what already exists.

Data Analysis - Interpretative Phenomenological Analysis (IPA)

In the following section, I discuss the key steps of IPA and how these were applied to the dataset.

Transcription and Familiarisation with the Data

During the first stage of data analysis, I repeatedly re-read my transcripts while listening to the audio recordings of the podcast interview. Smith et al. (2009) recommends paying particular attention to words and phrases that are interesting, unusual, or enigmatic. I searched for descriptive words or phrases that contained conceptual relevance and noted down my reflections and observations on the left-hand side of the transcript. I focused on not only what was said, but also how it was said, and the significance of this. Applying the recommendations of Smith and Osborn

(2009), I noted linguistic elements such as metaphors, pronouns, positive and negative descriptors, emotive terms and repetitive words. I also made note of pauses in speech, changes in tone and emotion and words that were inaudible. Analysing the data through a linguistic lens enabled me to interpret the data at a more conceptual level. For example, when examining the transcripts, I noted down the repetition of emotive words that reoccurred throughout the text. By doing so, I was able to delve into the underlying experience beyond the surface level descriptors. This enabled me to uncover the overarching abstract themes amongst the datasets. Through this process, new questions emerged regarding the meaning associated with the idiographic experience. These were then developed into descriptive comments that illustrated the things that mattered for each speaker.

Developing Emergent Themes

The hermeneutic principals of IPA position the researcher as an integral part of the research process (Peat et al., 2019). To reveal the inner experience of the participant, the researcher must engage with a process known as the hermeneutic circle. Once I had re-read the transcripts and made initial notes, I circled back to the beginning of the transcript and documented emerging themes. I annotated exploratory statements that captured both the individuals account and my interpretation of it; this was noted on the right side of the transcript. During this phase, it was important to document how these interpretations evolved in the reflexive journal.

Connecting Emergent Themes

Smith and Osborn (2008) advise looking for connections between emergent themes based on their conceptual similarities. Once experiential statements had been developed for the entire transcript, I listed the emerging themes in chronological order. I attempted to make sense of the themes by looking for connections between them. Themes that related to one another were clustered together with descriptive labels. Through this process, several subordinate and sub-themes emerged. While I clustered the themes together, I continuously referred to the transcript to

ensure the connections were aligned with the primary material. Following this, I organised subordinate themes onto a table under their superordinate headings, along with participant extracts as supporting evidence.

Moving on to the Next Case and Repeating

The idiographic commitment of IPA was upheld by providing a detailed examination of each case before looking for patterns of convergence and divergence across the entire dataset. The steps mentioned above were repeated for each subsequent case. Smith et al. (2009) suggest treating each account "on its own terms, to do justice to its own individuality" (p. 100). Keeping this in mind, I endeavoured to bracket the concepts that had emerged from previous transcripts, while acknowledging that this would not be entirely possible.

Looking for patterns across cases

Once I had individually analysed each case, I created a word document for each subtheme that was expressed in the data. I grouped common subordinate themes together and discarded those that were irrelevant to the research question. Following this process, I created a Master Table (Appendix B) of superordinate themes, subordinate themes, and indicative quotes. Following the recommendations of Smith and Osborn (2008), themes were selected based on their prevalence in the dataset, how well they illuminated aspects of personal experience, and the level of significance placed upon them by participants.

Quality Indicators of IPA Research

All efforts were made to ensure this research was carried out to the highest possible standard. In this section, I will outline how I have met the four quality indicators of IPA research outlined by Nizza et al. (2021). The four indicators include: (a) Constructing a compelling unfolding narrative; (b) developing a vigorous experiential and/or existential account; (c) close analytic reading of participant's words, and (d) attending to convergence and divergence.

Firstly, *constructing a compelling unfolding narrative* relates to the progression of the story. Nizza et al. (2021) suggest that within each theme, there should be an unfolding dialogue between participant extracts and the analytic interpretations of the quote. Each theme is then built cumulatively until a coherent, interconnected, and persuasive story emerges. The present study has constructed an unfolding narrative using subordinate themes. Each theme had its own story that was developed by through the alternation of participant quotes and an in-depth interpretation of these words. This narrative was then built by adding additional quotes until a cohesive story emerged.

The second quality indicator, *developing a vigorous experiential and/or existential account*, relates to the depth of analysis. Specifically, this quality is increased when the analysis engages with the individual's sense-making of major life experiences and the significance of these (Smith, 2019). Throughout analysis, I engaged with the content on a deeper level by examining the existential questions that emerged from experiential accounts and how these are meaningful in the context of one's life and the perinatal period.

The third quality indicator, *Close analytic reading of participant's words,* is the researcher's idiographic commitment to interpretation. Specifically, the researcher should analyse the respondents quotes closely to explore their significance; this can be achieved by focusing on the content of the immediate quote, while also thinking about the context of the wider transcript. This principal was upheld by carefully reading quoted extracts and searching for particular words of phrases, linguistics tones, ambiguity, imagery, and repetition that helped to deepen the meaning of the data and its wider psychological notions. Direct quotes from podcast guests have been included in the analysis to ensure the idiographic principles of IPA are upheld and to provide context and evidence of analysis (Smith, 2009).

Finally, the fourth quality indicator is *attending to convergence and divergence*. Since IPA research usually involves analysis of more than one participant, convergence and divergence can be

used to illustrate the similarities and idiosyncrasies between individual accounts. Striking a balance between these two elements demonstrates patterns of connection, while also highlighting the uniqueness of each experience (Smith & Shinebourne, 2012). This quality was upheld by ensuring that each individual case was attended to before moving to the next. Once every case had been analysed separately searched for commonality across the experiential accounts, as well as idiosyncratic characteristics (Smith et al., 2009).

Researcher Reflexivity

Researcher reflexivity is an important component of qualitative research (Smith et al., 2009). IPA recognises that discarding preconceptions and biases prior to research is not possible since the researcher is embedded within the research project (Noon, 2018). Reflexivity is the practise of being aware of how one's perceptions and knowledge influence the research process (Peat et al., 2019). The double hermeneutic between the researcher and participant is central to IPA, therefore it is essential to consider how the researchers' thoughts and attitudes may reveal themselves during analysis and interpretation (Peat et al., 2019). Rather than attempting to eliminate all preconceptions, IPA encourages the researcher to acknowledge and explore their predispositions and how these influence the research process (Schwandt et al., 2007).

Prior to collecting data, I journaled my own experiences, pre-conceptions, and anticipated outcomes. I reflected on these entries at each stage of the process. This served as a reminder to consider how my prior knowledge may affect the interpretative process. When I was carrying out the analysis, I checked to see if my preconceptions were reflected in my interpretation of the data. I then worked with my supervisor to doublecheck that my interpretations were firmly grounded in the dataset. This collaborative process involved critically reviewing the analysis, seeking consensus on emerging themes and exploring alternative interpretations. This served to enhance the credibility and rigour of the findings. I also noted down key decisions, such as changing my chosen methodology from narrative inquiry to IPA. Some of my personal reflections were shared with my

supervisor, along with participant extracts, to ensure interpretation was logical and transparent to the reader.

There were times in the project that I felt overwhelmed, not only by the project, but by other aspects of my life that I was trying to balance. I managed these stressors by speaking openly with my supervisor and my support network. Throughout the project, I continuously re-evaluated my position and strived for transparency and sensitivity when representing individual accounts of OCD; keeping in mind that these experiences were separate from my own (Rose & Kalathil, 2019).

Trustworthiness in Qualitative Research

Traditional scientific aspirations to obtain 'objective' knowledge is deemed unachievable and inappropriate for qualitative research aims (Yardley, 2017). The criteria that are commonly used to measure quality in quantitative research, such as internal validity, external validity and reliability do not align with qualitative objectives. Differences in epistemological assumptions and aims requires a different approach for demonstrating the quality of research (Yardley, 2017). In response to this issue, Yardley (2008) proposed four core principles for evaluating the validity of qualitative research: sensitivity to context, commitment and rigour, coherence and transparency and impact and importance. In the following sections, I will explain what each principal relates to, and how I have adhered to these throughout my research.

Sensitivity to Context

Within the IPA paradigm, researchers recognise that the inner world of participants is contingent upon social, cultural, and historical factors (Eatough & Smith, 2008). To demonstrate sensitivity to context, Yardley (2017) recommends that researchers draw upon existing literature, pay close attention to the socio-cultural and linguistic content of the research, and demonstrate sensitivity towards participants. At the beginning of my project, I conducted a comprehensive literature review on OCD in the general population, followed by a review of OCD specific to the perinatal population. The theoretical concepts that emerged in this review were later discussed in my discussion chapter, along with participant quotes, to ensure they linked back to the current

literature. Areas of divergence were also sufficiently explored, including those that have not been discussed previously within the literature.

Commitment to Rigour

According to Yardley (2000), *commitment to rigour* refers to the completeness of the data analysis. To achieve the criteria of commitment, the researcher should collect sufficient data for the research aims, be competent the methods employed and demonstrate ongoing engagement with the research topic. The rigour criteria are determined by the amount of data collected and the depth of the interpretation. I have lived experience of OCD and therefore I can relate to this topic first-hand. I have been engaging with the OCD literature for the past four years and thus I consider myself to be immersed in this topic. I have become more knowledgeable in qualitative methods, specifically IPA, since beginning this project. My small homogenous sample was guided by the recommendations of Smith et al. (2009) and the concept of information power. These guidelines ensured that I had sufficient data to answer the research questions, whilst still being able to uphold idiographic commitments. Lastly, the criteria of rigour were met by repetitively re-reading each quote and interpretation to check if the interpretation was accurate and allow space for new insight to emerge.

The third criteria, *transparency and coherence*, refers to the persuasiveness of the research. Transparency in this context relates to how clearly a reader can derive the interpretations from the data. The concept of coherence describes the ‘fit’ between the research question and the philosophical underpinnings of the research, the methods employed and the analysis approach (Yardley, 2017). To enhance transparency, I have clearly outlined the procedural steps of this study and justifications for chosen methods of data collection, analytical produces as ethical decisions. I have attached an exemplar transcript, along with initial notes and emergent themes to assist readers with understanding how I derived these interpretations. Additionally, I have attached a Master Table of themes in the appendix, to illustrate how superordinate themes and subordinate themes were

determined by participant extracts. To address the criteria of coherence, I have explicitly outlined the philosophical and methodological assumptions of IPA to explain why this approach is suitable for the chosen topic. Finally, I acknowledge the active role I have played in the present study; thus, it was important for me to engage in an ongoing process of reflexivity (Willig, 2013). Examples of my reflexive practise include noting down my preconceptions, acknowledging my positionality, and critically reflecting on how my own experiences influenced the research process.

Impact and Importance

According to the fourth criteria, *impact and importance*, research must have theoretical or practical impact on the community for whom the findings were deemed relevant. I believe that this project is an incredibly worthwhile topic. It has the potential to shed light on a disorder that is frequently misunderstood. Further, increasing awareness and normalising these experiences may positively impact on expectant or new mothers who face similar challenges, by reducing the stigma related to poor maternal mental health. This is particularly important given that motherhood is a vulnerable time that is compounded by wider societal expectations and judgements. Finally, a core element of this study was to investigate the strategies and tools that have helped women move forward with their life. These discoveries have the potential to generate impact at both a theoretical and practical level.

Chapter 3: Analysis

The following chapter discusses the superordinate themes and the corresponding subordinate themes which have been developed from the analysis. The IPA analysis produced three superordinate themes. Theme one 'stuck in a horror story' described the terrifying and tormenting experience of having perinatal OCD. Theme two 'an arduous but worthwhile road to recovery' identified the strategies used to overcome perinatal OCD, and the challenges associated with treatment. In theme three 'words of hope' women in the study shared uplifting messages of recovery. Combined, these themes describe significant elements of the lived experience of perinatal OCD.

Table 2

Summary Table of Superordinate and Subordinate Themes.

Superordinate Themes	Subordinate Themes
1. Stuck in a Horror Story	1.1: Overwhelmed with Terror 1.2: Robbed of Joy 1.3: The Stakes are High 1.4. Thoughts have meaning
2. An Arduous but Worthwhile Road to Recovery	2.1: Finding the Right Therapeutic Fit 2.2: Relief through Medication 2.3: Discomfort as a Catalyst for Growth 2.4: Self compassion is Central to Recovery
3. Words of Hope	

Superordinate Theme 1: Stuck in a Horror Story

The first superordinate theme: 'Stuck in a horror story' describes how women in the study experienced their OCD as terrifying, destructive, extremely distressing, and inescapable. This experience was likened to a horror movie, where horrific thoughts and images played repeatedly in

their minds, causing immense psychological and physical distress. The relentless nature of OCD hindered the women's ability to experience the joys of motherhood and gradually eroded their sense of self. Eventually, the women contemplated extreme actions to break free from the torment within their minds.

Within this superordinate theme fell four subordinate themes: overwhelmed with terror, robbed of joy, the stakes are too high, and thoughts have meaning, which are discussed below.

Subordinate Theme 1.1: Overwhelmed with Terror

Women in the study described being tortured by intrusive thoughts and images of harming their infants. For most women, these intrusions started a few weeks after giving birth. Mia recalls a sudden and severe onset of OCD symptoms, that were experienced as terrifying:

> *"It was like a switch just went off in my head, and I started having thoughts about strangling my daughter. I dismissed it, but they kept on coming back and getting worse and worse. Like it wasn't just about strangling her. There were so many other instances where I could have caused harm to her, and it was absolutely terrifying."*

In the extract above, Mia recalls how rapidly she was consumed by terrifying thoughts of harming her daughter through strangulation. The metaphor *"a switch went off in my head"* describes how suddenly her attention was dominated by these disturbing thoughts, as if her mind had been hijacked against her will. While the violations initially involved thoughts of strangling her baby, they quickly evolved into endless scenarios of harm that played relentlessly in her mind. Mia's attempt to dismiss the involuntary thoughts only increased their intensification, she recalls that they "*kept on coming back and getting worse and worse"* illustrating their gripping, repetitive and persistent nature. This was a devastating time for Mia, because she couldn't make sense of the thoughts or understand why they were targeting her daughter, who she described in the podcast as her "*absolute world"*. This confusion further amplified the fear and terror they evoked within her.

Audrey also described how her thoughts had developed into haunting narratives:

> *"I just had this really awful thought that I was going to you know, what if I snatched him off her and kind of whacked him against the wall. I saw it in all its detail, and it was the most terrifying thing I had ever seen. It came with it a load of other images of things, you know, like the front page of the paper, with the story on the sensation story title of what I've done. I would see my family watching the news, you know, having lost their, you know this little new baby and their daughter had just lost it you know."*

Audrey's account illustrates how her intrusive thoughts had evolved into convincing stories. In these haunting stories, Audrey imagined herself as villain, acting out her deepest fears. The development of this narrative heightened its credibility and capacity to elicit fear. Audrey's description "*I saw it is all its detail and it was the most terrifying thing I had ever seen"* illustrates the vivid and life-like quality of the mental imagery. It also exemplifies how Audrey's thoughts were experienced both emotionally and physiologically, as if they were tangible events happening in the present moment, giving them a heightened sense of realism as though she was living in a horror movie. The embodiment of intrusions amplified their impact, rendering them even more frightening and overwhelming.

Many women in the study described resorting to physical and or/mental compulsions to alleviate the distressing thoughts and images. Amelia reports spending 95% of the day "*in her head"* attempting to neutralise and rationalise her intrusions by performing mental compulsions. These compulsions included undoing thoughts and repeating words. Other efforts included replaying scenes in her head and editing out gory or bloody scenes and replacing them with scenarios she deemed more appropriate. Efforts to reduce intrusions resulted in a heightened state of fear and anxiety that surged throughout her body, which ultimately contributed to her experience of having a *"breakdown":*

> *"It's just like I could feel the cortisol, like rush up and down my body. Each time I wouldn't eat, each time I would have like a breakdown thinking I would lose control and end up in the psych ward. And, like the episodes were lasting, like longer too."*

Amelia describes the cyclical nature of her experience "*each time I wouldn't eat, each time I would have a breakdown thinking I would lose control and end up in the psych ward*," illustrating a repetitive pattern of behavioural and emotional reactions that evoked a deep sense of fear. Amelia was overwhelmed by obsessions to the extent that she felt that she was losing control of herself. This perceived lack of internal control causes physiological and psychological symptoms of intense anxiety, which Amelia describes as cortisol rushing up and down her body - symptoms of extreme panic. The distress was so acute that Amelia stopped eating and absolutely dreaded getting out of bed in the morning. She attempted to restore a sense of control by performing excessive mental compulsions, but this ultimately led to more intrusions and a reduced sense of control, contributing to her emotional breakdown. For Amelia, the perceived loss of self-regulation signified that her deepest fears would manifest; she would act out her worst fears and be placed into psychiatric care.

Subordinate Theme 1.2: Robbed of Joy

Some women reported that the OCD had robbed them of the ability to experience joy throughout motherhood, resulting in feelings of loss and discontentment. Jane described how dominant discourses and social expectations around pregnancy left her feeling empty:

> *"I'd kind of felt like this anomaly, because I was pregnant, and so many people, they're like, you know, oh, it's the most joyful time of your life, aren't you just, isn't everything wonderful, and you're just revelling in this… and part of me just felt like, I died inside when people would say that, you know, cause I wasn't happy. I was miserable. So, I just kind of felt like, oh, I'm not even doing pregnancy right."*

While Jane was happy to be pregnant, navigating symptoms of OCD throughout her pregnancy made this time of her life extremely challenging. Within the context of social norms, pregnancy was

considered a happy time. She reported feeling *"like this anomaly"* because her experience did not align with what society dictates a typical pregnancy should feel like. She also expressed self-doubt, self-criticism and feelings of inadequacy for *"not doing pregnancy right"*, revealing complex interplay between Jane's internal experience and external influences. This dissonance was further compounded by her interactions with others, who reinforced dominant narratives of pregnancy as a "*joyous time of your life"* These interactions left Jane feeling like there was something wrong with her, because she was feeling miserable but being told to feel happy, which further compounded the pain and misery she experienced. Jane felt like there was something wrong with her and that she wasn't allowed to feel this way. The metaphor *"I died inside when people would say that"* conveys the overwhelming emotional pain she experienced in response to these comments.

While pregnancy went smoothly for Olivia, she reported similar feelings following the birth of her child. Like Jane, she had expected motherhood to be a profoundly enjoyable experience, however she described feelings of emotional conflict and inner turmoil shortly after giving birth:

> *"I remember sitting in an armchair with my baby, and I should have been overjoyed to have this beautiful baby. Even though he had allergies, he was still my beautiful baby. And I couldn't enjoy him because I was grieving like he was already dead."*

Olivia states she *"should have been overjoyed to have this beautiful baby"* indicating a sense of conflict between what emotions she expected to feel as a new mother, compared with her actual emotions. The phrase *"even though he had allergies"* demonstrates that the presence of intrusive thoughts may have hindered her ability to connect with her baby and experience joy. Olivia interpreted her baby's allergies as a sign of heightened vulnerability, prompting her to engage in excessive compulsions to protect him against allergens. This perceived vulnerability is further increased by the COVID-19 pandemic; Olivia was convinced that she would catch the virus and infect her baby, ultimately leading to his death. She further explains that she "*couldn't enjoy him because I was grieving like he was already dead".* This illustrates that the obsessions were so believable and

convincing that they elicited strong emotions of grief and loss. This suggests a profound emotional struggle, where feelings of grief completely smothered the joy and happiness that she had anticipated feeling.

Similarly, OCD had compromised Amelia's ability to feel joy while parenting:

> *"I shouldn't be noticing things to this extent, like I would go to kiss or tickle my son and I would experience joy and then my OCD would question or doubt that feeling like it was foreign or something, like I wasn't feeling it right*. *And then, you know, my fortune telling thinking would be like, I would never experience joy in those moments. Like, I would sometimes be like, disturbed by the concept of my own thinking process, like as it was happening, and I was like noticing it."*

Amelia recalls being "*disturbed by the concept of my own thinking process, as it was happening, and I was noticing it*," illustrating a heightened level of awareness into her own thought patterns and emotional responses. Amelia found this intense introspection of seemingly ordinary interactions with her son to be highly unsettling. She used the metaphor "*fortune telling thinking"* to describe how her mind projected her anxieties into future emotional states, where she imagined an existence that was devoid of joy. Her experience with the fortune telling voice led her to believe that she would never feel the joys of parenting, leading to a heightened state of anxiety and hopelessness. In times where she did feel joy, her inner narrator would question and doubt her experience, interfering with her ability to embrace the positive emotion. Her mind reframed normative positive feelings as problematic feelings, robbing her of a sense of joy. The constant analysis of her own emotions hindered her ability to experience spontaneous and inhibited joy. Amelia described a sense of not *"not feeling it right"* demonstrating that self-doubt and uncertainty affected her ability to feel and interpret emotions accurately, generating a sense of disconnection or alienation from her own feelings.

Subordinate Theme 1.3: The Stakes are High

Many women in the study reported feeling an overwhelming sense of responsibility for keeping their baby safe, this was compounded by the fragility of their newborns. Audrey recalls feeling unprepared for motherhood:

> *"They'd handed me this tiny little thing. I never even changed a nappy by that point, you know, so maybe I could have done a bit more prep work myself. But I had this tiny little baby that was so vulnerable, and I was absolutely convinced that I would make a mistake, just something would go wrong, and that he would die."*

Here, Audrey described her baby as "*tiny and vulnerable*," emphasising the helpless and defenceless nature of her newborn. In this moment, Audrey realises that her infant is completely reliant on her for care and protection. This vulnerability triggered an immense sense of responsibility in Audrey, making her doubt her ability to care for the baby. Audreys statement "*she has never even changed a nappy"* illustrates how inexperienced and unprepared she felt when facing the normative and routine tasks of being a mother. This statement indicates that Audrey is overwhelmed with what she perceives to be the basics of parenting, leaving her completely daunted by the enormous responsibility that comes with the wider scope of motherhood. Audrey extract "*I was absolutely convinced that I would make a mistake, just something would go wrong and he would die"* demonstrates the persuasive and catastrophic nature of OCD, where even the smallest of mistakes can have disastrous outcomes. It also further illustrates Audrey's existential awareness, as she reflects upon the fragility and mortality of human life.

Ivy also perceived her intrusive thoughts as substantial risks to her baby's safety. Two weeks after giving birth, Ivy experienced an intrusive thought of breaking her son's ankle while putting his socks on:

"I remember vividly dropping the sock, and just the stakes are too high. The stakes are too high. The stakes are too high. I'm not going there. I remember backing away from my son and I told my husband you have to do this. I'm not, I can't do this."

While Ivy completed the seemingly ordinary task of putting her babies' socks on, she was struck with the thought of breaking his ankle. The action of putting the sock on suddenly became a dangerous threat to her baby's safety. In this moment, Ivy was acutely aware of her baby's utter vulnerability, realizing that even the smallest of tasks could have devastating consequences. Ivy's repetition of the phrase *"the stakes are too high"* demonstrates that she had assessed the potential risks and outcomes of putting his socks on and determined that it was too dangerous to undertake. This realisation was met with an overwhelming sense of responsibility to keep her baby against the perceived danger. Ivy responded to this strong protective drive by stepping away from the activity and requesting that her husband take over dressing the baby.

Audrey also engaged in avoidant behaviours; however, these actions only perpetuated the intrusive thoughts she was experiencing. Within weeks, Audrey could not trust herself to be alone with her baby anymore.

"I wouldn't be on my own with him at all. I would only be in the same room with him if my husband was in between us. You know, I'm not a small lady. I'm just shy of six foot and I'm strong. I had to make sure that the only person who is big enough and strong enough to stop me, if I just lost it and went for him, he was in-between us."

This extract demonstrates how Audrey's perception of risk became more exaggerated as the disorder progressed. For Audrey, there was a perceived risk that her body would become possessed and she would be incapable of stopping herself. As the stakes escalated, she had too much too loose. She couldn't take any chances - there was no tolerance for uncertainty. For many women in this study, this overestimated sense of risk led to them engaging in safety behaviours in attempt to

protect their babies and restore a sense of safety. For example, Ivy recalls driving her son back from the grocery store and needing to constantly check that she hadn't left him behind:

> *"It wasn't enough to just look in the rearview mirror and see him there. I started to have thoughts, you know, are you so sleep deprived that you're seeing something you're not seeing? And so, then I had this thing where I would have to engage all my senses, like it wasn't enough to see him, I had to talk to him and have him respond back to me. And that wasn't enough. And then I had to reach back, and you know, touch him with my hand. And that wasn't enough, I was getting to the point where I had to pull over on the side of the road, unbuckle him from his seatbelt and physically hold him."*

For Ivy, checking her senses never felt like enough proof that her baby was safe. The uncertainty and doubt permeated her being until she couldn't trust her own perceptions and memory anymore. Over time, she habituated to the compulsions; they lost their ability to provide reassurance and relief. This led to Ivy engaging in more complex and time-consuming rituals to alleviate her anxiety. Eventually she pulled over on the highway to physically hold her baby because it felt too risky to not do so. These behaviours reinforced the loop of obsessions and compulsions, leading to more doubt and uncertainty.

For other women in the study, the intrusive thoughts made it feel too risky to leave the house. Sophia recalls being plagued by 'what if' scenarios about harming other people's babies:

> *"I started thinking what if, what if like, I take him to the café, and then I hurt someone else's baby? What if I strangle someone else's baby when I'm out. I just started to refuse to go out basically, and I didn't want to go out. Didn't want to go anywhere near anyone else's baby, just about managing with my own."*

Sophias statement "*what if I strangle someone else's baby?"* demonstrates the spiralling nature of intrusive thoughts. Initially, Sophia's fears centred around harming her own child within the context

of her home. However, these anxieties gradually extended to other people's children and public environments. What can be seen in her story is an expanding sense of anxiety and diminished sense of safety, where the boundaries of her comfort zone began to shrink. Eventually, Sophia avoided public spaces altogether as a protective mechanism to reduce the risk of her acting out on her intrusive thoughts.

Subordinate Theme 1.4: Thoughts have Meaning

All women in the dataset were disturbed by their intrusive thoughts and reported ruminating over the meaning and significance of them. Mia described how the repetitive thoughts made her question her sense of self:

> *"If you keep on having a thought over and over again in your head, you often think, is this something I want to do? Is it me? Because it's a thought you automatically assume it's who you are. I wasn't able to understand it at the time. I was so crippled by it. It was absolutely devastating for me, especially being a first-time mum."*

In the above statement, *"If you keep having a thought over and over again, you often think, is this something I want to do?"* Mia is describing how the frequency of the thoughts made them more salient and meaningful in her mind. She began to question whether these thoughts reflected her true desires and intentions. The statement ''*because it's a thought, you automatically assume it's who you are''* demonstrates that Mia believed that the thoughts were indicative of her character, which lead to profound questioning of her identity. This extract demonstrates how the thoughts began to fuse with Mia's sense of self. The blurred boundaries between the thoughts and her identity caused immense distress for Mia, who believed that the thoughts meant she was a bad mother. This was especially devastating for Mia because it was her first time having a baby and didn't have any other experience to draw on.

Audrey also experienced relentless thoughts which led to self-doubt and uncertainty.

> *"I wasn't delusional at all. I knew well, I hoped I wouldn't do it. But it got to the point where I didn't know I definitely wouldn't. I was so bombarded by these horrible thoughts, day in, day out, that I just thought, blimey, maybe I will."*

At the beginning of this extract, Audrey confidently states *"I wasn't delusional. I knew, well, I hoped I wouldn't do it''* signifying that she recognised the irrationality of her thoughts. However, as the frequency of intrusions increased, her initial sense of self-assurance diminished *"I was so bombarded by these horrible thoughts, day in, day out, that I just thought, maybe I will."* With each reoccurrence, the thoughts became more convincing in Audrey's mind, increasing her perceived likelihood of acting on them. As the thoughts became more persuasive, Audrey's sense of self started to merge with the OCD.

> *"Despite what I did, I could not completely get my head around that fact that actually, it wasn't me. I wasn't this really horrendous person. I understood I had OCD, but you know, it kind of wore me down so much that it was almost tattooed on my brain."*

Audreys extract demonstrates how difficult it was to maintain a cohesive sense of self amidst the presence of OCD. Her statement *''I understood I OCD, but you know, it kind of wore me down so much that it was almost tattooed on my brain"* conveys how pervasive and deeply ingrained the intrusions became, gradually eroding her sense of self. Eventually, Audrey could no longer separate herself from the disorder *''I could not completely get my head around that fact that actually, it wasn't me. I wasn't this really horrendous person."* Despite having an intellectual understanding that her intrusive thoughts were a manifestation of OCD, Audrey struggled to accept that the thoughts did not define her. As time passed, OCD succeeded in convincing Audrey that she was a baby-killing monster. She considered taking her life as a way of escaping her mind. Finally, Audrey went to see her doctor in a state of desperation:

> *"I went to my GP, stormed in, and was like, you have to take me away, I'm not safe. And it wasn't a hospital. I wanted to go to prison. I wanted them to remove me from society, because I wasn't safe. I'd said goodbye to my husband and little boy."*

Audrey's statement "*you have to take me away, I'm not safe"* illustrates how deeply entrenched the maladaptive beliefs had become; Audrey holds conviction that she is dangerous. Her desire to go to prison and be removed from society reflects a desperate need to protect her family. She firmly believes that their safety can only be ensured if she is confined to a prison cell, this is an example of how the thoughts had meaning.

Audrey's extracts illustrate how the disorder progressed over time. Her first statement *"I wasn't delusional at all. I knew well, I hoped I wouldn't do it,"* demonstrates that initially she had good insight; she knew that the intrusions might not be true. The later extract *"I wanted them to remove me from society, because I wasn't safe. I'd said goodbye to my husband and little boy"* demonstrates that as the disorder worsened, Audrey had poor insight into the irrational nature of her thinking. She starts to act on the thoughts in the sense that she says goodbye to her family, because she firmly believes she will be removed from them and the rest of society.

Similarly, Emma interpreted her intrusive thoughts as evidence that she was a bad person.

> *"I thought I was gonna, I thought I was going mad, and I thought I was a bad person. And I was really concerned that my child was, you know, I wasn't fit to look after her."*

The above statement *"I thought I was a bad person"* demonstrates a fusion between Emma's intrusive thoughts and her identity. The mere presence of intrusive thoughts made her question her moral integrity and view herself as a bad person. Emma believes that simply having these thoughts holds the same moral significance as acting on them, leading her to feel unfit to care for her daughter. Like Audrey, Emma feels compelled to go to the doctor:

> *"I need to go to the doctor. There's something that made me think I need to go to the doctor. If the doctor thinks that I'm a danger and that I need to be locked up, then that's the best thing for my child."*

This statement reflects Emma intense feelings of distress and concern for her child's safety. The internal turmoil was so overwhelming that it prompted Emma to seek advice and reassurance from a professional. Emma was willing to accept drastic measures, such as being institutionalised, if it meant her child would be safe. The statement *"if the doctor thinks that I'm a danger and that I need to be locked up, then that's the best thing for my child"* demonstrates that Emma was experiencing great conflict between her role as the child's protector, while also experiencing herself as the potential aggressor. This conflicted sense of identity evoked emotions of intense guilt, confusion, and shame.

Summary

Superordinate theme one illustrates how intrusions escalated into frightening narratives causing immense psychological and physiological distress. Women in the study described how inner conflict, doubt and anguish hindered their ability to experience the joys of parenthood. Their perception of risk became more pronounced as the disorder progressed, leading to more complex and time-consuming compulsions. The repetitive and persistent nature of the intrusions made them more meaningful and believable, eventually merging with the mother's sense of self.

Superordinate Theme 2: An Arduous but Worthwhile Road to Recovery

The previous superordinate theme discussed the experience of perinatal OCD. The following superordinate theme discusses the therapeutic tools that were utilised on the road to recovery. Within this superordinate theme falls four subthemes: finding the right therapeutic fit, finding relief through medication, discomfort as a catalyst for growth, and the importance of self-compassion.

All women in the dataset armed themselves with multiple tools throughout their recovery journey. Some of these unique strategies included writing creative stories to externalise their struggles, joining OCD support groups, hearing other people's stories, and sharing their own experiences. Common interventions that were reported across the group include therapy, psychoeducation, the use of medication, CBT and ERP, and ACT.

Subordinate Theme 2.1: Finding the Right Therapeutic Fit

For most women in the study, finding the right therapeutic alliance proved to be challenging. Several women experienced harmful outcomes from their interactions with healthcare professionals. Amelia spoke about a negative encounter with a therapist who lacked expertise in ERP. During these sessions, the therapist focused on the exposure aspect of ERP, but neglected to address response prevention. This had an extremely detrimental impact on Amelia:

> *"I ended up basically exposing myself, like doing some gnarly scripts, and then walking out of the room and doing 1000 compulsions in my head and ruminating about it, and basically like, making myself, like at my wits end, I mean I felt like shit, I was so incredibly ill, like so, so, sick."*

Amelia describes how ERP exacerbated her symptoms because she was not taught how to resist compulsions. Without the necessary tools to manage this state of panic, Amelia reverted to her familiar coping mechanisms of engaging in compulsions. The perpetuation of obsessions and compulsions was debilitating for Anna. She describes being "*so incredibly ill, like, so, so sick."* The repetition of the work "*so"* emphasises the intensity of her suffering and impairment. The passage above demonstrates that Amelia's quest to find appropriate support was a challenge in itself.

Mia also experienced a devastating encounter with a healthcare professional. She recalls:

> *"Unfortunately, in my case, when I did finally open up to my therapist, she mistook what I was saying, and because I said I hid knives because I was scared of the thoughts I was*

> *having. It got misconstrued and then social services were alerted, because I was posing a danger to my child."*

The statement "*unfortunately, in my case, when I did finally open up to my therapist"* illustrates the pivotal moment when Mia decided to confide in her therapist. However, this interaction took an unintended turn when Mia's therapist failed to identify her thoughts as egodystonic. Mia's use of the word "*unfortunately"* sets a sombre tone, conveying a sense of regret or disappointment regarding the events that followed the disclosure. This interaction had traumatic consequences for Mia because it reinforced the belief that she was a dangerous person, making her OCD symptoms worse. Despite child services determining that Mia was a good mother, the missed opportunity for therapeutic intervention resulted in another year of suffering for Mia until she finally received a diagnosis.

The healthcare experiences of Amelia and Mia highlight the difficulty and importance of finding the right support in the treatment of OCD. They also illuminate the harmful impacts of misdiagnosis or professional incompetency on recovery. The following extracts demonstrate how the right therapeutic fit had life changing benefits. Mia's second encounter with a therapist was profoundly positive, a direct contrast to her first. She describes her experience:

> *"It was having someone not judge you, and you being able to speak to them about the thoughts you're having and for them to not bat an eyelid is the best feeling in the world."*

Here, Mia is reflecting on disclosing her thoughts in a safe space. Finding a non-judgmental therapist who understood the disorder was essential for Mia's recovery. While grappling with OCD, Mia's inner voice was highly critical and judgmental. This led Mia to conceal and suppress her intrusive thoughts which only served to magnify their intensity. Concealing these thoughts weighed heavily on Mia until she was able to express them. Being able to speak freely without shame and judgement was a liberating and profoundly positive experience for Mia, which she described as the "*best feeling*

in the world." Mia's therapist responded in a calm and dismissive manner, indicating to Mia that there was nothing wrong with her thoughts.

Similarly, Jane described how her therapist's response helped to normalise her experience:

> *"I'd be like, oh this is weird, I had this thought. And he was like no, you don't even know how many people have told me that. Like, this is not a big deal."*

Jane also found great reassurance in her therapist's approach. He fostered a dismissive attitude towards her thoughts by causally stating they were "*not a big deal*," signalling to Jane that the intrusions were not worthy of concern. For Jane, the normalisation of these thoughts provided her validation that she was not an abnormality - these responses were to be expected for someone with OCD. She recalls:

> *"So having a therapist be like, yeah, that's normal for someone's who's pregnant with OCD, like yes, this is normal. And this is what we are going to do, and here's why…. It was like someone who just offered me a bouquet of hope, you know like, you are going to be okay. You're not weird."*

Janes's therapist explained what type of symptoms were to be expected during pregnancy and helped her to develop a treatment plan. Psychoeducation played an important role in Jane's recovery because it helped her understand the condition better, making it less daunting. Jane had previously experienced a sense of alienation from her own emotions, and this resulted in feelings of being different or abnormal. The therapist's reassurance, "*you're not weird,*" and "*that's normal for someone who's pregnant with OCD*," played a pivotal role in countering Jane's negative self-perception and fostering a sense of acceptance. These therapeutic strategies played a crucial role in Jane's journey to recovery.

Subordinate Theme 2.2: Relief through Medication

All women in the study were prescribed medication to assist with their recovery. Most were prescribed medication in addition to therapy. Audrey was prescribed a high dosage of anxiety medication after she went to the doctors declaring that she was unfit to care for her child. By this stage, Audrey had stopped sleeping to watch her baby breathing throughout the night.

> *"I got given diazepam because I think I had reached a point where the only thing that would, you know, just help was knocking me out for awhile, I had to kind of rebuild. I started eating again, I started sleeping again."*

Medication enabled Audrey to function on a basic level, which she was unable to do previously. While the medication proved helpful, she was still significantly impaired.

> *"So, I still remember a month of just being a zombie, but it was a zombie that could spend time with you know, her baby, without her bodyguard, the bodyguard that needed to be between the pair of them. I still struggled to do anything. To go for a walk around the block with him in the pram, go anywhere near a bridge or train station, you know, these kind of thoughts and impulses would be huge."*

For Audrey, medication was the first step in her recovery journey, but it was not enough as a standalone treatment. While the medication enabled a basic level of functioning, it did not address the root cause of her fears.

Emma started medication later in her recovery journey. Emma decided not to take medication initially because she was concerned about its side-effects, however medication proved to be a key component in her recovery toolkit.

> *"It just kind of freed up my brain a bit to be able to, yeah, to be able to use all the tools that I've learnt basically."*

Here, Emma is describing how medication provided a clearer headspace where she was able to apply the cognitive therapy tools she had learnt more effectively. Medication was complimentary to the therapeutic interventions because it lessened the emotional burden of intrusive thoughts and enabled cognitive flexibility. In hindsight, Emma feels regret for not taking medication sooner. She believes that this decision hindered her recovery process.

Similar to Emma, Jane also struggled with the idea of taking medication because of the potential impact it might have on the baby.

> *"There was a lot of stuff I grappled with. We went to so many doctors to kind of get reassured that, no, I could take this, and you know, serotonin, and it was going to be okay."*

After consulting several medication professionals, Emma decided to take medication. This was an important step in her recovery:

> *"Figuring that out, getting my levels where they needed to be. It was just day and night you know, like I was still having obsessive thoughts and certainly compulsions and things, but it, but I felt like myself again, and that was just, that was just everything."*

The extract above demonstrates how medication helped Emma reclaim her identity after experiencing a loss of self. As discussed in subtheme 1.4, Emma's sense of self had merged with the intrusive thoughts; she firmly believed she was a bad person. Her statement "*I felt like myself again, and that was just, that was just everything"* indicates that regaining her sense of self was a pivotal moment in her recovery journey, surpassing the alleviation of specific symptoms. Emma was still having obsessive thoughts; however, they were no longer fused to her sense of self. Emma's account exemplifies the multidimensional nature of recovery, by moving beyond symptom management to encompass the emotional and existential aspects of healing.

Subordinate Theme 2.3: Discomfort as a Catalyst for Growth

All women included in the study engaged in CBT or ERP as part of their recovery journey. Many women reported that ERP was extremely challenging, yet it played a crucial role in overcoming OCD. For most women, facing their fears head-on was a means of overcoming the disorder. Audrey described her exposure exercises:

> *"I had to force myself to stand on the edge of rail tracks with my son in my hands. I had to force myself to stand on the side of busy main roads, you know, and bring on thoughts of throwing him under the buses as they went past. There were words that frightened me. So, things like stab, slips, slice absolutely terrified me, and I had to sit there saying drown, drown, drown, drown, I'm going to kill my baby, I want to kill my baby."*

As part of ERP therapy, Audrey is asked to confront her deepest fears by placing herself in triggering situations. The language Audrey uses "*I had to force myself*" demonstrates the deep resistance she felt in response to these situations. She worked insanely hard to challenge her fears by confronting them head-on. Exposure work was a source of great distress, yet through repeated exposure, the intrusive thoughts gradually loosened their grip:

> *"Anything I could do, just to take the power away from that was you know, it changed everything. It absolutely changed everything. I very, very quickly whilst working insanely hard, I just went back, I was back to as close to normal or what I thought a normal mother should be."*

For Ivy, taking an offensive stance helped her to conquer her fears.

> *"So instead of purposely listening to my typical, you know, feel good music and avoiding listening to this audiobook, I'm going to purposefully go back to that book that I knew I was avoiding, from two years ago, and I'm going to listen to that chapter where the baby fell off that balcony, and that mum is just sitting in devastation and perpetual guilt for the rest of*

her life. And I'm not going to listen to it once. I'm going to listen to it 1500 times if I have too."

This extract demonstrates a pivotal moment in Ivy's journey towards overcoming OCD. The statement "*I'm going to purposely go back to that book that I knew I was avoiding, from two years ago"* described a proactive shift in her mindset, marking an important turning point in her recovery, where she actively and willingly chose to challenge her avoidance behaviours. The choice to repeatedly "*listen to it 1500 times if I have to"* reflects Ivy's sense of dedication, commitment, and perseverance to overcoming the disorder. Ivy further states:

"I think it's really important to go out of your way to show the OCD who's boss, and I'm not going to be here just waiting for you, whenever you show up, like I'm going to come for you."

Ivy framed her recovery in terms of a power relationship "*I think it's really important to go out of your way to show the OCD who's boss,"* where she actively decided to take the dominant role of *boss,* by being assertive and confident in the presence of OCD. Instead of responding to her fears, she actively seeks them out in a confrontational manner. Her statement "*I'm going to come for you*" conveys the sense that she is no longer willing to take a passive role in the face of OCD's unpredictable nature. She made a conscious decision to not be a victim to OCD anymore, which provided her with a sense of self-empowerment and agency in her recovery journey.

A few women spoke about the difficulties of resisting compulsions during exposure work. For Rachel, resisting compulsions felt like an impossible feat:

"It's like someone is stabbing me, it's not just like uncomfortable, where you can just sit there and be like, be in it like, I want to die. Like I gotta get out of this. You know, it's like, if you're on fire, do you just sit in the flames being like, this is burning my body, but I'll just sit here and like deal with it? No, you jump, and you get away. So, it's really true agony, and I think to do nothing sounds so simple, but yet, it's so so hard, but it's so effective."

In the extract above, Rachel used two powerful metaphors to convey how intolerable distress feels when resisting a compulsion. She describes the feeling as *"true agony"* to illustrate the severe pain and anguish she felt in these moments. The question "*if you're on fire, do you just sit there in the flames?"* illustrates the urgency and desperation that Rachel felt to escape the distress, as well as her instinctive need for self-preservation. While it feels impossible to sit in the discomfort, Rachel acknowledged that these feelings will eventually subside:

> *"If you can just sit in the burning flames as long as you can, you know, little by little it gets better."*

For Jane, ERP taught her how to ride waves of discomfort:

> *"I had to have these thought experiments where I would just put myself in that place of fear and go through and kind of just feeling the terror and letting that come into my body, and then, just watching it as it went away."*

Here, Jane is describing the cyclical nature of emotions. When Jane experiences anxiety, she imagines a wave of emotion that flows in and out of her body. This imagery resonates with Jane because she is a creative writer. This visualisation exercise has taught Jane that she does not need to respond to her anxious thoughts, instead she can practice acceptance by allowing them to enter her body and focusing on her breathing until they pass. Giving permission for the emotion to be there allows it to come and go freely, without becoming stuck:

> *"It's so helpful to know like okay, I feel like in this moment, like I'm never going to be okay again, but I know that is not true, and I'm just going to breathe through it, and I'm going to wait for that wave to come back down."*

The gripping nature of intrusive thoughts made it easy for women to regress. Some women expressed the importance of being held accountable by others in their recovery journey. While

personal accountability was essential, partners and therapists took on support roles. Jane expressed how her husband kept her accountable when her avoidance behaviours crept in:

> *"He was really diligent about you know, he'd be like, no, I think you need to touch that, and then you need to hold the baby… this is what you need to do. And then, I would do that. And it was like, it was hard, but also wonderful at the same time, it almost felt like, yeah, I needed to do that."*

Jane's partner was supportive of her recovery. He actively encouraged her to engage in specific exposure tasks when he recognised that she was anxious. This was important because Jane was going through significant life changes during this period, which increased her risk of relapse. Jane's statement "*it was hard, but also wonderful at the same time, it almost felt like, yeah, I needed to do that"* reflects the dual nature of her experience towards exposure work. It acknowledges the discomfort associated with confronting her fears, while also acknowledging the positive and transformative aspect of the exercise that resonated on an instinctual level.

Subordinate Theme 2.4: Self-compassion is Central to Recovery

Several women spoke about relapsing after CBT, due to the negative self-perceptions they held. Audrey recalls how her low self-esteem led to relapse:

> *"There was just something about the way I viewed me, you know, something about the way I felt about myself, you know, that kind of wasn't right and that's when I went back to therapy."*

The above extract highlights how the disorder impacted Audrey's self-perception, resulting in a marked discrepancy between her actual self and perceived self. As discussed in theme 1:4, Audrey had spent six months believing that she was a monster that wanted to harm her baby. This negative self-perception taken a huge toll on her self-esteem and overall sense of self-worth. Despite Audrey's triumph over her fears, she continued to grapple with a relentless inner critic, which

ultimately derailed the progress she was making with ERP. Audrey began working with her therapist to improve her self-esteem. Her therapist set her homework tasks that included keeping a positive feedback journal and writing letters of self-compassion. Over time, these exercises helped Audrey cultivate a kinder attitude towards herself. As her self-esteem improved, she was able to implement her other therapeutic tools more effectively:

> *"If my recovery was a building wall, and the bricks were like the CBT activities and the ERP and you know, having a healthy diet and getting enough sleep, the foundations of that wall, and the cements between those bricks has been my work on my self-compassion, my self-esteem."*

Audreys account emphasis the powerful role of self-esteem on her recovery journey. The metaphorical *bricks* in the wall symbolise the practical tools used in OCD treatment, such as CBT and ERP. These techniques act as essential building blocks, providing structure and support in reducing obsessive thought patterns and compulsive behaviours. However, it was self-esteem that played a pivotal role as the psychological binding agent, bringing together the interventions cohesively. For Audrey, self-esteem was the crucial element that unified her recovery experience and provided a sense of completeness in her journey.

Emma also completed CBT, but she felt like something was missing in her recovery journey. While CBT helped ease her obsessions and compulsions, she was overly critical when she made a mistake. For example, sometimes she would become angry and shout at her children. This would lead to excessive self-blame and guilt, followed by two days spent in bed crying. Emma's behaviour was having a negative impact on her children who were deeply concerned about her. She was determined to set a positive example for the children, by showing them that it is okay to make mistakes. This led her to Acceptance Commitment Therapy (ACT).

> *"With ACT, it helped me to see what my values were and so for example, do I want to beat myself up? Let my kids say that making a mistake is a bad thing? Or do I want to show them*

a bit more kindness? Showing them that it's OK to make mistakes? It's OK to move on from them."

Throughout her engagement with ACT, Emma was able to develop a kind and forgiving attitude towards herself. The ability to let go of unhelpful responses, such as self-judgment and shame, enabled Emma to move forward when she experienced setbacks instead of remaining stuck. This shift in mindset was the final piece in Emma's recovery journey.

Summary

Women in the podcast described arming themselves with multiple tools throughout their recovery journey. Finding a competent OCD therapist proved to be a challenge. Several women reported negative encounters with healthcare professionals that had detrimental impacts on their wellbeing. However, finding the right support paved the way to recovery. Therapeutic skills such as validation and normalisation had a profoundly positive impact on how women perceived themselves. All women were prescribed medication, and this was largely deemed beneficial in their recovery journey. Women reported that ERP was extremely challenging but essential for overcoming their fears. Learning to tolerate uncertainty and distress was a catalyst for growth and transformation. For several women, OCD had eroded their self-esteem. The practice of self-compassion was the completing element of recovery.

Superordinate Theme 3: Words of Hope

Each of the women in the study had uplifting messages of hope to offer the podcast audience. Several women wanted to convey that the perinatal period represents a vulnerable time for mothers, rendering them more susceptible to heightened intrusions and anxiety:

> *"So much research is coming out now about just how many women experience obsessions and compulsions, and those types of tendencies leading up to the birth and then certainly after the birth. So even if it doesn't reach full blown OCD, where it's disordered, you know,*

> *new moms are definitely at a heightened experience and heightened kind of vulnerability to experience these intrusions. So, I think that really comes down to I call it a triple whammy. So, OCD is going to have a field day with anything that is uncertain. And what's more uncertain about having a newborn, or even a child and a toddler, right, like that all is so uncertain. We feel so responsible for this human being. And it's obviously the most valuable thing in our lives at that point. So, it's just the perfect melting pot, put some hard-wired maternal instincts in there, to be anxious so that you can be vigilant and so that you can act."*

Prior to giving birth, Ivy had practiced as an OCD therapist for seven years and had no personal history of OCD. She had previously believed herself to be immune to the condition given her extensive knowledge and expertise in treating the condition. Consequently, the onset of perinatal OCD came as a complete shock to her. Ivy makes sense of this experience by drawing on the context of motherhood *"it's just the perfect melting pot, put some hard-wired maternal instincts in there"* as a means to understand why she developed OCD. She reassured podcast listeners that obsessions and compulsions are normal for new mothers, considering their heightened vulnerability during this period. Ivy's explanation *"OCD is going to have a field day with anything that is uncertain. And what's more uncertain about having a newborn, or even a child and a toddler, right, like that all is so uncertain. We feel so responsible for this human being. And it's obviously the most valuable thing in our lives at that point"* illustrates how she made sense of her own experience by drawing upon her intellectual understanding of the disorder, the knowledge she has gained in therapeutic practise, and her personal experience as a new mother. This insight has enabled her a new perspective to better understand and contextualise her experience in a meaningful way.

Many women in the study wanted to share that recovery is absolutely possible, despite how hopeless it may feel in the moment, so that their stories could represent a "beacon of hope":

> *"Oh my gosh, there is hope there's so much hope… I want to be that beacon of hope and offer hope that no matter how long you have been suffering, no matter how old you are, and*

> *where you are in your life, that you can find someone to help you. And you can get that help that you so rightfully deserve and get better and make your life more beautiful than you ever imagined."*

Olivia had struggled with severe OCD throughout her life; these periods were accompanied by depression and suicidality, which lead her to attempt suicide twice. She described a reoccurring pattern of pulling herself out of depression and rebuilding her life, only to have it all come crashing down again. She consistently grappled with feelings of stigma and a sense of being different because she was unable to lead a normal life like everyone else. After ongoing therapy, Olivia finds herself living a life that is more beautiful and fulfilling than she ever could have imagined. Olivia's metaphorical statement "*I want to be that beacon of hope"* illustrates her desire to provide hope and guidance to individuals navigating OCD in their lives. She finds purpose in being a *"beacon of hope"* because there were times in her life where she felt utterly hopeless to the point where she didn't want to live anymore. She wants her story to be perceived as a symbol of encouragement and resilience and a reason to believe there are better days ahead.

Every woman in the study expressed that seeking treatment was fundamental to their recovery and encouraged others to do the same. Jane encouraged listeners to seek treatment:

> *"You're doing the best thing. You really, really are starting, recovery is terrifying. It really is the best thing you can do for yourself. And that's what it's about doing something for you. Because you mean something, you matter. I think OCD tricks us into thinking that we don't, and we have that inner critic all the time, telling us something very negative. But taking that step forward into recovery, it's I can't even, like, describe how amazing it is for anyone who's starting that journey right now."*

Jane had grappled with feelings of being abnormal or weird throughout her experience with OCD, as discussed in theme 2.1. Fortunately, Jane's therapist had helped to counteract the negative self-perceptions that had been caused by the OCD. Jane's message *"you mean something, you matter. I*

think OCD tricks us into thinking that we don't" reflects her personal experience and the personal learnings she gained from therapy. Drawing from her own experience, she acknowledges that the OCD voice can be very cruel. With these insights, she encourages listeners to pursue recovery as an act of self-love and care, as a way of counteracting the inner critic that under that undermines their sense of worthiness.

All women who spoke on the podcast perceived recovery to be a transformative and life-changing experience, albeit a difficult one:

> *"You're gonna have tough days, it's not going to be easy. It really isn't. And it takes a lot of hard work. It really does. But it's always about the small steps that you take. Not the giant leaps, it is always about the small steps. And before you know it, you've taken all those small steps, you've taken a giant leap into recovery, and it will change your life. By doing that, you have said, I deserve better than this. And you do. And it will get better."*

Mia's extract highlights the temporal nature of recovery by recognising that it is a gradual process requiring consistent effort over time; it not a destination that can be reached overnight. Mia's statement "*You're gonna have tough days, it's not going to be easy. It really isn't"* indicates a sense of acceptance towards the difficulties and hard work associated with the recovery journey. Her narrative of hope was to inspire others to take small steps forward; for these small steps accumulate into giant leaps forward, and therefore, should not be underestimated.

Summary:

In the final superordinate theme, women shared messages of hope for overcoming OCD. They acknowledged the struggles and vulnerabilities that new mothers face, and reassured listeners that intrusive thoughts were common to all new parents. They also expressed the importance of knowing that recovery was a possible outcome. Having hope was central to recovery, because it enabled them to keep going despite their inner critic telling them it was a hopeless pursuit. Thus, they

wanted to convey the importance and validity of having expectations for successful recovery; this is key to countering the negative illness perceptions driven by the OCD. Seeking treatment was a life-changing experience for women in the dataset. They strongly encouraged others to take a leap of faith and begin their own journey towards recovery.

Chapter 4: Discussion

This study investigated the lived experience of nine women with perinatal OCD and their journey to overcoming the disorder. To date, only a handful of studies have investigated the lived experience of perinatal OCD using qualitative approaches (Beck, 2022; Meehan et al. 2021), and only one study has explored the lived experience of perinatal OCD recovery (Beck, 2022). Addressing this important gap, the purpose of this investigation was therefore to: (a) develop an understanding of how women in the study experienced perinatal OCD, and how these experiences were interpreted and made sense of; (b) uncover the experience of recovery and (c) uncover the therapeutic tools and interventions that contributed to their recovery as experienced by these women. This chapter summarises the main findings of this research and compares these conclusions with prior research and theoretical models. The following section then discuss the implications, strengths, and limitations of the current study, as well as recommendations for future research. The chapter concludes with a discussion on reflexivity, followed by a closing statement.

Summary of Main Findings and Comparisons with Previous Research

The findings of superordinate theme one *Stuck in a horror story* addressed the research aims of understanding the lived experience of perinatal OCD. The theme illustrated the terrifying, tormenting, and unrelenting nature of OCD. *Stuck in a horror story* was comprised of four subordinate themes that provided deeper insights into the multifaceted dimensions of women's experiences of perinatal OCD. Subordinate theme 1.1, *overwhelmed with terror*, highlighted the sudden and intense onset of intrusive thoughts. For most women in the study, intrusions began one-three weeks postpartum. Consistent with prior research on perinatal OCD, women in the study described being tortured by disturbing thoughts of harming their infants (Beck et al., 2022; Challacombe et al., 2016; Meehan et al. 2021). These vivid thoughts and mental images played repeatedly in their minds, evolving from single horrifying acts into elaborate narratives that caused immense physiological and psychological distress. The subsequent engagement in compulsions illustrated their desperate attempts to neutralise or rationalise these intrusions, ultimately

exacerbating their terror. The cyclical pattern of fear, attempts to regain control, and subsequent breakdowns further illustrate the distressing and debilitating nature of these experiences, as reflected within the existing perinatal OCD literature (Beck, 2022; Meehan et al., 2021).

In subordinate theme 1.2, *robbed of joy,* women in the study described how their OCD experience had robbed them of joy that is normatively expected with motherhood. The presence of intrusive thoughts led women to doubt and question the authenticity of their emotions. They became hyper-aware of their own thought processes and engaged in constant self-analysis. Even when they experienced fleeting moments of joy, their inner narrator would cast doubt on those feelings, preventing them from fully embracing them. The self-doubt was so intense that it gradually eroded their ability to trust their inner experiences altogether.

The experiential accounts in the present study expand the findings of Meehan et al. (2021), where one participant reported a pervasive sense of doubt that penetrated the core of her being, leading her to question whether she really loved her baby. These findings demonstrate how doubt had dominated other emotions entirely, leaving no space for uninhibited and spontaneous joy. In the present study, one woman spoke about grief, as opposed to doubt, as the overpowering emotion that robbed her sense of joy. The intrusions were so convincing that she was already grieving as though she had lost her baby, despite him breathing in her arms. This was a novel finding and further research is needed to better understand the connection between OCD and feelings of grief. The experiential accounts of women in the study highlighted the pervasive impact of OCD on their ability to find joy and fulfilment in their roles as mothers.

As noted in the broader literature, societal expectations dictate that motherhood should be a happy and fulfilling time in a woman's life (Beck, 2002; Boyd & Gannon, 2019; Collins, 2019). These norms can generate misconceptions that equate becoming a mother with total fulfilment and happiness; the pressure to conform to these norms can be particularly intense for all new mothers. Many women internalise these dominant narratives and struggle in silence because their experience

deviates from the 'norm'. Women in the present study noted that their expectations of pregnancy and motherhood did not align with their actual experience, leading to self-criticism and a sense of emptiness. Living with OCD as a new mother was extremely challenging, resulting in the loss of positive emotions such as joy and contentment. In alignment with the findings of Challacombe at al. (2016), the disorder interfered with their ability to enjoy the experience of parenting. The absence of these positive emotions left women feeling anxious, miserable, guilty, and inadequate. Many women in the general population may share similar feelings of guilt and inadequacy in response to dominant ideologies of motherhood, however, for those with perinatal OCD, this may take on a particular quality, such as intense self-doubt. The experiences of the women in the study illustrate the ways in which dominant ideologies of motherhood had influenced how they made sense of their experience. Women in the present study did not have 'typical' experiences of motherhood and therefore interpreted this as meaning something was wrong with them. These findings demonstrate how the internalisation of social norms can intersect with the experience of OCD within the context of motherhood.

In the third subordinate 1.3, *the stakes are high*, women grappled with an overwhelming sense of responsibility to keep their infants safe, this was compounded by the fragility and vulnerability of their newborns. Consistent with previous findings, intrusive thoughts were interpreted as substantial risks to the infant's wellbeing, which drove women to engage in excessive compulsions to keep their child safe (Challacombe et al., 2016; Meehan et al. 2021). Some of these compulsions included checking the baby constantly, avoiding routine tasks, or avoiding being left alone with the baby altogether. As the perceived risk escalated, women performed more complex compulsions, yet these never provided enough reassurance. The compulsions became all-consuming and, in some instances, jeopardised their safety. One woman recalled having to pull over on the highway to physically hold her baby to make sure she hadn't left him at the supermarket. As she performed these rituals on the highway, she had placed both herself and her baby in a situation of increased risk of a car accident. These personal accounts reveal the insidious nature of OCD by

illustrating how the disorder manipulated and distorted their perception of risk. These findings support Salkovski's (1985) cognitive model of OCD. They illustrate how cognitive factors, such as inflated sense of responsibility and a tendency to overestimate the probability of harm underlie the misinterpretation of intrusive thoughts. These underlying cognitive factors drove the women in the present study to engage in compulsive behaviours to prevent the dreaded consequences from occurring.

These findings from *the stakes are too high* can also be explained drawing on theoretical models of parenting. Research has found that both mothers and fathers experience a heightened consideration of potential threats and harm avoidant behaviours that peak following childbirth, and typically decrease 3-4 months postpartum (Leckman et al. 2013). The perinatal period has been associated with a significant increase in one's sense of responsibility and perception of potential threats. From an evolutionary perspective, parents are inherently programmed to safeguard their children from potential harm. Being hypervigilant and taking proactive measures to prevent harm is beneficial for the infant's survival, especially in less favourable environmental conditions. This heightened state creates a fertile environment conductive to the development of obsessional problems, where seemingly harmless intrusive thoughts are misinterpreted as threatening, as observed in the present study (Fairbrother et al., 2007). Therefore, perinatal OCD may represent the severe end of a normal range of obsessions and compulsions that are commonly reported by new parents.

The subordinate theme 1.4, *thoughts have meaning,* illustrates the profound impact of intrusive thoughts on one's sense of self and identity. Women in the study were deeply disturbed by their thoughts and found themselves ruminating on the meaning and significance of them, making them question whether the thoughts revealed hidden desires. Consistent with the findings of Meehan et al. (2021), women in both studies conveyed a profound conflict between their role as a protector, while also experiencing themselves as a potential aggressor. This inner turmoil manifested

as a coinciding urge to safeguard their baby, while harbouring fears of causing harm or endangering the baby. As the disorder progressed, the women struggled to separate themselves from the intrusions. The presence of these horrible thoughts meant that they were a bad or dangerous mother. Eventually, the thoughts had become infused with their sense of self, causing a distorted perception of their own character. These findings align with previous research, where participants described themselves as murderous, evil, immoral, and crazy (Meehan et al., 2021; Murray et al., 2011).

For women in the study, the persistent nature of the intrusions made them more credible and plausible in their minds. Consequently, several women contemplated drastic actions such as being institutionalised or committing suicide. The findings from this theme can be understood through the cognitive model of thought action fusion (TAF), a cognitive bias where individuals believe that thinking an intrusive thought is morally equivalent to committing that action (Amir et al., 2001). The fusion between thoughts and their perceived moral implications leads individuals to conclude that the intrusive thoughts must imply moral flaws in their character (Shafran, 1996). The convincingness of the thoughts can also be explained through likelihood TAF, the belief that merely having a negative thought increases its likelihood of occurring (Amir et al., 2001).

The second research objective was to investigate the lived experience of recovery, and subsequently, identify the therapeutic tools that facilitated it. The superordinate theme *an arduous but worthwhile road to recovery* spoke to the numerous challenges and obstacles that the women faced in the path to recovery. It also highlighted the immense effort and perseverance required to overcome the disorder. However, despite the struggle and hardship faced along the way, the journey was ultimately perceived as worthwhile, healing and rewarding. This overarching theme was comprised of four subthemes.

Subordinate theme 2.1, *finding the right therapeutic fit,* highlighted the challenges of finding a suitable therapeutic alliance. Some health care professionals were unable to identify symptoms of

OCD or provide an appropriate intervention due to a lack of knowledge regarding the condition, thus supporting previous findings (Benfield, 2018; Challacombe, 2014; Christian & Storch, 2009; Gershkovich, 2019). In most cases, women found that these interactions were detrimental to their wellbeing. This was exemplified by the account of one woman, whose disclosure led to a report being made to social services. In this case, the professional not only failed to provide the needed support but also reinforced her maladaptive beliefs, leading to prolonged suffering. Similar experiences have been reported by Challacombe (2014), in which several participants were reported to social services, and Christian and Storch, (2009), where another participant was involuntarily hospitalised due to misdiagnosis. These traumatic accounts illustrate the harmful consequences that can occur when health care professionals are unable to detect perinatal OCD.

On the contrary, positive therapeutic experiences made a world of difference in the healing process. Having a safe and non-judgemental space to share their thoughts was deemed essential for recovery. Women in the study found it both liberating and relieving to speak about their experiences without being shamed. Psychoeducation played a crucial role in treatment by enhancing their understanding of the disorder and offering a sense of hope for the future. This psychoeducation was most effective when tailored to the context of perinatal OCD, as noted in previous literature (Gershkovich, 2019; Hudak & Wisner, 2012; Puryear & Treece, 2020). Therapists helped to normalise intrusive thoughts using strategies of reassurance and validation which countered negative perceptions of being abnormal or different. During therapy, an ongoing state of meaning-making took place between the women and their clinician, until OCD was reconceptualised as something less frightening and overwhelming. Overall, these results support those of the wider literature, that emphasise the importance of psychoeducation in the treatment of OCD (Gershkovich, 2019; Hudak & Wisner, 2012; Puryear & Treece, 2020).

The women in the study armed themselves with multiple tools in their effort to overcome perinatal OCD. Subordinate theme 2.2, *relief through medication,* highlighted the role of medication

in OCD recovery. Medication was a common element of treatment which was prescribed to all women in the study, in conjunction with therapy. In some cases, medication was the first step in recovery and helped women to regain basic functionality, such as eating and sleeping. Other women started medication later in their journey due to apprehensions around taking it during pregnancy or while breastfeeding. One woman noted that medication had helped to regain her sense of self despite experiencing constant obsessions. Others noted that medication had provided them a clearer headspace to implement the strategies and tools they had learnt in therapy. Although medication was perceived as beneficial, it was not considered sufficient as a standalone treatment. These experiences highlight the complementary nature of medication and therapy combined for symptom relief and the restoration of one's sense of self and overcoming perinatal OCD.

Within the general population, SSRIs are often recommended as a first-line treatment for individuals with severe OCD (Abramowitz & Jacoby, 2006). However, there is currently limited research supporting the use of SSRI's specific to the perinatal period. Without clear guidelines, medical professionals need to carefully communicate the associated risks of treatment and untreated illness. Participants across several studies were concerned about taking medication while breastfeeding, because SSRIs are passed through breastmilk (Alwan et al., 2007; Burton et al., 2022; Chelmow & Halflin, 1997; Gershkovich, 2019). These concerns may be particularly overwhelming for women with OCD, especially those with high responsibility appraisals and obsessions related to harm or contamination (Sharma, 2018). Women in the present study consulted with numerous health care professionals before deciding whether medication was the right fit. These combined findings highlight the complexities surrounding medication use throughout the perinatal period. They also emphasise the importance of comprehensive medical consultations for helping individuals make informed decisions.

In subordinate theme 2.3, *discomfort as a catalyst for growth,* women spoke about their experiences with CBT and ERP. Engaging in exposure work was a source of great distress, with one woman

describing it as a “literal hell”. However, facing their fears head-on proved to be a fundamental strategy for conquering their obsessions and compulsions. Resisting compulsions required immense effort, determination, and perseverance. Through repeated exposure work, the OCD gradually loosened its grip, restoring a sense of normalcy to their experience of motherhood. Women learnt to accept the cyclical nature of their emotions. They learnt to embrace discomfort as part of the healing process, knowing that eventually it would subside. Personal accountability and support form partners and/or therapists were vital for sustaining process amid occasional setbacks and relapses. This theme emphasised the transformative role of discomfort in fostering growth in the recovery journey.

Numerous randomised clinical trials provide substantial evidence regarding the effectiveness of CBT and ERP in OCD treatment in the general population (Cottraux et al., 2001; Foa et al., 2005). However, evidence for the perinatal population is limited to observational trials without a comparator group (Challacombe & Salkovskis, 2011). The findings of subordinate theme *discomfort as a catalyst for growth* revealed that CBT and ERP could be an effective treatment choice for the perinatal population. Investigating ERP experience through a qualitative lens generated novel insights regarding treatment attitudes. For example, the study revealed that the ability to accept and embrace discomfort was linked to effective treatment outcomes. Therefore, it could be inferred that treatment efficacy demonstrated in clinical trials may be supported by internal acceptance and the acknowledgement that discomfort is an inherent part of the recovery process. While these findings are promising, they cannot be deemed conclusive due to the small sample size.

The subordinate theme 2.4, *self-compassion is central to recovery,* emphasised the importance of self-compassion in the recovery journey. Some of the women in the present study experienced setbacks due to excessive self-criticism, self-blame, and low self-esteem, illuminating the impact that the disorder had on their self-perception. Specific therapeutic exercises were employed to address these issues, including writing letters of self-compassion, and keeping positive

feedback journals and engaging with Acceptance and Commitment Therapy (ACT). These tools helped women in the study to rebuilding their self-esteem. Self-esteem was framed as a psychological binding agent that brought together the practical tools of treatment. The importance of self-compassion was also noted by Beck et al. (2022), however participants in their study had cultivated self-compassion through other means, such as yoga and meditation.

Prior research has demonstrated that the role of self-esteem may be relevant for OCD, considering that individuals afflicted with the condition are often highly self-critical and have a tendency to punish themselves for their thoughts (Abramowitz et al., 2003). The association between self-compassion and OCD symptoms have only been investigated within the broader OCD literature, revealing a negative correlation between obsessive beliefs, symptom severity and self-compassion (Miegal et al., 2020; Fergus & Bardeen, 2014). The present study extends the existing literature by illuminating the relationship between self-compassion and OCD symptoms in the perinatal population. These findings indicate that interventions designed to enhance self-compassion may be beneficial alongside ERP.

In the final superordinate theme, *words of hope,* women shared uplifting messages of hope, by focusing on the challenges faced by new mothers during the perinatal period. They acknowledged that being a new mother was tough. The combination of uncertainty, responsibility, and maternal instincts can make mothers more susceptible to intrusive thoughts and anxiety. These heightened experiences serve a purpose because they enable mothers to be vigilant and protect the newborn. It’s important to recognise that these thoughts are a natural part of the motherhood journey, and they are not indicative of a problem.

All women acknowledged that recovery was entirely possible, even when it seemed completely out of reach. They wanted to serve as beacons of hope, conveying that regardless of the duration of suffering, age, or life circumstances, help is available to those who seek it. They unanimously stressed the importance of seeking treatment as a crucial step in recovery. Seeking

treatment was viewed as an act of self-love and self-care that was essential for countering the negative self-perceptions that are fuelled by OCD. Recovery was viewed as a gradual process, made up of small and consistent steps that contributed to cumulative growth. Some women expressed that their battle with OCD had made their life more fulfilling and beautiful, in a way they could not have imagined. Enduring these dark times had enabled them to access deeper expressions of love towards their children, which they were grateful for.

The present study contributes to the growing body of recovery literature, by adding more women's voices to research on this important issue. Secondly, this study reaffirmed the recommended treatment options for OCD in the general population, which include CBT, ERP, and medication. It also shed light on aspects of treatment that have been less explored, such as the value of community support, the value of psychoeducation, the role of self-compassion and self-esteem. It highlighted a wider societal need to support mothers by normalising intrusive thoughts and diverse experiences of motherhood. Overall, this study contributes to the literature in the sense that long-term OCD recovery is possible. While the literature is sparse, the present study presents a robust and consistent set of findings. This is particularly important contribution, considering that previous research has only investigated the short-term impact of therapeutic interventions using quantitative approaches.

Study implications

The findings from the present study offer valuable insight into what it is like to live with OCD as a new mother, highlighting the terrifying and debilitating nature of the disorder. This experience is further compounded by the responsibility of taking care of a newborn, and wider social norms that dictate what motherhood should feel like. The findings indicate that OCD can develop during pregnancy or after childbirth; irrespective of onset, the disorder can advance rapidly. If OCD is not identified and treated promptly, the impact can be long-standing. The repercussions of untreated

OCD were exemplified by some women in the present study, who became severely impacted by the disorder, and were unable to maintain employment or leave the house.

These findings illuminate the need for accurate post-natal screening tools that can detect OCD. While screening for anxiety and depression is common practice, screening for OCD is less frequent in clinical settings. The absence of suitable screening tools and a lack of awareness among healthcare professionals can lead to intrusive thoughts being misinterpreted as postnatal depression or psychosis, leading women to conceal their symptoms. These findings, in alignment with existing literature, stress the crucial role of clinicians and health professionals in recognising intrusive thoughts and compulsive behaviours throughout the perinatal period. This is particularly vital given the prevalence of perinatal OCD and its devastating consequences.

This study also highlighted the importance of addressing intrusive thoughts as a common and expected occurrence during the perinatal period. However, it is equally important to acknowledge that when these intrusive thoughts lead to distress or impairment, they could be indicative of OCD. Consequently, enhanced training for healthcare professionals on the subtleties of intrusive thoughts may help in identifying women who might otherwise go undetected. This training could also enhance healthcare professionals' confidence in providing support to women who are navigating OCD.

The present research contributes to the recovery literature by identifying the therapeutic tools that have been effective for recovery. The findings of the present study demonstrate that recovery requires the use of multiple tools and interventions, rather than relying on one singular approach. While medication was largely regarded as a positive contributor to recovery, it was not a complete solution. There are no current guidelines one the use of medication throughout the perinatal period, and therefore, medication is recommended case by case. Women in the present study expressed concerns about the safety of medication. These concerns were flagged as a barrier

to commencing treatment. However, with reassurance and proper information, women expressed satisfaction and relief after initiating medication.

These findings may be relevant to healthcare providers, particularly general practitioners (GPs), who typically serve as the first point of contact for patients. Applying these findings to a practical setting, doctors should discuss the risks and benefits of continuing or starting medication, so that patients can make fully informed decisions. Without additional research tailored to the perinatal population, it is difficult to conclude if medication will have similar treatment responses as the general population, however this study suggests that it may. With no clear clinical guidelines regarding the use of SSRIs during the perinatal period, medication requires careful consideration of the risks, compared to the risks associated with untreated illness. The benefits of using multiple interventions, as discussed earlier, may also be informative for health care professionals. These findings indicate that a multi-pronged approach, rather than a singular approach, may be more effective at treating perinatal OCD. Further research is required to investigate how this would be implemented in clinical practice, and the efficacy of using combined interventions.

Finally, the present study has potential implications for women who are currently living with perinatal OCD. It is hoped that they will take comfort in the knowledge that they are not isolated or alone in their struggles. Another hope is that they would realise that recovery is possible and attainable with the right support. Further, the findings from this study, particularly those discussed in superordinate theme two *an arduous but worthwhile journey to recovery*, may offer them valuable insights from women who have faced similar challenges. These insights may be helpful in providing them with practical strategies for managing and overcoming OCD. Lastly, it is hoped that the present study may contribute in some way to the minimising of stigma surrounding motherhood and mental health, this would be a remarkable achievement.

Study Strengths

The present study had several strengths. Firstly, the findings contributed to the current literature on perinatal OCD and recovery, which has been fairly limited to date. These contributions fill a gap in the research by providing novel insights about the experience and treatment of OCD among this population. The findings of this study can be used to help inform medical practitioners and mental health professionals on the various therapeutic tools that may be used to support recovery. They may also be beneficial to women who are currently struggling with perinatal OCD.

Another strength was the use of interpretative phenomenological analysis as the research methodology. Utilising this research approach was appropriate because there is very limited research into the topic. The approach enabled the researcher to collect a vast range of experiences that were not limited by pre-set parameters (Atieno, 2009). Employing this thematic approach allowed for common and shared elements of experience to be uncovered, as well as idiosyncrasies. While this study may have captured broader elements of experience and recovery, its findings may be used as a foundation for more focused research, for example, to investigate the efficacy of various interventions within the perinatal population. The use of this methodology was also fitting for the phenomenon under investigation, considering that the experience of perinatal OCD can be sensitive, emotionally laden, and difficult to articulate (Smith & Osborn, 2015).

Recovery has typically been defined as remission from symptoms, or a return to baseline functioning (Davidson et al., 2020). This narrow definition of recovery has been largely applied to the broader OCD literature. Using IPA to analyse the experience of recovery was a key strength of this study. This methodology enabled the women in the dataset to subjectively define recovery in their own terms. Women defined recovery as the reclamation of their identity and an ongoing process of self-growth. Recovery was not defined as symptom remission, but rather the ability to find meaningfulness, hope, and connection, despite the presence of ongoing symptoms. The use of IPA ensured that recovery was illuminated through an affirmatory and empowering lens.

Study Limitations and Directions for Future Research

The present study had several limitations. The final dataset of nine podcasts was a small sample, comprised of women who were able to talk about this highly stigmatised condition. This suggests that they may have different ways of engaging with stigma compared to those who may not be able to speak publicly about their experiences. As discussed in perinatal literature review, cultural expectations may impede disclosure and help seeking, this was observed in the study of Fang et al. (2018), where a Chinese participant feared she would bring disgrace to her family. The women in the present study are from Western countries. Therefore, it is important to consider how their cultural backgrounds may have shaped their experience of perinatal OCD and enabled them to speak about more freely on the topic. Thus, the findings cannot be generalised or considered representative of the population.

Some women in the dataset mentioned that they had co-morbid disorders such as depression and PTSD, which may have influenced or intersected with their experience of OCD. While this may have resulted in more varied or exacerbated symptoms, it is estimated that 90% of individuals with OCD suffer from co-morbid disorders. The use of a secondary data sources also meant that the researcher was unable to ask follow-up questions when an intriguing aspect of experience was discussed. In specific instances, the talk lacked depth and context, but overall, there was sufficient data to provide rich and nuanced interpretations of experience.

Prior research has determined that intrusive thoughts are common to all new parents, including fathers and non-biological parents (Fairbrother & Abramowitz, 2007; Zambaldi et al., 2009; Miller & O'Hara, 2020). The present study only included biological mothers, but did not include data from non-biological parents, adoptive parents, and fathers. Further, the study only included data from cis women who identified as women. Consequently, their relationship with motherhood discourses may be different from trans and non-binary people who birth and experience OCD.

Future research should include these populations groups, given that intrusive thoughts and OCD-like tendencies are prevalent amongst all parents. As discussed in chapter two, the data in the present study was collected from an international source due to ethical concerns. It is expected that these findings will be relevant to the perinatal population in Aotearoa. However, future research would benefit from conducting a similar study in Aotearoa, specifically around treatment experience, within its own cultural discourses of mental health and mothering. These insights could be used to determine what support resources are readily accessible to individuals, and where supports are lacking.

The present study deemed IPA the most appropriate method to answer the research questions, due to the limited scope of the literature. Throughout the analysis phase, it became apparent that the stories of lived experience followed a restitution narrative; they all had a beginning, middle, and ending. This type of narrative is used to explore the individuals transitions to back to health, and the meaning of these experiences. The foundation of a restitution narrative is "Yesterday I was healthy, today I am sick, but tomorrow I'll be better" (Frank, 2013, p.77). A limitation of the present study is that the dataset only includes women who have had positive experiences in terms of diagnosis and treatment, and subsequently, recovery. Future research should explore in further detail the nature of this restitution narrative and explore if there are other narratives in the perinatal population, given that the present study only included women who had positive experiences.

The women in this dataset have most likely chosen to tell their stories because they have relatively good endings. This type of narrative may reflect a contemporary expectation that there is permanent cure for OCD, and thus portray an overly optimistic or unrealistic depiction of the disorder's prognosis (Whitehead, 2006). While these types of narratives can be inspiring for people who are suffering, they can also be intimidating if the individual is unable to see a way forward (Whitehead, 2006). It is important that future research includes participants who are still grappling

with the disorder and may not have a positive story to tell. This would help to gain a more comprehensive and balanced perspective of the disorder. Further, it would help identify the supports that are needed for those who are currently facing it, so that findings are more relevant to this population.

Reflexivity

Within IPA, there is an underlying assumption that the researcher plays an active role in the interpretation of situated knowledge (Cohen et al., 2007). I acknowledge that my role as researcher may be influenced by my lived experience of OCD. I consider myself to be a partial insider, having experienced the disorder but not within the context of pregnancy and birth. I took considerable efforts to manage my personal biases and beliefs, however my personal experience and knowledge would have influenced the findings to some degree. Efforts to manage these biases were discussed in the methods chapter under researcher reflexivity.

I feel my position as a researcher and a partial insider has enhanced this study. My lived experience with OCD has enabled me to step into the shoes of the women in the study, in a way that someone without lived experience might not be able too. While I understand what it is like to be stuck in a constant loop of obsessions and compulsions, I do not know what it is like to be a new mother with OCD. My personal experience has enabled me to understand the distressing aspects of OCD, while also providing me with enough distance from the context of the perinatal period. I believe this has enabled me to interpret the data with more depth, while also enabling me to bracket my own experience from those experiences that have been interpreted in the study. Overall, I think my positioning in the research positively contributed to the study. It would be beneficial, however, for future studies to co-research with women with lived experience of perinatal OCD, to further enhance the voice of these women to inform research generated knowledge.

Concluding remarks

This study contributes to the literature by exploring the lived experience of women with perinatal OCD and their journey to overcoming the disorder. It has demonstrated that perinatal OCD

is a highly debilitating disorder that can interfere with one's sense of self and the experience of motherhood. Recovery was not achieved using one therapeutic tool, but rather a range of interventions including therapy, medication, CBT and ERP, and the cultivation of self-compassion. The study revealed that the journey to recovery was long and arduous, but experienced as entirely worthwhile, because it enabled the women to reclaim their identity and find meaning in their experience. It is hoped that this study will be informative to health care professionals who treat new mothers, in terms of identifying OCD and the range of potential treatment options. Future research is needed to develop appropriate screening tools that can detect symptoms of OCD during pregnancy and post-birth. Additionally, further training for health care professionals would help them to distinguish between psychosis and perinatal OCD, as well as discern between normal occurrences of intrusive thoughts and those that cause significant distress.

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Appendices

Appendix A: Participant Information Form

The lived experience of perinatal OCD and recovery

Participant information

Dear_______,

My name is Tasha and I'm a research student from Massey University in Aotearoa New Zealand. Part of my postgraduate qualification involves doing a research project. I have personal lived experience of obsessive-compulsive disorder and I am passionate about understanding the condition and the journey to recovery. Firstly, I want to acknowledge the insightful, honest, and important work you have been doing in speaking publicly about your post-natal experience of OCD on 'The OCD Stories' podcast.

The purpose of my research is to explore the lived experience of women who have overcome perinatal obsessive-compulsive disorder (OCD). Mothers are often scared to disclose their experience of OCD, due to fears of being perceived as a bad mother, or having their child taken from them. It is thus a hidden but important topic to better understand. The study aims to identify the support systems, strategies and resources that have helped women recover. Sharing this information will better support people who experience OCD. It will also help to normalize the

experience of having intrusive thoughts during the perinatal period, thereby undermining the stigma associated with it.

This is a courtesy email to let you know that I would like to use some of the information you shared on the podcast episode #000. I hope that my research will benefit the community by contributing to a wider public discourse that normalizes and supports the diverse experience of parenting through producing a research thesis available on the Massey repository. If you are okay with me using your blog, I will not include any demographics such as name, age or location that may lead back to you. Nor will I include any contextual information or verbatim quotes that could lead to your identification.

If you do not want your podcast information to be included in the study, please reply to this email and let me know. If I don't hear back from you within a month, I will assume that you are okay with me using the data.

Please feel free to contact me if you have any questions or concerns.

Thank you for sharing your experiences publicly and for seeking to support more women.

All the best in the future.

Kind Regards,

Tasha Francis

Appendix B: Participant Descriptive and Interpretative Codes

Podcast 9

Descriptive notes	**Audrey**	**Interpretive coding**
	10.21	
Audrey had a really good pregnancy One anxious episode happened during pregnancy, she laughs recalling this event – perhaps reflecting on how irrational it was? This anxious event was attributed to maternal instinct and hormones (influenced by social narratives of 'pregnancy'?) Midwives did not identify symptoms of OCD.	We wanted to start, you know, kind of extend our family a little bit, and I got pregnant. And look, I had a really good pregnancy. Towards the end of the I started getting a bit anxious. And I do remember, I remember it to my dying day, that like I live around the corner from the Olympic Stadium. And it was Super Saturday. Oh, yes. When they were winning every all their goals and everyone was screaming, and I remember like to the backdrop of this absolute euphoria with me making my husband take me to hospital because I was convinced that I had moved funny and had broken my baby's arm. So, I was just, again, alarm bells didn't really go off and it was just because what happens when you're pregnant is everything gets put down to you know, kind of maternal instinct or hormone, or. So, yeah, I kind of came back from that incident of midwives just looking at me, like, I was just from another planet when I was trying to explain what I was worried about.	Pregnancy went well. Anxiety flared up towards the end of pregnancy. Mental state was a contradiction to the event. Pregnant women are perceived as hormonal and irrational. Anxiety during pregnancy was attributed to hormones and maternal instinct. Did not feel validated by the health care professionals. Symptoms of anxiety were not addressed by health care professionals.
	11.09	
Delivery did not go well.	Um, but yeah, I was fine until, I had, I had a dodgy labor. It wasn't great. Came home. And I was, I was pretty weak. And I think about five days after, no, a couple	Labor was complicated. I felt fragile after birth.

Intrusive thoughts began a few days postpartum. Did not have a label for the intrusive thoughts she was experiencing. Audrey felt unprepared to care for her baby. This feeling was magnified by the vulnerability of the infant. Worried that she would do something wrong and the baby would die. This led to her doing continuous safety checks (compulsions) in attempt to keep the baby safe. Convinced that her cat would suffocate her baby. The compulsions and safety behaviours became more complex over time. Laughs when mentioning the cat hadn't grown, perhaps out of embarrassment, or the reflecting on how irrational it was. Did not realise at the time that these behaviours could be putting the baby at risk. Living in a	of days after I started getting some real intrusive thoughts about again, I've never heard of intrusive thoughts. So it was just kind of images to me, of harm coming to my baby, you know, they'd handled handed me this tiny little thing. I never even changed a nappy by that point, you know, so maybe I could have done a bit more prep work myself. But I had this tiny little baby who was so vulnerable. And I was absolutely convinced that I would make a mistake or just life, you know, I just something will go wrong, and that he would die. And so I spent a lot of my time going around and doing safety checks. And a lot of it, seemed to make sense. So like, I'll give you an example, I had a beautiful cat, absolute gorgeous boy called Archer. And I became absolutely convinced that this lovely cat would go up, try to snuggle up with the baby and suffocate him. So now I know that there is a basis to that, you know, it does kind of make sense not to have a cat near a brand-new baby - just because of allergies. And you know, things like that, it's just a good idea not to have a baby asleep in the same room that a cat can access. But so convinced was I that this was going to happen, you know, it was the extreme again, like the killer Berg was, that I started barricading our bedroom door at night. So it started off with a couple of books to make sure that the cat couldn't push through. Um it grew, I bought chair up from the dining room, put a couple of books on that. And as the nights went by, kind of chairs were added to it, the items got heavier, they got intertwined and kind of interlocked you know, this was all to stop one shorthair, domestic Tabby, you know, he hadn't grown.	Rapid onset of intrusive thoughts following birth. Unprepared for motherhood, no one taught me how to do this. My baby is so small and vulnerable. Immense sense of responsibility for keeping baby safe. Feeling a lack of control over the situation. Safety checks provided a sense of being in control. Any mistake could lead to a disastrous outcome. I could justify my actions because they made sense on some level. Worried about making mistakes and causing harm to the baby. Convinced the worst-case scenario would happen. Must engage in compulsions to protect the baby. Compulsions become more complex and excessive over time. The cat will kill my baby

heightened state of anxiety can lead to tunnel vision and prevent 'rational thinking' as your brain is hyper focused on the perceived threat. Reflects on previous behavior as odd, however this made sense at the time.	And it just became this, you know, at no point did it dawn on me that if there was a fire in the house, I would have no way of getting out of that room with my little one in times get out of the house. You know, as far as I was concerned, the threat was the cat. And I was dealing with it in the best way I can. And so that was just, that's just one example from start to finish of what I was doing. There were loads more, there were loads more really odd things that I'd started doing, like removing everything that I deemed toxic from the house.	Being stuck in a cycle of distress takes you out of the present moment. OCD can narrow your focus and impair your ability to notice other risks. Lack of coping strategies. Believed she was doing the best for her baby.
Physically and mentally unwell after giving birth. Aware of what others might think about her intrusive thoughts. Uses strong language to describe the content of the thoughts i.e., 'really awful', 'terrifying' Intrusive thoughts consist of verbal dialogue 'what if' and images of harm. Intrusive thoughts evolved into pervasive horror stories.	13.55 And I think it was about um about a week later. And I was just really not very well at all. They'd missed a couple of things from labor. So I was I wasn't healing as well. And I was still, I was quite anemic. So very, very tired. But I remember just kind of sitting and this isn't this might sound a bit shocking, you know, for people who haven't heard this spoken about so bluntly, but I think it's important get it out there. But I was sitting on the sofa. And I remember staring at like, my mother in law who was cuddling my little boy. And I just had this really awful thought that I was going to you know, a what if thought of what if I just snatched him off of her and kind of whacked him against that wall. And it I saw it you know this imagination. I saw it in all it's detail and it was the most terrifying thing I've ever seen. And it kind of came with it a load of other images of things like you know like the front page of the paper. Kind of with the story on the sensation story title of what I've done. And I would see my family watching the news, you know,	The medical treatment I received during labor was substandard. Felt exhausted after birth. My OCD experience was really awful and terrifying. Plagued by 'what if' scenarios. My imagination ran wild with vivid images. I experienced intrusive thoughts and images.

Intrusive thoughts of accident and deliberate harm are considered typical post-natal OCD symptoms.	having lost their, you know, this new little baby and their daughter had just lost it, you know. So, um, and it just, it was awful. And it grew to the point where, like, I was so terrified that I would deliberately, this isn't an accident coming to him, I was terrified that I would deliberately hurt him or harm him or kill him. And it got to the point where I literally couldn't look at a single thing in the house without seeing a way that I could use it to harm him.	Imagining myself as a monster through my family's eyes. Scared of losing control Intrusive thoughts evolved into horror stories. I was convinced I would hurt or kill my baby. Intrusive thoughts tainted my perception of everything.
Strong belief that talking about these experiences is important (for her own recovery? Or for public awareness?) OC symptoms were not limited to intrusive thoughts or images, they also included impulses.	15.48 And I haven't actually spoken about this for a while, well it came out in the OCD action newsletter this week. But again, it's another thing I think it's really important to talk about, is that I actually experienced intrusive impulses as well. So just like, you know, you get the urge to jump out in front of the train sometimes or the air to jump off or somewhere really high. That kind of really strange, fleeting impulse, I had this impulse to kind of like, throw him, it just, it took me completely by surprise.	Talking about intrusive thoughts is important for recovery and public awareness. I experienced intrusive thoughts, images and impulses. Impulses are spontaneous and catch you by surprise. Perceives impulses as a strange physical sensation.
In hindsight, Audrey understands that these are normal. Audrey reassures the listeners that these impulses are experienced by most people.	16.07 So whereas I could, I now understand, everyone gets things like this. And I now understand that every single, Well, the majority of new parents, because they're all focused on their baby would have an intrusive thought like this. And now that	Intrusive thoughts are normal to new parents. New parents are hypervigilant to threats.

Can laugh about these thoughts now. Uses more emotive language to reflect on previous experience 'awful', 'absolutely horrendous'	I've spoken to people about it, I failed. They're like, yes, hello, let me tell you this one, and we have a laugh about it. But at the time, it was absolutely horrendous.	Failed to perceive this as a normal experience at the time. The thoughts are funny when you don't have OCD. My experience of post-natal OCD was absolutely horrendous.
The harm impulses were worse than the thoughts. Having impulses was evidence that she would harm her baby (thought-action fusion). Had slight insight into the disorder initially, but this deteriorated as the condition worsened. Couldn't function – severe OC symptoms. Audrey checks baby sleeping - references 'maternal instinct gone wild' supporting the evolutionary theory that these thoughts may be at the extreme end of a continuum.	16.36 And so whereas before, I thought harm thoughts were awful, and I could just about cope, the impulses, kind of, to me counted as evidence that I was going to do it that I wanted to, and that I was just a monster, really. And I very, very quickly. I mean, I didn't know that intrusive thoughts and impulses were part of OCD, I no longer knew that what I had was OCD, I kind of had an inkling that the chairs against the door to stop the cat in was OCD, but I didn't know that this was and I thought I thought I may have you know, postpartum or postnatal psychosis, but I was too with it for that. I thought maybe depression, you know, there was nothing that kind of, I didn't know it existed this this side of OCD. So yeah, I very, very, very, very quickly went downhill. I just, I wasn't functioning at all, I, you know, I'd stopped sleeping, initially to watch my baby breathe to check that he was safe. But it was my maternal instinct just gone wild. And because I was convinced that it was me, he was at risk. I put into place all these things to keep him safe. So I would only be on my own. No, actually, that's wrong, I wouldn't be	The harm impulses were worse than the intrusive thoughts. The impulses made me doubt myself. I believed I was a monster. I quickly spiraled. Harm impulses were evidence that I would hurt my baby. Initially I recognized that I had OCD, but I lost this insight as the disorder progressed. Couldn't function when OCD symptoms were severe. Checking the baby – maternal instincts gone wild Needing constant reassurance that baby is safe.

Audrey was convinced that she was the threat to her baby. She did not trust herself around the baby. OCD targets the things that people value the most. In hindsight, these thoughts/behaviours made sense to Audrey because she cared deeply about children. Awareness around why OCD latched onto these topics. Believes that she might commit harm because the thoughts are so repetitive (thought-action fusion). Audrey continuously engaged with the thoughts and questioned them (perpetuating the cycle). References the first weeks of motherhood as 'rubbish'.	on my own with him at all. And I would only be in the same room with him If my husband was in between us, you know, I'm not a small lady. I'm just shy of six foot and I'm strong. And I had to make sure the only person who I kind of know in my life, who is big enough and strong enough to stop me. If I just lost it and went for him, was in between us. That's how convinced I became that I was going to do it. And I mean, I've I should say that now people kind of say to me, you know, you didn't you realize no, you're a teacher. You love children, everything about your life up to this point has been about you know, trying to enrich future generations. And you know, it just it kind of now I know made sense that it attached to that, it made it made sense. They're attached to my little my little baby. You know, I do have OCD. So that's why I took those thoughts seriously. And also, I think it's really important to mention as well, that what you know, you become quite irrational. You know, I wasn't delusional at all. I knew well, I hoped that I wouldn't do it. But I got to the point where I didn't know I definitely wouldn't. I was so bombarded with these horrible thoughts. Day in and day out that I just thought well, blimey, maybe I will. Who does this? Who, who stacks these chairs up against the door like this? There's obviously something not right with me. Who has thoughts and impulses like this? And you know, it just it was nothing to do seriously. I did not. It was not what I thought for my first few weeks of motherhood. So, yeah, it was it was really, really rubbish. Um, I rang my midwife, good East London, you know, you don't have just one midwife, you have a team and they sent a mental health midwife round. And I tried telling them I didn't tell	Having these thoughts and impulses meant that I was a risk to my baby. I do not trust myself. I am a threat to my infant. My thoughts conflicted with my personal values. Making sense of the intrusions. OCD targeted my values. The thoughts are so convincing. Repetition of thoughts makes them more convincing. Something must be wrong with me. Constantly analysing the thoughts and what they meant about my character. My first few weeks of motherhood were rubbish. Reaching out for help

Midwife meant well, but threatened to put Audrey on the risk-register if she disclosed specific information. Audrey was too scared to admit what she is experiencing due to fears of her baby being taken away. Laughs in disbelief over the situation. Conversation with midwife reinforces the belief that she is dangerous to her baby. OCD symptoms worsened; Audrey was unable to function. Audrey started considering suicide as a way to escape her intrusive thoughts. Felt immense guilt about the impact her condition was having on her family.	him anything else, I just think I'm bit depressed and I feel a bit rubbish. And I remember she kind of put her hands out and she was a really lovely lady. You know, she wasn't being horrible. I think she was actually trying to help me and she said, Look, I just need to let you know. That if, if you tell me that you have postnatal depression, I'm gonna have to put a little man on the At-Risk Register. And I remember just that I was like, you what? And then I styled out, I was like, You know what, I did get a few panic attacks during my you know, my teachers training year and try to back out with it that way. Because I was like the queen of faking it. I wasn't eating, I wasn't sleeping, but my goodness, would I have the energy to try and convince them? Not to start, you know, safeguarding, It was terrifying. I'm laughing now because I can't quite believe it happens. You know, I can't, I can't believe it happened. But so yeah, I am that did absolutely nothing other than confirming to me that I was dangerous. And, and that's where I think it sounds very dramatic. But I think that's kind of where the the fight for, for my life really started. I just, I wasn't capable of anything. I just sat on the sofa, just in a perpetual state of sheer terror. And I started to think about, you know, kind of taking my own life as a way of just one escaping. And also, even when I was feeling better enough to know that I wouldn't do this. I could see what a drain I was having. I mean, there were there were bereavements, and other things going on in my life as well. So I couldn't have every family member with me, but I could see what it was doing to my husband. He had this brand-new baby, and this wife who was just sitting rocking on the sofa. And, you know, I just thought they don't	Healthcare professionals threatened to put me on the risk-register. Too scared to disclose my thoughts. Conflicted feelings - My baby is not safe around me, but don't take him away! Feeling pressure to fake mental 'wellness' The advice I received was unbelievable. Healthcare professionals reinforced OCD beliefs. Fighting for my life. Frozen in terror. Considers suicide as a possible escape. Feeling guilty for having the disorder.

Believed her family would be better off without her. Audrey made a last-ditch attempt to visit her GP. Tried to convince her doctor that she should be in prison because she was unsafe to society (meta-cognitions about the meaning of thoughts & TAF – thinking about committing an immoral action is the moral equivalent to committing it). GP identified that Audrey was experiencing anxiety due to their personal history. This provided Audrey with very temporary reassurance. Audrey was prescribed a high dose of medication.	need this. And I honestly went through a phase where I thought that they would be 100% better off without me. And I don't know what happened. Just like last minute, I decided to kind of go to the doctors, and I'm really glad I did. Went my GP, stormed in, I was like, you have to have to take me away, I'm not safe. And it wasn't a hospital. It was, I wanted to go to prison. I wanted, I wanted them to remove me from society. Because I wasn't safe. I'd said goodbye to my husband and my little boy, you know, I'd kind of said, you know, Mommy's got to go off, and go off to do something, and I thought that was over. And my chief, you know, it's kind of my GP was like, Audrey, it's anxiety. I saw you the whole way through your 20s for this. And it's just come back and I just still I just I didn't believe him, is what OCD does, isn't it? So OCD does it tells you that You know, it kind of reassured me for 30 seconds. And then I was like, Nope, he doesn't know everything I'm thinking. Yeah. So yeah, that's some kind of, I'll just, I'll just summarize the rest that I basically spent the next six to seven months just showing, you know, I spent a couple of months really out of it at quite a high dose of medication. **Podcast Host** 23:07 Are you getting on to your recovery now? **Audrey**	My family would be better off without me. Last-ditch attempt I am unsafe to society. I deserve to go to prison. I had said goodbye to my family. GP identified symptoms of OCD. Re-assurance was comforting. Relief of diagnosis was short-lived. He doesn't know the truth of who I am. Prescribed medication as treatment. I was just existing.

	23:11 Oh, am I right? **Podcast host** 23:12 No, no, no, no, no, no. I mean, was, I wasn't sure if you were getting on your recovery, because if you were I wanted you to stop there. So we could unpack some of the stuff you've talked about before we kind of	
Audrey indicates that recovery was not a linear process (included relapses).	**Audrey** 23:23 Oh, yeah. Well, it kind of recovery, but there was a load relapsing gray area. **Podcast Host** 23:31 Let's lump that into the recovery bit because relapse is part of it. Firstly, thank you for being so open and sharing your story because I know it's not easy to be so vulnerable. And talk about these things, especially around Thank you, especially around like the safeguarding and I completely agree, I think, sadly, safeguarding has to go to the extreme to where most of the cases they're flagging up are completely innocent. But sadly, they have to do that to catch the couple cases	Recovery is non-linear. Relapse is common.

	that aren't innocent. And if they don't, they're going to miss them, which is frustrating for people like you who will no risk to their child. But yeah, it's kind of that it's annoying, but in a way, it has to be annoying for it to be effective.	
The threat of having her baby taken away had a huge impact on her recovery journey.	**Audrey** 24:21 I must say I moan about that a lot, because the personal impacts of me was huge because of that. But I would still absolutely say I'm glad it happened because yes, they did make a mistake. But if it means that they're out there catching the times when it isn't, then I'm glad that's what they're doing, you know.	Healthcare professionals can be a barrier to recovery. Sometimes health care professionals get it right.
	Podcast Host 24:39 Yeah, absolutely. And I think you're kind of all you exactly said this isn't a safeguarding now, but you said something about kind of who has these thoughts and, and ironically, millions of people, not just from the study that came out that said 95% of the population has intrusive thoughts, the difference between them and us is that ours stick. But just, you know, people with OCD alone, there's millions of people around the world right now with OCD that have these weird sort of thoughts. So it is normal, because it's normal for millions of people.. But that doesn't make it easier. And I think what you're doing by sharing your story with your blog, teaming Olivia and being so open, yes, it's hard and tough and	

	makes you vulnerable and scared. But, you know, someone hears that, you know, a few 100,000 people hear that message, it's no longer weird for them to come out and say, I had a thought that I would stab my baby or throw it against a wall or something equally like that, because someone else is gonna go, Oh, it sounds like OCD. Whereas if people don't speak up, and someone hears that, they're gonna be like, what's wrong with you? So the so you know, I respect you for opening up because you're allowing that, you're allowing, OCD to become normal in the public eye. **Audrey** 26:00 Oh, yeah. Now, this idea that the brain is just like, you know, it's evolved to just do all this really random stuff. You know, it's brilliant. I quite enjoy because we do lots of really random awesome stuff as well with it. Just the thought that, the you know, talking about the not so the great side, and I'm so used to doing it now. And I just love it, you know, talking about it, I talk about it to parents on the way home from the school run, certain elements, you know, and you can always see the relief on people who don't have OCD, talking about, you know, these kind of secret taboo thoughts that people have, everyone seems quite relieved to find out that They're not the only ones having them, you know, so yeah, the more we can talk about it, that's awesome.	
Audrey referencing evolutionary theory again – the evolution of the brain to awesome things (in reference to childrearing). Enjoys normalising the experience of intrusive thoughts by talking about them with others. This is a big change from when she was afraid to share her thoughts with her midwife and highlights the progress she has made in recovery.		The brain has evolved to do some awesome things. There are two sides to the human brain. Talking about taboo thoughts has become an enjoyable activity. Talking about intrusive thoughts helps to normalize them.

Reflects on how normal intrusive thoughts are, but also recognizes how scary they can be when they are about your own child.	**Podcast Host** 26:39 Well, absolutely, I agree. And like, you know, I don't have the theme of homosexual OCD. But occasionally, I will get an intrusive thought of me lunging forward and kissing another man. And I have no urge to do that. And I'm not anxious about it, but the thought pops into my head. So yeah, I but obviously, most guys would never ever say that. **Audrey** 27:02 No, totally, totally, do you know, I, I walked down the stairs behind my mum once and had this urge, like this kind of very strange impulse for a second to kick her the rest of the way down. And it just, it didn't hit me until I was like, That is weird. And I even told her about it. I was like, you know what, you're lucky, you made it to the bottom there love, you know just. And I just, it just, it was so normal. So, you know, it's just normal. But these ones that have to do with Will were just like, oh, my goodness, you know, they was terrifying. So, it wasn't every intrusive thought it was just the ones that you know, in my mind condition decided to attach to. **Podcast Host**	Its easier to brush off intrusive thoughts when they aren't targeting your deepest fears.

Audreys husband wanted her to get better but didn't want to make her feel bad. Audrey hid her compulsive behaviours from her husband (perhaps realising that they didn't make sense? Or maybe to conceal her illness?) Husband was exhausted after birth of baby. Husband tried to encourage her to see the doctor.	27:40 What so with your husband, when you were progressively putting more and more things against the door to keep the cat out? Yeah, at what point did he kind of say what's going on here? **Guest** 27:58 He was utterly torn between making me feel worse by making me feel bad about it. He also, and I must say this, I hid a ton from him. I mean, I've been practicing hiding the stuff that I do for a very long time, I'm an expert at it. So you know, I kind of make up a reason why another chair had to go upstairs. And because he wasn't sleeping initially in the same room with us, because we had to kind of try and take it in turn, So that one of us got a decent night's sleep away from the baby. So he was in a different space completely, we're in a flat. So he was totally the other side of the house. I was upstairs with the baby, and I did it quietly. You know, he I worked out a way of trying to encourage him not to come up to the bedroom because it woke us up when it was so that he didn't you know, you kind of see what I've done behind the door, you know, is that quite an element of me hiding things from him. And also, you know, we mustn't forget he, he was exhausted. He didn't know what day it was himself, you know. So he did try to encourage me to go to the doctor. And he did try, you know, making me look free in my own sanity book, which was, you know, there's no point there was	My husband was conflicted. I became an expert at concealing my behavior. I didn't want my husband to stop me. My husband encouraged me to see a doctor, but my OCD was manipulative.

Husband was very supportive. Audrey admits that she manipulated her husband because she believed she was protecting her baby by performing these compulsions.	absolutely nothing in it about intrusive thoughts. But yeah, he did everything he could. But again, I just I've got to hold my hand up I manipulated my way out of any help he tried to give me. **Podcast Host** 29:26 so the only that there's a question has come up for me now is that I do get questions from people to ask the various guests sometimes around, you know, how can I get my child to go to therapy, they don't want to go. How do I get my loved one or partner, so in that case, you know, like you said, you no matter how hard he tried, you kind of didn't want to do it or go. What could he have done? Do you think that would have made it better? Or more likely for you to go seek help, In hindsight? Obviously not criticizing them just trying to look for ways to help others was going forward?	I wasn't ready to receive help.
Audreys husband was supportive and rational. Audrey would have been motivated to go to therapy if she understood how much the condition was	**Audrey** 30:01 I get that I get that totally, I think, knowing me the way that would have done it. I think he was trying to be so, is it stoic the word? he was trying to be supportive and rational. Just he was. He was trying to be very strong for me. And I think having spoken to him later finding out what that was like for him had he had I had	Understanding how my condition impacted my loved ones would have motivated me to go to therapy.

affecting him. Conflicting as she previously mentioned contemplating suicide because she saw how much her condition has affected her family? Audreys husband didn't confront her about how he was feeling. Both Audrey and her husband had fears around child protection being involved. This was a barrier to seeking treatment.	a glimpse of just how much it was affecting him. I think that would have got me there. Yes. Yeah, absolutely. I think he didn't want to add anything to me. So he didn't like onto my worry, or my loads that if he didn't tell me what it was doing to him, really. And also, you know, I don't think he he's really seriously very chilled out, man. You know, I mean, it's obviously, it's obviously it's a track that very much relationships, but he also, you know, kind of like, you know, you know, doctor said, it's anxiety, isn't it? You know, so he try and help me out that way. So I think, yeah, it was being, if he was very honest with how awful he was finding the whole event, I think I would have forced myself into going. But then our situation is a little bit different, because both of us were terrified of child protection. **Podcast Host** 31.18 Oh, of course. Yeah. That adds an extra element. Yeah, yeah. All right now, but that's very helpful information. Thank you. Okay, so when I one other thing that actually came up before we kind of get into recovery is that it's ironic to me that I know know this about OCD, obviously, but we do these things, like lock the door to keep the cat out. But as you said, you know, actually, you were putting yourself in more danger in your child, because if there was a fire, you'd almost be screwed. Yeah. And it's like, you know, if we think we hit someone in our car, and we keep going back and forth down a road, we're probably increasing our	My ability to perceive how others were affected by my illness was limited. My husband tried to ease the load. I would have gone to therapy for my husband's sake, but not on my own accord. The fear of child protection was a barrier to seeking treatment.

	chances of own a car crash because we're not truly focusing on the road, we're focusing back and forth on this one area, turning around doing U turns. So in a way we're putting ourselves in more danger. And I could do it on every type of obsession or compulsion I don't want to trigger people or make them feel guilty. But it is almost to use that as motivation to to get better and seek treatment because actually, the, the, the overactive brain and anxiety is probably putting us at more risk and in many cases, not all, but	
Audey was grieving the loss of both her parents and cat. Four drunken adults on a bike were heading straight for her and the baby. Audrey was not present because she was stuck in a cycle of distress.	**Audrey** 32:28 I totally and absolutely agree with that. I mean, I won't go into too much detail about this because this is obviously an OCD, focused blog, but I lost my parents, and my lovely boy Archer are all within eight months of each other and I remember we went away for a little while. And I was walking down the road a little man. And we went to Butlings actually my goodness and I really love a bit of vodka actually. And but yeah, they had these really dodgy kind of like bike things. I don't think I've told anyone this story before. They had like this really dodgy like these pedalo things, but they weren't on the water, you know, they were kind of like scooters for people to go around on. And I remember just being so lost in my heads between the grief and between, like the kind of intrusive thoughts and stuff that I saw this one coming straight for little man. And it had these four kind	I was dealing with other major life challenges at the same time. Lost in emotion, unaware of surroundings. Rumination and distress impaired my ability to be present in the moment.

She managed to get herself and the baby out of harms way. She knew that the distress cycle had caused a delay in her reaction times. Realisation that her untreated OCD may cause harm in other ways, due to her not being present with her son. Draws conclusions that the condition can cause harm in other ways. Audrey perceived this event as an incentive, or wake up call, to seek help.	of drunken adults in it. And it took me longer to get him out the way, I know this. I absolutely know that it took me longer to realize what was going on, and to get him out of the way. Because I was so in my head. Had I been present, Had I been there, I would have and this isn't a mother going and I wish I'd done it differently, I absolutely, I'm 100% convinced that I would have got there much faster had I not been ruminating, you know, and that was the bit where I was like, hello, wake up call. I mean, he was fine. I got them out of the way and kind of saw a bit of these people. But he, you know, they is that, Yeah, that really was a moment where it was like, alright, so or I have OCD. I'm not going to harm him, but my ruminating might, because I'm not watching him as well as I could be. So yeah, that's the same kind of thing, I think, isn't it? Yeah. **Podcast Host** 34:22 Yeah, really good. Really good. Illustration there. And, and yeah, that's not you know, given these examples and not to make anyone feel bad. It's just to kind of use it as another kick up the ass to do something and really start with treatment **Guest** 34:38 An incentive, isn't it? It seems thing to you is that thing that makes you go, Alright, and let's, you know, let's go nail this.	Being stuck in my head was a risk to my child's safety. Untreated OCD can lead to other undesirable outcomes. My actions won't harm him, but my inability to be present might. Realising how your disorder is impacting your parenting abilities can be an incentive to seek help.

Medication helped to ‘knock’ her out so she could sleep. The intrusive thoughts continued, but the medication made Audrey numb to them (perhaps by reducing the physical anxiety symptoms?)	**Podcast Host** 34:45 Yeah, yeah. And the other. The other side is, you know, if you weren't in your head at Butlins, you probably would have enjoyed that trip more and been more present with your child etc. And so that's another kind of incentive is to feel like you're living a bit more, Oh yeah, I never thought Bognor Regis would come up on my podcast. Okay, so let's get on to your recovery now. So, you know, relapses medication therapy, let us know what happened. **Audrey** 35.34 Right. Okay. So um yeah, I came away, and I had medication, I had Dizalapram or which works very well, for me, actually, I know it hasn't for a lot of people. And I also got given diazepam because I think I've reached the point where the only thing that would, you know, just help was knocking me out for a while, I had to kind of rebuild. And so yeah, that happened. I started eating again, I started sleeping again, I started to, actually I kept having the thoughts, but I didn't feel any kind of reaction to them. But what I did feel was quite numb. I'm actually still on medication now. And I don't feel that numbness. So I don't want people to kind of assume that me being down on you know, medication, but it took me a long time to, to get used to being on them. I'm very sensitive to them. So I do	Medication helped me to sleep. Medication helped to take care of myself at a basic level. Medication made me numb at first. I have adjusted to my medication now.

Audrey still takes medication but has now adjusted to it. Doesn’t experience numbness anymore. Still struggled to take the baby out to do regular activities. Tried to come off the medication several times, but the symptoms were unmanageable. Audrey felt like a failure for starting medication again (perhaps due to stigma around mental illness). Audrey felt like she didn’t need any additional treatment because she was managing to function at a basic level. Reflects on having low standards on what she considered to be well enough. Stumbled across her symptoms on the internet. Was euphoric when she realized she had OCD.	remember about a month of just being a zombie, but it was a zombie that could spend time with you know, her baby without her bodyguard, the bodyguard needed to be between the pair of them. But yeah, I kind of, I still struggled to do anything. To go for a walk around the block with him in the pram, go anywhere near a bridge anywhere near a train station, you know, these kind of thoughts and impulses just be huge. And every time I tried to come off the medication, it just all came back again. And I do remember one night and just bawling my eyes out to my husband because I had to go back on my medication. Again, I felt the biggest failure ever. But I hadn't done any form of recovery work other than take a tablet. I still hadn't been diagnosed with OCD. So I was just kind of, just a bit of a walking mess. 36.00 And I think because I could now do things that mothers could do. I kind of told myself, it was alright that no more work was needed, you know, his mom was reasonably normal. At least I wasn't, you know, at least I wasn't not sleeping anymore. And I wasn't kind of thinking about ending my life. And that, you know, you kind of have very low bar of what was alright. And yeah, so every time I kept trying to come off, it just didn't work. I put in one night into Google its like, you know, a mother's in fear of harming their child. And that's when a few OCD articles popped up. Because I expected to see like, you know, a lot of prisoner profiles come up on the screen. And it wasn't, it was OCD, and I just couldn't believe it. And I just kind of spent two days and just this state of absolute	I felt like a zombie going through the motions. Medication helped, but I still struggled. Avoiding situations that triggered thoughts or impulses. Medication was a band aid. Feeling like a failure for going back on medication. ‘’well enough’’ Low standards of wellbeing Medication did not address the underlying fears Discovered symptoms on the internet Conviction that ‘people like her’ were prisoners.

This elation was short-lived because the OCD convinced her that she was different. Audrey thinks about having another baby. In hindsight, reflects on how irrational it was to consider this at the time. Comes to the conclusion that she needs more than medication to get well. Audrey found an 'incredible' therapist. She was scared that the therapist would put her in psychiatric care. She received 20 weeks of CBT therapy. She learnt to challenge her thoughts and thinking styles. Audrey jokes about how she would receive the top scores on	euphoria. That, yes, I have OCD, I'm not a not a child killer monster, I actually have a condition this is fabulous. That again, didn't last very long. Because OCD convinced me, actually, I'd kind of just didn't count, you know, I was different from the other side, I actually wanted to do it. So I kind of yo-yoed on and off medication for a while, really, really wanted to have another baby. And that obviously wasn't a very good idea for me at the time. That will kind of give you an indication of how I suppose, non-sensible my thinking was at the time even considering that. And then yeah, eventually I went to my doctor and I thought there's got to be something else. There's gotta be something else these medications, medication, just alone isn't enough. And he told me about I-apped, you know, the part of the Northeast London Trust, which is outstanding, actually, it's amazing. I'm very lucky to live where I do. Because I know sadly, not everyone has that. But I went to CBT, this absolutely incredible therapist, I'm gonna write to you soon and let her know everything she's helped me do here. But I kind of I still walked into that thinking that when I told her the nature of my thought she'd kind of hold my gaze, smile, you know, press a big alarm under her desk and these people will will just like, come take me away. I was absolutely convinced that was what's gonna happen. And it didn't so I you know, thankfully, I went through 20 weeks of very intensive therapy. I had to learn how to challenge my thoughts. I had to learn how to just basically relearn every thinking style that I had, you know, we used to joke because every time she gave me a questionnaire, I would get 100%, 100% of what you didn't want, you know cuz like I get a gold star again	I was euphoric when I was able to put a label on experience. My OCD convinced me that I was the exception. My thinking was illogical at the time. Hopeful that something else will help. Medication is not enough to overcome the disorder. Privileged to find help. I resonated with my therapist. Grateful for my therapist. Convinced they were going to take me away. Challenging my thoughts

questionnaires, alluding to how severe her OC symptoms were. Experienced panic attacks in response to therapy. Psychoeducation about the biology of panic was helpful and 'changed' her life. Audrey was making process and building up to ERP, but then she experienced a relapse following her parents death. ERP was challenging, she uses emotive language "absolutely horrendous" and "insane" ERP included holding knives, standing on railway tracks and the side of the road.	today, it's always the stuff that, you know that you shouldn't really be doing. And yeah, so I worked so hard, I did my homework all the time, I was in such a state that I couldn't even touch exposure for a while I had to work on, you know, kind of digging myself out of this depression that I'd got into. I was having panic, panic attacks the whole way through as well. So I had to learn about, you know, the biology of panic. And it was just fascinating stuff. It was fascinating, absolutely changed my life, it was absolutely incredible. And I gradually built up to exposure. And what I'm gonna do now, because my story gets a bit complicated, but after I finished my first lot of therapy, that was when I kind of came away and lost my parents. And then I just relapsed really badly, perhaps go back to therapy, but what I'm gonna do is just shove the two therapists into one big one, if that's all right, so it won't really be logical. But yes, so I eventually got on to ERP. And the stuff I had to do my goodness, I had to stand holding a knife in like a kind of stab position. I had to make dinner, you know, and then like, kind of hold my knife and really strange like, like, I was going to go for someone kind of position when I talked to people. Unbelievable. Like, I shouldn't laugh, I'm sorry, but I just can't help it. It was absolutely horrendous. And I had to force myself to stand on the side of railway tracks. With my son in my hands. I had to force myself to stand on the side of busy main roads, there a lot of around where I live, you know, and bring on thoughts of throwing him under buses as they went past. I had to, there were words that frightened me. So things like stab, slips slice, absolutely terrified me. And I had to sit there saying, you know, drown, drown, drown, drown, drown,	Therapy induced panic attacks Psychoeducation was fundamental to recovery. Unexpected events led to a relapse. OCD was triggered by grief Intrusive thoughts came back with a vengeance. I had to act like a crazy person. ERP made me confront my fears. Doing these exercises required all my effort and strength. Leaning into the anxiety

Exposure work required Audrey to intentionally think of intrusive thoughts and phrases. ERP took the power out of the OCD. She describes it as "life changing" Audrey felt normal again for awhile. Then she relapsed again because she viewed herself in a negative light. Audrey did more therapy, this time focusing on self-compassion work. Audrey uses a wall analogy to explain her recovery. The building bricks are sleeping, eating well, ERP and CBT. The cement that holds these bricks together is self-compassion and self-esteem. This analogy illustrates that the recovery process cannot be complete without self-compassion.	I'm going to kill my baby, I want to kill my baby. That's all I want to do in this life. And it just, it was insane. So there was it was around a time when you know, Boaty McBoatface came out general when there was stuff, stabbed face glycemic slice, right. So anything I could do to just take the power away from that was you know, those words and you know, it changed everything. It absolutely changed everything, I very, very quickly whilst working insanely hard. Kind of just, I just went back, I was back to as close to normal or what I thought a normal mother, should be pretty quickly for a while. And then I kind of dipped again, because they were just I was learning all the strategies, there was just something about the way I viewed me, you know, some way about the way that I felt about myself that, you know, you kind of wasn't right, and I went back and I did that's when I went back to therapy. And I did a lot of self-compassion work. And a lot of yeah, that that was central to everything. I mean, I'll talk about that later. But I see as in like, if I'm if my recovery was building a wall, and the bricks were things like you know, the CBT activities and the ERP and you know, eating well and dieting and getting enough sleep or not, not dieting, sorry, having a healthy diet and getting enough sleep. The foundations of that wall, and the cement between those bricks has been my work on self-compassion, my self esteem.	ERP changed my life. I worked really hard to get better I compared myself to other mothers Low-self-esteem led to relapse. Intrusive thoughts made me hate myself. Self-compassion therapy was the final tool in recovery. Practicing self-compassion helped me love myself.

Recalls being awful to herself. Believes this self-hate is a result of the intrusive thoughts that have convinced her she is a monster. The therapist asked Audrey to write a compassionate letter to herself. This process enabled Audrey to feel sympathy for herself. Keeping a positivity journal became a natural process. She had to make sure this didn't turn into a compulsion that would undermine the recovery process. Build her self-esteem up from rock bottom. Techniques included gazing at herself in the mirror, making eye contact with people.	**Audrey** 43:56 yeah, no, I just when I in therapy, I had to I was so awful to myself, my therapist was like, honestly, where's this come from? And I just, you know, I just might, it's come from six months of thinking, I'm a monster, who wants to kill my baby, you know, it doesn't leave you feeling great about yourself. And I had to write a letter, a compassionate letter to myself. And something happened during that activity, where I just felt the floodgates open and I felt so sad for me, you know, what, what the condition had done, and I, I have to keep a positivity journal so that every single night I had to write down things that I'd done and all the positive things that said about me, you know, that was how bad I felt about myself. And gradually over time, it became natural. So, you know, I had to make sure it didn't come a compulsion. I had to make sure that I wasn't doing as a safety behavior, you know, kind of oh, look at me, I'm so marvelous. And going out doing things deliberately, just that I could write them in my books. I had to kind of be sensible about it, but I had to build myself up from nothing, you know, absolutely nothing, I learned how to look at myself in the mirror, I learned how to make eye contact with people. And that has changed my life. You know, it's almost like putting a filter on a pair of glasses that I wear, you know, I, I protect myself and my health now I learn, I've learned to say no. You know, it has been the center of	The repetition of intrusive thoughts makes them more believable. Intrusive thoughts derail your self-esteem. Finding compassion for myself Keeping a positivity journal helped. I had to build my self-esteem from the bottom up.

Inner narrative was constantly questioning and judging her everyday experiences. Working on her self-esteem has enabled Audrey to feel confident and do things she never would have considered. Learning to love herself has been the best thing she has done in terms of therapy. Audrey has put new habits in place, including eating healthily, drinking water and exercising. This isn't always perfect.	everything, my inner narrator was constantly like, what on earth are you thinking about that for you know, how daft and now it's like, you know what, if you make a mistake, it's just a mistake, you didn't mean it. You know, and it's allowed me to do so much. You know, if I hadn't worked on my self esteem, there's no way we'd be talking now. There's no way I would have come to that meet up. I mean, I'm not saying I, I didn't feel nervous about those things beforehand. Now I did. But I felt confident enough in my ability to handle it to be able to say yes to those things to do those things, you know, and it has, it has changed everything that work. I just, I would talk about it forever. So I should stop. But yeah, it's, it's been central to absolutely everything learning to love me as cringy as it sounds, has been the thing that that just changed everything and allowed me to access every other thing that I've ever done. I exercise now, I eat well, you know, I make sure I drink enough water. Don't always do it. I mess up quite a bit. But I do like a good night's sleep. You know, so all of those things have come from this, of me trying to work on looking after me. And keeping me well. **Podcast Host** 46:41 Yeah, that's I mean, I give you as a really like, you know, self-compassion, in theory, and in reality is actually so simple. But yet, as humans, we don't, we don't do it for one another. And having I put a post out today, obviously, by the time people are listening to this, it would be like my mum for a month in the past. But I	My inner narrator constantly judged my thoughts and actions. Self-care is treating yourself compassionately. Making mistakes is OK. I feel more confident Learning to love myself has been fundamental to recovery. Self-compassion enabled me to use the other tools I had learnt in therapy. Self-care and good habits are key to recovery.

	put up posts about learning to love ourselves. And, you know, we have to learn to love ourselves as part recovery and part of life. And we should do that before we love anyone else. The cliche of putting the oxygen mask on yourself on an aeroplane. First, it's the same with compassion, you know, you're human, you're gonna make mistakes, you're gonna have bad thoughts, and that's okay. And it's just about learning to love his service. And I'm trying and that's good enough. **Audrey** 47:30 Oh, yeah, that's a perfect analogy. Actually, I haven't thought of that I will think about in future. That's very, yeah, that's absolutely right. I think you if you know that you're gonna, you know, knowing that I used to beat myself up about stuff, stop me doing it. I'd be like, what if I messed up, you know, because I'd really beat myself up about it. But I feel that I can take part in things now. Because if it just doesn't work out, then it just doesn't work out. And it's also allows you to write it allows you to be creative in how to express your, you know, your views and stuff. Because if you're, you know, if you know that actually, you're coming from a place of you're trying to help people, then you don't mind making mistakes, you know, you can kind of embrace that failure. **Podcast Host** 48:07	
She has learnt that it OK is to make mistakes. Doesn't beat herself up about it anymore.		It's OK to make mistakes. What is meant to be, will be. It doesn't matter if you make mistakes if you had good intensions.

	Absolutely, yeah. True. I also because it's not about you anymore. In a weird way, like when when you focus on others, like the work you're doing, you like you said, you can make mistakes, because you've taken away that kind of the word. I want to say ego, I don't mean in like an arrogant way, but ego in the term and like the self, he's just focusing on others, that gives you permission to be human. And I think we need to learn to give ourselves permission at all times to mess up to. Yeah, so that's really good that you deem that so important in your recovery. And it's a message that I want to spread at the minute as well. **Audrey** 48:49 Yeah, absolutely. I honestly, I could talk about it all night. Oh, I know, I'm going on but it was central to everything. And that would be a piece of advice that I gave everyone you know, even if your therapist isn't doing it, read about it. Read about it. Practice. You know, I had, to I had to look at myself for extended amounts of time in the mirror. You know, that's how much I disliked myself. But you can do it and I you know, yeah, it's just it's so important. It's so important. **Podcast Host** 50:25 So I have a couple of listener questions now. So the first one, or this is more of a statement, but the question is kind of just any advice for this situation. So	
Audrey encourages others to educate themselves on self-compassion and practice, because it is so central to recovery.		Practice self-compassion. Educate yourself on self-compassion Self-compassion is central to recovery.

	recovery is about living a life in spite of OCD, by worry about having to sacrifice having a family to keep OCD at bay? What would you say to that person? Oh.	
	Audrey	
	51:35	
She is contemplating a second child but is afraid of being ill again. She recognises this as an avoidant behavior. Doesn't want to compromise her recovery. Afraid of the OCD coming back.	Oh um, That's I'm only taking a while to think about that, because I, you know, I want to make sure I get the answer, right, I totally, totally understand where this person is coming from, because actually, I'm contemplating not having a second, because I know it's avoidance. But I also know how desperately poorly I got. And a lot of me just wants to go with who, you know, I've got little man, somehow he came out unscathed. And I want to focus on on him and not rocking the boat. But what I would say is, I had the experience I did because I didn't know that I could get that kind of OCD.	Afraid to have another child. Afraid to challenge my good luck Scared of the OCD coming back.
	52.00	
Knowledge is power. She encourages women to educate themselves as much as possible on the condition. Get advice before deciding to have a child.	I think if you know that you've got the condition already, you're almost in a position of power. So you get every piece of advice you can, you talk to, you know, maternal experts, or a wonderful charity who are attached to OCD action. And there's of course, OCD UK, you know, you get, get as much advice as you possibly can before you make that decision. Because I think there will be some people who are living their lives because they're just, you know, without because they've decided not to do it. And there are others who have gone down that	Knowledge is power. Educate yourself on OCD. Seek advice from professionals Arm yourself with information

Repeats that women should get as much information as possible. This will enable them to identify OC avoidance symptoms and seek help. Repeats that you should learn everything about it, and use tools that have worked in the past. Another repetitive suggestion to 'arm' yourself, as if OCD is dangerous to motherhood.	road, and it's been absolutely fine. So I think I obviously can't say whether to do it or not, but it would be, you know, just arm yourself with as much information as you possibly can. And if you know that there's a possibility that, you know, two weeks after, you're going to think, Oh, I'm not gonna take the baby here, there anywhere, you know, you, you know immediately that that's OCD, and you go off and get help. So you learn every, everything you can about it. There's no guarantees, that won't happen. But then again, if you can handle it, if you can, if you've got things that have worked for you in the past, and you make sure that they're in place. You know, I think that's, that's absolutely the best thing you can do. Just make sure you arm yourself. **Podcast Host** 53:20 Absolutely. So that's good advice. And other therapists on the show before say, Never let it stop you doing anything. And that's simple. That's simple to say. But obviously, you know, if you want a kid and not having a kid, then that's obviously avoidance. And that's going to make OCD worse, so the thing you're afraid of will get worse by not having the kid potentially, I don't want to say that's its a guarantee, but it is avoidance. And we know that, you know, the more we run from fear, the bigger fear gets.	Gather information before deciding to have a child. Learn everything about OCD. Arm yourself with tools.

Challenges the interviewer's suggestion, by suggesting that some experts don't realise how hard it is to parent with OCD.	**Audrey** 53:52 yeah, I guess if some of those people though, I respect their opinion have never tried to parent with severe OCD. **Podcast Host** 54:00 Yeah, I mean, I don't know the context of this question, because it could be like, This person has contamination theme, in which case they're worried about just generally managing well, they're having a kid. But then again, it could equally be that they're worried about having the similar force that you had, you know, **Audrey** 54:17 I've never had I've never had them until I had a baby you know, jumps around. So you can't quite tell just what you've had before. And It will stay the same. **Podcast Host** 54:27 but I agree with you like the you know, you you're in a position of power now to think okay, I want a kid I max age I want it by then let's say gives me a couple years let me just go hammer to the wall if that's the saying, and just go all out,	Parenting with OCD is hard. OCD is unpredictable.

It is important to be prepared for OCD. This puts you in a stronger position to look after yourself. The more tools you have, the better prepared you are to manage it.	trying to recover doing everything reading every single book there is on Amazon, including the OCD stories book, but and, you know, going to every clinician you can afford or if you're in the UK, obviously it's free offices waitlist is free. You know, take every medication the psychiatrist recommends with, obviously, within the limits, just do everything possible go to every support group, running out of ideas here, but I know there's a million things as long as you kind of stay open and keep questioning and keep searching. And when you've exhausted every single resource this world has to offer, then worry about not having another kid because of OCD. But if you haven't consumed every single thing on this earth, then you do that first. **Audrey** 55:32 And also do it, we'll talk about this. In the meantime, I remember, you know, the, the idea that because you, you know that there's this kind of condition there, you've gone out and you've done more work than that, you know, a person without OCD. So actually, not only are you going into that prepared, you're going into that way more prepared than other people who don't have OCD, you know, you're going to know what to look out for, you're going to know what works for you, as opposed to someone who's just randomly decided to, you know, have a baby, and maybe it hits them afterwards, you know, or maybe it doesn't, but then	Education and tools can help you manage OCD.

Audrey reassures listeners that some people who have experienced OCD go on to have additional children without any issues.	you're in a much stronger position to look after your mental health and your emotional wellbeing. And the more kind of tools, you've got in your belt. **Podcast Host** 56:11 Absolutely, that's a really good point. And like, you can put strategies in place, if you think, Okay, I have OCD now. And it may get worse, and it may latch on to the baby itself, then, you know, let close family know how they can support you, if that happens, you know, have your your GP or your psychiatrist, whoever, at standby, so to speak, to say, Hey, this may get worse. You know, what do I do in that case? What numbers do I call what email? have the support systems in place. You know, as a worst case, but at least then you're going in knowing that if shit hits the fan, excuse the expression, you've got a safety net. **Audrey** 56:48 No, absolutely, absolutely. And I am answering this coming from someone who was desperately ill as a result. And you know, I'm, we're all individuals, we got to make the best choices for us. But, and I obviously can't use names, but I am very aware of people who did make the decision to have a second child and every or third or fourth or whatever, you know, the one after the onset. Every effort was made to keep them well, and they had amazing pregnancies, you know, they they	Knowledge is empowering and protective. Lack of knowledge made illness worse.

	knew what was going on the whole way through. So yeah, I wouldn't, I wouldn't let it stop you. But I would absolutely make sure that I was tooled up first. **Podcast Host** 57:25 Absolutely. Yeah. Good, fine. Um, Okay, so next listener, question is they've put some practical ways to manage OCD is to aim for normal routines, including healthy eating and regular sleep, as you mentioned there, and then they put obviously, when dealing with a newborn, these two points can be difficult to achieve for a mother with OCD. Does Audrey have any practical suggestions to assist with that? So I thought this was a good really practical question.	Utilising tools can help you manage OCD.
Recommends delegating housework and other duties to wider support networks, going against dominant social discourses of what is expected of a new mother. Highlights the difference between Western child rearing norms and other cultures.	**Audrey** 57:56 Yeah, it's amazing, right? I would delegate, and I mean, Delegate delegating, so you literally have no jobs to do - we have a very strange culture here. And I won't go into too much detail here. But we don't, you know, there's not the support for new mothers as there might be in the Western cultures there are in others, you know, so very often, it's the one the man with a newborn carrying, you know, the baby and making a dinner for everyone who's coming to visit and stuff. So I would basically say just none of that, you sleep when the baby sleeps, batch Cook, get	New mothers lack support Delegation is important. I didn't have much support.

Recommendations: • sleeping when the baby is sleeping. • Minimal housework. • Easy healthy food that can be cooked in batches or delivered to the house. • Ask people to stay over and get up in the night to look after the baby. • Ask for help. • Employ as many people as you can to assist. Audrey regretted not doing these things when she first gave birth. Reiterates that self-care is important, housework can wait.	someone to batch Cook, and just, you know, if you're not breastfeeding, and freeze as much as you possibly can, I would, you know, I didn't do very much housework at all the focus became looking after me, um, So it depends on your support network. You know, I know some women are lucky enough that you know, all their mates suddenly do a kind of rotor, people who come around and cook for you or clean and things like that, but if you are doing it by yourself, or just with one or other one or two other people, I would say focus solely on those things. You know, you don't have to go shopping and get them to deliver. If you can to your door. keep it healthy, keep it really really simple. So that basically as much time as you possibly have, goes on you and ask for it or you know, you and your baby you're not gonna be able to help them at all if you're if you're tired, or if you're hungry. Ask people to stay over. Ask people to get up in the night baby. You know, they've just got to you've got to employ as many people as you possibly can and sleep when they do - I never did that. Every time little man went to sleep I tidied the house and it was ridiculous. You know, so I would as soon as they're down I go down to it just normal life does not need to resume, you know, you just you do what you can to stay well looked after, but you know the house can be tidied another time. **Podcast Host** 1:00:03	Some women have more support. Make your life as simple as possible following birth. You can't help others if you aren't helping yourself. I regretted prioritizing housework. Housework is not important.

The biggest roadblock to recovery was her lack of self-esteem. Truly believed that she was a monster. Worn down by the OCD, the intrusive thoughts were tattooed into her brain. She is referencing her blog 'taming Olivia' as a tool that helped her as a strategy. Recognizes that writing a blog and getting creative isn't typically recommended as an OCD	Yeah, no, absolutely. Yeah. Good excuse to leave some housework for a while. Okay. That's my excuse. Okay, so, question here is my own question now. Was there any kind of roadblock? I'm sure there are many, but any one in particular, in your recovery? And how did you overcome that kind of roadblock or obstacle? **Audrey** 1:00:34 I think the biggest one was what I was saying about, you know, the kind of self-esteem elements. And the, you know, that kind of dealt with, but a lot of it kind of goes into, actually is going to be the introduction of Olivia, um, you know, I just could not, despite what I did, I could not completely get my head around the fact that actually, it wasn't me. I just wasn't this really horrendous person. I understood I had OCD, but you know, it kind of, it wore me down so much that it was almost like tattooed in my brain is thought that what if, what if, what if for you know, and, and I tried externalizing it, just giving me a name and stuff like that. It just didn't work. And it was a strategy that just worked really nicely. It wasn't a safety behavior. It wasn't a compulsion. I'm really visual, I've got very vivid imagination. And that's where I'm kind of decided to use that to help me. And actually, that kind of concept of externalizing, the condition got me over a huge roadblock, because it didn't matter how much better I was still feeling, you know, I was feeling I still just could not get rid of that, you know, kind of knock that I just actually was this really horrible person. So that that externalizing, it	Low self-esteem can be a roadblock to recovery. Cannot separate the self from the disorder. Internal beliefs were distorted What if it isn't OCD? Intrusive thoughts were tattooed on my brain. Writing my blog helped me recover. Having a creative outlet helped me.

treatment, however it worked for her on an individual level, to externalize the condition. Audrey does not need to use this method anymore, demonstrating that she has made progress in her recovery journey.	worked for me. And I know, there's not a load of, you know, evidence-based studies on it and stuff like that. But it just, it was something that just worked for me. And that made such a massive difference. Actually, I've come on leaps and bounds since kind of that externalization. And really, I don't need it at all anymore. It just, it just helped at the time. But yeah, it was that I had to kind of go off road. Everything that I was reading books, didn't quite nail that one bit. And I thought, What do I know about me? I know that, you know, I'm, I'm good at imagining stuff. So let's see if I can use this to help me. And it worked. Thankfully, **Podcast Host** 1:02:37 yeah, no, that's really good. You know, I'm all for evidence-based treatments. And absolutely ERP is that, and that's why it's the gold standard, and other evidence. So other research that proves various things in recovery. But you made a valid point there about you did what worked for you. And I think that's part of successful recovery is each one of us on this earth are individuals with individual brain chemistry, individual support systems, lifestyles, upbringings, all of that makes us unique. And we need to figure out along with, you know, things like ERP and potentially medication, we need to then tailor it to ourselves and think how can we make this work for us? And that was a good example. So tell us a bit more about taming Olivia. Kind of what you're doing with the blog, your hopes, dreams, wishes, etc.	Couldn't shake the feeling I was bad Externalizing the disorder helped. My vivid imagination was a source of pain but also a source of recovery.

Worried to talk about her hopes and dreams- perhaps due to anxiety that she may lose these things? Found online support groups triggering. She decided to write her book to help other people in the same position. She received great feedback on her book. She wanted to spread the message although her experience was really bad, she managed to overcome it.	**Guest** 1:03:33 I'm worried about answering this because they've kind of like come true. And I get really. So yeah, right. Taming Olivia. Olivia was a little concept that just came to me. I thought it got me overheard, or it was all part of my self esteem work that I thought you know what? I think I told someone, I didn't go very close to forums, I found them really triggering. But I kinda told someone, a woman and she was just like, oh my goodness, I'd love that. Because what was happening if a lot of people were telling, you know, to kind of children to imagine these characters that were bullies. And I just found it absolutely horrifying. We thought that the kids were living with OCD, and you know, sharing their bedrooms and their lives with these horrible things, harassing them, like evil witches all the time. And goodness and, and I thought, You know what, I'm just gonna put Olivia out there, I thought it'd probably come from nothing. And I wrote a couple of, you know, not a negative way but just in a kind of, I didn't know where I really wanted it to go. I just hoped that maybe someone who had been in a position that I've been in you know, it just might help someone I just hoped and, and it grew. And it got really incredible feedback. Mainly, I must say from the states that you know, there were a lot of really awesome letters that I saw emails that I started getting from people. And it was I wanted it to be very much focused on recovery, I didn't want it to be, you know, I was prepared to talk about my path in	Online support groups were triggering. Motivated to help others with the disorder. Spreading messages of hope and recovery.

In her book, she shares strategies that she used to overcome OCD. Has taken some time off writing lately. No longer needs to use coping tools. The book aims to bring public awareness to perinatal OCD but also share Audrey story, through the character of Olivia. Audrey wants to share her story with the public, but is hesitant to constantly relive her past (perhaps this is triggering for her?) The character has fulfilled its purpose for Audrey (in terms of the recovery process)	terms of letting people know just how bad that had got, but then I still managed to overcome it. So every blog that I wrote, became, you know, me talking about the strategies that I've used. I've just finished one actually on self-esteem. And, I mean, the blog has had like, six months, just, you know, kind of down periods poor old olivia, but um, she actually no, that's a good thing. Ya know, she, I've, I've spent the past six months, ahh, kind of sharing my story. So the it started off just being you know, I had bad OCD, I was triggered a lot after having my son then including the harm thoughts and then including the harm impulses. So it's kind of got two bits at the moment, there's this kind of advocacy side of, you know, bringing attention to perinatal, postnatal OCD and whatnot, and harm intrusive thoughts as well, you know, you don't have to just had a baby to have these kind of thoughts and, and then there's the Olivia side of things. It just, it's kind of taken on a life of its own. It really is, you know, I've just, sometimes I look at my eyes, sometimes I wake up in a cold sweat, like, what have you done? Absolutely incredible. I, I'm, I hope to keep writing. So I want to get my story out there. I know, I'm not the kind of person who wants to travel the country constantly reliving my past, I work very hard to get past that. And whilst I'd like it out there to help people, I don't necessarily want it to be me, that has to keep telling it. Yeah. So that's out there. And then I'm going to focus on Olivia more. And she's not actually really a concept that I use anymore. I totally understand, you know, she did a job while she was there. But I like the artistic element of it. I do it with my husband, it's great to have a bit of laughter in the artwork and stuff, you	Things were bad, but I overcame them. I don't need to rely on my recovery tools anymore. I want to share my story. My past might help others, but I don't want to relive it. Externalising my experience helped me to overcome OCD. Using creativity to explore the disorder.

Creating the character Olivia was a way for her to externally visualize her thoughts and feelings. The visualisation of the character was to aid other people to connect with the character. Disbelief that she is here, speaking about her journey. Inspired to talk about recovery strategies and inspire hope for others.	know, so it's, it allows me to kind of explore my creative side, I should, I should explain to people that I don't actually think that I kind of spend my days with Olivia, I know that the thoughts, feelings, everything. For me. It's just a way of kind of visualizing all of that into you. And then the journalist kind of said to me, and how is Olivia today, and I found myself just looking at the floor next to me, try and think how to answer the question. I just wanted to make it very clear that I'm not asking her. I'm not asking you to think that I imagined myself wandering around with this kind of creature around me all the time. It's just a visualization and having her drawn that allows other people to kind of see it. So yeah, I'm just going to carry on blogging that. I would like to given my kind of educational backgrounds, I would like to maybe try and work with some people. Some children, like get some resources made that might help kids explore feelings, and things like that. So yeah, it's watch this space. Really, I didn't ever think it would get this. But I'd never thought I'd be talking to you. I didn't think I'd ever have, you know, kind of the numbers of you know, you kind of the the charity, kind of leaders in my phone that I talk too about stuff, you know, so I kind of I find it very hard to predict where it's going to go because it just, it's kind of gone much further than I ever thought it would anyway. But yeah, recovery strategies, talking about recovery, and how possible it is. That's what I'm gonna do. **Podcast Host** 1:08:32	Olivia is not part of my identity. I can't believe I'm here after everything I've been through. I hope to inspire others that recovery is possible.

Losing her parents was very hard, but the inheritance has enabled her to take time off work and pursue her passions. She views this as a legacy for them.	Absolutely. Well, yeah, like is this, you know, you just started that because you were being creative, and you wanted to help some people if they were willing to listen, and, and now it's getting bigger and bigger, and you're getting more and more opportunities. And I think that's the best way. I think when you go into things with a with a goal sometimes or a focus, it doesn't work out. But when you just follow your gut, which sounds like you did, it worked out. **Audrey** 1:08:57 Yeah, totally. And like I mean, losing my parents I inherited, and it's been something that's nice, but kind of come from something absolutely horrendous. You know, I used some of my inheritance to buy me out of work for a little while. And that's why you know, and I can work on that and it's almost like a kind of a legacy for them to, you know, it's a really, I love doing it. I really, really do love doing and unfortunately at some point, I'm gonna have to go back to full time work. Because I think my husband's very like, hello. But until then, yeah, I'm gonna carry on doing it. **Podcast Host** 1:09:30 Alright awesome, now congrats. It's great to see all that you're doing. I guess a few more questions. Next one is What did you wish you would have known? Let's	I value working with children. I want to help children.

Audrey wishes that she had known what OCD was and how this can manifest in the perinatal period. This represents a larger issue regarding stereotypical portrayals of OCD in the media.	think of a time period. I guess when you first when that, the doctor said to you, it's anxiety and maybe OCD. What would you wish you would have known at that point? **Audrey** 1:09:57 I wish I would have known, One the difference between anxiety and OCD, but I would have wished I'd known that impulses and harm thoughts were part of OCD, because I would have believed him a little bit more. I think it was the I didn't know, you know, when he told me it was anxiety. I just thought, you know, I'm not checking the front door. It's not that so I wish I had a bit more of an understanding. Or that I'd been well enough to actually come away and read a bit about it. That's what I'm, you know? Yeah, yeah. **Podcast Host** 1:10:38 Yeah, that's good to hear. And, yeah, so what what would you like to tell mothers and fathers just starting their recovery journey? So mothers and fathers with OCD, I should say **Audrey** 1:10:53	Knowledge would have helped me. I wish I had known what OCD was. I suffered because I did not understand the condition. Understanding the condition would have me get better quicker.

She wants to reassure people that recovery is a possible outcome. You can have OCD and live a meaningful life. OCD doesn't dictate your relationship with your child. It can get better with the right help and support.	that, Oh, my goodness, that recovery is totally possible. I know, this gets debated what is recovery? And, but like, I still have OCD, I'm not fully recovered yet, yet, I have a completely normal, happy life. And I'd want them know, that is absolutely possible for them. And I'd want them to know that, you know, your little one will be fine. You know, very, very few few children that are born without slight going on in their family, you know, and that with the right help, and the right support, you can get better. And that you you know, you you'll be an awesome parent or grandparent or carer, whoever we you know, whatever the relationship is. And it doesn't have to define define your relationship, you know, it's something that's a little that's a knock at first and massive knock, but it can get so much better. It's so much better. And, you know, I mean, I never thought I'd be talking about these impulses, you know, you will get to the point where you will find them so non terrifying that you will talk to them on a podcast that's going to be listened to by loads of people. It does it gets, it just gets so much better. Oh, my goodness, it really does. Was there anything else you want to say? I haven't asked. **Audrey** 1:15:18 I should just mention, I think in terms of going to seek help, I mean, I never ever want to put anyone off of that. Because you absolutely must you absolutely must, that there's so much support out there. But something that put me off was worrying that people would, you know, take what I said the wrong way, you know,	Things turned out better than I expected. Recovery is possible. You can lead a happy life with OCD. You can get better with the right support. You can still be a mother if you have OCD. Things are better. I've come so far. Things will get better. Don't let your fears stop you from reaching out for support. There is so much support out there.

People who are worried about safeguarding should approach an OCD charity instead. The impact of her previous experience is apparent, she is cautious of some professionals. Encourages people to start by speaking about the impact OCD has on them and working up to discussing the content of the intrusive thoughts.	we talked a bit about fly safeguarding and stuff like that. Yeah. And I just kind of want people to know that, if they're worried about that, and if that is the thing that's putting them off, getting help that, you know, to talk to the charities. Yeah, I mean, we've said that already, but do not use that as an excuse, or not an excuse, but as a reason not to go and get help. Because you know, we do. I mean, every now and again, as you said before, you know, to catch cases where it's really important that children are noticed, unfortunately, sometimes, you know, the wrong people are caught up in that. But that absolutely doesn't mean that you don't go and you get help you just make sure that you talk to the right people about it, you know, and that you get that kind of information from you know, the charities. And you also don't need to say, exactly the nature of what you're worried about, if that's what you're worried about, you could just talk about the impact and the life, you know, until you get to that point. So, yeah, if you're worried at all about it, because I know my story does kind of imply that if you talk to specialists, sometimes they don't. They don't, you know, get it right. Yeah, just seek advice about it. Talk to people, but don't let it be a reason why you don't get help. **Podcast Host** 1:16:53 Absolutely. Yeah, good point. I think it's important to share your story because it you know, sometimes that is the harsh reality. But that doesn't mean it's a deal	Approach an OCD charity if you are worried about child protection. Sometimes health-care professionals get it wrong. Talk about your experience with a professional. Don’t let your fears stop you from seeking support.

	breaker, it just means we have to be resourceful and find a way around it. And like you said, speak to the charities. Sometimes if it gets, you know, if it gets to a point, it's quite bad, the charities can write a letter or they can get on a call, I'm assuming work for them. But so as long as they got the bandwidth, they can do that. And that will help your corner, so but I'm sure most of the time it would never get to that and it would all go smoothly. **Audrey** 1:17:28 Oh, blimey, absolutely. Yeah, I just needed to make sure I got that in they otherwise would have been ringing you later all anxious. **Podcast Host** 1:17:34 Yeah. So now I mean, Audrey, I appreciate getting to know you better on this podcast. Obviously, we've met in person but you know, we spent a good hour and 20 here and it's been a pleasure getting to know you and I appreciate the work you're doing and how vulnerable you're being with it. I think it's a a needed service for the world.	

Appendix C: Master Table of Themes

Superordinate Themes	Subordinate Themes	Podcast Guests	Notes	Quotes
Stuck in a Horror Story	**Overwhelmed with Terror**	Mia, Olivia, Emma, Sophia, Grace, Audrey, Jane	The participants spoke about the overwhelming sense of fear they experienced; this made everyday tasks feel unmanageable. Mia talked about how her intrusive thoughts started rapidly and quickly escalated until they became consuming, it was impossible to dismiss them. This was terrifying as a new mother.	Jane: "there was a fear, the fear was around that I was going to somehow hurt the baby…And so I really thought I was losing my mind. You know, I mean, I didn't know what was happening. To me, it was really scary…and, and now I was so terrified, sometimes even get out of bed, because of all the triggers that that I was facing''. Mia: "It was like a switch just went off in my head. And I started having thoughts about strangling my daughter. I dismissed it. But they kept on coming back and coming back and coming back. And getting worse and worse and worse. Like it wasn't just about strangling her. There was so many other incidences where I

				could have caused harm to her. And it was absolutely terrifying.… And this happening, I would say two weeks after having her it was it was I I don't know how else to explain it. But absolutely terrifying. absolutely terrifying.’’
			Mia spoke about how consuming the thoughts were, they penetrated her mind 24/7.	Mia: “At my worst, I was having intrusive thoughts nearly every minute. It was that bad. And it was 24/7. Even when I slept I had intrusions, it was constant’’
			Participants described feelings of intense physical and mental anxiety. These feelings made them feel out of control. Each time it happened, it was experienced as worse than the previous time.	Amelia: “It's just like I could feel like the cortisol like rush up and down my body. Each time it wouldn't eat, each time I would have like breakdown thinking I would lose control and like end up in like the psych ward. And, like the episodes were lasting like longer too.’’ Amelia: “So like this last episode, this most recent one. This is the one that kind

				of changed over anything it began like early this past December. And I could say like, it was kind of like a fight for my life''
			Audrey talked about how she felt paralysed with fear and unable to function. Leaving the house was extremely difficult because of the thoughts and impulses. She feared she would throw her son off the bridge.	Audrey: "But I think that's kind of where the the fight for, for my life really started. I just, I wasn't capable of anything. I just sat on the sofa, just in a perpetual state of sheer terror." Audrey: "But yeah, I kind of, I still struggled to do anything. To go for a walk around the block with him in the pram, go anywhere near a bridge anywhere near a train station, you know, these kind of thoughts and impulses just be huge".
			While the intrusions started off as thoughts and images, they developed into dark narratives that captured them as the main villain. The imagery and details of these	Audrey: "And I just had this really awful thought that I was going to you know, a what if thought of what if I just snatched him off of her and kind of whacked him against that wall. And it I saw it you know

			stories were so vivid and life-like. Grace speaks about the anxiety as more than distress. For her, it feels like true agony, she wants to escape the pain.	this imagination. I saw it in all it's detail and it was the most terrifying thing I've ever seen. And it kind of came with it a load of other images of things like you know like the front page of the paper. Kind of with the story on the sensation story title of what I've done. And I would see my family watching the news, you know, having lost their, you know, this new little baby and their daughter had just lost it, you know" Grace: "You know, when they say like, you know, you're in distress, I don't think it's distress. I think it's like true agony. Like it is like pure pain, like your heart is racing, like you're doing, you want to do anything and everything to get that feeling like to just be gone.''

	Robbed of Joy	Jane, Olivia, Amelia	Participants expressed feeling miserable and joyless during pregnancy and following birth. They had expected to feel a different way. The OCD often got in the way of their parenting experience. Jane describes feeling miserable, like she is failing to meet the social expectations of motherhood. She is reminded of this when she interacts with others. These interactions leave her feeling like there is something wrong with her.	Jane: "I'd kind of felt like this anomaly, you know, like, and I think, especially for women, too, because I was pregnant, and so many people, they're like, oh, it's the most joyful part time of your life, you know, like, aren't you just, isn't everything wonderful, and you're just revelling in this….And part of me just felt like, like, I died inside, when people would say that, you know, because I wasn't happy. I was miserable…And I mean, I was so happy about the baby, but like this other thing that I was dealing with and OCD like That was awful. And, and having the two at the same time was, was really challenging to navigate. So I, I kind of felt like, Oh, I'm not even doing pregnancy, right. You know, like, I'm not, I'm supposed to be I'm supposed to be doing this. I'm supposed

				to be doing that. Like and, and I just couldn't I was just in a different space.''
			Olivias baby had allergies, and this made him more vunerable in her mind. She feared she would kill him during the pandemic. The fears felt so real to Olivia; she feels the emotion as though they have already come true.	Olivia: "I remember sitting in an armchair with my baby, and I should have been overjoyed to have this beautiful baby. Even though he had allergies. He was still my beautiful baby. And I couldn't enjoy him because I was grieving, like He was already dead, thinking that I had infected him with COVID-19. And I was grieving as if this were real. And it was just this extreme low point.''
			Participants were disturbed by their thinking processes; they were hyperaware of their emotions, thoughts and reactions.	Amelia: "my fortune telling thinking would be like, I would never experience joy in those moments. Like, I would sometimes be like, disturbed by the concept of my own thinking process, like it was happening. And I was like noticing it. And I was I shouldn't be noticing it like this.''

			Amelia describes this hyperawareness as disturbing. It interfered with her ability to experience joy.	Amelia: “Like I shouldn't be noticing these things to this extent, like, I would go to like, kiss or tickle my son and like I would experience joy. And then my OCD would like question or doubt that feeling like it was foreign or something like, like, I almost wasn't feeling it just right or feeling it completely.’’
	The Stakes are High	Ivy, Sophia, Mia, Audrey, Emma	Participants intrusive thoughts were perceived as more and more risky each day. As a result, they performed more complex and time-consuming compulsions. The more they engaged in compulsive behavior, the biggest the risks felt. Ivy see’s danger everywhere. Every interaction with her son, even the mundane ones, are a potential hazard to his safety. For Ivy, the risk is too	Ivy: “the stakes felt so high to not check him or to do any of these other rituals. But the stakes were getting so high in the other direction to like, I can't keep pulling over on the side of the highway like this, this is dangerous. And I'm going to lose my mind.’’ Ivy: “And I remember very vividly dropping the sock and just the stakes are too high. The stakes are too high. The stakes are too high. I'm not going there. I remember backing away from my son and

			high, she avoids dressing her baby altogether. Participants saw risk everywhere. OCD had tainted their perception of everything. The compulsions were extremely time consuming. No matter how hard Sophia tried, things never felt quite right. This feeling made her repeat tasks such as preparing bottles, because she feared poisoning her son.	I told my husband you have to do this. I'm not I can't do that.'' Mia: ''I would be scared to hug her because I was scared that I was strangle her, I would be scared to give her like, have pillows around her. So I got rid of those and cushions. Because I didn't want to suffocate her.'' Mia: ''I was hiding everything, scissors, knives,there would be like sewing needles over tight, I hid anything that could potentially harm her.'' Sophia: "Have I left something that he might choke on? or going checking in the night, he's still breathing all those things. Me and my husband would make up bottles, for like the next 24 hours, we'd like do a kind of fridge full of bottles, and I'd wake up six in the morning and think I

				can't give him those bottles. I'd think I think I did it wrong. I've put all the milk down the sink. And I have to do all over again"
			Sophia describes a fear that grew and spread with time. Initially, her fears involved harming her own child. However, as the disorder worsened, she became afraid of hurting other peoples children. Her safety net was growing smaller and smaller.	Sophia: "So I started thinking what what if, like, I take him to the cafe and then I hurt someone else's? Like what if I you know, five just I was just like, what if I wanted to strangle someone baby when I'm when I'm out. And I just started to refuse to go out basically and didn't want to go out. Didn't want to go in when near anyone else's baby just about managing of my own" Audrey: "I just, I wasn't functioning at all, I, you know, I'd stopped sleeping, initially to watch my baby breathe to check that he was safe. But it was my maternal instinct just gone wild. And because I was convinced that it was me, he was at risk. I

				put into place all these things to keep him safe.”
			Audrey didn’t trust herself around the baby. She worried she would become possessed and hurt him. She only felt safe when her husband was around, because he could stop if she ‘lost control’.	Audrey: “I wouldn't be on my own with him at all. And I would only be in the same room with him If my husband was in between us, you know, I'm not a small lady. I'm just shy of six foot and I'm strong. And I had to make sure the only person who I kind of know in my life, who is big enough and strong enough to stop me. If I just lost it and went for him, he was in between us.’’
			Participants described how small and vulnerable their babies were. These qualities enhanced feelings of responsibility. The desire to keep the baby safe became overwhelming. Even the smallest mistakes could have massive consequences.	Audrey: ‘’you know, they'd handled handed me this tiny little thing. I never even changed a nappy by that point, you know, so maybe I could have done a bit more prep work myself. But I had this tiny little baby who was so vulnerable. And I was absolutely convinced that I would make a mistake or just life, you know, I

				just something will go wrong, and that he would die."
			Ivy described her compulsions as all consuming. Eventually, she could not trust her senses to determine whether her baby was in the car.	Ivy: ''I would have that intrusive thought, like, are you sure that you got him in the car seat? And, you know, it wasn't enough to just look in the rearview mirror and see him there. I started to have thoughts, you know, are you so sleep deprived that you're seeing something that you're not actually seeing? And so then I had this thing where I had to engage all of my senses like I had to it wasn't enough to see him I had to, like, talk to him and have him respond back to me. And so I could see him and hear him. And then that wasn't enough. And then suddenly, I had to reach back and hold him, or, you know, touch him with my hand. And that wasn't enough, I was getting to the point where I was pulling over on the side of the road, to unbuckle him from his seatbelt and

				physically hold him, so that I could like check off all the boxes of my senses that he was there, and you did not leave him somewhere and you are not so sleep deprived that you are not registering this right now.''
			Emma realised what a huge responsibility motherhood was. She felt it overwhelming that her baby was completely dependant on her.	Emma: ''I think I remember the moment actually looking at her, looking at her and just feeling that intense rush of love. And then also this sinking feeling, following it. And I think that I think that it's just it's just a responsibility. It's like, shit, am I allowed to swear? It's not Oh, my God, I I've got to be part of this human. I'm barely an adult myself."

	Thoughts have Meaning	Ivy, Mia, Audrey, Emma	Participants were concerned about their instrusive thoughts. They began to ponder on why they were experiencing them, and the meaning behind them. Mia described the repetitive nature of the thoughts. She started to think that they were indicative of who she was. This was extremely confusing, because it was her first experience of motherhood.	Ivy: "I have the baby. I bring my baby home. And I remember my first intrusive thought, which was I was trying to put on socks on my newborn, maybe a couple of weeks old. And I had this thought, what if I snapped his ankles? And then I had the subsequent thoughts of why did you have that thought? Does that mean that you wanted to do that?'' Mia: "Because if you keep on having a thought over and over again, in your head, you often think, is this something I want to do? Is it me? Because it's a thought you automatically assumed that it's who you are. And I wasn't able to, to understand that at the time. I was so crippled by it. It was absolutely devastating for me, especially being a first time mum…'' Audrey: "I think it's really important to mention as well, that what you know, you

			Audrey described becoming irrational. The more she experienced intrusive thoughts, the more she believed that they might come true.	become quite irrational. You know, I wasn't delusional at all. I knew well, I hoped that I wouldn't do it. But I got to the point where I didn't know I definitely wouldn't. I was so bombarded with these horrible thoughts. Day in and day out that I just thought well, blimey, maybe I will" Audrey: "And so whereas before, I thought harm thoughts were awful, and I could just about cope, the impulses, kind of, to me counted as evidence that I was going to do it that I wanted to, and that I was just a monster, really"
			Eventually, Audrey became convinced that she was a bad person who would harm her baby. She had lost sight of her true self.	Audrey: "I just could not, despite what I did, I could not completely get my head around the fact that actually, it wasn't me. I just wasn't this really horrendous person. I understood I had OCD, but you know, it kind of, it wore me down so much that it was almost like tattooed in my brain is

				thought that what if, what if, what if for you know”
				Audrey: “because it didn't matter how much better I was still feeling, you know, I was feeling I still just could not get rid of that, you know, kind of knock that I just actually was this really horrible person.”
			Eventually, Audrey goes to her doctor with the conviction she is dangerous. She believes this so strongly, she thinks she should be put in prison. Audreys accounts demonstrate how her insight worsened as the disorder got more severe.	Audrey: ‘’Went my GP, stormed in, I was like, you have to, have to take me away, I'm not safe. And it wasn't a hospital. It was, I wanted to go to prison. I wanted, I wanted them to remove me from society. Because I wasn't safe. I'd said goodbye to my husband and my little boy, you know, I'd kind of said, you know, Mommy's got to go off, and go off to do something, and I thought that was over.”
			Emma also became convinced that she was a bad person,	Emma: “And I thought I was a bad person. And I was really concerned that my child

			and her daughter was not safe in her care.	was, you know, I wasn't fit to look after the, you know, I wasn't fit to look after her.’’ Emma: “I just thought, well, I need to go to the doctor, there's something in me made me think I need to go to the doctor. If the doctor thinks that I'm a danger, and that I need to be locked up, then that's the best thing for her for my child. So that's how I looked at it.’’
An Arduous but Worthwhile Road to Recovery	**Finding the Right Therapeutic Fit**	Jane, Mia, Ivy, Grace, Amelia	Participants expressed difficulty finding the right professional help. Some participants had negative experiences that made their symptoms worse.	Amelia “So yeah, I am. I didn't stay with her. And I didn't know what what I needed. But I knew that I wasn't getting what I needed.” Amelia: “But anyway, I saw a couple of different therapists to kind of went from therapist to therapist, and none of them were very helpful.”

				Amelia "So yeah, the perinatal psychiatrist, referred me to an OCD specialist. And I saw him privately..''
			Amelia had a very poor experience with one therapist who failed to teach response prevention. This made Amelia very unwell.	Amelia: ''But this most recent therapists, she wasn't versed in ERP, like, she would emphasize exposures, but then say nothing about response prevention. So basically, I would do all of this self help outside of therapy, like outside of our weekly sessions, and it was making it so much worse like my OCD. I'm going to put a little disclaimer in here, if I can. I just want to say do not do ERP on yourself outside of Being in the care of like an OCD therapist.''
			Eventually, Amelia found a therapist she resonated with. She described this experience as life-changing.	Amelia: "that's when I found Cornerstone OCD, and anxiety group where, Mary's that Mary's my therapist, she's amazing Mary Taurus So yeah, I mean, like, I know, she'll deny this up and down. But like, I

			Participants expressed that it was extremely important to speak with someone in a non-judgemental environment. Therapeutic tools, such as validation and normalisation helped tremendously. This helped to counteract the negative self-perceptions caused by the disorder.	almost owe my life to Mary because like, like, it's her work and her passion that I'm where I'm at today.’’ Amelia: “Like, I'm 100% for therapy. Everybody should have therapy therapy for all… Yeah, it was having, having someone not judge you, and you being able to just speak to them about the thoughts that you're having. And for them not to bat an eyelid is the best feeling in the world.’’ Grace: ‘’I will say my paediatrician has some type of like paediatrician angel, like I don't know where she came from. But I am like, it's like I won the lottery with her. She is so well versed in anxiety and OCD. She's a huge support system.’’ Grace: ‘’Like, you know, I make a joke out of it. And you know, she never laughed,

				and she never made me feel bad about it. And she was like, I get it. I understand''. <u>Grace</u>: ''I remember being like, I mean, it'd be hysterically crying in her office and like, she has so much empathy, you know, so she never ever questioned or made me feel bad about it.'' <u>Grace</u>: ''And she's like, never made me feel ashamed. I think we put enough shame on ourselves. Like I said before, she is it, you know, big support, she doesn't enable. She, she understands and she gets it. And, and on top of that, obviously, she's an amazing doctor, which is obviously the most important thing. But it is also really an extra added gift here that she's like such a part of my support group. I guess my support bubble.''

			Ivy had a poor experience with a midwife. When she finally built the courage to share her struggles with a professional, her experience was minimised.	Ivy: "I'm always, you know, devastated to tell this story. But this is how it can go for moms here, which is I went and I finally I was, I was in tears. I was like, I can't do this anymore. I'm really struggling, I'm having these thoughts that I don't want to have about harming my baby or something horrible happening. And my OBGYN looked at me and she said, you know, all moms struggle like this. I think women just need to be easier on themselves. And you know, if your son needs a pacifier, just give him a pacifier. And that was just devastating to me.''
			Mia's healthcare professional misdiagnosed her condition. She mistook it for post-natal depression and alerted social services. This was devastating and confusing for Mia, because she wanted to protect her baby but was being told she was dangerous.	Mia: ''And unfortunately, in my case, when I did finally open up to my then therapist, she mistook what I was saying, and because I said I had knives because I was scared of the thoughts that I was having. It got misconstrued. And then

				social services were alerted. Because I was posing like as a danger to my child…. And that was an absolutely terrifying moment because I'm doing all of these things to protect her but then someone from the outside is telling me that I might be a danger." Mia: "And so having a therapist be you know, basically be like yeah, that's that's, that's normal like for you know, some for someone who's pregnant that has OCD like yes, this is normal. And so this is what we're going to do. And this is where we're going to do it and here's why. You know, you can expect it to be you know…You're not weird. Because this, because you're, you're dealing with this, you know, you're just a person that this OCD that has OCD, and, and this happens sometimes, and this is how we get through it. And it was

				just so oh, my gosh, it was it was wonderful.'' Jane: "but I feel like talking to my therapist, and just, I think really having the validation that I was not again, that I was not like this weirdo, you know, like, for lack of a better way to say it, because I'd be like, Oh, this is weird. I had this thought. And he was like, no, like, you don't even know how many people have told me that. Like, this is not a big, like, you know, like, just this demeanor of like, this is not a big deal. And I was like, Really, it's like, so weird. And he's like, No, not really, like, you know, like, this is why. And so that kind of reassurance just really, I guess, the, like, the way that he normalized, it was really, for me, really a big deal. And that helped me a lot.''

				Jane: "but just having like that good rapport with a therapist, I felt really comfortable. And we could almost kind of like joke about it sometimes, you know, like, get to that place. That was really helpful, too.''
	Discomfort as a catalyst for growth	Olivia, Ivy, Audrey, Sophia, Amelia, Mia, Jane	All participants talked about how difficult ERP was. It was extremely challenging to resist their compulsions and let go of their sense of safety. While it was incredibly hard, it was an extremely powerful tool for overcoming their obsessions. Olivia described exposure work as a special type of hell. She likens it to sitting in fire without escaping. Her powerful description conveys how hard she found it to resist her compulsions.	Olivia: "I really don't like when people say, like, you know, just really lean into it and like sit in the distress like, okay, it's not, it's more than that. It's literal hell, it's like, I'm in a nightmare. It's agony. It's like someone is stabbing me, it's not just like, uncomfortable, where you can just sit there and like, be in it will know, like, I want to die. Like I gotta get out of this. You know, it's like, if you're like, on fire, do you just sit in the, in the flames being like, this is burning my body, but I'll just sit here and like, deal with it, like, No, you, you jump and you get away and you whatever. So it's like, that's what it really kind of is, at least for me, and I think

				probably for like most people. So it's really, it's true agony, and I think to do nothing, is sounds so simple, but yet, it's so so hard, but it's so effective. And one thing that I'll say to myself, when I'm in this, and I don't know about other people, but I know if I do nothing, this is gonna pass in two days, this feeling this urge this compulsion, this thought this fear, whatever it is, is gonna be less.''
			Audrey describes facing her fears head-on. This was a terrifying experience. Eventually, the exercises took the power away from the OCD.	Audrey: "I had to force myself to stand on the side of busy main roads, there a lot of around where I live, you know, and bring on thoughts of throwing him under buses as they went past. I had to, there were words that frightened me. So things like stab, slips slice, absolutely terrified me. And I had to sit there saying, you know, drown, drown, drown, drown, drown, I'm going to kill my baby, I want to kill my baby. That's all I want to do in this life….."

				Audrey: "So anything I could do to just take the power away from that was you know, those words and you know, it changed everything. It absolutely changed everything, I very, very quickly whilst working insanely hard. Kind of just, I just went back, I was back to as close to normal or what I thought a normal mother, should be pretty quickly for a while".
			Sophia found the psychoeducational part of ERP to be beneficial because it helped her to recognise that her thoughts were meaningless.	Sophia: ''I know everyone calls it ERP now, but it was, it was the same thing. And I saw a therapist privately then. And we did ERP. And I think a lot of a lot of me getting better was just realising what it was. And I didn't mean anything, but thoughts didn't mean anything. But yeah, I just I just slowly improved."

				Amelia: ‘’We did ERP, like, we had daily homework and projects. And I went from being completely terrified of OCD. And like my own minds to like, finding so much hope in the psychoeducation part of it and, and especially like in the podcast, I these these episodes, like I, I went from being really scared to listen to any of it to just like going through and scrolling and finding like it like in my, in my ERP, I would find like the one that would trigger me the most and just listen to it and sit with it.’’
			Participants talked about challenging the OCD, instead of being passive to it. They purposely confronted their fears, instead of avoiding them.	Ivy: “So instead of listening to my typical, you know, feel good music, and avoiding listening to this audiobook, I'm going to purposefully go back to that book that I knew that I was avoiding, from two years ago, and I'm gonna go to the chapter where that baby fell off the balcony, and the mom is just sitting in that devastation and that perpetual guilt for the rest of her

				life. And I'm not gonna listen to you at once, I'm gonna go back, and I'm gonna listen to it 1500 times if that's what I have to do.'' Ivy: "It's I mean, in that, in that moment, where you're resisting your rituals, everything is going against you, right? Like, this is going to be the time where you mess up, this is gonna be the time where you actually did forget him, this is going to be the time where he's actually not breathing, and you just have all these flashes of how awful that would be. …And the regret that you'll feel for the rest of your life if you don't do this ritual''. Ivy: "I think that's really important to go out of your way to show the OCD who's boss, and I'm not just going to be here waiting for you, whenever you show up, like I'm going to come for you. I think that

				more offensive stance is really important. But I also found a lot of benefit, just in my defensive stance, right. So I have to go to the grocery store, instead of having my husband do it on going to make sure that I do it, I'm going to make sure that I get myself to the grocery store, I bring Eli and as I'm carrying my grocery bags out to the car, I know, okay, I'm going to put him in his car seat, and I'm going to drive, put him in his car seat, I'm gonna drive. And I know, I'm gonna feel the urgency to go back and check or to, you know, be extra effortful about his seat belt, so on and so forth. So that I can have that in my memory that you definitely locked him in the car seat. Just going to keep going, doing the opposite of kind of what the OCD would want me to do.''

			ERP required hard and consistent work, but it had a huge impact on recovery. It was perceived as life-changing and transformative.	Mia: "I was introduced to CBT therapy, which I really, I just CBT I guess, but like, really changed my life…. It was so hard. I mean, like, so hard. But I did that work. And I mean, it saved me, you know, like I finally getting on a track with people that believed what I was going through that that knew that it wasn't my fault.'' Mia: "Like even though I was, yeah, I just I, I needed to I just really where I was, at my that point in my life, I needed to just constantly be doing the challenges the therapy that that was given to me. Really, every day, or else I'd, I'd kind of go backwards.'' Mia: "CBT taught me that thoughts are meaningless… It made me actually stop and think it's and not just react. Because before it was like,

				Okay, if I would use a knife, I would have a horrible thought about hurting my daughter, and then I would stop using the knife pushes away, hide it. But now, I'll use a knife. I may have an intrusive thought. And I continue to use the knife, because it's just a thought. That is all it is.’’ Mia: “it's not the thought that's the problem. It's the way attached to it, that, that you are, if you have a horrible thought, you think I'm a horrible person, I'm going to do something horrible. And then that fork gets magnified. Because it because of your reaction, it thinks that it's an important thought when it really really isn't, it's not important at all. And CBT, really, really taught me that and I screamed to the hills, that CBT is amazing.’’

				Jane: "as a writer, I had to do writing exercises, I had to, about, like, the fears that I had, and I had to have these, these thought experiments where I would like put myself in that place of fear and go through, and kind of just feeling the terror and letting that come into my body, you know, and then, and then watching as it went away, because I wasn't actually in that place, you know, but just kind of letting it go through my body. And so we, I use that a lot, still, just the idea of that it's okay to have those feelings, but also that they are cyclical, and that, you know, you if you find a way to kind of breathe and get through them.'' Jane: "I really, that imagery for me, just really resonates. And so I use that a lot. And it's in the book to like the characters in the book. Because that really helped me and when I was like going through

				panic attacks and things like that, and, and I still I still use it because it's so helpful to know like, okay, like, I feel like in this moment, like, I'm never going to be okay again. But I know that that's not true. And I'm just going to breathe through it. And I'm going to wait for that wave to come back down.''
			Learning to ride the wave of emotion and accept feeling of discomfort was a valuable healing tool.	Jane: "So say, I'll be doing like an exposure on I'm reading an article about like, a tragedy that happened to a family like they're murdered or you know, like something or like a mom like going crazy. So I'll like set myself up to do this exposure. And instead of letting the discomfort sit with me, my OCD will be like, Okay, so why am I not feeling anxious? Or am I feeling anxious enough? How am I feeling? Am I doing this exposure, right, like, it almost immediately changes. And it was very,

				very frustrating. And I think that's what like a two tailed spike or something or a backdoor spike one of those things, and it's just like, Okay, well, this is also a thing. And now I have to think like, I'm gonna do this exposure, and I'm gonna feel the way I feel whether it's right or wrong.''
			Participants reported the value of having someone to hold them accountable, whether it was a therapist or partner. This helped them to stay on track when they experienced anxiety spikes.	Ivy: "I told him like when I just like say these things to you. I want you to know my thought process and why that's probably ritualistic. It helps me in the moment, but it makes me feel worse in the long run. And so now, he will say things like, I love you, but I'm not answering that, and like, I don't want to hear about that. It's not good for you to be saying that, or I will." Ivy: "I'm going to try really hard to keep myself accountable. And in those small percentages of times when I can't hold

				myself accountable, or I slip up, I need you to do this instead. And he would say, you know, if I asked him by mistake when he would be coming home, you'd say, I'm not telling you that you told me that that's not helpful. So I'm not going to tell you that information. Sometimes he would just straight up not answer my questions. Or just you know, I love you. But you're, you're, you're, on bath duty tonight.'' Jane: ''I was able to kind of vocalise to him, like, I don't want to touch that. And he was like, well, do you need do you need to touch it? Like, is it for your therapy? And I was like, yes, I'm supposed to be able to and he was like, okay, well, then you need to do that, you know, and so having him there. I mean, he's certainly not a therapist or anything, but just having like, a support person to just kind of like, hold me accountable.''

				Jane: "so he was really diligent about you know, he'd be like, No, I think you need to touch that. And then you need to hold the baby. And I was like, oh, my God, but it was also like, it's his baby, too. Right? And so, he and he's, you know, being like, No, this is what you need to do. And then, and I would do that. And it was like, it was hard, but also wonderful at the same time, like, it will almost feel like okay, yeah, I needed to do that.''
	Self-compassion was Central to Recovery	Audrey, Emma	Some participants reported feeling low-self esteem as a result of the disorder. The disorder had impacted the one they viewed themselves. Engaging in self-compassion exercises helped them to rebuild their self-esteem. They learnt to be kinder to themselves.	Audrey: "There was just something about the way I viewed me, you know, some way about the way that I felt about myself that, you know, you kind of wasn't right, and I went back and I did that's when I went back to therapy. And I did a lot of self-compassion work. And a lot of yeah, that that was central to everything".

			Audrey described self-esteem as the binding agent for all the other interventions she had put in place. Rebuilding her self-esteem was the final part in her recovery.	Audrey: "But yeah, it's, it's been central to absolutely everything learning to love me as cringy as it sounds, has been the thing that that just changed everything and allowed me to access every other thing that I've ever done" Audrey: "But I see as in like, if I'm if my recovery was building a wall, and the bricks were things like you know, the CBT activities and the ERP and you know, eating well and dieting and getting enough sleep or not, not dieting, sorry, having a healthy diet and getting enough sleep. The foundations of that wall, and the cements between those bricks has been my work on self-compassion, my self-esteem". Audrey: ''it's come from six months of thinking, I'm a monster, who wants to kill

			Self-compassion exercises included writing a letter of self-compassion, reading positive feedback, and learning to make eye contact.	my baby, you know, it doesn't leave you feeling great about yourself. And I had to write a letter, a compassionate letter to myself. And something happened during that activity, where I just felt the floodgates open and I felt so sad for me, you know, what, what the condition had done, and I, I have to keep a positivity journal so that every single night I had to write down things that I'd done and all the positive things that said about me, you know, that was how bad I felt about myself. And gradually over time, it became natural. So, you know, I had to make sure it didn't come a compulsion. I had to make sure that I wasn't doing as a safety behaviour, you know, kind of oh, look at me, I'm so marvellous. And going out doing things deliberately, just that I could write them in my books. I had to kind of be sensible about it, but I had to build myself up from nothing, you know,

				absolutely nothing, I learned how to look at myself in the mirror, I learned how to make eye contact with people. And that has changed my life. You know, it's almost like putting a filter on a pair of glasses that I wear, you know, I, I protect myself and my health now I learn, I've learned to say no. You know, it has been the center of everything, my inner narrator was constantly like, what on earth are you thinking about that for you know, how daft and now it's like, you know what, if you make a mistake, it's just a mistake, you didn't mean it. You know, and it's allowed me to do so much. You know, if I hadn't worked on my self-esteem, there's no way we'd be talking now.''
			Emma wanted to teach her kids that it was OK to make mistakes. She had been particularly hard on herself as a mother, and decided she wanted to be a better role	Emma: "I decided, because of CBT was working to a certain extent, but it I felt like there was something missing that I needed something else. And then that's

			model for her children. Emma used ACT to develop self-compassion.	when I discovered act….and act has been amazing. It's really got my self-esteem back.’’ Emma: “So with act, it helped me to see what my values were and so for that example, do I want to beat myself up? Let my kids say that making a mistake is a bad, bad thing? Or do I want to show myself a little bit more kindness? Showing them showing them that it's okay to make mistakes? It's okay to to move on from them. And that's how I managed to get my I don't know, it was just those it was just that shift in mindset.’’

	Finding Relief through Medication	Emma, Audrey, Olivia, Mia, Jane	All participants took SSRIs to manage their OCD symptoms. SSRI use was largely regarded as positive and a means to restoring basic functioning. Emma took medication later in her recovery journey because she was worried about the side effects. She wished she had taken it sooner because it made her thoughts clearer. She was able to implement her other interventions with ease.	Emma: "Another thing is that I decided I didn't want to take medication. Which was actually one of the worst things that I should have. I decided too late in the day to take medication. And when I took it, it was the most amazing most amazing thing if I was like this, how normal people think.'' Emma: "It was just before we went on the camp and it just started to kick in and medication then it just chilled. Yeah. Yeah, it was brilliant. And that just kind of freed up my my brain a bit to be able to. Yeah, to be able to use all the tools that I've learned basically''. Emma: "But yeah, if I had I was taking it sooner, probably done myself a massive favour. So that was probably a bit of a hindrance."

			Medication helped Audrey regain basic functioning, such as eating and sleeping. This was the starting point in her recovery journey, but it did not treat the underlying fears.	Audrey: "I had medication, I had Diazepam, which works very well, for me I know it hasn't for a lot of people. And I also got given diazepam because I think I've reached the point where the only thing that would, you know, just help was knocking me out for a while, I had to kind of rebuild. And so yeah, that happened. I started eating again, I started sleeping again, I started to, actually I kept having the thoughts, but I didn't feel any kind of reaction to them. But what I did feel was quite numb". Audrey: "But yeah, I kind of, I still struggled to do anything. To go for a walk around the block with him in the pram, go anywhere near a bridge anywhere near a train station, you know, these kind of thoughts and impulses just be huge. And every time I tried to come off the medication, it just all came back again.

				And I do remember one night and just bawling my eyes out to my husband because I had to go back on my medication. Again, I felt the biggest failure ever”. Audrey: “and then yeah, eventually I went to my doctor and I thought there's got to be something else. There's gotta be something else these medications, medication, just alone isn't enough”.
			SSRIs helped Olivia. She took them throughout pregnancy.	Olivia: “My daughter, so I've got three, I went on to have another baby as well. And after my two daughters didn't suffer at all postnatally which was amazing. But they had supported me to stay on my SSRI throughout pregnancy and breastfeeding, which was really good. And really, really positive. It was completely different experience.”

				Mia: “after been doing CBT and taking medication, I'm at a point now where I can go days without having an intrusive thought or doing a compulsion I, my life has completely changed.’’
			Participants were initially concerned about the side effects of medication.	Jane: “I didn't want to be on medicine at first because of the pregnancy. And there was a lot of stuff there that I grappled with. And we went to so many different doctors to kind of get reassured that No, I could take this, and you know, serotonin, it was going to be okay.’’ Jane: “Like CBT really worked having serotonin, figuring that out, getting my levels where they needed to be, it was just, it was kind of like, night and day, you know, like, I was still having, like, obsessive thoughts, and certainly, compulsions and things but it but I felt like myself again, you know, and that was just,

				that was everything. So now, I really like to tell people to like how, how much that helped me, you know, finding the right level of serotonin. And because people do if they have, you know, a physical condition, they go to the doctor and get medicines. So it's just, it just makes sense. You know, if that's recommended in your treatment plan, so I wanted to destigmatise that, too.'' Jane: "And so, I did have to, at one point up my therapy, like just how many times I was going, we had to play around with medications, because the one that worked for my, before I was had given birth the first time, I ended up switching to a different one. And so I tell people to like, don't just because one doesn't work, you know, you might want to try a different one. Because we, so we had to play

				around with that a little bit to get the right. Something that felt right.’’ Jane: “My daughter, so I've got three, I went on to have another baby as well. And after my two daughters didn't suffer at all postnatally which was amazing. But they had supported me to stay on my SSRI throughout pregnancy and breastfeeding, which was really good. And really, really positive. It was completely different experience.”
Words of hope		Ivy, Mia, Jane, Audrey, Olivia	Participants wanted to share words of hope with other women listening to the podcast. Ivy encouraged women to start recovery as a form of self-care.	Ivy: ‘’Do it for your, do it for your tomorrow self. Do it for your two week from now self, do it for your, you know, future self. I think so many times we act on fear, because of how it feels now, because it's scary. We're challenging ourselves now. To create experiences for later where we're stronger. We're more self-confident we have more self-efficacy

				while we're building those muscles that we have to be cheering and working for that long term self.'' But you just have to keep moving forward. And it's really hard to do that. But you just have to, you have to leave all of that in the dust. And you have to just keep going forward.''
			Mia reassured people that recovery is worth it. She encouraged them to take the step forward and disregard the inner critic that tells them that they are undeserving.	Mia: "You're doing the best thing. You really, really are starting, recovery is terrifying. It really is the best thing you can do for yourself. And that's what it's about doing something for you. Because you mean something you matter. I think OCD tricks us into thinking that we don't, and we have that inner critic all the time, telling us something very negative. But taking that step forward into recovery, it's I can't even, like, describe how amazing it is for anyone who's starting that journey right now.''

			Amelia wanted to portray a realistic view of recovery. She talked about how hard it was. She encouraged people to take small steps forward, rather than big leaps. Life can and will get better.	Amelia: “And you're gonna have tough days, it's not going to be easy. It really isn't. And it takes a lot of hard work. It really does. But it's always about the small steps that you take. Not the giant leaps is always about the small steps. And before you know it, you've we've all those small steps, you've taken a giant leap and into recovery, and it will change your life. And it does change your life. Whatever form of therapy you've taken or whatever form of recovery you're taking, you have put yourself first. By doing that, you have said, I deserve better than this. And you do. And it will get better. It does get better. If I got better, I'm sure anyone can”. Jane: ‘’And yeah, you're gonna have tough days. But when once you realize that I'm slowly getting better. It's just the best feeling.’’

			Audrey reassured listeners that recovery is totally possible. It is possible to lead a normal and happy life after OCD. Audrey spoke about how intrusive thoughts are common in all parents. Motherhood is really tough, and this needs to be normalised.	Audrey: “Oh, my goodness, that recovery is totally possible. I know, this gets debated what is recovery? And, but like, I still have OCD, I'm not fully recovered yet, yet, I have a completely normal, happy life. And I'd want them know, that is absolutely possible for them. And I'd want them to know that, you know, your little one will be fine.’’ Audrey: “And, you know, we just don't talk about these things, right. Moms already have so much against them. In terms of, you know, you have to you know, love your baby at first sight and have that instant connection and don't you just enjoy every part of being a parents. We don't talk about not enjoying every moment not to mention having sexual intrusive thoughts about your baby, right? We don't talk about those things. And so I think a lot of women

				consequently struggle and experienced these things, but they struggle in plain sight. They are dealing with it, they're walking around with it. And they're just like I was they're walking around thinking they're the only ones they've never heard about this before. I must be crazy. I must be just a horrible mom. And so I think, you know, lots of things that we could do, but it's a it's a mess. It's kind of a mess over here when it comes to new parenthood, and especially for new moms.'' Audrey: "So much research is coming out now about just how many women experience obsessions and compulsions, and those types of tendencies leading up to the birth and then certainly after the birth. So even if it doesn't reach full blown OCD, where it's disordered, you know, their new new moms are definitely at a heightened experience and heightened

				kind of vulnerability to experience these intrusions. So I think that really comes down to I call it a triple whammy. So OCD is going to have a field day with anything that is uncertain. And what's more uncertain about having a newborn, or even a child and a toddler, right, like that all is so uncertain. Are they healthy? Are they sleeping through the night? Am I doing enough, so on and so forth. So that whole experience of having a child and being a new parent is so uncertain. I think the next thing that OCD really latches on to is obviously anything that we value. So especially as a new parent, what more do we value in those moments, or in general, more than our own child or children, right. And then we also know that OCD latches on to what we feel responsible for. So you know, we have that heightened sense of responsibility. Bringing a child, a newborn baby, and especially the moms in that

				newborn phase, we feel totally uncertain about that. We feel so responsible for this human being. And it's obviously the most valuable thing in our lives at that point. So it's just the perfect melting pot, put some hard wired maternal instincts in there, to be anxious so that you can be vigilant and so that you can act.''
			There is so much hope when it comes to recovery. There is so much support out there for people who are suffering. It's so important to speak up and ask for help. Life can and will get more beautiful if you engage with treatment.	Olivia: "Oh my gosh, there is hope there's so much hope… that I want to be that beacon of hope and offer hope that no matter how long you have been suffering, that no matter how old you are, and where you are in your life, that you can find someone to help you. And you can get that help that you so rightfully deserve and get better and make your life more beautiful than you ever imagined.''