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POSTPARTUM OBSESSIVE-COMPULSIVE DISORDER:

MOTHERS' LIVED EXPERIENCES OF RECOVERY FOLLOWING EFFECTIVE COUNSELLING

BY

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Dedication

This thesis is dedicated to all the postpartum mothers with thoughts that scare them and to my mother who is the strongest and most resilient person I know.

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Abstract

Postpartum obsessive-compulsive disorder (OCD) is characterized by distressing intrusive thoughts (obsessions), typically related to infant-harm, and behaviours (compulsions) that a mother engages in to reduce distress about the obsessions. Postpartum OCD is a common perinatal mood and anxiety disorder (PMAD) that causes mothers to suffer immensely. Mothers' experiences of recovery following effective counselling are largely missing in the research literature. The purpose of this qualitative study was to use interpretative phenomenological analysis (IPA) to examine mothers' lived experiences of recovery from postpartum OCD following effective counselling to fill current gaps in knowledge. Eight mothers participated in this study to elucidate their recovery experiences following counselling. Individual semi-structured interviews were conducted via Zoom. Five postpartum OCD recovery themes associated with effective counselling were identified. These included: (I) Strong Therapeutic Alliance: Fostered through Trust, Safety, and Security, (II) Intervention Strategies including three subthemes: (IIa) Education about PMADs, (IIb) Cognitive Restructuring and Defusion, and (IIc) SSRI medication, (III) Self-Acceptance including one subtheme: (IIIa) Acceptance of Intrusive Thoughts and Postpartum OCD, (IV) Sense of Belonging within PMAD Community, and (V) PMAD Advocacy. Implications for counselling practice are discussed as well as practical guidelines and recommendations for counsellors and psychologists in order to best support mothers in their postpartum OCD recovery.

Keywords: counselling, interpretative phenomenological analysis, lived experience, motherhood, obsessive-compulsive disorder, postpartum, postpartum obsessive-compulsive disorder, recovery

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Lived Experience. *Lived experience* can be defined as subjective experience that someone lives through personally (Tuffour, 2017). In this study, *lived experience* will refer to mothers' perceptions, views, attitudes, thoughts, beliefs, feelings/emotions, physical reactions, and psychological symptoms of personally living with and recovering from OCD during the postpartum period.

The Postpartum Period. *The postpartum period* commonly refers to the time frame immediately following the delivery of the baby up to six- or eight-weeks following delivery (Berens, 2018). There is consensus in the research literature when the postpartum period starts (i.e., immediately following the delivery of the baby); however, the end of the postpartum period is not well defined with some scholars citing up to six- to eight-weeks following delivery while others cite up to 6- or 12-months following delivery.

Obsessive-Compulsive Disorder (OCD). According to the DSM-5, OCD is a neuropsychiatric illness characterized by intrusive, unwanted, distressing, and repetitive thoughts, images, or impulses and/or behavioural or mental rituals (American Psychiatric Association, 2013).

Postpartum Obsessive-Compulsive Disorder (OCD). Obsessive-compulsive disorder that is experienced in the *postpartum period* (as defined above) will be referred to in this study as *postpartum OCD* (APA, 2013; Vigod et al., 2016).

Chapter 1. Case Vignette

Amina is a 32-year-old first-time mother. She has experienced anxiety and worries throughout her life, though did not have any symptoms of obsessive-compulsive disorder before or during pregnancy. At four weeks postpartum, Amina is having frequent intrusive thoughts and images about smothering her baby to death with a pillow while the baby sleeps. In addition to being consumed by these intrusive thoughts, Amina experiences strong urges to repeatedly check that her baby is still breathing. She constantly ruminates about whether she will harm her baby and seeks reassurance from her partner that her baby is okay and breathing. Amina also avoids being alone with her baby, and had gathered all the pillows from her home and put them on the top shelf at the back of her closet. Amina feels temporary relief when she performs checking behaviours and receives reassurance from her partner. She finds it difficult to ignore or push away the intrusive thoughts and images, and does not know how to prevent them. She feels helpless and scared about having such awful thoughts and wishes she knew how to stop them. Consequently, Amina feels tremendous guilt and is ashamed. She feels mentally and physically exhausted, and believes she is failing as a mother. With the support of her partner, Amina seeks help from her family doctor with whom she discloses some of her struggles of coping with new motherhood. Her doctor diagnoses her as having postpartum depression and assures her that mood and anxiety disorders are common among new mothers. Amina is hesitant to tell him about the content of these repugnant thoughts and images. She feels an intense fear that the police will be called and that her baby will be taken away. She expresses that she is not feeling sad, but worries about her baby's safety and well-being. Her doctor tells her that she is anxious then hands her a prescription for an anxiolytic (anxiety medication) and assures her she will start feeling better in six to eight weeks. Feeling frustrated and unheard, Amina sees a counsellor and discloses the intrusive thoughts she experiences. She does not receive compassionate understanding from the counsellor and feels even worse about herself and as a mother.

This case illustrates postpartum obsessive-compulsive disorder (OCD) is a debilitating illness that leads to immense suffering of mothers. For mothers like Amina who are experiencing symptoms of OCD, the intrusive thoughts and images feel very real and are vivid and detailed. As a result, these internal experiences are particularly jarring, disturbing, and terrifying.

This case also illustrates that OCD is often poorly understood (Brok et al., 2017) and frequently misdiagnosed by primary care physicians (Glazier et al., 2015) who are not asking the right questions or who do not have the full picture with mothers afraid to disclose intrusive thoughts. In addition, psychologists and counsellors often lack awareness about how common intrusive thoughts are in the postpartum period. A lack of necessary counsellor education and

training to differentiate between postpartum OCD and postpartum psychosis leads to inappropriate and fear-based treatment decisions (Kleiman & Wenzel, 2010) such as in Amina's case.

Introduction

In this thesis, I will provide an introduction on the topic of perinatal mood and anxiety disorders (PMADs), specifically postpartum OCD. Following this introduction, I present a rationale and impetus for the current study. Next, I present the key concepts central to this work grounded in the research literature. I will then provide a review of the research literature. Following this, I will introduce the conceptual framework and a rationale for choosing Interpretive Phenomenological Approach (IPA) as the qualitative study methodology for the current study. I will then present the study results and discuss the practice implications for counsellors and other healthcare professionals who work with mothers experiencing postpartum OCD. Finally, I describe the benefits and limitations of the current research and suggestions for future research directions.

Postpartum Mental Illness

To better understand postpartum OCD, and how treatment approaches can be improved for mothers like Amina, it is important to briefly review the broad spectrum of PMADs. The postpartum period is associated with an increased risk for the onset, recurrence, and exacerbation of maternal and paternal PMADs (American Psychiatric Association (APA), 2013). Similar to their female counterparts, males also experience PMADs. Depression and anxiety disorders are common amongst fathers in the perinatal period; between 2% and 8% of males experience depression and between 4% and 18% of males experience anxiety disorders (Glasser & Lerner-Geva, 2019; Leach et al., 2016). Although paternal PMADs is an important area of discussion, it will not be discussed further as it is beyond the scope of this study. For women in the reproductive phase of their life, PMADs represent a broad spectrum of mental illness, including

postpartum depression (PPD), postpartum bipolar disorder, postpartum psychosis, postpartum anxiety and panic (e.g., generalized anxiety disorder, panic disorder, specific phobia, social anxiety disorder), postpartum obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) (Goodman et al., 2016; Meltzer-Brody et al., 2018; Vigod et al., 2016). The most widely known of the postpartum mental disorders is PPD. In brief, PPD is characterized by periods of low mood while postpartum bipolar disorder involves mood swings of depression and elevated mood. Although less common than the other PMADs, postpartum psychosis is the most severe and debilitating. Mothers with postpartum psychosis experience a break from reality, hallucinations (auditory, visual, tactile, olfactory), and delusions about themselves, their baby, and others. As such, postpartum psychosis is a medical emergency and mothers should be hospitalized given the higher rate of homicide and suicide with this population (Scrandis et al., 2007; Spinelli, 2004). Anxiety disorders are the most common amongst women in the postpartum period and include generalized anxiety disorder (general nervousness or worries about the baby that the mother finds difficult to control and that are often accompanied by physical symptoms), panic disorder (frequent, short-lived panic attacks that involve spontaneous and rapid physiological symptoms), specific phobia (excessive fear and avoidance of a specific object or situation), and social anxiety disorder (persistent fear of social or performance situations that are avoided or endured with distress). Mothers with postpartum OCD experience repetitive and distressing intrusive thoughts or images (obsessions), that are typically related to infant-harm, and perform physical or mental actions (compulsions) to reduce distress that the obsessions evoke. Lastly, PTSD during postpartum is triggered by a traumatic childbirth experience or re-experiencing symptoms from a previous traumatic event.

The 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013) does not classify PMADs as distinct disorders, but instead has a "peripartum-onset" specifier identified with general mental disorders (i.e., bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma- and stressor-related disorders) to acknowledge the increased risk of new onset, recurrence, and exacerbation of mental disorders during pregnancy and up to one year postpartum (APA, 2013; Vigod et al., 2016). The lack of full representation of PMADs in the DSM-5 may be associated with less awareness and understanding of PMADs. Anxiety disorders, OCD, and PTSD are highly prevalent during pregnancy and the postpartum period (Fairbrother et al., 2016). Therefore, it is imperative to examine mental health issues that arise during this time. Postpartum OCD, in particular, is the most widely misunderstood and under-recognized mental disorder in the postpartum period with mothers suffering immensely due to this debilitating illness (Booth et al., 2014).

Postpartum Obsessive-Compulsive Disorder

Postpartum OCD is characterized by unwanted, distressing, and repetitive intrusive thoughts or images (obsessions) and/or physical or mental actions (compulsions) that the mother feels driven to perform to reduce distress (APA, 2013). The content of intrusive thoughts that are experienced by mothers with postpartum OCD vary widely but are often related to the mother's fears of accidentally or deliberately harming their baby (Hudak & Wisner, 2012). For instance, mothers may fear that they will drop, stab, drown, suffocate, poison, or decapitate their baby (Booth et al., 2014). Thoughts may also be of a sexual nature relating to their baby, including sexual perverse thoughts or images about one's baby or the intrusive and recurrent thought of sexually molesting one's baby (e.g., "what if I sexually abused my daughter when I was bathing

her?"). Other thoughts may be about their baby being contaminated by dirt or germs or harmed by others (Christian & Storch, 2009). Longitudinal studies have reported that unwanted, intrusive thoughts about harming one's baby is common amongst 70-100% of new mothers (Abramowitz et al., 2007; Fairbrother & Woody, 2008). However, the important distinction between having unwanted, intrusive thoughts and diagnosable OCD is the mother's negative interpretation of these thoughts and the level of distress and impairment caused (Abramowitz et al., 2010; Miller et al., 2015). Women with postpartum OCD interpret these thoughts as alarming and meaningful and believe that they may unwittingly act on these thoughts and therefore take precautions to avoid them harming their baby.

While some mothers with postpartum OCD may only experience obsessive thoughts, images or impulses, these obsessions are frequently associated with irrational behaviours or mental acts (compulsions) that the mother feels a strong urge to perform in order to reduce the distress triggered by the thoughts (Hudak & Wisner, 2012). Women with postpartum OCD may also engage in avoidance behaviours to prevent harm to their babies. For example, a mother who experiences intrusive thoughts or images about aggressively harming her baby may avoid using sharp objects or being alone with her baby, or may attempt to neutralize the aggressive thought or image with a loving thought or image. A mother who has sexually perverse thoughts about her baby may avoid changing or bathing her baby; or a mother who is afraid that her baby will become contaminated by dirt or germs may excessively bathe her baby, repeatedly clean her baby's clothing and toys, or wash her own hands multiple times a day. Left untreated, postpartum OCD can be debilitating, negatively impacting the mother, baby, and family unit, and become chronic with symptoms persisting or worsening (Christian & Storch, 2009).

It is estimated that approximately 2.4% of mothers in North America experience postpartum OCD (Russell et al., 2013). A recent study reported that 3.6% of Canadian mothers in the first three months of postpartum met diagnostic criteria for OCD, which is higher than the prevalence of OCD in the general population (Fairbrother et al., 2016). Clinically, the authors know that 2.4% and 3.6% are likely underestimates of postpartum OCD given the stigma and shame associated with postpartum OCD, as well as the real fear mothers feel about possibly being separated from their baby or the police being called, which often precludes mothers from seeking help and receiving the treatment they need.

The clinical and research focus of PPD has traditionally overshadowed postpartum anxiety disorders and postpartum OCD (Coates et al., 2014). Despite postpartum anxiety disorders being more prevalent than postpartum depression (17.1% vs 4.8% respectively), depression is still considered by healthcare professionals and researchers to be the primary mental health concern for women in the postpartum period (Fairbrother et al., 2016; Toler et al., 2018). Anxiety disorders and depression frequently co-occur in the postpartum period (Falah-Hassani et al., 2017; Farr et al., 2014), which leads to anxiety symptoms being obscured by depressive symptoms; therefore, depressive symptoms are easier to identify, diagnose, and mistakenly become the focus of treatment (Johnson, 2013). Women who do not experience depression in the postpartum period may feel marginalized by loved ones or healthcare professionals because of the dominant discourse that focuses primarily on PPD (Wardrop & Popadiuk, 2013). Although the dominant discourse of PPD is slowly changing, anxiety disorders and OCD are neither specifically nor consistently screened for in postpartum women (Wardrop & Popadiuk, 2013).

Postpartum OCD is under-recognized and untreated in postpartum women (Kleiman & Wenzel, 2010). Mothers are routinely screened for PPD but not postpartum anxiety disorders nor postpartum OCD (Wardrop & Popadiuk, 2013). The reason for this may be that there are more reliable and specific screening tools and protocols available for PPD than postpartum anxiety or postpartum OCD (Wardrop & Popadiuk, 2013). The Edinburgh Postnatal Depression Scale (EPDS) is a brief, self-report questionnaire consistently used as a specific screening measure for postpartum depression (Fairbrother et al., 2015). Despite the EPDS containing three items relating to anxiety, the EPDS is insufficient as a specific screening measure for anxiety disorders (Toler et al., 2018). There continues to be a lack of consistent and specific screening measures for postpartum anxiety disorders and postpartum OCD, which impacts diagnosis and treatment for women with postpartum anxiety disorders and postpartum OCD. The lack of consistent and specific screening measures for postpartum OCD is further complicated by the fact that mothers are often reluctant to disclose the content of their intrusive thoughts to loved ones and healthcare providers, particularly when the thoughts relate to infant-harm. Mothers often fear that they will be involuntarily hospitalized, have the police called, or have their baby taken away (Hudak & Wisner, 2012). Therefore, postpartum women may be more willing to discuss anxiety or depressive symptoms that they are experiencing than their intrusive thoughts out of fear that they will be hospitalized or have their baby taken away (Hudak & Wisner, 2012). It is also possible that postpartum women without a previous history of OCD may lack insight about these intrusive thoughts characterizing a disorder and therefore do not seek help or entirely avoid seeking help (Challacombe & Salkovskis, 2011). Unfortunately, mothers who do not seek help for intrusive thoughts leads to under-recognized and untreated OCD in the postpartum period (Brok et al., 2017), which can be fatal (Grigoriadis et al., 2017).

There is a lack of awareness, education, and training surrounding postpartum OCD and its treatment (Kleiman & Wenzel, 2010). Healthcare professionals continue to not ask the right questions when they ask postpartum women if they are experiencing anxiety, and even when healthcare professionals do ask, women may deny feeling anxious as they do not trust that their healthcare professional knows what to do with this information (Kaeni, 2017). In addition, healthcare professionals are not asking postpartum women specifically about intrusive thoughts (e.g., "Are you having scary thoughts?") and postpartum women do not trust that their healthcare professional can help them. According to Kleiman and Wenzel (2010), healthcare professionals may fail to directly ask a new mother if she is having intrusive thoughts because they lack awareness about how common intrusive thoughts are in the postpartum period. They assume intrusive thoughts indicate postpartum psychosis and lack the necessary education and training to provide effective treatment, which confirms the mother's fears about coming forward (Kleiman & Wenzel, 2010).

Healthcare professionals often misdiagnosis postpartum OCD as PPD or postpartum psychosis in cases where women disclose intrusive or "bad" thoughts relating to their baby (Booth et al., 2014; Challacombe & Wroe, 2013). Intrusive thoughts are very common among new parents in the postpartum period (i.e., between 69-91% of mothers and 58-88% of fathers; Abramowitz et al., 2006; Abramowitz et al., 2003) whereas psychotic thoughts during postpartum are rare (i.e., approximately one to two in 1,000 childbirths; VanderKruik et al., 2017). It is crucial to understand the difference between the unwanted, intrusive thoughts of infant harm present in OCD and infanticidal ideations present in postpartum psychosis as each have their own clinical and treatment implications (Glazier et al., 2015). The intrusive thoughts that are experienced by postpartum women with OCD are ego-dystonic, meaning that these

thoughts are inconsistent with her personality, values, desires, wants, and intentions, which is what makes the thoughts so distressing (Sharma & Sommerdyk, 2015). Women with postpartum OCD who view themselves as loving and nurturing are arguably the least likely to ever harm their baby (Booth et al., 2014). Indeed, it is challenging to locate research in the area of women with postpartum OCD and no other mental illness committing harmful acts against their baby (Booth et al., 2014; Fairbrother & Woody, 2008; Ross & McLean, 2006; Wong, 2012). Additionally, women with postpartum OCD feel terrified and suffer tremendously; although they have no intent to act on the intrusive thoughts, they fear that they will unwittingly act on these thoughts or believe that the mere presence of these thoughts is the same as having acted on these thoughts (Booth et al., 2014). Therefore, women with postpartum OCD often engage in avoidance or safety behaviours to prevent their baby from being harmed. In contrast, women with postpartum psychosis lack insight into their illness and do not experience any fear or anxiety about the infanticidal ideations (Spinelli, 2009). Women with postpartum psychosis experience hyperactivity, flight of ideas, decreased need for sleep, reckless behaviour, confusion, delusions, and hallucinations that put themselves and their baby at a real risk for aggression or violence (Sharma & Sommerdyk, 2015; Spinelli, 2004; Vigod et al., 2016). Therefore, "postpartum psychosis is a psychiatric emergency. Inpatient psychiatric treatment is essential to ensure the safety of mother and baby" (Spinelli, 2009, p. 406).

Misdiagnosing a woman who has postpartum OCD with postpartum psychosis has several potential implications for mother, baby, family unit, and community. The mother may be involuntarily admitted to hospital, separated from her baby, receive harmful or ineffective treatment, and/or have the police called. These circumstances can lead to disrupting the mother-baby bond, reinforcing the mother's own feelings of shame and anxiety, and perpetuating further

stigma of postpartum OCD in the community (Booth et al., 2014; Challacombe & Wroe, 2013). There have been cases portrayed in mainstream media where new mothers have disclosed intrusive or "bad" thoughts to healthcare professionals (i.e., nurses, counsellors) and have been reported to children's aid society or involuntarily hospitalized. Recently, a new mother from California disclosed to her healthcare team that she was experiencing intrusive thoughts related to her baby and, despite expressing that she had no intent to act on these thoughts and wanted help, she felt criminalized and was involuntarily admitted to hospital (Wong & Letourneau, 2018).

Problem Statement

There is a dearth of qualitative research in the area of mothers' perspectives or lived experiences of recovery from postpartum OCD following effective counselling. The lack of descriptions of mothers' lived experiences with postpartum OCD in the research literature may be associated with a lack of awareness, education, and training surrounding postpartum OCD. As a result, counsellors are often unaware of how to effectively treat postpartum OCD.

Study Significance

Examining mothers' lived experiences with postpartum OCD following effective counselling may help psychologists and counsellors to better understand how to provide effective counselling for mothers who are experiencing postpartum OCD. This study may also help mothers who are currently struggling with postpartum OCD to recognize that they are not alone, instill hope, and encourage them to seek the help they need.

Purpose

The purpose of this study was to examine mothers' lived experiences of recovery from postpartum OCD following effective counselling to fill the current gaps in knowledge

surrounding key aspects of effective counselling that contribute to recovery in women with lived experience of postpartum OCD.

Research Question

What are the lived experiences of mothers' recovery from postpartum obsessive-compulsive disorder (OCD) following effective counselling?

Definitions of Key Constructs

The key concepts of this study that are grounded in the research literature include: (1) lived experience; (2) the postpartum period; (3) OCD; (4) postpartum OCD.

Lived Experience

Lived experience can be defined as subjective experience that someone lives through personally (Tuffour, 2017). In this study, *lived experience* will refer to mothers' perceptions, views, attitudes, thoughts, beliefs, feelings/emotions, physical reactions, and psychological symptoms of personally living with and recovering from OCD during the postpartum period. This lived experience is grounded in a philosophical framework about the beliefs about reality and truth potentially.

The Postpartum Period

The postpartum period commonly refers to the time frame immediately following the delivery of the baby up to six- or eight-weeks following delivery (Berens, 2018). There is consensus in the research literature when the postpartum period starts (i.e., immediately following the delivery of the baby); however, the end of the postpartum period is not well defined with some scholars citing up to six- to eight-weeks following delivery while others cite up to 6- or 12-months following delivery. Given that the first postpartum year is a critical time

during which women are at increased risk for the new onset, recurrence, and exacerbation of mental disorders, including OCD (Vigod et al., 2016), this study will include mothers who have experienced OCD immediately following delivery up to 12-months postpartum.

Obsessive-Compulsive Disorder

According to the DSM-5, OCD is a neuropsychiatric illness characterized by intrusive, unwanted, distressing, and repetitive thoughts, images, or impulses and/or behavioural or mental rituals (APA, 2013).

Postpartum Obsessive-Compulsive Disorder

Obsessive-compulsive disorder that is experienced in the *postpartum period* (as defined above) will be referred to in this study as *postpartum OCD* (APA, 2013; Vigod et al., 2016). As previously described, the DSM-5 does not classify the postpartum mental disorders as distinct disorders, but instead has a "peripartum-onset" specifier to acknowledge mental disorders occurring in pregnancy or up to four-weeks postpartum. In addition to the description provided earlier, postpartum OCD is characterized by persistent, distressing and unwanted ideas, thoughts, or images (i.e., obsessions) and/or repetitive or ritualized behaviours (i.e., compulsions) that are triggered or exacerbated following childbirth (APA, 2013). These ideas, thoughts, or images enter the mother's mind against her will and are often incongruent with the mother's self-concept (APA, 2013). Obsessions may fall into various symptom domains including aggressive, contamination, sexual, somatic, and miscellaneous obsessions, or the need for symmetry or exactness (Goodman et al., 1989). For instance, the intrusive and recurrent thought of sexually molesting one's baby or unwelcome violent images of dismembering one's baby would be classified as a sexual obsession and aggressive obsession, respectively. Compulsions may

include the following themes: cleaning/washing, checking, repeating, counting, ordering/arranging, and miscellaneous compulsions (Goodman et al., 1989). For example, excessively using wet wipes to clean the baby's hands (cleaning/washing behaviours), checking baby for any signs of physical harm (checking behaviours), or thinking "good" thoughts to counteract the "bad" thoughts (mental ritual).

Summary

Perinatal Mood and Anxiety Disorders (PMADs) represent a broad spectrum of mental illness in the reproductive phase of a woman's life. Postpartum OCD is the most widely misunderstood and under-recognized mental disorder in the postpartum period among healthcare professionals with mothers suffering immensely due to this debilitating illness, as shown in Amina's story where her family doctor and counsellor failed to accurately identify her experience with postpartum OCD (Booth et al., 2014; Brok et al., 2017). To date, there is a dearth of published psychological treatment studies in postpartum OCD (Brok et al., 2017), specifically on women's perspectives of recovering from postpartum OCD following effective counselling experiences. Examining mothers' lived experiences with postpartum OCD following effective counselling may help mental health professionals better understand how to provide effective counselling for mothers who are experiencing postpartum OCD. So far, I have presented Amina's story, an introduction to PMADs, the purpose and significance of the current research, and key concepts. In the next chapter, I review research literature that informs the conceptual framework and methodology for the present study.

Chapter 2. Literature Review

Postpartum obsessive-compulsive disorder (OCD) is characterized by unwanted and intrusive thoughts or images (obsessions), typically related to infant-harm, and physical or mental behaviours (compulsions or rituals) aimed at reducing distress (APA, 2013). As a mother experiencing postpartum OCD, Amina is having extremely upsetting intrusive thoughts and images of smothering her baby with a pillow while the baby sleeps. In an effort to get rid of the distress associated with these intrusive thoughts, she compulsively ruminates, checks whether her baby is still breathing, avoids being alone with the baby, and seeks constant reassurance from her partner. It is estimated that approximately 2.4% of mothers in North America experience postpartum OCD (Russell et al., 2013), although cases are likely much higher given the reluctance of mothers to report symptoms to medical professionals. Fairbrother and colleagues (2016) identified that 3.6% of Canadian women in the first three months of postpartum met diagnostic criteria for OCD, which is higher than the prevalence of non-perinatal OCD. Given the unrecognized higher rate of postpartum OCD, there is a parallel lack of published psychological treatment studies in postpartum OCD, which mainly consist of case reports and one randomized controlled trial (RCT) (Brok et al., 2017; Challacombe et al., 2017). In addition, there is a dearth of studies focused upon postpartum women receiving psychotherapeutic treatment, besides cognitive behavioural therapy (CBT) and exposure and response prevention (ERP), for postpartum OCD recovery.

In the pilot RCT study of psychological treatment for postpartum OCD, Challacombe et al. (2017) involved 34 mothers with a primary diagnosis of OCD in the postpartum period. They were randomized to the intensive CBT group (n = 17) or the treatment as usual (i.e., wait-list)

group (n = 17). A mentally healthy control group of postpartum mothers (n = 37) was also included. The authors defined *intensive CBT* as 12 hours of individual CBT treatment delivered over a two-week period (i.e., four sessions of three hours). Study results indicated that intensive CBT is an effective psychological treatment for postpartum OCD based on significantly different mean reduction scores on the gold-standard Yale-Brown Obsessive Compulsive Scale (the primary outcome measure) between intensive CBT and treatment as usual groups (48.4% reduction vs 12.8% reduction, respectively). While the researchers focused on psychological treatment for mothers with postpartum OCD, this study did not identify the key aspects that were associated with recovery in women experiencing postpartum OCD following therapy.

Researchers in another study conducted a pilot CBT group for pregnant and postpartum women with various perinatal anxiety disorders, including generalized anxiety disorder, social anxiety disorder, and OCD; however, this study included just one postpartum woman with OCD (Green et al., 2015). The remaining psychological treatment studies published on postpartum OCD have been case studies utilizing CBT and ERP treatment only (Challacombe & Salkovskis, 2011; Christian & Storch, 2009; Craner et al., 2017; Fang et al., 2018; Gershkovich, 2019; Hudak & Wisner, 2012).

Case studies typically provide rich descriptions and a deeper contextual understanding of a lesser-known phenomenon. Unfortunately, there are limited case studies published on the psychotherapeutic treatment of postpartum OCD, which include CBT and ERP treatments only. In these studies, participants received intensive (multiple and/or longer treatment sessions delivered over a two-week period of time) or non-intensive (treatment sessions delivered over the course of multiple weeks or months) CBT and ERP treatment. CBT treatment involved psychoeducation about OCD, such as how common intrusive thoughts are amongst postpartum

mothers, typical content of intrusive thoughts during postpartum, what strengthens and maintains OCD, and that thoughts are not actions. A woman in one of the case studies reported that the psychoeducational aspect of treatment was a major factor in her postpartum OCD recovery because she learned that she did not have postpartum psychosis, postpartum OCD is common, and having harm intrusive thoughts about her child did not mean she would act on these thoughts (Hudak & Wisner, 2012). Cognitive restructuring to notice and change beliefs about intrusive thoughts and fears was also an important aspect of treatment. ERP treatment included having the women in the case studies put themselves in situations where the intrusive thoughts would be triggered and then refrain from engaging in any compulsive, ritualistic, or avoidant behaviour to reduce anxiety. Putting themselves in these triggering situations without compulsing allowed them to challenge the belief that having the thoughts meant they were going to act on them. While the case studies focused on women's recovery from postpartum OCD following CBT and ERP, these studies are limited to CBT with ERP treatment and did not examine women's experiences of recovery from postpartum OCD following counselling.

Therefore, future psychological treatment studies in addition to CBT and ERP in postpartum OCD are needed, particularly focusing upon mothers' perspectives of recovering from postpartum OCD, to identify what characteristics of psychological treatment are helpful for recovery. There is a dearth of research on postpartum OCD. The few studies that do exist primarily consist of quantitative studies that focus on the prevalence, frequency, symptomatology of intrusive thoughts among new parents, and corresponding behavioural responses wherein participants complete a diagnostic or semi-structured interview and questionnaires. Despite the published case studies for postpartum women with OCD, rich descriptions of women's experiences with postpartum OCD are lacking in the current research

literature as these studies have focused solely on CBT and ERP treatments. Moreover, it is challenging to locate phenomenological studies focused on mothers' lived experiences of postpartum OCD. More specifically, no published qualitative research studies exist that examine mothers' experiences of recovery from postpartum OCD following effective counselling. Due to the nature of intrusive thoughts, it is conceivable that women with postpartum OCD may feel criticized, judged, or ostracized by loved ones, healthcare providers, and the media. As a result, such negative judgment may impact women's self-concept and identity as a mother and lead to women with postpartum OCD feeling ashamed, guilty, humiliated, or incapable. The "not good enough" discourse for these mothers is ubiquitous.

Therefore, qualitative research beyond case studies is needed to learn more about postpartum OCD and how it specifically impacts women in order to provide effective counselling for this vulnerable population. In particular, more phenomenological research is required to better understand the complexity of the phenomenon of postpartum OCD and to inform effective counselling for women experiencing postpartum OCD. As such, I set out to explore the rich experiences of mothers who have recovered from postpartum OCD following effective counselling. The purpose of this study was to use interpretative phenomenological analysis (IPA) to examine mothers' lived experiences of recovery from postpartum OCD following effective counselling to fill the current gaps in knowledge surrounding key aspects of effective counselling that contribute to recovery in women with lived experience of postpartum OCD. The following central research question guided this study: What are the lived experiences of mothers' recovery from postpartum OCD following effective counselling?

Summary

In this chapter, I have reviewed and discussed the relevant research literature on postpartum OCD, including the published psychotherapeutic treatment studies on postpartum OCD to date. Although the current research literature on postpartum OCD psychological treatment studies focuses on effective treatment for postpartum OCD, these studies are limited to CBT and ERP treatments and do not specifically examine the key aspects of therapy that contributes to postpartum OCD recovery.

Chapter 3. Conceptual Framework

Given the homogeneity of postpartum OCD psychological treatment studies, and therefore a lack of mothers' experiences of postpartum recovery following effective counselling in the research literature, I conducted a qualitative study that focused on mothers' subjective experiences of recovery from postpartum OCD following effective counselling.

The current research study is rooted within a feminist and constructivist framework. Constructivism and feminism share common ontological tenets, including the idea that there are multiple realities that are constantly changing and shaped by social, cultural, and political contexts (Locher & Prugl, 2001; Mertens, 2015). From a constructivism lens, society influences how participants construct meaning in their lives and experiences. A central epistemological tenet of constructivism is the ideology that the researcher and participant engage in an active and collaborative research relationship wherein they inevitably influence one another (Guba & Lincoln, 1994; Mertens, 2015). It is openly acknowledged that the researcher inherently brings their own set of values, biases, beliefs, assumptions, knowledge, and experiences to the research process, which is viewed as a strength (Mertens, 2015). Therefore, an axiological framework requires the researcher to self-reflect on how their biases, values, perspectives, and cultural background influence their understanding of participants' lived experiences (Creswell & Poth, 2018). In addition, applying a feminist lens fits with the scope of this research as women continue to be subjected to structural inequalities and are systematically oppressed in society (Campbell & Wasco, 2000). In society, motherhood is often represented in an unrealistic way (Kleiman & Wenzel, 2010; Wong, 2012). For instance, the belief that all new mothers are selfless and filled with unlimited joy and love for their babies that it is not acceptable for mothers

to experience fatigue, sleep problems, depression, anxiety, or any other postpartum mental disorder. Mothers with postpartum OCD who do not meet society's motherhood standard experience marginalization secondary to feeling criticized and stigmatized (Wardrop & Popadiuk, 2013; Wong, 2012). This study provided the space for women to share their personal journey of recovery and have their voices heard in the hopes that sharing these experiences would be liberating and empowering. Given the inherent power differential in the researcher-participant relationship, equalizing this power differential in a feminist and constructivist research paradigm was important for ethically interacting with participants.

Chapter 4. Methodology

Interpretative Phenomenological Analysis

Qualitative research seeks to capture and understand how participants make meaning of their experiences (Creswell & Poth, 2018). This exploratory qualitative study was informed by interpretative phenomenological analysis (IPA), a qualitative research approach that positioned women who have recovered from postpartum OCD as being the "experts on their own experiences" and having expertise in the phenomenon of postpartum OCD (Reid et al., 2005, p. 20). This approach is aligned with the research question to examine women's experiences of effective counselling, which aimed to enhance knowledge about postpartum OCD and effective psychological treatment for women with postpartum OCD. IPA is comprised of three theoretical underpinnings, including phenomenology, hermeneutics, and idiography (Smith et al., 2009). Phenomenology is the philosophical study of the participant's world; to look through the subjective lens of the participant to authentically experience their perception, which is filtered through the societal lens (Smith & Osborn, 2009; Tuffour, 2017). Hermeneutics is the theory and method of interpretation or meaning through written, non-verbal, or verbal language (Tuffour, 2017). During data collection and analysis, while participants were making meaning of their experiences, the researcher attempted to interpret participants' meaning making, which is known as a *double hermeneutic* (Pietkiewicz & Smith, 2014). Meaning making is a dynamic process whereby the researcher is continuously open to interpreting and re-interpreting the meaning of participants' experiences when new information is revealed (Smith et al., 2009). Interpretative phenomenological analysis takes an inductive approach to research in that themes are derived from participants' meaning and interpretation of their own experiences (Pietkiewicz & Smith,

2014; Tuffour, 2017). Finally, idiography is fundamental to IPA as it focuses on capturing, in detail, an individual participant's unique and nuanced experience before themes are generated for all participants (Pietkiewicz & Smith, 2014; Tuffour, 2017).

An IPA approach fits with this research given its focus on exploring, describing, and interpreting the meaning and content of participants' subjective experiences of a phenomenon (Smith et al., 2009; Tuffour, 2017); in this study the researcher conducted an in-depth exploration to better understand postpartum OCD from the viewpoint of mothers who have recovered from postpartum OCD. This study is unique in that it used IPA to specifically examine mothers' experiences of recovery from postpartum OCD following effective counselling. Asking mothers to speak about their personal experiences with postpartum OCD in their own words, and have their stories heard by the researcher, emphasized the importance of the participant's voice in the research process. Moreover, mothers sharing their postpartum OCD experiences contributed to the development of rich descriptions of these experiences and helped fill the gaps in knowledge on mothers' recovery experiences with postpartum OCD following effective counselling.

A feminist constructivism research paradigm, informed by an IPA methodological approach, was well-suited for studying the phenomenon of postpartum OCD as the focus was on mothers' salient subjective experiences of motherhood and recovery from postpartum OCD, which are believed to have been shaped by larger society. The research question was framed broadly and openly to be consistent with an IPA approach (Smith & Osborn, 2009): What are the lived experiences of mothers' recovery from postpartum OCD following effective counselling?

Research Design

Interpretative phenomenological analysis (IPA) was employed in this study in order to position mothers, who have recovered from postpartum OCD, as being the "experts on their own experiences" and having expertise in the phenomenon of postpartum OCD (Reid et al., 2005, p. 20). As such, study eligibility required participants to have personally experienced postpartum OCD, participated in counselling to specifically address postpartum OCD, and considered themselves recovered from postpartum OCD following effective counselling. There are various definitions of recovery in the research literature and mothers who have experienced postpartum OCD may define recovery differently. In this study, recovery was defined as a period of six months or longer since participants had been distressed by intense intrusive thoughts. A phenomenological method of inquiry aligned with the study research question. This method aimed to enhance knowledge about the phenomenon of postpartum OCD and identify effective counselling processes for mothers with postpartum OCD. Qualitative one-on-one interviews allowed for each mother to speak about their personal experience with postpartum OCD in their own words and have their stories heard by the primary researcher. This process emphasized the importance of the participant's voice in this study and contributed to the development of rich descriptions of these experiences.

Participants and Recruitment

Eight female participants between the ages of 31 and 54 years participated in this study, including five participants who resided in Canada and three participants who resided in the United States. Seven participants were Caucasian and one participant was Asian Canadian. All participants were married, highly educated (education ranging from 16 to 18 years of schooling),

middle to upper class, and had one to three children. Participants were recruited from a purposive sample through online study advertisements, primarily the *Maternal Mental Health Progress in Canada* Facebook page. Interviews were conducted via Zoom (Zoom Video Communications Inc, 2018). In this study, a purposive sample was defined as individuals who have experienced the phenomenon of postpartum OCD. Seven participants were previously diagnosed with OCD by a registered mental health professional during the first year of the postpartum period. One participant personally identified as having gone through postpartum OCD (she was not formally diagnosed by a registered mental health professional). All participants reported having recovered from postpartum OCD following effective counselling.

In order to protect participants' confidentiality yet allow a sense of the mothers' voices, a pseudonym (i.e., a fictitious name) was assigned for each participant.

Yuki is a mother in her mid 30s with one child. She has experienced anxiety, OCD, and panic disorder since the postpartum period. Her intrusive thoughts started around two months postpartum and focused on a variety of themes, including fears of her or her baby developing an illness or disease and dying, dropping, throwing, or squeezing her baby too hard, and a need for symmetry or exactness. Before seeking help, Yuki lacked a desire to live and had considered suicide as an option.

Toni is a mother with two children in her mid 50s. She has a history of bipolar disorder and anxious worries about getting fired from her job and never finding a boyfriend or having a family before pregnancy. She began experiencing intrusive thoughts about stabbing her stomach with a knife eight months into her first pregnancy. She experienced OCD with her two living children and during her third pregnancy with her third child. She chose to terminate her third pregnancy due to experiencing intrusive thoughts about her physically harming her unborn child.

Her main obsessions were putting her baby in the oven, believing that she was not needed by her family or did not have a role in her family anymore, and driving her vehicle into incoming traffic or running over a pedestrian while she was driving.

Danica is a mother in her late 30s to with two children. Since childhood, she has experienced OCD, and since adolescence, she has had bouts of depression. She endured a traumatic birth experience with her first-born child that exacerbated her OCD. Her primary intrusive thoughts were fearing that her baby would suffocate or die from sudden infant death syndrome (SIDS) while she slept.

Cora is a mother in her early 40s with three children. She has experienced anxiety and OCD throughout her life, including with her third-born child. Her intrusive thoughts started around three weeks postpartum and related to throwing her baby down the stairs, running over her baby with her vehicle, and pushing her baby's soft spot on her head too hard.

Emma is a mother in her late 30s who experienced two miscarriages before having her two living children. She endured a traumatic birth experience with her first-born child and had difficulty bonding with her second-born child. She experienced depression, anxiety, and intrusive thoughts in the postpartum period with both of her living children. Her intrusive thoughts focused on others harming herself or her babies, such as being kidnapped, assaulted, attacked, abducted, or finding her baby dead.

Olivia is a mother in her early 30s with two children. Prior to the postpartum period of her first-born child, she had experienced anxiety but not OCD. After the birth of her first child, she had intrusive thoughts about someone breaking into her home while her partner was away and her needing to protect herself and her baby from danger.

Hannah is a mother in her early 30s with two young children. When she was younger, she experienced separation anxiety from her parents. Following the birth of her second child, she experienced postpartum depression, anxiety, rage, and OCD. Her intrusive thoughts started around three months into postpartum and involved self-harm, such as imagining herself holding a gun in her mouth, and shaking her baby or slamming her baby against a wall.

Charlie is a mother with three children in her early 30s. When she was a child, she was sexually abused. She experienced postpartum anxiety and OCD with all three of her children. With her third-born child, she experienced PPD and worsening of her anxiety and OCD. Her intrusive thoughts focused on her dropping her baby down the stairs, stabbing her baby with a knife, her baby becoming sick from germs, or her baby being in the dryer.

Data Quality and Trustworthiness

According to Lincoln and Guba (1985), evaluating data quality and trustworthiness in qualitative research involves establishing credibility, transferability, and confirmability. I enhanced and maintained credibility of this study by performing *member checks* of the themes and subthemes (Lincoln & Guba, 1985). The term *member checks* refers to the process of participants checking the accuracy and interpretation of their data (Lincoln & Guba, 1985). Following the interviews, participants were invited to comment on whether the preliminary recovery themes and subthemes resonated with their experiences and to provide general feedback on the recovery themes and subthemes. Participants were sent via email: (1) a figure of the postpartum recovery themes associated with counselling (see Figure 1), (2) a summary of the findings, and (3) three questions to answer for each corresponding theme and subtheme (i.e., does this match your experience? If yes, how? If no, why not? Do you want to change anything?

If yes, what do you want to change? Please be as specific as possible. Do you want to add anything? If yes, what do you want to add? Please be as specific as possible). Seven of eight participants (87.5%) provided feedback on the study results, which served as member checks for this study.

Transferability is established in qualitative research when the results of a study can be applied to other contexts (Lincoln & Guba, 1985). I was careful not to generalize the results of this study to other mothers' experiences of recovery from postpartum OCD following effective counselling. Instead, I emphasized mothers' accounts as a description of eight Canadian and American mothers' experiences of recovery from postpartum OCD following effective counselling.

Confirmability can be defined as "the extent to which the findings of a study are shaped by the respondents' [words] and not researcher bias, motivation, or interest" (Pandey & Patnaik, 2014, p. 5746). It is acknowledged in qualitative research that researchers bring their own set of values, beliefs, biases, assumptions, stereotypes, and worldview (i.e., how they view the world based on their cultural background, knowledge, and experience) to the research process, which impacts how researchers interpret and present study results. Reflexivity is a technique that enhances the confirmability of qualitative research (Palaganas et al., 2017). According to Pandey and Patnaik (2014), reflexivity is "an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process" (p. 5752). To foster reflexivity and a reflexive research design, I recorded my initial reflections and reactions, including my thoughts, feelings, questions, and observations on the interviews as well as identified and noted similarities or patterns across participant mentions as

memo documents in NVivo (Lincoln & Guba, 1985). This reflexivity contributed to the overall credibility and trustworthiness of this study (Doyle, 2012; Palaganas et al., 2017). Finally, I was directly supervised by a professional (i.e., Dr. Gina Wong) who has experience using IPA. Therefore, my research thesis supervisor acted as a second set of eyes for helping me interpret the data correctly to enhance the data quality and trustworthiness of this study. My supervisor reviewed one participant transcript to further verify the themes and subthemes for confirmability. My supervisor and I had weekly Zoom meetings between August 2020 and September 2020 with discussion over email thereafter reviewing the process of analysis, organizing and understanding the data, and collaborating on identifying, naming, remaining, and re-categorizing emerging themes in the data.

Ethical Considerations

This study was approved by the Athabasca University Research Ethics Board prior to initiating any study-related activities (see Appendices C and D). On August 10, 2015 (see Appendix E for certificate), the researcher completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE).

Informed Written Consent

Informed consent is an ongoing process; informed consent from participants was obtained and maintained throughout the research process. Mothers were invited to participate in this study and read the letter of information and informed consent form (see Appendices F and G), which explained the purpose of the research study, the responsibilities of research participants, possible risks and benefits, limits of confidentiality, and the rights of participants. Written informed consent was obtained by those wishing to participate in this study after reading

and understanding the consent form as well as having all questions answered to their satisfaction. Informed consent was maintained by ongoing verbal reaffirmation from participants.

Confidentiality and Anonymity

Participants' data was handled in a strictly confidential manner to ensure that participants were not personally identifiable in the dissemination of results (i.e., presentations, publications). The limits of confidentiality were clearly explained to participants during the informed consent process, which included participant disclosure of imminent risk of harm to self or others. I only asked and collected the information I believe I needed for this study. Pseudonyms were assigned to ensure participants were not identifiable. Any verbatim quotes from participants' interviews may be used with their pseudonyms in presentations, publications, and this final thesis document.

Emotional Trigger

During the course of this study, there was a possibility that the interview may be emotionally triggering for participants in bringing up unpleasant thoughts, feelings, or memories. However, I believed that the impact and benefit of participants sharing their experiences of recovery and effective counselling as well as having their voices heard was positive overall. At the time of informed consent, participants were provided with a list of mental health resources (i.e., counselling services) in their local communities as well as crisis telephone numbers that they could contact for emotional support.

Data Collection

This study was approved by the Athabasca University Research Ethics Board prior to the initiation of any study related activities.

Demographic Information Sheet

Basic demographic information for participants was collected including name, age, gender, country of origin, cultural background, marital status, total number of years of education, highest degree obtained, and current occupation (see Appendix A). Participants were asked the following questions: (1) How many pregnancies have you had? (2) Have you had any issues with fertility? (3) How many miscarriages have you had? (4) How many children do you have?; (5) What are the ages of your living child(ren)?; (6) Which child(ren) did you experience postpartum OCD with (i.e., 1st born, 2nd born, etc)? This information was collected to gain a better understanding of the study participants' cultural location.

Qualitative Interviews

Qualitative interviews are a common methodology in phenomenological research (Creswell & Poth, 2018). Semi-structured interviews are known as the most effective data collection instrument in IPA research studies because they allow the researcher to probe important areas that organically arise from the dialogue between the researcher and participant (Smith & Osborn, 2009). Individual interviews are easy to manage, allow the researcher to develop rapport with the participant, create an environment where participants can speak and have their voices heard, and allow for an intimate discussion (Reid et al., 2005). Individual semi-structured interviews were conducted via Zoom (Gray et al., 2020), a cloud video conferencing program (Zoom Video Communications Inc, 2018). Zoom is a secure, password protected program that does not store recorded meetings on their server unless opted in by the researcher. For this research, Zoom recordings were saved onto my password protected computer. Recordings were only accessible to myself and my supervisor and will be retained for 10 years from point of collection, at which time the recordings will be destroyed according to Tri-Council

policy recommendations. Interview dates and times occurred on one or two occasions depending on participants' preference and convenience. The interview process was guided by a list of proposed questions (see Appendix B). This interview guide provided space for me to ask follow-up questions and for participants to share what was important to them.

Data Analysis and Interpretation

Qualitative software, NVivo version 12 for Windows, was used to manage, code, and analyze data for emerging themes according to the IPA analytic process (Smith et al., 2009). Following completion of all participant interviews, I followed this data analysis process:

1. I transcribed two individual participant interviews to text, verbatim from Zoom recordings. I used Scribie.com to transcribe six interviews (due to time constraints).

2. I read each participant transcript individually line by line and recorded my initial reflections and reactions, including my thoughts, feelings, questions, and observations, on the interviews as memo documents in NVivo as part of the descriptive coding process. As I read each subsequent participant interview, I identified and noted similarities or patterns across participant mentions. I also conducted a linguistic perspective-taking in memo documents within NVivo as part of my reflections to further inform my descriptive coding and IPA analysis. Descriptive coding focused on the words participants used to describe their thoughts, feelings, and lived experiences (Smith et al., 2009). Linguistic coding considered how participants used language to convey content and meaning, including tone and volume of voice, emoting (e.g., laughter, cheerful, somber, tearful), pauses in speech (e.g., how they use silence), repeating content, and use of metaphors (Smith et al., 2009).

3. In NVivo, I re-read each individual transcript line by line and highlighted the text that I thought may be important, relevant, or become an important theme. I then created a new node (i.e., coding category) to include this text in, created a new sub-node within an already existing node, or added this text to an already existing node or sub-node to track the number of similar nodes or quality mentions across participants. The descriptive reflective comments in NVivo memos were used to inform the nodes and sub-nodes. Therefore, the highlighted text/descriptive coding served as confirmation for my developing themes.

4. Once all participant interviews were re-read and coded into various nodes and sub-nodes, I collapsed nodes by identifying nodes and sub-nodes that grouped together based on content similarity. For example, positive affirmations were collapsed with self-acceptance and self-empowerment statements due to the similarity in content. I also identified and removed outliers based on the frequency of mention (i.e., nodes and sub-nodes that were less frequently discussed by participants).

5. I identified, named, and rearranged coding categories based on chronological order (i.e., before seeking help, seeking help, after seeking help, recovery).

6. Given that the recovery theme category would help answer the study research question, I re-read through the individual transcripts one last time to ensure relevant and important recovery aspects were captured within the recovery category.

7. The themes and process of analysis was discussed with my supervisor whom reviewed one participant transcript to verify the recovery themes and subthemes for confirmability.

8. I identified where the preliminary themes were within the recovery theme category by writing each node and sub-node on individual sticky notes. Following this, I physically arranged and re-

arranged the sticky notes on my coffee table (like putting pieces of a puzzle together) to search for connections in the emergent themes.

9. Based on discussion, my supervisor and I collaboratively re-named or re-categorized preliminary themes. I reviewed each coding and sub-coding category in NVivo to confirm the nodes within each category were best suited to that category, and for those that were identified as being better suited for a different category, I moved the node or sub-node to the appropriate category.

10. Participant quotes for the recovery theme category were identified by reviewing the researcher's reflection memo documents as well as participant transcripts in NVivo to support and help define the preliminary recovery theme.

11. I created a document for the purposes of completing participant member checks using synthesized analyzed data (Birt et al., 2016; Harvey, 2015). My supervisor and I discussed what to include in this document before sending to participants.

12. I individually contacted participants via email to invite them to comment on whether the preliminary recovery themes and subthemes resonated with their experiences and to provide general feedback on the recovery themes and subthemes.

13. When all feedback was received from participants, I reviewed participants' comments, cross referenced the comments with existing themes and subthemes, and integrated comments into existing themes and subthemes, which further validated and formalized the study results. For instance, following participant feedback, it became clear to me that the words of affirmation subtheme were better suited to the self-acceptance subtheme so participant comments were integrated into the self-acceptance subtheme. This feedback from participants served as

synthesized analyzed data as a method of member checking to enhance credibility and trustworthiness of the study results.

Chapter 5. Results

To help contextualize the postpartum OCD recovery themes associated with counselling, it is important to note how mothers in the study personally defined postpartum OCD recovery. When mothers were asked for definitions of recovery, their responses reflected the following themes: (1) less frequent and intense intrusive thoughts; (2) acknowledgment and effective management of intrusive thoughts; and (3) no interference of intrusive thoughts with daily living. All mothers spoke about themselves effectively managing intrusive thoughts when they arise, for example, during times of stress or when feeling overwhelmed, so that these thoughts are no longer interfering with living their life (e.g., being able to "acknowledge" intrusive thoughts and "let them come and go").

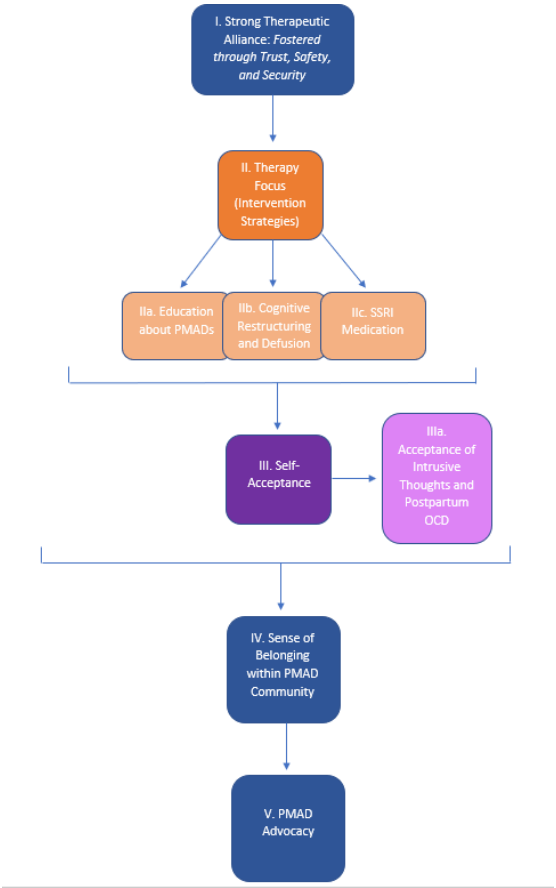
Postpartum OCD Recovery Themes and Subthemes Associated With Counselling

To answer the research question of: "What are the lived experiences of mothers' recovery from postpartum OCD following effective counselling?", five major themes and four subthemes of recovery associated with effective counselling were identified (see Figure 1). The first theme identified was (I) strong therapeutic alliance: fostered through trust, safety, and security. From the first theme, the second (II) and third (III) themes emerged. The second theme was therapy focus or intervention strategies. Within the second theme, three subthemes were determined, including education about PMADs (IIa), cognitive restructuring and defusion (IIb), and selective serotonin reuptake inhibitor (SSRI) medication (IIc). The third theme was self-acceptance and included one subtheme, which was acceptance of intrusive thoughts and postpartum OCD (IIIa). From the three themes of strong therapeutic alliance fostered through trust, safety, and security,

therapy focus (intervention strategies), and self-acceptance, a fourth theme (IV) emerged. The fourth theme was sense of belonging within PMAD community. As a result of this sense of belonging within PMAD community, a fifth theme (V) was determined, which was PMAD advocacy.

Figure 1

Postpartum OCD Recovery Themes and Subthemes Associated With Counselling



Theme I: Strong Therapeutic Alliance: Fostered Through Trust, Safety, and Security

All participants spoke about the importance of having a strong therapeutic alliance with their therapist as being central to their recovery. Within this theme, mothers specifically noted connecting with their therapist on cultural (e.g., ethnicity) and/or identity dimensions (e.g.,

motherhood, age, gender, lived experience of PMADs) and through their therapist providing a comfortable, secure, and safe space for them to share their fears and intrusive thoughts.

Shared cultural and identity dimensions helped participants connect with their therapist and, as a result, facilitated trust, openness, and vulnerability within the therapeutic relationship making postpartum OCD recovery possible. For instance, Yuki mentioned: “I would not be comfortable talking to a male psychologist about this topic…being able to relate to [a female] psychologist is important for the relationship, comfort, and the feeling of safety.” Yuki also shared that having a shared ethnicity with her psychologist was helpful for building trust and rapport with this psychologist:

> I think what really drove, I guess attracted me to her was that she also came from a similar ethnic background as me… so then I just thought, "Okay, this lady, she probably is going to understand some things without me explaining too much”…I think that somebody who was a mom and had experience in this, would be the ultimate package for a person who was going to deliver help to a mom that was postpartum. (Yuki, 2020)

Hannah noted: “My counsellor is the same age as me with young kids and related to the daily struggles. She also [has] gone through postpartum anxiety. Without having that connection, I wouldn’t have continued counselling” and “What was helpful the most was the counsellor I see, she hasn't gone through postpartum OCD, but she's gone through postpartum depression and anxiety so she could relate to what I was saying.” Another participant, Cora, noted that:

> She's from a small town right next to my small hometown…she didn't divulge a lot but she said anxiety is a beast [and that] she has struggled with that so I knew there was some common ground, that she's not just studying it and repeating things, she's lived it. I don’t know that she had intrusive thoughts herself, but just to know that she had struggled with

> some kind of postpartum [was important]. I certainly don't think I would have felt that comfort from a man or from somebody that wasn't a mother at the very minimum, but to know that she was a mom that has experience with postpartum issues just felt more real to me. (Cora, 2019)

Despite not knowing her therapist's personal experience with mental health or motherhood, Olivia felt that her therapist understood her experience and postpartum OCD: "She was very understanding. I don't know her story at all, I don't know if she has kids, but she seemed to really understand this diagnosis." Charlie reported that it was not necessary for her therapist to relate to her own experience, but more so that her therapist was emotionally attuned to her, understood her experience, and provided a safe space to share her thoughts and feelings while also instilling hope:

> I didn't need my therapist to have gone through my own experience, I just needed her to hear me, see me, make me feel safe in sharing my fears and intrusive thoughts and reassure me that I was capable of getting better. (Charlie, 2020)

Theme II: Therapy Focus (Intervention Strategies)

The establishment of a strong therapeutic alliance built on a solid foundation of trust, safety, and security, allowed for psychotherapeutic intervention strategies to be effective in helping mothers in their journey towards postpartum OCD recovery. These intervention strategies included education about PMADs (IIa), cognitive restructuring and defusion of thoughts (IIb), and SSRI medication (IIc). Participants expressed learning about intrusive thoughts and the names for the different postpartum disorders, how to view intrusive thoughts

from a different perspective to make them less relevant and powerful, and the importance of taking SSRI medication.

Subtheme IIa: Education About PMADs. All mothers reported how helpful it was for their therapist to name and provide education about the different postpartum disorders and, specifically, explain what intrusive thoughts were in the context of postpartum OCD. In addition to learning about PMADs from their therapist, four mothers described benefiting from different resources. These resources included maternal mental health websites, online articles and blogs authored by mothers with lived experience of PMADs as well as books and podcasts on PMADs.

Prior to seeking counselling, the majority of mothers shared that they were aware of postpartum depression and postpartum psychosis, but had not heard about intrusive thoughts or postpartum OCD. For example, Cora stated “I did not know it [postpartum OCD] existed. I had only heard about postpartum depression and postpartum psychosis…I didn't know there was any other variation.” Yuki echoed this: “I feel like I knew of the two extremes; I was aware of the blanket definition of depression and I also was aware of the very scary psychosis, but haven't really heard very much about OCD and postpartum.” Additionally, Yuki shared that learning about the spectrum of PMADs from her psychologist was particularly helpful: “She kind of explained to me about the names of some of these conditions without feeling labeled, which I think is a really important thing.” Charlie noted that her general practitioner introduced the concept of intrusive thoughts to her and named her experience as such: “She definitely said, "Yeah, intrusive thoughts. I was calling it, "I'm just not myself."

For Toni, not only had she not heard of intrusive thoughts or postpartum OCD, but also had not heard of postpartum anxiety prior to counselling: “Seriously, I've never heard of this in my whole life, I've never heard the term, postpartum anxiety…I knew about the baby blues,

postpartum depression, and postpartum psychosis, but had never heard about postpartum OCD." Hannah shared, "No one told me about this; that you could have intrusive thoughts about hurting your children." Danica reported that it was not until she sought counselling for intrusive thoughts that she learned that she had been experiencing OCD since childhood: "My therapist actually was like, "Well, that's your OCD", and I was like, "I don't have OCD. What are you talking about?" And so, she really had to educate me." Cora was fearful that what she was experiencing was postpartum psychosis until her therapist explained the difference between postpartum OCD and postpartum psychosis:

> In my head it triggered, "I'm not depressed so this is psychosis…I'm crazy and I'm going to hurt myself or somebody until she [her therapist] described intrusive thoughts so at least I knew that there was a name for it and that it wasn't psychosis. (Cora, 2019)

Emma noted: "I mostly learned about postpartum depression and anxiety, and that there is some overlay in the symptoms and how they present in the sense that my anxiety led to some pretty obsessive thoughts." Olivia highlighted the importance of education surrounding PMADs in helping to understand her own experience and treatment:

> It [postpartum depression and anxiety] can look so different in different settings and with different people. And so, just the education was so helpful in understanding what was happening and then how to treat it, and I just didn't have that understanding ahead of time. (Olivia, 2020)

Half of the participants also spoke about helpful educational resources that were recommended and shared by their therapist, such as articles and online blogs of mothers with lived experience of PMADs, and maternal mental health websites, podcasts, and books. For instance, Yuki noted:

One of the first things was she sent me some articles of other moms and I read them and learn[ed] that other people have experienced similar things to me that were not depression or psychosis." And then she kind of give me this podcast which I still listen to, which is the "Mom & Mind" one. (Yuki, 2020)

Hannah also shared how helpful it was for her therapist to recommend educational resources and for her to read online stories of mothers with similar experiences to her own:

> I understood it [postpartum OCD] more and got some different resources that I was able to read online that I could relate to…I was given the website postpartum progress that did have some first-person blogs people had written about [postpartum OCD]. (Hannah, 2019)

Toni noted that her therapist suggested she read a book on CBT and provided her with a handout with a list of unhelpful thinking patterns: "He would give me some resources…he recommended I read a book on CBT. He [also] gave me a sheet on twisted thinking…the twisted thinking and then the catastrophizing and everything else." Although not specifically introduced or provided by her therapist, Danica noted doing independent research on intrusive thoughts and discovering healing resources:

> I found Postpartum Support International online and I also read a bunch of blogs. I found Karen Kleiman [and] started reading her [Karen Kleinman's] books. I [also] took the two-day Components of Care training…that experience, too, was very healing because I felt like the more I learned the more blame I took off myself. (Danica, 2020)

Subtheme IIb: Cognitive Restructuring and Defusion of Thoughts. All participants shared how learning about PMADs and the nature of intrusive thoughts within the context of a strong therapeutic alliance facilitated cognitive restructuring and defusion of these thoughts.

Specifically, participants spoke about noticing and externalizing their intrusive thoughts, which helped them personally detach themselves and get distance from these thoughts.

For instance, Cora expressed learning that intrusive thoughts were ego-dystonic (i.e., intrusive thoughts, images, urges, and impulses are inconsistent with an individual's wants, wishes, desires, intentions, values, and sense of self) helped her de-identify with the thoughts:

> I learned a lot about ego-dystonic so that was also very helpful just to kind of help put it back into perspective [and] you don't need to be scared of thoughts; thoughts can't do anything. (Cora, 2019)

Toni also noted that education about intrusive thoughts from her therapist helped her to see these thoughts differently: "He [her therapist] told me thinking something and doing something are two different things, which gave me a great comfort." Similarly, Danica had created mantras based on learning about the nature of intrusive thoughts:

> I have my mantras like, "that's a thought, that's only a thought. Thinking it isn't going to make it come true or thinking it isn't going to keep it from coming true. I just have those kinds of things that I repeat to myself. (Danica, 2020)

Participants also spoke about noticing and externalizing their intrusive thoughts, which helped them to de-identify with the thoughts and feel more empowered. For instance, Yuki described the healing power of journaling her thoughts: "I think one of the most helpful things was her [her psychologist] telling me or introducing me to journaling…so this is a little journal I wrote for myself. I would say this is when I started feeling better." Hannah expressed how verbalizing the intrusive thoughts aloud to her counsellor helped her experience the thoughts as less powerful:

> When I started having those thoughts, my counsellor would make me say them out loud, which I hated doing because I just hated those words coming out of my mouth and hearing them, but after a while it gives it less power over you and that's one thing that she always had me do. (Hannah, 2019)

Danica also reported saying the intrusive thoughts aloud to her husband: “Telling my husband, "I'm having intrusive thoughts, I'm having scary thoughts about harm coming to our child.” Similarly, Cora described repeatedly writing out and verbalizing the thoughts aloud to her loved ones:

> She [her therapist] had me verbalize thoughts [intrusive thoughts] to my husband and my mother, in a very specific way, every time an intrusive thought came into my mind. I had to say, “I'm having an intrusive thought,” “Anxiety is telling me I want to throw my son down the stairs” and then I would describe it in detail every single time it came up. It was very, very repetitive. I would [also] write in very, very graphic detail about the thought, which gets it out of your head and makes it not so big and scary. The more that you can say it or write it [the intrusive thought], the less power it has overtime.” (Cora, 2019)

Charlie mentioned the power of recognizing and reminding herself that she was not her intrusive thoughts, which helped her to reframe the intrusive thoughts:

> When I was having those [intrusive] thoughts, I would recognize them and then work on telling my brain that it's not all you, that you are human. She [her therapist] has a whole system approach that she does and it really does work. It was about like, okay, so you're catching it. You're going to recognize and reframe it. I would actually say like, “Is this

> the truth? Is this absolute truth, or am I just running wild with my thoughts?" (Charlie, 2019)

Emma learned to creatively externalize her intrusive thoughts by identifying and labeling the thoughts as 'dementors' (Rowling, 1999):

> I started to refer to my intrusive thoughts as my Dementors, because they would suck me out, and I was paralyzed, and I couldn't get released from it. There's nothing that I could do for it. And then it would stop, and it was like the Dementor just dropped me, and I was left like a puddle on the ground. So, I often started referring to it that way. (Emma, 2020)

Emma then described practicing being curious about and witnessing her 'dementor' thoughts whenever they showed up as opposed to feeling controlled by them:

> One of the main things we did, and I still do sometimes when I'm overwhelmed, is just observe the feeling. So, it's like, "Oh, interesting. I'm having an intrusive thought." And I watch it versus have it flood me and take me over. So, I learned to catch them pretty early and just start to look at them and be like, "Oh, look. Yep, you're having this really weird, crazy thought again." And that helped a lot to differentiate me and separate me from it. And I could just let it be. (Emma, 2020)

Olivia shared how helpful it was for her therapist to recommend a mindfulness workbook and incorporate mindfulness exercises into the counselling process to stop her from compulsively ruminating:

> She [her therapist] got me to get this workbook, it was a mindfulness thing. It [the mindfulness workbook] gives you quiet meditations to read or go through, and then journal questions, kind of like CBT. I defined my ruminating and the [intrusive] thoughts.

> The workbook was really helpful, she [her therapist] just walked me through some of the, "What can you control and what can't you control? And the things that you can control, can you get those things done?" I only needed a couple of sessions in order to get the tools to stop the ruminating. (Olivia, 2020)

Subtheme IIc: SSRI Medication. As part of effective counselling, six mothers expressed that taking a SSRI medication was pivotal to their recovery. Despite her preference for natural treatment methods, Emma shared that SSRI medication helped stabilize her in her journey towards postpartum OCD recovery and to maintain her recovery:

> It [SSRI medication] helped me get my feet under me, so to speak. It's ideal…I don't have any side effects from it and I really am confident that it is like the piece that has held this together for me. I'm in no rush to get off it…the benefits of medication, no more intrusive thoughts and minimal anxiety, definitely outweighs my desire for natural healthcare. (Emma, 2020)

Toni described taking medication to treat her bipolar disorder and anxiety prior to experiencing intrusive thoughts during her first pregnancy. Therefore, although she was not specifically prescribed SSRI medication for OCD, she noted that her medication has helped with the intrusive thoughts and her overall sense of wellness.

Three mothers, Yuki, Hannah, and Cora, chose not to start taking SSRI medication in the beginning of their counselling journeys. Although reluctant at first to take medication due to fear and uncertainty surrounding how the medication would make her feel, which related to her intrusive thoughts about the possibility of being poisoned and dying, Yuki decided to start Zoloft after experiencing a severe panic attack during a social event. She noted, "intrusive thoughts are

really scary. The intrusive thoughts did not feel less powerful for me with the counselling intervention strategies alone. I needed the help of medication as well." Similarly, Hannah and Cora decided to start SSRI medication well into their counselling journeys when they stopped making significant gains in counselling. Hannah shared that in addition to helping with her OCD and anxiety, Zoloft helped with her postpartum rage and depression:

> I felt that I had made a lot of strides with counselling, but I felt like I just couldn't get over that last little hump or hill…the rage was awful and that was something I just couldn't control or get under wraps. I noticed some effects within 10 days to 2 weeks where it really helped with my intrusive thoughts, anxiety, and my postpartum rage (Hannah, 2019)

Cora also reported that, although her therapist was helpful, she began medication (Zoloft then later switched to Lexapro due to experiencing severe side effects, including suicidal ideation) after seeing her therapist weekly for three months and still suffering immensely: "My therapist was very helpful…I just wasn't getting the relief that I needed [from counselling]." Olivia revealed that SSRI medication helps to manage her mood and intrusive thoughts, and described the importance of taking her medication consistently to maintain her recovery:

> If I miss a dose in medication, I can feel it; if I'm just busy in the morning [and] I forget to take it, my mood will tank [and] I will have a few intrusive thoughts, or all of a sudden I'll think, "God, I'm a terrible mom. Man, I suck at this" and get really hard down on myself, and then I realize I forgot [to take] my medication this morning. (Olivia, 2020)

Unlike the six mothers above, Charlie described feeling "very reluctant" to take SSRIs for her intrusive thoughts due to experiencing fear about taking psychiatric medication and traditionally

having a preference for more natural treatment and healing methods. However, despite not taking medication as being primarily a personal choice for her, Charlie shared that she had felt guilty and selfish for not taking medication:

> Am I making a bad decision? I'm sure all kids want their moms just to be happy. So, was I being selfish in trying to work through this without the help of prescription medication? and I'm just like, "No, that's how I work, that's what I wanted to do. (Charlie, 2019)

Lastly, Danica was prescribed a benzodiazepine, Clonazepam, at the start of her postpartum OCD recovery journey, which she continues to take, though rarely, as needed.

Theme III: Self-Acceptance

Participants shared that having a strong therapeutic alliance, fostered through trust, safety, and security, coupled with interventions strategies brought them to a place of self-acceptance. Without the help of counselling, Hannah believed that her situation may have worsened: “I can’t imagine what things would be like for me now, or how worse they would have been, if I wasn’t able to go to counselling.” Prior to recovery, mothers who participated in this study described feeling “powerless,” “inadequate,” like “a complete and utter failure,” a “crazy person,” “a monster,” and held the belief that they “can’t do it [motherhood],” were “messing up motherhood,” and that this was “not a job that [they were] good at.” Mothers expressed that, during or following effective counselling, they learned to separate themselves from the intrusive thoughts they were having. As a result, mothers gained a better understanding of postpartum OCD while learning to accept the diagnosis of postpartum OCD and themselves as individuals living with postpartum OCD. As such, the self-acceptance subtheme was an important shift that mothers described.

Subtheme IIIa: Acceptance of Intrusive Thoughts and Postpartum OCD. As part of their journey towards self-acceptance, mothers described learning to accept the diagnosis of postpartum OCD, including the presence of intrusive thoughts. Six mothers described a shift in the way they spoke to and viewed themselves as women and mothers in their journey towards self-acceptance and postpartum OCD recovery. For example, participants commented on their improved confidence in their role as woman and mother. Words of affirmation they shared were: "I'm a good mom" (Cora and Yuki), "I'm doing a great job" (Charlie), "I'm trying my hardest" (Danica), and "I'm not crazy" (Hannah). Hannah indicated, "After coming to terms with postpartum OCD, I didn't feel like such a monster. I realized that I just needed help." Cora described learning to accept herself as someone who experiences postpartum OCD yet not being defined by this label: "Just learning, kind of relearning again, who I was I guess is the big part of it; part of the postpartum OCD [education] was just learning to not define myself by it." Yuki shared, "Understanding and accepting [intrusive thoughts and postpartum OCD] was the pivot point for recovery," and expressed accepting herself as someone living with postpartum OCD after reading an article about another mother's experience:

> I think it was when I read the article, then I really understood what it was and then realized that I had it too, because everything that the mom was explaining was what was happening or how I felt. So, it was actually through reading that, somebody else's experience specifically around OCD, that I realized that I have OCD. And then I was able to acknowledge or accept that this thing was happening to me and this is what it's called. (Yuki, 2020)

Hannah shared how she initially disagreed with her diagnosis of postpartum OCD as her experience did not align with traditional forms of OCD that she was familiar with:

> Everything I read was people who, after they had a thought or image, would check the locks or wash their hands, stuff like that, and I didn't have any of that so I didn't agree with that diagnosis [postpartum OCD] at first and then when I saw my current psychiatrist, she explained it a bit better to me, that it's more rooted in intrusive thoughts and images as opposed to the stereotypical OCD things like hand washing and counting. (Hannah, 2019)

Danica described a long personal journey towards accepting herself as someone with postpartum OCD, which in addition to therapy was further supported by continued learning:

> It actually took a while for me to accept it [having postpartum OCD] even at that point [when her therapist would name OCD during sessions], but reading and attending a PSI conference, and just the more I learned I was like, "Oh yeah, I have OCD. (Danica, 2020)

Through effective counselling, including the process of acceptance, Charlie learned to love herself again: “I love myself. I love myself. Yeah, I hadn't been able to say that in a long time, but I truly meant it, I love myself. And every day I wake up and I love myself.” Recovering from postpartum OCD following effective counselling helped Cora transform into a stronger, more likeable person:

> You know I always say Henry* [*name of child changed to protect confidentiality] saved my life because I'm a much different person now than I was when I got pregnant with him… I like myself a lot, lot more and I learned a strength I never knew I had. (Cora, 2019)

Similarly, Emma shared increased self-confidence and self-empowerment in her ability to manage intrusive thoughts which was supported by the strategies she learned in counselling:

> It feels like now it's just maintenance, like it's a part of me, but now I know and I have the ability and I have the support and I have the cognitive awareness and ability to be watching for it and to know what to do about it. (Emma, 2020)

Emma also detailed how critical it was in her recovery to integrate her past self with her current self in identifying as a mom with postpartum OCD:

> One of the things that helped me in my recovery has been integrating my new role as a mom. So, with Zion* [*name of child changed to protect confidentiality] especially, it was so hard for me to reconcile my old self with my new self. So, who I used to be was just gone. So not only was I managing depression, but it was also like, "Who am I now?" And so, with both of my kids, this really neat thing has happened. (Emma, 2020)

Yuki echoed this sentiment by stating, "I relate to the feeling of "being like different people" – the person before baby, the person after baby, and the newfound self once those two personas are combined." Yuki also described feeling like she could live again compared to, before recovery, when she had frequently experienced thoughts about not wanting to live anymore and doubting whether she could continue to live life feeling the way she did. She noted:

> When I was in one of those moments of extreme fear, I just...I didn't want to live, I was like, this is not living. I cannot move forward in my life if I have to spend the rest of it feeling like this and if this isn't going to stop. So that thought, that specific thought about not wanting to live, did come across all the time. Pretty much every time I was having one of those episodes, I was like, "I can't do this. This is not living, this is too scary. (Yuki, 2020)

Theme IV: Sense of Belonging within PMAD Community

Five participants spoke about the additive healing power of sharing their experiences with and relating to other moms, which created a sense of community and acted as a helpful companion to their individual counselling. Yuki shared, “Talking about having thoughts is already hard. Trying to talk to someone who has never experienced it, or someone who cannot relate to it is just another barrier.” Danica described feeling validated while listening to a professional talk at the Postpartum Support International annual conference:

> Meeting Karen Kleiman and going to one of her talks at that conference on OCD and seeing those MRIs of moms who were having intrusive thoughts, and that it was the protective part of their brain that was lighting up, I was just like, "Oh my gosh, this is what happened to me. These are my people. This is my life now." And that, I really felt like was just incredibly healing for me. (Danica, 2020)

Emma expressed feeling hopeful about recovery after receiving reassurance from a close friend who had recovered from a PMAD:

> Just that normalization that yes, somebody else that knows what it's like, knows how to talk about it, has been through it, and has come out the other side. That was really helpful, that she was just so reassuring, and she knew how to check in with me. Like, my other friends that just didn't know how to talk to me, she knew exactly what to say, and that was just very comforting. (Emma, 2020)

Hannah and Cora shared how personally healing it was for them to participate in a support group for new mothers. For instance, Hannah noted: “Being in a support group for

women with all PMADs was so beneficial for recovery. Postpartum OCD is hard to open up about, but there was another mom who had experienced it so I felt comfortable sharing." Cora commented on how normalizing, validating, and hopeful it was to connect with other mothers who had similar experiences:

> So just hearing other intrusive thoughts, that they can take all shapes and forms and, just being able to relate and to say to somebody, "I'm having this thought," there's something with knowing that that person knows without me saying how scary and debilitating it is...just being able to connect to other women that have those feelings…everybody is going to be at a different level of healing, and those that are a little bit farther along [in their healing journey] can give hope to those that are new to the process. (Cora, 2019)

Theme V: PMAD Advocacy

Feeling a sense of community with other postpartum mothers, six mothers described their desire for increased maternal mental health advocacy in general. Mothers indicated that having gone through the experience of postpartum OCD had ignited an interest in educating themselves and others on PMADs, expressing hope to other mothers, and helping other mothers experiencing PMADs. Charlie noted how important it was for her to educate new mothers on when to seek help based on her own experience of not getting help sooner:

> With my first and second one [children], nothing. And again, I don't even think I realized that until with my third one [child], it was really bad where it was like my body was screaming, like "Wake up! This is not normal. You need to figure this out." And so now I'm preaching it. Now I'm telling the world. After two weeks [postpartum], if you're not

> feeling like these certain things, it's not normal. That's what I wish everyone knew. (Charlie, 2019)

Hannah mentioned, “I am now in [a] place where I feel I am able to advocate for PMADs, although I do get triggered sometimes sharing my experience.”

Some mothers expressed a particular interest in not only educating others about maternal mental health in general, but also on postpartum OCD specifically, due to their own initial misunderstanding or unawareness of postpartum OCD. For instance, Toni noted, “I’ve never heard of this [postpartum OCD] in my whole life, I’ve never heard the term [postpartum OCD].” Toni wants other mothers, who were currently struggling with intrusive thoughts, to know that help is available and that they can get better:

> Before there's a beginning, there's an ending. And between the beginning and the ending, there's the wilderness where you'll have no idea where you are, and you just want someone to turn on the lights, and to help you. And look for people. Look for people to help you, because they're out there. (Toni, 2020)

Yuki stated the importance of helping mothers differentiate postpartum depression from postpartum OCD for increased awareness: “I think defining maternal mental health as a whole and differentiating that from just postpartum depression is important for understanding and education.”

Some participants shared that their counselling journey was partly a springboard for pursuing professional work in PMADs to help support other women. For example, Danica indicated, “Yeah. So, it was healing, and I think it also kind of kick-started me wanting to get into this work.” Cora also expressed wanting to help other mothers, particularly mothers who

were seeking help for the first time, so that they would have a more helpful encounter with a healthcare professional than what she had had when she first approached a nurse for help:

> Right about at two years, it wasn't immediate, I just noticed a lift, and umm, that's when I decided that I wanted to start helping other women, umm, that are going through it so they don't get that phone call where they say, you know, someone says "just relax" or, you know, where maybe thoughts are approached differently than, "Do you want to hurt yourself or your child?" (Cora, 2019)

Cora recalled feeling "defeated" when the nurse she had spoken to was unaware of intrusive thoughts and does not want any mother to feel this way when seeking help.

Chapter 6. Discussion

The aim of this study was to conduct an IPA to examine mothers' lived experiences of recovery from postpartum OCD following effective counselling. We found five main factors contributed to postpartum OCD recovery following effective counselling in participants, which were a strong therapeutic alliance; intervention strategies including PMADs education, cognitive restructuring and defusion, and SSRI medication; self-acceptance; sense of belonging within PMAD community; and PMAD advocacy.

Participants noted the importance of a strong therapeutic alliance and their therapist providing a trusting, safe, and secure space for them to share their experiences. These findings are well supported in the counselling research literature (Bachelor & Horvath, 1999; Norcross & Lambert, 2011) and suggest that a strong therapeutic alliance is the foundation for effective counselling. Given the increased stigma and shame associated with psychiatric illness during the postpartum period, it appears that a strong therapeutic alliance was the conduit within counselling that helped mothers with postpartum OCD in the study engage in the intervention strategies. Furthermore, some participants discussed connecting on cultural (e.g., ethnicity) and/or identity (e.g., motherhood, age, gender, personal experience of PMADs) dimensions with their therapist as an important factor in their counselling journey towards postpartum OCD recovery. Although some research has shown shared cultural identities between therapist and client lead to positive client outcomes in counselling (e.g., Flaskerud & Liu, 1991; Kuldhir, 2014), the consensus is that cultural match between therapist and client does not significantly impact therapy outcomes (Ilagan & Heatherington, 2021). However, for mothers who have recovered from postpartum OCD in this study, there was a strong preference for shared cultural

and/or identity variables with their therapist, which suggests that factors such as shared gender, ethnicity, age, motherhood, and experience of PMADs helped these mothers connect with their therapist on the journey towards postpartum OCD recovery.

Mothers also cited the therapy focus on education about PMADs, cognitive restructuring and defusion of intrusive thoughts and beliefs, and SSRI medication as contributing to their postpartum OCD recovery. Specifically, participants recognized learning about the nature of intrusive thoughts and PMADs, specifically postpartum OCD, as particularly helpful. Psychoeducation is an important component of CBT treatment for various psychological conditions, including OCD. Moreover, mothers shared how helpful it was to receive resources from their therapist connecting them to mothers' PMAD stories via blogs, articles, or podcasts (i.e., *Mom and Mind* podcast). The *Mom and Mind* podcast is hosted by a certified specialist in perinatal mental health and PMADs, and connects individuals to a supportive maternal mental health community wherein they can hear others' experiences with PMADs, including postpartum OCD, and their healing journey. Psychoeducation and accompanied resources seemed to be a catalyst in increasing participant willingness to reframe their intrusive thoughts and engage in cognitive defusion practices. There is a large body of research showing evidence for the effectiveness of acceptance and commitment therapy (ACT) in the treatment of OCD (Bluett et al., 2014; Phillip & Cherian, 2021). ACT is a psychological treatment approach that aims to increase psychological flexibility by helping clients be more present and notice and allow difficult thoughts and feelings so that they can take action on what is important to them (Hayes et al., 1999). There are six key processes of change in ACT, which include awareness of the present moment, cognitive defusion, acceptance, self-as-context, values, and committed action (Hayes et al., 1999). Cognitive defusion is a skill used to detach or separate from distressing thoughts and

feelings (Hayes et al., 1999). Given the abundance of research support for ACT in OCD treatment and how cognitive defusion is a key intervention in ACT, it is unsurprising that participants in this study found cognitive defusion to be effective in helping them relate differently to their intrusive thoughts. As part of effective counselling, the majority of mothers in the study highlighted the role of SSRI medication as another key factor in their postpartum OCD recovery. SSRIs are well known as an effective pharmacological treatment for OCD (Soomro et al., 2008). Moreover, from the authors' clinical experience in working with mothers with postpartum OCD, SSRIs have made a substantial difference in contributing to effective counselling in this population. Overall, the intervention strategies were central to mothers' postpartum OCD recovery as they also helped move participants towards self-acceptance.

Participants developed greater acceptance for themselves as mothers experiencing postpartum OCD and for the intrusive thoughts they were having and counselling served as a conduit for these shifts. Prior to effective counselling, mothers were unaccepting of their intrusive thoughts and felt defined by them. Through the counselling process, mothers became accepting of their intrusive thoughts and, by extension, postpartum OCD after learning to separate these thoughts from the core of who they are. As a result of this self-acceptance, mothers felt a sense of belonging to the PMAD community through sharing of their own experiences with postpartum OCD and hearing other mothers' postpartum OCD experiences. As such, the majority of mothers who participated in this study expressed their desire to become maternal mental health advocates in recovery from postpartum OCD.

Implications for Practice

Results of this study make an important contribution to the maternal mental health community and fill an important gap in knowledge regarding key aspects of counselling that

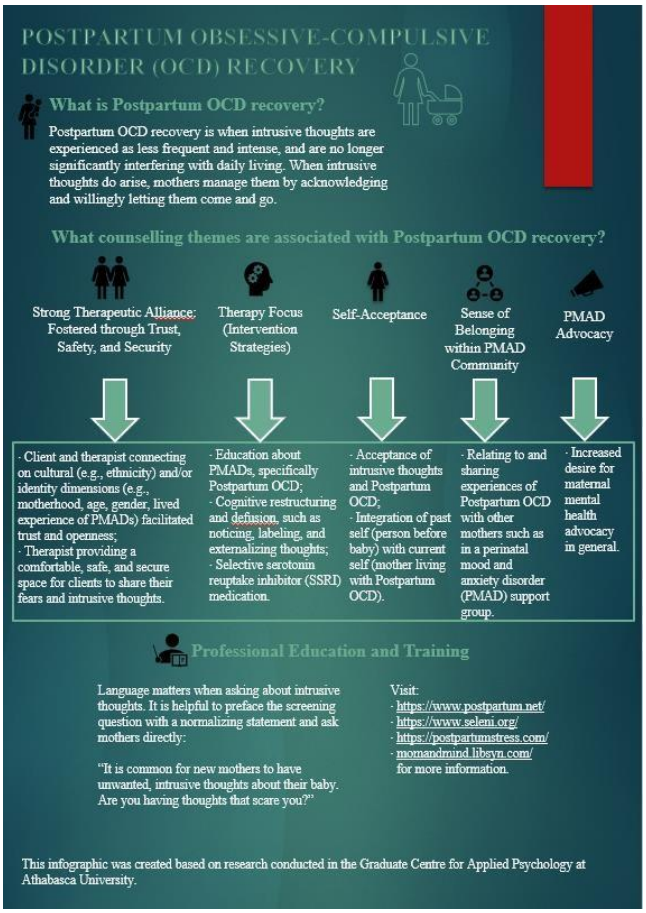
contribute to recovery in mothers with experience of postpartum OCD (see Figure 2). The key elements that were associated with effective counselling and laid the groundwork for later postpartum OCD recovery were a strong therapeutic alliance, fostered through trust, safety, and security, intervention strategies focused on PMADs education, cognitive restructuring and defusion of thoughts, and SSRI medication. In addition, self-acceptance, a sense of belonging within the PMAD community, and PMAD advocacy were also prominent as a result of a strong therapeutic alliance and the intervention strategies. Based on study findings, it is suggested that mental health professionals working with women experiencing postpartum OCD incorporate ACT interventions that help build cognitive defusion, acceptance, and mindfulness skills.

Findings of this study also showed that it matters how healthcare providers ask about the presence of intrusive thoughts and that, before doing so, trust and rapport must be developed and the mother needs to feel safe to disclose the intrusive thoughts that she is experiencing (see Figure 2). That is, healthcare providers should ask, “Are you having thoughts that scare you?” or “Do you have any thoughts that scare you?” and should refrain from saying, “Are you thinking of harming your baby?” or “Do you have thoughts of hurting your child?” It is critical for healthcare workers who are working alongside mothers experiencing postpartum OCD to provide education about the spectrum of PMADs and the nature of intrusive thoughts in postpartum OCD (e.g., that these thoughts are ego-dystonic) to help mothers begin to de-identify with the intrusive thoughts and develop acceptance for having postpartum OCD and the intrusive thoughts. Relatedly, healthcare providers should share with mothers that postpartum OCD is common and treatable. Findings of this study also support providing helpful resources on PMADs and connecting mothers with other others experiencing PMADs and the wider maternal

mental health community through sharing of blogs, articles, podcasts, or local support groups. Finally, given the lack of knowledge about PMADs and the pervasive stigma surrounding maternal mental health, formal training in PMADs is highly recommended for healthcare workers wishing to work with women with PMADs. The Postpartum Support International (PSI) (https://www.postpartum.net/) offers a two-day components of care course on PMADs, the Seleni Institute (https://www.seleni.org/) offers an intensive course on maternal mental health, and The Postpartum Stress Center (https://postpartumstress.com/) offers training on *The Art of Holding* (Kleiman, 2017). At a minimum, professional consultation with a PMAD specialist such as a PSI trained professional (these professionals will have the 'PMH-C' designation, which stands for 'Perinatal Mental Health Certification') is highly encouraged.

Figure 2

Postpartum OCD Recovery Infographic for Counsellors and Psychologists Working With Women With Postpartum OCD



Note. Infographic for counsellors and psychologists of the recovery process for mothers with postpartum OCD.

Benefits, Limitations, and Future Directions

The benefits and limitations of this research will be presented. Suggestions for future directions based on study findings will also be provided.

Benefits

Benefits of this study included an opportunity for participants to share their lived experiences of recovery and effective counselling as well as have their voices heard, which may be liberating and empowering. Although there was no guarantee that participants would benefit directly from participating in this study, the impact of participants sharing their experiences may help mothers currently struggling with postpartum OCD feel less alone and seek help. Providing rich descriptions of mothers' lived experiences with postpartum OCD following effective counselling may also better inform healthcare providers about postpartum OCD and encourage them to learn about effective treatment for this debilitating condition.

Limitations

A methodological limitation of this study may include a perceived small sample size from proponents of quantitative research or different research paradigms. From a qualitative research perspective, a large sample size and result generalizability are not the goals of an IPA approach and therefore was not the goal of this study. For a qualitative study, whose norm is five to 10 participants, having eight participants included in this study was acceptable. The constructivist/interpretive research paradigm views detailed, rich descriptions of participants' individual experiences as a strength and, therefore, does not reduce the meaning and importance of these subjective experiences to numbers or generalities. The in-depth exploration of lived experiences as told by mothers' voices is critical to better understanding the complexity and underexplored phenomenon of postpartum OCD. Another potential limitation of this study was the risk of misinterpreting the meaning of participants' lived experiences. While researcher interpretation is acknowledged and transparent within IPA, to enhance and maintain the quality of study data, member checks of the themes and subthemes were completed where participants

were provided with a figure of the themes and subthemes of recovery (see Figure 1), a summary of the findings along with interview quotes, which represented the themes and subthemes, and invited to provide detailed comments. Where applicable, I made revisions to the data and provided additional details regarding the results. This validation improved the accuracy, credibility, and confirmability of the study. Finally, the participants in the study comprised of a homogeneous group as all participants were female, married, middle to upper class, highly educated, and all but one participant identified as Caucasian.

Future Directions

The current study identified how critical it is to build a strong therapeutic alliance fostered through trust, safety, and security when working with women experiencing postpartum OCD. A strong therapeutic alliance was shown to lay the foundation for the intervention strategies and for later postpartum OCD recovery. When study participants did not feel safe or secure or were mistrusting of a healthcare provider, it prevented women from receiving the psychological treatment they deserved and needed. Therefore, our findings are an important reminder for healthcare professionals providing postpartum OCD treatment not to underestimate the power of a solid therapeutic relationship. Future studies should treat the therapeutic alliance as an important necessary element in helping women recover from postpartum OCD. With the exception of the current study, the psychological treatment studies published on postpartum OCD to date have solely focused on CBT with ERP treatment. The findings from the current study found that ACT interventions aimed at increasing cognitive defusion, acceptance, and mindfulness skills helped contribute to postpartum OCD recovery. Therefore, future psychological treatment studies should consider utilizing ACT interventions with mothers experiencing postpartum OCD. Given how the majority of study participants identified as

Caucasian, were married, and had a higher socioeconomic status, future qualitative studies would benefit from including a more diverse participant sample. We hope this study will generate future qualitative research inquiry into the lived experiences of mothers who have recovered from postpartum OCD following effective counselling to enhance awareness, education, and training surrounding postpartum OCD and its effective treatment.

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Appendix A: Demographic Information Sheet

Study Title: Postpartum Obsessive-Compulsive Disorder: Mothers' Lived Experiences of Recovery Following Counselling

Researcher: Marissa Williams, M.Sc. (Athabasca University, Graduate Centre for Applied Psychology, mwilliams2@athabasca.edu)

Supervisor: Dr. Gina Wong (Athabasca University, Graduate Centre for Applied Psychology, ginaw@athabascau.ca or 1-866-442-3089)

Name:

Age:

Gender:

Country of Origin:

Cultural Background:

Marital Status:

Total Number of Years of Education:

Highest Degree Obtained:

Current Occupation:

How many pregnancies have you had?

Have you had any issues with fertility?

How many miscarriages have you had?

How many children do you have?

What are the ages of your living child(ren)?

Which child(ren) did you experience postpartum OCD with (e.g., 1st born, 2nd born, etc)?

Appendix B: Proposed Qualitative Interview Questions

1. What were your own expectations of being a new mother? What do you believe the expectations are of a new mother?

2. What is your understanding of postpartum OCD?

3. How did you think about yourself as a mother experiencing postpartum OCD? Was this consistent or inconsistent with the societal expectations of a new mother?

4. How did you feel about yourself as a mother experiencing postpartum OCD? Was this consistent or inconsistent with the societal expectations of a new mother?

5. Have you ever experienced symptoms of OCD prior to the postpartum period? If so, when? Describe the symptoms of OCD you experienced (i.e., mentally, emotionally, and physically).

6. When did you first experience symptoms of postpartum OCD (you may not have recognized them as symptoms of OCD at the time)?

7. If you feel comfortable sharing, can you describe some of the intrusive thoughts/images or compulsive behaviours you experienced? Were they similar or different to #3 if you had experienced OCD prior to the postpartum period?

8. Who did you tell? How did they respond? Did you feel supported about postpartum OCD by your significant other (if applicable), family, and friends?

9. Did you seek information online? If so, any particular networks or groups?

10. What led you to seek counselling? What was the time period between when you considered seeking counselling and when you made an appointment for counselling? Did anything stand in the way of seeking help? Who did you seek counselling from?

11. What was it about counselling that helped?
    a. What was it about counselling that helped with recovery?
    b. What was unhelpful about counselling? What was it about the counselling that made it unhelpful?
    c. How long did it take for you to recover from postpartum OCD or feel like yourself again?
    d. In hindsight, are you satisfied with your decision to seek counselling for postpartum OCD? What were the reasons you felt satisfied with your decision to seek counselling?

12. What else helped with recovery besides counselling?

13. Were you ever formally assessed for postpartum OCD? If so, how many weeks or months postpartum were you? Which professional did the assessment?

14. Were you ever formally diagnosed with postpartum OCD? If so, how many weeks or months postpartum were you? Which professional gave you the diagnosis? How did you feel about the diagnosis?

15. Were you ever misdiagnosed? If so, when, with what, and by whom?

16. Were you ever hospitalized for postpartum OCD? If so, when and for how long?

17. If you feel comfortable sharing, did you ever consider ending your own life?

18. What do you wish healthcare providers knew about postpartum OCD and women experiencing postpartum OCD?

19. What would you want other mothers, who are currently struggling with postpartum OCD, to know?

Appendix C: Certification of Research Ethics Board Approval

The Athabasca University Research Ethics Board (AUREB) has reviewed and approved the research project noted below. The AUREB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS) and Athabasca University Policy and Procedures.

Ethics File No.: **23521**

Principal Investigator:
Ms. Marissa Williams, Graduate Student
Faculty of Health Disciplines\Master of Counselling

Supervisor:
Dr. Gina Wong (Supervisor)

Project Title:
Postpartum Obsessive-Compulsive Disorder: Mothers' Lived Experiences of Recovery Following Counselling

Effective Date: July 22, 2019 **Expiry Date**: July 21, 2020

Restrictions:

Any modification or amendment to the approved research must be submitted to the AUREB for approval.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

A Project Completion (Final) Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date:** July 22, 2019

Carolyn Greene, Chair
Athabasca University Research Ethics Board

Athabasca University Research Ethics Board
University Research Services, Research Centre
1 University Drive, Athabasca AB Canada T9S 3A3
E-mail rebsec@athabascau.ca
Telephone: 780.675.6718

Appendix D: Certification of Research Ethics Board Approval Renewal

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: **23521**

Principal Investigator:

Ms. Marissa Williams, Graduate Student

Faculty of Health Disciplines\Master of Counselling

Supervisor:

Dr. Gina Wong (Supervisor)

Project Title:

Postpartum Obsessive-Compulsive Disorder: Mothers' Lived Experiences of Recovery Following Counselling

Effective Date: June 16, 2020 **Expiry Date**: June 15, 2021

Restrictions:

Any modification or amendment to the approved research must be submitted to the AUREB for approval.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

A Project Completion (Final) Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: June 16, 2020**

Carolyn Greene, Chair

Athabasca University Research Ethics Board

Athabasca University Research Ethics Board

University Research Services, Research Centre

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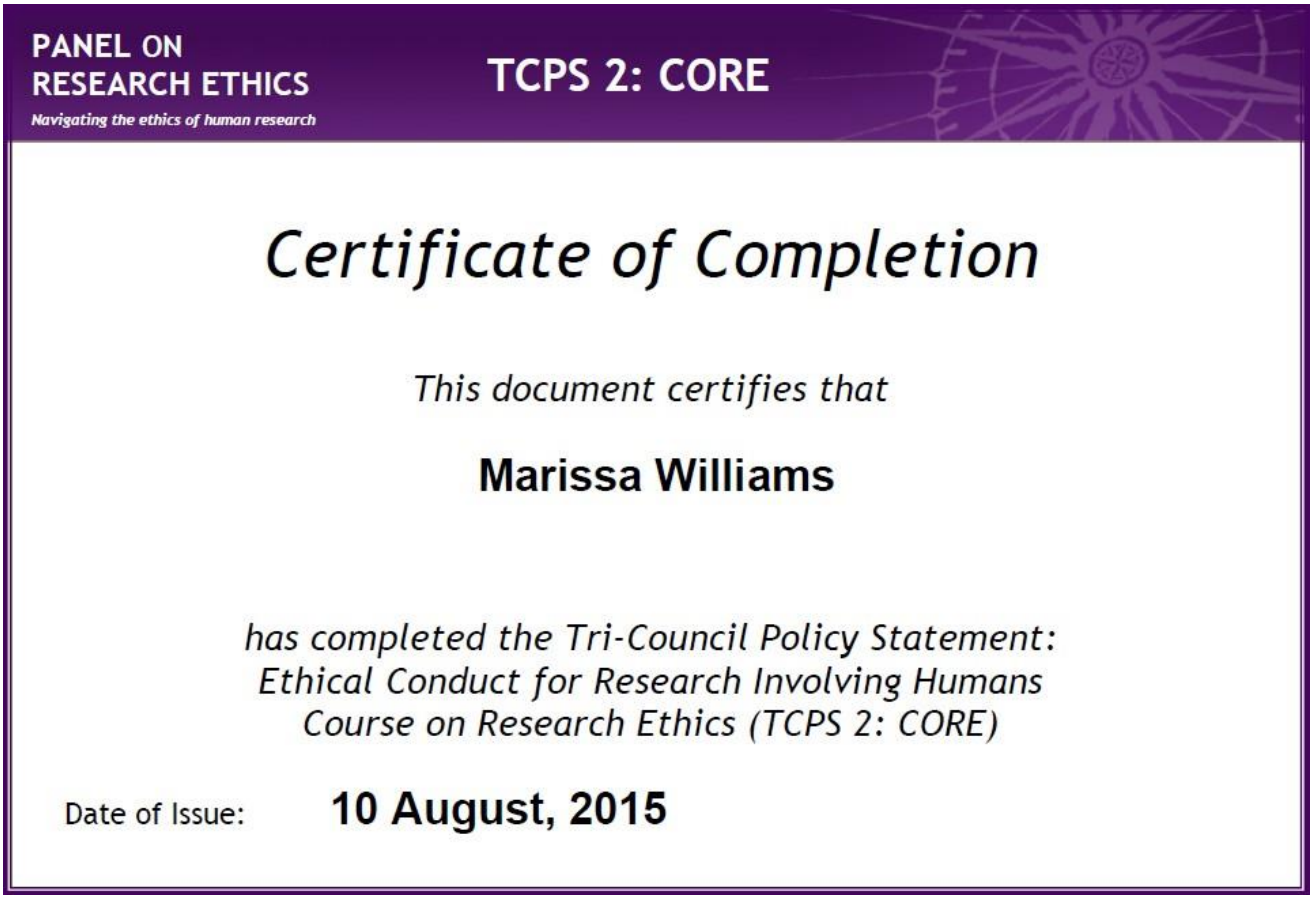
Appendix E: Tri-Council Policy Statement Certificate



PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Marissa Williams

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **10 August, 2015**

Appendix F: Letter of Information

Study Title: Postpartum Obsessive-Compulsive Disorder: Mothers' Lived Experiences of Recovery Following Counselling

Researcher: Marissa Williams, M.Sc. (Athabasca University, Graduate Centre for Applied Psychology, mwilliams2@athabasca.edu)

Supervisor: Dr. Gina Wong (Athabasca University, Graduate Centre for Applied Psychology, ginaw@athabascau.ca or 1-866-442-3089)

INFORMED CONSENT

This form explains the purpose of this research study, provides information about what happens in the study, possible risks and benefits, and the rights of participants.

Please read this form carefully and ask any questions you may have. You will have this form and all information concerning the study explained to you. You may take as much time as you wish to decide whether or not to participate. Please ask the researcher to clarify anything you do not understand or would like to know more about. Make sure all your questions are answered to your satisfaction before deciding whether to participate in this research study.

Participating in this study is your choice (voluntary). You have the right to choose not to participate, to stop participating in this study at any time, or to respond to certain questions only.

INTRODUCTION

You are being asked to consider participating in this study because you have experienced and recovered (i.e. six months or longer since you have been distressed by intense intrusive thoughts) from postpartum obsessive-compulsive disorder (OCD). Postpartum OCD is characterized by intrusive, unwanted, distressing, and repetitive thoughts or images (obsessions) and/or behavioural or mental rituals (compulsions) that the mother feels driven to perform (American Psychiatric Association, 2013). The content of intrusive thoughts that are experienced by mothers with postpartum OCD vary widely but are often related to the mother's fears of accidentally or deliberately harming their baby (Hudak & Wisner, 2012).

Postpartum OCD is the most widely misunderstood and under-recognized mental disorder in the postpartum period (Postpartum Support International, 2015). It is estimated that approximately 2.4% of mothers in North America experience postpartum OCD (Russell, Fawcett, & Mazmanian, 2013). This is likely an underestimate given the stigma that is associated with postpartum OCD, which prevents mothers from seeking help and receiving timely treatment.

WHY IS THIS STUDY BEING DONE?

The purpose of this study is to learn about your unique experiences with OCD during the postpartum period and share your story of recovering from OCD. While some research has been done, rich descriptions of women's experiences with postpartum OCD are lacking in the current research literature. Moreover, there is a lack of awareness, education, and training surrounding postpartum OCD and its treatment.

We want to find out how your past counselling experiences helped in your recovery (e.g., what was it about counselling that helped, who did you seek counselling from, what was unhelpful, what do you wish healthcare providers knew about postpartum OCD?). We also want to find out what else helped in your recovery besides counselling.

The results of this study will help doctors, nurses, psychologists, counsellors, and other professionals to better understand how to help women with postpartum OCD. This study will also hopefully help those who are currently struggling with postpartum OCD to seek the help they need.

WHAT WILL HAPPEN DURING THIS STUDY?

If you agree to participate, you will complete a brief demographic information sheet, which will include age, cultural background, marital status, to name a few. You will also complete a two-hour interview with the researcher. This interview is designed to hear your story and experiences with OCD during the postpartum period, and will include questions on: experiences of OCD, expectations of a new mother, and past counselling experiences, among others. This interview can take place on one or two occasions depending on your preference and what is most convenient for you. The interview will be recorded on Zoom, a cloud video conferencing program, to ensure accuracy in transcribing information. Zoom is a secure, password protected program that does not store recorded meetings on their server unless opted in by the researcher. For this research, Zoom recordings will only be saved onto the researcher's password protected computer.

After the interview, your interview transcript will be sent to you within a month so that you can fill in possible gaps, clarify statements, and ensure that the researcher has accurately captured and interpreted your experiences. At that time, you will have the opportunity to ask any further questions and include any additional information to your interview transcript that you believe is relevant. The researcher may also ask you further questions to help her better understand your experiences.

A follow-up interview may be scheduled. During this second interview, you will be able to see what themes the researcher has identified and check these themes for accuracy. The researcher will request your feedback and incorporate it into the study. If you disagree with any interpretations the researcher has made, you will be able to work with her to revise it. You will be able to ask the researcher any questions you have about the study. This follow-up interview will take a maximum of one hour and will be scheduled for a date and time that is most convenient to you. The recordings, transcripts, and all other information collected about you for

the purposes of this study will only be accessible to you, the researcher, and her supervisor, Dr. Gina Wong. All email communications will be kept private and confidential.

HOW MANY WOMEN WILL TAKE PART IN THIS STUDY?

It is anticipated that 7-9 women will participate in this study throughout Canada. The length of the interview for this study is about two hours. The entire study is expected to take about 1 year to complete and the results should be known in 1.5 years.

The results of the study will be available following the completion of the study should you be curious. You will not be personally identified in the dissemination of results (i.e., presentations, publications).

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

There are some potential risks associated with participating in this research study that you should be aware of.

There is a possibility that the interview may be triggering for you and bring up unpleasant thoughts, feelings, or memories. However, we believe that the impact/benefit of people sharing their story of recovery and having their voice heard will be positive. If you decide to take part in this study and experience overwhelming or uncomfortable feelings or thoughts, you may choose to pause, have the interview rescheduled for another time, or withdraw from the study. Before the interview (e.g., at the time of informed consent), you will be provided with a list of mental health resources (e.g., counselling services) in your local community as well as crisis telephone numbers that you can contact for support.

Another potential harm of the study is that the interview will be recorded to ensure that your story and experiences are accurately portrayed in the research findings. Whenever an interview is recorded, there is a theoretical risk that the information is accidentally accessed by someone who does not have permission to access the files. Interview recordings will be password protected and stored on the researcher's password protected computer. Transcripts and other digital files relating to the study will also be password protected and stored on the researcher's password protected computer.

If you have specific questions about the study, please feel free to contact Dr. Gina Wong (Athabasca University, Graduate Centre for Applied Psychology, ginaw@athabascau.ca or 1-866-442-3089).

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

You may or may not benefit directly from participating in this study. A potential benefit of participating in this study is that you will be sharing your story of recovery and having your voice heard, which can be liberating and empowering. Your participation may or may not help

other women with postpartum OCD seek help in the future and inform counsellors, psychologists, and psychiatrists about effective treatment for postpartum OCD.

WHAT OTHER CHOICES ARE THERE?

If you decide not to participate in this study, you will not be required to complete the interview or study procedures.

CAN PARTICIPATION IN THIS STUDY END EARLY?

You can choose to end your participation at any time without having to provide a reason. If you choose to withdraw, there will be no negative consequences for doing so.

You may withdraw your consent at any time. If you withdraw your consent, the information about you that was collected before you left the study may still be used if data was already analyzed. No new information about you will be collected without your permission.

WHAT ARE THE COSTS OF PARTICIPATING IN THIS STUDY?

Participation in this study will not involve any additional costs to you.

By signing this consent form, you do not give up any of your legal rights.

ARE STUDY PARTICIPANTS PAID TO PARTICIPATE IN THIS STUDY?

This study is completely voluntary. Therefore, you will not be paid to participate in this study.

HOW WILL MY INFORMATION BE KEPT CONFIDENTIAL?

You have the right to have any information about you and your health that is collected, used, or disclosed for this study to be handled in a confidential manner. If you decide to participate in this study, the researcher will ask and collect only the information they need for this study.

Interview recordings will be password protected and stored on the researcher's password protected computer. Transcripts and other digital files relating to the study will also be password protected and stored on the researcher's password protected computer.

Email or telephone correspondence with the researcher will be kept private and confidential. All confidential information will be accessible only to the researcher, Marissa Williams, and her supervisor, Dr. Gina Wong. Data will be retained for ten years from point of collection, at which time it will be destroyed according to Tri-Council policy recommendations. After ten years, digital copies of data files stored on the researcher's computer will be erased using a software application (e.g., Eraser) that is designed to overwrite data files rendering them obsolete.

All information that you provide will be held strictly confidential, except when legislation or a

professional code of conduct requires that it be reported (e.g., imminent risk of harm to yourself or someone else). Your name will not be attached to your interview transcript. Instead, you may choose a pseudonym, or one will be assigned to your data files that will be used to identify them.

When the results of this study are disseminated, your identity will not be disclosed. Quotes from your interview may be used, but you will not be identified.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please contact Marissa Williams (Athabasca University, Graduate Centre for Applied Psychology, mwilliams2@athabasca.edu).

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You have the right to receive all information that could help you make a decision about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction, before you make any decision. You also have the right to ask questions and to receive answers throughout this study.

If you have any questions about this study you may contact the person in charge of this study, Dr. Gina Wong (Athabasca University, Graduate Centre for Applied Psychology, ginaw@athabascau.ca or 1-866-442-3089).

The Athabasca University Research Ethics Board has reviewed this study. If you have questions about your rights as a research participant or any ethical issues related to this study that you wish to discuss with someone not directly involved with the study, you may call the **Chair of the Athabasca University Research Ethics Board at 1-866-569-8040.**

Appendix G: Documentation of Informed Consent

You will be given a scanned copy of this informed consent form after it has been signed and dated by you and the researcher.

Full Study Title: Postpartum Obsessive-Compulsive Disorder: Mothers' Lived Experiences of Recovery Following Counselling

Name of Participant: _____

Participant

By signing this form, I confirm that:

- This research study has been fully explained to me and all of my questions answered to my satisfaction.
- I understand the requirements of participating in this research study.
- I have been informed of the risks and benefits, if any, of participating in this research study.
- I have been informed of any alternatives to participating in this research study.
- I have been informed of the rights of research participants.
- I have read each page of this form.
- I understand that the researcher will ensure accurate meaning, interpretation, and respectful portrayal of my stories and experiences before my participation in the study is complete.
- I understand that there will be no way for others to identify who I am.
- I have agreed to participate in this research study.

_____	_____	_____
Name of Participant (print)	Signature	Date

Researcher

By signing this form, I confirm that:

- This study and its purpose have been explained to the participant named above.
- All questions asked by the participant have been answered.
- I will give a copy of this signed and dated document to the participant.

_____	_____	_____
Name of Researcher (print)	Signature	Date