Parenthood in the Context of Anxiety

Rebekah Chadwick

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Coventry University, Faculty of Health and Life Sciences

University of Warwick, Department of Psychology

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List of Abbreviations

APA	American Psychiatric Association
IPA	Interpretative phenomenological analysis
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Clinical Excellence
GAD	Generalised Anxiety Disorder
OCD	Obsessive-Compulsive Disorder
PTSD	Post-Traumatic Stress Disorder

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Declaration

The chapters of this thesis contain my own work, conducted under the academic and clinical supervision of Dr Carolyn Gordon, Dr Fiona MacCallum and Dr Kirstie McKenzie-McHarg. No part of this work has been submitted for any other degree or to any other university, nor has any part of it been published. Chapters one and two are intended to be submitted for publication under the authorship of myself and the aforementioned supervisors. The final chapter of the thesis is prepared for submission under my own authorship.

Summary

This thesis explores parenthood in the context of anxiety. Chapter One presents a systematic literature review exploring parenting behaviours in parents with anxiety disorders. This aims to critically review studies which consider the association between parental anxiety disorder and parenting behaviour towards school-aged children, specifically those that independently observe parent-child interactions. Fifteen such studies of parents diagnosed with anxiety disorders were reviewed. The majority of studies presented comparative data of anxious and non-anxious parents, frequently finding no differences between groups. Inconsistencies in the findings are highlighted and discussed. Methodological and theoretical limitations, implications for clinical practice and theory, and recommendations for future research are discussed. The review concludes that evidence does not consistently demonstrate a relationship between parental anxiety disorder and parenting, which supports findings of other reviews in the area. However, numerous methodological limitations associated with the use of independent observation must be considered.

Chapter Two is an empirical paper regarding mothers' experiences of obsessive-compulsive disorder (OCD). Nine mothers who associated their OCD onset or exacerbation with a pregnancy or child's birth were interviewed. Interpretative Phenomenological Analysis was used to explore their experiences, with particular consideration to motherhood in the context of OCD. Two superordinate themes of 'changing identity' and 'disconnection' were interpreted. Consideration is given to how these findings relate to existing research into obsessive-compulsive disorder, maternal mental health and motherhood. Methodological limitations, clinical implications and potential future directions for research are discussed.

Chapter Three provides reflections on the research journey. Specifically, the paper considers the researcher's selection of the research area and explores reflections on areas where the researcher's experience of the research converged with experiences of the mothers with OCD who participated in the research project.

Overall word count (excluding footnotes, tables, references, appendices and words in illustrative quotes): 19083

Chapter One

Examining the association between parental anxiety disorder and parenting behaviour: A critical review of observational research of parent-child interactions

This chapter has been written in preparation for submission to Parenting: Science and practice (see Appendix A for journal Aims and Scope and Manuscript Submission Guidelines.) Additional information is currently included, particularly in the method section, to meet the requirements for the thesis. Few style guidelines are offered for review articles so this chapter conforms to APA style recommendations. Minor changes to heading styles, in order to conform with style guidelines, will be undertaken prior to submission.

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1.1. Abstract/Synopsis

Given prevalence estimates, it is likely that many parents experience anxiety disorders. Anxiety disorders aggregate in families and parenting may have a role in the development or maintenance of child anxiety. Observational studies of parent-child interactions have identified differences in parenting behaviour towards anxious, compared to non-anxious, children. Differences in behaviour between anxious and non-anxious parents may also be evident. Fifteen studies observing the parenting behaviour of parents with anxiety disorders are reviewed. Most present comparative data of anxious and non-anxious parents; few found significant differences. Limitations, clinical implications and recommendations for future research are discussed. The review concludes that evidence does not consistently demonstrate a relationship between parental anxiety disorder and behavioural differences in parenting but methodological limitations must be considered.

Keywords: warmth; control; anxious modelling

1.2. Introduction

1.2.1. Anxiety Disorders: Definition, Prevalence and Impact on Children

Anxiety disorders are characterised by persistent excessive fear, anxiety and related behavioural disturbances such as avoidance (American Psychiatric Association [APA], 2013). Additionally, an elevated sensitivity to threat is evident (Craske, Rauch, Ursano, Prenoveau, Pine & Zinbarg, 2009). Global prevalence is estimated at 7.3% (Baxter, Scott, Vos & Whiteford, 2013). In England, 11% of adults experience anxiety disorders; generalised anxiety disorder (GAD) and post-traumatic stress disorder (PTSD) are most common with 4.4% and 3% prevalence rates respectively (Deverill & King, 2009; McManus, Meltzer & Wessely, 2009).

Many people with mental health difficulties have parental responsibility (Nicholson, Biebel, Kinden, Henry & Stier, 2001). More adults aged 16-54 years, who are most likely to be parenting children under 18-years-old, experience anxiety disorders compared to those over 54-years-old (Deverill & King, 2009). Prevalence is greater in females (Baxter et al., 2013), who are usually primary caregivers, and risk of anxiety disorders appears to be increased antenatally and postnatally (Ross & McLean, 2006). Perinatal prevalence estimates of anxiety disorders vary between 4.5% and 15% (Paschetta et al., 2014). Pregnant and postnatal women are at increased risk of GAD and obsessive-compulsive disorder (OCD) (Russell, Fawcett & Mazmanian, 2013; Wenzel, Haugen, Jackson & Brendle, 2005). Anxiety is more common than depression antenatally and postnatally (Lee, Lam, Lau, Chong, Chui & Fong, 2007; Reck et al., 2008). Antenatal anxiety is also a risk factor for

postnatal depression (Robertson, Grace, Wallington & Stewart, 2004), which can impact parenting (Lovejoy, Graczyk, O'Hare & Neuman, 2000).

Glasheen, Richardson & Fabio's review (2010) suggests postnatal anxiety may be associated with behavioural problems, psychopathology and poorer cognitive and social development in young children. Parental anxiety significantly predicts child anxiety (Bayer, Sanson & Hemphill, 2006; Festa & Ginsburg, 2011). Children of parents with anxiety disorders risk developing anxiety disorders by middle-childhood (Beidel & Turner, 1997). Genetic heritability accounts for only 30-40% of the familial transmission of anxiety (Hettema, Neale & Kendler, 2001). One potential environmental factor implicated in the development of anxiety is parenting.

1.2.2. Parental Warmth and Control

Literature identifies parental warmth and control as relevant to children's development (McLeod, Wood & Weisz, 2007; Putnam, Sanson & Rothbart, 2002). The dimension of warmth relates to acceptance and rejection (Rohner, Khaleque & Cournoyer, 2005). Warmth is characterised by positive affect, affection and acceptance, with low levels of rejection. Rejection can comprise withdrawal or neglect, hostility and aggression (Rohner, 2004; Rohner, et al., 2005). The construct of control reflects intrusiveness or over-control, with low levels of encouraging/granting autonomy. Baumrind (1966; 1996) suggests that authoritative parenting, characterised by appropriate levels of discipline with encouragement of

autonomy, is optimal for positive child development. Parenting styles considered less optimal are over-controlling or overly permissive non-controlling styles (Baumrind, 1966). Particularly problematic is a parenting style comprising high control and low warmth, known as authoritarian parenting (Baumrind, 1966) or affectionless control (Parker, 1983).

Parental affect appears to be reliably associated with parenting behaviour. In non-clinical samples, parental negative affect is associated with harsh-negative parenting behaviour while positive affect is associated with supportive-positive parenting behaviour (Rueger, Katz, Risser and Lovejoy, 2011).

Acceptance is considered universally necessary and beneficial for good child development (Rohner et al., 2005). Rejection is associated with poorer outcomes, such as child social anxiety (Festa & Ginsburg, 2011). Regarding control, positive interactions with infants are those characterised by sufficient structure with freedom of expression and autonomy (Kaitz & Maytal, 2005). Warmth and granting autonomy are associated with secure attachment (Karavasilis, Doyle, & Markiewicz, 2003), which is linked to higher adolescent self-esteem (Laible, Carlo & Roesch, 2004). Low parental warmth with over-involvement is linked to child anxiety and depression (Yap, Pilkington, Ryan & Jorm, 2014) and social impairment (Masia & Morris, 1998).

Research suggests children with anxiety disorders perceive their parents as more controlling (Wei & Kendall, 2014) and reviews show substantial consistent links

between observed parental controlling behaviour and child anxiety (van der Bruggen, Stams & Bögels, 2008; Wood, McLeod, Sigman, Hwang & Chu, 2003). Although anxious children also perceive less acceptance, independent observation of parenting behaviour does not always support this perception (Siqueland, Kendall & Steinberg, 1996). Hudson and Rapee (2001) observed parents of children with anxiety disorders to show more intrusiveness and negativity than parents of non-anxious children; however, a review by Dibartolo and Helt (2007) found that observed parental over-control, but not necessarily low warmth, is associated with child anxiety.

It is unclear whether differences in parenting contribute to child anxiety (as theorised by e.g. Chorpita & Barlow, 1998) or anxious children elicit different parenting responses. Parenting behaviour may also be influenced by parental factors, as suggested by evidence that within families, parental behaviour observed with an anxious child and their non-anxious sibling is similar (Barrett, Fox & Farrell, 2005; Hudson & Rapee, 2002). A potential parental factor is parental anxiety. Research indicates that parental report of their child's anxiety is correlated with their anxiety (Bögels & van Melick, 2004) and many parents of children with anxiety disorders also have an anxiety disorder (Cooper, Fearn, Willetts, Seabrook & Parkinson, 2006). This potential confounder has not always been assessed or controlled for in parenting research with anxious children. Research considering parenting behaviour of parents with anxiety disorders is discussed next.

1.2.3. Parental Anxiety and Parenting

Bögels & van Melick (2004) assessed parental and child anxiety and parent-, child- and partner-report of parental behaviour in a community sample of children and parents recruited via secondary schools. After controlling for child anxiety, findings demonstrated correlations between maternal, but not paternal, anxiety and autonomy-granting/overprotection and paternal, but not maternal, anxiety and acceptance-rejection. This study did not sample parents with diagnosed anxiety disorders, for whom anxiety may have greater implications for parenting behaviour. Lindhout et al. (2006) found that parents with anxiety disorders report more restrictive parenting, less granting of independence and less nurturance than parents without anxiety disorders. This combination of behaviours may suggest an affectionless controlling parenting style. Children, however, reported more parental overprotection but not more rejection or less warmth.

Reliance on self-report measures can introduce biases, for example due to parental mood, understanding and attributions about their child (Gardner, 2000). Anxiety disorders may increase parental self-criticism, encouraging reporting of non-optimal parenting behaviours. Alternatively, social desirability bias may cause misleadingly positive reports. Factors associated with utilising report measures may therefore confound research findings. Independent observation of parental behaviour offers more objectivity and some relevant observational research is considered next.

Mothers diagnosed with panic disorder have been found to show less sensitivity[1] in interactions with their infants compared to non-anxious mothers (Warren et al., 2003). Murray, Cooper, Creswell, Schofield and Sack (2007), however, found no such effect of social phobia on sensitivity during mother-infant interactions. Instead, other behavioural differences were identified between mothers with and without social phobia. Anxious mothers were less actively engaged, displayed greater anxiety and were less likely to encourage an infant's interaction with a stranger. The authors suggest anxious modelling may be a mechanism by which parental anxiety enhances risk for child anxiety.

Observational research with infants tends to reveal anxious mothers to be more intrusive and over-controlling than non-anxious mothers, although withdrawn responses may also be likely (Kaitz & Maytal, 2005). However, van der Bruggen et al.'s (2008) meta-analytic review indicates no consistent association between parental anxiety and parental control. A further review suggests anxious mothers may show lower levels of warmth but findings regarding parental control were inconsistent (Dibartolo & Helt, 2007). Both reviews include few studies comparing parents with clinically diagnosed anxiety to non-anxious parents and comprise large

[1]Sensitivity refers to a mother's ability to perceive and interpret her child's cues and respond appropriately (Ainsworth, Blehar, Waters & Wall, 1978). Behavioural responses associated with warmth and control form part of this construct; however, sensitivity comprises more than parental behaviour as it is dynamic, contingent on child/infant behaviour and is reciprocal (Shin, Park, Ryu & Seomun, 2008). For this reason, papers assessing the construct of sensitivity were excluded from this review, (see 1.3.2.) and consequently little discussion of research relating to sensitivity is offered in this introduction; instead consideration is given to specific parenting behaviours which relate to the dimensions of warmth and control discussed in theoretical literature.

age-ranges of children. With school-aged children, van der Bruggen et al. (2008) found small but significant effects of parental anxiety on control and it may be that differences which are undetectable across ages may become more evident when examining particular ages or developmental stages. Reviews selecting studies which focus on narrower age-ranges may yield more meaningful findings about parenting behaviour.

1.2.4. Rationale and Aim

Parental anxiety is associated with negative child outcomes, making it a clinical and public health issue. Reviews indicate that parenting behaviour is associated with child anxiety (van der Bruggen et al., 2008; Wood et al., 2003). However, its association with parental anxiety has received less research interest, particularly in observational research. No known reviews are available. A conference proceedings abstract by Pape & Collins (2010) appears to review parental anxiety and parenting but full details are not published. Identifying whether, and how, parental anxiety affects parenting behaviours is of theoretical and clinical significance in understanding the development of anxiety and could contribute to clinical interventions with families.

Maternal anxiety may impact on mother-infant interactions (Kaitz & Maytal, 2005). However, parental behaviour may alter as children develop and non-optimal parenting behaviours may not persist. Whether the parenting of older children is affected by parental anxiety warrants review. By focussing on school-aged children,

this review adds to current literature. It complements and updates existing reviews which have focussed on control (van der Bruggen et al., 2008) or included few studies considering parental anxiety disorder and parenting (Dibartolo & Helt, 2007). This review aims to critically examine observational studies which explore the association between parental anxiety disorders and parenting behaviours with school-aged children.

1.3. Method

1.3.1. Search Strategy

Database searches of Web of Science (Core Collection), MEDLINE (via Web of Science) and PsycINFO (via the ProQuest platform) were conducted in October 2014 and again in April 2015. Abstract, title and keyword searches were undertaken. Potentially relevant articles were considered, in relation to specified inclusion/exclusion criteria. The search was supplemented with reference and cited searches of papers identified for inclusion, alongside reference searches of relevant published review articles.

Final search terms, listed in table 1.1, were selected as a result of preliminary searches undertaken to develop the review question. Any terms relating to parenting were combined with any terms relating to parental anxiety, using the Boolean operators ‘OR’ and ‘AND’. Where necessary, terms were truncated to ensure inclusion of expanded terms, pluralisation and English and American spellings.

Table 1.1: Systematic Literature Review Search Terms

Terms associated with parenting practices	**Terms associated with parental anxiety disorders**
"parenting practice*"	"Maternal anxi*"
"parenting behav*"	"Paternal anxi*"
"parental behav*"	"parental anxi*"
"parenting style"	"Parental mental"
"Maternal behav*"	"Maternal mental"
"Paternal behav*"	"Paternal mental"
"Mother-child interaction*"	"anxious parent*"
"Father-child interaction*"	"anxious mother*"
"Parent-child interaction*"	"anxious father*"
Rearing	
Childrearing/child-rearing	
Mothering	
Fathering	**denotes truncation*

1.3.2. Selection Criteria

Table 1.2 details inclusion and exclusion criteria. As per inclusion criteria, parents met diagnostic criteria for anxiety disorders; 'anxious' is used throughout to refer to clinically diagnosed anxiety disorders, unless otherwise specified. Non-Western settings were excluded to maximise applicability to Western culture and health services. Studies considering the broad construct of sensitivity were excluded to facilitate ease of comparison across studies. Studies in which the primary aim was not examining the impact of parental anxiety on parenting behaviours, were

included if they met inclusion criteria and reported data relevant to the aim of this review.

Table 1.2: Inclusion and Exclusion Criteria

Inclusion Criteria	▪ Written in English and published in a peer-reviewed journal. ▪ Assess parental anxiety in terms of clinical diagnosis of anxiety disorder(s). ▪ Examine parenting behaviour of anxious parents in independently-observed parent-child interaction(s). ▪ Include parents with anxiety disorders and a comparison group without anxiety disorders. ▪ Rate behaviours related to specific parenting constructs (namely warmth, control and anxious modelling). ▪ Report statistical data about the association between parental anxiety and parenting behaviour. ▪ Observe interactions with school-aged children (not infants; specifically, aged $\geq$ 3 years old).
Exclusion Criteria	▪ Non-empirical and non-peer-reviewed papers – e.g. reviews, book reviews, editorials, meeting abstracts etc. ▪ Full-text was not published in English. ▪ Sample was exclusively recruited based on child anxiety diagnosis. ▪ Sample was based on non-clinical levels of anxiety, for example state anxiety. ▪ Sample was based on alternative parent- or child-diagnoses. ▪ Interactions were coded only for sensitivity. ▪ Conducted in non-Western settings.

1.3.3. Search Results

Database searches yielded 610 records, of which 14 met inclusion criteria. Reference and cited searches highlighted a further relevant paper (figure 1).

1.3.4. Quality Assessment

Assessing the quality of published research is necessary to interpret findings appropriately. Caldwell, Henshaw and Taylor's (2011) framework for evaluating empirical research was utilised, elaborated with Coughlan, Cronin and Ryan's (2007) guidelines which specifically consider theoretical framework and operational definitions. Using twenty questions, studies were rated on a three-point scoring system developed based on the guidelines (appendix B). Two points were given where a study fully met the quality standard, one where it partially satisfied the standard, and zero where the study did not satisfy criteria. Total scores were converted to percentages to ascertain an overall quality score, intended to aid critique; these are available in table 1.3.

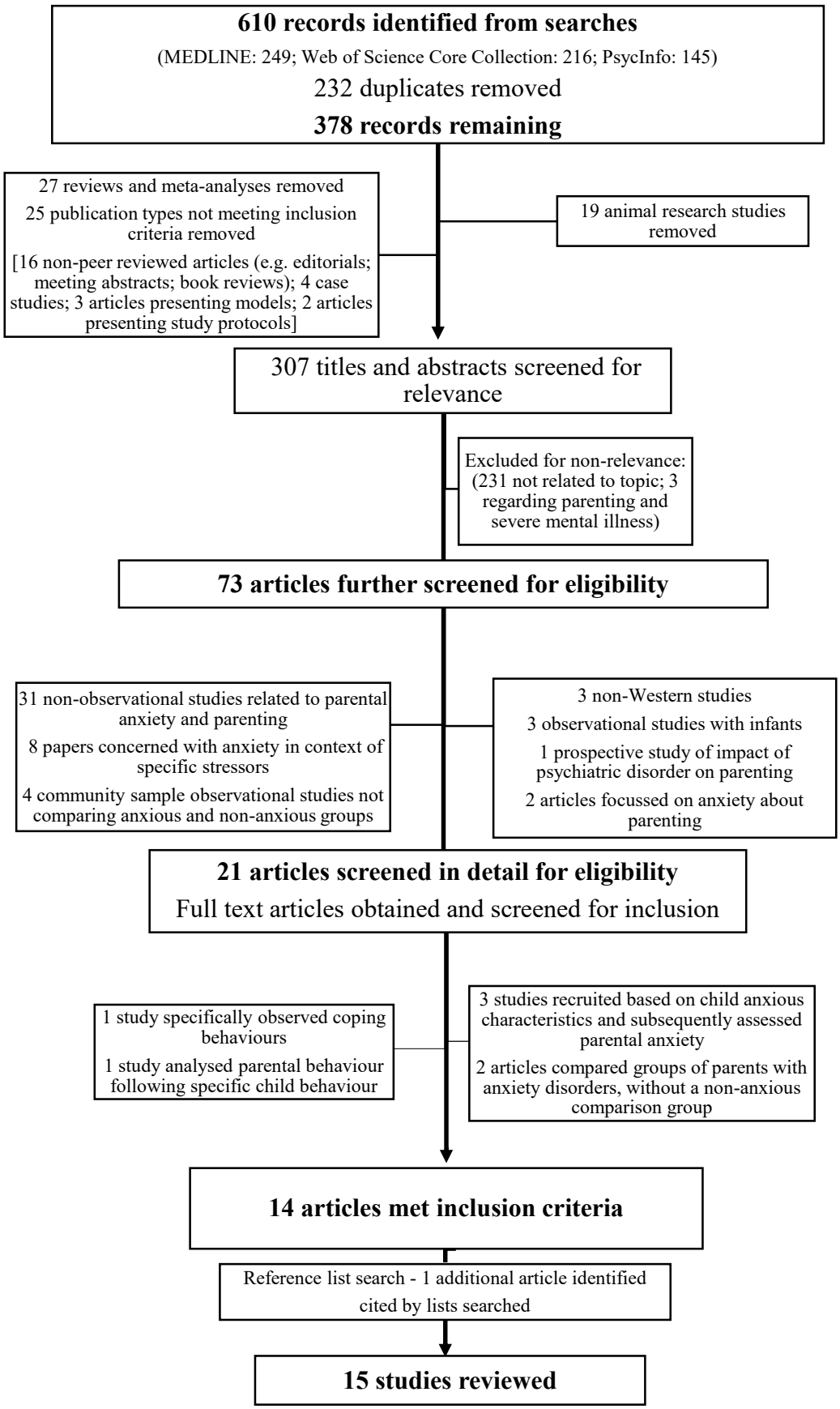

Figure 1: Systematic search strategy for literature review

1.4. Review of the Literature

1.4.1. Overview

Table 1.3 provides a summary of the fifteen studies reviewed. To facilitate comparison across studies, key results and effect sizes are included. Effect sizes are independent of sample size and offer an indication of the magnitude of differences between groups (Sullivan & Feinn, 2012). Cohen's *d* was selected as this is commonly used and accepted broad standards for what constitutes a small, medium or large effect exist (Thalheimer & Cook, 2002). Cohen's *d* is particularly useful in this review, as it assesses the amount of difference between two groups and provides a statistical measure of effect which is independent of base rates (McGrath & Meyer, 2006). Effect sizes were calculated using guidance by Thalheimer and Cook (2002)[2].

Twelve studies compared parenting behaviours in anxious and non-anxious parents. Two studies reported correlational findings of relevance (Festa & Ginsburg, 2011; Harvison, Chapman, Ballash & Woodruff-Borden, 2008). One study reported hierarchical logistic regression results only (Drake & Ginsburg, 2011).

….[2] Where means and standard deviations were available these were used to calculate Cohen's *d*. Where the necessary means and standard deviations were not available, Cohen's *d* was calculated from t-test t-values and analysis of variance F-values.

Table 1.3: Details of Papers Reviewed

Study Details (Authors, date, country of origin)	Anxious Group	Comparison Group	Inclusion of Children with Anxiety Disorders	Age-range of Children (years)	Interactional Task(s) Coded	Parenting Constructs Coded	Construct Definitions	Coding Criteria	Analysis method & statistical results	Effect sizes (on parental behaviour) (Cohen's *d*)	Key Findings
Becker & Ginsburg 2011 USA Quality score: 82.5%	38 mothers diagnosed with current anxiety disorders	37 mothers in non-clinical group, not meeting criteria for any lifetime psychiatric disorder	No	6-14	Speech preparation task (5 minutes)	Over-control Anxious behaviour	Intrusive, unsolicited help or commands. e.g. pressuring child to talk about specific topics Anxious verbalisations & non-verbal anxious behaviours (e.g. worried facial expression)	Developed own coding scheme based on past observational research Coded each minute, then overall frequency of behaviours during task	Between-group comparisons - t-tests No significant difference between anxious (M=0.49, SD=0.61) & non-anxious mothers (M=0.27, SD=0.45) on anxious behaviour (t=1.62, p>0.05) No significant difference between anxious (M=0.86, SD=0.91) & non-anxious mothers (M=0.91, SD=0.68) on over-control (t=0.27, p>0.05)	Anxious behaviour = 0.415 Over-control = 0.063	Maternal anxiety did not affect observed parenting behaviour
Challacombe & Salkovskis 2009 UK Quality score: 87.5%	23 mothers diagnosed with current obsessive compulsive disorder (OCD) 8 mothers diagnosed with current panic disorder	20 mothers in non-clinical group, with no current or past psychiatric disorder except specific phobia	Not reported, but no significant differences in child-report of anxiety between groups	7-14	Conflict discussion task (5 minutes) Anxiety discussion task (5 minutes) (Pooled ratings of parental behaviour across tasks)	Warmth Granting autonomy	Warm behaviours (e.g. expresses affection); positive feedback; negative feedback Degree to which mother constrains or encourages child's individuality (e.g. tolerates differences of opinion)	Developed own coding based on Whaley et al. (1999) & Siqueland, Kendall & Steinberg (1996)	Between-group comparisons - one-way analysis of variance (ANOVA) conducted for each parenting behaviour Overall ANOVA warmth: F(2,58) = 3.81; p<0.05; granting of autonomy: F(2,58) = 3.23, p<0.05 Mothers with OCD (p=0.035) & panic (p=0.013) were significantly less warm than non-anxious mothers (different anxiety disorder diagnoses did not differ significantly from each other) Mothers with OCD (p=0.047) & panic (p=0.024) granted significantly less autonomy than non-anxious mothers (different anxiety disorder diagnoses did not differ significantly from each other)	*Panic disorder:* Warmth = 0.847 Granting autonomy = 0.886 *OCD:* Warmth = 0.640 Granting autonomy = 0.683	Anxious mothers with OCD & anxious mothers with panic disorder showed less warmth & less granting of autonomy than comparison group

Drake & Ginsburg 2011 USA Quality score: 97.5%	38 mothers diagnosed with current anxiety disorder	44 mothers with no history of any current or lifetime psychiatric diagnosis	No	6-13	Speech preparation task (5 minutes)	Granting autonomy Warmth (positive affect) Criticism Anxious behaviour	E.g. acceptance of child's thoughts; lets child make decisions (reverse coded for measure of over-control) E.g. verbal & non-verbal expressions of positive regard & affection E.g. negative statements about, or blaming of, child E.g. verbal expressions of fear; engages in perfectionistic behaviour	Coding scheme developed by Ginsburg & Grover (2007)	Hierarchical logistic regression analyses. Maternal anxiety status did not significantly predict independent observer ratings of behaviour for any parenting construct & accounted for non-significant proportions of variance (ranging between -0.23% & 0.09%) after controlling for race, mother-reported child anxiety levels & child-reported anxiety levels (granting autonomy: β=0.14, R^2= 0.13, p>0.05; warmth: β=-0.23, R^2= 0.09, p>0.05; criticism β=0.07, R^2= 0.01, p>0.05; anxious modelling: β=-0.23, R^2= 0.08, p>0.05)	Separate means & standard deviations for anxious & non-anxious mother groups not available T-test & F values not reported by authors Cohen's d not calculated	Maternal anxiety did not predict independent observation of any of the parenting behaviours
Festa & Ginsburg 2011 USA Quality score: 85%	26 parents diagnosed with anxiety disorder	37 parents with no psychiatric diagnosis	No	7-12	Speech Preparation task (5 minutes)	Control (composite of over-control & granting autonomy)	Granting autonomy: e.g. acceptance of child's thoughts; lets child make decisions (reverse coded) over-control: intrusive, unsolicited help; directing child with commands; attempts to take over task.	Coding scheme developed by Ginsburg & Grover (2007) [as in Drake & Ginsburg (2011)]	Reported intercorrelations between variables of parental anxiety & parental over-control/granting autonomy Non-significant correlation between parental anxiety status & parental over-control/granting autonomy, $r(61) = 0.12$, p>0.05	Over-control/granting autonomy = 0.244	Parental anxiety was not correlated with parental over-control/granting autonomy No comparative data between groups available
Gar & Hudson 2008 Australia Quality score: 85.5%	75 mothers with a current primary diagnosis of anxiety disorder	60 mothers with no current anxiety disorder	Yes	4-16	Speech preparation task (3 minutes)	Involvement Negativity	Observed mothers' 1) general degree of involvement, 2) degree of unsolicited help, 3) degree to which mother directs the speech, 4) focus during the interaction 1) general mood/ atmosphere of interaction, 2) mother's degree of positive affect, 3) mother's tension, 4) mother's degree of verbal & non-verbal encouragement & criticism	Developed own coding scheme based on observational research with anxious children (Hudson & Rapee, 2001) Interactions coded across 4 scales for involvement & 4 for negativity	Between group comparisons -two-way analysis of variance (ANOVA) conducted, examining impact of parental & child anxiety on parenting behaviour Non-significant effect of maternal anxiety on involvement ($F(1,33)=0.88$, p>0.01) & negativity ($F(1,133)=2.51$, p>0.01) No significant interaction between maternal & child anxiety for involvement ($F(1,133)=0.19$, p>0.001) & negativity ($F(1,133)=0.90$, p>0.01)	Involvement = 0.164 Negativity = 0.276 Interaction between maternal & child anxiety: Involvement = 0.76; negativity = 0.166	Maternal anxiety did not affect either dimension of parenting behaviour

Ginsburg, Grover & Ialongo 2004 USA Quality score: 80%	25 mothers meeting criteria for a primary diagnosis of current anxiety disorder	25 mothers with no psychiatric diagnosis	Not reported.	5-8 (in 1st grade)	Etch-A-Sketch task - 3 designs (5 minutes each)	Over-control Granting autonomy Negative affect Criticism Positive affect Anxious behaviour Self-efficacy	E.g. provides unsolicited help Supports, encourages, accepts child's opinions Displays tension, frustration or hostility Insults, blames child Expresses positive affect, words or gestures Expresses fear, worry, perfectionism Expresses competence beliefs about self and/or child	Developed own coding scheme based on observational research with parents of anxious children, e.g. Hudson & Rapee (2001) Rating of presence of behaviour in each 1-minute interval.	Between-group comparisons - t-tests No significant differences between anxious & non-anxious mothers were evident in t-test analyses (statistics not reported by authors)	Over-control = 0.020 Granting autonomy = 0.030 Negative affect = 0.247 Criticism = 0.381 Positive affect = 0.260 Anxious behaviour = 0.040 Self-efficacy = 0.195	No significant differences between mothers with & without anxiety disorder
Ginsburg, Grover, Cord & Ialongo 2006 USA Quality score: 85% (same sample as Ginsburg, Grover & Ialongo)	25 mothers with anxiety disorders	25 mothers with no psychiatric diagnosis	Not reported but groups matched on child's self-reported anxiety	5-8	Etch-A-Sketch task - 3 designs (5 minutes each) Child-directed free play (5 minutes) Compared behaviour on each task	Over-control Anxious behaviour Criticism	Providing unsolicited, intrusive help; commands Verbal & non-verbal expressions of fear, worry or perfectionism Insults, negative comments about child's performance/ability; blaming child	Developed own coding scheme based on observational research with parents of anxious children, e.g. Hudson & Rapee (2001) Rating of presence of behaviour in each 1-minute interval.	Compared maternal groups & different task-types Between-group comparisons - two-way analysis of variance (ANOVA) examined effect of maternal anxiety & task-type on parenting behaviour No significant effects of parental anxiety were evident (statistics not reported by authors) Significant effects of task-type were evident for over-control ($F(1,47) = 19.45$; $p<0.001$), anxious behaviour ($F(1,47) = 42.53$; $p<0.001$) & criticism ($F(1,47) = 19.65$; $p<0.001$) Non-significant interaction between maternal anxiety & type of task observed; however, interaction for criticism approached significance ($F(1,47) = 3.40$; $p=0.072$), such that, for anxious mothers only, criticism was greater in the structured task compared to unstructured free-play.	*Effect of maternal anxiety - Structured Etch-A-Sketch task:* Over-control = 0.020; Anxious behaviour = 0.040; Criticism = 0.381 *Unstructured free-play task:* Over-control = 0.274; Anxious behaviour = 0.225 Criticism = 0.406 *Effect of task-type on maternal behaviour:* over-control = 1.273; anxious behaviour = 1.28; criticism = 1.882 *Interaction between task-type & anxiety:* criticism = 0.532	Maternal anxiety did not affect observed parenting behaviour Task-type affected parental behaviour

Harvison, Chapman, Ballash & Woodruff-Borden 2008 USA Quality score = 80% (part of Woodruff-Borden et al., 2002 included in review)	28 mothers with criteria anxiety disorder	36 mothers with no current anxiety disorder	Yes	6-12	Working on unsolvable anagrams (10 minutes) Speech preparation task (10 minutes)	Affectionless Control (composite of negative interaction + over-control)	Negative interaction: e.g. negatives, interruption, explicit or implicit rejection, complaints about the task Over-control: e.g. attempts to regulate child's behaviour, takes over, commands	Developed own coding scheme All identifiable units of words or behaviour were coded into a behaviour category (e.g. interruption) Composites of these behaviour categories were used to generate the 4 parental constructs	Calculated correlations between maternal anxiety disorder diagnosis, maternal affectionless control & child factors (child anxiety disorder diagnosis & child behaviour) Regression analyses to assess proposed mediational model (maternal affectionless control mediating a link between child anxious affect & child disengaging behaviour) Non-significant correlation between maternal diagnosis & maternal affectionless control: r (62) = 0.24, n.s. No comparative data between groups available	Affectionless control = 0.509	Maternal diagnosis was not associated with maternal affectionless control
Moore, Whaley & Sigman 2004 USA Quality score: 87.5% (extension of Whaley et al., 1999)	37 mothers with current or lifetime diagnosis of anxiety disorder	31 mothers who have not experienced anxiety or depressive disorder since the birth of their child	Yes	7-15	Conflict discussion task Anxiety discussion task	Warmth Granting autonomy Catastrophising	E.g. expressed affection, appears responsive & engaged in discussion with child E.g. solicits child's own opinion, encouraged child to think independently	Global rating of maternal behaviour on 5-point Likert-type scale. Based on coding scheme used in Siquel& et al. (1996) Catastrophising was coded dichotomously (as rarely occurred)	Between group comparisons - two-way analysis of variance (ANOVA) conducted, examining impact of parental & child anxiety on parenting behaviour No significant effects of maternal anxiety disorder status on warmth ($F(1,62) = 2.97$, $p>0.05$) or granting autonomy ($F(1,62) = 1.60$, $p>0.05$). Significant effect of maternal anxiety on catastrophising (measured dichotomously): $x2(1,n=68) = 7.748$, $p<0.01$ Significant effect of child anxiety on observed maternal warmth ($F(1,62) = 6.56$, $p<0.05$) & granting autonomy ($F(1,62) = 21.35$, $p<0.01$)	*Effect of maternal anxiety on maternal behaviour:* Warmth = 0.164; Granting of autonomy = 0.276 Catastrophising = 0.717 *Effect of child anxiety on maternal behaviour:* *W*armth = 0.633 Granting autonomy = 1.142 *Effect of interaction between maternal & child anxiety:* Warmth = 0.429 Granting autonomy = 0.699	Maternal anxiety status did not impact on observed warmth or granting autonomy Catastrophising comments more likely in mothers with an anxiety disorder diagnosis Child anxiety status was associated with less warmth & less granting of autonomy by mothers.

Murray et al. 2012 UK & USA Quality score: 82.5%	50 mothers with current or antenatal social phobia 8 mothers with current or antenatal generalised anxiety disorder	62 mothers with no anxiety disorder	Yes	4-5	Unstructured play (with play dough) (5 minutes) Speech (5 minutes preparation & 3 minute speech) Mysterious box task (unreported time)	Warmth Encouragement / granting of autonomy Positive modelling Anxious modelling Passivity / withdrawal Promotion of avoidance Intrusiveness	Affectionate, shows positive regard verbally or non-verbally Provides positive motivation to child to engage in task & shows enthusiasm for task & child's capacity/efforts Models target behaviour Verbal & non-verbal signs of anxiety Withdrawn, inhibited, unresponsive to child behaviour & communication Actively encourages/supports child avoidance Interferes, attempts to take over & impose own agenda	Developed own coding scheme based on literature (McLeod et al., 2007 & van der Bruggen et al., 2008) & previous findings (Murray et al., 2007,8).	Between-group comparisons - two-way analysis of variance (ANOVA) conducted, examining impact of maternal anxiety & task-type on parenting behaviour Significant effects of maternal anxiety on levels of encouragement ($F(2,146) = 3.74$, $p<0.05$, $n^2=0.05$), passivity ($F(2,146) = 7.91$, $p<0.01$, $n^2=0.10$) & expressed anxiety ($F(2,147) = 7.18$, $p<0.01$, $n^2=0.09$) Trend towards significance for warmth: warmth $F(2,147) = 2.71$, $p=0.07$, $n^2 =0.04$) Non-significant differences between anxious & non-anxious mothers for promotion of avoidance ($F(2, 146) = 1.80$, n.s., n2 = 0.02), intrusiveness ($F(2,147) = 1.68$, n.s., n2 = 0.02) & positive modelling ($F(2,146) = 2.19$, n.s., n2 = 0.03)	*Social phobia:* Encouragement = 0.481 Warmth = 0.416 Expressed anxiety = 0.727 Passivity = 0.753 Promotion of avoidance = 0.343 Intrusiveness = 0.236 Positive modelling = 0.496 *Generalised anxiety disorder:* *E*ncouragement = 0.451 Warmth = 0.389 Expressed anxiety = 0.255 Passivity = 0.636 Promotion of avoidance = 0.354 Intrusiveness = 0.379 Positive modelling = 0.241	Mothers with either anxiety disorder showed less positive (encouragement) & more negative (passivity, expressed anxiety) parenting behaviours compared to non-anxious mothers, but behaviours were mainly evident in disorder-specific tasks
Schneider, Houweling, Gommlich-Schneider, Klein, Nundel & Wolke 2009 Europe (Switzerland, Germany & UK) Quality score: 77.5%	57 mothers with panic disorder with or without agoraphobia	29 mothers with no current mental health disorder	Yes	13-23	Etch-A-Sketch (2 drawings, maximum 12 minutes for each)	Control Criticism Warmth	Maternal verbal control, child verbal control & mother-child control over the interaction Maternal criticism, harmony of mother-child interaction Harmony/conflict throughout mother-child interaction	Standardised coding scheme - The Assessment of Mother-Child Interaction with the Etch-A-Sketch (AMCIES) Analysed whole interaction of both drawings	Between-group comparisons - multivariate analysis of variance (MANOVA) Overall MANOVA for maternal behaviour showed a significant difference between mothers with panic disorder & those without, $F(3,104) = 6.88$, $p<0.001$. (Adjusted for presence of depression: $F(3,103) = 6.89$, $P<0.001$) Anxious mothers were more verbally controlling ($F(3,104) = 13.99$, $p<0.001$, partial n2 = 0.12), more critical ($F(3,104) = 3.89$, $p<0.05$, partial n2 = 0.04) & had interactions that were less harmonious ($F(2,105) = 7.128$, $P<0.01$, partial n2 = 0.06)	Maternal verbal control = 0.779 Maternal criticism = 0.411 Harmony of interaction = 0.553 Control of interaction = 0.423	Mothers with panic disorder were significantly more controlling & critical in their interactions with their children Interactions between mothers with panic disorder & their children were less harmonious & more likely to be characterised by conflict

Schrock & Woodruff-Borden 2010 USA Quality score: 75%	91 parents with a primary diagnosis of an anxiety disorder	67 parents with no anxiety disorder	Yes	3-12 (different tasks for older & younger children)	Cognitive task – Ages 3-5 years completed puzzles; Ages 6-12 years attempted to complete unsolvable anagrams (10 minutes) Social task - children aged 3-5 told a story aloud; children aged 6-12 years preparing a speech to be delivered to camera (10 minutes)	Productive engagement Disengagement / withdrawal Negative interaction Over-control	E.g. positives, agreement, praise or compliments, humour, offers assistance E.g. silence, minimal response, ignoring or switching topic E.g. negatives, interruption, explicit or implicit rejection, complaints about the task E.g. attempts to regulate child's behaviour, takes over, commands	Developed own coding scheme adapted from Kerig, Cowan & Cowan (1993) [as utilised in Woodruff-Borden et al., 2002, included in review] Behaviours & utterances were coded into a behaviour category. Four composites were generated from these	Between-group comparisons: analysis of covariance (ANCOVA) of overall parenting behaviour (a combination of the behaviour composites) & ANCOVAs of the 4 behaviour constructs Non-significant main effect of parental anxiety Significant interaction between parent & child anxiety on overall parenting behaviour: $F(1,152) = 5.74$, $p<0.05$, partial $n^2 = 0.04$ Significant interaction between parent & child anxiety on parental negative interaction ($F(1,152) = 5.38$, $p<0.05$, partial $n^2 = 0.03$)	*Maternal anxiety:* Productive engagement = 0.272 Disengagement = 0.106 Negative interaction = 0.094 Over-control = 0 Overall interaction between parent & child anxiety = 0.388 *Interaction of parent & child anxiety*: parent negative interaction = 0.376	Parental anxiety did not significantly affect parenting behaviours Significant interaction between parental anxiety & child anxiety on overall parenting behaviour & parental negative interaction
Turner, Beidel, Roberson-Nay & Tervo 2003 USA Quality score: 72.5%	43 parents with a current anxiety disorder	38 parents with no current or past anxiety disorder	Yes	7-12	Risky play apparatus (5 minutes)	Over-protection Criticism Expressed anxiety	E.g. says be careful; verbally directs anxiety Made critical statement about child. *Note this occurred so infrequently that inter-rater reliability estimates were rendered invalid & it was removed E.g. appears apprehensive; makes positive comments	Developed own coding scheme based on past research (Whaley et al. 1999; Hirshfeld et al., 1997) Rated occurrence or non-occurrence of behaviour during 10 second periods throughout the interaction	Between-group comparisons - multivariate analysis of covariance (MANOVA) Significant group differences on parental behaviour: Hotelling's $t2(5,70) = 3.13$, $p<0.05$, power = 0.85, $n^2 = 0.18$ Non-anxious parents (M=2.83) were more likely to st& close & follow their child than were anxious parents (M=0.78), $F(1,98) = 7.53$, $p<0.01$) No significant differences in parental behaviour toward anxious or non-anxious children	Stands close/follows child = 0.599	Non-anxious parents were more likely to be standing close & following child as they played. Other behaviours were not affected by parental anxiety Child anxiety did not affect parenting behaviour

Whaley, Pinto & Sigman 1999 USA Quality score: 80%	18 mothers with a current anxiety disorder	18 mothers with no anxiety disorder or depression since the birth of their participating child	Yes	7-14	Ideal Person discussion task (not time-limited) Conflict discussion task (5 minutes) Anxiety discussion task (5 minutes)	Warmth Control - conversational dominance & granting of autonomy Catastrophising Criticism Positivity (reacts negatively/ positively)	Warm behaviours (e.g. expresses affection); positive feedback; negative feedback; disconfirmatory statements (corrections & feedback intended to redirect performance) Degree to which parent constrains or encourages child's individuality	Developed own coding scheme based on Siquel& et al. (1996) & Hammen (1991). Rated degree to which mother showed warmth & granted autonomy on Likert scale of 1-5. Conversational dominance calculated by dividing the amount of time mother spoke by the amount of time the child spoke.	Between group comparisons - multivariate analysis of variance (MANOVA) Overall MANOVA showed significant difference between anxious & non-anxious mothers ($F(7,28) = 3.43$, $p<0.01$) Anxious mothers showed less warmth ($F(1,34) = 13.02$, $p<0.001$), granted less autonomy ($F(1,34) = 12.98$, $p<0.001$), & were less positive ($F(1,34) = 10.80$, $p<0.001$), more critical ($F(1,34) = 4.78$, $p<0.05$), & catastrophised more ($F(1,34) = 7.43$, $p<0.01$) No significant differences on conversational dominance (statistics not reported by authors)	Warmth = 1.236 Granting autonomy = 0.896 Conversational dominance = 0.268 Criticism = 0.755 Catastrophising = 0.937 Positivity = 1.085	Anxious mothers showed less warmth, positivity & granting of autonomy & more catastrophising & criticism
Woodruff-Borden, Morrow, Bourland & Cambron 2002 USA Quality score: 90% (Harvison et al., 2008 is part of this study)	25 parents with current anxiety disorder	26 parents with no current or past anxiety disorder (or other axis 1 disorder)	Yes	6-12	Working on unsolvable anagrams (10 minutes) Speech preparation task (10 minutes)	Productive engagement Disengagement /withdrawal Negative interaction Over-control	E.g. positives, agreement, praises or compliments, humour, offers assistance E.g. silence, minimal response, ignoring or switching topic E.g. negatives, interruption, explicit or implicit rejection, complaints about the task E.g. attempts to regulate child's behaviour, takes over, commands	Developed own coding scheme adapted from Kerig, Cowan & Cowan (1993) [as utilised in Schrock & Woodruff-Borden, 2010, included in review] All identifiable units of words or behaviour were coded into a behaviour category (e.g. interruption). Four composites were generated from these.	Between group comparisons - multivariate analysis of variance (MANOVA) Overall MANOVA significant: $F(4, 46) = 3.04$, $p<0.05$, $n2=0.21$ Anxious parents showed more signs of disengagement ($F(1,49) = 4.40$, $p<0.05$) & less productive engagement ($F(1, 49) = 5.25$, $p<0.03$) behaviours than parents without anxiety Non-significant differences on over-control ($F(1,49) =0.15$, $p=0.41$) & negative interaction ($F(1,49) = 3.59$, $p=0.06$)	Productive engagement = 0.652 Disengagement/ withdrawal = 0.601 Negative interaction = 0.545 Overcontrol = 0.110	Anxious parents behaved in ways that were more disengaging & less productively engaged

Some studies selected specific disorders: GAD, social phobia (Murray et al., 2012), OCD (Challacombe & Salkovskis, 2009) and panic disorder (Challacombe & Salkovskis, 2009; Schneider, Houweling, Gommlich-Schneider, Klein, Nündel and Wolke, 2009). Many included anxious children, some intentionally assessing interactions between parental and child anxiety. Predominantly mothers participated in a variety of observational tasks. Behaviours rated broadly reflected the parenting dimensions of warmth and control identified in theoretical literature, often with inclusion of anxiety-related behaviours. Findings are therefore delineated in relation to warmth, control and anxious modelling.

1.4.2. Warmth

1.4.2.1. Positive affect/warmth.

Five studies report an association between anxiety and lower levels of behaviours related to warmth. Challacombe and Salkovskis (2009) compared mothers with OCD and mothers with panic disorder to a non-anxious control group, observing significantly less warmth during conversational interactions of both anxious groups. Schneider et al. (2009) used a standardised coding scheme to examine parent-adolescent interactions. Findings indicated that interactions involving parents with panic disorder were less harmonious and more conflictual compared to interactions involving non-anxious parents. While other studies use minute-by-minute frequency-ratings of behaviour, this study's consideration of mother-child harmony/conflict throughout the whole observed interaction may enable inclusion

of additional relevant information such as instances where conflict occurred but was resolved.

Also observing conversational interactions, Whaley, Pinto and Sigman (1999) found anxious mothers showed significantly fewer warm behaviours than non-anxious mothers. The authors also conducted regression analyses, which revealed that maternal anxiety status significantly contributed to levels of warmth and positivity. However, a significant difference in depressiveness between anxious and non-anxious groups confounds these findings, particularly as depression has been linked to compromised parenting (Lovejoy et al., 2000). This study had the smallest sample of all those reviewed (36 parents in total), increasing the risk of erroneous significant results due to low power (Ioannidis, 2005, 2008). As with all studies, findings are not generalisable to fathers. Although this study demonstrates awareness of its limitations, findings should be interpreted with caution.

Furthermore, the majority of mothers in Whaley et al.'s (1999) sample had panic disorder: these findings and those of Schneider et al. (2009) and Challacombe and Salkovskis (2009) may not be generalisable to all anxiety disorder diagnoses. The unexpected nature of panic attacks in panic disorder (APA, 2013) may mean parents with panic disorder are anxious more constantly than those with other anxiety disorders whose anxiety may arise in response to specific triggers. Consequently, their greater anxiety may leave fewer resources to respond positively to their child. Panic attacks are associated with greater psychopathology severity (Craske et al., 2010) and parents with panic disorder, compared to other

anxiety disorders, may experience more severe anxiety with greater consequences on their parenting behaviour.

Woodruff-Borden, Morrow, Bourland and Cambron (2002) analysed composite measures of behaviours across two challenging tasks. Their composite 'productive engagement' comprised behaviours associated with warmth. They report that, compared to non-anxious parents, anxious parents showed significantly fewer productive engagement behaviours, particularly less agreeing with and praising their children. As noted by the authors, specific behaviours within the composite may account for between-group differences. Helpful behaviours, which could be associated with control, were also included within productive engagement; however, significant between-group differences were not evident in the frequency of over-controlling behaviours (further discussed in 1.4.3).

Murray et al. (2012) recruited mothers from the community and subsequently assessed for anxiety disorders. Observations indicated no difference between anxious and non-anxious mothers in terms of warmth. However, anxious mothers showed significantly less encouragement/autonomy promotion, defined as motivation and enthusiasm. Their definition of 'encouragement/autonomy promotion' differs from other studies' definitions of 'granting autonomy' (see table 1.3) and may instead reflect warmth. Indeed, this construct was significantly positively correlated with warmth across observed tasks, whereas no other parental behaviours were consistently correlated. As highlighted in the critique framework, adequate definition of constructs is important and this study's quality rating was

compromised by a lack of clarity in defining constructs. Studies vary in the selection of behaviours considered to represent warmth, usually using a combination of warm, positive and rejecting, negative behaviours. These may, however, have differential effects on children. The presence of more negative behaviours, such as more conflicts evident in anxious mothers' interactions (Schneider et al., 2009), may be more detrimental than an absence of positive behaviours as found by Woodruff-Borden et al. (2002).

Despite these studies suggesting an association between parental anxiety and less warmth, most studies report non-significant differences in warm behaviours between anxious and non-anxious parents. However, the small sample size of some studies may increase the risk of concluding that no significant differences are evident when they are in fact present (type 2 error). In contrast to their findings regarding productive engagement, Woodruff-Borden et al. (2002) report that differences in levels of negative interaction approached, but did not reach, significance. Effect size calculation indicates a medium effect, which may have been statistically significant had the study had greater power. Moore et al. (2004) report that child anxiety, but not maternal anxiety, was associated with fewer warm behaviours. Exact significance values are not reported, so it is unknown if a statistical trend towards lower levels of warmth was evident, as with Woodruff-Borden et al. (2002).

Schrock and Woodruff-Borden (2010) report that anxious and non-anxious parents did not differ in levels of negative interaction or productive engagement. Additional

analyses demonstrated that child and parental anxiety interacted to affect parenting behaviour. Fewer negative interaction behaviours were evident in non-anxious parent–non-anxious child interactions compared to anxious parent–anxious child interactions. Their larger sample offers greater power for statistical analyses. However, the study's lack of clarity about the design, aims and hypotheses, relative to other studies, resulted in a lower quality rating.

Non-significant findings of three further studies may be attributable to their recruitment method. By recruiting parents through the community instead of clinics, their resultant samples may represent mothers who are less functionally-impaired. Drake and Ginsburg (2011) found that independent observation (and child report) of warm behaviour was not lower in anxious mothers. Ginsburg et al. (2004) report no differences between anxious and non-anxious mothers in displays of positive or negative affect. Although groups were matched for ethnicity, their predominantly African American sample limits generalisability. African American children are at greater risk of living in poverty (Costello, Keeler & Angold, 2001), which may itself affect parenting (lower maternal warmth has been associated with residing in poorer neighbourhoods [Klebanov, Brooks-Gunn & Duncan, 1994]). Compared to European Americans, African American parents report using more physical discipline and have been observed to be less supportive in their parenting style (McLoyd & Smith, 2002; Whiteside-Mansell, Bradley, Little, Corwyn, & Spiker, 2001). Hall and Bracken (1996), however, found that adolescents' perceptions of parenting did not indicate differences between African American and Caucasian parenting styles. Observer perception of behaviour, particularly where the researchers differ in ethnicity from participants, may not be an accurate

interpretation of behaviour as it is perceived by the parent and child, and these perceptions may be more important for child outcomes.

Gar and Hudson (2008) found that maternal anxiety was not associated with negativity, which incorporated positive affect, atmosphere of interaction and verbal and non-verbal criticism and encouragement. However, integrating criticism within the construct of negativity could lead to levels of positive affect masking levels of criticism, which may impact children. Other studies rated criticism separately, offering opportunity for investigating how criticism and warm behaviours may be differentially affected by parental anxiety. Findings of these studies are considered next.

1.4.2.2. Criticism.

Criticism may be part of the same parenting dimension as warmth, potentially representing rejection/negativity, as in Gar and Hudson's construct of negativity. McLeod et al. (2007) include criticism within a sub-dimension of rejection termed 'aversiveness'. Whaley et al. (1999) and Schneider et al. (2009) report concordant findings regarding warmth and criticism; both studies found that, compared to non-anxious mothers, anxious mothers made more critical comments towards their children and showed less warm behaviours.

Similarly, studies finding no association between parental anxiety and warmth also found no association with criticism. Ginsburg et al., (2004) and Ginsburg, Grover,

Cord and Ialongo (2006) utilise the same sample; the latter aims to compare behaviour across tasks. Findings indicated similar levels of criticism in anxious and non-anxious mothers, although the lack of statistically significant difference may be attributable to the under-powered small sample (25 in each group). Small to moderate effect sizes were evident for criticism, larger than those evident for the other behaviours rated. Ginsburg et al. (2006) report that across both a structured, challenging task and child-directed free-play, levels of criticism were correlated for anxious but not non-anxious mothers; additionally, an interaction between task-type and anxiety, such that only anxious mothers displayed more criticism in the structured task than in free-play, approached significance. The authors suggest that anxious mothers may show greater overall levels of criticism, perhaps exacerbated under stress. However, Drake and Ginsburg's (2011) study found that maternal anxiety did not predict criticism. Their larger sample contributed to a higher quality rating.

Turner, Beidel, Roberson-Nay and Tervo (2003) observed low frequencies of criticism in anxious and non-anxious parents, consequently excluding this from analyses. In summary, most studies rating criticism do not indicate an association with parental anxiety. However, relatively low frequencies of criticism may have meaningful cumulative effects on children over time. In addition to criticism, withdrawal may be a sub-dimension of rejection (McLeod et al., 2007). Three studies reporting disengagement/withdrawal are discussed next.

1.4.2.3. Disengagement.

Schrock and Woodruff-Borden (2010) report no effect of parental anxiety on levels of disengaged behaviours. However, findings from Murray et al. (2012) and Woodruff-Borden et al. (2002) suggest links between parental anxiety and withdrawn behaviours. During interactional tasks designed to elicit parental anxiety, Murray et al. (2012) rated 'passivity', defining this in terms of withdrawn behaviour and unresponsiveness. Mothers with GAD or social phobia showed significantly greater passivity than non-anxious mothers, with moderate to large effect sizes for both groups. Differences remained when controlling for child anxiety factors (expressions of anxiety during task and infant behavioural inhibition). A strength of this study is its focus on a narrow age-range of children (4-5-years), which offers understanding of parental behaviour at a specific developmental stage. The anxious sample included mothers who no longer met diagnostic criteria but who had experienced anxiety disorders antenatally and continued to report significantly higher anxiety on disorder-specific validated measures. Thus, these findings may underestimate the impact of anxiety on parenting, especially given that research into maternal depression indicates that current diagnosis has larger effects on parenting than historic diagnosis (Lovejoy et al., 2000).

Woodruff-Borden et al. (2002) also found that anxious parents were significantly more likely to show disengaged behaviours than non-anxious parents. In their study, disengagement/withdrawal was correlated with a continuous measure of anxiety (scores on a self-report anxiety measure), suggesting increased anxiety is

associated with increased disengagement/withdrawal. Inclusion of this measure of anxiety is a strength of this study, offering a dimensional understanding of anxiety which may be more appropriate (Brown & Barlow, 2009). Episodic anxiety or sub-clinical distressing levels of anxiety may affect parenting behaviour (Murray et al., 2012). Most studies impose artificial dichotomy based on diagnostic criteria, which decreases validity and reliability (Widiger, 1992) and loses valuable clinical data such as severity and subtle changes over time (Watson, 2005). These factors may affect parenting. However, it is unclear if Woodruff-Borden et al.'s (2002) behavioural composite of 'disengagement/withdrawal' validly assessed warmth. Disengagement/withdrawal was not correlated with productive engagement, which comprised behaviours associated with warmth (e.g. praise), but was strongly correlated with negative interaction, perhaps reflecting the opposite end of the warmth dimension. It also showed a moderate significant correlation with over-control. Disengagement could in fact represent extremely low control (Dibartolo & Helt, 2007), the next construct discussed.

1.4.3. Control

1.4.3.1. Over-control and granting autonomy.

Typically studies observed over-control/intrusiveness and/or granting autonomy, considering these opposing ends of the dimension 'control'. The majority of studies found no association between parental anxiety and over-controlling behaviours. However, three studies report greater controlling behaviour in anxious parents.

These also report significantly lower warmth in anxious mothers, which may indicate affectionless control (Parker, 1983). Schneider et al. (2009) observed parent-adolescent interactions during collaborative tasks. Controlling for adolescent anxiety, parents with panic disorder were more likely to verbally control interactions. Whaley et al. (1999) and Challacombe and Salkovskis (2009) report that, during conversations, anxious mothers granted less autonomy than non-anxious mothers, with large effect sizes evident in both studies. However, Whaley et al.'s (1999) research has numerous limitations, stated in 1.4.2.1. Cautious interpretation of Challacombe and Salkovskis' (2009) results is warranted, as interactions coded by the first author who was not blind to maternal diagnosis may bias findings, although a sample of interactions second rated by a researcher blind to diagnostic status showed adequate inter-rater reliability.

A strength of these three studies is that most participants were observed at home, offering greater ecological validity. Usual behaviours may be more evident in this more naturalistic environment. In contrast, non-home settings may increase anxiety of parents and children and/or alter behaviour. Behaviours considered less helpful can be more evident in home settings compared to laboratory settings (Schneider et al., 2009). Schneider et al. (2009) found that anxious mothers were significantly more likely to have participated at home than at the research laboratory. This may have contributed to the greater differences reported between groups in this study. This finding also suggests that participating in non-home settings may be associated with greater anxiety. Anxious parents willing to participate in non-home settings may be less anxious than those who choose to be observed at home, which perhaps explains the significant findings evident in these three studies compared to other

reviewed studies. Most studies involve non-home observations and their anxious groups may therefore represent less functionally-impaired anxious parents, whose parenting behaviour may also be less affected by anxiety.

In contrast to these studies, other studies found no association between anxiety and over-control. Festa and Ginsburg (2011) explored predictors of social anxiety in children, reporting no correlation between parental anxiety, as assessed by a self-report measure, and over-controlling behaviour. Over-control comprised levels of parental over-control and granting autonomy. As part of Woodruff-Borden et al.'s (2002) study, Harvison et al. (2008) investigated the potential mediating role of maternal behaviour between child anxiety and child disengagement from stressful tasks. Parental anxiety disorder status was not correlated with affectionless control, which was a composite measure of negative affect and over-control. Affectionless control mediated a link between child anxious affect and disengagement from the observed task. The authors suggest that affectionless controlling parenting may encourage a child's withdrawal from stressful tasks; thus, it is perceived to contribute to the development and maintenance of child anxiety by promoting avoidance.

As part of a study primarily examining children's self-evaluations, Becker and Ginsburg (2011) observed over-control in anxious and non-anxious mothers, finding no significant differences. Moreover, maternal task anxiety, assessed immediately before the task commenced, was not significantly correlated with over-control. As with Woodruff-Borden et al. (2002), Becker and Ginsburg's

(2011) inclusion of a continuous measure of anxiety may be more meaningful in understanding anxiety (Brown & Barlow, 2009). Their assessment of task anxiety provides a validity-check of the extent to which the interactional task elicited anxiety. This is a strength of this study as anxiety-provoking tasks may be more likely to elicit particular behaviours (see 1.4.5.2.). Most studies did not include subjective ratings of parental anxiety regarding the interactional tasks and so the extent to which the selected behavioural observations elicited anxiety is often unknown.

Gar and Hudson (2008) found no effect of maternal anxiety on involvement, designed to represent control. However, child anxiety disorder was associated with greater involvement. Schrock and Woodruff-Borden (2010) found no association between parental anxiety and over-controlling behaviour. Similarly, Drake and Ginsburg (2011) found that maternal anxiety does not predict over-controlling behaviour. Over-control was operationalised as low levels of behaviours related to granting autonomy rather than presence of overtly controlling behaviours. These two aspects of control, although related, may have different impacts on children.

Woodruff-Borden et al. (2002) found non-significant differences in levels of over-controlling behaviour between anxious and non-anxious parents. This study included the most fathers, yet participants were still primarily mothers (84%). Gender may affect parenting behaviour. Furthermore, internal consistency of the construct of control was poor and over-control was significantly correlated with the other rated behavioural constructs (disengagement, negative interaction and

productive engagement). Together, these factors undermine their findings about control and suggest that those behaviours considered to represent over-control may be more suitably integrated into other constructs.

The discussed studies finding no association between anxiety and control all utilise the speech preparation task, with three only observing interactions during this task. One possible explanation for non-significant findings is that this task does not elicit controlling behaviour, perhaps because its predominant focus is on the child and their performance. However, maternal anxiety was also not associated with controlling behaviour in more collaborative tasks, including Etch-A-Sketch tasks (Ginsburg et al., 2004), conversations (Moore et al., 2004), unstructured play and interacting with potentially scary items (Murray et al., 2012). This suggests that controlling behaviour does not differ between anxious and non-anxious parents even during tasks in which parents may feel challenged or consider that their performance is being assessed. The lack of significant findings in these studies may be explained by observations taking place in unfamiliar settings, in contrast to those studies including in-home observations.

However, all studies reviewed utilised brief, somewhat artificial interactions. Parenting behaviour which commonly occurs may not have been evident during the observations. Behavioural differences between anxious and non-anxious parents may be evident over longer time periods, where there is more opportunity for behaviours to occur. The research setting is novel and non-naturalistic and generalisability to other situations is limited.

1.4.3.2. Overprotection.

Protection is often considered related to control. It has been implicated in the development and maintenance of anxiety, by suggesting that the world is dangerous and decreasing a child's sense of control over their environment (Chorpita & Barlow, 1998; Murray, Creswell & Cooper, 2009; Rapee, 1997). Moore et al. (2004) found that autonomy-granting behaviours were less evident with anxious children compared to non-anxious children, irrespective of maternal anxiety, and concluded that mothers may be more protective of anxious children.

Turner et al. (2003) focussed on protectiveness and included examination of parental behaviour while observing their children (aged 7-12 years) play on 'risky' apparatus. Behaviour ratings included verbally directing the child and standing close, which could both be considered examples of controlling/overinvolved behaviour. Results demonstrated no association between parental anxiety and increased protection, controlling for child anxiety. From the finding that non-anxious parents were significantly more likely than anxious parents to stand close to their children while they played, and actively join them on the apparatus, the authors suggest that non-anxious parents may be more comfortable with their child engaging in risky activities. However, increased proximity could be considered to represent overprotection. Additionally, the significant difference in parental levels of playing with their child may be due to anxious parents' anxiety associated with deviating from task instructions, in which they were instructed to sit in a chair

while their children were advised they could play. This study received a lower quality rating, as operationalisation of protection was unclear and discussion of their findings was relatively unbalanced, perhaps biased towards presenting significant findings which supported their hypothesis that anxious parents are more protective. Turner et al.'s (2003) behaviour ratings also included displaying anxiety. Observation of anxious behaviour is discussed next.

1.4.4. Anxious Modelling

Theories indicate children may learn anxiety through parents' anxious modelling. Murray et al. (2012) report that mothers with social phobia modelled greater anxiety than non-anxious mothers. Conversely, other studies rating anxious modelling all found non-significant effects. Drake and Ginsburg (2011) found that maternal anxiety did not predict independent-observer or child-rated anxious behaviour, although did predict maternal self-reported anxious modelling. The authors suggest anxiety may affect parents' perception of their behaviour.

Becker and Ginsburg (2011) found that anxious, compared to non-anxious, mothers reported significantly greater anxiety before completing an interactional task, and maternal-reported task anxiety was significantly correlated with greater anxious behaviours. However, observed levels of anxious behaviours were not significantly different between anxious and non-anxious groups. Ginsburg et al. (2004) found no differences in anxious behaviour between anxious and non-anxious mothers. However, correlations between anxious behaviour and other rated behaviours

reflecting control and warmth were evident for anxious mothers only. Specifically, as anxious behaviour increased, levels of negative affect and over-control increased and levels of granting autonomy and positive affect decreased. The authors suggest that anxious parents may show more negative parenting behaviours during times of increased anxiety. Reliability of these findings is reduced due to poorer inter-rater reliability for the rating of anxious behaviour in comparison to ratings of other behaviours. Turner et al. (2003), however, demonstrated good inter-rater reliability for ratings of displaying anxiety and report a similar pattern of findings: anxious parents did not display, but did report, higher anxiety.

Whaley et al. (1999) and Moore et al. (2004), expanding on the former, included ratings of catastrophising. They suggest anxious mothers may model fearful cognitions by verbalising catastrophising comments to their children. Both report that catastrophising comments were significantly more likely in anxious mothers. Moore et al. (2004) found infrequent occurrences of catastrophising and consequently rated it as 'present' or 'not present'. This dichotomisation reduces its power. Overall, these findings relating to anxious behaviour or verbalisations offer little evidence that anxious parents' interactions are characterised by anxious modelling.

1.4.5. Further Comparisons

1.4.5.1. Specificity of disorder.

Two studies compared groups of parents with particular anxiety disorders with a non-anxious control group, ensuring that mothers in each group did not have comorbid diagnoses of the other disorder. Challacombe and Salkovskis (2009) report no differentiation between disorders. However, Murray et al. (2012) report slight differences; mothers with social phobia showed less warmth and more expressed anxiety than non-anxious mothers, whereas those with GAD did not, (although mothers with GAD showed a trend towards lower warmth). As mentioned previously, Murray et al.'s (2012) sample included anxious mothers no longer meeting diagnostic criteria. A greater proportion of the GAD sample no longer met criteria which may account for the lack of significant difference from controls.

As most studies included diverse anxiety disorder diagnoses, inconsistent findings may be explained by differentiation between diagnoses. For example, fear disorders (e.g. panic disorder, social phobia) may differ from distress disorders (e.g. GAD, PTSD) which may be more closely linked to depressive disorders (Watson, 2005).

1.4.5.2. Specificity of observational task.

Evidence suggests parenting behaviour may be changeable dependent on the interactional task observed. Using the same sample as Ginsburg et al. (2004), Ginsburg, Grover, Cord and Ialongo (2006) report that both anxious and non-anxious parents displayed higher levels of over-control, criticism and anxious behaviour when observed completing a structured task compared to when observed during child-directed unstructured play. The authors suggest that more stressful, anxiety-eliciting tasks may elevate the likelihood of unhelpful parenting behaviours.

Further evidence comes from Murray et al.'s (2012) comparison of mothers with GAD, mothers with social phobia and a control group. Mothers were observed during three interactional tasks, designed to elicit social anxiety, general anxiety or to be non-stressful. Consistent with their hypotheses, Murray et al. (2012) found more marked behavioural differences between anxious and non-anxious mothers in the disorder-specific tasks. Indeed, during the non-stress play-based task, neither anxious group differed from the healthy control group in levels of observed parenting behaviours. Mothers with GAD showed lower encouragement and more passivity in both anxiety-provoking tasks. In the non-social yet still potentially anxiety-provoking task, mothers with social phobia did not differ from controls in their parenting behaviours, while in a social task, significant differences were evident in warmth, encouragement, passivity and expressed anxiety. Thus, non-

significant differences reported throughout this review may be attributable to the task not eliciting sufficient anxiety for anxious parents to exhibit different parenting behaviours. Studies have typically included multiple anxiety disorder diagnoses in one heterogeneous anxious sample, and the interactional tasks selected may not have elicited anxiety for all participants with anxiety disorders.

1.4.6. Child Behaviour

Most studies are limited by only rating parental behaviour. Coding of parental behaviours without consideration of child behaviours during interactions does not account for the antecedents and consequences of behaviour (Masia & Morris, 1998) and the dyadic nature of any interaction. Three studies rated child behaviour. Murray et al. (2012) found that child expressed anxiety did not affect parenting. This finding suggests that the relationship between child anxiety and parenting behaviours is not due to child anxiety eliciting different parenting behaviour, offering support for the role of parenting in the development of anxiety.

Woodruff-Borden et al. (2002) and Schrock and Woodruff (2010) rated child and parent behaviours using the same behavioural composites. Schrock and Woodruff-Borden (2010) found that anxious children showed greater frequency of productive engagement with non-anxious parents and non-anxious children displayed greater over-controlling behaviour with anxious parents. Woodruff-Borden et al. (2002) included sequential analysis to assess how child behaviour may elicit particular parental responses theorised to be implicated in the development of anxiety.

Findings suggest that child negative affect may elicit parental negative affect and control; this could be considered an affectionless controlling response. This research provides evidence for dyadic interactional processes.

1.5. Discussion

1.5.1. Summary and Relation to Research

This review suggests that parental anxiety is not associated with observable parenting behaviours. Consistent with other reviews of observational research with anxious parents, parental anxiety was not associated with over-control (van der Bruggen et al., 2008). Although more evidence exists for a relationship with warmth (Dibartolo & Helt, 2007), most studies found no association between parental anxiety and observable warm behaviours. This review's findings differ from self-report studies. For example, Lindhout et al.'s (2006) findings suggest parents with anxiety disorders show a different childrearing style to those without anxiety disorders, based on child- and parent-report. Parents reported themselves as less warm and more restrictive, while children's perspectives indicated greater control or overprotection but not less warmth. However such differences do not appear to be consistently demonstrated in observational studies. Discrepancies may be due to maternal report indicating differences in parenting which are not evident to others, including their children (Drake & Ginsburg, 2011).

However, parenting behaviour does appear to be affected by the type of task regardless of anxiety-disorder status (Ginsburg et al., 2006). Furthermore, Murray et al.'s (2012) findings may explain inconsistencies in the observational research. This study found that parenting behaviour differed significantly between groups when mothers were observed in different tasks relating to their specific diagnoses, suggesting that mothers' observed behaviour is not influenced by the presence of an anxiety disorder per se, but may be influenced by state anxiety as triggered by disorder-specific tasks.

This review supports observational findings that parenting behaviour is affected by child anxiety (e.g. Hudson, Comer & Kendall, 2008; Hudson & Rapee, 2001; Hudson & Rapee, 2002). It provides some evidence that parental behaviour is affected by a relationship between child and parent anxiety and by dyadic processes within interactions. Similarly, Williams, Kertz, Schrock and Woodruff-Borden (2012) found that parental and child responses to specific behaviours are affected by anxiety. Sequential analysis demonstrated that, when children displayed controlling behaviour, anxious parents were less likely to respond to their anxious children with warmth compared to non-anxious parents' responses towards their non-anxious children. The authors suggest that interactional processes may maintain negative responses and anxiety.

Van der Bruggen, Bögels and van Zeilst (2010) report that parental over-control was lower in parents with higher trait anxiety. Additional analyses indicated a curvilinear effect in which trait anxiety was associated with high and low levels of

control. Supporting Kaitz and Maytal's (2005) suggestion, the authors suggest parents may respond to anxiety through either over-control or withdrawal. This may account for the non-significant findings when comparing anxious and non-anxious groups.

1.5.2. Limitations

Despite good quality scores, limitations of studies require consideration.

1.5.2.1. Overview of methodological limitations.

As discussed, all studies are limited by relatively small samples, dichotomous classification of anxious and non-anxious parents and gender bias. Findings may be confounded by other parental and environmental factors which could affect both parental anxiety and parenting, such as inter-parental conflict (Rapee, 2001) or personality factors. Unremitting anxiety may be associated with personality disorder (Massion, Dyck, Shea, Phillips, Warshaw & Keller, 2002) and parents with personality disorders show non-optimal parenting behaviours when controlling for anxiety and depression (Johnson, Cohen, Kasen, Ehrensaft & Crawford, 2006). Studies did not assess personality disorder, thus potentially the presence of personality disorder in addition to anxiety may have contributed to parenting behaviour in studies reporting significant findings. Furthermore, child factors such as birth order or temperament may influence parenting behaviour. Generalisability of studies may be reduced due to child age or anxiety disorder status. Studies

frequently sampled a large age range of children, which may miss potentially significant differences in parenting behaviours at specific developmental stages.

As stated, limitations arise from observing short interactional tasks, usually in non-home environments and from using varying construct definitions, incorporating numerous parenting behaviours rated using different coding schemes. Subtle differences evident between anxious and non-anxious parents (e.g. where differences approached significance) may impact children. Based on theoretical notions of parenting (1.2.2.), studies regard parenting behaviours as positive or negative, yet this is likely to be context-dependent – for example, in dangerous situations, controlling behaviour may be positive (Dibartolo & Helt, 2007).

Rating frequencies of behaviour does not consider that certain behaviours may have greater consequences for child outcomes and/or behaviours considered detrimental may be outweighed by other positive behaviours. For example, compared to English mothers, Italian mothers tend to display more over-controlling behaviours, but also display more warmth, which appears to counteract potential negative impacts on children. Levels of maternal warmth in Italian mothers moderated relationships between maternal intrusiveness and overprotectiveness and child anxiety (Raudino et al., 2013). Although this finding may reflect cultural differences, in both parental behaviour and researcher's interpretation of specific behaviours, it also suggests that the relationship between parental anxiety and behaviour is more complex than can be captured in frequency ratings.

Raudino et al.'s (2013) findings demonstrate that parenting behaviour may vary across ethnic or societal cultures. Findings in this review were based on samples of predominantly Caucasian, or African American (Ginsburg et al., 2004), participants and may not generalise to other ethnicities. Parenting styles adaptive in some cultures may be associated with negative child outcomes in others (Bornstein, 2012). Children may be affected by deviations from cultural norms of parenting behaviour – for example experiencing highly controlling parenting in comparison to peers may have a greater impact on children than experiencing highly controlling parenting which is commonplace in the child's culture.

Key design limitations include the dominance of cross-sectional designs, which do not allow for assessment of changes in parenting over time or account for the potential dynamic nature of parenting. Also, the lack of including comparison groups meeting criteria for an alternative psychiatric condition means that significant findings could be due to mental health difficulties in general.

Children's perceptions of parenting, rather than observable behaviours, may be more meaningful when considering how parenting affects children (Rohner, 2004). Rohner et al. (2005) suggest that undifferentiated rejection, an individual's belief that their parents do not care, despite no clear behavioural indicators of this, is a significant aspect of the warmth dimension. Such rejection is overlooked in observational research.

1.5.2.2. Theoretical limitations.

Theoretically relevant parenting dimensions are poorly defined (Masia & Morris, 1998) and classifying parental behaviour is problematic. Clarification of parenting constructs is necessary, particularly developing clear, non-interrelated definitions for warmth and control (Dibartolo & Helt, 2007), which are of theoretical importance. However, whether these dimensions are independent is contentious. Constructs such as overprotectiveness combine elements of both warmth and control (Thomasgard & Metz, 1993). Moreover, Rubin, Cheah and Fox (2001) suggest behaviour at the extreme end of warmth may be associated with control. It is likely that selecting appropriate behaviours for assessing these constructs is affected by cultural, temporal and group-specific factors, as behaviours may have different meanings for different groups.

Given some of the methodological limitations considered above, the research in this area is limited by the focus on quantitative studies. Parenting constructs are evidently difficult to measure reliably; rating frequency of parental behaviours does not adequately capture dyadic processes and requires researchers to make assumptions about how behaviours are perceived or experienced; problems are associated with dichotomous assessment of anxiety disorder. These limitations demonstrate the difficulty of measuring anxiety and behaviour, which presents a fundamental difficulty for the reductive theoretical stance of quantitative research. Furthermore, this stance assumes an objective 'truth' exists regarding parental behaviour. However, what an observer considers a behavioural manifestation of a

parenting construct such as warmth may not be considered as such by either/both dyad member(s). Factors such as personality, perception and interactional experiences outside the observed interaction are all likely to contribute to how parents and children experience their interactions, and consequently, the impact these interactions have.

1.5.3. Limitations of this Review

One limitation of this review is the inclusion of Schneider et al.'s (2009) study, who observed parenting behaviour with adolescents aged 13-23-years. This may differ from behaviour towards younger children. Indeed, mothers were less verbally controlling with older children (Schneider et al., 2009). However, many other studies sampled adolescents within the age-range included in their sample. Additionally, Gar and Hudson (2008) report no significant age-related differences when they separately analysed parenting of younger (4-11-year-old) and older (12-16-year-old) children, suggesting that maternal behaviour is consistent across ages.

This review excluded studies with infants and consequently cannot draw conclusions about parenting across child development stages. Inclusion of studies exclusively rating sensitivity would have extended this review. Sensitivity may be a more meaningful assessment of parenting, as it is more dynamic (Shin, Park, Ryu, & Seomun, 2008). Findings of this review are limited to parents meeting diagnostic criteria for anxiety disorders and by the discussed limitations of differentiation according to diagnosis. In light of limitations associated with objectively observing parental behaviour, this review is limited by its focus on observational studies.

The review is biased towards English-speaking, Western cultures. As discussed, cultural considerations may be relevant to parenting behaviours. While inclusion of other cultures may confound findings, findings are not generalisable across cultures.

1.5.4. Implications for Practice, Policy and Theory

This review has implications for clinical practice with anxious families. Discrepant findings between this review and self-report research suggest anxious parents may hold overly negative self-perceptions of their parenting which may warrant exploration in clinical work with parents with anxiety disorders. Early intervention with anxious mothers is warranted in light of findings discussed. Findings indicate that parental and child behaviour are inter-related. Therefore, psychological treatments with children, particularly who experience anxiety disorders, may need to consider the role of parental behaviours and utilise family-based approaches with parents who also experience anxiety.

This review does not provide consistent evidence that parenting behaviour is a mechanism by which anxiety is passed from anxious parents to their children, suggesting instead that parenting may maintain a child's anxiety.

1.5.5. Future Directions

Critique of the reviewed studies offers future directions for research. Firstly, some of the discussed methodological limitations are addressed. Use of naturalistic observation would be beneficial, with more in-home observations. Greater use of disorder-specific tasks and validity-assessing is necessary. Structured interactional tasks may be more likely to elicit behaviours associated with parenting constructs of theoretical interest; however, researchers should aim to maintain ecologically validity. Greater clarity regarding theoretically meaningful parenting constructs is necessary to enhance their utility in research. Standardised coding schemes, with adequate internal consistency, should be used. Greater research into paternal behaviour would offer insight into potential gender differences, as well as increasing generalisability of findings. Research focussing on perceptions of parenting would address some of the potential difficulties in assessing parenting behaviour across cultures and may be more important when considering the impact of parenting on child outcomes. Finally, to address theoretical limitations relevant to the area, qualitative research could provide insight into how parenting behaviours are experienced during interactions. Qualitative research regarding people's perceptions and assumptions about the meanings of behaviour could contribute to clarifying definitions of constructs for specific groups.

Further development of the area requires longitudinal designs, to explore potential cumulative effects of parent behaviour, and prospective designs to explore the impact of behaviours and how parenting may change over time and across children's developmental stages. Smaller age ranges of children could elucidate

potential differences across developmental stages. Further research exploring how parenting may mediate relationships between parental anxiety and child anxiety or predict particular child responses would develop understanding of anxiety development. Additional research utilising sequential analysis would offer greater understanding of the contexts and precursors in which parents with anxiety disorders may behave differently and could contribute to theories of anxiety development. Similarly, considering sensitivity could further enhance understanding of reciprocal dynamic processes in parent-child interactions.

1.6. Conclusion

In conclusion, evidence does not consistently demonstrate an association between parental anxiety disorder and observed behavioural differences in parenting. However, specific and general methodological limitations should be considered and addressed in future research. A challenge to this is the complexity of the area, making it difficult to draw meaningful conclusions. In particular, identifying behaviours which relate to parenting constructs is fraught with difficulty, and measuring parenting behaviour without consideration of child behaviour fails to recognise the dynamic and dyadic nature of interactions.

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Chapter Two

Experiences of motherhood for mothers with obsessive-compulsive disorder symptomatology associated with a pregnancy or birth of a child: an interpretative phenomenological analysis

This manuscript is prepared for submission to The Qualitative Report (see appendix C for submission guidance). Additional detail is included, particularly in the Methodology section, to meet the requirements for the thesis. Although the journal recommends the active voice, as this paper is initially for fulfilment of the academic aspect of clinical psychology training, the more formal passive voice is used throughout, with the intention that this would be changed prior to submission to the journal.

Overall chapter word count (excluding tables, footnotes, keywords, words in illustrative quotes and references): 7159

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2.1. Abstract

Experiences of obsessive-compulsive disorder (OCD) can be associated with a pregnancy or child's birth. Such 'maternal obsessive-compulsive disorder' has received considerable quantitative research interest, yet little qualitative research is available. Interpretative phenomenological analysis of interviews with nine mothers who associated the onset or exacerbation of obsessive-compulsive difficulties with their pregnancy or child's birth generated two themes of 'changing identity' and 'disconnection'. In particular, the experience of OCD symptomatology in motherhood challenged mothers' perceptions of their identity as a mother, and consequent feelings of shame exacerbated feelings of disconnection. Findings are considered in relation to existing research into obsessive-compulsive disorder, maternal mental health and motherhood. Methodological limitations, clinical implications and potential future directions for research are discussed.

Keywords: maternal wellbeing; postnatal; antenatal; anxiety

2.2. Introduction

Research into antenatal and postnatal mental health is vital due to potential consequences for child development (Kingston & Tough, 2014). These periods appear to be associated with increased vulnerability to mental health difficulties (Brockington, 2004). Many women experience postnatal anxiety (Matthey, Barnett, Howie & Kavanagh, 2003). Indeed, anxiety is more common than depression antenatally and postnatally (Lee, Lam, Lau, Chong, Chui & Fong, 2007; Reck et al., 2008). Antenatal anxiety is a risk factor for postnatal depression (Robertson, Grace, Wallington & Stewart, 2004). Obsessive-Compulsive disorder (OCD) occurring antenatally and postnatally, termed 'maternal OCD', has received considerable quantitative research and media attention (e.g. Stone, 2004). However, little qualitative research of the area exists. This study utilises interpretative phenomenological analysis (IPA; Smith, 1996) to explore mothers' experiences of OCD, specifically where they associate the onset or exacerbation of their difficulties with pregnancy or childbirth.

2.2.1. Obsessive-Compulsive Disorder

OCD is characterised by obsessions and/or compulsions. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) defines obsessions as unwanted, recurrent and persistent thoughts, images or urges and compulsions as repetitive behaviours or mental acts undertaken to avoid or reduce distress, or prevent feared events. Diagnosis requires symptoms to be distressing, time-consuming or to interfere significantly with functioning (APA, 2013).

Approximately 1-2% of the population has OCD (National Collaborating Centre for Mental Health, 2006). In England, figures suggest 1.1% of adults aged 16-75 are diagnosed with OCD and prevalence is greater in females (Deverill & King, 2009). Community samples indicate greater prevalence – a US study reports lifetime prevalence of diagnosable OCD of 2.3% (Ruscio, Stein, Chiu & Wessler, 2010). Symptoms may best be considered on a continuum of severity (Abramowitz, Schwarz & Moore, 2003) and subclinical obsessive-compulsive symptoms in community samples are more prevalent than diagnosable OCD (Ruscio et al, 2010; Fullana et al., 2009).

2.2.2. Maternal OCD

Postnatal intrusive thoughts appear to be normal for many new parents (Ross & McLean, 2006). Fairbrother and Woody (2008) report that, in a community sample of ninety-one first-time mothers, assessed four weeks after childbirth, all disclosed experiencing intrusive thoughts of accidental harm coming to their infant and thirty-nine reported thoughts of intentionally physically harming their newborn. However, for some mothers, such experiences result in OCD.

Russell, Fawcett and Mazmanian's (2013) meta-analysis found higher prevalence of OCD in pregnant and postpartum women compared to the general population. Studies indicate prevalence rates from 0.2-3.5% antenatally (McGuinness, Blissett & Jones, 2011); postnatal prevalence is higher, at 2.7-3.9% (Ross & McLean, 2006). Uguz and Ayhan (2011) report that new-onset OCD, in the absence of a history of psychiatric problems, is evident antenatally and postnatally, while existing symptoms can also worsen during pregnancy (Uguz, Kaya, Gezginc,

Kayhan & Cicek, 2011). Although findings may indicate heightened vulnerability to OCD at these times, increased prevalence might represent exacerbation of previously undiagnosed or sub-clinical difficulties (Speisman, Storch & Abramowitz, 2011). Maternal OCD can occur comorbidly with postnatal depression (Abramowitz, Schwartz & Moore, 2003).

Obsessional content in maternal OCD tends to focus on risk to the infant (McGuiness et al., 2011). Obsessive-compulsive symptoms starting during pregnancy tend to relate to contamination concerns, with associated cleaning compulsions, whereas intrusions commencing postnatally often relate to the child being harmed, with associated avoidance behaviour (Abramowitz, Schwartz, Moore & Luenzmann, 2003).

Despite the literature's focus on antenatal and postnatal periods, mothers can experience significant distress throughout early motherhood. More mothers experience depression at four years postpartum than experience postnatal depression (Woolhouse, Gartland, Mensah & Brown, 2014). As this suggests a need to expand research and service provision beyond the one-year defined postnatal period (Meltzer-Brody & Brandon, 2015), OCD difficulties occurring after the postnatal period, which mothers associate with a child's birth, may require consideration.

2.2.3. Maternal Distress and Motherhood

The transition to parenthood is a time of adjustment and reorganisation (Glade, Bean & Vira, 2005). Although research has tended to overlook the usual

experiences of motherhood and focus on motherhood in the context of physical and emotional difficulty (Smith, 1999), a growing body of research provides insight into the typical experiences of mothers. Qualitative research suggests that motherhood is characterised by changing identity and social roles (Smith, 1999; Laney, Lewis Hall, Anderson & , 2015), responsibility (Akerjordet & Severinsson, 2010), introspection, growth and transformation (Nelson, 2003). Mothering involves emotional work (see Arendell, 2000). Anxieties specifically relating to pregnancy can be evident for pregnant women (Huizink, Mulder, Robles de Medina, Visser, & Buitelaar, 2004), and adjusting to the demands of motherhood is linked to postnatal psychological distress, which can impact on mothers' experiences of motherhood (Coates, Ayers & de Visser, 2014).

Qualitative exploration of postnatal depression (Hall, 2006) and anxiety (Wardrop & Popadiuk, 2013) has identified themes regarding unrealistic expectations about motherhood and perceived competence as a mother. Mothers experiencing postnatal anxiety can feel misunderstood because their experiences differ from those of postnatal depression, which is more widely recognised (Wardrop & Popadiuk, 2013). No known research has qualitatively explored motherhood in the context of maternal OCD.

2.2.4. Rationale

The need for utilising hermeneutic approaches to research mothers' mental health has been highlighted (Blegen, Hummelvoll & Severinsson, 2010). Additionally, more understanding of the lived experience of OCD is required (Fennell & Liberato, 2007). Qualitative exploration of mothers' experiences of maternal OCD

will add to the existing quantitative literature, which has thus far focussed on prevalence, obsessional content and treatment efficacy.

Identifying antenatal and postnatal difficulties and responding with appropriate, timely support is imperative (Paschetta et al., 2014). However, UK public policy recognises that anxiety disorders occurring antenatally and postnatally are not always identified (National Institute for Health and Clinical Excellence, 2014) and OCD at these times can go unrecognised or misdiagnosed (Speisman et al., 2011). This research could inform clinical practice and aid healthcare professionals in recognising obsessive-compulsive difficulties.

2.2.5. Aims

The following questions were considered:

- What is the lived experience of women who associate difficulties, which they consider to be OCD, with a pregnancy or child's birth?
- How do mothers make sense of these experiences?
- How do mothers experience motherhood within the context of OCD?

2.3. Methodology

2.3.1. Design

An IPA approach was employed, as it is valuable for exploring a phenomenon that may be significant in a person's overall life experience (Smith, Flowers & Larkin, 2009). IPA's flexible exploration facilitates consideration of issues which may or

may not have arisen in quantitative research regarding maternal OCD or qualitative research into antenatal and postnatal distress. Additionally, IPA is useful for healthcare research (Biggerstaff & Thompson, 2008).

2.3.2. Participants

2.3.2.1. Inclusion and exclusion criteria.

Inclusion and exclusion criteria are displayed in Table 2.1.

Table 2.1: Participant Inclusion and Exclusion Criteria

Inclusion Criteria	▪ Participants must be the mother of at least one living child, under the age of 18 years old. ▪ Participants understand their difficulties in the context of OCD and associate the onset or exacerbation of these difficulties with a pregnancy or child's birth. ▪ Participants must be at least 16 years old. ▪ Participants must have adequate fluency in English to participate in a detailed interview regarding their experiences.
Exclusion Criteria	▪ Participants must not have a current or past diagnosis of schizophrenia, psychosis or personality disorder.

As little qualitative research has explored women's experiences of maternal OCD, exclusion criteria were minimal. For example, criteria relating to diagnosis and duration were not defined. However, mothers were asked if they had experienced the excluded mental health conditions as it was felt that additional serious mental illnesses could compromise the sample homogeneity and consequently the

transferability of findings. In light of Meltzer-Brody and Brandon's (2015) suggestion to extend the focus of research into maternal mental health, inclusion criteria did not stipulate that OCD symptom onset or exacerbation had occurred within a year after childbirth and screening did not enquire about this; however, the participant information sheet given to participants before they agreed to take part did state that participants' experiences should have occurred during pregnancy or within a year after childbirth.

2.3.2.2. Participant characteristics.

Nine participants were recruited via charitable organisations associated with OCD, antenatal/postnatal mental health issues and parenting forums (appendix D provides a list of these organisations). Twenty-five women expressed an initial interest in participating. Eleven declined participation or did not respond to contact by the researcher; three were unable to meet to be interviewed; two did not meet inclusion criteria.

Table 2.2 presents participant information. All names are pseudonyms.

Table 2.2: Descriptive and Contextual Participant Information

Name	Age (years)	Ethnicity	Marital status	Highest educational level	Employment Status	No. of children	Age(s) of children at time of interview	Timing of OCD onset / exacerbation
Helen	32	White British	Married	Masters Degree (currently doing PhD)	Student	2	9 years, 5 years	Onset following birth of second child
Jessica	46	White British	Married	Diploma	Not working	2	20 years, 18 years	Exacerbation following birth of second child
Alice	36	White British	Married	Degree & PGCE	Not working	2	5 years, 4 years	Onset with both pregnancies
Clare	33	White British	Married	Degree	Self-employed	5	12-years – 1 year	Onset following birth of first child
Linda	49	White British	Married	Degree	Not working	2	22 years, 18 years	Exacerbation following births of children, particularly second
Anita	39	White European	Married	Masters Degree	Employed – currently on sick leave	1	1 year	Exacerbation following birth of child
Lily	26	White British	Married	Degree	Employed – currently on maternity leave	1	9 months	Onset following birth, however now retrospectively identifies with OCD
Faye	33	White British	Married	Degree	Employed – currently on maternity leave	1	6 months	Onset following birth, however now retrospectively identifies with OCD
Kate	48	White British	Married	Masters Degree	Employed	2	17 and 14 years	Onset following birth of second child

2.3.3. Materials

An interview schedule was devised with support from the supervisory team (appendix E). This incorporated prompt questions to elicit information and was designed as a framework in which participants' experiences could be explored as and when they arose, recognising the participants' expertise on their experience (Smith & Osborn, 2003).

2.3.4. Procedure

This research was approved by Coventry University Ethics Committee (appendix F) and conducted in line with British Psychological Society (2014) principles. Research advertisements, with a link to an online survey where participants could enter their contact details to receive information about the research (appendix G), were placed on charity websites, a charity Facebook page, a charity twitter-feed and parenting forums. Paper versions were also available (appendix H). Charities distributed paper flyers and founders approached potential participants. The researcher also attended a local support group to discuss the research.

The researcher contacted people who responded to the online survey or flyers. The Participant Information Sheet (appendix I) was emailed, requesting that recipients replied to advise whether or not they would like to participate. A follow-up email was sent approximately four weeks later, where people did not respond. Research appointments were made with those that responded positively and met inclusion criteria.

Participants were interviewed face-to-face in their homes. They completed a consent form (appendix J) and, if willing to do so, answered demographic and eligibility questions. Interviews were audio-recorded; participants were advised when recording started and finished. After interview, participants received a debrief sheet (appendix K) and verbal information about the study and researcher's motivation.

Interviews lasted between 52 minutes and 2 hours. Recordings were transcribed verbatim, with identifying information removed. Transcripts displayed the content of interviews, with notable pauses, emphases and aspects of speech dysfluency, offering sufficient detail for IPA (Smith et al., 2009).

2.3.5. Analysis

Analysis was guided by Smith et al.'s (2009) stages of IPA analysis (appendix L offers details). Additionally, consideration was given to Ashworth's (2003, 2006) 'contingencies of the lifeworld' (appendix M), regarded as essential features of people's experiences. These can be utilised as a 'lens' through which to view data in phenomenological research (Finlay, 2011). Themes were generated and analysis was confirmed through write-up and discussion with supervisors (Smith et al., 2009). An excerpt of a coded transcript and an example of themes generated for a participant are provided in appendices N and O.

2.3.5.1. Validity.

The IPA approach recognises that direct access to participants' experience is impossible and interpretation of given information is necessary. Although interpretations are based within the data, the analytic process is inevitably influenced by researcher preconceptions (Smith et al., 2009). To enhance validity, the researcher approached the research process reflectively. Participation in a 'bracketing' interview (Rolls & Relf, 2006) prior to recruitment explored assumptions based on personal and clinical experience. This led to explication of an assumption that mothers may have experienced traumatic births. Furthermore, as a result of an increased awareness of a diagnostic, problem-focussed conceptualisation of OCD, the interview schedule was revised. The bracketing interview also facilitated openness to relatively unconsidered issues such as loss and guilt. Encountering participants during the research also affected assumptions (Smith, 2007), requiring a cyclical approach to bracketing (Smith et al., 2009). Reflections were therefore undertaken before and after each interview.

Part of a transcript was coded by, and themes were discussed with, peers who were also undertaking IPA analysis. Extracts of analysis were shared with the supervisory team, who have experience of IPA.

2.3.5.2. Position of the researcher.

In line with Yardley (2000), transparency regarding researcher position is warranted. The research formed part of the researcher's training in clinical psychology. The researcher had existing clinical knowledge of, and experience

working with, OCD, predominantly from a Cognitive Behavioural Therapy (CBT) perspective. The researcher is not a mother.

The researcher tends towards a psychodynamic psychological perspective and an attachment-based understanding of psychological difficulties, also considering systemic aspects of experience important.

2.3.6. Dissemination

In addition to submitting for publication, it is intended that findings are shared with charities who facilitated recruitment and interviewees, who all selected to receive a summary of the results.

2.4. Results

2.4.1. IPA Analysis

Two superordinate themes were identified, presented in table 2.3.

Table 2.3: Superordinate and Subordinate Themes

1. Changing identity	1a Identity as mother
	1b Powerless versus powerful
	1c I didn't want to say 'I'm OCD'
2. Disconnection	2a Disconnection from reality and normality
	2b Disconnection from others

The first theme explores how identity changes with the transition to motherhood and the experience of OCD symptomatology. The second explores participants'

disconnection from reality, including perceptions regarding the normality of their experiences, and disconnection from others due to OCD difficulties.

2.4.1.1. Theme 1: Changing Identity

Within 'changing identity', three subordinate themes were distinguished. 'Identity as mother' explores changes to identity associated with motherhood and how this relates to OCD symptomatology. 'Powerless versus powerful' considers divergence in the experience of the powerful self in the context of obsessive-compulsive difficulties and motherhood. 'I didn't want to say I'm OCD' explores the degree to which participants consider OCD symptomatology part of their identity.

2.4.1.1.1. Theme 1a: identity as mother.

Within the context of changing identity, this theme explores the extent to which participants define themselves by their 'mother' identity, responsibility and expectations associated with motherhood, and how motherhood and obsessive-compulsive experiences are linked.

Numerous mothers expressed the importance of gaining their 'mother' identity. Alice "really wanted children" (L3) while Lily "always wanted to have a family" (L2); Faye describes her experience within the context of difficulty conceiving; Linda equated having children with having a life (L291-2). However, the degree to which participants owned the identity of 'mother' differed. While some participants emphasised the importance of being a mother by introducing this at the start of their interview, others began with information about themselves or their work, or with

their identity as a wife when introducing themselves. Given that participation in the research is due to their 'mother' status, opening statements demonstrating other aspects of themselves suggests a need to assert that their sense of identity comprises more than just 'mother'. Helen explicitly described the loss of self which she experienced through being a mother. Regaining a sense of her independent identity through starting a PhD has been significant in her recovery.

> It {PhD} gives me something to focus on other than the children. […] I feel like a, person and not a mother. […] in the world of motherhood […] you're very much 'mum' and you're very much er an adjunct to your child, everybody knows you through your child, so I'm [*daughter's name*]'s mummy or [*son's name*]'s mummy, I'm not *me.* [1]
>
> (Helen, L461-6)

Similarly, Faye associated returning to work with recovery.

> I'm hoping when I go back to work and my mind is occupied again, that that will take some of it away
>
> (Faye, L1836-7)

Both these mothers, and Kate, made reference to the challenging nature of

[1.] Note regarding quotations used to illustrate analysis: words in square brackets, e.g. [laugh], denote a non-verbal/linguistic feature within the participant's account or removal of identifying information such as a child's name. Ellipses in square brackets (i.e. […]) indicates that words have been removed to ensure the quote concisely demonstrates analytic interpretations. Words in curly brackets, e.g. {Community Psychiatric Nurse} have been inserted by the researcher to offer clarification in quotes. Words written in italics denote emphasis placed on the word by the participant. Verbal minimal encouragers by the interviewer have been removed.

motherhood, particularly with an infant, perhaps believing that this contributed to their postnatal mental health difficulties. Helen and Kate experienced postnatal distress after both their children. When describing her positive experiences of motherhood at interview, Helen noted that "the early years are not good for me" (L364-5), conveying the sense that the initial experiences of mothering were detrimental to her wellbeing.

Lily and Jessica also suggested a relationship between the importance of their 'mother' identity and their OCD symptomatology, although a continued struggle to understand their experiences was evident. Jessica suggested a link between her OCD symptoms and being advised she had abnormal cervical cells during her second pregnancy. This explanation had helped her to make sense of why she experienced intrusions after her second, but not her first, child.

> I've wondered if the thoughts that came about the kids […] is somehow tied in with me worrying about leaving them because because I was frightened of getting cancer and then dying. I don't know if I'm right but it's it's kind of – do you think, I mean [exhales], it makes sense in a sort of roundabout fashion doesn't it?
>
> (Jessica, L863-75)

Lily linked her desire for a family with her postnatal experience of intrusive images of her daughter dying, which demonstrated a fear of losing her newly-gained 'mother' identity. She had also previously experienced fears relating to becoming a mother, which she now understood as OCD. These fears were very powerful.

> I'd convinced myself that I would not be able to have a baby
>
> (Lily, L17)

> I never really prepared for the fact that I *was* going to have a baby. […] she was born and I even, I said to the midwife "oh my god is she alive?!"
>
> (Lily, L43-5)

Lily's fears that she would not be able to gain an identity of 'mother' may in fact reflect a fear regarding changes to identity and loss of self associated with motherhood. Her certainty that she would not become a mother prevented her from making realistic preparations for her new role, which perhaps protected her from acknowledging the imminent change to her identity. Her experience also demonstrates that experiencing intrusive images disconnected her from reality, further explored in theme 2a.

Jessica's obsessive-compulsive difficulties irretrievably changed her 'mother' identity by affecting her behaviour:

> …you can't switch it back, even now that they're 18, 19, you know 20 I still can't behave in that normal way that I would have done before, even now.
>
> (Jessica, L232-7)

For Jessica, and also Linda, whose children are now adults, "OCD has tainted" (Linda, L578) the entirety of motherhood. An evident consequence of experiencing obsessive-compulsive difficulties was loss. It appeared that their whole 'mother' identity had been affected by their obsessive-compulsive difficulties. Similarly, Lily expressed sadness about the loss of her early bonding experiences with her daughter, indicating that she considered this important for developing her 'mother'

identity. By switching between present and past tense in her interview, she demonstrated an ongoing difficulty in accepting her experience.

> it's just something that I've had to kind of gradually, accept and deal with and know that it's not going to go away, it's always going to have happened.
>
> (Lily, L138-9)

> I just have to, accept that it happened that it's never going to change. Um, that part of her life is gone now. That part of my life is gone.
>
> (Lily, 337-8)

Expectations about the identity of mother were evident, with self and societal expectations implicated. Clare described feeling "pressured" (L61), which perhaps reflected both self and external (family/societal) expectations of herself as a mother. Anita and Jessica described prioritising their children's needs despite their own psychological distress, which appeared to represent an expectation to be a good mother.

> it doesn't matter how *I* feel, even if I need to crawl to her I will crawl and just like [happy voice:] 'good morning! Did you have a nice sleep?' […] doesn't matter how low I am, I will pick, for *her*.
>
> (Anita, L473-5)

Helen's self-expectation to be a 'perfect mother […] seen to be doing *everything* right' (L298) stemmed from societal expectations, which were also evident in Faye's narrative (for example, "you're just not allowed to say if you're finding

things difficult being a first time mum" [L1719-21]). Helen's recovery was associated with relinquishing this 'perfect mother' identity, alongside increased self-acceptance. In a society in which she perceived "there's this idea […] that motherhood is what everybody wants and is good for everybody" (L422-3) and "all women love babies" (L444), she has accepted herself as different, and appears to have internalised this identity.

> I've come to the conclusion that I don't *have* to be normal, I don't have to fit into the boxes that everybody else, fits into. […] I *definitely* don't like babies
>
> (Helen, L310-11)

For all participants, motherhood was associated with responsibility and a change to a 'protector' identity. Most described fears of harm coming to their baby/child, from external sources or themselves. Although the content of Clare's OCD focussed on her own wellbeing, this was to ensure her ability to protect her daughter. Thus, for all mothers interviewed, an expectation of responsibility to protect predominates, and OCD symptomatology appeared to be a manifestation of a fear associated with this increased responsibility. This was linked to a sense of being powerful, considered in theme 1b.

> You're a hundred percent completely responsible, it's so scary! […] I lived in like constant fear that something would happen, whether she will fall, whether I will drop her, she will eat something, she'll get poisoned or something, she will be too cold, too hot, she might die
>
> (Anita, L32-6)

Clare and Linda demonstrated a sense of overwhelming, sole responsibility for protecting their children, suggesting that they regarded this as an integral part of their 'mother' identity.

> I wanted to protect my child but *I* had to be the one to do it. […] so it was very much if *I'm* in any way stopped from doing it I'm *never* going to be, um, able to support her.
>
> (Clare, L230-2)

In contrast to protecting, intrusive thoughts and images frequently displayed violence towards children, from either accidental or deliberate harm.

> Pick him up by his heels [voice breaking:] and bang him against the wall. [tearful]
>
> (Kate, L540)

> it went from her being stabbed in the chest to um her arms being sawn off with one of our kitchen knives.
>
> (Lily, L60-61)

Mothers reported significant distress associated with these intrusive thoughts and images, and experiencing them frequently challenged participants' perceptions of their 'mother' identities.

> I started really doubting myself about why I'd had these thoughts and what did it mean […] had I done anything wrong? Was I going to do anything wrong?
>
> (Jessica, L162)

The aggressive content of intrusions could be interpreted as expressions of anger or hatred reflected towards their children; this contradicted with participants' self-expectations about their 'mother' identities. Kate, Lily and Faye feared their own power for aggression, further explored in theme 1b. However, even where fears related to accidental harm, thoughts frequently involved the child dying, perhaps interpretable as indicating murderous rage. Only Helen explicitly expressed feeling "really resentful" (L376) and angry towards her son with whom she experienced obsessive-compulsive symptomatology. These feelings were linked to the responsibility of motherhood.

> *Anything* that needed doing needed to be done by mum. […] Really angry with him that […] he needed me so much.
>
> (Helen, L404-5)

The resultant fear of intrusions may indicate fear of the angry, hateful feelings apparent in the aggressive content of intrusions, as these negative feelings conflicted with mothers' perceptions of their 'mother' identity.

> I related having the, sort of images and the intrusive thoughts to *being* a bad mum
>
> (Lily, 151-2)

As a consequence, these negative feelings appeared to be turned inwards into self-hate and depression. Faye stated "you kind of hate yourself for thinking that thought" (L1427-31) while Lily and Kate both reported having experienced subsequent "horrendous depression" (Lily, L116) and suicidality as a consequence of their intrusions, because of how their experiences impacted their 'mother'

identity.

To summarise, motherhood was associated with a change in identity for these participants, characterised by loss of self and increased responsibility. Self and societal expectations of motherhood appeared to influence participants' perceptions of their 'mother' identity and experiencing OCD challenged these perceptions.

2.4.1.1.2. Theme 1b: powerless versus powerful.

Participants indicated a sense of powerlessness in the face of OCD, which was presented as powerful. Many participants' descriptions suggested OCD took over. Jessica describes OCD as "*very* strong" (L685). Lily describes herself as "just a *wreck!*" (L164) at the peak of her distress, implying she was destroyed by OCD. Similarly, Helen states her experience of OCD was "crippling" (L13), indicating a loss of functioning and perhaps even of herself, which Alice explicitly noted (L507) – this loss of her identity while experiencing OCD indicates the oppression of OCD. For Faye, however, despite a sense of potential powerlessness, she regains some power over OCD by not responding to compulsions thereby "refusing to give into it" (L675).

Clare's OCD was itself empowering. By focussing on controlling her food intake to avoid anaphylaxis, she could accept a lack of control elsewhere in her life, which enabled her to overcome postnatal generalised anxiety.

> everything outside of me I couldn't control, there was *nothing* I could control whatsoever. […] whereas what was going *into* me, that, that was one thing that I could control
>
> (Clare, L1114-8)

Lily, Faye and Kate all experienced intrusions related to their own potential to harm; their powerful self was evident, in contrast to their vulnerable infant.

> It was like, 'if I picked up that coaster, if I hit him on the head, he would die, and I could kill him, he's that fragile'
>
> (Faye, L302-305)

Jessica, too, alludes to intrusions about her power to harm. The impact of her thoughts on her interaction with her children, demonstrated in the quote on the following page, may suggest fears of harming them physically or sexually which may be too distressing or shameful to verbalise in interview.

> the thoughts started to affect everything, when I was with them, when I was bathing them, or changing them or taking them out or doing anything, I was like monitoring myself all the time to see um, how I was holding them or what I was doing with them.
>
> (Jessica, L171-4)

Her consequent monitoring of her behaviour demonstrates fear of her powerful self. This is also evident in Linda's narrative, who feared "all this potential to be dangerous" (L736). Other mothers' intrusions focussed on external or accidental risks and were associated with compulsive behaviours designed to protect their children. Again, their powerful self, and self-agency to minimise risks, is evident. Associated with the responsibility of motherhood is a sense of being powerful.

However, some mothers demonstrated a sense of powerlessness related to the responsibility of motherhood.

> I felt you know 'I can't go out, I can't do this, I can't do that' and I felt like I was being held hostage by him constantly, all the time. Um, and his health, and his needs and his wants.
>
> (Helen, L405-6)

> when they're tiny you look at them and it feels like a life sentence (!) before they can even go to *school* let alone the rest of it.
>
> (Kate, L890-1)

In summary, participants demonstrated both feelings of power and powerlessness due to OCD and motherhood. Many mothers presented OCD as powerful and dominating; however, for Clare it was empowering. The responsibility associated with motherhood contributed to an identity as a powerful self, which elicited fear, yet this responsibility was also experienced as oppressive.

2.4.1.1.3. Theme 1c: I didn't like to say 'I'm OCD'.

Many participants demonstrated a conflict about linking OCD to their identity. This theme links with 'disconnection from reality and normality', expounding how experiences considered abnormal affected identity.

Few mothers had been formally diagnosed with OCD. Lily and Alice received diagnoses from healthcare services but both experienced difficulty identifying with and accepting this diagnosis.

> I didn't like to say 'I'm OCD'. Which is why I'd always referred to it as a type of OCD, hoping that makes it sound a bit less serious.
>
> (Alice, L520-1)

Although this was in part because they did not identify with the stereotype of OCD as "manically cleaning" (Alice, L249) and "related to hand washing" (Lily, L102), the stigma of a mental health diagnosis and feelings of shame were also apparent. A conflict was evident as both also expressed the helpfulness of knowing their experience was a "recognised" condition (Alice, L426; Lily, L119). Identifying with a condition was an important part of other mothers' experiences too.

> I found the er description maternal OCD on a website and I thought 'this is me! This is exactly what I've been suffering'
>
> (Helen, 106-7)

Lily's diagnosis facilitated understanding of lifelong experiences as 'symptoms of OCD' (L11); thus, her diagnosis does not change her identity. Similarly, Faye now identified past behaviours as "OCD-like" (L181), although had not previously considered these problematic. Both also identified anxiety as part of their identity, suggesting they consider this relevant when making sense of their OCD. Lily described herself as "a worrier" (L370); Faye introduced herself as an "anxious person" (L22) early in her interview. Identification with being 'anxious' appears to be more acceptable than identification with OCD. The latter appears to present a greater challenge to identity, with two mothers describing themselves as "freaks" (Lily, L119; Alice, L278). Additionally, Faye questioned herself, "'if you're having

these thoughts, so what kind of person are you?'" (L429-31). Although in this way she considered intrusions part of her identity, she also referred to them as "things called anxious predictions and intrusive thoughts" (L45-6), appearing conflicted about whether OCD is connected to her identity. For Kate, a similar conflict was neatly summarised by a quote (see over) demonstrating a personal connection to her intrusions while also distancing herself from them by expressing them as "voices".

> I never told her {Community Psychiatric Nurse} about, feeling that I want, wanted to kill my child. No, that hearing voices telling me that I had to hurt him.
>
> (Kate, L728-9)

This also indicates disconnection from reality, explored in theme 2a. Kate's externalisation of OCD may help her cope with the distress of her intrusive thoughts. Faye's recovery is associated with a move towards considering OCD external and a change in her perception of her identity, as defined by actions not thoughts. Through this, her perceived identity as "monster" (L343) is alleviated. Similarly, Alice's externalisation of OCD as "this weird thing" (L253) may help her accept her diagnosis, by reducing the shame associated with being a "freak". Jessica too externalises her intrusive thoughts, distancing herself from the doubt they elicit about her 'mother' identity:

> I didn't know where it had come from, it was just there.
>
> (Jessica, L156)

However, Jessica appears to internalise a sense of being different. Like Jessica, Linda and Anita experienced OCD prior to becoming mothers. All demonstrate a

sense of abnormality as intrinsic to their sense of self.

> I've been told that ordinary people have all sorts of thoughts
>
> (Jessica, L1859)

> I'm trying to at least pretend that I'm normal
>
> (Anita, L493)

Clare, however, does not demonstrate a sense of her identity with OCD as abnormal, seemingly because her experiences are similar to those of other family members.

> I think everyone in my family has experience of it to an extent, to the point that, I'm just normal really to them.
>
> (Clare, L900-2)

In summary, a difficulty considering OCD part of identity was evident, although mothers with longstanding OCD tended to internalise a sense of being different. Distancing OCD from the self, through externalising it, occurred frequently and was interpreted as a way to more easily accept a diagnosis and to protect mothers from the distressing content of intrusions and the consequent attributions they made about their identity.

2.4.2.2. Theme 2: Disconnection

This theme considers how OCD disconnected mothers, firstly from normality and reality, and secondly from others, including both mothers' social networks and healthcare services.

2.4.2.2.1. Theme 2a: disconnection from reality and normality.

Experiencing OCD temporarily disconnected some mothers from reality. Lily expressed this most strongly.

> I said "[daughter]'s being stabbed and someone's chopping her arms off". My mum was like "no darling, she's fine […]" um I was like "no you *don't* understand, it's happening, I can see it happening, […] she's going to die"
>
> (Lily, L76-80)

Lily's experiences were "so vivid and so graphic" (L56) that perhaps the only way to express them was as if they were outside reality. She was initially misdiagnosed with puerperal psychosis, presumably due to her difficulty distinguishing her thoughts and images as separate from reality. At interview, Lily continues to struggle to express her experience of intrusions:

> I can't, really describe… I don- because it was it was as though it was *happening*. It was so real, it wasn't like it was just a thought it was in front of me… she was, there this beautiful little baby… *stabbed*.
>
> (Lily, L309-11)

Helen could describe her experience of intrusive images, whilst maintaining her connection to reality:

> a bus or something would come past […] then I would *see* my son lying on the floor having been squashed […] then I would see him next to me and go,

> "oh no actually he's ok" and then it was this constant confusion of I've just seen him die […] but yet he's next to me, at the same time.
>
> (Helen, L32-6)

However, she also demonstrated how OCD disconnected her sensory experiences from reality:

> I could not only see it, but I could smell it and I could *feel* it
>
> (Helen, L477-81)

Other mothers questioned their sanity, which was interpreted as fears that they were becoming disconnected from their sense of normality. Participants unanimously suggested that OCD experiences were abnormal and/or unusual.

> I thought I was having them {intrusive thoughts} because I was going mad and er, I thought 'this isn't normal. This *definitely* isn't normal'.
>
> (Kate, L794-5)

> you *know* […] it's sort of a bit…weird […] You're doing something to protect your child but you also know it's rather strange.
>
> (Linda, L437-9)

Considering OCD experiences abnormal appears to result in shame. This is evidenced by numerous mothers' efforts to deliberately present an external façade in order to "appear to be normal" (Helen, L308). For example, Linda referred to a "mask" (L441) and Jessica recalled feeling "like I had this plastic smile on my face all the time" (L1701-2). Thus, internal and external experiences were disconnected.

Faye felt her experiences *might* be normal, with part of her thinking "'this is just my brain, it's just thoughts, it's just normal'" (L622-3), yet also feared disclosing her experience. Although normalising OCD has been important for Faye's recovery, an ongoing struggle to fully accept that her experience could be normal was evident in her interview. She both normalised and questioned normalising explanations of OCD. This was evident when she described her husband's response when she told him her thoughts. Although he advised her that such thoughts were natural and that he too had experienced thoughts about harming people he loved, namely her, she doubts that he may have similar intrusive thoughts to her:

> he {husband} was like […] "oh [name], that's natural', I was like "no, no, it's not, it's not", "it is, it is, it is. I've had had thoughts about hurting you but I'm not going to do it." […] And I don't think, you know, when he says stuff like that, I don't think he has the sort of – well, maybe he does, you know, I don't know
>
> (Faye, L1305-18)

Furthermore, she expressed doubt about whether other new mothers may experience similar intrusive thoughts:

> we go to baby groups and I just think 'I wonder if they're having these thoughts.' And I very much doubt it.
>
> (Faye, L1659-61)

Others also continued to consider OCD as not entirely normal, despite increased awareness of it being a shared experience, which appeared to decrease feelings of disconnection from normality and resultant shame.

> it's normal to a degree if so many women are having these symptoms […]

> that's been the biggest help, just knowing that other people have been having exactly the same things as me.
>
> (Alice, L699-702)

In summary, this theme interprets how OCD experiences disconnect mothers from normality and reality. This is associated with shame and feeling disconnected from others, which is explored in the next theme.

2.4.2.2.2. Theme 2b: disconnection from others.

Disconnection from others due to OCD was frequently evident. Many expressed "how isolating and how lonely" (Jessica, L1753-4) their experience of OCD was/is. At times, mothers isolated themselves by withdrawing from connection with others. Alice did not fully convey her experience to others, such as her mother, and explicitly stated that she did not wish to talk about it, thereby preventing others from supporting her.

> I kind of mentioned it to my Mum and said 'I've got some form of OCD but I don't like talking about it' […] so she never asked me about it again.
>
> (Alice, L260-1)

As Alice also reports that she "felt ashamed when it was diagnosed as OCD" (L167-8), reluctance to disclose experiences can be interpreted as associated with shame. Similarly, Linda's use of the word "skulking" highlights her feelings of shame which prevented her from disclosing her experiences.

> I used to be skulking around libraries trying to find a book that would tell me what was wrong with me because I couldn't tell anybody
>
> (Linda, L339)

For all participants, difficulty sharing their experiences with others, and shame, were evident to some extent. Shame appeared to arise from perceiving intrusive thoughts as "irrational" (Anita, L330), feeling that OCD experiences were abnormal and negative appraisals about identity (theme 1). Such shame inhibited mothers from accessing support, from both social networks and healthcare services.

> I feel really cross with myself that I didn't, I *couldn't* ask for help
>
> (Helen, L579-80)

Many mothers feared losing their children if they disclosed their intrusions, particularly to healthcare professionals. This is linked to their beliefs about their 'mother' identity in the context of experiencing OCD, and a fear of others' perceptions of this. Faye was adamant she would not tell her GP, while Jessica asserted certainty in her belief that she risked losing her children if she divulged her experiences.

> But I was in no way going to say about me harming the baby!
>
> (Faye, L556-7)

> I was frightened that they would just come and just cart the kids off. That's what I thought would happen. […] I couldn't risk that so I wouldn't, I just didn't talk to them about it.
>
> (Jessica, L360-6)

For Jessica, feeling disconnected from healthcare professionals (such as a locum psychiatrist, as illustrated below) also contributed to her non-disclosure.

> You think 'this person, I don't even know who they are, they don't know who I am', you know, um, so, […] you don't talk about anything specific
>
> (Jessica, L386-88)

Having "some kind of relationship" (Jessica [L379]) and trust with clinicians is considered important by Jessica. This perhaps decreases fear and shame associated with disclosing OCD experiences. Frequently, however, mothers experienced some disconnection from healthcare services, which were experienced as abandoning and unsupportive. This left participants feeling "let down" (Helen, L252). Alice received little support from a perinatal team during her first pregnancy, who she recalled advising her "'if you had depression, we could put stuff in place, um, but for OCD there's not a lot we can do'" (L247-9). She felt similarly unsupported by non-perinatal mental health services during her second pregnancy.

> I remember my therapist saying she'd never come across it in pregnancy and even she wasn't that sure about how to deal with it
>
> (Alice, L272-3)

Some mothers' attempts to communicate their experiences were met with misunderstanding and/or dismissiveness, which increased feelings of shame and disconnection from others.

> he {husband} got a bit cross, constantly because he didn't understand what was wrong with me. […] he'd say 'don't be silly. Don't be silly, what are you talking about? Don't be silly' and, and I thought, 'well now I'm silly on top of everything else'!
>
> (Helen, L138-41)

> I phoned my mum […] she just didn't know what I was going on about. […] she didn't understand at all.
>
> (Jessica, L162-3)

In summary, experiencing OCD was isolating and associated with feelings of shame. Participants' own non-communication and withdrawal, as well as others' responses, perpetuate feelings of disconnection. Connections with healthcare professionals were difficult to establish, in part due to mothers' fearing losing their children if they disclosed their experiences, and healthcare services were frequently experienced as unsupportive.

2.5. Discussion

In the theme 'changing identity', participants' narratives indicated that both OCD and motherhood impact on identity and that these experiences interact to affect mothers' perceptions of themselves. Mothers appear to make sense of their OCD experiences in terms of the importance of becoming a mother and the increased responsibility associated with motherhood. A further interpretation is that OCD is linked to mothers experiencing a loss of self and negative feelings associated with motherhood.

The theme of ‘disconnection’ demonstrated that experiencing OCD was associated with disconnection from reality and normality. Participants unanimously agreed that their experiences were not entirely normal and consequently felt shame. Participants frequently reported feeling isolated and healthcare services were sometimes unsupportive. Experiencing mental health difficulties disrupted participants’ connection with their usual social support structures and shame associated with their difficulties inhibited accessing professional support. Additionally, participants’ mother status may limit their connection to regular mental health services, as was evident for Alice, whose ‘pregnancy-specific’ OCD was a new concept to her therapist.

2.5.1. Relation to Research

Regarding ‘changing identity’, findings correspond with existing research and theoretical considerations of motherhood for mothers without mental health difficulties, as well as those experiencing postnatal distress. Smith (1999) acknowledges that a loss of identity can be associated with motherhood and that pregnancy is associated with preparation for the ‘mother’ identity, while Laney et al. (2015) highlight women’s changing identity as a consequence of motherhood. As with Akerjordet and Severinsson (2010), the importance of responsibility was evident.

Simultaneous love and hate for an infant/child, or maternal ambivalence, is considered inevitable by some theorists (Almond, 2010). Winnicott (1947/1975) suggests that a mother must be able to tolerate hate towards her baby, without expressing this to the baby or responding to this through action. Perhaps

experiencing OCD intrusions of harm towards a child is a natural reflection of feelings of hate which occur for all mothers when faced with the demands of a child. Indeed, quantitative research indicates that aggressive intrusive thoughts and images are relatively normal for new mothers (Fairbrother & Woody, 2008). A difficulty considering such intrusions acceptable or normal, and becoming significantly distressed by them, could be considered an inability to tolerate feelings of hate. Winnicott (1947/1975) suggests that denial of hate is unhelpful for both mother and child, and prevents optimal child development; one might consider that greater distress in response to intrusions, or greater aggressive content within intrusions, may indicate greater denial of hateful feelings.

Oberman and Josselson (1996) suggest that motherhood is experienced as a 'matrix of tensions' by all mothers, including "loss of self-versus expansion of self, experience of omnipotence versus experience of liability, life promotion versus life destruction, maternal isolation versus maternal community" (p. 344). Findings of this analysis relate to their model. Aspects of theme 1a and 1b demonstrated that responsibility in motherhood is associated with liability and a sense of power, and identified mothers' loss of self and feelings of aggression. 'Disconnection' considered how the experience of OCD, and its interpretation as abnormal, exacerbated feelings of isolation and perhaps prevents mothers from forging links with a maternal community.

The tensions proposed by Oberman and Josselson (1996) are likely to elicit ambivalent feelings. Thus, theories suggest that ambivalent feelings can be part of the usual experience of motherhood. Perhaps maternal distress arises when mothers

struggle to amalgamate their mixed feelings, or to tolerate and accept negative feelings. Indeed, for one mother interviewed, recovery appeared to be associated with an acceptance of negative feelings towards babies: 'I *definitely* don't like babies' (Helen, L311).

The analysis indicated that many mothers externalised OCD, not accepting it as part of their identity. Externalising psychological difficulties, through objectification or personification, can be a valuable therapeutic approach within narrative therapy (White and Epston, 1990) and may have facilitated recovery in this sample.

In the theme of 'Disconnection' mothers' experiences of shame and self-stigma were apparent. All the women sampled here considered their experiences abnormal and many avoided disclosure, often by presenting an external façade. This finding supports research by Fennell and Liberato (2007) who report that people experiencing OCD often consider their experiences abnormal, and that self-stigma, and self-presentation in order to manage stigma, are aspects of living with OCD (Fennell & Liberato, 2007). Furthermore, findings correspond with Wardrop & Popadiuk's (2013) qualitative research with new mothers experiencing anxiety, which noted the stigma associated with disclosing struggling in motherhood. Thus, both motherhood and OCD are experiences which can be associated with stigma. Similar to Coates et al.'s (2014) findings that mothers with postnatal distress feel uncared for and unknown within healthcare systems, disconnection from healthcare professionals was evident in this analysis.

Findings also relate to the literature on antenatal and postnatal OCD. Abramowitz,

Schwartz and Moore (2003) provide evidence that healthy new mothers and fathers experience intrusive thoughts relating to harm coming to the infant. Additionally, Fairbrother and Woody (2008) offer evidence for the relative frequency of intrusive thoughts of harm and behavioural responses to such thoughts, in a study of new mothers who were recruited during pregnancy. However, findings here suggest that some mothers experiencing OCD symptoms do not consider their experiences normal. Cognitive-behavioural theory postulates that the appraisal of intrusions drives anxiety and consequent compulsion(s) (Salkovskis, 1985). Thus, thoughts which are evident for many parents may not be appraised as a normal aspect of parental experience and may instead be considered, for example, inappropriate or dangerous. Evidence suggests that intensive cognitive behavioural therapy (CBT) is effective for mothers with post-natal OCD (Challacombe and Salkovskis, 2011). Societal expectations and constructions of motherhood may be overly positive; perhaps relatively normal negative experiences such as intrusive thoughts of harm are excluded from popular views of motherhood.

Two participants' experiences offer support for depression occurring secondary to experiencing distressing OCD as suggested by Abramowitz et al. (2010). The analysis implicates feelings of "intolerable anger focussed on the baby" in the development of postnatal depression, as purported by Blum (2007, p53). Fairbrother and Abramowitz (2007) propose a model of postpartum OCD in which an increased sense of responsibility is a contributing factor for the development of OCD. In this analysis, mothers' narratives indicated feeling a sense of responsibility, which appeared to provoke anxiety and could be interpreted to have contributed to their OCD symptoms.

Some participants identified past anxiety or OCD-like behaviours prior to pregnancy or childbirth, offering evidence for OCD and anxiety existing on a continuum of severity (Abramowitz, Schwartz & Moore, 2003). Understanding anxiety dimensionally may be more appropriate than traditional dichotomous measurement (Brown & Barlow, 2009). Increased anxiety appears to be a feature of pregnancy and postnatal experiences. While for some this reaches clinically diagnosable levels, even subclinical levels may be considered important by mothers.

2.5.2. Limitations

Sampling women who were not formally diagnosed with OCD is a potential limitation, and participants' experiences may not reflect those of a clinical population. However, as the analysis suggests, shame and fear can prevent mothers who are experiencing OCD symptomatology from accessing healthcare services, which would facilitate diagnosis. Research of motherhood traditionally focuses on pathological experiences (Smith, 1999). This study's recruitment method enabled exploration of the experience of distress considered significant by mothers but which does not meet conventional views of mental health issues in terms of diagnostic criteria. Recruiting mothers who self-identified with the term OCD offered insight into the myriad ways women utilised support and overcame their difficulties. Regardless of whether the mothers in this sample would have met diagnostic criteria for OCD, identifying their experiences as OCD offered them a way to make sense of their difficulties. Furthermore, evidence suggests that experiencing intrusions can be commonplace for new parents (Fairbrother and Woody, 2008). Understanding why some mothers experience significant anxiety

and/or seek an explanation for their experiences, and self-identify with OCD, could aid understanding of why and how OCD symptomatology may develop into OCD.

As with all idiographic studies, the transferability of these findings is limited. Mothers opted to participate, and may have particular motivations for participation which could introduce bias. All were White European, living in the UK; their experiences may not be shared by mothers from other cultures or ethnicities. All were heterosexual and married at the time of interview. Their experiences may differ notably from those of, for example, single mothers or mothers in same-sex relationships. Furthermore, all had some post-school educational qualification which may indicate higher socioeconomic status.

Some heterogeneity within the sample may have influenced analysis. It is possible that qualitative differences exist between participants experiencing OCD antenatally and postnatally or between those who experienced new-onset OCD compared to those whose existing OCD was exacerbated. However, two participants who had recently developed understanding of their experiences as OCD now retrospectively identified past experiences in the same way, suggesting that new-onset and exacerbation may not always be distinct. Mothers differed in their involvement with healthcare services, which may facilitate particular understanding of difficulties based on treatment modalities. The current ages of participants' children varied substantially, thus mothers' antenatal and postnatal experiences spanned a large time period. Factors such as societal attitudes to pregnancy, parenting and motherhood, and availability of perinatal healthcare provision, are

likely to vary over time, and may affect mothers' experiences. Furthermore, recall and sense-making may be affected by time elapsing. Additionally, mothers differed in how recently they had identified their difficulties as OCD and consequently the extent to which they had developed an understanding of their experiences in this way.

2.5.3. Clinical Implications

Clinicians need to be aware that OCD symptoms may be occurring even where mothers do not outwardly show or disclose symptoms. Potential signs may be mothers asking multiple questions to seek reassurance. Clinicians should enquire about OCD experiences in ways which facilitate disclosure and respond to disclosures in ways which are sensitive, normalising, understanding and acknowledging of how distressing experiences of intrusive thoughts may be for mothers. Raising awareness that intrusive thoughts of harm can occur for new mothers and that intrusive images, with greater sensory power than thoughts, can be a normal, albeit frightening, experience may be beneficial.

Given the distressing nature of intrusions, clinicians should consider that those with antenatal and postnatal depression may be experiencing undisclosed OCD symptoms. As mothers with OCD experiences may feel disconnected, service engagement is likely to be key.

To offer further support, healthcare professionals working with new mothers could normalise the experience of maternal ambivalence and the presence of both

negative and positive feelings during the transition to motherhood. Normalising even experiencing feelings of hate at times may reduce mothers' feelings of shame, and/or reduce mothers' negative interpretations about their identity as a mother. Encouraging mothers to acknowledge and express negative feelings may be helpful.

2.5.4. Future Research

Further qualitative research to expand understanding of maternal OCD would be beneficial. In light of discussed limitations, future research should examine experiences of new-onset and exacerbation of existing OCD symptoms separately, narrow inclusion criteria regarding the age of the child with which mothers associate their OCD experiences, and aim to engage mothers from different cultural and ethnic backgrounds.

2.6. Conclusion

This research contributes to literature on maternal OCD. Although participants were not formally diagnosed, the analysis provides insight into the experience of OCD symptomatology. Experiencing intrusive thoughts challenges mothers' identity, and mothers appear to make sense of their OCD experiences in terms of the importance of becoming a mother and responsibility. A further interpretation is that OCD experiences are linked to a loss of self, and a difficulty tolerating feelings of hate towards their child. Disconnection permeates the experience of OCD symptomatology in the context of motherhood – mothers feel isolated and fear that their experiences are disconnecting them from normality. Despite some sample

limitations, the findings have meaningful clinical implications. Healthcare professionals working with new mothers have significant potential to normalise mothers' experiences of intrusive thoughts of harm. Clinicians need to be aware that experiencing fear and shame due to their OCD symptomatology may prevent mothers from disclosing their experiences and/or actively seeking help. However, although research indicates that thoughts of harm coming to the baby are a common phenomenon for new parents (Fairbrother and Woody, 2008), some mothers become distressed by these experiences and consider them abnormal, and may pathologise relatively normal experiences in their efforts to make sense of their perceived difficulties.

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Chapter Three

Convergence between researcher experience and participant experience in qualitative research: reflections of a trainee clinical psychologist undertaking interpretative phenomenological analysis with mothers with obsessive-compulsive disorder

This paper is prepared for submission to Reflective Practice (see appendix P for aims and scope)

Chapter word count (excluding tables, keywords and references): 3513

3.1. Abstract

This reflective paper considers my personal experience of the research process of completing a literature review about parental anxiety and a study exploring mothers' experiences of obsessive-compulsive disorder which they consider to be associated with a pregnancy or childbirth using Interpretative Phenomenological Analysis. Specifically, the paper explores ways in which researcher experiences mirrored aspects of participants' experiences. Specifically reflections on loss, responsibility, self-doubt, ambivalence, control, avoidance and changing identity are discussed.

Keywords: reflective practice; reflexivity; maternal obsessive-compulsive disorder

3.2. Introduction

Integral to phenomenological approaches such as Interpretative Phenomenological Analysis (IPA) is an attitude of reflection (Finlay, 2008). Additionally, reflective practice is a core competency of clinical psychologists (British Psychological Society [BPS], 2014). Throughout the process of this research, undertaken for the purposes of training in clinical psychology, reflection was considered vital for the research and for my personal and professional development. A reflective approach enabled transparency necessary for generating a valid piece of qualitative research (Yardley, 2000) and supported my development as both a researcher and a clinical psychologist.

3.2.1. Defining and Developing Reflection

Within IPA, the attitude of reflection applies to both participant and researcher (Smith, Flowers & Larkin, 2009). IPA is concerned with how people make sense of significant experiences and the phenomenological aspect of this approach accesses participants' reflections at multiple layers, described in table 3.1. (Smith et al., 2009). Significant events of research interest will elicit participants' reflections and the process of the research interview may elicit further reflections. Similarly, the researcher engages in reflection to become aware of preconceptions, yet is also affected by the process of the interviews with participants and preconceptions may be further highlighted during the process of engaging with data in analysis (Smith et al., 2009). Thus ongoing reflexivity is necessary.

Table 3.1.: Layers of Reflection (Smith, Flowers and Larkin, 2009)

Pre-reflective reflexivity
The reflective 'glancing at' a pre-reflective experience
Attentive reflection on the pre-reflective
Deliberate controlled reflection

To support the development of my reflexivity, I engaged in a 'bracketing interview' (Rolls & Relf, 2006) to explore existing assumptions before embarking on the empirical research. This is designed to enable awareness of preconceptions and how personal experiences may influence the research. However, IPA is aware that such preconceptions cannot be 'stepped outside of' and bracketing can only be partially achieved (Smith et al., 2009). In recognition of the cyclical approach necessary for bracketing, I kept a reflective journal throughout the research process. This reflective material contributes to this paper.

3.3. Reflections on Selection of the Research

As this research was a necessary aspect of my training as a clinical psychologist, it in some ways represented a 'means to an end'. However, the selection of the research area was influenced by my personal and clinical interests and experiences. A tendency towards psychodynamic thinking and an attachment-based understanding of development (Bowlby, 1969; Gerhardt, 2004) influences my therapeutic work. As a result of these approaches, I am interested in antenatal and postnatal distress because of its potential impact on early attachments and child development (see e.g. Kingston, Tough and Whitfield, 2012). Thus, I sought an

empirical project with a focus on perinatal mental health. The IPA approach appealed to my interest in individual experience, also fundamental in my therapeutic engagement with clients.

The literature review focusses on parenting behaviour of parents with anxiety disorders, thus considering the systemic influence of anxiety. This corresponds with my interest in family relationships and how these relate to psychological difficulties, and indeed, my own experience of being parented by a parent who can, at times, experience anxiety which affects our immediate family. Although the selection of obsessive-compulsive disorder (OCD) in particular does not have a personal resonance for me, my selection of the empirical research was also influenced by my experience with my mother, including an awareness that she experienced psychological distress following my birth and consideration of how this may have affected my own attachment style.

Although I initially considered the importance of diagnosis, perhaps partly based on my reading of the quantitative literature on maternal OCD, I selected to sample mothers who themselves associated with OCD rather than who those had received formal diagnoses. This suited the IPA stance in which people's sense-making of their experiences is important and enabled inclusion of participants who had not accessed professional healthcare services, which I feel is a relative strength of the research. Furthermore, this actually fits more comfortably with my therapeutic stance, in which I consider that issues of the psyche and potential psychological distress are fundamental aspects of all our experiences, and that diagnostic

classification of mental health difficulties can create arbitrary distinctions between people whose experiences are similar. This is, however, a stance which developed through training concurrent to the research process, and my original focus on diagnosis may reflect my past experience of working in a healthcare setting with a strong emphasis on diagnosis.

3.4. Convergence with Participant Experiences

A researcher's position can fluidly exist as both 'insider' and 'outsider' (Le Gallais, 2008). While I was in some ways an 'outsider', given that I am not a mother, in others I was an 'insider' – similar in that I am female, White European, living in the UK and educated. Qualitatively exploring the experiences of participants with whom the researcher lacks immediate points of identification (such as gender and ethnicity) can present challenges (Fawcett & Hearne, 2004) and my similarities enabled empathic engagement with the mothers. Reflecting on the research process, I noted aspects of my experience of the research which converged with experiences of mothers I interviewed.

3.4.1. Loss

During the research process, the issue of loss was significant for me. Similarly, participants' experiences of loss were highlighted during the data collection and analysis phase. Interestingly, it was only through the bracketing interview that I considered the potential significance of loss for mothers experiencing maternal

OCD. For participants, loss was evident in the prior experiences of mothers, such as miscarriages or abortions, and in terms of their experience of OCD. Narratives of numerous participants demonstrated that OCD had caused them to lose something of the experience of motherhood. For Faye and Lily, two first-time mothers with infants, aspects of the transition to motherhood had been lost (such as enjoying their pregnancies) and expectations had been unmet; at the opposite end of the experiences of my sample, two mothers with children who were now adults, Linda and Jessica, had lost something of their entire experience of motherhood. Loss of identity was also evident.

For me, the most notable loss was in analysing the data. IPA involves a number of analytic steps (table 3.2). An early part of this is 'initial noting', which involves making detailed notes on the content of the interview and expanding the data. The following stage is to develop 'emergent themes' based on these notes, and the process is then repeated for multiple participants until a final set of themes across participants is developed. The early phase was far more tolerable than the latter phases. On reflection, this is due to the fear of losing important aspects of the data during the process of analysis and interpretation. Making decisions from stage three of the analysis onwards was difficult for me. Synthesising the results when establishing themes across cases involved the loss of themes which were pertinent for particular participants', but did not represent the whole group. Indeed, even aspects of experiences which seemed initially to resonate with multiple participants were not included in the final analysis. The process of writing up the analysis itself involved loss, for example in selecting particular quotes to illustrate themes, and in removing a particular theme which did not directly relate to the research questions.

Implicit in the process of making decisions about what to include is loss, as each decision represented loss of a potential alternative.

Table 3.2: Stages of IPA Research (Smith, Flowers & Larkin, 2009)

1. Reading and re-reading
2. Initial noting
3. Developing emergent themes
4. Searching for connections across emergent themes
5. Moving to the next case
6. Looking for patterns across cases

Particularly given the necessity of engagement with participants' experiences or 'entering the lifeworld' of participants (Finlay, 2012), my difficulty with loss reflects a desire to accurately portray the experiences of the mothers who participated and to do justice to their participation. All participants made reference to the fact that their experiences are not something they shared widely, meaning that the research had afforded me an insight into their experiences which few others were allowed. Indeed, Jessica explicitly stated at the end of her interview that, aside from her husband, she had not divulged such detail of her experience to anyone else:

> apart from [husband's name] I don't think I've talked to anybody else about it ever! [laughs]
>
> (Jessica, L1765-6)

Her laughter may represent a defence against feeling quite uncomfortable about sharing her experiences with me, or an attempt to minimise how isolating her experiences were. Considering myself as researcher in a privileged position enhanced my sense that my analysis should not disregard any elements of the mothers' experiences. However, it was impossible to include everything.

Some mothers' experiences resonated more strongly with themes than others. Despite an effort to engage in processes to enhance validity (Yardley, 2000), some participants' voices may be more strongly heard in the analysis. This may reflect my own personal identification more strongly with some participants than others. I am aware that I found it easier to engage with some of the younger participants, perhaps because I can more easily imagine myself in their position. Additionally, the high levels of distress evident for some participants (Kate, Lily and Anita in particular) contributed to me feeling a stronger empathy for these participants. It is also worth noting that interviews with Faye, Lily and Kate, who I believe may be more strongly represented in the research, were the last three interviews that I conducted, and by this point my IPA stance was established and my interview technique had improved substantially, in that I did not follow the interview schedule so prescriptively and maintained more neutrality. A difference in those most represented may also be affected by the fact that these mothers, compared to other participants, more closely corresponded to the quantitative research of the area, with which I was familiar. Thus the noted heterogeneity of the sample in terms of onset or exacerbation of OCD and nature of intrusions may have affected analysis.

A further difficulty with loss was associated with a difficulty excluding participants in line with my exclusion criteria. Although this may in part be affected by my need for recruitment, I also felt that by denying mothers opportunity to share their stories within this research I was dismissing the importance of their experiences. Perhaps this also reflects a fear of missing out on potentially valuable data by losing the experiences of mothers willing to participate. Certainly I recognise a fear of missing out in other aspects of my life, which may be associated with a characterological defence (Lemma, 2003). In my email responses to those participants who didn't meet criteria, I wanted to convey sensitively a recognition of the significance of their experiences alongside my gratefulness for their willingness to participate. In this way, I attempted to manage their potential feelings about losing the opportunity to participate and managed my own feelings of guilt and loss about not being able to include them in the research.

Additionally, I felt a sense of loss in relation to my first interview, in which I felt my interview technique prevented much valuable data from being collected. This interview was the shortest, and significantly shorter than some, yet was with a mother who reflected very openly and meaningfully about her experience. I felt both frustrated and sad that I had not been able to maximise the potential of this mothers' participation. My journal reflections indicate that at times I resisted probing or commenting because I feared introducing my own biases and making interpretations about the participants' experiences, yet at others I spoke too much and did not allow the participant's expertise to be at the fore of the interview. Regarding the former, perhaps anxiety as a novice researcher limited my natural engagement with the participant's story. Furthermore, I was aware of my more

familiar ‘clinician’ role and the need to keep this separate from my role as ‘researcher’. However, my ‘reflection in action’ (Schön, 1983) here perhaps caused a self-consciousness which, instead of enhancing the research process through reflexivity, hindered the data collection. The contrasting issue of me talking too much was revealed through immediate reflections after the interview and through transcription. This demonstrated processes and preconceptions that I was less aware of and ‘reflection on action’ (Schön, 1983) was necessary to develop my interview technique. Some preconceptions and biases were evident on further reflection, in that I jumped to conclusions about some elements of her experience and did not follow up other aspects which may have been significant (such as failure to follow-up on her rapidly listing a number of life events which occurred prior to her son’s birth and postnatal OCD). The opposite processes occurring in my interview technique required consideration, and reflexivity enabled later interviews to reflect the IPA stance a little more.

My difficulty with loss was also evident in the literature review, in terms of removing information to adhere to word count requirements. This mirrors experiences of past assignments during my training as a clinical psychologist, in which I have struggled to make decisions about what information is essential for inclusion and what can be disregarded. I believe this is associated with an internal sense that I should always do more, perhaps in order to prove my value as a clinician and researcher and, more fundamentally, as a worthwhile person. This was also reflected in my felt sense that I had not done the analysis ‘properly’ – motivation to undertake a piece of IPA research in the future may reflect a defence against this feeling.

I believe that the parallels in loss evident for me and the participants are partly because my experiences were influenced by participants' experiences. IPA recognises that a researcher's cognitive and emotional responses in interviews can add to an understanding of a participant's experiences. Extending this further, from a psychodynamic perspective, I may have experienced participants' projections of their feelings about loss. Such projections are a means by which people can 'get rid of' difficult feelings so that they do not have to consciously deal with them (Lemma, 2003). Additionally, as IPA requires empathic engagement with participants, it is perhaps unsurprising that my engagement with mothers during interviews and their narratives during analysis, brought to the fore my own experiences and attitudes in relation to motherhood, both as someone who has been mothered and as a potential mother. My difficulty with loss in this research process reflects my own personal experiences of loss, which are somewhat related to my choice of research area, as acknowledged previously. A reluctance to lose aspects of the data may unconsciously represent my reluctance to accept my own losses.

3.4.2. Responsibility

Just as the power of responsibility was evident for these mothers with OCD, and was associated with fear, so I experienced anxiety associated with the power and responsibility of being a researcher. As I was made privy to mothers' thoughts and experiences, I had a degree of power. This was evident in interviews, in which participants disclosed much yet I disclosed little. In my post-interview reflections, I noted that where I sensed that mothers may have had greater difficulty with the interview (evidenced by hesitancy or becoming tearful when sharing an aspect of

their experience), I disclosed more of my personal experiences and motivation for conducting the research. This may have been an unconscious attempt to redress the balance of power of the interview process and to manage my feelings of discomfort or guilt about the perceived impact of my research on participants.

Making decisions throughout the analysis and selecting meaningful quotes confers a degree of responsibility and gave me power over the participants' narratives. This process was anxiety-ridden, from an anxiety about whether my initial emergent themes had been 'good enough' through to anxiety regarding the final analysis write-up, which I believe is associated with the power inherent in the research process. Again, this also reflects my anxieties about my role and value as a researcher and clinical psychologist.

3.4.3. Self-doubt

Many participants highlighted self-doubt associated with OCD. Similarly, my experience of the research process generated self-doubt, about my ability not only as a researcher within the context of clinical psychology but also regarding the other aspects of my clinical psychology role. Thus, self-doubt extended from the research into other areas of my identity. As with the participants, my self-doubt reflects, and exacerbates, my anxiety.

3.4.4. Ambivalence

Interpretations were made about the potential role of maternal ambivalence (Almond, 2010) in contributing to OCD, and the distress associated with negative feelings in motherhood, which is perceived to be a happy experience. A degree of ambivalence was evident in my engagement with the research. While I felt enthused by the topic area, I also showed avoidance and felt demotivated at times. The demands and challenges of the research, particularly in terms of time, evoked feelings of irritation, even anger; however, especially once I had started interviewing, I was also engrossed with the data and consequently talked at length to those close to me about the research, demonstrating love for the topic and empathy for the participants. Similarly, with the literature review I was both actively interested and deeply frustrated with the process. Thus, my experience of both positive and negative feelings during this significant experience parallels the mothers' ambivalence about motherhood.

3.4.5. Control

Similar to one participant's use of control (through her OCD) to manage her anxiety, so I too noticed a link between my levels of control and anxiety. Redrafting the interview schedule was an area where my reluctance to relinquish control was particularly apparent. Reflecting on this, I associated the open neutral questions required for IPA with reduced perceived control. While the potential for varied and unexpected information to arise in interviews is an exciting aspect of the IPA approach, for me it was also associated with some anxiety. I experienced a

difficulty in allowing myself and the analysis to be controlled by participants' experiences and not by my prior assumptions or interests.

3.4.6. Avoidance

Avoidant behaviour was evident in many mothers, which helped them to manage their anxiety. Likewise, my avoidance within the research process was a (somewhat maladaptive) strategy designed to reduce the anxiety associated with the research and its importance for the outcome of my training. My avoidance was evident from engaging with selecting a topic at the very beginning of the process right through to writing up. For participants, avoidance isolated them further, impacted their functioning and affected their relationships. For me, my avoidance contributed to me falling behind desired deadlines, feeling under time pressure to gather the data, and having to work long hours as the deadline for submission neared. Ultimately, this approach served to increase anxiety and negative feelings associated with the research (as discussed in 'ambivalence').

3.4.7. Changing Identity

This research process affected the whole of my training process, which itself has been a time of changing identity as I develop my competencies and knowledge as a clinical psychologist. Through this project I have learned not only research skills but also about myself, thus the research has developed my identity personally and professionally. As with the transition to motherhood in which a new identity is irreversibly created, so for me this training grants me a new identity as 'clinical

psychologist', and I cannot 'undo' this identity change. Similarly, I am "irretrievably changed" by the encounters with participants (Smith, 2007, p.6). Perhaps as with the potential tension for mothers of loss and expansion of the self associated with transitioning to motherhood (Oberman and Josselson, 1996) so this training and research process represents both a loss and expansion of my identity.

Additionally, my own desire and hope for a future changed identity to 'mother', and my own experiences of loss, were strongly evident during the analysis write-up. This concurrently enhanced and impeded my engagement with the data. For example, at times my emotional reaction to the data made me want to avoid working on my research; however, my empathy with participants, and desire to perceive things from their perspective, facilitated a rich exploration of the data.

3.5. Conclusion

In conclusion, my own personal and professional experiences influenced the selection of both the literature review and the empirical paper contained in this thesis. In my reflections I have noted that my own experiences during the research process have some similarities to experiences of the mothers with OCD who I interviewed. The most salient of these convergences was in my experience of loss associated with the research; however, other parallels were evident in relation to the superordinate themes identified in my research and aspects of the mothers' experiences embedded within these themes. Reflective engagement with the research process has been an enjoyable aspect of this journey, and I believe my

reflection of this research as a significant event within my experience of training and my overall life experience will progress through Smith et al.'s (2009) layers of reflection. Thus, further reflections not yet evident are likely to emerge and my experience of engaging with these mothers' stories will continue to influence me in ways I cannot yet imagine.

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Appendix A: Aims and Scope and Manuscript Submission Guidelines for *Parenting: Science and Practice*

Aims & scope

Impact Factor now 1.065

5-Year Impact Factor: 1.622

Parenting: Science and Practice strives to promote the exchange of empirical findings, theoretical perspectives, and methodological approaches from all disciplines that help to define and advance theory, research, and practice in parenting, caregiving, and childrearing broadly construed. "Parenting" is interpreted to include biological parents and grandparents, adoptive parents, nonparental caregivers, and others, including infrahuman parents. Articles on parenting itself, antecedents of parenting, parenting effects on parents and on children, the multiple contexts of parenting, and parenting interventions and education are all welcome. The journal brings parenting to science and science to parenting.

Parenting: Science and Practice is a quarterly international and interdisciplinary peer-reviewed journal that seeks to publish rigorous empirical, methodological, applied, review, theoretical, perspective, and policy pieces relevant to parenting; contributions from the humanities and biological sciences as well as the social sciences are invited. The journal also publishes notices of books and other publications or media representations relevant to a scientific approach to parenting.

Departments

Parenting: Science and Practice has five main departments: Inquiries about prospective submissions to any department should be addressed to the Editor (email: Marc_H_Bornstein@nih.gov).

- **Empirical Articles.** The journal is principally committed to the publication of empirical articles. Creative, comprehensive, and clear reports that advance theory and the empirical base in the field of parenting studies are sought, and all modes of empirical research are invited: experimental, observational, ethnographic, textual, interpretive, and survey.
- **Reviews**. Reviews of the literature may be empirically grounded or theoretical; they should be scholarly, integrative, and timely, synthesizing or evaluating an issue relevant to parenting. (Published reviews are sometimes accompanied by a small number of solicited commentaries from specialists in parenting as well as in allied fields.)
- **Statements.** Statements provide a forum for the rapid dissemination of new hypotheses, fresh concepts, alternative methods, or emerging trends. Statements should be tightly reasoned and empirically grounded and must be cogent and succinct. Statements should not exceed 3,000 words in length.
- **Tutorials.** *Parenting* publishes occasional tutorials that debut a new concept in parenting or explore the intersection of parenting with an academic specialty pertinent to parenting studies. These papers define the concept or the field, crystallize its major contributions, detail direct associations with parenting, and augur future directions of application.
- **Media Notices.** Summaries and evaluations of books, periodicals, websites, and other media that concern themselves with parenting studies or practices will appear in the journal. Send relevant material to the Editor.

MANUSCRIPT SUBMISSION

Cover Letter.

(1) Include a brief statement that indicates what the study will tell the readership of the journal and indicate the intended department. (2) If submitting an empirical report, warrant that the study was conducted in accordance with the ethical standards of the American Psychological Association (APA). (3) Affirm that all authors are in agreement with the contents of the manuscript.

Submission.

Parenting: Science and Practice receives all manuscript submissions electronically via their ScholarOne Manuscripts website: http://mc.manuscriptcentral.com/hpar. ScholarOne Manuscripts allows for rapid submission of original and revised

manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. For ScholarOne Manuscripts technical support, you may contact them by e-mail or phone support viahttp://scholarone.com/services/support/ . If you have any other requests please contact the journal editor at Marc_H_Bornstein@nih.gov.

Address: Dr. Marc H. Bornstein
Editor, *Parenting: Science and Practice*
8404 Irvington Avenue
Bethesda, MD 20817-3838 U.S.A.
TEL: 301-656-1642
FAX: 301-480-4039

EMAIL: Marc_H_Bornstein@nih.gov

Please note that *Parenting: Science and Practice* uses CrossCheck™ software to screen papers for unoriginal material. By submitting your paper to *Parenting: Science and Practice* you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Review.

Manuscripts are reviewed by the Editor, members of the Board of Editors, and invited reviewers with expertise in the area(s) represented by the manuscript. Submissions must be appropriate and of moment to the readership of *Parenting: Science and Practice* and should meet a high level of scientific acceptability. A first level of review determines the appropriateness, import, and scientific merit for the journal; on this basis, the Editor reserves the right to review the manuscript further. The Editor also retains the right to decline manuscripts that do not meet established ethical standards. A system of blind reviewing is used; however, it is the author's responsibility to remove information about the identity of author(s) and affiliation(s) from the body of the manuscript. Such information should appear on the cover sheet. The Editor will have the discretion to integrate solicited reviews into a determinative response.

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. Authors are required to secure permission to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher.

All parts of the manuscript should be word-processed, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in a brief Synopsis. Avoid abbreviations, diagrams, and reference to the text in the Synopsis. Please see the Style Guide for reference.

References.

Cite in the text by author and date (Smith, 2010). Prepare the reference list in accordance with the APA Publication Manual, 6th ed. Examples:

Journal: Brierly, D. (2007). Emotional memory for words: Separating content and context. *Cognition & Emotion*, *21*, 495-521.

Book: Smith, E., & Mackie, D. (2000). *Social psychology*. Philadelphia, PA: Psychology Press.

Contribution to a Book: Tanner, W. P., & Swets, J. A. (2001). A decision-making theory of visual detection. In S. Yantis (Ed.), *Visual perception* (pp. 48-55). Philadelphia, PA: Psychology Press.

Illustrations.

Illustrations submitted should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files
- Included at the end of the manuscript

Color Reproduction.

Color art will be reproduced in color in the online publication at no additional cost to the author. Color illustrations will also be considered for print publication; however, the author will be required to bear the full cost involved in color art reproduction. Please note that color reprints can only be ordered if print reproduction costs are paid. Print Rates: $900 for the first page of color; $450 per page for the next three pages of color. A custom quote will be provided for articles with more than four pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

Tables and Figures. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

Proofs and Reprints.

Page proofs are sent to the corresponding author using Taylor & Francis' Central Article Tracking System (CATS). They must be carefully checked and returned within 48 hours of receipt. Authors from whom a valid email address is received will be provided an opportunity to purchase reprints of individual articles, or copies of the complete print issue. These authors will also be given complimentary access to their final article on*Taylor & Francis Online*. Reprints of individual articles are available for order at the time authors review page proofs. A discount on reprints is available to authors who order before print publication.

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Taylor & Francis Open Select provides authors or their research sponsors and funders with the option of paying a publishing fee and thereby making an article fully and permanently available for free online access – *open access* – immediately on publication to anyone, anywhere, at any time. This option is made available once an article has been accepted in peer review. Full details of our Open Access programme.

Search Engine Optimization. Search Engine Optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guide here.

Parenting: Science and Practice Style Guide

PARENTING
SCIENCE AND PRACTICE

Marc H. Bornstein
Editor

STYLE GUIDE

Parenting: Science and Practice receives all manuscript submissions electronically via its ScholarOne Manuscripts site located at http://mc.manuscriptcentral.com/hpar. ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts and facilitates the review process as well as internal communications among authors, editors, and reviewers via a web-based platform. ScholarOne technical support can be accessed at http://scholarone.com/services/support.

Generally follow the guidelines on requirements, format, style, and ethics provided in the *Publication Manual* (6th ed.) of the American Psychological Association. In addition, adhere to the requirements in this Style Guide.

Each submission should include a separate cover letter containing the title of the manuscript, the name(s) of all author(s) and affiliation(s), and the street address, telephone, fax, and electronic mail of the corresponding author.

The ms. should be blinded as to the author(s) identity and should adhere to the following format:

TITLE PAGE

The title of the paper should appear on the first page of the text.

SYNOPSIS

Written in lay English, the SYNOPSIS should follow this outline in a single paragraph with the four sections clearly labeled. ***Objective***. Normally a one-sentence description of the motivation for the study. ***Design***. Provides essential information who was studied (including the *N* of participants), what was done, and how. ***Results***. Summarize the main findings succinctly. ***Conclusions***. The take-home message for the reader.

INTRODUCTION

METHOD

Participants/Sample
Procedures

RESULTS

DISCUSSION

IMPLICATIONS FOR PRACTICE, APPLICATION, THEORY, AND POLICY

REFERENCES

APPENDIX (if applicable)

TABLES
FIGURES

Notes:

- IMPLICATIONS FOR PRACTICE, APPLICATION, THEORY, AND POLICY. Use a variant of this formulation appropriate to the study. This brief (250-word) paragraph should convey the practical, clinical, theoretical, or policy implications of the study for parenting.
- FIGURES (set in Book Antiqua)

If the ms. is accepted for publication, add after the IMPLICATIONS paragraph:

AFFILIATION(S) AND ADDRESS(ES):

Corresponding author: Whole name, full mailing address, email address. Names and affiliations (only) of co-authors (if any) follow.

ACKNOWLEDGMENTS
FUNDING

Format Text:
There are 3 possible levels of subhead

Level 1:

INTRODUCTION

All caps...bold...centered...text following is flush left.

Level 2:

Participants

Caps and lower case...bold...flush left...text following is paragraph indent.

Level 3:

Measure. Caps and lowercase...bold...paragraph indent, followed by a period, and run into the text that follows, with a regular space between the period and the text that follows.

Lists:
Standardize "listings" throughout the manuscript.
For paragraphs:

(1) XXXXXXXXXXXXXXXXXXXXXXXXX.
(2) YYYYYYYYYYYYYYYYYYYYYYYY.
(3) ZZZZZZZZZZZZZZZZZZZZZZZZZZZZZ.

For short lists in the text, numerical in parentheses: (1) xxxx, (2) yyyy, and (3) zzzz.

Ages of Children:

Wherever possible, provide ages of children in lieu of or in addition to grade; ages and times appear in numerical format: 4-year-olds, 6 min.

Some Conventions:

Preferred	*Not Preferred*
active voice	passive voice
versus	v. or vs. caregiver caretaker
participants or sample	subjects laboratory lab
first, second, third	firstly, secondly, thirdly
European American, African American	white, black
preterm, term, postterm	pre-term, full-term, post-term
in order to	to
Figure	Fig. and so forth, and the like
etc. infant, child	it

Usage:
"relation" for mathematical or variable associations; "relationship" for familial or interpersonal associations
"while" implies temporal coextension; "whereas", "even if", "although" as appropriate otherwise
"since" implies temporal quality; "because" expresses causal relation
"rear" for children; "raise" for animals
A series of three (or more) items has commas after each item in the series: X, Y, and Z.
"datum" is singular; "data" are plural.
Dates: 1950s.
"Variety" and "series": Each mass noun takes a singular verb: a variety is, a series is.
Spell and grammar check the manuscript.
cf. means "compare," rather than "see."
Verify quotations and provide page numbers. Quotations longer than 500 words must have permission in order not to violate "fair use."
Put spaces around hyphens, statistical symbols, and so forth instead of cramming them together.

Sexism in Language:
Avoid sexism in language; use plural phrases as, "children and their toys" for "a child and his toy."

Footnotes:
Footnotes should not be used; important information should be incorporated into the text.

Statistics--*t*, *r*, *F*, and the like:

- Normally statistics are reported to 2 places (after the decimal point).
- Statistics are set off from the text with commas (not parentheses).
- Statistics should specify degrees of freedom.
- Correlations: $r(df) = .xx$, $p < .0x$: begin with .xx, not a leading zero, 0.xx
- Range...like other descriptive statistics (*M*, *SD*), range should be italicized and followed by = (not a colon :).
- *N* for whole sample size, *n* for subsample sizes.
- Specify the *p* level to 2 or 3 places only.
- Means should be accompanied by a measure of dispersion (*SD*).
- $*p < .05$. $** p < .01$. $***p < .001$.

Appendix B: Quality Assessment Framework

Adapted from Caldwell, Henshaw and Taylor (2005, 2011) and Coughlan, Cronin and Ryan (2007)

Each study was rated on each question, noting relevant points. Total scores were calculated and converted to percentages.

1. Does the title reflect the content?

0 – Title is misleading or inaccurate
1 – Title is confusingly too short or too long but broadly reflects the content of the study or title does not fully capture all relevant information about the content
2 – Title clearly informs reader of the content of the study

2. Are the authors credible?

0 – Authors do not hold academic qualifications relevant to the area or this information is unavailable
1 – Authors hold appropriate qualifications relevant to the area
2 – Authors hold appropriate qualifications and have published within their field

3. Does the abstract summarize the key components?

0 – Abstract is poorly written and/or lacks necessary information such as study aim, methodology, sample size, main findings and conclusions/recommendations.
1 – Abstract succinctly includes the majority of necessary information (i.e. aims, methodology, sample size and selection, main findings and recommendations).
2 – Abstract is well-written and succinct, providing information about the aims, methodology, sample size and selection, main findings and conclusions/recommendations.

4. Is the rationale for undertaking the research clearly outlined?

0 – No
1 – Partially
2 – Yes

5. Is the literature review comprehensive and up-to-date?

0 – Literature review lacks inclusion of key research relevant to the area
1 – Literature review includes appropriate literature but fails to adequately critique the relevant literature and/or to identify gaps in the current literature
2 – Literature review is appropriately broad and in-depth with critique of the studies referenced.

6. Has a conceptual or theoretical framework been identified? Is the framework adequately described? Is the framework appropriate?

0 – no or little reference is made to theoretical framework
1 – a theoretical framework has been alluded to but not adequately described
2 – a clear theoretical framework has been identified and described, in which relevant themes from the literature are used to guide the research and relationships between concepts are demonstrated.

7. Is the aim of the research clearly stated?

0 – no

1 – partially
2 - yes

8. Are all ethical issues identified and addressed?

0 – No reference is made is to ethical approval or issues
1 – Partial discussion of ethical approval and/or issues is included
2 – Adequate discussion of ethical issues and reference to ethical approval is included

9. Is the design clearly identified and a rationale provided?

0 – Design is not identified or is not justified
1 – Design is made partially evident and is justified
2 – Design is clearly identified, including reference to observational methodology

10. Is there an experimental hypothesis clearly stated and are the key variables identified?

0 – Study lacks clear hypotheses
1 – Hypotheses are stated but not clearly and/or only partially state the relationship between variables
2 – Directional hypotheses are clearly stated, with the relationship between independent and dependent variables made clear

11. Operational definitions

0 – Little or no explanation of relevant terms, theories and concepts is included
1 – Terms, theories and concepts are generally clearly defined
2 – All the terms, theories and concepts mentioned in the study are clearly defined

12. Is the population identified?

0 – population not identified
1 – population is only partially identified
2 – population is clearly identified

13. Is the sample adequately described and reflective of the population?

0 – Sample is not adequately described
1 – Sample is adequately described but lacks some aspect of relevance, enabling only some assessment of the degree to which the sample represents the population.
2 – Sample is adequately described, including reference to the method of sampling and to size and inclusion and exclusion criteria, enabling assessment of the degree to which the sample reflects the population.

14. **Is the method of data collection valid and reliable?**

0 – Process of data collection is not adequately described and/or little or no reference is made to reliability and validity
1 – Process of data collection is adequately described with some reference made to reliability and validity
2 – Process of data collection is clearly and adequately described. Reference is made to reliability of observational coding and validity issues and these are satisfactory (correlation coefficient for observational coding moderate-strong, i.e. >0.6).

15. **Is the method of data analysis valid and reliable?**

0 – Inappropriate analysis methods are used and/or analysis methods are not described
1 – Analysis methods are adequately described and appropriate statistical analysis is utilised

2 – Appropriate analysis methods are utilised with sufficient statistical tests run and significance ratings reported

16. Are the results presented in a way that is appropriate and clear?

0 – Results are presented in an unclear fashion
1 – Results are generally presented clearly enabling the reader to easily ascertain the results
2 – Results are presented clearly and consistently throughout, enabling the reader to easily ascertain results

17. Is the discussion comprehensive?

0 – Findings are not discussed or are discussed with little or no reference to previous literature.
1 – Findings are discussed with reference to some previous research. At times the discussion lacks balance.
2 – Findings are discussed with reference to previous research and links back to hypotheses and the literature review. The discussion is balanced.

18. Are the results generalisable?

0 – Findings are not at all generalisable
1 – Findings are partially generalisable
2 – Findings are suitably generalisable of the population of interest (i.e. anxious parents)

19. Is the conclusion comprehensive?

0 – Conclusion is non-existent or inadequate; findings do not support the conclusion.
1 – Conclusion is generally supported by the findings and adequately identifies some limitations, makes some recommendations and offers some implications for clinical practice and/or theory.
2 – Conclusion is clearly supported by the findings and clearly identifies limitations, makes recommendations and offers implications for clinical practice and/or theory.

20. Are references accurately referenced?

0 - no
1 – partially
2 – yes

Appendix C: Journal Submission Guidance for *The Qualitative Report*

Editorial Statement

The Qualitative Report (ISSN 1052-0147) is a peer-reviewed, on-line bi-monthly journal devoted to writing and discussion of and about qualitative, critical, action, and collaborative inquiry and research. *The Qualitative Report*, the oldest multidisciplinary qualitative research journal in the world, serves as a forum and sounding board for researchers, scholars, practitioners, and other reflective-minded individuals who are passionate about ideas, methods, and analyses permeating qualitative, action, collaborative, and critical study. These pages are open to a variety of forms: original, scholarly activity such as qualitative research studies, critical commentaries, editorials, or debates concerning pertinent issues and topics; news of networking and research possibilities; and other sorts of journalistic and literary shapes which may interest and pique readers.

The Qualitative Report is published by Nova Southeastern University. Its Uniform Resource Locator (URL) is

http://www.nova.edu/ssss/QR/index.html

Article Submission Guidelines

In 1990, we launched *The Qualitative Report* as a paper journal in order to give writers and researchers an outlet for expressing themselves in and about qualitative research. The world back then was not so qualitative research-friendly as it is today. It was difficult to find journals totally dedicated to qualitative approaches or ones open to publishing research utilizing such methods. We envisioned the journal as a safe haven for authors and readers to explore these new and strange approaches to discovery and exploration.

A couple of years later, we took *The Qualitative Report* online and reached out to a worldwide audience. We have seen our readership and paper submissions increase dramatically (see *TQR* "By the Numbers" for these figures). We have seen a decided improvement in the state of qualitative research as an accepted family of approaches to research and reflection. We have also been witness to the wonderful growth of quality in the field. We have found the emergence of all of these events to be quite fulfilling and rewarding.

Over these years, as we have worked with our authors, we have begun to approach them and their papers in a way that we think is different from what may be the standard procedure at other journals. We became more and more curious about our own process. We reviewed our reviews and we spoke with our authors and editorial board members. In this reflection, we began to see a mentoring pattern develop. The reviewers and editors enjoyed the emerging style and felt the authors appreciated what we were

trying to do. The authors agreed the reviews they were receiving were different too. They thought *The Qualitative Report* feedback was richly developed, extremely helpful, and respectful of their ideas and of them.

Based upon these reflections, we introduced a new editorial process at *The Qualitative Report* in 2002. Our goal for this process continues to be focused on helping our authors to prepare their papers for eventual publication in the journal. In this system, all authors who submit papers are accepted as members of *The Qualitative Report*'s community.

The hallmark of *The Qualitative Report* is not be built upon rejection rates; rather, we distinguish ourselves by assisting authors to improve themselves and their texts. We strongly believe all authors and their research have merit. Sometimes, that quality is not readily apparent in the text so our goal in this approach is to help authors to develop their ideas and to work collaboratively with their mentoring reviewers to help them to bring out the best in their work. The tenor of this editorial relationship will be one of respect and collaboration.

Our mission is to nurture and mentor authors who submit their papers to *The Qualitative Report* and to support them throughout the paper development process. In doing so, we have envisioned *The Qualitative Report* as a learning community, one through which we will commit our collective human and informational resources to help each and every author produce papers of excellence and distinction.

In 2004, we moved into another developmental phase of *The Qualitative Report* which greatly assisted authors in the improvement of their manuscripts submitted even more efficiently and effectively. We kept the manuscript as our centerpiece by focusing our attention throughout the process from initial submission to final publication on improving the text. In the manuscript development process, we, the editors in partnership with our authors, focus on embedding the collective manuscript improvement efforts into the manuscript itself. In other words, the manuscript is the centerpiece of the entire reviewing, editing, and revising enterprise. Instead of producing separate review and response documents that can move us all away from the manuscript, we work together to weave all our collective comments and responses in the manuscript to create an evolving audit trail that will ultimately produce the published paper. To do this we assume more consultative role by offering both editing and revising suggestions and recording them for your use via some special features of Microsoft Word. This creates an audit trail that eases tracking and addressing changes in revising and improving manuscripts. Please see "A Guide for TQR Authors" for more information on this innovative process.

In 2009, we introduced our online submission portal know as the **MSTracker Manuscript Submission Page** located athttp://mstracker.com/submit1.php?jc=tqr. With advent of the MS Tracker system, we improved our capabilities to manage the manuscript

development process and enhanced authors abilities to track their paper's progress and to communicate with the editorial team.

Our latest editorial innovation came in 2011, when we introduced the *TQR* Rubric. With the advent of the *TQR* Rubric, every paper submitted to the journal receives a score and preliminary review. For those author's whose papers receive a score of 13 points or higher, their manuscript continues on through the *TQR* manuscript development process. For those papers receiving a score below 13 points, the authors are informed of their score and are given the opportunity to revise and resubmit their manuscript until a score of 13 points or better is achieved so the next steps of the manuscript development process can continue.

Submissions to *The Qualitative Report* are **peer reviewed**. After earning a score of 13 points of higher on the *TQR* Rubric, each author is assigned to an editorial development team headed by one of the journal's editors, who works closely with the author as manuscript consultants in pursuit of developing the paper for publication in *The Qualitative Report*. The manuscript development group focuses on helping the author develop as a writer and researcher. By making this acceptance, we dedicate ourselves to creating a context in which all participants in the editorial development process can grow as authors and mentors. As a team, they work together to improve the manuscripts until the submissions become published papers in this journal.

Manuscript Criteria

Papers submitted for review to *The Qualitative Report* must be original works on the part of the authors, must not have been published previously, and must not be under review with another publication at any time during the review process. A wide variety of submissions are welcomed to *The Qualitative Report*. Given the richness and diversity of qualitative research and researchers from around the world, papers reflecting scientific, artistic, critical and clinical postures are all fitting contributions to the electronic pages of this journal. Methods depicted in these papers may be qualitative, comparative, mixed, collaborative, action-oriented, appreciative, and/or critical in nature. Papers may be qualitative research studies, commentaries about the conduct of qualitative research, prescriptive pieces on carrying out qualitative research, "back stage" essays in which authors give a perspective on how they created and crafted a particular project, presentations on technological innovations relevant to qualitative researchers and their inquiries, and any other issues which would be important for practitioners, teachers, and learners of qualitative research.

The length of submitted works may vary greatly. Since *The Qualitative Report* is not restricted by the economics of paper, contributors can concentrate on the particularities of their paper at hand and let those considerations shape the length of their narrative rather than an arbitrary limit of words or pages. Having said that, it is important for authors to remember *TQR* publishes article-length manuscripts and not book-length

manuscripts so authors should give careful consideration to manuscripts over 45 pages. In such instances, the author should consider whether or not the manuscript reflects ideas for two separate papers and then edit the manuscript so the text is more focused before submitting it to *TQR*. In such cases, the author might consider submitting two papers after the revisions are done on the original opus.

Given the ways in which a style guide can shape the writing choices made by an author, we want to assist you as you prepare your submissions by letting you know that we use *The Publication Manual of the American Psychological Association* (APA; 6th ed.) as a guide for contributors to *The Qualitative Report*. This means that we ask authors to look to APA recommendations regarding the title, abstract, and headings used in the paper, as well as the format of references and citations within the text. We also request some writing practices we think improve the reporting of qualitative research methods and results, such as the use of active voice and the inclusion of the researcher's context as it relates to the topic under study. Otherwise, style is a matter of choice on the parts of authors. We recognize that the style of writing for contributions to *The Qualitative Report* is a matter of particularity for authors, and we welcome a range of writing styles.

Even though *The Qualitative Report* is based on a textual metaphor, nontextual forms of representation are also welcomed. Graphics, pictures, sounds, moving images, and hyperlinking may all be features in works presented in this journal.

Contributors to *The Qualitative Report* can also engage in a process known as "Living Documents" (Ives & Jarvenpaa, 1996) with their published works in the pages of the journal. In the "Living Documents" approach to writing, authors can nurture their published works and cultivate them as new developments arise within the scope of the paper, as hyperlinked resources located in the paper are updated or changed, and/or as the author's thinking evolves on the topic. Authors wishing to participate in this living scholarship approach with any of their writing in *The Qualitative Report* need only to email the editor and the process of enlivening the text can ensue.

Manuscript Submission Guidelines

Contributors submit their work electronically to *The Qualitative Report* by going to our **MSTracker Manuscript Submission Page** located at http://mstracker.com/submit1.php?jc=tqr. Once there you can submit your paper online and also track the editorial and reviewing process of your paper from submission to publication.

If you have any questions regarding the submissions process please email Managing Editor Laura Patron at lp764@nova.edu

Conclusion

If we are successful in our labors, we will create a sustainable learning community that will foster growth in qualitative researchers and improvement in qualitative research. We trust authors find this new beginning an intriguing opportunity to learn and consider joining us in this pursuit.

References

American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.

Ives, B., & Jarvenpaa, S. L. (1996, Spring). Will the Internet revolutionize business education and research? *Sloan Management Review, 37*(3), 33-41.

Appendix D: List of charities and organisations approached

Maternal OCD
OCD Action: www.OCDaction.org.uk
OCD UK: www.ocduk.org
Triumph Over Phobia: www.topuk.org
Association for Postnatal Illness: www.apni.org
National Childbirth Trust: www.nct.org.uk
Pre and Postnatal Depression Advice and Support (PANDAS): www.pandasfoundation.org.uk
Best Beginnings: www.bestbeginnings.org.uk
Mumsnet: www.mumsnet.com
Netmums: www.netmums.com

Charities and Organisations Involved:
Maternal OCD
OCD Action
OCD UK
Pre and Postnatal Depression Advice and Support (PANDAS)
Mumsnet
Netmums

Appendix E: Interview Schedule

Introduction to Interview

Okay, now I'm going to move on to the interview. I am interested in what you have to say about your experiences and what is important to you. I will ask a few questions but these are designed to encourage you to talk openly about your experiences and there may be long periods where I just let you talk. There are no right or wrong answers; I am interested in what's important to you.

I'd like to remind you that you don't have to answer any questions that you don't feel comfortable with. We can take a break if you need, and you can ask to end the interview at any point if you feel that you need to stop.

Are you okay to start? I'll start recording now.

Interview Schedule (redrafted)

Note: Throughout the interview, use general probing questions and prompts, to elicit richer, more detailed information, such as:

Why?
How?
Can you tell me more about that?
What was that like for you?
Can you give me a specific example?
What did/do you think about that?
How did/do you feel about that?
What do you mean by X?
Could you talk a bit more about X?

- To start with, can you tell me about you and your family?

- Ok, as you know, this interview is looking at your experiences of obsessive-compulsive disorder that started or got worse around the time of your pregnancy or shortly after X [name of child] was born. Can you tell me what that's (been) like?

Prompts:
What was going on for you around the time of your pregnancy?
What was it like around the time you gave birth?
Can you tell me about your experience of support?
– e.g. partner, family, friends, healthcare services, charitable support?
What's motherhood like for you?

Catch-all final question:
Do you have any other thoughts or comments that we haven't covered about your experience of being a mother with OCD, or anything else that you'd like to add?

Appendix F: Ethical Approval

Coventry University
Priory Street
Coventry CV1 5FB
Telephone 024 7688 7688

Professor Guy Daly
Executive Dean

Prof Jane Coad
Chair of Ethics Committee
Tel: (024) 7679 5831
Email: ethics.hls@coventry.ac.uk

4 November 2014

Dear Sir/Madam

Re: Ethical Approval – P21608

I am writing to confirm that **Rebekah Chadwick** has received ethical approval on 9 June 2014 for the research project: *Exploring mothers' experiences of maternal obsessive-compulsive disorder*. Project end date 30/09/2015.

An amendment, to change recruitment to online and widen to several other voluntary and community groups was submitted on 1 October 2014, and approved 27 October 2014.

The research project has addressed the main ethical issues appropriately, and has been approved by a member of the Faculty of Health & Life Sciences, Ethics and Governance Committee at Coventry University.

If you have any further queries please do not hesitate to contact me.

Yours sincerely

Prof Jane Coad

Faculty of Health & Life Sciences
Direct Line
Fax

www.coventry.ac.uk

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Rebekah Chadwick .....

Faculty/School/Department: [Faculty of Health and Life Sciences] Clinical Psychology

Research project title: Exploring the experience of mothers with experience of obsessive-compulsive disorder.

Comments by the reviewer

1. Evaluation of the ethics of the proposal:

2. Evaluation of the participant information sheet and consent form:

3. Recommendation:

(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

X	Approved - no conditions attached
	Approved with minor conditions (no need to re-submit)
	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
	Rejected for the following reason(s) – please use other side if necessary
	Not required

Name of reviewer: Anonymous .....

Date: 09/06/2014 .....

Appendix G: Online Research Advert and Survey

The lived experience of maternal obsessive-compulsive disorder

Are you a mother with experience of OCD?

Do you have experience of obsessive compulsive disorder (OCD) which started during pregnancy or shortly after your child was born? If so, we would like to hear about your experiences.

We are conducting some research to explore the experiences of mothers who have experience of maternal OCD. The research is interested in mothers' personal experiences of living with OCD and their experience of motherhood and parenting in the context of OCD. It does not matter whether you still experience OCD symptoms or you have recovered, whether you have been formally diagnosed with OCD or not, or whether you are currently undergoing treatment, hearing your experiences would be valuable in this research.

Research indicates that pregnancy and motherhood can be a time when mothers experience anxiety and that obsessive-compulsive disorder can develop or worsen around this time. Although research has been conducted into how common OCD is in new mothers and into treatment, little research has explored mothers' personal experiences. We hope this research will provide insight into the experience of maternal OCD, improve awareness in healthcare professionals and increase support for new mothers with similar experiences.

If you are interested in finding out more, please continue through this survey (by clicking 'continue' at the bottom of this page) to securely send your details to the Primary Researcher, Rebekah Chadwick.

Alternatively, you can contact Rebekah directly:
Email: rebekah.chadwick@warwick.ac.uk
Tel: 07517834913

If you contact me, I will discuss the research with you in more detail and ask you a few questions to see if you meet our criteria for participation. I can send you an information sheet and then you can take some time to decide if you would like to take part. If you would like to take part, we will arrange a meeting at a time and place convenient for you. In the meeting, I will ask you to complete a consent form, some questions about yourself, such as your age, and an interview about your experiences. If you contact me, you are not obliged to participate in the research. Furthermore, if we arrange a meeting or you do the interview but later change your mind about taking part, you can withdraw your information from the research.

The lived experience of maternal obsessive-compulsive disorder

Study title: The lived experience of maternal obsessive-compulsive disorder

Primary Researcher: Rebekah Chadwick, Trainee Clinical Psychologist
Supervisors:
Dr Kirstie McKenzie-Mellarg, Consultant Clinical Psychologist, Warwick Hospital
Dr Fiona MacCallum, Associate Professor, Warwick University
Dr Carolyn Gordon, Academic Tutor, Coventry University

I'm interested in finding out more about taking part.

If you are interested in participating in this research, or finding out more about the research, please provide your name and contact details below.

If you enter your details, you are giving your permission to be contacted by the Primary Researcher, Rebekah Chadwick.

1. Name:

2. Telephone number: *(Optional)*

3. Email address: *(Optional)*

4. Please indicate how you prefer to be contacted:
- Telephone
- Email

Thank you. Please click continue to securely send your details.

Continue >

The lived experience of maternal obsessive-compulsive disorder

Thank you very much.

Your details have been securely sent to me, the Primary Researcher, Rebekah Chadwick.

I will contact you to discuss the research.

You can now close this page.

Appendix H: Research Flyer

Front:

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8326
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

Are you a mother with experience of OCD?

Do you have experience of obsessive compulsive disorder (OCD) which started during pregnancy or shortly after your child was born? If so, we would like to hear about your experiences.

We are conducting some research to explore the experiences of mothers who have experience of maternal OCD. The research is interested in mothers' personal experiences of living with OCD and their experience of motherhood and parenting in the context of OCD. It does not matter whether you still experience OCD symptoms or you have recovered, whether you have been formally diagnosed with OCD or not, or whether you are currently undergoing treatment, hearing your experiences would be valuable in this research.

Research indicates that pregnancy and motherhood can be a time when mothers experience anxiety and that obsessive-compulsive disorder can develop or worsen around this time. Although research has been conducted into how common OCD is in new mothers and into treatment, little research has explored mothers' personal experiences. We hope this research will provide insight into the experience of maternal OCD, improve awareness in healthcare professionals and increase support for new mothers with similar experiences.

If you are interested in finding out more, please contact Rebekah Chadwick, Primary Researcher:

Email: rebekah.chadwick@uni.coventry.ac.uk

Tel: 07817834913

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5806
Head of Department of Psychology

Back

If you contact me, I will discuss the research with you in more detail and ask you a few questions to see if you meet our criteria for participation. I can send you an information sheet and then you can take some time to decide if you would like to take part. If you would like to take part, we will arrange a meeting at a time and place convenient for you. In the meeting, I will ask you to complete a consent form, some questions about yourself, such as your age, and an interview about your experiences. If you contact me, you are not obliged to participate in the research. Furthermore, if we arrange a meeting or you do the interview but later change your mind about taking part, you can withdraw your information from the research.

Primary Researcher: Rebekah Chadwick, Trainee Clinical Psychologist

Supervisors:

Dr Kirstie McKenzie-McHarg, Consultant Clinical Psychologist, Warwick Hospital

Dr Fiona MacCallum, Associate Professor, Warwick University

Dr Carolyn Gordon, Academic Tutor, Coventry University

Consent to be contacted form:

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

Consent to be Contacted Form

Study Title:
Exploring mothers' experiences of maternal obsessive-compulsive disorder.

Primary Researcher: Rebekah Chadwick, Trainee Clinical Psychologist
Supervisors:
Dr Kirstie McKenzie-McHarg, Consultant Clinical Psychologist, Warwick Hospital
Dr Fiona MacCallum, Associate Professor, Warwick University
Dr Carolyn Gordon, Academic Tutor, Coventry University

If you are interested in taking part in this research, or finding out more about the research, please provide your name and contact details below:

Name: _____

Please indicate how you prefer to be contacted:

Telephone number: _____

Email address: _____

I will then contact you to discuss the research and arrange a research appointment, at a time and location convenient to you.

Thank you.

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805
Head of Department of Psychology

Appendix I: Participant Information Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eva Knight
BSc Clin Psy D, CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

PARTICIPANT INFORMATION SHEET

Study Title: Exploring mothers' experiences of maternal obsessive-compulsive disorder.

Primary Researcher: Rebekah Chadwick, Trainee Clinical Psychologist
Supervisors:
Dr Kirstie McKenzie-McHarg, Consultant Clinical Psychologist, Warwick Hospital
Dr Fiona MacCallum, Associate Professor, Warwick University
Dr Carolyn Gordon, Academic Tutor, Coventry University

Background

Research indicates that pregnancy or motherhood can be a time when anxiety problems such as obsessive-compulsive disorder (OCD) can develop or worsen. Research has looked at how often new mothers experience obsessive compulsive symptoms and what treatments may be effective. However, there has been little exploration of the experiences of mothers who have experience of OCD. This research is specifically aiming to explore the experiences of mothers who have experience of OCD which developed or worsened during pregnancy or within a year after the birth of their child. It also explores the experience of motherhood and parenting in the context of OCD. It is part of a Doctorate in Clinical Psychology at the Universities of Coventry and Warwick.

Would I be a suitable participant?

This research is interested in the personal experiences of mothers with experience of maternal OCD. If you are a mother who has experience of developing OCD, or whose symptoms of OCD worsened, during your pregnancy or within a year of your child's birth, we are interested in hearing about your experiences and are inviting you to take part in this research. It does not matter whether you still experience OCD symptoms or you have

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Treasure BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

recovered, whether you have been formally diagnosed with OCD or not, or whether you are currently undergoing treatment, hearing your experiences would be valuable in this research.

Participants must be over 18 years old, with a child between the ages of 0-18 years. The research requires completing an interview and a fluency in English is essential. Mothers who have also had experience of psychosis, schizophrenia or personality disorder, in addition to OCD, will not be included in this research.

Do I have to take part?
Your participation is entirely voluntary and you do not have to take part.

What will be involved if I take part?
If you agree to take part, you would be asked to have an appointment with the researcher, at a time and place convenient to you. The researcher will usually meet with you face-to-face, although it can sometimes be done via Skype. During this appointment, we will talk again about the study and you will have the opportunity to ask questions. If you are still happy to take part, you will be asked to sign a consent form. You will also be asked some standard questions about yourself, such as your age. After that, the researcher will interview you about your experience. The researcher is interested in your unique experience and will encourage you to talk freely. However, it is up to you how much information you choose to share, and if there is anything you do not want to talk about you do not have to. You can choose not to answer a question that the researcher asks.

How long will it take?
In total, the research appointment will take approximately one to two hours.

Will my information be confidential?
Your information will be kept confidential and secure. You will not be identifiable from the final research write-up or any publications resulting from this research.

Your signed consent form and the form containing questions about yourself will be kept securely and will be kept separately from transcriptions of your interview with the researcher. Only the researcher will know which documents correspond to each interview.

The researcher would have a duty to break confidentiality if you disclose information which

indicates that you, or others, are at risk of harm or may present a risk to others. If the researcher is concerned about a disclosure of harm, the researcher will discuss this with you.

What will happen to my interview?

Your interview will be audio-recorded. This audio-file will be password-protected and stored on an encrypted memory stick and researcher's password-protected laptop. Once the interview is completed, everything said in the interview will be typed up, and the researcher will remove all names, places and other identifying information. Each word-document will be assigned a unique participant code and only the Primary Researcher will know which code matches which participant. The word-document will be password-protected and stored on an encrypted memory stick and password-protected laptop. The original recording will be deleted following completion of the research. Anonymised quotes from the interview may be used in the final write-up or in published findings.

What happens to the information I provide?

The information you give in your interview will be analysed by the researcher to see what experiences and issues are relevant for mothers with OCD. Anonymised comments from interviews will be used to demonstrate themes that are evident.

What will happen with the results of the study?

The study is part-fulfillment of a Doctorate in Clinical Psychology and the research will be written up to form part of the Primary Researcher's thesis. The results may also be published following completion of the thesis.

The research will be completed by September 2015. If you wish you can receive information about the findings of the research. You will have the opportunity to request a summary of the results when you complete the consent form for participating.

What are the benefits of taking part?

This research aims to provide a valuable insight into the experiences of women who develop OCD during pregnancy or shortly after childbirth. By participating, you will be contributing to a largely unexplored field of research. It is hoped that the information may help healthcare professionals to better recognise and identify OCD in new mothers, and to provide support for mothers with similar experiences.

Participation also provides you with a personal opportunity to share your experience and to

reflect on your experiences in a way that you may find beneficial. There is no financial or other incentive for taking part.

What are the possible risks of taking part?

You may find talking about your experiences in detail distressing or difficult. You may take a break during the interview and you can stop at any point during the interview and decide no to go on, without giving a reason.

What if I agree to take part and then change my mind?

You can stop the interview and withdraw from the research at any point without giving a reason. You can withdraw even if you have completed the interview, by contacting the researcher or supervisors, using the details below. You do not have to give a reason for withdrawing at any point. However, if we have not heard from you within four weeks after your interview, we will assume you are happy for your anonymised data to be used and it will be included in the final research report. You will be reminded of this when you sign the consent form and in the debrief sheet you receive after participating.

Who has organised this research?

This research has been organised by the Primary Researcher, Rebekah Chadwick, a Trainee Clinical Psychologist and forms part of the researcher's Doctorate in Clinical Psychology.

What if there is a problem?

If you have a concern about the study or wish to make a complaint you can contact the Primary Researcher directly, or one of the research supervisors, using the contact details below. If you remain unhappy, you can complain to the Programme Director of the Doctorate in Clinical Psychology, Dr Eve Knight (Tel: 024 7688 8328; Email: e.knight@coventry.ac.uk).

Ethical Approval

This study has ethical approval from the Universities of Coventry and Warwick.

Contact Details

Primary Researcher:

Rebekah Chadwick: chadwi11@uni.coventry.ac.uk

Supervisors:

Dr Fiona MacCallum: Fiona.MacCallum@warwick.ac.uk
Dr Kirstie McKenzie-McHarg: Kirstie.McKenzie-McHarg@swft.nhs.uk
Dr Carolyn Gordon: Carolyn.Gordon@coventry.ac.uk

Thank you very much for taking the time to read this information sheet.

If you would like to take part in this study, please contact the Primary Researcher:
Email: Chadwi11@uni.coventry.ac.uk
Tel: 07817834913

If I have not heard from you within four weeks, I will contact you again to confirm whether or not you would like to take part in this study.

Appendix J: Consent Form

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

CONSENT FORM

Study Title:
Exploring mothers' experiences of maternal obsessive-compulsive disorder.

Primary Researcher:
Rebekah Chadwick, Trainee Clinical Psychologist

Supervisors:
Dr Kirstie McKenzie-McHarg (Consultant Clinical Psychologist, Warwick Hospital)
Email: Kirstie.McKenzie-McHarg@swft.nhs.uk
Dr Fiona MacCallum (Associate Professor, Warwick University)
Email: Fiona.MacCallum@warwick.ac.uk
Dr Carolyn Gordon (Academic Tutor, Coventry University)
Email: Carolyn.Gordon@coventry.ac.uk

Please read the following statements and initial each box to indicate you understand and agree to the statement. Please also provide your name and signature at the bottom.

If you would like to receive a summary of the results, please initial the box next to statement 8 and provide your contact details below.

1.	I confirm that I have read and understood the information sheet for this study, titled 'Exploring mothers' experiences of maternal obsessive-compulsive disorder.'	☐
2.	I confirm that I have had the opportunity to ask questions about the study and had these answered satisfactorily.	☐
3.	I understand that participation involves completing an interview with the researcher, Rebekah Chadwick, which will be digitally recorded and later typed up by the researcher.	☐
4.	I understand that my participation is entirely voluntary and that I can withdraw from the study at any point during the interview. I also understand that should I wish to withdraw after the interview has been completed, I am free to do so, without giving a reason, by contacting the researcher within four weeks of completing the interview. After four weeks, if I have not contacted the researcher, my anonymised data will be included in the final research report.	☐

5.	I understand that the information I provide will be kept confidential. However, I understand that if I disclose information which indicates harm, or potential harm, to me or others, the researcher has a duty to break confidentiality. If I make any such disclosure, I understand that the researcher may have to share information with the supervisory team and other services.	☐
6.	I understand that the information I provide will be anonymised and I will not be identifiable in any research findings that are published.	☐
7.	I understand that I am giving permission for comments that I make to be displayed as anonymised extracts in the researcher's write-up, and that the anonymised text typed up from the interview may need to be submitted as part of the researcher's thesis.	☐
8.	I agree to take part in this study, described above.	☐
9.	I would like to receive a summary of the results (if so please provide your contact details below).	☐

_____ _____ Date:

Name of participant *(please print)* Signature

_____ _____ Date:

Name of researcher Signature

Contact Details (if you wish to receive a summary of the results)

Name: _____

Email address:

_____

Appendix K: Participant Debrief Sheet

Front:

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eva Knight
BSc Clin Psy D, CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

PARTICIPANT DEBRIEF SHEET

Study Title:
Exploring mothers' experiences of maternal obsessive-compulsive disorder

Thank you very much for taking part in this research.

This research asked you about your personal experience of being a mother with experience of OCD. To our knowledge, this is the only research that specifically asks about the experiences of mothers who have experience of OCD which developed or worsened during pregnancy or within a year after the birth of their child. We hope that by gaining a better understanding of what it is like to be a new mother experiencing OCD, we can help healthcare professionals recognise and identify OCD during pregnancy and in the post-natal period, and provide improved support for mothers who have similar experiences.

The researcher will now type up everything that was said in your interview, removing all names, places and other identifying information. The typed document of the interview will be anonymised so that the information that you provided is kept confidential. The interview will be analysed by the researcher to see what experiences and issues are relevant for mothers with experience of OCD.

All the data you provided will be kept confidential. You will not be identifiable in the report of the research or any publications resulting from the research, although anonymised quotes from your interview may be used to demonstrate findings from the research in the final report.

If you change your mind about taking part and you wish to withdraw from the research, you can withdraw without providing any reason. To do so, please contact one of the research team (details below) within four weeks after your interview in order for us to remove your data from the research. If we have not heard from you after four weeks, we will assume you are happy for the researcher to use your anonymised data and it will be included in the final research report.

This research is part of a Doctorate in Clinical Psychology. The thesis, including the final report for this research, will be completed by September 2015. If you wish, you can receive information about the findings of the research. Please contact one of the research team if you would like to receive a summary of the findings.

If you have any further questions please do not hesitate to contact one of the research team.

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Treasiian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

Back:

Contact Details

Rebekah Chadwick: chadwi11@uni.coventry.ac.uk; rebekah.chadwick@covwarkpt.nhs.uk

Dr Fiona MacCallum: Fiona.MacCallum@warwick.ac.uk
Dr Kirstie McKenzie-McHarg: Kirstie.McKenzie-McHarg@swft.nhs.uk
Dr Carolyn Gordon: Carolyn.Gordon@coventry.ac.uk

If you require support due to any of the issues discussed, please contact your GP. You can also access support through charities such as Samaritans (www.samaritans.org; 08457 90 90 90), or through the maternal OCD charity specifically for mothers with OCD (www.maternalocd.org.uk: email: info@maternalocd.org)

Thank you.

Appendix L: Stages of IPA Analysis

Reading and re-reading	The aim of this stage to become immersed in the data and in the participant's experience.
Initial noting	Detailed, comprehensive exploratory notes are made, expanding the data. Comments on the data can be descriptive, linguistic and contextual, moving towards interpretation of the explicit information given by the participant. This stage facilitates further engagement with the data and introduces interpretation based on the analyst's experiential and professional knowledge.
Developing emergent themes	Emergent themes are developed based on the detailed notes generated in the above stage. These themes will reflect closely the participant's inner world but also the researcher's interpretation, aiming to reflect an understanding of the participant's experience.
Searching for connections across emergent themes	The researcher establishes connections between the emergent themes for that participant.
Moving to the next case	Leaving aside the previous case, the researcher progresses to the next case and repeats the initial analytic stages. Through reflexivity, effort is made to ensure bias from the previous analysis does not impact on the analysis of this case.
Looking for patterns across cases	Patterns are established across cases. Themes may be grouped under superordinate headings, discarded and/or relabelled.

Appendix M: Contingencies of the lifeworld (Ashworth, 2003; 2006).

Temporality	*How is the sense of time, duration, biography affected?*
Spatiality	*How is their picture of the geography of the places they need to go to and act within affected by the situation?*
Self-hood	*What does the situation mean for social identity; the person's sense of agency, and their feeling of their own presence and voice in the situation?*
Sociality	*How does the situation affect relations with others?*
Embodiment	*How does the situation relate to feelings about their own body, including gender, including emotions, including "disabilities"?*
Project	*How does the situation relate to their ability to carry out the activities they are committed to and which they regard as central to their life?*
Discourse	*What sort of terms—educational, social, commercial, ethical etc.— are employed to describe—and thence to live—the situation?*
Mood as Atmosphere	*What's the 'feeling-tone'?*

Appendix N: Example of Coded Transcript

Role as wife **Role as mother** **Significance of medical diagnoses**	16	P:	Yeah. I've been married for nearly 25 years, believe it or not. {mmm} I've got two grown-up children. Um, my daughter is twenty. She has diabetes and er high-functioning autism. Er, my son – who I've had the experience with the OCD – he is nearly nineteen and um he, he has OCD as well. {okay} And his OCD is *very* similar to mine. He suffers with checking compulsions but he also has the intrusive thoughts, which are the ones that bother him the most.	Married, 2 grown-up children. Medical needs. Married nearly 25 years – 'believe it or not' suggests surprise, it's a significant length of time. Medical diagnoses significant. ?predominant medical explanation for experiences – medical model valued OCD experience brought in early. 'as well' – as her Highlights (and emphasises with 'very') similarity between her and son and their experiences of OCD. Suffers – this is a problem. Intrusive thoughts considered more bothersome than checking compulsions – considered separate experiences within experience of OCD. 'also has' – implication that some people have compulsions only
	17	I:	Yeah	
View of self - self as abnormal **OCD as abnormal** **Social stigma/societal view**	18	P:	Er my husband is normal! (laughs) ish. [laugh] He doesn't have any of the er, of the things that we have {mmm} I think it's *probably* come through, down through my side of the family.	Notes difference between husband and rest of family. Normal – thus OCD and autism are *not* normal? Social stigma? Laughter – making light of difficulties in comparison to normal husband? social stigma of mental health – not normal. Familial transmission explanation 'down through my side' – transmission progresses downwards…
	19	I:	Okay	Trying to make sense of the familial link – notes sister and previous generations.
Familial transmission of OCD as explanation/sense-making	20	P:	My sister has two children who interestingly are *both* on the spectrum as well {okay} but before our generation, there wasn't anyone that we were aware of that had, was on the autism spectrum {mmm} *or* who had OCD. There were a few eccentric family members! [laugh] {okay} But nobody that we actually were told of or knew {okay} had OCD or or even on the spectrum, so we actually think er that there *may* be *some* kind of genetic link {okay} there. Which is interesting. So um	Notes commonality within her side of family. Her sister has children with ASD. 'Interestingly' – considers it important, interesting that sister has children on ASD spectrum. Helps her make sense of things. Prior to this generation they weren't aware of any family members with ASD or OCD. Few eccentric family members – makes a joke. Eccentric – not normal. OCD and ASD linked in this genetic explanation? Articulates her sense-making that there's a some kind of genetic link. Sense of agency is defeatist, fatalistic 'we' – who? Her and her sister? Her immediate family? Her wider family? Short sentence sums up that this sense-making is interesting. Tails off
Genetic link				

	21	I:	Yeah, yeah.	Shifts focus – away from sense-making to describing family
	22	P:	So, er anyway, in terms of [son's name] he is living partly at uni and partly here. {okay} Er but he's still – he's a lot, lot better than he was but he is still struggling at times with his intrusive thoughts.	Son lives partly at home and partly at uni. Lot better than he was – sets son's experience within a time-frame, where past things were worse than they are now. He used to struggle more. Son still struggles with his intrusive thoughts. still needs her as mother? But she can try and help her son.
	23	I:	Mmm. Mmm	'fortunately' – positive
Ability to help others using own experience	24	P:	But fortunately I can try and help him a bit {yeah, yeah} with that.	How can she try and help him? – ?presumably due to her own experience of OCD
	25	I:	And how does that feel?	Disappointed that her son is experiencing similar difficulties. Disappointed – does this really encapsulate her feelings about it? Weak emotion – not sad, or angry that he has it
Disappointment and pain that son has OCD too **OCD hurts** **Using own experience (to help son)**	26	P:	It's, er, disappointing really that he's got to go through the same thing. {mmm} er, it's, it's hurts worse really him having it than me having it, to be honest {mmm} because it, there's nothing worse really than seeing your child go through something that you've been through. But on the positive side I can, I can use my own experience to help him.	It hurts worse him having it than herself having it. 'hurts worse' a) him having OCD is hurtful, b) her having OCD is hurtful too 'hurts' – pain. Physical. – emotions are felt physically? link to medical expl for OCD – 'er, it's it's' – difficult to articulate this point. Difficulty describing/ articulating/sharing emotional experiences? Switch to 3rd person – generalisation. Shared experience with others whose children go through things they've been through? Can use own experience to help him. Reiterates this positive. Reiterating her help to son – presenting herself as helpful mother. Importance of mothering role.
	27	I:	Okay	How does her experience help him? Because their experiences are similar? How does own experience help you to help others?
Role as mother **Self-expectation as mother**	28	P:	But on the other side of it, sometimes I find that even the knowledge that I've got and the experiences I've had are not enough. {okay} And, er we've actually had a private CBT therapist to work with him as well which has helped a lot {okay} um so that was a bit of a shock really because I thought I would probably be the one that would know enough to be able to sort of say, 'right, this is it [son's name] and this is why you have this and this is why you have this so okay, you alright now?' and, of course it doesn't work like that!	Positive side of situation - defence against difficult feelings associated with the fact that her and her son both have OCD? Defence against guilt that she's passed it to him through genetic link? 'even the' – feels she has lots of knowledge and experiences which could help. 'but' – counteracts the negative emotions. Positive side of situation - defence against difficult feelings associated with the fact that her and her son both have OCD? Defence against guilt that she's passed it to him through genetic link? 'not enough' –insufficient, inadequate. ?mirrors view of self as mother/helper? Surprised and shocked that her knowledge and experience wasn't enough to help son. - perceived failure as a mother who can support her son?
	29	I:	Mmm	
Value of professional,	30	P:	Um, so, sometimes you do need that objective, you	Had a private CBT therapist which helped a lot. 'er' – some difficulty

outside, objective support			need that outside support too.	admitting to having a private therapist? Private CBT therapist – ?could afford this, ?medical insurance - prioritises care for son by accessing outside support. Yet little outside support for herself is mentioned through transcript. 'so okay, you alright now?': suggests sense that she thought she could help and it would be easy fix. yet her difficulties have been going on a long time 'of course' – obviousness that it doesn't work like that, yet she was shocked it didn't.
	31	I:	Yeah.	
	32	P:	Yeah.	
	33	I:	I wonder how you felt about that?	
	34	P:	about he-, him?	
	35	I:	Yeah, and	
	36	P:	Um, he hasn't, he realises that he's probably inherited the condition from me, but he doesn't actually, er, he doesn't appear to, to sort of blame me or anything like that, you know. {mmm} He's actually always been, he trusts me because he knows that I've had the same condition and if he's really worried he'll tend to come to *me* rather than anyone else to talk about it. {yeah} He does try to deal with it himself but when he gets the thoughts badly he will come and chat to me about it. {mmm} So {okay} that's a positive really.	CBT therapist provided objective support from outside. Outside support is objective. Professional support is objective? She isn't objective? Stating son doesn't blame her for OCD suggests this was a worry of hers. Guilt associated with passing OCD to him? Describes son's experience. Son trusts her – reaffirms her role, shows her position as mother. Emphasises that son turns to her over other people. – presents herself as helpful (link to involvement with charity work) Son tries to deal with OCD difficulties on his own, but sometimes gets thoughts badly and chats to her. Reiterates positive side than son turns to her for support. - continued defence against negative feelings
Role as mother **Ability to be helpful** **Role as mother**				
	37	I:	Yeah, yeah.	
	38	P:	Mmm…	
	39	I:	Okay. So, as you know the interview's looking at your experiences of obsessive compulsive disorder {mmhmm} that started or got worse around the time of your pregnancy {yes, it did, yeah} or after [son's name] was born. {yeah} Can you tell me what that's been like?	OCD started or got worse around time of pregnancy 'yes it did yeah' – twice affirming this is true Starts with medical experience – obvs feels this is significant and contributed to her OCD 'to cut a long story short' – doesn't want to give me all the details? Doesn't think I'll be interested? Link to comment about her talking a lot (L6) Gets quickly to the point that she perceives as important
Stressful experiences during	40	P:	Um, it was, um – to cut a long story short, I had,	She had abnormal cervical cells during pregnancy which couldn't be treated

pregnancy			when I was pregnant I had some abnormal cells, {okay} cervical cells. Er they were just abnormal, but they were quite severe. {mmm} They couldn't do the treatment er during pregnancy, it might have caused miscarriage.	on during pregnancy, as it might cause miscarriage. - stressful experience during pregnancy. Associates this with OCD States that they were severe. Positions self as victim/sufferer? Evident that she didn't want to risk miscarriage – son was planned and/or wanted She was assured that it was okay to have treatment shortly after her son was born but she had to wait a long time as it was early in the pregnancy. 'horrible cells things' – negative, not understood While waiting she didn't know if the cells were changing. This was early on – time context. So later on wouldn't have bothered her as much? Daughter was only young. Use of 'of course' – implies obviously, but of course what? Having a young child was an additional stressor while dealing with anxiety about the cells? Having a young child involved lots of work? Or worried about being unwell and leaving daughter? Dying and leaving daughter? Experience was very frightening and quite upsetting and she was angry about it. It seems unfair. Self as victim? Only 26 – considered self young. young women shouldn't have to deal with this kind of stress? Too young to have abnormal cells? Too young to become ill and die? Summarises by saying she 'just felt that it was not good.' – minimises. Worried a lot during the pregnancy. Experience 3 days after she came home after childbirth – physical symptoms – panic attack. - 'it really was' – fears I won't believe her? Experience of not being believed/taken seriously about this symptoms in the past? Laughter – describing scary moment/experience – defence against feelings associated with this experience First person she went to was her husband; rushed – emergency. Unable to cope alone. Dependence
	41	I:	Okay	
	42	P:	So they assured me that it would be okay to have the treatment just after he was born, a few months after, but this was quite early on in the pregnancy so I had to sort of wait {mmm} nine months with these, you know, horrible cells things that I didn't really know whether they were getting any worse or whether they were just staying the same. {yeah} And of course my daughter was quite young too, she was about one-and-a-half {okay} something like that. Um, so it was just very frightening really and quite upsetting {mmm} and I was really quite angry about it as well because I was only twenty-six, something like, {yeah} Yeah, twenty-six. And you know, I just felt that it was not good. So I worried a lot about it during pregnancy and then when [son's name] was born, about three days after I came home, I went up for a nap, to sleep and when I woke up my right side had gone numb {okay} er, which I thought was – and it it really was, it was completely, it was numb. [laughs] So I went downstairs, rushed downstairs to my husband and	
Minimises difficult emotions				
Frightened and upset and angry during pregnancy (due to stressor)				
Worried a lot during pregnancy				
Physical symptoms of anxiety				
Trivialises scary experience				
Role as wife				

Appendix O: Example of Emergent Themes for one Participant

'Lily'

Acceptance of self with OCD experiences
- Conflict about acceptance
- Identification with diagnosis
- OCD as part of identity (intrinsic to self)
- Recovery as a process
- Self as anxious

Transitioning to motherhood
- Importance of becoming mother
- Expectations did not meet reality

Battling OCD
- OCD takes over
- Powerful OCD – power of conviction
- Ongoing battle
- The aftermath (depression, loss, self-blame)

Help
- Benefit of professional help
- Communication as helpful
- Relationship between communication and understanding (each facilitates the other)
- Fear of communicating/seeking help
- Importance of knowing it's a shared experience

Appendix P: Aims and Scope for *Reflective Practice*

Reflective Practice: Aims and Scope

Reflective Practice: International and Multidisciplinary Perspectives is a refereed journal publishing papers which seek to address one or more of the following themes:

- The different kinds of reflective practice and the purposes they serve
- Reflection and the generation of knowledge in particular professions
- The ways reflection is taught and learned most meaningfully
- The links between reflective learning and the quality of workplace action

Reflective Practice: International and Multidisciplinary Perspectives publishes original, challenging and stimulating work which explores reflection within and on practice, as an individual and collective activity, that concerns personal knowing and transformation, collective regeneration and political activism, reflection and voice, values, negotiated meaning, identity and community.

Reflective Practice: International and Multidisciplinary Perspectives includes papers that address the connections between reflection, knowledge generation, practice and policy. The journal also publishes shorter pieces on recent initiatives, reports of work in progress, proposals for collaborative research, theoretical positions, knowledge reported in poetic, diagrammatic and narrative form illuminated by line drawings and photography, provocative problem and question-posing thought pieces, reflective dialogues and creative reflective conversations. Reflective Practice also incorporates, from time to time, Special Issues on 'hot' topics.

Peer Review Policy:
All research articles in this journal have undergone rigorous peer review, based on a three-fold process of initial editor screening, double-blind review by two of the journal' referees and a final judgement by the editor.