HOW DO NEW/RECENT MOTHERS EXPERIENCE THOUGHTS OF HARM RELATED TO THEIR NEWBORN? A THEMATIC ANALYSIS.

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ABSTRACT

Several recently published studies indicate that infant-related harm thoughts are common among new parents, with the majority of new mothers reporting the experience of intrusive, infant-related thoughts of accidental harm (e.g. Fairbrother & Woody, 2008). Evidence suggests that unwanted ideation of intentionally harming the baby are also common, experienced less frequently but causing more distress than their accidental counterparts. No evidence of a link between intentional harm thoughts and parental aggression has been found. This study sought to address the gaps in the literature to explore qualitatively the nature of infant-related harm thoughts experienced by a new mother: how she herself defined and assimilated such thoughts, in relation to her cultural expectations of motherhood. A gap also existed in the research that considers how mothers experienced infant-related harm thoughts, images and impulses (IRHTs) within a diverse sample. The overarching aim of this study was to elicit a fuller, critical understanding of the common experience of IRHTs in a mixed, non-clinical sample, exploring how they are understood and shared by women.

Semi-structured interviews were conducted with eight new/recent mothers who had experienced IRHTs related to their youngest child, born within the last two years. Thematic analysis yielded three key themes: Heightened emotions – impact and consequences; Constructions of motherhood and effects on maternal identity; Costs and benefits of sharing. The findings highlighted different ways women conceptualised their IRHTs, their intense emotional impact, and barriers to reporting them due to the surrounding stigma. Additionally, the findings illustrated ways in which the pervasive ideology of motherhood informed mothers' assimilation of IRHTs. Some women pathologised them in order to maintain a 'good' mother identity. However for others, IRHTs prompted reconfiguring of their maternal identity through a constructive process of self-development. Recommendations for clinical practice/future research are outlined, including educating new/recent mothers about the nature of IRHTs. Training for health professionals is also recommended to enhance their understanding and skills in relation to these thoughts, in order to provide a safe space for women to discuss IRHTs, given barriers to disclosure.

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1. INTRODUCTION

The present research is situated broadly within the field of new mothers' experiences postpartum. More specifically, it aims to build on an under-studied area through enhancing understanding of new mothers' experiences of intrusive thoughts of harm related to the newborn. While researchers have traditionally focused on experiences of postpartum depression eliciting the stresses and strains of adjustment (e.g. Nicolson, 2001), the present study will explore the experience of unwanted, infant-related harm thoughts, images or impulses (IRHTs), found to be common among new parents (Abramowitz, Khandker, Nelson, Deacon, & Rygwall, 2006; Abramowitz, Schwartz, & Moore, 2003; Fairbrother & Woody, 2008).

This section of the thesis will introduce readers to the research topic. First, an introduction outlining the historical context of pregnancy, childbirth and the postpartum[1] period in contemporary British culture is given. Within this sub-section, the reader is also introduced to the ways in which motherhood is conceptualised in Western British society, including discussion of the dominant beliefs and myths pertaining to this prevailing discourse. Next, the consequences of Western-centric cultural myths of motherhood as 'natural' and desirable are expanded upon. Within this sub-section, the reader is given a summary of women's lived experiences regarding the reality of motherhood. The range of identified perinatal pathology is then touched on. Next, a critical review of IRHTs is provided (1.8). Finally, the justification, aims and research questions of the present study, as derived from the literature review, will be discussed.

[1] The term 'postpartum' refers to the period immediately following childbirth, and tends to refer to the mother, while the term 'postnatal' refers to the baby.

1.1 Background

1.1.1 Historical Context: Medicalisation of Pregnancy, Childbirth and Postpartum Period in Contemporary British Culture.

It is recognised that historically, the process of pregnancy and childbirth is framed within culturally bound practices. Within the developed world this tends to sit within a medical model. The more recent development around medicalisation of the child-bearing domain in Western culture appears to belong to a wider historical trend towards medicalising aspects of human life. For example, as has been described in the “medicalisation” of misery (e.g. Rapley, Moncrieff & Dillon 2011).

The era of wise women and midwives reigning over the arena of reproduction, emphasising pregnancy, labour and childbirth as ‘natural’, has gone. Instead, antenatal care has shifted from the private, domestic realm to the public sphere, partly in a bid to improve maternal and infant mortality rates (Gross, 2010). In this respect at least, the shift towards medicalisation has been successful. This has resulted in increasingly medicalised management of pregnancy, controlled and positioned by medical experts as a “normal illness” (Heiman, 1965) that is “inherently hazardous” (Hewison, 1993). Even in highly medicalised settings, enduring gendered power dynamics are arguably still at play. In the case of pregnancy and childbirth, patriarchy represents one way in which men can exert control over women’s bodies; antenatal care and birth have been located in hospitals since the 20th Century (Hanson, 2004; Oakley, 1984). Feminist writers argue that, consequently, the pregnant body is positioned as a docile, passive container to be submitted to the all-controlling medical gaze, as an object of expert control and management (Ussher, 2006). “Pregnancy, childbirth and postnatal period have been pathologised in the same (convenient) way, positioning women’s experiences as an illness in need of intervention, and interpreting any distress or unhappiness as individual pathology…childbirth has been construed as a technological accomplishment on the part of the expert - the woman herself positioned as a passive recipient…” (Ussher, 1992, p.47-8).

Intervention rates reflect this shift to the public sphere, with only one per cent of births in the UK taking place outside hospital care, compared to 50 per cent in 1965 (Wiegers, 2003). Meanwhile Caesarean section rates are currently at 26 per cent, an increase from three per cent in the 1950s (Campbell & Duncan, 2016). Intervention takes place even before birth, with modern reproductive technology detecting a wide range of abnormalities, where the woman can feel she is treated purely as a vessel for her child. The focus centres around the foetus primarily, and the woman predominantly in terms of her capacity to produce a healthy child.

Medical experts' wrestling for control over women's bodies is evident in the abundance of advice given to pregnant women, for example, from the National Health Service (NHS) or government agencies such as the US Food and Drug Administration ruling out certain dietary choices. Foods including soft or blue cheeses, shark or marlin, fats and sugar, caffeine and alcohol are all ruled out. Women contravening these clear guidelines are charged with responsibility for stunting growth or impairing intellectual ability, positioned as 'bad' mothers before the baby is even born (Mahler, 2003). The contradictory nature of advice compounds their challenge: regarding alcohol consumption, abstinence is currently recommended, but advice comes with the suggestion that small quantities may do no harm (National Institute for Health and Care Excellence (NICE), 2008). Research into "Fetal Alcohol Spectrum Disorder" (Sokol, Delaney-Black, & Nordstrom, 2003) has shown that the threshold for risk-drinking during pregnancy (enough to potentially damage offspring) has not been adequately identified. Still, expectant mothers are often criticised for drinking publicly. Some women privilege the wide range of medical advice, which has been viewed as internalisation of the sense of the passive, bio-medically managed body (Mahler, 2003). This may also reflect broader trends in developed countries in terms of how we view our bodies and our relationship with biomedical science. Meanwhile, others attend to advice passed down from mothers and grandmothers (Fox, Heffernan, & Nicolson, 2009).

In either case, it is not surprising that the proliferation of advice and the increase in technical monitoring and surveillance during this time can magnify women's anxiety. Indeed, Heron et al. (2004) identified a significant number of

women experienced anxiety during pregnancy, with prevalence rates at around 13 per cent (NICE, 2017). Alongside the negative impact this may have on the developing foetus, “protecting the emotional state of pregnant women” (Odent, 2004) appears notably neglected within the current biomedical framework.

The trend around increased medicalisation and management of perinatal care, and technological intervention into the childbirth process, applies to developed, Western countries. Given the importance of socio-historical context, the present study will focus on the UK, operating within particular structures available through an accessible, free healthcare system, the NHS. This system lies in contrast for example, to the United States (US), which is constrained by insurance-based systems excluding access to free healthcare. In the UK alone, child-bearing occupies a significant domain owing to the sheer numbers involved; in 2016, there were 696, 271 live births in England and Wales, a slight dip of 0.2% from 2015. The average age of mothers increased to 30.4 years, compared with 30.3 years in 2015, while pregnancy rates in women in their 40s rose over the same period to 28,744 conceptions (Office of National Statistics, 2017).

In order to contextualise the medicalisation of childbirth and pregnancy in contemporary British culture, an exploration of how motherhood is conceptualised within Western society is required. The dominant beliefs and myths reinforcing this prevailing discourse are expanded on below. It is acknowledged that some ideas around motherhood are shared with inter-dependent Eastern cultures. However, for the purposes of the present study, discussion will focus around ‘first world’, developed Westernised countries.

1.2 Conceptualisation: Motherhood in Western British society. Cultural myths of motherhood.

1.2.1 The idealised ‘fantasy’ mother

It is suggested above that within the current biomedical framework, motherhood and childcare has become managed by ‘experts’, including doctors, midwives, health visitors, psychologists and social workers, as well as broader realms of

government agencies offering advice and guidance. In combination, these contribute to the idea that being a ‘good’ woman equates with being a ‘good’ mother.

As Oakley has noted (1980, p.50): “Cultural femininity and biological reproduction are curiously synonymous in the proclamations of medical science about women”.

Within the prevailing medical discourse shaped by patriarchy, it is argued that motherhood retains a mythical and powerful status, to which all women aspire. This is evident in the cultural myth of motherhood as ‘natural’, blissful and desirable. Western-centric cultural representations of the ‘fantasy’ mother are communicated through the media, exemplified by the beatific Madonna gracing church windows and recreated in modern celebrity culture in images of blissed-out, bare-breasted supermodels with a suckling child. These representations surround women from an early age, and supplement archaic and moralistic fairytales fed to girls (and boys), in which women pursuing the ‘happy ever after’ of marriage and motherhood are rewarded with joy and fulfillment.

Even in today’s modern world in which women are faced with increased lifestyle options, significant numbers of women do become mothers. On an individual level, women acknowledge their biological capacity to bear children and, through socialisation to female norms, come to associate femininity with marriage and motherhood, often viewing women who do not do this as deficient (Ussher, 2006). Research supports this view that motherhood is often seen as an entry into womanhood (Figes, 2008; Ussher, 2006). Feminist writers argue that such a value system is linked to partriarchy’s romanticisation of motherhood, as a means of subjugating women. As Nicolson (1998, p.13) suggests: “It suits men for women to mother”.

In addition, Nicolson (1998, 2001) proposes myriad ways in which 19th and 20th Century medical/biological and psychological/social science has partly controlled the status of motherhood. For example, she points to evidence of scientific experts taking ownership of parenting after World War II, offering a ‘correct’ way to mother. These normative prescriptions privileged certain knowledge claims of scientists, serving the needs of the patriarchy (Foucault, 1972). One example relates to experts highlighting negative consequences of

suboptimal mothering, reinforced by Bowlby's 'maternal deprivation' thesis (1963). Bowlby's research emphasised the value of mother love and unconditional availability in infancy, which proved highly influential in popular culture and subsequent infant development research. Promoting a 'healthy' way to parent through provision of a secure base charged mothers with a moral responsibility, since the onus of providing this form of attachment fell upon them, irrespective of circumstances and abilities (Ainsworth, 1992).

Within this mother-focused discourse, one of the most potent charges refers to "refrigerator" or "schizophrenogenic" mothers (Fromm-Reichmann, 1950; Kanner, 1943). These labels referred to women with children diagnosed with autism or schizophrenia, whose maternal coldness and inconsistency were perceived as adversely affecting infant-mother attachment, and consequently infant development (Murray, 1992). Here, the onus of appropriate parenting is clearly imposed on the mother: more generally, fathers are dramatically under-represented in the literature on parenting and child development (Phares, 1992). Within these domains, 'parenthood' and 'motherhood' become synonymous terms, where the man is seemingly airbrushed out. The pressure this places on mothers is unsurprising; only recently has research begun to explore the role of fathers (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008), despite men devoting significantly more time to childcare since the 1970s (O 'Brien, 2005).

Since Bowlby's early work developing 'attachment theory' (Bowlby, 1969), its core concepts have led to fruitful lines of development for understanding an infant's emotional life. According to Bowlby's theory, babies are born biologically predisposed to form relationships from which they can experience security and comfort. Infants internalise early interactions with key caregivers as mental representations of the self and others, termed 'internal working models'. When attachment security is compromised, negative ways of relating to the self, others and the world can develop, resulting in a weaker sense of psychological self. 'Insecure' attachment develops when the infant experiences insensitive, neglecting or rejecting parenting (Ainsworth, Blehar, Waters, & Wall, 1978). This is reflected in the organisation of the child's behavior, as assessed by Ainsworth et al.'s (1978) 'Strange Situation' research paradigm. The notion of attachment

styles was further developed by discovery of the ‘disorganised’ pattern of attachment, a response derived by the same parental figure providing both fear and comfort (Main & Solomon, 1986).

Attachment theory has informed the growing disciplines of developmental psychology and ‘affective neuroscience’, expanding in part due to technical advances, as emotion can now be measured and quantified (Schore, 2003; Siegel, 1999). For example, fMRI scanning allowed neuroscientists to create a visual map of the brain when emotions are being experienced (Panksepp, 2004). From the early 1970s, the use of video to explore the world of mother and infant, through analysing interactions of mothers and babies, frame by frame, enhanced our understanding of early development (Stern, Jaffe, Beebe, & Bennett, 1975). More recently, microanalysis of four-month mother-infant face-to-face communication was found to predict 12-month infant ‘disorganised’ attachment in a US urban community sample (Beebe, Lachmann, Markese, & Bahrick, 2012). This research generated a complex, dyadic view of early communication disturbances, exploring affect, attention, orientation and touch, in co-constructing attachment disorganisation.

Much research has been conducted to establish the social benefits of early intervention (e.g. Kitzman, Olds, Cole, Hanks, Anson et al., 2010). Gerhardt (2015) argues for the importance of prevention, in particular from conception and during the first two years, when the ‘social brain’ is shaped and an infant’s emotional style and emotional resources are built. The ‘social brain’ is developed through an infant learning that their feeling states can be understood and contained, and how to manage feelings in line with others. Gerhardt (2015) suggests that development of a regulatory capacity is also shaped by a person’s stress response, immune response and neurotransmitter system. Evidence suggests that a baby’s nervous system is established and formed by experience during this time, so that how a parent behaves influences their child’s emotional capacities as much as their genetic make up.

Neuroscientific evidence emphasising the quality of the infant-parent relationship, as influencing both the biochemistry and infant’s brain structure, is compelling. Research also shows how the infant’s early attachment

organisation shapes his or her developmental pathway (Svanberg, 1998). Such research has helped fund therapeutic interventions such as the 'family nurse partnership' model (Barnes, Ball, Meadows, Howden, Jackson et al., 2011), Watch, Wait and Wonder (Bateman & Fonagy, 2004), and Circle of Security (Powell, Cooper, Hoffman, & Marvin, 2016). These aim to support parents to increase their capacity to notice, 'tune in' and sensitively respond to their child's signals in order to regulate their emotional states and thus provide a secure base (Silver, 2013). Such interventions are also tailored to assess the internal working models of mothers, as these have been found to predict infant child attachment more strongly than maternal parenting behaviours (Gerhardt, 2015).

However, the suggestion that positive outcomes for a child rely more on the mother and father than on the baby, continues to place enormous responsibility on the parent. A mother can feel that her capacity to sufficiently 'attach' to her child may be compromised by pressure to work, relationship and financial difficulties, or feeling isolated and unsupported at home. Now that the concept of 'attachment' is widely known, this can shape ideas of the 'good' mother, and women may evaluate their own parenting based on these understandings. Women enter motherhood with their own experiences of being parented, with their own experiences influencing their subsequent roles as parents (Moran & Hubbard, 2015). As outlined in the Solihull Approach, an intergrative model incorporating psychodynamic, child development and behavioural ideas, experiences of being parented can then impact on attachment behaviours (Douglas, 2004). Populist notions of 'attachment' can also lead to misapplication and misunderstandings, compounding pressure on modern mothers to parent 'correctly' for fear of negative outcomes for their child. For example, in terms of what constitutes adequate mother-infant 'attunement', some parenting approaches incorporating 'attachment' ideas (e.g. Sears & Sears, 2001) propose almost constant proximity to the baby, advocating breast-feeding on demand and co-sleeping. However, research shows that key caregiver(s) providing 'secure' attachment only 'get it right' in terms of successful attunement to the baby around thirty per cent of the time (Tronick, 1989). More importantly for babies to develop trust in the parent, is that when mismatches occur, efforts are made to repair the disruption, organising

expectations of whether and how mismatches are righted (Beebe, Jaffe, Markese, Buck, & Chen et al., 2010).

1.2.2 The myth of ‘maternal instinct’

It is argued that the institution of motherhood as ‘natural’ is underpinned by another powerful, socially constructed myth relating to the notion of maternal ‘instinct’. This is the idea that women are biologically driven to bear children, and to care for them (Figes, 1994), purely because having a womb, ovaries and breasts grants them the capacity to. This prevailing maternal ‘instinct’ discourse, introduced by childcare experts in 19th Century, was again reinforced by Bowlby’s (1963) ‘maternal deprivation’ theory. It has since been bolstered by ‘popularised’ media accounts of biologically driven explanations in sociobiology and evolutionary psychology, which support the notion that women’s brains are ‘hard wired’ to bear and bring up children (Nicolson, 2010).

Today, the ‘instinct’ myth is promoted in modern postnatal care units where, for example, health professionals emphasise ‘skin to skin’ contact immediately following delivery. Mothers are expected to feel a rush of natural love towards their newborn based on the idea that attachment comes instinctively. Consequently, an unhelpful ‘bonding’ discourse has arisen, meaning that the reality of women’s lived experiences can often lead to self-pathologisation.
“I thought this was the worst thing I’d ever done - had a baby and felt nothing” Samantha, Interview 2 (Nicolson, 1998, p.62).

Research has increasingly exposed this crude, deterministic view of ‘instinct’ as a myth. Badinter (1981, p.23) separates maternal ‘instinct’ from love in her study of motherhood: “Maternal love is a human feeling. And like any feelings, it is uncertain, fragile and imperfect. Contrary to many assumptions, it is not a deeply rooted given in women’s natures”. Studies exploring women’s mixed responses to their newborns contradict the notion of maternal instinct (Crouch & Manderson, 1995). Women expecting to feel this kind of love experience guilt and distress in its absence (Nicolson, 1998).

1.2.3 Masks of motherhood

A new baby brings joy but the immediate transition to motherhood represents a shock, both physically and emotionally (Oakley, 1980). The idealisation of motherhood as a straightforward, emotionally-fulfilling process contrasts starkly with the lived experience of women's day-to-day reality, often involving multiple losses related to a mother's identity, body and relationships with others (Nicolson, 2001). Mauthner's (1995) qualitative study of 18 women highlights the distress experienced by those who felt that their feelings of low mood and despair contradicted the 'fantasy' mother ideal.

"It's really awful being with other women who look as if they're coping…you just think, 'Oh they're so happy with their family and I'm not'." (Pam, p. 317)

The challenges of motherhood are not to be underestimated. For the majority who assume the task without outsourcing to paid staff, it encompasses sheer hard work, frustration, isolation and a heavy domestic burden. It also involves self-sacrifice, organisation, and infinite patience. Breen (1975) found that first-time mothers who struggled most were those whose internalised idealised representations of a 'good' mother did not fit their perception of themselves. Pressure to live up to the cultural 'fantasy' mother construction of the calm, coping woman led to self-surveillance, self-silencing for fear of being 'found out', and self-punishment for their perceived failure. Thus, their efforts to hold the mask in place serve to perpetuate the illusion of idealised motherhood.

1.2.4 Maternal ambivalence

The degree of self-sacrifice and ability to juggle competing demands in new motherhood can provoke some women to dislike, even hate, their children in times of acute stress (Ussher, 2006). This experience of maternal rage tends to be suffered in silence, producing feelings of fear and shame. Such feelings relate to women's perception that it contradicts their own notion of a 'good' mother or that of other mothers, and therefore, the experience is also associated with fear of social denigration.

Some writers have begun to break down the taboo nature of maternal ambivalence, articulating the complex emotions around it (e.g. Parker, 1995; Rich, 1984). Rich (1984, p.21) describes “the murderous altercation between bitter resentment and raw-edged nerves and blissful gratification and tenderness.”. However, the majority of women continue to keep the mask firmly in place, holding up a public face of gentle and controlled motherhood, leaving feelings of anger, distress, and frustration simmering under the surface. When rage or despair bubble up, these negative feelings are often labelled as ‘depression’.

1.3 Consequences of Western-centric cultural myths of motherhood as ‘natural’ and desirable

1.3.1 The reality of motherhood: women’s lived experiences

“Belief in the all-powerful mother spawns a recurrent tendency to blame the mother on the one hand, and a fantasy of maternal perfectability on the other” (Chodorow & Contratto, 1982, p.55).
Evidence of mother-blaming has already been noted. Additionally, belief in the ‘fantasy’ mother creates taken-for-granted assumptions about how to be ‘good’, placing pressure on women to assume the burden of motherhood unconditionally (Nicolson, 1998). Women can then experience distress when the imaginary dream comes as a ‘shock’ (Parker, 1995). The transition to motherhood is often accompanied by a sense of disillusionment and disappointment - largely due to the gap between powerful cultural myths of motherhood and the everyday reality (Mauthner, 1999).

Although the majority continue to embrace the challenge of motherhood, women today have more lifestyle options. Motherhood is experienced within different kinds of families outside the traditional, ranging from single mothers, a mother in a lesbian relationship, to cohabiting with the baby’s father or a man who is not father to the child. The second half of the 20th Century has seen a disintegration of the extended family, where those with educational and employment aspirations may leave their local community to pursue opportunities. Consequently, reduced social support postpartum can compound

the stress of new motherhood. Many women also now work outside the home alongside motherhood for financial and/or aspirational reasons; fewer than before are stay-at-home mothers. These lifestyle changes present modern new mothers with a dilemma: they are expected to fulfil a dual role, of an independent working woman as well as ‘good’ mother, all at high personal cost. A host of factors can intersect with the extent to which women identify as ‘good’ or ‘bad’ mothers, including characteristics such as class (Braun, Vincent, & Ball, 2008) and race (Reynolds, 2001).

In Western culture, the norm is for adjustment post birth to be quick and seamless. Mothers are expected to cope immediately after the delivery, be back on their feet soon after, and ultimately to return to work in some capacity. Ussher (2006) notes how tiredness is viewed as a sign of pathology, despite findings from one study in which as many as 86 per cent of 50 healthy non-depressed mothers reported extreme fatigue in the weeks following childbirth (Ruchala & Halstead, 1994). This pressure on women to cope with the transition contrasts with postpartum practices in non-Western cultures, such as in India, China and the Middle East, emphasising maternal rest (Kim-Godwin, 2003). Such Eastern rituals can be equally constraining, however nurturing the mother is arguably preferable to the “rigid disciplines of Western stoicism” which leave postpartum women feeling weak, isolated and inadequate (Figes, 2008, p.22).

A further paradox that can compound stress for Western mothers is that while motherhood may be transformative, it retains low social status. Idealised mythic notions of motherhood as the most valued job in the world appear to contradict the way in which mothers’ responsibilities and strengths are often denigrated in contemporary culture (Figes, 1994).

Nicolson (2001) argues that postnatal distress, which tends to be labelled as ‘postnatal depression’ (‘PND’, on which more below), requires a reconceptualisation in research and clinical practice. Nicolson, who bases her systematic exploration of ‘PND’ on quantitative research and qualitative pre- and post-natal interviews with 24 women, suggests that ‘PND’ should be viewed as a normal, understandable experience for the majority of new mothers. On this account, low mood and despair is experienced as a ‘grief reaction’ to the

reality of mothering in settings where women are struggling to live up to impossible ideals of femininity and motherhood. “Women and men have to understand the consequences of motherhood in the context of Western industrial life in the absence of kinship networks, in the face of financial struggle, gender inequalities and gender power relations in the family” (2001, p.109). In contrast to idealised notions of motherhood, Nicolson proposes arguably the greatest paradox of this complex transition: namely, that joy and loss co-exist.

1.4 Rise in identification of perinatal pathology

Within the contemporary Western landscape of managing pregnancy and childbirth, there has been a subtle shift from the rhetoric of ‘doctor knows best’ to that of informed choice and risk (Nicolson, 2010). While pregnancy news is usually met with jubilation, the postpartum period represents an increased risk for women to develop psychiatric or mood problems, with approximately fifteen per cent of women affected at any one time (Challacombe et al., 2016). Not only is women’s physical health monitored and scrutinised, but so also their psychological state, with a view to applying clinical diagnoses. These include “baby blues”, PND, puerperal psychosis (PP), and obsessions or compulsions (Challacombe et al., 2016). Evidence shows that perinatal ‘disorders’ influence obstetric outcomes, mother-infant interactions and longer-term infant development (Topiwala, Hothi, & Ebmeier, 2012). The range of identified perinatal emotional ‘disorders’ sets the scene for women becoming distressed, anxious or low around having particular thoughts and feelings in the context of concerns around being labelled ‘disordered’ or ‘mentally ill’.

1.4.1 Screening

Perinatal psychosocial assessment measures, such as the Edinburgh Postnatal Depression Scale (EPDS), may enhance awareness of psychosocial risk (Cox, Holden, & Sagovsky, 1987). However, robust evidence does not exist for routine screening leading to improved perinatal mental health (Harris, 2016). In order to identify clinically vulnerable subgroups, practitioners recommend enquiring about depressive symptoms at screening visits (Topiwala et al.,

2012). Enquiries should particularly relate to a personal and family history of puerperal psychosis (especially bipolar affective disorder) and severe depression, as these represent confirmed risk factors for PP and PND respectively.

1.4.2 Pathology of distress

Feminist and critical psychologists such as Ussher (2006) argue that following childbirth, medical regulation and control of the pregnant body/container continues among new mothers, developing into pathologisation of their distress. These academics also highlight a tendency within contemporary hegemonic accounts for negative feelings such as anger and despair to be blamed on the woman's defective, excessive and uncontrolled reproductive body.

What is clear is that within the dominant framework, hormonally based explanations for 'PND' dominate (e.g. Dalton, 1989). This prevailing view is thought to stem from an increased knowledge and awareness of endocrinology in the 20th Century, with PND attributed to oestrogen (Dalton, 1989; Garnett et al., 1990), or to genetics (Bebbington, 1998). However, Beck's (2001) meta-analysis of 84 studies identified as many as 13 aetiological risk factors for developing 'PND', with lack of partner support acting as the strongest predictor. Oakley (1980) proposes 'PND' is an ideological label: "PND mystifies the real social and medical factors that lead to a mother's unhappiness". Nicolson (2001), too, criticises the traditional focus on the physiology of childbirth rather than its physical and emotional context - highlighting numerous risk factors including hormonal fluctuations, trauma in childbirth or postnatal wards, loss of a sense of autonomy and self-esteem. Nicolson suggests that a woman's life history and circumstances will also impact on how she relates to feelings of low mood. Therefore, mothers who are socially isolated, struggle financially, live in poor housing, or those with a history of emotional problems, remain more at risk (e.g. Breitkopf et al., 2006).

In feminist writing, depression following childbirth has been reconceptualised as an understandable reaction to the stresses and strains of new motherhood (Nicolson, 1998), associated with high and unrealistic expectations (Mauthner,

1999), and reduced social support (Mauthner, 1995). Social support has been found to be a strong protective factor, but the quality of support offered is key (Mauthner, 1999). Research supporting this theory show single mothers receiving positive support suffer fewer emotional problems than married/ cohabiting women, whose partners undervalue their parenting skills or contribute little to childcare (Brown, Andrews, Harris, Adler, & Bridge, 1986). Furthermore, Miller (2002) found that cultures in which women receive strong social support postpartum have lower rates of postpartum depression. Feminist writers also reject the dominant, medicalised understanding of negative emotions related to new motherhood, where deviation from Western-centric representations of idealised femininity is blamed for distress.

Given the rise in screening and potential diagnoses, where psychological screening has become a key feature of psychological monitoring by midwives and health visitors, women have become increasingly aware of their own mental state. One important instance of this relates to new or recent mothers' experience of IHRTs, which may cause distress for those already doubting their ability to function and to mother.

1.5 Literature review: IRHTs

Unwanted, intrusive thoughts, images and impulses are not unique to new or recent mothers. Research in the general population has identified that these are common, reported by nearly four fifths of people (Niler & Beck, 1989; Parkinson & Rachman, 1981; Purdon & Clark, 1993; Rachman & De Silva, 1978). However, only a small number of academics have begun focusing on the phenomenon related to the postpartum experience. This reluctance or delay around exploring IRTHs only contributes to their taboo or stigmatising nature, despite widespread experience.

1.5.1 Literature search

An exhaustive review of the literature was performed across PsycINFO, Academic Search Complete, Embase, Maternity and Infant Care, CINAHL and Medline with an unrestricted timeframe. Searches were conducted between

November 2014 and December 2017. Search terms and permutations including “harm*”, “harm thoughts”, “intrusive thoughts”, “child*”, “newborn”, “mother*”, “prenatal*”., “postpartum”, “perinatal” and “postnatal” were inputted. An initial search generated 2,395 papers (case, group, review and conference presentation), of which 61 relating to IRHTs were included (Appendix A). References of relevant articles were also searched for unidentified literature. An initial literature search identified that maternal ambivalence was also drawn upon by several authors in relation to IRHTs directly, or mapping onto the experience of IRHTs. Therefore, a separate search pertaining to maternal ambivalence was conducted, leading to inclusion of an additional 11 papers/books.

1.5.2 Conceptualisation of IRHTs

Researchers have started to examine IRHTs, commonly experienced by new or recent mothers in the postpartum period (e.g. Abramowitz et al., 2006, 2003; Fairbrother & Woody, 2008; Hall & Wittkowski, 2006). The content of this ideation relates to one’s current concerns (Klinger, 1996) and is typically elicited by external and/or internal stimuli (Parkinson & Rachman, 1980), including stressful situations and negative emotional states (Brewin, Hunter, Carroll, & Tata, 1996; Horowitz, 1975; Wroe, Salkovskis, & Richards, 2000).
In Fairbrother & Woody’s (2008) study conducted in Canada, examples of accidental IRHTs included suffocation, the baby falling/being dropped, illness, contamination, neglect (i.e. forgetting the infant in the car), sexual abuse by another, drowning, burns, and being responsible for accidental harm. Intentional IRHTs ranged from verbal or passive aggression (e.g. thoughts of screaming at or shaking the baby) to potential infanticide (e.g. throwing the baby out the window). Such intrusions peak in the initial postpartum weeks, especially for first-time mothers, and are often accompanied by disgust by those experiencing them (Abramowitz et al., 2006; Abramowitz, Schwartz, & Moore, 2003; Fairbrother & Woody, 2008).

Fairbrother & Woody (2008), who explored IRHTs in 98 women four and 12 weeks postpartum, found that postpartum accidental IRHTs were universal, while nearly half of the sample reported intentional IRHTs. However,

participants were predominantly middle-class, married or co-habiting and well-educated. The majority of research focuses on similarly homogenous samples, limiting the generalisability of findings to mothers who differ in terms of racial/ethnic background, education, income and other potential modifying factors.

1.5.3 Risk related to IRHTs

No evidence of a correlation between intentional[2] IRHTs and parental violence has been found (Fairbrother & Woody, 2008). Fairbrother and Woody (2008) found that the only intentional IRHT associated with harsh parenting behaviour was ideation about screaming at the baby. Unlike puerperal psychosis, aggressive thoughts in postpartum obsessive-compulsive disorder (OCD) and a non-clinical sample are experienced as 'ego-dystonic' and therefore not associated with greater risk of violence (Fairbrother & Woody, 2008; Lawrence, Craske, Kempton, Stewart, & Stein, 2017). Ego-dystonic thoughts are accompanied by one's awareness of conflict between the intrusion and their self- and world-concept, evoking distress or anxiety (Fairbrother & Abramowitz, 2007).

Researchers have distinguished between the relatively common experience of IRHTs and clinical obsessions reported by individuals with OCD. It is thought that intrusive thoughts exist on a continuum (Belloch, Morillo, Lucero, Cabedo, & Carrió, 2004; Leckman et al., 1999), where clinical obsessions are characterised by severity of symptoms. Severity is defined by the frequency and time consumed by intrusions, and the degree of distress and functional impairment caused by such ideation. "Shorter in duration than worry and less frequent than obsessions, unwanted intrusive thoughts nevertheless are capable of provoking intense negative affect" (Fairbrother & Woody, 2008, p.221). However, despite the significant distress and high prevalence, many

[2] Fairbrother & Woody (2008) were the first authors to systematically distinguish between accidental and intentional IRHTs, and these terms are used mostly in the literature. Accidental harm refers to a mother's IRHT featuring a baby coming to harm without her active interference or merely by accident, whereas intentional harm refers to thoughts, images or impulses in which she actively harms her infant. In some cases, these terms are replaced with terms such as "passive" or "active" harming intrusions (e.g. Brok et al., 2017). This study will employ the terms "accidental" and "intentional".

mothers and healthcare professionals are unware of the IRHT phenomenon (Brok et al., 2017). This often compounds mothers' feelings of shame and guilt, maintaining their non-disclosure (Barr & Beck, 2008; Fairbrother & Woody, 2008). Mothers also fear that their baby may be removed from them by statutory services, suggesting that prevalence rates are likely under-estimated (Lawrence et al., 2017).

What can additionally compound distress caused by IHRTs are the numerous contradictory discourses confronting new parents. Just as women are prescribed boundless and often conflicting advice regarding diet and risk in pregnancy, so too in parenting they face polarised prescriptions regarding child-rearing. For example, regarding infant sleep, abundant parenting manuals, websites and blogs suggest competing agendas (Burkeman, 2018). These range from co-sleeping within the 'attachment parenting' movement (Sears & Sears, 2001), to "Cry it out" sleep-training methods emphasising routine (Ferber, 2006). Such contradictory messages further hinder new mothers' reliance on their instincts. For someone already vulnerable, the experience of IRHTs can add yet more stress, as a new mother then feels less able to dismiss such thoughts.

1.5.4 Measures

Instruments used to assess IRHTs vary among studies, making it difficult to compare or summarise results. Only one mixed-design study to date has assessed accidental and intentional IRHTS in a non-clinical population, using the Postpartum Intrusions Interview (PII) (Fairbrother & Woody, 2008). The PII is based on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) (Goodman et al., 1989), adapted according to prior research and authors' clinical postpartum experience. Other Canadian and US studies also customised instruments, such as the Perinatal Obsessive-Compulsive Scale (POCS) (Lord, Rieder, Hall, Soares, & Steiner, 2011), a self-report scale of perinatal obsessions and compulsions, and the Postpartum Thoughts and Behaviour Checklist (PTBC) (Abramowitz et al., 2006). The PTBC is a semi-structured interview, comprising a checklist of 32 IRHTs derived from Abramowitz et al.'s (2003) previous US study, and a 14-item checklist of psychological and

behavioural neutralising strategies, again similar in format to the Y-BOCS. However, for all these instruments, ideation was assessed using pre-determined categories, rather than allowing women to elucidate their experience of IRHTs freely.

The Yale Inventory of Parental Thoughts and Actions-Revised (YIPTA-R) (Kim, Mayes, Feldman, Leckman, & Swain, 2013) assesses prevalence of IRHTs in different domains including preoccupation of the baby's needs and wellbeing, and anxious intrusive thoughts and harm avoidant behaviours, at 2-4 weeks and 3-4 months postpartum. It was revised to include domains about the positive experiences of parenting and positive thoughts about the baby. However, in Kim et al.'s US study (2013), some of the domains had low alpha scores, indicating a need to replicate research in larger and more diverse samples to support reliability and validity of the measure. Among all the tools used to identify IRHTs, the POCS is the only validated instrument.

1.6 IRHTs related to perinatal mood disturbance

American researchers have paid particular attention to the occurrence of IRHTs as a function of postpartum psychopathology (Wisner, Peindl, Gigliotti, & Hanusa, 1999), such as depression (Jennings, Ross, Popper, & Elmore, 1999) and OCD (Abramowitz et al., 2006).

1.6.1 IRHTs in postpartum depression

Harm thoughts in postpartum depression are likely to be more severe (Abramowitz et al., 2010). Compared to IRHTs in non-postpartum depression, IRHTs occurring in postpartum depression tend to be more violent, with ideation including drowning/stabbing the baby (Wisner et al., 1999).

Two studies investigated whether depression is linked with increased IRHTS among postpartum women (Abramowitz et al., 2010; Jennings et al., 1999). Abramovitz et al. (2010), who examined 60 postpartum depressed women in the US, found that nearly ninety per cent reported IRHTs, similar to the

prevalence among healthy mothers assessed with the Postpartum Thoughts and Behaviour Checklist (PTBC). Depression severity measured by the Edinburgh Postnatal Depression Scale (EPDS) was purely related to the frequency and severity of IRHTs. Meanwhile, Jennings et al. (1999) compared 100 clinical depressed mothers with 46 healthy mothers, again in the US. Their experience of intentional IRHTs was assessed by only one question, without measuring associated frequency, distress or likelihood she might carry out such thoughts. Of the depressed mothers, nearly half experienced intentional IRHTs at nine months postpartum compared to seven per cent of healthy women. However, in both cross-sectional studies, it is not possible to identify causality; that is, whether depression occurred due to distress evoked by IRHTs, or if depressive symptoms initiated the occurrence of IRHTs.

1.6.2 Postpartum psychosis

It is acknowledged that ego-syntonic depressive ruminations and psychotic thoughts may alter the course and outcome of IRHTs (Chandra, Bhargavaraman, Raghunandan, & Shaligram, 2006). In Chandra's (2006) study, which explored the link between infant-related delusions and mother-baby interactions in 105 southern Indian women in an inpatient psychiatric facility, mothers with delusions towards the baby reported aggression including shouting, hitting and smothering. However, the nature of such ego-syntonic intrusions, experienced as attuned to one's current sense of reality and mood, will not be elaborated on, existing outside the scope of the present study.

1.6.3 IRHTs in Postpartum Obsessional Compulsive Disorder (PPOCD)

In retrospective studies of OCD, pregnancy and childbirth have been marked as onset or exacerbating life-events (e.g. Maina, Albert, Bogetto, Vaschetto, & Ravizza, 1999). PPOCD is typically characterised by obsessions of causing harm or of harm coming to the infant (Abramowitz, Schwartz, Moore, & Luenzmann, 2003) along with compulsions. In PPOCD, the content of obsessional thoughts tend to be more aggressive than in non-postpartum OCD (Uguz, Akman, Kaya, & Cilli, 2007). Intrusions pertain to fears of contamination, aggression, religion, sex, making mistakes, or severe illnesses (Abramowitz,

Schwartz, Moore, et al., 2003). Feelings provoked by these obsessions include guilt and shame, a sense that it was a mistake to have a baby, and lack of control (Dunnewold, 1997; Misri, 2005).

Estimates of prevalence differ profoundly, ranging from 0.7 – 9 per cent (Challacombe et al., 2016). Identifying whether this indicates a significantly increased risk compared with non-postpartum populations is not straightforward given the different cultural contexts and methodologies used (McGuinness, Blissett, & Jones, 2011).

1.7 IRHTs in non-clinical samples

1.7.1 Prevalence

In addition to Fairbrother & Woody (2008), three studies examined the prevalence of IRHTs in non-clinical postpartum samples. Abramovitz et al. (2003), who interviewed 117 healthy parents (77 mothers, 40 fathers) in the US at four months postpartum, found that nearly three quarters of mothers and two thirds of fathers experienced IRHTs. One fifth of mothers and nearly a quarter of fathers reported intentional IRHTs. In the second study (Abramowitz et al., 2006), which examined 43 US-based mothers and 42 fathers 12 weeks postpartum, nine tenths of parents reported accidental IRHTs, and approximately one third reported intentional IRHTs. Hall et al. (2006) explored whether 158 non-depressed new/recent mothers in the United Kingdom (UK) experienced negative thoughts, using the 54-item Postnatal Negative Thoughts Questionnaire. This measure was derived from qualitative interviews with 10 depressed mothers. Over three fifths of women reported thoughts about their baby dying. Findings were irrespective of demographic characteristics and corroborated themes of negative intrusive thoughts occurring in other explorations of non-depressed people (i.e. ideation about death) (e.g. Rachman & De Silva, 1978). As noted, prevalence of IRHTs is highest in the initial weeks postpartum, significantly declining by the third month (e.g. Kim et al., 2013). Researchers have made efforts to include fathers in some clinical studies, and prevalence rates will be reported here. However, for the purposes of this research, the focus will be on the experience of mothers.

1.7.2 Etiology

1.7.2.1 Stress

Within the limited research exploring the etiology of IRHTs in healthy postpartum women, stress is identified as a key factor in initiating and maintaining their occurrence. One Spanish study (Labad et al., 2011), which examined the correlation between hormonal levels of stress and IRHTs, found that increased morning adrenocorticotrophin hormone (ACTH) within the hypothalamic-pituitary-adrenal (HPA) axis, was linked with higher subsequent reports of IRHTs in postpartum women. These results were independent of anxiety, depression and social support. However, findings were based on only one morning blood sample, therefore not accounting for the impact of nocturnal changes on morning HPA activity, as other studies have reported in OCD (Kluge et al., 2007). Evidence of fathers experiencing IRHTs as well as mothers, albeit with less frequency and distress, indicates the need to investigate stress as an environmental factor (Abramowitz, Schwartz, & Moore, 2003).

As noted, IRHTS are similar to ‘normal’ intrusions in that they are typically triggered by external and/ or internal stimuli (Parkinson & Rachman, 1980; Rachman, 1998), such as stressful situations and negative emotions (Brewin et al., 1996; Horowitz, 1975; Wroe et al., 2000). Evidence also suggests that their content relates to one’s current concerns (Klinger, 1996). It therefore follows that infant crying, which increases in hours per day in the second month of life, was identified as a significant trigger for the experience of intentional IRHTs in primiparous mothers in Canada (Fairbrother, Barr, Pauwels, Brant, & Green, 2015). Intentional IRHTs were also found to be associated with increased feelings of frustration, negative emotions and the urge to flee the infant (Fairbrother et al., 2015). Regarding the latter finding, Murray (1979) suggested that infant crying can arouse both altruistic urges (to comfort the baby) and egoistic urges (to escape the crying). She argued that the egoistic response to crying is elicited by the wish to minimise parental distress (and not that of the baby), and that an altruistic response can become an egoistic response to

infant crying when it becomes prolonged. Fairbrother et al. (2015) propose alternative hypotheses supporting their results. One is that mothers reporting IRHTs experienced the crying as more aversive (than those who did not report IHRTs), strengthened by the fact that these women reported increased frustration and negative emotions. Alternatively, it may be that experiencing IRHTs intensifies negative emotions and frustration and therefore the urge to flee. Strengths of this study are its experimental design, with the use of protracted (i.e. 10 minutes) infant crying. Limitations include the use of prerecorded sounds of an infant unknown to the mothers, whose emotional and cognitive experiences are likely to be amplified through hearing their own baby cry.

Fairbrother & Woody (2008) found high parenting stress was associated with intentional IRHTs four weeks postpartum. The self-report Parenting Stress Index - Short Form (Abidin, 1995) was used to measure stress in 98 healthy first-time mothers in Canada, yielding a total stress score, plus three subscales: Parental Distress, Parental-Child Dysfunctional Interaction, and Difficult Child. In this study, high parenting stress was found to refer specifically to the parent's perception of her relationship with the baby.

1.7.2.2 Social support

The same study, along with Maimon (2012), also found that low perceived social support (but no other demographic variables*)* correlated with the occurrence of intentional IRHTs. Social support was measured by a 10-item scale, the Social Support from Partner and Social Support from Others, which assesses material, practical, affective and informational support, plus satisfaction with received support.

In combination the above findings suggest that mothers who feel negatively about their relationship with their baby, unsupported in their new maternal role, and/or are upset when their infant is distressed, are more likely to experience intentional IRHTs.

1.7.2.3 Psychological Factors (and Related Behaviours)

IRHTs are commonly conceptualised within a cognitive-behavioural framework, adhering to the medical model. For example, Fairbrother and Abramovitz (2007) propose that a normal IRHT becomes a clinical obsession when new mothers appraise the intrusion as highly threatening by over-estimating (a) their own responsibility for prevention of harm, and (b) the probability of harm befalling the infant. Therefore, if a mother "misappraises" an unwanted intrusion to drown her child as signifying an evil nature and intent to carry out this action, the thought itself of such behaviour will evoke high levels of distress. This cognitive misinterpretation is referred to as thought-action fusion (TAF), the tendency to believe that having a "bad" thought equates one with moral badness or increases the likelihood of catastrophic consequences (Abramowitz, Schwartz, Moore, et al., 2003). "Likelihood" TAF describes the belief that merely having the destructive thought increases likelihood of harm befalling those featuring in the thought (Salkovskis, Shafran, Rachman, & Freeston, 1999).

According to this conceptualisation, fear and distress associated with the feared thoughts provoke efforts by new mothers to avoid activities that elicit the thought (e.g. being alone with the infant), or to conduct compulsive rituals to "neutralise" the cognition or make sure that feared consequences do not arise (Abramowitz, Schwartz, & Moore, 2003; Abramowitz, Schwartz, Moore, et al., 2003). Although both IRHTs and clinical obsessions may lead to attempts to control the thought (e.g. avoidance, distraction), the former tend not to be associated with behavioural compulsive rituals. Unwanted IRHTs also differ from clinical obsessions that occur as part of OCD in that they are not clinically significant, are more fleeting, less upsetting and easier to dismiss (Fairbrother & Woody, 2008).

Some studies have explored which psychological factors make mothers more vulnerable to experiencing IRHTs. One US study (Larsen et al., 2006) found that worry, self-punishment and reappraisal of the IRHT were positively associated with the severity of obsessional symptoms. Other thought control strategies used to manage IRHTs included self-reassurance, distraction, checking, prayer, interacting with the infant, seeking social support, and

avoidance. Avoidance usually occurs when the mother views herself as the source of harm, whereas checking tends to stem from fear of harm from another source, leading to checking if the baby is still breathing or preventing anyone else caring for the baby. CBT is then indicated to help manage a person's (usually counter-productive) efforts to neutralise, dismiss or suppress intrusions. Researchers also call for psycho-education to help normalise IRHTs pre and post-natally, to help reduce distress and aid clinical decision-making for those reporting such thoughts (Fairbrother & Woody, 2008; Larsen et al., 2006; Lawrence et al., 2017).

Both avoidance and overprotection in the context of clinical obsessions may hamper mother-infant attachment and child development (Abramowitz et al., 2010). Kim et al. (2013) explored the relationship between parental thoughts and parent-infant interactive behaviours, such as sensitivity and intrusiveness, among 31 mothers and 28 fathers in the US, all Caucasian American. Increased IRHTs were associated with lower parental sensitivity for mothers. Scales in the sensitivity construct included typical postpartum behavior (gaze, affect, vocalisations, touch), a predictable style (consistency), and parental adaptation to the baby's cues (assessing the extent to which mother offers a "regulatory" environment). These researchers suggest that increased IRHTs may disrupt the mother's capacity to interact with her baby sensitively. However, more research is needed to fully understand the direction of the association.

1.7.2.4 Personality

Cognitive strategy may be shaped by personality. Fairbrother et al.'s (2015) experimental study, exploring first-time mothers' responses to infant crying, found that personal distress, empathy and trait anger facilitated the occurrence of intentional IRHTs. The authors' hypothesis that empathy may be associated with such thoughts arose from evidence that IRHTs occur as an adaptive response to parenting. On this account, one is motivated to protect the baby through increased maternal vigilance to potential harm (Leckman et al., 1999). These findings suggest that more empathic mothers (those most propelled to look after and protect their infant), and who are pre-disposed to feel anger, may be more likely to suffer and report intentional IRHTs. Other studies have found a

correlation between severity of IRHTs and other personality traits, such as negative self-image and prepartum anxiety (Humenik & Fingerhut, 2007), and higher psychoticism (Gutiérrez-Zotes, Farnós, Vilella, & Labad, 2013). The latter study yielded these results after adjusting for other personality aspects including neuroticism and extraversion, age, depression and life stress. However, Fairbrother & Woody (2008), examined neuroticism and psychoticism in their sample of 98 women, and found that neither personality variables significantly correlated with IRHTs.

1.8 Critique of the related mainstream literature

The scant body of research conceptualising IRHTs within a cognitive-behavioural model has limitations. First, studies are largely quantitative, neglect non-clinical populations and draw conclusions from cross-sectional data prohibiting causal inferences (e.g. Fairbrother et al., 2015; Fairbrother & Woody, 2008; Larsen et al., 2006). Future research is needed to clarify the direction of the links between women's perception of the quality of their relationship with the baby and their received social support. It is not yet known if mothers who feel frustrated with or sad about the nature of their interactions with the baby, or who feel unsupported by others as a mother, are more likely to experience intentional IRHTs. Alternatively, it may be the case that intentional IRHTs negatively affect women's appraisals of the quality of their parent-child relationship and social support.

As described earlier, generalisability of findings is limited due to samples predominantly comprising middle-class, educated and married/cohabiting women, suggesting a need to focus further research in a more diverse sample.

1.8.1 Neglected areas

The impact of infant temperament and maternal sleep deprivation on IRHTs has been largely overlooked in research. The role of childhood trauma in mothers has yet to be investigated. In the case of maternal postpartum sleep, research indicates a strong link between sleep deprivation and maternal depression (Kurth, Kennedy, Spichiger, Hösli, & Stutz, 2011), and reduced relationship

satisfaction (Insana, Costello, & Montgomery-Downs, 2011). Sleep problems have also been found to contribute to higher rates of obsessional ideation (Timpano, Carbonella, Bernert, & Schmidt, 2014). Future studies would benefit from further exploring maternal postpartum sleep, following hypotheses that such sleep deprivation may be linked to increased dissatisfaction in response to infant crying, as well as increased prevalence of IRHTs (Fairbrother et al., 2015).

Second, the experience of IRHTs tends to be pathologised, despite suggestions that it is 'normal' for new parents. As Murray & Finn (2012, p.43) note: "What is left unchallenged is the subtle assumption that ideations of harm are (at least potentially) undermining of good mental health and good mothering". IRHTs are rarely examined outside of the medical model and this lacks perspective. Examining IRHTs within a wider socio-cultural context would allow exploration of how cultural discourses, such as around the 'good' mother ideology, play into mothers' experiences of these thoughts. Few studies have accounted for cultural pressures and subsequently emerging notions of maternal ambivalence, in the context of IRHTs. One UK-based study (Murray & Finn, 2012) found that women understood their intentional IRHTs as either congruent or incongruent to their maternal identity. Elsewhere, Stern & Stern (1998) highlighted the positive function of IRHTs, operating as an effective warning system for mothers, teaching them to protect their babies.

Given the different responses to IRHT's, it is important to explore how women may experience and make sense of these in relation to wider discourses about mothering. While the main body of the literature tends to frame IRHTs negatively, treating them as mapping onto OCD, the qualitative data seems to indicate a more complex picture.

1.9 Justification & Aims

A gap exists for a study that qualitatively explores the nature of IRHTs experienced by a new mother, rather than using measures with pre-determined definitions. It is important to understand how a mother defines and understands IRHTS, and how this assimilates into her cultural expectations of motherhood.

Accessing a more diverse group appears relevant given how class (Braun et al., 2008) and race (Reynolds, 2001) can shape women's identification as 'good' and 'bad' mothers.

The aim of this study is to elicit a fuller, critical understanding of the common experience of IRHT's among new mothers. Experiencing IRHTs has been identified not as a risk factor but as commonplace yet distressing (Lawrence et al., 2017). Despite little evidence that IRHTs map onto the OCD model, they tend to be linked with pathology leading to people being offered treatment (Kleiman & Wenzel, 2011; Royal College of Psychiatrists, 2015). The former referenced example, aimed at American mothers and clinicians, excludes personalised women's accounts of IRHTs in their own words (Kleiman & Wenzel, 2011), further supporting the need to explore personal experiences of these. A mother's belief that sharing IRHTs will lead her to be stigmatised by professionals and potentially viewed as a risk to their baby is likely to compound distress. Therefore, this research aims to enhance understanding among healthcare professionals concerning the form and nature of IRHTs, and the ways in which women experience and report them. Such understandings may lead to professionals opening up non-judgmental discussions around IRHTs, without pathologising women's experiences.

1.9.1 Research questions

In response to research gaps, the proposed research aims to explore the following research questions:

- What is the impact of a mother's IRHTs on her?
- How does a mother attempt to account for and manage her IRHTs?
- How does a mother understand her experience of IRHTs in terms of relating her own expectations of mothering to her existing cultural beliefs, representations and understandings?
- What are a mother's experiences of sharing IRHTs with others?

2. METHODOLOGY

2.1 Overview

This chapter outlines the rationale for the qualitative design of the present study, as well as its epistemological position. Recruitment procedure, data collection and analysis and ethical considerations are also discussed.

2.2 Epistemological Position

Epistemology is concerned with a set of assumptions about knowledge and knowing, seeking to answer: “What and how can we know?” (Willig, 2012, p.13). These assumptions are shaped by philosophical reflection. As Denzin and Lincoln (2005, p.183) state, given that paradigms “are human constructions” defining “the worldview of the researcher…”, it is important for academics to own their epistemological position (Willig, 2012). This stance must be considered first, as it informs the choice of methodology and method (Willig, 2013).

There are a range of epistemological positions, and for quantitative research the approach is usually realist and positivist (i.e. assumption that research data directly reflects reality or truth). Within the body of qualitative research, epistemology can be viewed as existing on a spectrum, from realist to relativist (Harper, 2012). Researchers can adopt different positions depending on the extent to which data is viewed as reflecting reality. At opposite ends of the continuum are naïve realism and radical social constructionism (Willig, 2012). In adopting a naïve realist position, the researcher considers that data more or less directly reflects reality. Alternatively, a radical social constructionist (relativist) position assumes that “reality” is constructed through discourse and particular contexts, and examines the effects of these constructions both for those using them and for those who are positioned by them.

A critical realist epistemological position was adopted for this research, as the knowledge it produces through the process of data analysis is drawn both from

the participants' words and from "beyond the text" (Harper, 2012, p.89). It is acknowledged therefore that the data is only one representation of an underlying reality. This stance assumes that a reality exists for participants but that the theories/methods deployed to examine the experience of IRHTs is shaped by our own socio-cultural and political assumptions and beliefs (Pilgrim & Bentall, 1999). Therefore, a process of interpretation of the data is required, which allows for its consideration, while acknowledging a need to move beyond the data. Moving beyond involves drawing on "knowledge, theories and evidence from outside of our particular study" in order "to account for what we have observed" (Willig, 2013, p.21). In adopting this epistemological stance, it is recognised that the analytical process will be mediated by personal influences, and, for example, this researcher's position. However, explicating these aspects (see 2.9) enables the reader to view the analysis in context.

2.3 Rationale for Choice of a Qualitative Method

2.3.1 Qualitative methodology

The aim of qualitative research is to discern "what it is like" to experience particular conditions, and how people make meaning from certain events (Willig, 2013, p.51). This depends to an extent on the particular approach adopted. For example, discourse analysis is concerned with how language is deployed to construct particular representations and consequences of this. Overall, qualitative research elicits the "quality and texture of experience" rather than testing outcome predictions, through attempts to give voice to participants' understandings to allow rich descriptions to be heard (Willig, 2013, p.52). Therefore, a qualitative methodology is useful for elucidating exploratory areas (Yardley, 2000), and investigating sensitive and complex issues (Barker, Pistrang, & Elliott, 2002).

Qualitative research methods do not focus on preconceived hypotheses and variables but on participants' own attempts to make sense of the phenomena under scrutiny to generate new understandings. As already noted, there is a paucity of existing qualitative research in the area under study. The scant body of research investigating IRHTs is largely quantitative, utilising non-standardised questionnaires which impose pre-determined definitions of such

thoughts. IRHTs are usually conceptualised within a cognitive-behavioural model, and the evidence is decontextualised in terms of wider experiences of mothering (e.g. Fairbrother & Abramowitz, 2007). Given that the experience of IRHTs by new mothers remains under-studied and little understood, an exploratory study to generate new insights seemed appropriate. A qualitative endeavor aims to illuminate the nuances around the accounts and understandings of IRHTs by new/recent mothers, allowing women to account for their experience in their own words, with less of an agenda constructed by the researcher.

2.4 Thematic analysis

As Smith (2004) highlights, “one cannot do good qualitative research by following a cookbook” (p.40). However, different step-by-step guidelines for conducting thematic analysis do exist (Boyatzis, 1998; Fereday & Muir-Cochrane, 2006; Joffe, 2012), with a question mark over whether it represents a tool applicable across qualitative methods (Boyatzis, 1998), or a stand-alone research method (Braun & Clarke, 2006). Braun and Clarke (2006) argue that because thematic analysis is not wedded to a particular theoretical framework, it offers theoretical flexibility. Such flexibility is appropriate for exploring the research questions relating to the phenomenology of IRHTs, to yield a “rich and detailed, yet complex, account of the data” (p. 78).

However, in light of such theoretical flexibility, it remains important to make transparent assumptions underpinning the data. To this end, thematic analysis was considered the most appropriate method given that it can also constitute a ‘contextualist’ method, falling between constructionism and essentialism. This method accounts for the ways participants make sense of their experience, and how these meanings are shaped by the wider social context, within the realm of the material ‘reality’. In this way, it constitutes a method that “works both to reflect reality and to unpick or unravel the surface of ‘reality’” (Braun & Clarke, 2006, p.81). Therefore, it worked well to utilise thematic analysis embedded in a critical realist position described above.

To evaluate the most suitable qualitative method for this research, grounded theory was also considered in view of its aim to be inductive. However, it was

discounted in light of its focus on generating theory, whereas the exploratory nature of this project aimed more widely to enhance understanding. Interpretative phenomenological analysis (IPA) was additionally considered. The focus of this approach is on how participants make sense of their lived experiences within a phenomenological framework (Smith, Flowers, & Larkin, 2009). However, this method was not chosen as it is less suited to working from a critical realist stance than thematic analysis, which shares the epistemological underpinning most appropriate for this project. Additionally, the present study was not only interested in the 'lived experience' of having IRHTs, but in the triggers, consequences, and how they are understood and shared by women.

Thematic analysis enables identification of patterns and categories across data pertaining to a research question; specific patterns of meaning found in the data are conceptualised as themes. Such patterns of meaning are understood at either the descriptive or semantic (manifest) level, whereby themes map onto directly observable data, or work at the interpretive (latent) level accounting for wider contextual factors (Joffe, 2012). A critical realist approach allows identification of both types of explicit and implicit themes (Joffe, 2012); to this end a combination of semantic and interpretative themes were formulated.

Researchers have also distinguished between an inductive ('bottom up') (e.g. Frith & Gleeson, 2004) or a deductive ('theory-driven') (e.g. Boyatzis, 1998) approach to thematic analysis. An inductive approach allows identification and analysis of patterns of meaning in an under-studied area, where the researcher approaches the data without a pre-existing theoretical coding frame (Braun & Clarke, 2006). This approach could be deemed appropriate for the exploratory nature of the present study. However, as Braun and Clarke (2006) note, it is not possible for the researcher to be free of their theoretical knowledge base and to code data in an "epistemological vacuum" (p.84). Therefore, Joffe (2012) proposes high quality assurance through combining a dual "deductive-inductive" and "latent-manifest" set of themes (p.210). This allows the researcher to approach the data set with knowledge of the literature base, to avoid "reinventing the wheel", while staying open to novel, emerging concepts. For example, previous findings suggest that certain, culturally-relevant discourses around breast-feeding or baby's sleep may play into participants' experiences of IRHTs. However, it also seemed important to remain open to capturing new

understandings and ideas around IRHTs in the data without expectations related to the researcher's analytic preconceptions. Therefore, the dual approach was adopted, to maximise the potential for keeping in mind certain preconceived categories while remaining alert to new insights and understandings about the phenomenon in question.

2.5 Participants

2.5.1 Sampling

Qualitative researchers aim for theoretical saturation, where data collection ceases at the point at which it is deemed that additional data would generate no further new insights (Oppong, 2013). Given that a proposed participant number was required for obtaining permission to commence data collection, a reasonable attempt to evaluate the point of theoretical saturation was made prior to recruitment, and to sample in line with this. Guest, Bunce and Johnson (2006) suggest that saturation tends to be obtained between six and 12 participants. As the length of interviews ranged from 54 minutes to 117 minutes, it was deemed sufficient to recruit as many participants as possible within the available timescale of this project, aiming for minimum of six. In total, eight participants were recruited.

2.5.1.1. Recruitment procedure

Participants were recruited through children's centres, mother and baby groups and baby classes (e.g. Baby Rhymetime). As pre-arranged with the relevant facilitator, the researcher summarised the study for attendees after their session, and handed out information sheets (Appendix B) outlining overarching aims and procedure. Adverts (Appendix C) were also circulated in libraries, child-friendly cafes and breastfeeding clinics in multicultural areas across North London to target a diverse sample. Additionally, an information sheet was sent via email to other Clinical Psychology trainees by the researcher's supervisor, and own contacts. Participants were asked to email the researcher at a university email address to express interest. An email exchange then followed to arrange a suitable time to discuss the project further by telephone, which enabled the researcher to sensitively 'screen' potential participants according to inclusion/exclusion criteria. A convenient time and location (if the interview was

being conducted face-to-face) was then agreed with those considered suitable for inclusion.

Participants who had been screened for inclusion were sent a consent form (Appendix D) by post with a stamped addressed envelope in order for them to sign and return. Following advice from a midwife with experience recruiting new mothers with such demands on their time, and recruitment challenges identified in previous research, each participant was given a £10 Amazon voucher as reasonable reimbursement of expenses for any time incurred. Funding for these payments was sought from the University.

2.5.1.2 Inclusion and exclusion criteria

Given the practicalities of conducting a doctoral thesis with funding constraints (e.g. negating the use of interpreters), creating certain exclusion criteria was appropriate. Therefore, the study sought to recruit a minimum of six English-speaking new/recent mothers, who had experienced IRHTs related to their youngest child, born within the last two years. Participants were recruited from a non-clinical population and excluded if their pregnancy was not full-term, and/or if they had received treatment for depression or any other psychological condition.

2.5.1.3 Participants

In total eight new/recent mothers participated; basic demographic details are summarised in Table 1. All participants had experienced IRHTs related to their most recently born baby, aged under 24 months. The age of participants ranged from 32 to 46. Five women described previous or current employment or training in physical/mental health healthcare settings, although one participant, formerly worked a Forensic Psychologist, chose to self-identify as a “housewife”. Some participants also spoke of experiencing IRHTs related to older children, and inevitably described these occasionally during the interview. However, the interview sought to retain focus on IRHTs around the most recently born child. Such data was coded for as a way of helping to understand how IRHTs may connect with previous children. It is recognised that

participants' history and context cannot be divorced from the interview procedure.

Table 1: Participant Demographics

Pseudonym	**Demographic Information**	**Health and wellbeing of most recently born**
Kayleigh	29, White British, married, employed (at time of interview) as Trainee Clinical Psychologist. One child, 20 months.	No concerns
Salma	33, Asian, co-habiting with partner, self-identified as Stay at home mother. Two children, aged four and two years.	No concerns
Fee	40, White British, married, part-time mental health nurse. One child, 23 months	No concerns
Hannah	34, White British, married, taking time out from previous job as Primary school teacher. One child, six months.	No concerns
Lucy	34, White British, co-habiting with partner, training as child and adult psychotherapist. Two children, aged two and four months.	No concerns
Polly	41, British Greek-Cypriot, co-habiting, self-identified as Housewife. Two children, aged three and one.	No concerns
Malia	32, Nepalese, married, GP. One child, aged one.	No concerns
Yvette	46, "mixed" race (German/West Indian), married, self-identified as Stay at home mother. Four children, aged 21, nine, six and 23 months.	No concerns

2.6 Data collection

2.6.1 Semi-structured individual interviews

Given the sensitive, confidential nature of some interview questions relating to the research topic, individual interviews were chosen over focus groups as the method for data collection.

A semi-structured interview schedule (Appendix E) formed the basis of the interview. Questions were designed to focus on the research questions while remaining flexible and open-ended, in order to facilitate exploration and follow up as needed during the interview. Follow up 'probe' questions accompanied certain questions to help participants elaborate on points when required, as is usual practice in semi-structured interviews (Willig, 2013). The interview schedule was created based on existing literature, and drawn up with guidance from the thesis supervisor, an experienced research psychologist. The schedule included an introductory preamble in which it was reiterated to participants that unwanted IRHTs are common among new mothers, with specific examples given. This preamble (Appendix F) was supplied electronically on request by Nichole Fairbrother, a key academic researching this area, and was delivered to participants in the qualitative component of a recent study (Fairbrother & Woody, 2008).

The interview schedule was not piloted before commencement of data collection, however the last question specifically asked participants if there was anything relevant they had not been asked. The first interview generated an additional question organically ("What would you say to another mother experiencing IRHTs?"), and it became clear that mothers experiencing IRHTs had clear recommendations for others experiencing them with distress or discomfort. This question was subsequently asked of all participants.

2.6.2 Interview procedure

Participants chose the location of the interview, and one participant was interviewed in a café near her home, and another participant in her home. Due to demands on a new mother's time, the opportunity of a telephone interview was offered for those unable to meet face-to-face (see ethically approved amendment, Appendix G). As with face-to-face interviews, all six telephone

interviews were audio-recorded, with the stipulation that they take place in a quiet, confidential space. The rationale for telephone interviews was to ease participation for new/recent mothers and to preclude incurring travel-related expenses. It also allowed a more diverse sample to be reached, with one of the study aims to access a mixed demographic.

Audio-recording was explained to all participants prior to the interview. A digital voice recorder (Olympus WS-110) was used to audio record all interviews. Following interviews, audio recordings were transferred onto a password-protected computer and transcribed.

2.7 Ethics

Ethical approval was sought and obtained from the UEL School of Psychology Research Ethics Sub-Committee (Appendix G).

2.7.1 Informed consent

In order to gain informed consent, participants were given an information sheet at the point of recruitment. Participants were then posted a consent form to sign and return prior to the interview. At the point of interview, participants were reminded of points regarding consent, including the right to withdraw at any point without consequence. There was also the opportunity to ask questions.

2.7.2 Confidentiality

All participants were informed that confidentiality would be ensured through the use of pseudonyms and the removal of identifying references in transcripts. Data was stored on a password protected computer. Audio recordings will be destroyed after the viva, and completion of any stipulated amendments have been accepted by examiners and the graduate school. Anonymised transcripts will be erased after three years.

2.7.3 Distress

Given the sensitive nature of the topic, and the degree of emotional vulnerability that new mothers may feel, some degree of distress was anticipated throughout the interview process. It was emphasised that participants could take breaks when they wished during the interview, and afterwards they were given the

opportunity to debrief, and to reflect on the process of talking itself. An additional information sheet (Appendix H) listing appropriate support services was offered at the end of the interview for any participants requiring further support.

2.8 Data Analysis

2.8.1 Transcription

Each interview was transcribed by the researcher verbatim which helped facilitate the process of familiarisation with the data, as informing the early stages of analysis (Braun & Clarke, 2006). Punctuation can change the meaning of data (Poland, 2002). Given that thematic analysis does not necessitate the same level of detail in transcribing as other methods such as discourse analysis, attempts were made to achieve at a minimum “a rigorous and thorough orthographic transcript” to retain enough information from the verbal account that stays true to its original form (Braun & Clarke, 2006, p.88). In order to enhance readability and meaning, non-verbal utterances were recorded, including pause length, laughter or participant showing distress, using an adapted transcription key (Appendix I).

2.8.2 Analysis

Analysis necessitated six stages, as outlined by Braun and Clarke (2006): familiarisation with data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report.

During the process of transcribing italicised process notes were recorded to note preliminary reflections to help facilitate interpretative skills required to analyse the data (Lapadat & Lindsay, 1999). Transcripts were re-read to further enhance familiarisation with participants’ accounts. The process of coding then began. Each code comprised “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p.63). This generated a coding frame including both inductive codes from the raw data, and theory-led codes informed by awareness of the literature (for example, relating to particular societal

discourses around babyhood that might shape participants' experiences of IRHTs). As the overarching aim was for final themes to be predominantly "data driven" rather than theory-led, the entire data set was coded systematically. Some extracts were coded multiple times, if relevant, and contradictions and inconsistencies were also coded. A sample of coded data for an individual transcript is included in Appendix J. The final list of codes is presented in Appendix K.

Initial codes were organised into potential themes in an ongoing, iterative process. A "theme captures something important about the data in relation to the research question" (Braun & Clarke, 2006, p.82). This phase involved collating all the relevant data extracts in the form of colour-coded "mind maps", so that data could be represented visually to help examine patterns in the data. This led to considering relationships between codes and potential themes to form overarching themes, and subthemes (Braun & Clarke, 2006). An initial thematic map was sketched out (Appendix L); themes were then revised through a process assessing their internal homogeneity and external heterogeneity (Patton, 1990). Some subthemes were collapsed until collated extracts for each theme were judged to form a coherent pattern, and a central organising concept underpinned each theme (Braun, Clarke, & Terry, 2014).

The recursive process of reviewing themes occurred next, to ensure that "candidate themes reflect meaning across the whole data set" (Braun et al., 2014, p.104), and that reported patterns remained meaningful to the research questions. The final step of defining themes helped attempts to capture the "analytical interpretation of the data as well as describing the key concept encapsulated in the theme" (Braun et al., 2014, p.106). The final thematic map is presented in the following chapter.

2.9 Reflexive Statement

Reflexivity comprises an important aspect of qualitative research, namely the process of stepping back and showing accountability for my own contribution to the production of knowledge. It is acknowledged that my own personal and professional experiences influenced the development of research questions,

interview schedule, conducting of interviews and data analysis. As Harper (2007) notes, simply labelling one's social positions (e.g. 'white, middle class background') is inadequate. What is required is reflection and understanding on how these may have informed the research material. At the time of the study, I consider the following identities and experiences relevant.

- Female
- Mother
- White, British, middle class background
- Trainee Clinical Psychologist

My status as a female researcher will inevitably have influenced the research process. For this study, female participants were interviewed about a sensitive, 'taboo' topic, and IRHTs, particularly of an intentional nature, remain little talked about. It has been suggested that female interviewers are well positioned to access the 'real' lived experiences of other women in an interview setting (Hamberg & Johansson, 1999). This seemed particularly relevant for this project.

My own position as a recent mother, with two children under five-years-old (my youngest was born during the research process) undoubtedly influenced my engagement with the subject matter. I experienced accidental IRHTs following the birth of my first child, and was fortunate to feel able to discuss these thoughts and images with two friends, also recent mothers, who worked in mental health. I was aware that other mothers, whose support network may not permit space for such open discussions, may struggle to manage such thoughts which may impact on their ability to report them. My personal experience and reflections led me to investigate the topic initially and formed the basis for the study. As a mother, I have become keenly aware of the 'myths of motherhood', and that discourses around talking honestly about its paradoxical nature (as both good and bad) are only visible in certain contexts, emerging mainly in the form of humorous 'Mummy' blogs (e.g. Turner, 2016). Maternal ambivalence has been documented academically but it appears that discomfort and reluctance persists around openly expressing negative feelings around motherhood. I believe the experience of IRHTs is more likely to be experienced

negatively given that IRHTs are poorly misunderstood clinically and among the general public, and consequently tend to be associated with risk.

My role as a trainee clinical psychologist intersects with my personal experience as a mother. As part of DClinPsych training, my CAMHS placement in an Under 5s team reinforced some of my reflections regarding powerful discourses (e.g. relating to the 'good' mother), shaping what is acceptable to express around experiences of motherhood. My clinical practice and teaching throughout training has also helped focus particular interests in critical psychology approaches and systemic theories. These encompass the importance of considering power (Foucault, 1977) and considering multiple perspectives (Burnham, 1992). Therefore, I tried to remain mindful not to privilege certain issues in both the interview and analytic process. For example, during some interviews, I noticed how some participants' accounts might be shaped by certain societal/cultural discourses around mother/babyhood. I sought to remain open to and curious about unexpected or novel views, and to minimise my own influence on the process by facilitating participants' free speech as far as possible.

I feel strongly that a clinical psychologist has an ethical duty to advocate for those who may not have a voice. Identifying as a privileged, white British woman in my late thirties brought awareness that I have not faced oppression or discrimination related to social inequality in my life. However, one study aim was to recruit mothers from a mixed demographic; women from impoverished, working-class and/or minority backgrounds risk experiencing political, social and economic oppression, all of which is likely to shape their experiences of IRHTs. Identifying with feminist values I also believe that occupying a low-status (in some contexts) social position as a mother, combined with experiences of social inequality, may further play into women's lived realities. Therefore, I made efforts to recruit a diverse sample in order to reflect the range of experiences faced by new/recent mothers.

Documenting reflections throughout the process in a research journal helped me maintain awareness of my own positions and how they might have shaped the research (Ortlipp, 2008). I found recording my responses following

interviews and during transcription particularly helpful, as well as for helping manage any emotional impact on me. Example journal extracts are included in Appendix M.

3. ANALYSIS

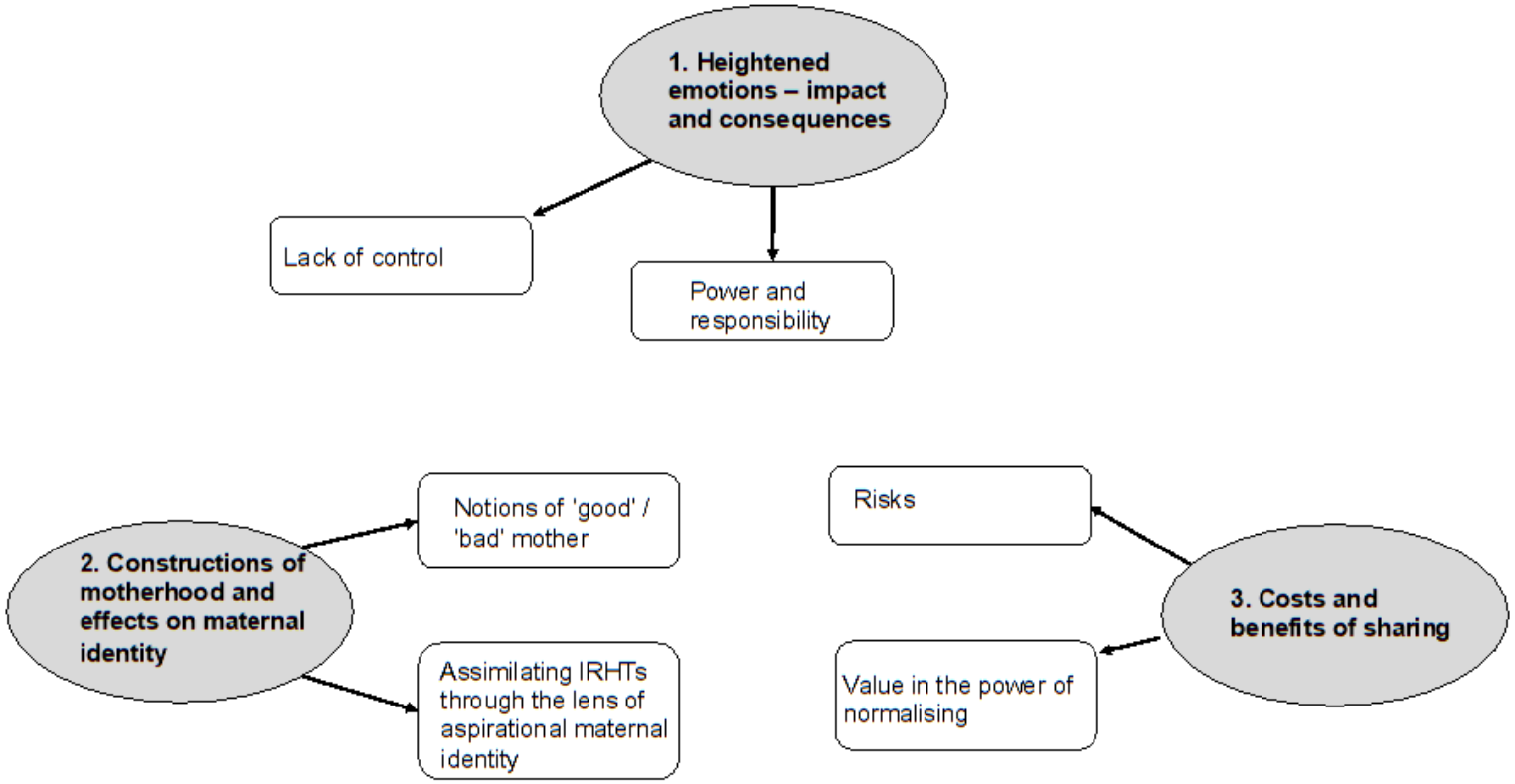

Figure 1: Thematic map illustrating three themes and six subthemes constructed from the analysis

3.1 Conceptualisations of harm

In describing the nature of their IRHTs, participants conceptualised sources of harm befalling the baby in certain ways. These descriptions did not emerge as a theme, but will be summarised below. Participants' IRHTs could be broadly classified as either accidental harm, experienced by six participants, or intentional harm, described by four participants.

Within the category of accidental harm, threat was perceived as arising in various different contexts, including the baby falling off a high surface such as a nappy changing table, off a bed or down stairs, stopping breathing due to Sudden Infant Death Syndrome (SIDS), or suffocating him/herself. Participants also conceptualised the sources of harm themselves in different ways. For example, one participant viewed an inanimate object (the baby's muslin) as potentially harmful.

> *My fear was, he always liked to hold a muslin cloth and he liked to have it in his mouth, I think it was comforting, but for me (.) I would take it away and he would get very upset. I had to watch him constantly (.) he was a very small baby and I thought it would take a few seconds for him to smother himself.* SALMA

For two participants, the source of accidental harm was identified as external, attributed to another person. These women both described fears of an elderly relative dropping the baby, or the baby drowning in a pond because of failure to reach the infant in time.

Or when people picking him and dropping him (.) and actually an image of my Dad dropping him because my Dad's quite old. And I still get those, I think that stays with me [….] I think it's specific to my dad because he's a little bit frail, and he has collapsed a few times for no reason so I do have the thought of what would happen if he did that while he's holding the baby. POLLY

….but Dad goes with her – poor dad – on Thursday afternoons and he's nearly 80 so it's just [thinking] about X running and Dad not being able to get there in time. FEE

However, the majority of women described accidental IRHTs in which they identified themselves as causing potentially fatal harm, due to momentary neglect. These instances related to their current concerns, such as bathing their children, co-sleeping with a newborn and monitoring a toddler near the road. Some IRHTs took the form of a vivid mental image while others were more 'verbal' in nature.

One horrible quite vivid one was him floating face down with his little hair.. hmm, it was horrible (.) yeah and just a mottled colour (.) Yeah, that I'd taken my eye off him for a second. I don't know what I'd done (.) and then just turned back to the bath like that. FEE

Yeah and the one where he's (.) when he was younger it was like I was going to roll on him and squash him and so I'd be like 'Hagh! I mustn't roll on him'. HANNAH

The other category of IRHTs described by participants belonged to those representing intentional rather than accidental harm. Again, with these kinds of thoughts, images and impulses, sources of harm were conceptualised differently. Two women located the source in an external threat, such as predators or perpetrators posing a risk, either by snatching or violently attacking their children (and themselves, in the instance of assault). Both

these IRHTs were directly related to a particular event covered in the media, recalled from some years ago:

> *But one night I really remember I got quite obsessive about the Jamie Bulger case. I was quite young when that happened. I started getting really worried that someone would snatch him, and it got to the point when I had to look up the case to see what actually happened. I was quite young when it happened so (.) I was just really worried that someone would take my baby when he was a bit older.* HANNAH

> *It was a very specific image, it was something I didn't think I remembered 'til I had my son, it was something that had happened years ago and I'd heard about it happening on the news about a mother who was being attacked with her children… they were in the park (.) and her children were very little. I think she was very badly hurt, and that story kept coming back in my head, and I kept thinking, 'That's what's going to happen to me. I'm going to go out with my children and I'm not going to be able to help them.'.* SALMA

In contrast to those describing external threats, half of the participants disclosed intentional IRHTs in which harm was conceptualised as endogenous. Experiences of impulses to shake, smother or throw their baby against a wall, all arose in the context of women suffering from sleep deprivation and struggling to settle their baby in the first six months postpartum. However, for the remaining intentional IRHTs described, the immediate contexts in which they occurred and the participant's circumstances all differed.

I think most of the thoughts have either been about me shaking him, maybe putting a pillow… even though we don't have a pillow in his bed (.) over his head, or throwing him against a wall. MALIA

-… everybody also saw that you had this beautiful baby and you should 'Ohh, she's so beautiful', and 'You're so lucky' when you didn't feel like that. You just didn't want to go, 'No actually I feel like throwing her off a bridge'. YVETTE

I had one that belonged to that other category – you know, unwanted impulse. [….] But it is a weird one for me (.) I was changing his nappy (.) or he was on his changing table and I had this sudden impulse to pinch him (.) just out of nowhere. HANNAH

3.2 Theme One: Heightened Emotions – impact and consequences

3.2.1 Lack of control

The majority of mothers vividly described how their IRHTs were accompanied by a powerful emotional experience, regardless of whether they were accidental or intentional in nature. A strong pattern developed in women's experiences relating to an overwhelming lack of control as their IRHTs occurred.

> *You almost couldn't control them at all […] it's almost soul-destroying.* YVETTE

> *Errr, I think it made me feel quite vulnerable actually, if I really think about it. Or maybe vulnerable is the wrong word (.) a sort of lack of control.* LUCY

> *I think just very anxious, not able to relax (.) you know not able to let go and let someone else look after him. You know obviously I did fall asleep but it wasn't a relaxing switching off type of thing. I did feel very anxious and very out of control.* FEE

Some participants also spoke about how the unpredictable way in which IRHTs "popped up", seemingly without an obvious trigger, also contributed to feeling out of control:

> *You know, history, and repetitive behaviour, it still difficult in the moment when the image pops into your head when you're changing your daughter…* POLLY

Hannah also described her IRHT related to the Jamie Bulger case arising "out of nowhere"; prior to her IRHT occurring it had not been recently in the news.

> *I really don't know where the thought of it came from, it suddenly popped into my head, but yeah, I just had to google it, and then the more I read the more I realised I didn't know the full extent of how horrible what they did was.* HANNAH

Participants deployed certain strategies to manage this felt lack of control. For some, engaging in self-dialogue was a way to try and manage IRHTs, where women sought to rationalise them internally.

I[3]: Yeah, and the rationalising it is putting it in context, thinking 'I'm a bit hormonal at the moment' and 'I've just had a baby'.
P: Yeah, definitely. Almost like keeping a hold of it I suppose.
I: Can you tell me a bit more about that?
P: Like making sure it doesn't take over, like making sure that I'm in control of it rather than the other way round. LUCY

The majority of participants also described immediate behavioral responses which helped increase their sense of control. Three women talked about using distraction as a tool, for example by checking their phone, listening to the radio, or making a cup of tea. Both Lucy and Hannah described actions which took the form of different compulsions, such as washing the baby's belongings if they had become "contaminated" by cigarette smoke, or checking information online.

P: A lack of control with my environment or almost a wanting (.) I felt like I had to have more control over it. So everything had to be washed [laughter] yeah, and clean for her. LUCY

I: Did it feel like it helped to know a bit more context?
P: Yeah because maybe it gave a bit more control over it (.) kind of not knowing what happened (.) I didn't realize the full extent of what they'd done to him. But yeah, I s'pose the worry for X was someone taking him and hurting him and somehow that just got linked with the Jamie Bulger thing (.) whereas reading the Jamie Bulger information (.) yeah I had a bit of control over it, in that. HANNAH

[3] In denoting dialogue between myself and a participant, I refer to myself, the interviewer, as "I", and participants as "P". Otherwise, participants are assigned pseudonyms as described in the previous chapter.

Six participants described responding by increasing their efforts to protect the baby through increased vigilance. This was not always explicitly named as enhancing a sense of control, but the two appeared to be strongly related.

> *It's a control thing – part of it but much more. […] he [husband] said he found it difficult, me watching over him (.) So at night-time, even if he had checked on the baby, I'd still go and check.* SALMA

> *Yeah, 'cos he was next to us in the cot, and still in our room for a year, so yeah I would check on him. Yeah, I'd sort of have to, I'd feel I have to check on him.* FEE

However, four of these participants felt that sometimes their chosen strategies to manage a perceived lack of control were not always helpful. Both Lucy and Hannah identified that checking information online could also amplify the intensity of their IRHT.

> *I: So one way to manage it was to look at Google was to read about it?*
> *P: Yeah but obviously that had the opposite effect, because that wasn't managing it, that was making me feel even worse. The managing it was more about […] spending less time in my own head, and more time in reality.* LUCY

Two participants also described the emotionally exhausting impact of feeling unable to “switch off” from experiencing IRHTs after giving over control to another to care for the baby, or feeling compelled to carry out constant checking themselves.

> *Yeah, yeah, definitely cos sometimes it would stop me sleeping for ages, and sometimes I’d just be that tired I’d end up nodding off. But it wouldn’t be a straightaway switch off sort of thing.* FEE

> *I had to watch him constantly (.) he was a very small baby and I thought it would take a few seconds for him to smother himself [...] I never took a break from him.* SALMA

3.2.2 Power and responsibility

Participants experienced the sense of responsibility as double-edged; on the one hand they felt duty-bound to act as protectors but they also occupied a ‘privileged’ position in terms of being able to inflict harm. In the context of adjusting to the enormous new responsibility of caring for a new baby, women described how feelings of intense anxiety accompanied their IRHTs.

> *The thing is a lot of the processes they’re internalised, going on in your head, dealing with lack of sleep, a lot of uncertainty, some babies are more difficult to settle. And it’s an anxious time trying to care for this little thing.* SALMA

> *I: So some of the worries were attached to some of the advice you might’ve read as well?*
> *P: […] Yeah so I think it was linked to that, and the lack of sleep, and the newness of it. The overwhelming responsibility.* FEE

Three participants described how this weighty feeling of responsibility ran alongside their experience of IRHT, in which acknowledgement of the power

dynamic between themselves and the baby made them starkly aware of their all-powerful role.

> *…I just felt this overwhelming feeling of protectiveness. And anything that I thought may be harmful, in terms of things I was watching, or anything coming into my house, like smoke or things like that, I kind of just wanted to protect her from them.* LUCY

> *Yeah, I guess so, yeah cos it does seem to be about keeping X safe. You know they all seem related to that. ….] So yeah I do feel they're related to keeping him safe and my role in that...* FEE

For some participants, their IRHTs represented a "sudden" realisation of the power dynamic, in terms of recognizing their own or another's capacity to harm this defenceless being:

> *I don't think (.) I didn't pinch him. I don't think I would've pinched him. But I suddenly had the realization that I could pinch him if I wanted to [laughter] (.) like it was kind of testing the boundaries of the power I had over him ….] I do think it was a sudden realization this person or this thing – 'cos in the early days they don't really feel like a person, and he doesn't have a traits of a real person, really, this thing is completely under your control. And if… you could pinch him if you wanted to and no one would know, you know that kind of feeling.* HANNAH

> *I think (.) I think for me it was a source of, you know, my little girl's vagina was in front of me, and thinking how small it is, and thinking how innocent this baby and child is, and how anybody could even go there, or touch that inappropriately, let alone have intercourse or anything like that, and also how damaging and painful that is.* POLLY

Another participant described some of the nuances around this power dynamic, in which she felt powerless in herself to repeatedly resist urges to

throw her baby from a sheer drop, but this did not mean the power resided then in the baby. Yvette described a “constant fighting with herself” to resist these urges.

> *Well there was this constant fighting with yourself where, because you did know on the one hand you didn’t want to do things like this but so scared that you were overwhelmed that you would […] it just felt like there was this constant battle with yourself to manage it, so you wouldn’t do it. But I don’t know if it was managing per se, because you didn’t feel like you were managing anything, you just kind of, you felt like your will had to be so strong to make yourself not to do it – not that I know if you ever would. I don’t (.) but I didn’t feel I was managing anything.* YVETTE

She later compared her reliance on her “will power” to prevent her from acting on her impulse, to the urge people give in to when they commit suicide:

> *Yeah it was like an argument (2) one side of you was pulling yourself one way (.) it’s not just you do normally, you know, wondering if you should do something, it’s very, very powerful that you (.) one side of you has this urge to do something and you’re stopping yourself from doing it. I certainly don’t have (2) I hadn’t had […] felt like that (.) and I kind of put it down to what people feel like when they want to commit suicide and then they actually, they then do it.* YVETTE

Meanwhile, another participant described her feeling of complete powerlessness in the face of struggling to cope with a new baby:

> *I felt very helpless. I remember some days feeling like, ‘Why did I have the baby if I couldn’t cope, why did I do this when I couldn’t take care of the child?’* SALMA

3.3. Theme two: Constructions of motherhood and effects on maternal identity

3.3.1 Notions of 'good'/ 'bad' mother

All participants described how their own early experiences of being parented combined with wider, cultural ideas, influences and pressures to shape their own aspirational maternal identity. The strength of this model provided the backdrop for their experiences of IRHTs, informing how they assimilated these in the wider context of their own lived experience as a mother. A strong theme developed around participants replicating some aspects of their own maternal figure, but more vehemently rejecting other aspects in favour of contrary qualities to create their own notion of a "good" mother:

> *-Yeah, I s'pose my mum was quite anxious with us, you know, always concerned about safety. Not that she really held us back from doing anything, but I think I'd want to be a fun mum (.) you know be able to explore, use their imagination and creativity and quite (.) free. But then, yeah, to grow up in a safe household but not for that to be an over-ruling thing. Yeah I think just be a fun mum.* FEE

> *There was almost a sense that she was unpredictable. ….] Yeah, yeah, she had a lot going on, so she was slightly more unpredictable than I like to think I am as a mum, or would want to be as a mum.* LUCY

Three women described experiences of being physically abused (for example, smacked or beaten) as a child by their mothers. They all spoke of deliberately rejecting use of this form of discipline with their own children in their new or recently acquired status of becoming a mother themselves:

I'd like to be a calm mother, not get too worked up, or raise my voice, definitely not a physically hands on mother. Because I had a mother who was, so I've always thought 'I'm never going to be that mother'. POLLY

So I wanted to do the things that my mother never did with us [….] My mother was temperamental, we got beaten a lot, my mother had no patience, no time, so (.) but that was also the timing (.) that time, kids were punished by beating them and we got beaten a lot. So I knew I never wanted to hit my children. YVETTE

I don't want to yell at X, and I know I'm not going to hit him even if he has got his finger in the plug socket he's not having a smack. It's not in my world now. Although it was when I was a child. HANNAH

Most participants described at least one positive maternal figure they had experienced alongside or in place of their own mother who for different reasons could not be sufficiently physically or emotionally present. For example, Yvette described an aunt who was an "ideal mum" and an "adult you could talk to", and Lucy experienced her boyfriend's mother as "a constant, being stable, being in control". Both Polly and Kayleigh spoke of close friends with older children or babies who modelled helpful ways of mothering.

For all participants, these experiences intersected with cultural representations and discourses that helped shape their aspirational maternal identity. There was no consensus on particular sources of information about child-rearing or baby development that participants described accessing, but the majority of women identified using 'Google' to look up information about aspects of babyhood. Extensive access to information was recognised by most participants as both helpful and as a mechanism for fuelling IRHTs, summarised by Kayleigh as being a "blessing and a curse". Similarly, comments on forums such as Mumsnet or Netmums were also found to be "helpful or really quite disturbing and judgemental" (Lucy). One particular

societal discourse around SIDS, and prescriptive advice around the dangers of co-sleeping, related specifically to three participants' IRHTs:

> *I think the rolling on him was because it was very much drummed into you about not co-sleeping and how dangerous it is to co sleep, even though they then say, many families do co-sleep and it's safe if you follow these rules. And I think early on because he was a breast-fed baby there will (.) you know, it's exhausting at the beginning, and I think perhaps I would drift off when he was feeding, and I think perhaps it was the guilt that perhaps something could have happened to him, maybe.* HANNAH

> *So I'd wind myself up and look on Google, about how it can have an impact on, how it can increase the risk of cot death and things like that.* LUCY

A pattern developed around participants' early experiences and wider cultural expectations and understandings, as placing pressures on the women to live up to their own internalised model of 'good' mother. This often clashed with the lived reality of motherhood.

> P: *I suppose the pressure was on for me to be almost the perfect mum*
> *I: Why's that?*
> *P: I don't know, maybe because my own childhood was slightly chaotic in terms of the stability of my family network, so the pressure was on coming from myself to make sure that my children's childhood is anything but chaotic.* LUCY

I remember I had my booking apt when I was 8 weeks being up at the crack of dawn making a cake because I wanted it for the midwife and [husband] was like, 'Why on earth are you up at this hour making a cake' [laughter] and I was like 'I want her to think I'm a good mum, I want her to think I'm a good mum!'…. KAYLEIGH

I wanted to be one of these mothers who's really hands on with everything, found everything really easy, you know, if I love my children, everything will be easy, everything would be the perfect picture but in reality (.) it's a lot of hard work (.) it's a lot of hard work. SALMA

3.3.2 Assimilating IRHTs through the lens of aspirational maternal identity

For all participants, their experience of IRHTs was very much shaped by these internalised representations of 'good' (and therefore 'bad') mother. These internal models informed how the women characterised their IRHTs; for half the sample, IRHTs were experienced as incongruent to their desired maternal identity (and associated values and expectations), underlying their lived experience of early motherhood. For these participants, the ways in which they characterised their IRHTs further indicated how their thoughts were experienced as clashing with their desired identity. This was evident in the way all four women pathologised their IRHTs - as signifying 'madness', 'danger' or 'badness'. This process of labelling appeared to have a function, allowing these women to retain their aspirational maternal identity.

For example, in Salma's case, her IRHTs around accidental harm befalling the baby became equated with not feeling able to cope. Given that her aspirational maternal identity pivoted around being one of those "bounce-back", "confident mothers", struggling to cope became tantamount to failure. The way she characterised the IRHTs as "irrational" further illustrates how her harm thoughts were experienced as incongruent to her aspirational maternal identity.

I tried taking breaks, you know, turning him away from me. But that was more upsetting for me. You know, I felt like I'm a bad mother and I can't cope with him. I knew in my head they were irrational thoughts, but I also knew the feelings I had about those were real. So even if someone said 'Oh you're being silly, he's not going to smother himself!', I knew that in terms of words, but in terms of feelings it was very real for me. SALMA

Similarly Lucy described her IRHTs as "irrational", and equated her experience of them with "failure". In Lucy's case, she objectified her IRHTs as a "contaminator", so that if she perceived the baby's belongings as becoming contaminated, so were her thoughts, and consequently the baby would experience her negatively. Her experience of IRHTs is externalised because it clashes with her aspirations to be "calm and in control".

> *P: Yeah, and almost get in the way of my normal experiences, like going home for Christmas. It felt like me feeling negatively about people smoking was going to affect the whole experience of going home with a brand new baby which should have been a really exciting time... but for me there was part of it that made me feel quite anxious.*
> *I: So correct me if I'm wrong but did you almost feel like the thoughts contaminated your experience, similar /*
> *P: Yeah, I used that word before – yeah, like these things were contaminated, and then if my thoughts were, the baby's thoughts were.*
> LUCY

Similarly, Yvette experienced her IRHTs as incongruent to her internalised model of 'good' mother, where she "felt nuts" because they directly challenged her sense of the "good, normal" maternal self, which she fought powerfully to retain.

I just felt nuts, and like you say, you didn't trust yourself, you didn't know how to deal with all these emotions. You didn't feel like a good, normal person anymore (.) […] you didn't know who you were anymore. YVETTE

I: And did experiencing the harm thoughts and images that you've described make you see yourself differently as a mum?
P: Yeah it did because you were frightened and at the time it was very hard to deal with, because you didn't feel yourself at all, so it was (.) you couldn't see yourself as being a good mum, but now (.) yes. – YVETTE

Yvette, who described feeling so overwhelmed by her experience of IRHTs that she experienced an urge to jump off a bridge herself on one occasion, described feeling "on guard all the time". She spoke of struggling to manage the frightening tussle with her darker side that was personified as experiencing powerful urges to throw her baby.

I: And you said your willpower was what got you through?
P: Well that's what it felt like, and my husband reassuring me (.) I hung on to that. 'It will get better, we will be happy'. I hung onto that, but at times you felt you know when you were walking down the stairs, holding her, you just kept going 'I'm not going to throw her, I won't, I won't'. You kind of feel that if you let your guard down, that you might have done (.) you might not (.) but I just felt like I was on guard all the time. YVETTE

In Hannah's case, her impulse to pinch her son became pathologised by identifying an externalised part of herself as a source of danger, through a process of self-judgement through the (imagined) eyes of society:

> *…and I wonder if it's a little bit, 'If I pinch him, will I feel it, No I won't'. And then also as soon as I'd had that thought 'If I pinch him, will it hurt me – no it won't', this secondary going, 'Oh my goodness, you wanted to pinch your child (.) do you want to pinch your child, are you a danger to your child, are you going to hurt your child?'.* HANNAH

Initially, she described her impulse as a "curious, innocent thought", which quickly led to her pathologising herself as a "bad, bad person" followed by fears that she "might become a potential abuser".

> *You know, the initial thought was a curiosity, how far is removed from myself, physically (.) but as soon as I had that curious, innocent thought, the whole kind of like society view thundered in, and I had to analyse whether or not I'm a danger to my child, you know, am I likely to abuse my child, how do I ensure I don't abuse my child, you kind of (.) this realization that I could abuse my child was quite shocking to me. […] And then it's like that 'Oh my goodness, you're thinking that (.) you're thinking 'How are you going to get away with pinching him?'' And it was a very rapid succession of thoughts. The initial impulse to pinch him was 'Oh isn't he cute, I could pinch him, I wonder if it would hurt me', and then straightaway it was massive fears that I might become a potential abuser which (.) I don't think (.) you know (.) I'm not (.) I'm not going to hurt my child.* HANNAH

As well as making sense of the power differential between her and her baby, as discussed earlier, Hannah also described the "rapid succession of thoughts". A "wondering" if pinching him would harm her swiftly moved to perceived judgement of herself as a societal risk. She then considered the potential punitive repercussions, namely increased self-surveillance:

I think my reaction to it was 'Oh my goodness, you bad, bad person, I'm really going to keep an eye on you now, that you don't do anything like that'. HANNAH

For the remaining four participants, their experience of IRHTs was also shaped by their internalised aspirational maternal identity, formed from past experiences and available cultural understandings. However, these women – who all had worked or continued to work in healthcare - were able to integrate their desired maternal identity with the stresses and strains of motherhood's lived reality. Consequently, their IRHTs were experienced as congruent and 'part of' them. Again, this process was illustrated by ways in which they characterised their IRHTs; these women understood that their IRHTs rose out of a particular context without attaching significance to what they might represent about them as a mother. Ultimately, they were able to reconcile them with a reconfigured 'good' mother identity.

So at least if I did have thoughts of harm coming to X I didn't think 'Oh that's going to happen' or 'Oh I'm a bad parent', yeah I was able to not go down that path. Probably working in mental health maybe helped a bit in that sense, not to be too overwhelmed with them. FEE

I think I'm a good mum, I spent lots of time with him (.) I've made that choice. Those thoughts are just like (.) I don't think they're a big deal. They haven't affected me really, I don't think. MALIA

In contrast to the other four participants, these women experienced their IRHTs as part of a dynamic – and sometimes painful – process of enhanced self-development. Their experiences were, as with the other women, accompanied by strong emotions, but in contrast their experience of IRHTs facilitated a constructive process around enhancing self-awareness as a new/recent mother. For Polly, she found that her IRHT related to child sexual abuse (CSA) was "upsetting" but that it helped her develop awareness around her own limitations, leading her to question whether she could return to working with the sex offending population as a psychologist. Polly perceived

her kidnapping related IRHT as constructive in helping her feel even more "protective" over her children. In Fee's case, the lived reality of being a mother and experiencing IRHTs relating to keeping her son "safe" brought understanding around what her own mother experienced rearing her. In making sense of her IRHTs she showed evidence of working towards reconfiguring her aspirational maternal identity, which revolved around aspiring to be "free" as a mother, without allowing anxiety to be "an over-ruling thing" (as she had experienced with her mother). Crucially, Fee's experience of IRHTs led to her understanding that being free of anxiety as a mother was "impossible":

> *I: And how did some of those images or thoughts or being a mum, how did they fit with the reality of being a mum?*
> *P: Well I realised it was impossible to be carefree [laughter]*
> *I: Yeah [laughter]*
> *P: Yeah to be led by them. Yeah it was very different. And God, with my mum, making sure everything was safe, and what she went through. I could really understand that.* FEE

For Kayleigh, her experience of self-development following an impulse to shake her son six months postpartum was perhaps even more dramatic, in signifying a "turning point" in her approach to mothering.

> *You know it's going to be hard work having a baby but I think the extra pressure of feeling you have to get it right. And I remember just thinking 'This is just crazy, it doesn't need to be like this at all, if I go and watch telly, he'll fall asleep on my chest and we'll all be fine? […] So it was a bit of a turning point…* KAYLEIGH

The day Kayleigh experienced the impulse liberated her to rid herself of the "extra pressure" of "getting it right" by following what she perceived as more mainstream, routine-led approaches. She could then see these had meant her "going against" her "instincts":

> *I think I wanted to be the kind of mother I have become, but there was a danger of me not being (.)[…] Because I was being swayed by the things I was worried I should be doing, like everyone else's baby has slept right through the night since [they were] 5 minutes old, [laughter] and that stress [….] This feeling that this isn't working and has to change, and that change was me being probably the kind of mother I wanted to be in the first place.* KAYLEIGH

Malia's experience of three intentional IRHTs from one to six months postpartum facilitated perhaps the most significant process of self-development. She described a process of feeling initially less able to dismiss her first IRHT, an impulse to shake her one-month-old son when he would not settle, and her second IRHT, an urge to smother her son when he woke prematurely from a nap. At both these points, she described self-assessing for depression as she had done with new mothers in her job as a GP. Malia described an awareness that these impulses were likely attributable to "stress", but it was not until her third IRHT, an impulse to throw her teething son against a wall, that she was able to assimilate the thought as signifying tiredness, not low mood – and therefore not representing anything about her as a mother.

> *I guess the time of four months when I wanted to do the pillow, and the time around a month when I wanted to shake him (2) I think what I was worried about was I was like 'Are those thoughts because I'm feeling depressed? Am I feeling low? And I think that's a lot to do with my profession and because we're all screening for that constantly in new mums. So I self-assessed myself and thought 'No I'm not depressed, I'm just (.) whatever that thought is, it's short, and it's just because I'm stressed or whatever'. And the thoughts at six months, you know, he was much more interesting and interactive at that time, and I was like 'I am having a really nice time with him, I'm definitely not depressed.' I think I was like this was purely because I was tired.* MALIA

Malia's experiences of IRHTs allowed her to reconcile her lived experience of motherhood over the first six months with her pre-baby 'fantasy' mother ideal. This process was facilitated by a strong support network and accessing online accounts describing the tough reality of motherhood. Malia was then able to understand its paradoxical nature: being both good *and* bad – and to accept her IRHTs, as representing some of these negative aspects she was living day-to-day, as "normal".

> *I see lots of mums socially and I feel like I'm quite honest, like maternity leave is not this holiday, like it is hard work, and it's hard (.) and I don't like being in the house all day, I have to go out at least once a day, so the way I rationalise it is, it's not a holiday, you get stressed at work, so it's normal to be stressed outside of work, and so thus those thoughts might happen […] I've just thought, you know, being a mum isn't easy, everyone struggles with it, thus this experience I've had is normal so (.) I'm fine.* MALIA

3.4 Theme Three: Costs and Benefits of Sharing

3.4.1 Risks

The majority of participants felt more able to share thoughts of accidental harm as opposed to intentional harm thoughts. However, participants identified a range of different risks around sharing both types of harm thoughts. None of the participants had shared their IRHTs with healthcare professionals, but those who spoke to a partner or friend(s), often demarcated limits around what they shared. For some women, sharing around their IRHTs was limited due to risks of being judged negatively for disclosing something unacceptable. Although the women did not label feelings of shame directly, these were implicated in the words of Yvette, who found her IRHTs "very embarrassing and very hard" and did not know anyone who had had a similar experience to her own. Shame was also implicit for Polly, who only alluded to

her IRHTs around CSA in describing her decision not to return to that field of work, without disclosing detail:

> *I wouldn't have gone into the detail of it, not for any particular reason, I guess it's not something to have stayed with me or bugged me, to feel the need to share. I don't think (.) actually maybe a lot of people don't want to think or talk about that, so why would I bring it up to get them to think about things like that, is my thought pattern around it.* POLLY

Two participants identified further fears around not feeling validated if they did share the extent of their IRHTs. Yvette told her husband how she was feeling "nuts" at the time, and felt he minimised her concerns by simply attributing her feelings to tiredness and "stress". Similarly, Salma, who only told one friend she was feeling "really anxious" without telling her the "whole story", feared not being validated.

> *At the time, I actually let the thoughts consume me, so I was part of the thoughts, I believed in them which it was why I never spoke to somebody because I feared if I spoke to somebody they'd say 'Oh you're just being silly, this is normal people feel, it will pass, just give them a bit of space'. But I didn't want to do that, I didn't want anyone to tell me what I was feeling and wasn't, and why, or (.) That it was silly.* SALMA

In disclosing IRHTs, a strong pattern emerged around women identifying fears of being perceived as failing to cope and therefore a risk to their babies. In the context of sharing with other mothers, this fear led to participants self-censoring their talk due to the possible consequences of being judged as unable to cope.

Female friends who hadn't had children, I didn't they'd completely understand and I think that was (.) I thought they would worry for me, and whether I was ok with my baby, and I didn't want that extra anxiety: 'Is she coping with the baby? Is something going to happen?' I didn't want to put fear in someone else's head that I couldn't cope with my children, or something. SALMA

Erm, yeah, so I haven't shared the throwing against the wall or the pillow thought. So I guess I feel like although I have a good network where for example, we'll say stuff like 'Don't you just love it when they go to sleep, it's amazing that you can just sit down' so, that's the extent to the sharing. And I guess (.) not that I don't trust anyone enough (.) […] I think it's because they feel like private thoughts and (.) I wouldn't want anyone to misinterpret them as me wanting to harm my baby, or asking me questions if they're worried about me (.) yeah, I don't want that, because I know that they're not serious. I don't want other people to be worried about me and the way I am with X. MALIA

In the context of choosing not to share IRHTs with healthcare professionals, four participants again spoke of fears of being perceived as a risk to their baby. For Malia, concerns revolved around disclosure to her GP warranting further psychiatric intervention which she "didn't want". Kayleigh also worried about "onward referrals to services" which she anticipated experiencing as "a bit meddling, a bit intrusive". She also expressed concern about professionals' "perception of it not being normal" when she believed her IRHTs to be a "normal experience". Both Salma and Hannah named their ultimate fear around potential removal of their baby from their care as a consequence of disclosure.

There were times when I felt like calling a Helpline and saying there's something wrong with the baby. […] But then I was very worried about going to a doctor, or a hospital, and I was very worried that they would step in, and take over, and say "She can't cope, we're going to take him away'. My worst fear down the line was that they would take my children away from me, both of them, because I couldn't cope. SALMA

P: I also think as well, because it was just that one time, for me to just go to a Health Visitor 'I wanted to pinch my baby the other day, it would make it into a massive deal' […] Well, just that you're worried enough to tell someone (.) would imply that if it's the tip of the iceberg whereas I know it was just a weird, little, suddenly, I wonder what it would be like to pinch him. You know, I wonder what it would be like to dye my hair [laughter] it's not necessarily something you're going to do [….]
I: And what would you be worried that they might do?
P: I think they'd start monitoring and watching me [laughter] […] Yeah, yeah, my big worry would be that they'd take the baby away…
HANNAH

As well as harbouring fears around the consequences of disclosure, participants also described how their appointments with healthcare professionals focused on physical rather than emotional health, without facilitating them opening up or disclosing their IRHTs. Fee described the "tick box" nature of questions around emotional wellbeing, which were "brushed over". This led to two participants engaging in further self-censoring by maintaining perceptions of coping and putting on "a good face".

…and her [the health visitor's] specific thing wasn't 'Is there anything you'd like to discuss?', it was 'Oh you look so happy!' […] I felt like I couldn't turn around and say 'Well actually I'm really miserable'. Whereas looking back now, if she'd said: 'How are you feeling?', or 'How's it been second time round?', I probably would've opened up, and if it wasn't so rushed, the appointment. SALMA

3.4.2 Value in the power of normalising

All six participants who felt able to share their IRHTs, or at least the negative emotions associated with their occurrence, described the powerful effect of having their experience "normalised" through sharing with another. Kayleigh described feeling less "alone" in experiencing IRHTs, and Fee felt "better" when other mothers responded to her volunteering her IRHTs with "more horrific" examples of their own. Salma finally felt able to share her IRHTs after another mother she met six months after postpartum volunteered her harm thoughts to her.

Yes, yes (.) she said she'd had them with all three of her children and as soon as she said that I thought 'Oh! Thank god!' I know it's a horrible thing to say, but I just thought 'Thank god somebody has said it. Thank god she's being open about it'. I needed somebody to be frank. And then I didn't feel like a bad mother then. I felt like somebody cared enough to tell me, and I thought well I want to share my feelings as well. SALMA

For two participants, for whom the experience of IRHTs had been incongruent with their desired maternal identity, the process of the interview itself served to normalise their IRHTs through their first attempts at sense-making with another. Both Yvette and Hannah then spoke of the importance of other mothers experiencing IRHTs to share them with a healthcare professional or at least discuss them more openly.

I: And what would you say to another mum experiencing harm thoughts?
P: A, that it's completely normal but also I would recommend to speak to somebody […] I felt like my will power was so strong that I got through it, but you almost don't know if you would have so I kind of would recommend someone to try and speak to somebody, you know a Health Visitor or somebody, I certainly wish I did at the time. YVETTE

Yeah, and in all the things I've read I've never come across this unwanted impulse thing, and actually if it is common, it probably should be something that's talked about. Because not being able not being able to talk about it means it becomes a bigger deal. HANNAH

However, Hannah highlighted the real difficulties of sharing particularly intentional IRHTs which are often little talked about among friends, let alone in healthcare settings. She described how she could only disclose her pinching impulse if it was framed with humour, and even then it would be difficult to bring up in conversation.

…you know if someone told me (.) I think someone wouldn't tell me, that's the thing, unless they were a really, really close friend and they were very worried about it and they wanted some reassurance about it (2) I just don't think (.) I can't imagine (.) it would have to come across as 'You know, isn't it so funny, he's so cute, I really wanted to pinch him the other day' , no one would openly say 'I thought about pinching my baby' just in the course of a conversation. HANNAH

The difficulties of sharing IRHTs were recognised by the majority of the participants, and they gave clear recommendations for other mothers experiencing them:

> *I spose don't (.) attach any meaning to them in terms of worrying about if it's (.) you're going to harm them (.) it doesn't mean you're going to do it. I s'pose likewise if you having thoughts of your baby being hurt, it doesn't mean it's going to happen or (.) talk about it and then maybe things you can do to alleviate those worries.* FEE

> *I'd tell her it was normal, it had happened to me [...] I'd just think everyone has it because it's hard being a mum and you don't really know what you're doing most of the time.* MALIA

> *But I feel that someone openly talking about it makes it better (.) I don't know why they don't have groups where people can have these conversations.* SALMA

> *…And sort of try to help them, that it doesn't mean something about them as a mum having a thought like that.* KAYLEIGH

4. DISCUSSION

Research findings are considered in relation to theory, clinical implications and future recommendations. An evaluation of this study will follow.

4.1 Findings in relation to the research questions

This exploratory study aimed to explore the following research questions:

- What is the impact of a mother's IRHTs on her?
- How does a mother attempt to account for and manage her IRHTs?
- How does a mother understand her experience of IRHTs in terms of relating her own expectations of mothering to her existing cultural beliefs, representations and understandings?
- What are a mother's experiences of sharing IRHTs with others?

The research questions will be answered by discussing how the themes identified in the analysis draw together. Overall, the findings illustrate how IRHTs are experienced in particular ways, which are partly shaped by culturally and experientially formed constructions of motherhood. These understandings shaped the ways in which participants attempted to understand and manage IRHTs, as well as influencing willingness to share them with others.

4.2 Discussion of the findings

Findings are considered with respect to existing literature together with the contributions arising from this study. This project is unique in that it explores the nature of new/recent mothers' experiences of IRHTs, considering their impact, how these are assimilated in the context of mothers' personal and cultural experiences, and how sense-making may influence decisions to share (or not), and if so, who with. Within the small body of evidence exploring IRHTs, the majority of research is quantitative, imposing pre-determined definitions without asking mothers how they themselves define and make sense of such thoughts. Existing research also tends to be decontextualised,

failing to consider mothers' experiences relating to wider cultural expectations about mothering, and neglects diverse samples.

4.2.1 Conceptualisations of harm

The ways in which participants articulated the nature of their IRHTs was not identified as a theme, however their descriptions were significant and will be summarised in relation to the literature. A distinction between accidental and intentional IRHTs has already been made in the literature (e.g. Fairbrother & Woody, 2008), and both types were described in this study. Consistent with previous findings, the majority of participants (six in total) reported accidental IRHTs, not all of which related to their own actions. These included suffocation, the baby falling or accidentally being dropped from a high surface, contamination, and accidentally being responsible for harm coming to the baby (e.g. through the baby drowning) (Abramowitz et al., 2006; Abramowitz, Schwartz, & Moore, 2003; Fairbrother & Woody, 2008; Hall & Wittkowski, 2006). Half of the sample reported intentional IRHTs, ranging from impulses to shake or smother the baby or throw the baby from a height, to an impulse to pinch the baby. Commonalities in the nature of intentional thoughts have been found previously, including physical harm and infanticide (Fairbrother & Woody, 2008; Maimon, 2012; Murray & Finn, 2012). These IRHTs have similarly been reported less commonly than accidental IRHTs such as contamination (Fairbrother & Woody, 2008).

However, this study is the first to explicitly distinguish between sources of intentional harm described as either external or endogenous. In the former case, two participants conceptualised sources of external threat as predators or perpetrators posing a public risk, through snatching or violently attacking themselves and/or their children. Figes notes that "a sense of 'skinlessness' and heightened vulnerability" to threats from outside start in pregnancy (2008, p.96). Both participants related their IRHTs directly to high-profile murders

covered in the media, one to the Jamie Bulger case[4] and the other to that of Rachel Nickell[5]. Understandably these IRHTs, which reflect every parent's worst nightmare and were recalled from news coverage some years ago, induced considerable anxiety and distress. It has been heavily documented that such anxieties connected to these horrifying cases, despite their rarity, arise from a "culture of fear" prevailing in contemporary British and American culture (Franklin & Cromby, 2009). Several factors play into our fearful culture, such as living in an individualised community leading to a mistrust of strangers and their motives, reinforcing a 'better safe than sorry' mantra, and creating an impression that the world is a highly dangerous place (Furedi, 2001). It is acknowledged that parent-infant relationships have always been shaped by contemporary issues, beliefs and norms. It is not hard to see how a media-saturated society, particularly with the rise of social media platforms, has seen an explosion of perceived risk in the media. This perpetuates the worry, anxiety and fear that feature heavily in modern western society (Glassner, 1999), leading to 'paranoid parenting' (Furedi, 2001). In reality the danger to children is statistically minimal; child murders by strangers remain low (Cromby & Franklin, 2009). However, disproportionate reporting creates the misconception that these rare acts are commonplace (Glassner, 1999). Figes (2008) highlights how the pressures of modern life, where women choose to have children, and fewer of them, only intensifies anxiety over their welfare.

This culture of fear, personified and perpetuated by the media, formed the context for other conceptualisations of harm. A third participant described images of harm relating to CSA in the context of changing her baby daughter's nappy, leading her to wonder if she could commit such an "easy" act of sexual abuse. This mother related her IRHT to formerly working with sex offenders as a forensic psychologist. However, it is likely that high profiles cases like Sarah Payne, Holly and Jessica Chapman and Madelaine McCann,

[4] Two-year-old Jamie Bulger was abducted (and later killed) by Jon Venables and Robert Thompson, both aged 10, while shopping with his mother in Liverpool on 12th February 1993.
[5] Rachel Nickell, a 23-year-old model from south-west London, was stabbed multiple times in daylight on Wimbledon Common, in 1992. Her two-year-old son was found clinging to her.

and subsequent News of the World and The Sun's "for Sarah" campaign, have contributed to paedophilia becoming a key concern in modern society, a moral panic and a social risk (McCartan, 2008). New parents are opened up to the possibility of threat from myriad sources that contribute to a 'free-floating' anxiety.

In contrast to external threats, participants conceptualised endogenous sources of harm. As the literature has identified, the occurrence of IRHTs in which the mother herself poses a risk are experienced as deeply discomforting, shameful and distressing (Fairbrother & Woody, 2008; Maimon, 2012; Murray & Finn, 2012). As found previously, experiences of intentional impulses (such as to shake, smother or throw their baby against a wall) all occurred in the context of stress and negative emotional states (Brewin et al., 1996; Horowitz, 1975; Wroe et al., 2000). Similarly for these participants, such ideation was triggered by situations when the baby would not settle or stop crying (Fairbrother et al., 2015). However, the remaining intentional impulses described did not occur in a specified stressful situation, but for some women in the wider context of increased stress and feeling isolated. Perceived reduced social support has been identified as predicting the occurrence of intentional IRHTs (Fairbrother & Woody, 2008). Meanwhile, for another participant (Hannah), an intentional impulse to pinch her son related to ongoing concerns (Klinger, 1996), arising while changing his nappy.

4.2.2 Theme One: Heightened emotions – impact and consequences

All participants spoke of the powerful range of emotions that accompanied their experience of IRHTs, regardless of their nature or how able they felt to manage them. Figes (2008) has suggested that new motherhood catapults women back to the intense, raw emotions of childhood. The majority of the literature that maps IRHTs onto an OCD model has identified feelings of distress around such thoughts, and some studies have specified emotions such as guilt and anger (e.g. Fairbrother et al., 2015). Of the few qualitative studies exploring IRHTs postpartum in a non-clinical sample, feelings of guilt,

fear, shame and shock were commonly expressed (Maimon, 2012; Murray & Finn, 2012).

In the present study, a particular pattern arose around participants' felt lack of control, related both to limited controllability around the occurrence of thoughts and the chaotic, overwhelming nature of adjusting to life with a new baby. Previous studies using non-clinical, non-postpartum samples have found that intrusive thoughts vary on a number of dimensions, including unpleasantness and controllability (Parkinson & Rachman, 1981; Salkovskis & Harrison, 1984). The literature on new motherhood has documented women experiencing multiple losses as well as gains through the transition, including loss of control (Nicolson, 1998). Some writers suggest that perceived lack of control is accentuated postpartum, experienced in contrast to a woman's individualistic life pre-childbirth, where being in control and achievement is privileged above all (Figes, 2008). Participants spoke of their IRHTs as characterised by this felt lack of control, associating their thoughts with anxiety and vulnerability. One participant (Malia) related her felt lack of control around her IRHTs more broadly to the shocking reality of motherhood, with all its tiny, hard to measure achievements, and a baby she felt was often beyond her control. Lack of control is intensified when it is experienced by women as deviating from idealised constructions of femininity, where women are expected to cope and maintain control in order to be a 'good' mother (Ussher, 2006). This is discussed further in relation to theme two.

Participants described deploying different strategies to help them manage their IRHTs, such as self-dialogue, where they sought to rationalise the thoughts (e.g. attributing IRHTs to hormonal changes post birth). Self-dialogue served as a coping strategy, identified by previous researchers (Abramowitz et al., 2006; Abramowitz, Nelson, Rygwall, & Khandker, 2007; Larsen et al., 2006). Another psychological response deployed by some participants was reappraisal of the thought's meaning, which has been found to be positively associated with obsessional symptoms (Larsen et al., 2006). Larsen's study (2006), which viewed IRHTs as mapping onto the contemporary OCD model (Salkovskis et al., 1999), related this finding to

parents potentially reappraising their IRHTs in negative ways, leading them to think they were a bad parent. Given the qualitative nature of this study, it was not assessed quantitatively whether such interpretations led to increased preoccupation and distress as research suggests (Fairbrother & Abramowitz, 2007). However, participants equating their IRHTs with 'badness' did speak of the recurrent nature of their IRHTs which intensified feelings of distress, sadness, anxiety, fear and shame. The pattern around some participants equating IRHTs with 'badness' merits wider contextualisation than accounted for in the above cited studies, and is discussed further in relation to theme two (4.2.3).

Most participants also described immediate behavioural responses which helped enhance their sense of control, including distraction, checking the baby, washing, reassurance seeking (from another person or accessing the internet about a particular fear). Studies assessing behavioural responses to IRHTs have similarly found that participants report at least one of these strategies (Abramowitz et al., 2006; Fairbrother & Woody, 2008; Larsen et al., 2006). The exhausting, time-consuming nature of increasing infant surveillance in an attempt to manage IRHTs was described by some participants. However, as noted earlier (section 1.7.7), IRHTs differ from clinical obsessions as they tend not to be associated with behavioural compulsions. This conceptualisation fitted with participants' descriptions, whose checking on the baby, accessing information online, or washing, was experienced as tiring and anxiety-inducing but did not appear to be so frequently occurring as to be clinically significant. On reflecting as the researcher, it is noted that reporting of participants' experiences in response to their IRHTs appeared to map onto the language utilised for certain CBT strategies. This was evidenced in particular terminology used to describe their responses in the analysis, such as "distraction", "strategies to manage" and "behavioural responses", despite critiquing models such as CBT in the literature review. Perhaps what this highlights is not necessarily that participants were consciously or selectively deploying CBT techniques, as they were not framed as such, but more that these cognitive and behavioural responses are widely recognised and available.

It is noted that none of the women in this study reported harsh or abusive behaviour towards the infant in response to IRHTs. This finding is corroborates research consistently showing that ego-dystonic thoughts experienced postpartum do not reflect intention to harm, and therefore do not contain increased risk to violence (Brok et al., 2017; Fairbrother & Woody, 2008; Lawrence et al., 2017).

What was expressed, in adjusting to the enormous responsibility of caring for a new baby, was acknowledgment of the double-edged nature of the mother-infant power differential. This recognition has been described elsewhere in the literature, where mothers position themselves as both a potential source of harm *and* defender against her baby's vulnerability (Maimon, 2012; Murray & Finn, 2012). Two participants (Hannah and Polly) described intentional IRHTs, the former relating to pinching her son and the latter to committing CSA when confronted with her daughter's genitals; both these signified a "sudden" realisation of their power. Rather than expressing an "unconscious wish", as Freud might have concluded, Stadlen (2004) acknowledges the challenge for new mothers faced with choosing to use her power for good or bad, life or death. Such IRHTs can be viewed as helping mothers delineate clear boundaries between what is morally acceptable and what is not, by serving as an "effective warning system" (Stadlen, 2004, p.50). In this way, vivid images or impulses to hurt the baby accidentally or intentionally represent natural fears that the infant will die through carelessness or inadequacy. As Stern and Stern conclude from their own observations of mothers, IRHTs "keep new mothers vigilant, the better to protect their babies and at the same time to help themselves internalise and absorb their new responsibilities" (1998, p.97). The suggestion that IRHTs may increase the baby's chance of survival by prompting mothers to increase their vigilance and protection has been made elsewhere (Fairbrother & Abramowitz, 2007; Leckman et al., 1999).

Increased stress, sleep deprivation and isolation can reinforce a mother's sense of powerlessness, as both Yvette and Salma reported. As already noted, perceived reduced social support has been associated with the

occurrence of intentional IRHTs (Fairbrother & Woody, 2008). It seems natural that these participants' recurring fears that they might endanger their babies, by unleashing frustrations with her own situation onto her baby (Yvette), or feeling inadequate to take sufficient care (Salma), would be experienced as frightening and distressing. Stadlen (2004) distinguishes between the mothers in the present study and those who struggle with conscious, ego-syntonic thoughts to harm their babies. She proposes that the latter group of mothers who are continually afraid of their thoughts do not learn to protect their babies and remain anxious. In contrast, these participants learnt gradually over time how to protect their babies and grew more confident in their positions of power. Arguably the picture is more complex than Stadlen suggests; frustrations around feelings of powerlessness and inadequacy related to wider cultural experiences and discourses are explored further in the following section.

4.2.3 Theme two: Constructions of the 'good' mother and effects on maternal identity

Participants' constructions of the 'good' mother were key to understanding how these informed their experiences of IRHTs. It was clear that participants' own early experiences of being parented intersected with available cultural discourses and experiences to form their own internal models of 'good' mother. These shaped their own internalised aspirational maternal identity. Many participants in this study, while recognising positive qualities in their own mothers, described rejecting certain negative aspects in favour of contrary qualities, which became synthesised into their internalised models. Abundant literature has documented the influence of maternal attachment styles on child outcomes (Belsky & Fearon, 2002; Murray et al., 2011). Participants' tendency to reject or replicate aspects of their own parenting has been highlighted in the non-academic literature (James, 2011). Three participants, who had endured physical violence at the hands of their mothers, all rejected physical force as a form of discipline with their own child(ren). Participants described mothers who, for different reasons, had not been sufficiently physically or emotionally present. For example, Fee rejected her

mother's tendency towards anxiety, which meant her father assumed much of her care growing up, so that being "carefree" and "fun" came to characterise Fee's aspirational maternal identity.

What came across perhaps most powerfully was the inescapable influence of cultural discourses on participants' desired maternal identities. The ways in which women drew heavily on the pervasive Western ideology of motherhood as a critical aspect of femininity (Stoppard, 2000) constituted an important backdrop to their assimilation of their IRHTs. This social construction of motherhood as idyllic, desirable, natural, and ultimately fulfilling to women, existing as selfless nurturers, has been highlighted in the literature (e.g. Choi, Henshaw, Baker, & Tree, 2005; Nicolson, 2001; Woollett & Marshall, 2000). Cultural representations portraying only positive images set the standard for what is a 'good' mother (and therefore a good woman) and what comprises a 'bad' one. This ideology has been shown to influence women's expectations of motherhood (Mauthner, 1999); participants spoke of experiencing phenomenal pressure to live up to this cultural ideal. Kayleigh described feeling it even in pregnancy, when she woke at dawn to bake so the midwife at her eight-week booking appointment would judge her to be a "good mum".

This powerful cultural ideal pervaded participants' beliefs and understandings in significant ways. For example, half the sample pinpointed particular qualities they admired in a positive maternal figure (e.g. an aunt or friend), experienced alongside or in the absence of their mothers. With the exception of one (Polly), these admired qualities all subscribed to the idealised "fantasy" mother, relating to being instinctual (Kayleigh), present (Yvette and Lucy), and "constant…stable and in control" (Lucy).

Evidence of participants drawing heavily on dominant cultural discourses to augment their own notions of 'good' mothering was also informed by prescriptive medical advice, offering 'correct' ways to parent. Some participants directly related their IRHTs to SIDS, expressing profound fears around co-sleeping lest it result in infant death. NHS guidance warning of the dangers of SIDS strongly advises parents to avoid placing infants to sleep in a

non-prone position, to keep them smoke-free and to breastfeed (2015). However, parents face dilemmas amid conflicting advice around bed-sharing. It is valued by its proponents (contingent on ethnic and sub-cultural identity) for reinforcing attachment, enhancing infant development and facilitating breastfeeding, but perceived by its critics as neglectful parenting, exposing babies to potential risk of SIDS (Ball & Volpe, 2013). Risk-focused advice around SIDS is yet another factor contributing to 'paranoid parenting' (Furedi, 2001). Such advice also belongs to the process of 'familiarisation' (Rose, 1990), in which experts "shore up the mechanisms of the state that take a 'policing' role towards mothers and fathers. The social and healthcare services take on responsibility for the assessment of good and bad ways to be parents". (Nicolson, 2001, p.133).

And so for all participants, assimilation of their IRHTs was powerfully influenced by their own internalised models of the 'good' (and therefore 'bad') mother, which shaped their desired maternal identity. Their constructions were heavily influenced by the ideology of motherhood and related cultural discourses, as highlighted above. Several researchers have illustrated more broadly how far women's expectations are influenced by this ideology, and when confronted with the reality, must accept that they cannot meet this ideal which produces conflict (e.g. Choi et al., 2005; Mauthner, 1999). Within the literature conceptualising IRHTs within the OCD model, researchers suggest that mothers experience IRHTs as more upsetting than fathers because of cultural expectation that the postpartum period should be joyful (Abramowitz, Schwartz, & Moore, 2003). However, their hypothesis shows the limited contextualisation of IRHTs within the evidence base adhering to the cognitive-behavioural OCD model. The present study goes further, identifying two distinct ways women related to their IRHTs in terms of managing the conflict produced when the ideology clashed with their lived reality of new/recent motherhood. Half of the sample experienced their IRHTs as incongruent to their aspirational maternal identity, and the remaining four participants experienced them as congruent. These findings illustrate contrasting ways in which participants perceived their IRHTs as belonging either outside their idealised realm of mothering, for those experiencing their IRHTs as

incongruent to their desired maternal identity, or as connected to it. These opposing ways of relating to IRHTs corroborate Murray and Finn's (2012) qualitative study.

Half of the sample defended against their IRHTs by externalising or pathologising them because such thoughts clashed with their desired maternal identity. This process of pathologising IRHTs appeared to have an important function, allowing participants to counter a "spoiled identity" (Goffman, 1990) and to continue to operate within the 'good' mother domain. Both Salma and Lucy characterised their IRHTs as "irrational" or "inconvenient" because they lay at odds with their aspirations to be "confident" (Salma) and "calm" and in control" (Lucy). For Salma, her accidental IRHTs became equated with feeling unable to cope, which she perceived as tantamount to failure. Meanwhile Yvette described feeling "nuts" owing to a frightening tussle for control between her "good, normal" self and a darker side within. It was this darker side to which she attributed powerful urges to throw her baby from a sheer height. In both cases, women attempted to explain their IRHTs in terms of something that was experienced as alien and 'other' or the fault of 'another side of me'. This was further evident in conversational tics deployed by Yvette, who spoke of herself in the second person "You" as a distancing mechanism. Such externalising tendencies represent the psychological strategy of splitting in order to retain the good within oneself while relegating the bad to an objectified, externalised object (Murray & Finn, 2012).

Meanwhile Lucy and Hannah positioned themselves as sources of danger. For Hannah, an impulse to pinch her son was initially a "curious, innocent thought", which swiftly led to her pathologising herself as a "bad, bad person" followed by fears that she might become a potential abuser herself. Locating herself as a source of danger personifies the idealisation-denigration binary that shapes the edifice of Western motherhood (Baraitser, 2009); Hannah can only exist as saint or sinner. It also highlights the effects of the governmental regulation of families from the last century, in which "childhood [became] the most intensely governed sector of personal existence" (Rose, 1990, p.121).

Parental surveillance, particularly targeted at mothers, was one strategy of normalisation, and here, Hannah taking on her own regulation exemplified what Foucault referred to as subjectification (Hollway, 2001).

The remaining four participants responded to their IRHTs differently, experiencing them as part of a, sometimes painful, process of enhanced self-development. The creative potential for IRHTs has been acknowledged in the literature (Murray & Finn, 2012). However, these unique findings identify different ways women showed agency in resisting the ideology of motherhood to reconcile conflict around the myth versus reality gap, and subsequently their IRHTs. This meant that their IRHTs were experienced as congruent, as they understood them as arising out of a particular context and not signifying maternal "badness". These findings corroborate Mauthner's (1999) study which showed women to be agentic in resisting the ideology of motherhood, but contrast with Choi et al.'s (2005) study in which evidence of agency and therefore resistance to this construction was not found.

In all four cases, their experiences of IRHTs signified deeper self-knowing, and a lesser to greater acknowledgement of maternal ambivalence. In Polly's case, her CSA-related IRHT produced greater awareness of her own limitations, namely becoming less "forgiving" after having children, leading to her not returning to her forensic psychologist role. For Fee, her IRHTs led to her modifying her self-expectations against the impossible ideal centred around being "fun", to understand that motherhood simply cannot be care-free. These participants showed evidence of acknowledgement that mothering evokes both positive and negative emotions, towards self-acceptance as the 'good enough' mother (Winnicott, 1971). Such findings are consistent with Mauthner (1999), who proposes that through efforts to resolve the conflict, women who adjust their expectations of themselves are less likely to become 'depressed'. However, these findings highlight that the process of adjustment through experiencing IRHTs is still emotionally challenging.

Similarly, Kayleigh and Malia showed agency in resisting dominant cultural discourses around motherhood. Malia, who experienced three intentional

IRHTs over six months postpartum, initially appeared to subscribe to the ideology discourse, experiencing conflict around her first IRHT through efforts to reconcile her “fantasy” mother ideal with her lived reality. However, like Kayleigh, drawing on “alternative” narratives and networks (for Malia, discussing lived realities of motherhood), Malia could accept her IRHTs as being understandable as arising from its daily stresses and strains. Again, she was able to accept the paradoxical nature of motherhood as both good *and* bad. Parker (1995) has highlighted the creative potential for acknowledging ambivalence as enhancing self-knowledge. However, it is not easy for women to move fluidly “in and out of intense emotional states” with no cost to her psychological wellbeing (Baraitser, 2009, p.51). Feminist writers have criticised traditional psychoanalytic theories/models of child development for positioning mothers solely as objects of their babies needs and failing to consider women’s separate set of needs and interests (Hollway, 2001). These assume a range of capacities in mothers including empathic understanding, attunement and mentalisation to help process a baby’s confusing, contradictory internal world through reciprocity (Bion, 1962). However, Malia’s transformation through experiencing IRHTs, punctuating everyday moments of motherhood, represented a more complex, realistic account of maternal subjectivity, without dissolving into the needs of the baby. She could then understand that the struggle around identifying her own needs as separate was “normal”, subsequently accepting that motherhood “may fix or free, trap or liberate. In all likelihood it does both” (Baraitser, 2009, p.236).

4.2.4 Theme three: Costs and Benefits of Sharing

Most participants felt more able to share accidental as opposed to intentional IRHTs; researchers have acknowledged that intentional IRHTs are less socially acceptable (Fairbrother & Woody, 2008). None of the participants had shared either kinds of IRHTs with a healthcare professional, but those who spoke to a partner/ friend demarcated limits around what they shared. Although shame was not named explicitly, it was implicit in the words of Yvette and Polly. In the literature, experiences of IRHTs have been associated with distress, guilt and shame, likely compounded by being poorly

understood by healthcare professionals and little talked about generally (Brok et al., 2017; Lawrence et al., 2017; Maimon, 2012).

Four participants identified fears around being judged as failing to cope and therefore a risk to their babies, leading them to self-censor their talk with other mothers. Breen (1975) highlighted women's tendencies towards self-silencing and self-policing when struggling to adhere to internalised idealised constructions of the calm, coping mother. In a society where postnatal distress positions women as 'mad' or 'abnormal', one can understand why women self-censor themselves in this way. As Butler (1990) highlights, participants were performing gender 'correctly' by masking their IRHTs and related feelings to take up the discourses of the "Supermum, superwife, supereverything" mother. Their performance became a façade that hid the opposite (Choi et al., 2005, p.177).

In choosing not to share IRHTs with healthcare professionals, women's fears of being perceived as a risk to their babies were underpinned by the fear of subsequent infant removal by statutory services. Lawrence et al. (2017) acknowledged this key concern underlying women choosing not to spontaneously volunteer intentional IRHTs. It is important to contextualise participants' fears, as they do not appear unfounded in light of extensive media coverage about child sexual abuse and consequent child protection plans. The contribution of the media to creating a climate of fear and mistrust in this field has been documented (Ayre, 2001). The Safeguarding Vulnerable Groups Act (2006), which extends statutory vetting and barring schemes to health and social care services, reflects the growing focus on risk and increased power of the state. Such risk aversion has led to record rises in the numbers of children being taken into care, despite research highlighting the limited predictive nature of risk assessment, further contributing to a culture of fear (Tickle, 2016). Accounting for the effects of these cultural narratives, participants' fears become quite understandable.

For the participants who were able to share their IRHTs, the powerful effect of having their experience "normalised" was strongly reported. This finding was

supported by McIntosh (1993), whose study on depressed mothers experiencing IRHTs highlighted the importance of reassurance by others (professional or lay). Hearing that others have similar thoughts and feelings helped to reinstate their sense of normality. Previous studies have also identified the importance of de-pathologising IRHTs through normalising the experience, found to be a "normative aspect of early parenting" (Fairbrother & Woody, 2008, p.228), yet not commonly or readily disclosed.

4.3 Implications for Practice

4.3.1 Supporting mothers experiencing IRHTs at service level

It is recommended that perinatal care is reconsidered from the understanding that participants experienced emotional exhaustion seeking to perform femininity (Stoppard, 2000) and to resolve conflict produced by IRHTs in order to conform to 'good' mother constructions (Choi et al., 2005). Prospective parents can be educated about the nature and impact of IRHTs, in light of these idealised notions. However, it is acknowledged that the antenatal focus tends to be on labour and childbirth due to women's understandable anxiety about the pain involved (Renkert & Nutbeam, 2001). Therefore, midwives and health visitors become pivotal in supporting women immediately postpartum when IRHTs have been found to peak in intensity and frequency (Fairbrother & Woody, 2008). It is recommended that all pregnant and postpartum women are given pamphlets about the nature of IRHTs, giving specific examples of accidental and intentional IRHTs and those relating to external or endogenous threat. These leaflets will also outline that they are commonplace, likely to occur during mundane moments as well as times of stress and frustration (e.g. in response to infant crying), which will be highly reassuring as well as helping to facilitate less stressful and anxious responses to the baby.

Given barriers to disclosure, and women reporting in this study about inadequate care from healthcare professionals, the hope is that these findings will enhance understanding among perinatal staff about the nature and impact of IRHTs. Appropriate training is essential to help guide clinicians to

understand the difference between a mother expressing ego-syntonic thoughts, which may indicate potential harm, and the ego-dystonic nature of IRHTs which are not associated with risk (Lawrence et al., 2017). A sensitive awareness of IRHTs may then equip clinicians to be alert to their possibility and prepared to pick up on what mothers say in conversation that may indicate such thoughts. Professionals can then create space for mothers to raise these cognitions. This may involve asking explicitly about their occurrence, without pathologising the experience. Asking directly about IRHTs is currently not recommended in routine guidelines for perinatal mental health (NICE, 2017), owing not least to a lack of awareness about their nature (Lawrence et al., 2017). If clinicians then felt concerned about the levels of distress accompanying such thoughts, they could offer a creative space for helping to validate and empathise with a mother's experience of IRHTs, and to teach effective strategies for managing the thoughts.

4.3.2 Interventions for women struggling to manage their IRHTs

As recommended by one participant in the present study, feeling isolated can increase the intensity of IRHTs, therefore sharing experiences in support groups can help to normalise and validate such thoughts. Feeling understood and less alone enhances a sense of control and empowerment, resulting in more effective ways of coping (Helgeson & Gottlieb, 2000). Therefore, a community psychology approach is recommended (Orford, 2008), seeking to support women by promoting their existing skills, agency and resilience, focusing on understanding experiences of IRHTs in the context of their material realities, set against idealised constructions of motherhood. This may help to a) challenge impossible ideals to reduce feelings of failure and inadequacy b) strengthen marginalised discourses around new understandings of motherhood as being paradoxically good *and* bad, through creating a safe space for women to voice negative aspects such as IRHTs c) engage women reluctant to engage with professionals due to stigma and fears around disclosure d) reduce isolation and increase sense of community.

4.4 Future research

This is the first study to consider how mothers experience and share IRHTS in the context of wider cultural discourses, and more qualitative work is needed to better understand this experience both among women and their support networks. Future research could interview partners about their experiences of IRHTs in relation to new parenthood and wider cultural forces. Participants tended only to refer to partners in terms of looking to them for reassurance around their IRHTs, or for assistance in checking the baby's safety. Despite research showing that the fathering role has become more intensive in recent years (Shirani, Henwood, & Coltart, 2012), the descriptions in this study appeared to echo a tendency in research and practice to neglect fathers and corresponding ideas around fatherhood. In light of the trend towards models of paternal involvement as a culturally powerful ideal, future qualitative research could explore men's experiences of IRHTs, in relation to the cultural aspirations and lived realities of their role.

Given the findings showing barriers to disclosure to healthcare professionals, more qualitative research among perinatal staff would elicit their understandings of IRHTs. Such research would have implications for improving quality of training among staff in order to enhance their understanding of IRHTs, particularly as women have judged postpartum care as inadequate elsewhere (Baker, Choi, Henshaw, & Tree, 2005).

4.4.1 Implications for policy

More quantitative and qualitative research into IRHTs overall would focus attention on its importance, with additional studies concluding its high prevalence and potential vulnerability factors in non-clinical samples working to change policy. For example, currently perinatal assessment of women does not ask routinely about the occurrence of IRHTs (NICE, 2017). It could become routine care for healthcare professionals to include a series of sensitively-worded statements inquiring about the occurrence of IRHTs, and the impact and consequences for positive responders. This would

communicate to new/recent mothers that IRHTs are common, as well as offering guidance around intervention in the presence of difficulties managing such thoughts, and/or high levels of distress.

This shift in policy could also contribute to challenging dominant discourses, through increasing social acceptance around the occurrence of IRHTs as part and parcel of new/recent motherhood. Given the present findings and previous research (Fairbrother et al., 2015) associating the role of stress with increased intensity and frequency of IRHTs, acknowledging material and psychological challenges facing modern mothers is more important than ever. More is expected of “good” or “good enough” mothers, yet as Figes (2008) notes, increased opportunities career-wise means that women now have more to lose financially and socially with their growing independence. Therefore, adjusting to motherhood can be riddled with even more uncertainty and ambiguity, likely to further impact the experience of IRHTs. Therefore, policy changes could feed into additional efforts to raise consciousness around IRHTs (e.g. in perinatal campaigns and print/social media) to break down the stigma and to normalise such thoughts. To date, accounts of IRHTs in the media tend to be sensationalised, as indicating maternal “mental illness” requiring appropriate treatment and care (Cliff, 2018). While there has been a growing movement in women talking more honestly about the reality of motherhood, it appears that ambivalent feelings can only be socially acceptable when couched in humour (e.g. Turner, 2016). It is recognised that this awareness-raising needs careful thought, with understanding that women construct their notions of the “good” mother slightly differently, based on their own cultural, social and interpersonal contexts to their lived reality. Exposing new/recent mothers to sensitively written, non-pathologising coverage about the occurrence of IRHTs postpartum will help validate women’s experiences, as well as reduce associated feelings of isolation and shame.

4.5 Assessment of research quality

Given the range of different approaches to qualitative research, agreeing on flexible criteria for evaluating its validity is challenging (Yardley, 2000). The

researcher drew on various sources to consider the quality of this research (Braun & Clarke, 2006; Willig, 2013). Key principles presented by Yardley (2000) were followed, which were considered to fit with the adopted critical realist epistemological stance.

4.5.1 Sensitivity to context

Attendance to sensitivity to context was illustrated by attempts to contextualise the study in terms of existing relevant theoretical and empirical literature relating to IRHTs. Most studies in this under-researched area are quantitative, in which IRHTs are conceptualised as mapping onto the cognitive-behavioural model of OCD (e.g. Abramowitz, Schwartz, & Moore, 2003). Working within the medical model leads to a tendency to pathologise postpartum distress, serving to reinforce prevailing cultural discourses of the 'good' mother, in which anyone deviating from the norm is labelled with mental ill health. The present study's attempt to attend to participants' different interpersonal, socio-economic and cultural contexts, and how these intersect with their experiences of IRHTs in the analysis, is a comparative strength. Sensitivity to context was also enhanced through the process of analysis, where extracts were chosen carefully to represent the broad range of perspectives. It is acknowledged that quotes from particular participants, such as Salma and Hannah, were included more frequently than others, such as Polly and Kayleigh. On reflecting on why this might be, it appeared that some participants articulated experiences in a particularly clear or concise way, which embodied the 'essence' of a theme or sub-theme's content. For example, more quotes from Salma were included in theme four, as she expressed a powerful experience of sharing her IRHTs, leading her to give clear recommendations for other women who may struggle to manage these thoughts. However, higher number of quotes from the majority of participants were included across different themes (for example, theme two included more quotes from Fee and Lucy), illustrating how efforts were made to represent the diverse range of experiences.

4.5.2 Commitment and rigour

Commitment can be shown by the researcher developing competence, skill, and immersion in the subject matter and data (Yardley, 2000). It is also suggested that unique insights can be gained through "an empathic understanding of participants' perspectives resulting from extensive in-depth engagement with the topic", which for this researcher was based on personal experience as a mother. Engagement with the topic was further increased through reading relevant literature, attending teaching, and keeping a critical eye on the research process. Rigour was achieved through developing greater competence in conducting thematic analysis. To maximise the potential of this process, over four weeks were devoted to analysis, and guidance through supervision helped me to retain commitment to the research questions and epistemological stance of the study. These cohered with the methodology and analysis undertaken for the research.

4.5.3 Coherence and transparency

Attendance to coherence was shown by the researcher's supervisor reviewing the different stages of analysis by reading quotes pertaining to each theme/subtheme during the finalising of the thematic map. An audit trail detailing the generation of initial codes and reviewing the thematic map are provided (Appendices K and L), bringing transparency to the decision-making and methodological process for the reader. Presenting data extracts also allowed readers to judge for themselves the patterns identified through analysis. A further means of maintaining transparency is demonstrating researcher reflexivity in the research process, outlined in sections 2.9 and 4.7, to highlight the researcher's own influences on the data. Reflective journal extracts are also included, and the 'Methods' chapter ensures transparency through outlining the methodology.

4.5.4 Impact and importance

This is the first qualitative study to explore not only the experiences of IRHTs, but also the consequences for new/recent mothers, including their own understandings as well as the reactions of others for those who shared them. The findings have important implications for clinical practice, in terms of helping mothers understand their natural occurrence in order to minimise potential distress around thoughts that may otherwise be associated with 'badness' or pathology. The results can also contribute to improving understandings among health professionals in order to enhance engagement with and education of women postpartum. This area is important to research to further elucidate the nature of IRHTs, and to understand how they intersect with women's wider cultural understandings. The finding that IRHTs produce conflict for those viewing them as incongruent to their desired maternal identity, based on the impossible cultural ideal, highlights the importance of tackling this pervasive yet unhelpful discourse. This presents a challenge, but the hope is that more focus on this topic will help break down the stigma around such taboo yet commonly occurring thoughts.

4.6 Study limitations

4.6.1 Sample selection

Efforts were made to recruit from a range of multicultural areas across North London to target a diverse sample. While the sample represented some degree of ethnic diversity, these differences did not intersect sufficiently with their IRHTs to form a pattern in the analysis. Participants were from broadly similar socio-economic backgrounds, identifying predominantly as middle-class, educated, and married or cohabiting. It is acknowledged that both class and race are likely to influence women's experiences of IRHTs, and future research that is able to recruit those with a wider range of socio-economic and racial/ethnic background would create a broader, more inclusive picture. For example in relation to class, Braun et al. (2008) show how working-class mothers show a high commitment to paid work, which leaves them at risk of

being characterised as inadequate mothers given the middle-class focus on ‘intensive mothering’ (Hays, 1996). It is recognised that the intersection of women’s material contexts affects mothering (Gillies, 2007), and is bound to play into experiences of IRHTs. However, in this study sample, women still differed as to which mothering approach they drew on, depending on the nature of their support networks (e.g. other mothers) and which cultural discourses were most readily available to them. Not all participants adhered to ‘intensive mothering’, characterised by centering the child and their needs accompanied by a considerable degree of maternal self-sacrifice. Therefore, the socio-economic homogeneity did not appear to hamper richness of data around heterogeneity in the understandings and responses of participants to their IRHTs.

Selection bias has potentially influenced this project, due to self-selection of those who were most interested in this topic. Five participants were employed, in training or had worked in healthcare, and it is possible that their more specialist knowledge around intrusive thoughts brought greater awareness to their experiences (e.g. knowledge that attaching significance can increase their frequency and intensity). This could have made them more comfortable to disclose their IRHTs; however this does not invalidate their accounts. As participants, whose babies ranged from being their first to the fourth, voiced their experiences, it became evident that there was some diversity across their accounts, giving rise to rich data. Accounts were also well balanced in terms of women describing both accidental and intentional IRHTs.

4.6.2 Telephone interviews

Six participants were interviewed over the telephone (one was interviewed in a café near her home, and another in her home). Interviewing over the telephone could have affected data from the perspective of building rapport. However, the researcher did not detect problems establishing rapport with interviewees, who were met in person during recruitment and had already discussed aspects of the research prior to the interview. Indeed, Cachia and Milward (2011) argue for the validity of researchers using thematic analysis to

conduct telephone interviews. These authors also highlight advantages such as offering greater flexibility in setting up the most convenient time, which applied particularly to new/recent mothers in the face of competing demands. Sturges and Hanrahan (2004) highlight methodological validity as well as convenience factors, as telephone interviews can offer greater privacy than face-to-face settings. In this study they were all conducted in participants' homes rather than busy, noisy cafes, which provided greater opportunity for collecting richer data. Finally, it is believed that the telephone mode may have enhanced disclosure around a taboo, stigmatised topic. While it is commonly perceived that lack of physical presence and visual cues may inhibit rapport-building, it is also possible that face-to-face interviews may impede participants' ability to articulate private thoughts through fear of judgement. This applied to concerns around sharing IRHTs.

Cross-sectional in nature

The study was cross-sectional, offering only a "snap shot" of participants' experiences. It is acknowledged that accounts may have been articulated in other ways on another day, informing a different analysis.

4.7 Researcher Reflexivity

To promote transparency, and to help manage the emotional impact of the work on the researcher, personal reflections on the process are described below.

4.7.1 Emotional impact

Thoughout the research process I have reflected on the fact that my subject matter and my own experience of motherhood are very linked. Overall, I find the dynamic feedback process between my research, and experience as a mother of two (initially one), constructive for 'integrating' my personal experiences with academic knowledge and clinical work. As a mother, I have noticed at various times the emotional impact of hearing the content of participants' IRHTs. This applied during some of the interviews, although

perhaps it felt more acute during transcription when I was less preoccupied with facilitating the interview process. One IRHT that was brought to the front of my attention during an interview related to the Jamie Bulger case. Having a son of a similar age perhaps contributed to this becoming a personal worry, and during transcription I noticed I was feeling upset and not wanting to have to re-engage with it. I consciously decided against accessing fuller details online despite feeling compelled to do so, in order to minimise the anticipated emotional impact, and opportunities to dwell further. I found it helpful to talk through with my partner, but I am also aware that sadness around such a rare but horrific case is normal. However, I have also noticed becoming more vigilant when I am in busy, public spaces with my children, and I wonder if that illustrates the double-edged nature of some IRHTs. In forcing us to confront the devastating horror of harm befalling our children, whether at the hands of others or our own, we are sharply reminded to take more care.

4.7.2 Bearing witness

As participants shared their IRHTs with me, I was struck repeatedly by the powerful role I occupied as researcher in bearing witness to their accounts. For some of those who shared their intentional IRHTs, which remain more stigmatised than accidental thoughts, I was the first and potentially only person to hear their detailed descriptions. I felt enormously privileged to be in that position. From an ethical perspective, I felt more comfortable understanding, with each interview, how powerful it was for them to have their IRHTs normalised through the safe space of the interview itself. During interviews, I was conscious of my researcher rather than clinician role, and became keenly aware of my responses to facilitate participants' talk. For example, below is a research journal extract written after interviewing Hannah, the first to disclose an intentional IRHT:

> I didn't want to say too much in order to retain some 'neutrality', whilst expressing warmth, empathy and understanding through my tone (e.g. 'hmms' of agreement), to facilitate us exploring her experience together. I was also aware that my responses were shaped by a desire

> to ‘normalise’ her experience as far as possible, to help her feel at ease.
>
> (Reflective journal, following fourth interview, March 2016)

Although a research interview, not a clinical session, I felt I was drawing on my clinical skills to sensitively facilitate her opening up. This led me to reflect on the researcher’s dilemma regarding how much to share personally, to help her feel I was alongside her with her experience. I decided against sharing my own IRHTs as I felt it would be inappropriate (as it would be with a client) and I wanted to keep the focus on her. However, I was aware that some of my ‘uh-huhs’ became more emphasised at various points to show understanding. Potter and Hepburn (2005) have criticised the interview process for its failure to capture naturally occurring interaction, and I became aware at times that the research interview can feel artificial in this way. More generally, I was also cognisant that my responses will have influenced participants’ responses, meaning that another researcher may have generated somewhat different data. However, my main concern was to express empathy through tone when participants spoke of the challenges arising from IRHTs, and to facilitate as much of their free speech as possible. In some cases, at the end of the interview, I shared my own IRHTs if they directly mapped onto the participant’s experience in some way, and if I believed it would be helpful, for further ‘normalising’ their experience.

It became clear that once women were reassured of the safety of the interview space (whether it was conducted in person or by telephone), they wanted to talk. This made me reflect on the fact that spaces for women to voice the complexities and ambiguities around motherhood, which clash with the ‘good’ mother ideal, are not sufficiently available. I feel strongly that much needs to be done to enhance the lived realities of new/recent mothers in ways that do not subject them to impossible-to-achieve cultural ideals. Understanding the nuances around women’s experiences through this research has reinforced to me the importance of the topic, motivating me to publish and disseminate more widely in order to ‘give voice’ to their accounts.

5. CONCLUSION

This study aimed to explore the experiences' of IRHTs among new/recent mothers, in relation to wider cultural understandings and discourses. Qualitative analysis of interview data produced three key themes: Heightened emotions – impact and consequences, Constructions of motherhood and effects on maternal identity, and Costs and benefits of sharing.

Findings corroborate previous literature showing IRHTs commonly occur among non-clinical postpartum mothers (Fairbrother & Woody, 2008; Abramovitz et al., 2003). Results also highlight the intense emotional impact of IRHTs, and barriers to women reporting them due to the surrounding stigma. This has also been documented in the literature (e.g. Fairbrother et al, 2015; Lawrence et al, 2017). Therefore, the study aimed to improve clinical practice through increasing understanding among health professionals regarding the phenomenology of IRHTs, and barriers to disclosure. The present study also highlighted ways in which the pervasive ideology of motherhood informed mothers' assimilation of IRHTs. Some pathologised their IRHTs in order for them to maintain their "good" mother identity. However, others reconfigured their maternal identity in response to IRHTs, through a constructive process of self-development.

The hope is that dissemination of these findings will improve experiences for new/recent mothers postpartum, as well as enhancing understanding among perinatal staff.

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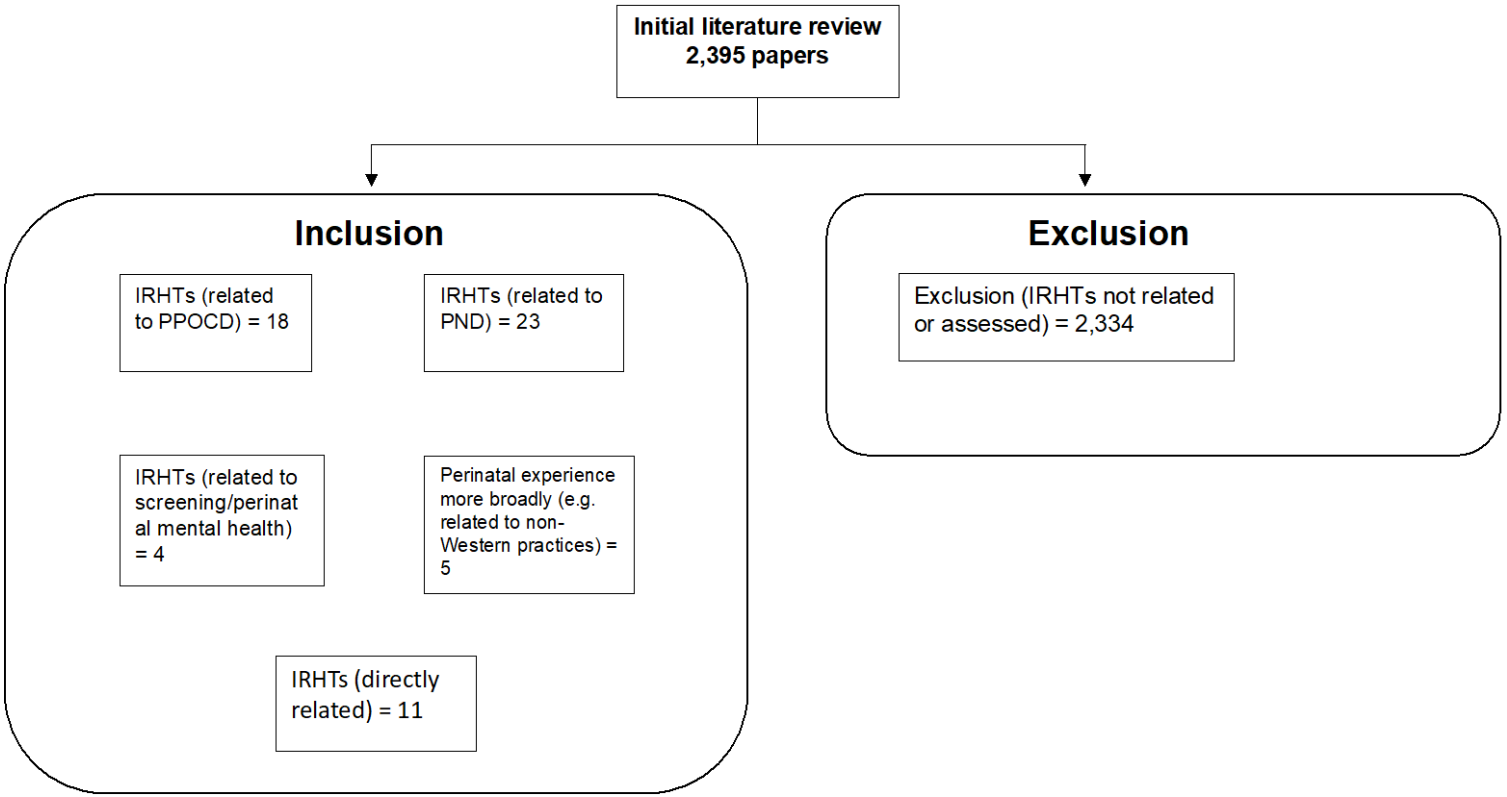
APPENDICES

APPENDIX A: Flow chart of study selection generated through initial literature search.



APPENDIX B: Participant information sheet

UNIVERSITY OF EAST LONDON

School of Psychology, Stratford Campus, Water Lane, London E15 4LZ

The Principal Investigator(s)

Caroline Boyd

[redacted]@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of a Clinical Psychology Doctorate at the University of East London.

Project Title

How do new/ recent mothers experience unwanted harm thoughts about their newborn?

Project description

The aim of this project is to explore how mothers experience unwanted thoughts about harm coming to their baby. We hope that the results will help to provide guidance to healthcare professionals working with new mothers.

What is the research about?

Harm thoughts can be common following the birth of a child. These thoughts can occur in the form of word thoughts (e.g. thoughts such as “my baby is not safe”), images (e.g. a mental picture of the baby falling down the stairs), or impulses or urges (e.g. the urge to smack or shake the baby). These thoughts can pop into a mother’s mind unexpectedly and cause distress - even though she would never hurt her baby intentionally.

Research has shown that nearly all new mothers experience some unwanted thoughts of harming, or of harm coming to their new baby. It is important to emphasise that having such thoughts, images or urges of harming your infant, and the fear that you might act upon them, does not indicate that you are a risk to your child.

What is required of you if you decide to take part?

The research involves interviews with new/recent mothers discussing their experience of having these harm thoughts. You will be asked questions about the harm thoughts you have experienced and your thoughts and feelings about them. There are no risks or dangers to taking part but given the sensitive nature of this topic, it is possible you may get upset if you are discussing something you find difficult or emotional. The researcher will provide contact details for organisations offering support.

What will happen to the results of the research study?

The project will be written up as a doctoral thesis at the University of East London and may be published in an academic journal. By sharing your experiences, you will be helping shed light on this under-studied phenomenon.

What will happen to the information I provide?

Your name and contact details will be stored in a password-protected folder on the researcher's computer. Consent forms will be kept in a locked cabinet in the researcher's home. Identifying references to participants will be removed from any material used in the research write-up. Audio recordings will be transcribed and the audio files deleted at the end of the study. Anonymised transcripts will be stored for further analysis.

Location

Interviews will be arranged at a time and location of your choosing. Given the demands of a new baby, it may be easier to talk in the privacy of your home, at a relatively quiet and private location convenient to you, or on the telephone.

Remuneration

You will receive a £10 Amazon voucher as reimbursement for your time in taking part in this study.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor. Dr Kenneth Gannon, Professional Doctorate in Clinical Psychology, School of Psychology, University of East London, Water Lane, London E15 4LZ. (020 8223 4021. k.n.gannon@uel.ac.uk)

or

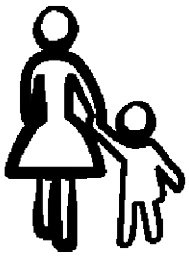
Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (020 8223 4576. m.finn@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Caroline Boyd, Trainee Clinical Psychologist

APPENDIX C: Study advert



THE MOTHER BABY WELLBEING PROJECT

Are you a new or recent mother who has experienced unwanted harm thoughts about your baby?

I am carrying out a doctoral study to explore how mums experience these unwanted harm thoughts. Examples include word thoughts (e.g. "my baby is not safe"), images (e.g. a mental picture of your baby falling down the stairs), or impulses or urges (e.g. to smack or shake your baby). These thoughts can pop into a mother's mind unexpectedly and be distressing - even though she would never hurt her baby intentionally.

Such thoughts have been found to be very common following the birth of a child, experienced by half to nearly all new mums. However, having such harm thoughts, and the fear that you might act upon them, does **not** indicate that you are a risk to your child.

Hope is that the results of this research will help to provide guidance to healthcare professionals working with new mums.

You will receive a £10 Amazon voucher as reimbursement for your time in taking part in this study.

Research interviews will be arranged **in person or on the phone**. If you have experienced harm thoughts related to your baby, and would like to take part in my research, or to ask any questions, please contact me:

Call or text: [redacted] **Email:** [redacted]@uel.ac.uk

All communication will be treated with strictest confidence.
Many thanks **Caroline Boyd**
Trainee Clinical Psychologist, University of East London

Appendix D: Consent form

CONSENT FORM: THE MOTHER BABY WELLBEING PROJECT

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

How do new/ recent mothers experience unwanted harm thoughts about their newborn?

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purpose of the research has been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the principal researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

I give permission for the researcher to include anonymised quotes from the interview in the thesis produced and in any subsequent publications.

I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS) Participant's Signature

…… ……

Researcher's Name (BLOCK CAPITALS) Researcher's Signature

…… ……..

Date: ……..…….

Appendix E: Interview schedule

SEMI-STRUCTURED INTERVIEW SCHEDULE

This interview schedule serves as a guide: it is to be used flexibly with participants to facilitate full, free accounts of their experiences.

Introductions and engagement:

-Introduce self and study
-Re-iterate consent, confidentiality, and the participant's right to withdraw at any time. Outline process of interview (e.g. approximate length), give eg's of IRHTs, and brief research information regarding common occurrence of IRHTs among new mothers, which do not indicate that they are a risk to their child.
-Check for participant queries
-Demographics. Participants will be asked state their ethnicity, employment and marital status, number of children, and health and wellbeing of their most recently born (the subject of discussion for the interview).

Interview questions/ topics

1. Can you tell me about what kinds of thoughts, images or impulses you have had of harming, or of harm coming to your baby?

2. How old was your baby when you started having these thoughts?

3. Do you think they are linked to any particular event or situation?

4. How did they make you feel at the time? And now?

5. How did/ do you try to make sense of these thoughts?

6. How do you try to manage these thoughts? (Probe: do you seek to control the thoughts in any way? Use any particular strategies?)

7. Do you share these thoughts with anyone else? (Possible probe: do you know of other mothers who have experienced such thoughts or do you feel alone in experiencing them?)

8. If you did share these thoughts with professionals, what was their response? (And if not, why did you feel you shouldn't, or couldn't?)

9.What kind of mother did you want to be? And not to be? (Possible probes: Where did your ideas about motherhood come from? From childhood and/ or culture? Who do you look at and regard as a good mother?)

10. How does this fit with the reality of being a mother? (Probe: Is motherhood different to how you expected it to be?)

11. Did experiencing these harm thoughts make you see yourself differently as a mother?

12. Where do you access information about motherhood? (e.g. family; parenting books / online forums/websites; NCT; health professionals) (Probe: What sources of support do you rely on?)

13. Do you feel you have bonded positively with your son/ daughter?

14. (If not already covered) From what you can remember, what was your own early experience like?

15. (added organically) What would you say to another mother experiencing IRHTs?

16. Is there anything I haven't asked that you think is relevant? Are there any questions you were expecting that I haven't covered?

Debriefing:
Thank participant and provide contact information regarding organisations for support.

Appendix F: Introductory preamble to interview (slightly modified version of passage created By Nichole Fairbrother, used in her study (Fairbrother & Woody, 2008)).

I am going to ask you some questions about different kinds of thoughts that you may have experienced since the birth of your baby.

Sometimes, following the birth of a child, mothers experience thoughts about harm coming to their infant. These thoughts can occur in the form of word thoughts (e.g., words such as "my baby is not safe" going through your mind), images (e.g., a mental image of your baby falling off the bed or drowning in the bath), or impulses and urges (e.g., such as the urge to throw your baby on the floor). These thoughts can be about your baby being accidentally harmed, or about harming your baby on purpose, even though you know you never would. Mothers experience both kinds of thoughts. Thoughts of intentionally harming one's infant (e.g., drowning your baby in the bath or throwing your baby out the window) are particularly upsetting.

The type of thoughts, images, impulses and urges you may have had about your new baby that we are interested in are the ones that are *unpleasant*, *unwanted*, and that pop into your mind *unexpectedly*. Nearly everyone has such experiences, but people vary in how frequently these occur and how distressing they are.

What this means is that I am NOT asking about worry thoughts, but rather intrusive, unwanted thoughts about your baby being harmed that pop into your mind unexpectedly, and that you experience as intrusive and inappropriate.

Although research in this area is still in the early stages, it appears that all new mothers experience some intrusive and unwanted thoughts of harming, or of harm coming to their new baby. In a recent study all of the new mothers interviewed reported some unwanted thoughts of accidental harm related to their baby, and half of the mothers interviewed reported unwanted thoughts of intentionally harming their infant, even though they knew they never would. By talking about the kinds of thoughts, images and impulses you have experienced in relation to your new baby, you are helping me to learn more about the range of thoughts of harm to one's infant that new mothers experience.

I realise that it may be difficult for you to tell me about these kinds of thoughts where your son/daughter is concerned. For example, you may be concerned that you are a bad parent, or that other people will think you are a bad parent. It is important to realise that most people have these kinds of thoughts from time to time—they are quite common among new parents. [Give personal examples, such as thoughts of scalding the baby with hot water.] Also, as I outlined in the information sheet, ideas, images or urges of harming your child, and the fear that you might act upon them do NOT indicate that you are a risk to your child.

Do you have any questions before we begin?

Appendix G: Ethical approval

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Kenneth Gannon **REVIEWER:** James Walsh

STUDENT: Caroline Boyd

Title of proposed study: How do new/ recent mothers experience unwanted harm thoughts about their newborn? A thematic analysis.

Course: Professional Doctorate in Clinical Psychology

DECISION *(Delete as necessary)***:**

APPROVED

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

- [ ] HIGH
- [ ] MEDIUM
- [X] LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*: James Walsh

Date: 11th June 2015

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:
*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mark Finn (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Mark Finn at m.finn@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant: CAROLINE BOYD Programme of study: PROFESSIONAL DOCTORATE IN CLINICAL PSYCHOLOGY

Title of research: How do new/ recent mothers experience unwanted harm thoughts about their newborn? A thematic analysis.

Name of supervisor: DR KEN GANNON

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
For participants who are unable to meet face to face, to be interviewed over the telephone at a convenient time.	Due to the demands on a new mothers' time, and recruitment challenges identified in previous research, it is requested that phone interviews take place for participants who are not able to meet face to face. This is to ease participation for the targeted sample, and will allow for inclusion of participants based geographically far away from the researcher. These participants will be recruited via the same updated information letter as participants completing face to face interviews, sent digitally from the researcher. Hope is that including participants living at a distance from the researcher (who is based in north London) will mean not only easing participation for participants and saving them from making a special trip and/or on research-related travel expenses. It will also allow for a more diverse sample to be reached. Accessing a more mixed group is one of the aims of the research study, given that the subject matter of the study has not been explored previously among a diverse sample. As with face to face interviews, all

	phone interviews will be audio-recorded. Recruitment related processes, such as making phone appointments at participants' convenience, providing them with relevant research information prior to the interview, and for telephone research interviews to take place in a quiet, confidential space, will remain the same. Processes regarding protection of confidentiality will also remain the same for participants completing telephone interviews.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	YES	

Student's signature (please type your name): CAROLINE BOYD

Date: 19.08.15

TO BE COMPLETED BY REVIEWER		

Amendment(s) approved	YES	
Comments		

Reviewer: M Finn

Date: 19/08/15

Appendix H: Additional information sheet listing relevant support services

THE MOTHER BABY WELLBEING PROJECT
Support groups and organisations

Psychological wellbeing:

Association for post-natal illness
A support system for women with postnatal depression
http://apni.org ; 020 7386 0868

The Birth Trauma Association
Support for all women who have had a traumatic birth experience
www.birthtraumaassociation.org.uk

British Association for Counselling and Psychotherapy (BACP)
Provides information for those considering counselling
www.bacp.co.uk ; 01455 883300

Gingerbread
Information and support for lone parents through a network of local groups.
www.gingerbread.org.uk ; Helpline: **0808 802 0925**

Home Start
Support and friendship for families with young children
www.home-start.org.uk ; 0800 068 63 68

Family Lives (formerly Parentline Plus)
Support for anyone parenting a child
www.familylives.org.uk ; 0808 800 2222

Samaritans
Confidential service offering emotional support to those in need.
www.samaritans.org ; **08457 90 90 90**

The UK Postpartum Psychosis Network, Action on Postpartum Psychosis (APP)

Information and support on postpartum psychosis, online chatroom, peer support network.
www.app-network.org ; 020 3322 9900

General:

National Childbirth Trust (NCT), The UK's largest charity for parents
www.nct.org.uk ; 0300 330 0700 (Helpline offering practical and emotional support in all areas of pregnancy, birth and early parenthood including help with feeding.)

Tommy's
A **charity** that funds medical research into miscarriage, stillbirth and premature birth and provides information on having a healthy pregnancy.
www.**tommys**.org ; PregnancyLine **0800 0147 800**

La Leche League GB
Friendly breastfeeding support from pregnancy onwards.
www.laleche.org.uk ; 0845 120 2918

Online:

To access local support groups:
http://www.netmums.com/local-to-you/local/index/support-groups/general

http://www.netmums.com/local-to-you/local/index/support-groups/antenatal-postnatal-support

Appendix I: **Adapted transcription key and additional alterations to quotes.**

(.) Pause

(2) Timed pause

[inaudible] inaudible section of recording

[laughter] laughter during the interview

[text] Clarificatory information

[…] Indicates removal of text not relevant to the point

/ Overlapping speech

<u>Text</u> Word(s) emphasised

Appendix J: Example of an annotated transcript

HOW CHARACTERISED: 'initial thought was a curiosity'. Emo: SHAME/MORAL JUDGEMENT: 'as soon as I had that curious, innocent thought, the whole kind of society view thundered in' and CONSEQ'S/ SELF PERCEIVED AS RISK: 'I had to analyse whether or not I'm a danger to my child..' P/ HOW CHARACTERISES IT/ M/ MORAL JUDGMENT (SELF PERCEIVED AS RISK)/ SD: Thought process immediately followed by another internalized dialogue with herself, critical voice questioning her desire to pinch her child, and equating this with her representing a danger to him. PD-So first thought process is more of a curious philosophical wondering related to her son's vulnerability and her power and capacity to hurt without anyone knowing, and the second thought process is an internalized critical voice representing societal discourses around risk and child abuse. Emo/M/S-T: she felt shocked by the idea that she could 'abuse' her child. Note how her wondering about pinching him as become tantamount to 'abuse' where she	physically (.) but as soon as I had that curious, innocent thought, the whole kind of like society view thundered in, and I had to analyse whether or not I'm a danger to my child, you know, am I likely to abuse my child, how do I ensure I don't abuse my child, you kind of (.) this realization that I could abuse my child was quite shocking to me. Not, not, I don't believe I could potentially do it, but the realization that if I did it, I wouldn't get found out yet? I found that shocking that I'd had had that logical reaction – if I hurt him, no one would know. And then it's like that 'Oh my goodness, you're thinking that (.) you're thinking 'How are you going to get away with pinching him?'' And it was a very rapid succession of thoughts. The initial impulse to pinch him was 'Oh isn't he cute, I could pinch him, I wonder if it would hurt me', and then straightaway it was massive fears that I might become a potential abuser which (.) I don't think (.) you know (.) I'm not (.) I'm not going to hurt my child. It was a sudden realization that I'm now in this position where I could. -Yeah, yeah - I don't know if any of that makes sense. - No it makes *a lot* of sense, and I think that you know, to me listening to it it goes back to what you said in the beginning, kind of a realization of your position of power, and that's – you know you *are* in a position of power as a parent, and sometimes it can be quite scary and sometimes it	

is the abuser – she is drawing on societal language here. MS/M/CONSEQ'S (externalises)-What she found most shocking was that the realization she could hurt him and no one would know. Describes how she might 'get away' with pinching him – voicing the injustice around those who do abuse without punishment, and the fear that she might be equated with the same (abusive) group. M: MORAL JUDGEMENT/ SELF PERCEIVED AS RISK / CONSEQ'S (SS). She believes her IT was 'innocent' but simultaneously questions herself for having it as represents herself as 'bad, bad' person. Leads to SS, and beliefs that her negative self judgments would only be amplified in eyes of others. *-Try to normalize what she's disclosed.* SH (RISKS): risk re self perceived as danger; fears of being judged and consequences (Emo): shame. P/M (S-T): Evidence of self-policing (SP) – in terms of thought and behaviour. Response to intentional IRHT was negative self judgement ('I am a bad bad person'), and (E) increased	can be overwhelming, it can be lots of different things. But that knowledge that you alone are taking care of someone else (.) yeah it's really interesting and I'm glad that you felt able to talk about that, because I think that it is actually quite normal. And it's really interesting that you say, you know it was just a curious thing perhaps related to your experience as a young child, you don't know that, but maybe it was, and then it became a societal thing, and other people, and what might they think. Out of interest where did you think you might pinch him? - Oh on the leg (.) upper thigh **laughs**. That cute, little fat bit **laughs** - And have you shared that thought with anyone? -No. no. I'm really fearful to share that one. And I wrote it on my list but then I didn't mention it, and then I felt bad that I hadn't mentioned it. I felt like a fraud. -What/ -Because I think (.) I don't know, I think my reaction to it was 'Oh my goodness, you bad, bad person, I'm really going to keep an eye on you now, that you don't do anything like that' (.) and I think that was me, and I know that I didn't pinch him and I wouldn't have pinched him to hurt him, it was just an innocent thought, I think if that's me judging me like that how much more would someone else judge me, they might think she might pinch your child.	

self-surveillance to monitor own behavior to ensure she doesn't do 'anything like that'.	-So your fear was around judgement and worries that you might be dangerous/ - When I read it on your information sheet I thought maybe.. when I remembered it.. I	

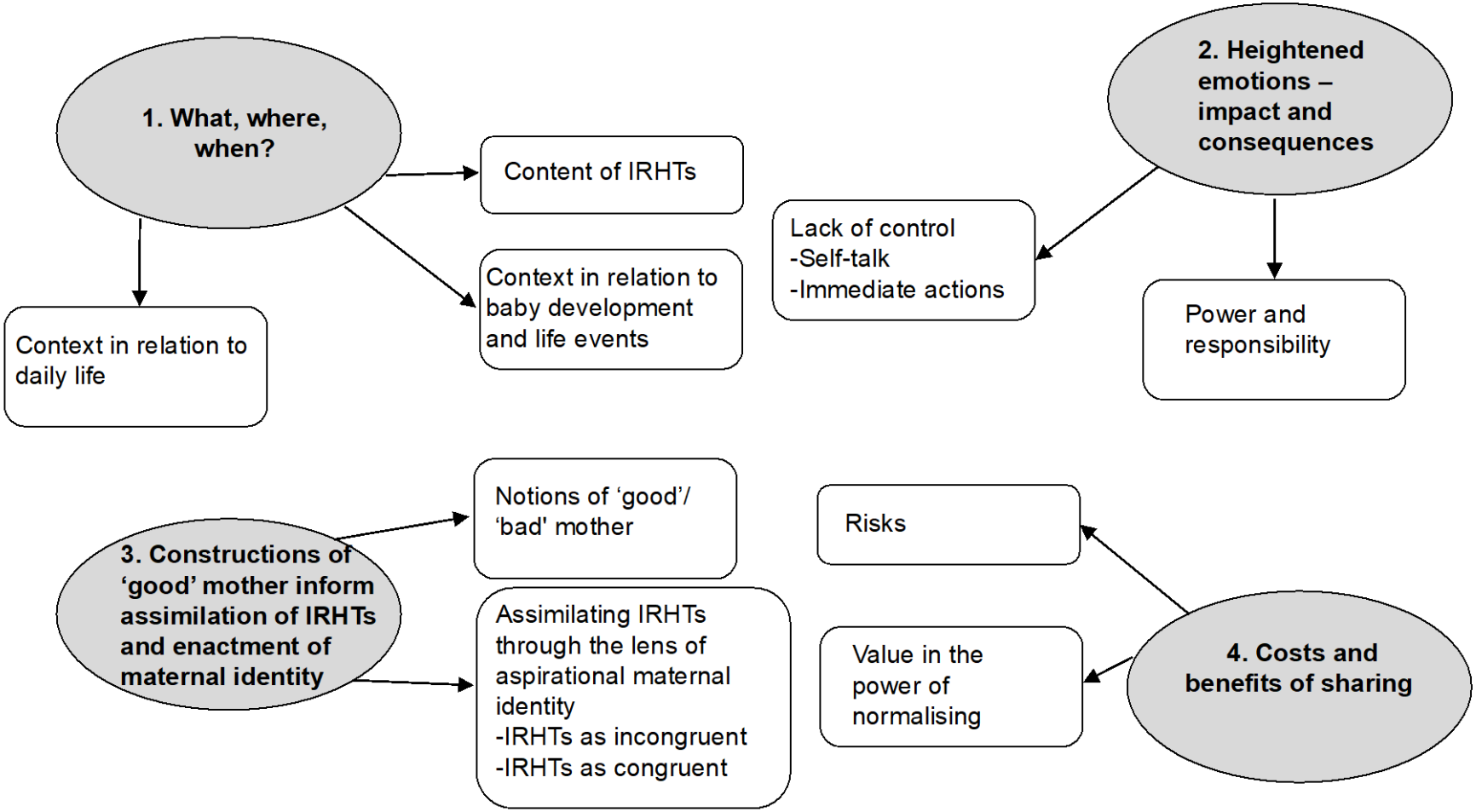
Appendix K: Final list of codes

No	Initial Code
1	Content of IRHT (C) (word thought/ image/ impulse etc)
2	C (AT): Accidental IRHT
3	C (IT): Intentional IRHT
4	F: Frequency
5	How characterised
6	Controllability
7	CON: (Specific) context in which IRHT occurs
8	E CON: (Wider) environmental context
9	WiS: 'What if?' type IRHT
10	T: Trigger
11	CF: Contributing factors (e.g. stress around feeding; sleep deprivation etc)
12	Emo: Emotions around IRHT
13	P: Process (of IRHT)
14	E: Effects of IRHT (what 'do' as a consequence)
15	Distraction
16	Avoidance
17	Checking baby
18	Check information online
19	Not let others take sole care of baby
20	Washing
21	M: Psychological management of IRHT (psychological processes)
22	S-T: self talk
23	Self reassurance / seek to rationalise IRHT
24	Imagery
25	Moral judgement
26	S-P: Self-policing
27	Attaching significance to IRHTs (links to 'How characterised'
28	Not attaching significance to IRHTs (links to 'How characterised'
29	Helpful responses
30	Increased vigilance/ protection of baby
31	Enhanced understanding/ self-development
32	Adjusting to responsibility
33	Accepting new role
34	Adjustment to lived reality (in contrast to expectations)
35	Increased confidence in mothering approach
36	Unhelpful responses
37	Constantly checking baby
38	Labelling IRHTs as indicating "badness"
39	Labelling IRHTs as indicating "madness"
40	Increased self-surveillance
41	Question self as mother
42	SS: Self-silencing / self-censoring

43	Power
44	Acknowledging mother-baby power differential
45	Mother feels powerless
46	Mother holds power
47	Tussle over who holds power
48	Social discourses
49	Pressure (to be good mother)
50	Pressure (to cope)
51	Support
52	Good quality support
53	Sharing IRHTs with others
54	What shared
55	Who with
56	Context for sharing
57	Consequences of sharing
58	Sharing is limited
59	Risks/ consequences of sharing
60	Perceived as not coping
61	Perceived as overly vigilant/ anxious
62	Not validated
63	Feeling judged in ability to mother
64	Self perceived as risk
65	Risk of baby removed from care
66	Risk of being medicalised/ pathologised (leading to further intervention)
67	IRHTs increase in frequency
68	IRHTs increase in intensity
69	Power of normalising IRHTs
70	Relief
71	Feeling validated
72	Feeling less judged
73	Feeling less isolated
74	More able to dismiss IRHTs
75	Feeling reassured (that harm will not come to baby)
76	Increased empathy for other mothers
77	GA: Generalised anxiety
78	Feeling vulnerable and not knowing immediately postpartum
79	Fears of being ‘found out’ by others
80	Identity as mother
81	Pre-baby identity
82	AF: Alleviating factors (e.g. letting others take care of baby), getting more sleep)
83	EE: early experiences
84	EE positive
85	EE negative
86	REP: replicates aspects of own experience of being parented
87	REJ: rejects aspects of own experience of being parented
88	EX: Own expectations of motherhood

89	CI: Cultural ideas/ beliefs/ representations
90	Hopes (e.g. links to idealised expectations)
91	Reality (e.g. in context of navigating expectations gap)
92	H-S: Help-seeking (e.g. nature of)
93	HC: Experience of healthcare professionals
94	RECS: Participant recommendations to healthcare professionals/other mothers to manage IRHTs
95	INFO: Experiences of accessing info re motherhood

Appendix L: Initial thematic map



Appendix M: Reflective journal extracts

Example excerpt of entry following interview

I am feeling emotionally exhausted after the interview – my fourth so far, and almost two hours long. I am becoming aware of the impact on me hearing the different kinds of harm thoughts women describe. I noticed I was feeling quite upset after discussing this participant's IRHTs, which revolved around fears of her child being kidnapped following the Jamie Bulger case. It wasn't something I had particularly worried about before the interview, certainly not so specifically, and I am now finding myself imagining my own son in this scenario, thinking how frightened and confused he would be. I feel compelled to look up more details around the case at this point but have consciously decided not to. During the interview, only brief, generalised details of the case were discussed, as we spent more time exploring her own responses to her thoughts. I know I'll feel more upset looking up more details and being confronted with the full horror of what happened.

This interview was interesting in that I'm not sure she was planning to disclose her intentional harm thought at all, or at least she may not have been sure how to describe the thought when she did. I experienced the first part of the interview, which was spent discussing her accidental harm thoughts, as building on creating a safe space in which she felt we had built enough trust and rapport to disclose her less 'socially acceptable' thought. She is the first participant to share an intentional harm thought with me, and I felt very aware of my interviewer responses. I didn't want to say too much in order to retain some 'neutrality', whilst expressing warmth, empathy and understanding through my tone (e.g. 'hmms' of agreement), to facilitate us exploring her experience together. I was also aware that my responses were shaped by a desire to 'normalise' her experience as far as possible, to help her feel at ease.

I felt very struck afterwards by the powerful role I occupy as interviewer, as I was the first person this participant had shared her intentional harm thought

with. In the previous interviews I also felt extremely privileged to hear these women's stories making sense of particular IRHTs, in some cases for the first time. I am reflecting now on the powerful process of the interview itself as providing a safe space – particularly for this latest interview – for the participant to begin this process when previously it had been so internalised and accompanied by strong emotions. It brings to mind some of the IRHTs I experienced following the birth of my daughter, and how lucky I was to have friends in my network with whom I could discuss such thoughts. I remember my tendencies to engage in self-dialogue, as I reassured myself that these thoughts didn't mean anything bad about me, and linking them to my clinical psychology teaching around OCD. I had learnt that attaching significance to thoughts only increases occurrence, preoccupation and distress. I remember consciously using mindfulness strategies to try to 'let go' of thoughts in an attempt to dismiss them. This participant felt that the thought represented something very bad about her. I am struck by how distressing these thoughts must be for women less familiar with psychology related knowledge and practices. After this interview – as with the previous participants – I am reminded of the enormous impact of these IRHTs. This makes me feel more motivated to complete the research to contribute to the small knowledge base in order to help new/recent mothers.

Entry following preliminary stages of analysis

I am feeling totally overwhelmed! My supervisor assures me that this is 'normal' to feel like this after finishing coding, and that at this stage qualitative researchers can feel 'lost' in the data. There seems to be so much of it, and I feel so much pressure on myself to do a good job of capturing the key stories in participants' accounts. At this point, there seems to be so many competing stories, all vying for my attention, and I feel a responsibility to create themes that capture them as faithfully as possible. Part of the challenge is holding so much in my head, and I feel very weighed down by it. I am looking forward to the cathartic process of 'pinning down' my themes and storying them confidently, but that feeling of confidence feels very far off at the moment.

What I have noticed about this research process, in contrast to previous experiences conducting qualitative research (e.g. doctoral research assignment, MSc dissertation), is that I feel more comfortable with 'owning' my different positions in the context of how these may inform data analysis. That's not to say it feels completely comfortable, as I still feel tension around trying to balance a systematic (more 'objective') approach to coding with the more 'subjective' nature of interpreting the data. However, I have learnt from previous experience that a certain degree of interpretation is required for qualitative research, as long as I state my own positions reflexively, enabling me to consider the analysis in context. Reflecting on this is helping me work hard to consider what might be shaping my interpretations (e.g. in terms of personal or professional experiences), and my ethical duty to represent participants' voices fairly. Thinking about implications and potential recommendations of the research has also facilitated this process.