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"I'm Afraid I Might Hurt My Baby"

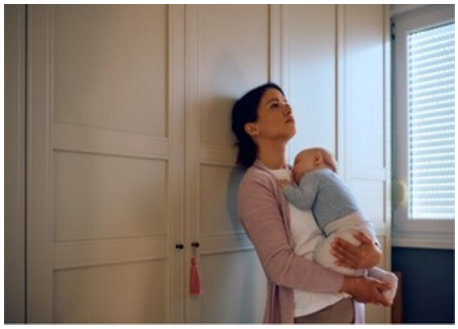
Intrusive Maternal Thoughts, Perinatal OCD and the Fear of Harm

An online webinar with

Dr Brooke Laufer

Zoom Webinar
2 March 2027, Tuesday
Times:
6:00 pm – 9:00 pm, London UK
1:00 pm – 4:00 pm, New York, USA

CPD hours: 3



Location: Online streaming only
(all our webinar tickets now include complimentary access to a video recorded version for 1 year or 3 years, depending on the ticket type)

She is standing at the top of the stairs, the baby asleep against her shoulder, when the thought arrives.

Not a wish.

Not even close to a wish.

Gone almost before she can properly see it — followed by the sickening recognition that she thought it at all.

She does not tell her partner. She does not tell her health visitor or doctor. Eventually, she tells you, in the flattened voice of someone who has been carrying something very carefully for far too long:

I think there might be something wrong with me.

She is not alone.

Unwanted thoughts of accidental or deliberate harm are among the most common — and most concealed — experiences of the perinatal period. Most are profoundly distressing, entirely at odds with what the mother wants, and are not associated with an increased likelihood of harming her baby.

Yet many mothers never disclose them. Saying the thought aloud can feel perilously close to confessing an intention. The shame surrounding the thought may become larger than the thought itself.

But not every frightening presentation means the same thing.

For one mother, the thought may be the passing intrusion of an anxious and exhausted mind under extraordinary pressure. For another, it may have become part of perinatal obsessive-compulsive disorder: recurrent thoughts, images or impulses accompanied by checking, avoidance, reassurance-seeking or mental rituals intended to prevent catastrophe. For a much smaller number of mothers, unusual beliefs or frightening behaviour may arise within postpartum psychosis — a psychiatric emergency involving impaired reality testing and a very different level of clinical risk.

The clinician's task is to distinguish between them.

That distinction may need to be made within a single encounter, under considerable pressure, with consequences for the mother, her baby and the therapeutic relationship. Underreaction may leave a rapidly deteriorating mother without urgent care. Overreaction may lead to unnecessary hospitalisation, inappropriate safeguarding responses or a frightened mother learning that honesty is dangerous.

A therapist may reassure too quickly, refer too urgently, avoid asking directly or seek a degree of certainty that no single assessment can provide. Unfortunately, few practitioners receive sufficient training for this moment.

This workshop addresses one of the most difficult and consequential questions in perinatal mental health:

How do we distinguish a frightening thought from genuine risk — without minimising danger or mistaking the content of a thought for evidence of dangerousness?

This evening is designed to help clinicians move from alarm and uncertainty towards a more structured judgement: knowing what to ask, what to listen for, how to respond without deepening shame or compulsive reassurance-seeking, and when the presentation requires urgent specialist intervention.

Drawing on more than fifteen years of clinical work in maternal psychology and perinatal mental health, together with extensive scholarship on the rare circumstances in which maternal harm becomes real, Dr Brooke Laufer will guide participants through the differential assessment of common intrusive thoughts, perinatal OCD and postpartum psychosis.

Brooke's work at the outer edge of maternal experience gives her an unusual vantage point from which to clarify where the overwhelming majority of frightening maternal thoughts are not heading, while remaining alert to the rare presentations that demand urgent intervention.

Through clinical vignettes, close examination of the language mothers use to describe these experiences, and a structured differential-assessment framework, Brooke will demonstrate how apparently similar disclosures can require very different clinical responses.

Central to this work is a deceptively simple principle: assess the **form** of an experience, not only its content.

A thought is not an image.

An image is not an impulse.

An impulse is not a command.

And none of these is the same as a delusional belief.

The clinical interview changes when therapists begin asking not only *what* a mother is thinking, but *how she experiences the thought*.

- Did it arrive uninvited?
- Does she experience it as alien, unwanted or inconsistent with who she is?
- Does she fear that having the thought means she might act on it?
- Does she resist it, avoid situations associated with it or seek repeated reassurance?
- How strongly does she believe the feared event will occur?
- Can she consider that her interpretation may be mistaken?
- Is her reality testing intact?

These questions help distinguish obsessional fear from fixed belief, an unwanted impulse from intention, and distress about losing control from an actual loss of control.

Most mothers experiencing perinatal OCD describe their thoughts as ego-dystonic: unwanted, resisted and horrifying. They recoil from the thought. They may repeatedly check that the baby is breathing, avoid carrying the baby near the stairs, move knives out of sight or insist that another adult remain present.

The mother who checks the cot six times before leaving the room.

The mother who quietly hands every kitchen knife to her partner before preparing dinner.

The mother who can no longer bathe her baby because she cannot stop imagining drowning.

These behaviours are not, in themselves, evidence of dangerousness. They are the visible architecture of a mind working exhaustively to prevent a catastrophe the mother may recognise as irrational, yet cannot experience as safely dismissible.

Participants will examine how checking, avoidance and reassurance-seeking temporarily reduce anxiety while strengthening the obsessional cycle. They will consider how to acknowledge the mother's terror and reduce shame without repeatedly offering certainty, becoming part of the checking process or inadvertently confirming that the thought requires special protection.

This is not a full training in Exposure and Response Prevention. However, participants will learn how early therapeutic responses can either support disclosure and appropriate care or unintentionally reinforce the mother's belief that the thought itself is dangerous and must be controlled.

The workshop will also distinguish perinatal OCD from intrusive thoughts that occur commonly during otherwise uncomplicated adjustment to motherhood. A distressing thought does not automatically constitute a disorder. Assessment must consider its frequency, persistence, associated distress, functional impact and the extent to which the mother has reorganised her behaviour around preventing the feared event.

Postpartum psychosis requires a different form of attention.

Unlike an ego-dystonic obsession, postpartum psychosis involves a disturbance in reality testing. A mother may develop hallucinations, confusion, paranoia, markedly impaired insight or beliefs held with delusional conviction. She may believe that her baby has been replaced, become possessed or must be harmed in order to save them.

Unlike the mother experiencing an unwanted obsession, she may not recognise the belief as irrational or experience it as an intrusive thought. The belief may feel true, necessary or externally commanded.

Participants will learn to assess the distinctions between:

- intrusive thoughts and genuine intent;
- images, impulses and commands;
- obsessional doubt and psychotic conviction;
- anxiety-driven avoidance and impaired reality testing;
- distressing thought content and evidence of actual risk;
- preserved insight and a rapidly deteriorating mental state.

Postpartum psychosis is rare, affecting approximately one to two mothers in every thousand births, but it can develop quickly and requires urgent specialist assessment. Brooke will review warning signs including rapid deterioration, severe insomnia or a reduced need for sleep, agitation or unusual energy, racing thoughts, confusion, disorientation, paranoia, hallucinations, disinhibition and delusional beliefs.

Participants will consider when work can remain within an outpatient therapeutic setting, when consultation or referral is indicated, and when the presentation requires immediate contact with specialist perinatal mental health or emergency services in accordance with the practitioner's local pathway.

Throughout the evening, Brooke will attend not only to what the clinician identifies, but to how the clinician asks.

A blunt or alarmed enquiry may close the conversation precisely when fuller disclosure is most needed. Equally, reassurance offered too quickly may obscure important information or reinforce an obsessional search for certainty.

Participants will explore how to ask directly about harm, intent, conviction, control and reality testing without communicating horror, suspicion or premature judgement. The aim is neither to normalise everything nor to catastrophise everything, but to create the conditions in which the mother can describe her experience accurately enough for a sound clinical decision to be made.

The workshop finally turns towards the clinician.

These cases evoke powerful countertransference. There is the fear of missing genuine danger, accompanied by the equally powerful fear of overreacting and causing unnecessary harm. The therapist may feel compelled to reassure, refer immediately, seek impossible certainty, avoid asking directly or assume responsibility for guaranteeing that nothing will happen.

Both extremes can distort assessment.

Brooke will help clinicians recognise these pressures and develop a steadier position: one capable of taking risk seriously while remaining curious, precise and emotionally available to a mother who is terrified of her own mind.

Who This Evening Is For

Psychotherapists, psychologists, counsellors, psychiatrists, social workers, psychiatric nurses and other mental health professionals working with women during pregnancy or the postpartum period.

It will also be relevant to practitioners who do not specialise in perinatal mental health but may encounter intrusive maternal harm thoughts, obsessive-compulsive symptoms or an emerging psychiatric emergency within general clinical practice.

By the End of the Evening, Participants Will Be Able To:

1. Differentiate intrusive thoughts, images, impulses, commands, intentions and delusional beliefs, using ego-dystonicity, resistance, insight, conviction and reality testing.
2. Distinguish common perinatal intrusive thoughts from perinatal OCD by assessing frequency, persistence, distress, functional impact and the degree to which the mother has reorganised her behaviour around preventing harm.
3. Recognise the behavioural architecture of perinatal OCD, including checking, avoidance, mental rituals and repeated reassurance-seeking, and respond without inadvertently strengthening the obsessional cycle.
4. Ask direct questions about harm, intent, control and mental state in ways that encourage honest disclosure rather than increasing shame or silence.
5. Differentiate obsessional fear from psychotic conviction and identify evidence of impaired insight or disturbed reality testing.
6. Recognise early warning signs of postpartum psychosis, including rapid deterioration, severe sleep disturbance, unusual energy or agitation, confusion, paranoia, hallucinations and delusional beliefs.
7. Determine when outpatient therapeutic work remains appropriate and when consultation, urgent specialist referral or emergency assessment is required.
8. Manage the countertransference pressures of fearing to miss danger, seeking impossible certainty or reacting in ways that may silence the mother, while maintaining a position of confidence, precision and compassion.

There is no known commercial support for this program.

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