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Experiences of Well-Being in Child-Bearing Women: What Helps and Hinders
Expériences sur le bien-être des femmes enceintes : aides et obstacles

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ABSTRACT

Little research has been done to date to understand, qualitatively, the contributing factors of psychological thriving during pregnancy, birth, and postpartum, particularly from the voices of mothers themselves. In order to better understand what women perceive as contributing to a healthy and positive child-bearing experience, the authors asked postpartum women to report what factors contributed to their well-being. Using the enhanced critical incident technique, women reported what they found was helpful, hindering, or what they would have wished for in their pregnancy, birth, and postpartum experiences. Implications and recommendations for counsellors working with women during pregnancy and the postpartum period are discussed.

RÉSUMÉ

Bien peu de recherches ont été menées à ce jour pour comprendre, qualitativement, les facteurs qui contribuent à favoriser le bien-être psychologique durant la grossesse, au moment de l'accouchement et durant la période de post-partum, particulièrement en ce qui concerne le point de vue des mères elles-mêmes. Pour mieux comprendre ce que perçoivent les femmes comme étant des facteurs qui contribuent à une expérience de grossesse saine et positive, les auteurs ont demandé à des femmes en période de post-partum de rapporter les facteurs ayant contribué à leur bien-être. Au moyen de la technique améliorée d'analyse d'incident critique, les femmes ont indiqué ce qu'elles avaient trouvé favorable et défavorable, autrement dit ce qu'elles auraient souhaité comme expériences durant leur grossesse, leur accouchement et le post-partum. L'article présente une discussion des implications et recommandations à l'intention des conseillers et conseillères qui travaillent auprès des femmes durant les périodes de grossesse et de post-partum.

Pregnancy, childbirth, and the postpartum period represent a significant series of events in a woman's life and can ultimately contribute to the formation of a woman's identity (Dahlen, Barclay, & Homer, 2010). The consequences of poor well-being during pregnancy, childbirth, and postpartum are significant for both mothers and infants. Women's failure to thrive psychosocially during pregnancy,

birth, and postnatally has negative impacts on their physical health and medical birth outcomes, the mother-child attachment relationship, and the biopsychosocial development of the child (Bornstein, 2014; Chuang et al., 2011; Hart & McMahon, 2006; Sabuncuoglu & Basgul, 2016; Topiwala, Hothi, & Ebmeier, 2012).

The existing research heavily favours the exploration of medical components of pregnancy, birth, and postpartum, such as health outcomes and medical interventions, using quantitative methodology. Research focused on "repairing damage within a disease model of functioning… neglects the fulfilled individual and the thriving community" (Seligman & Csikszentmihalyi, 2000, p. 5) and, as a result, fails to adequately address what helps to shape women's experiences during pregnancy, childbirth, and the postpartum period. Therefore, the present research aims to address a gap in the literature focusing on psychosocial aspects of women's well-being during this critical period, using a qualitative design (Dahlen et al., 2010; Declercq & Chalmers, 2008; Kwee & McBride, 2015).

The core of professional care for child-bearing women in Canada has traditionally been focused on medical aspects of prenatal and postnatal care, thus this is a timely opportunity for the consideration of psychosocial well-being in the discipline of counselling psychology. A literature review addressing women's perinatal needs and interventions highlighted significant existing mental health needs of women during pregnancy, birth, and postnatal (McBride & Kwee, 2016). Although emotional distress is normative among child-bearing women, psychosocial support during routine perinatal medical care is often inadequate.

The existing research about women's psychosocial health during pregnancy, birth, and postpartum demonstrates the importance of women's well-being, not only for psychological thriving but for the partner relationship and the ability to parent effectively (McBride & Kwee, 2016). For example, the Canadian Maternity Experiences Survey (MES) conducted in 2006-2007 provides a backdrop to the present research from a large-scale, public health perspective (Chalmers, Dzakpasu, Heaman, & Kaczorowski, 2008). The MES especially allows for women's views to be considered regarding current maternity care policies and practices in Canada. While the existing findings are important, they do not present a cohesive and qualitative narrative from the perspective of women's psychosocial experiences, which is inclusive of interpersonal relationships and support, personal wellbeing, community, cultural aspects, and how these events shape and influence each other.

Bronfenbrenner's (1979) ecological model offers important insights into understanding different aspects of a woman's experience through pregnancy, birth, and postpartum. An ecological model proposes that an individual's experiences are a result of bidirectional interactions between the individual and their environment, which varies based on the individual's context and culture, and changes over time (Bronfenbrenner & Morris, 2006). Therefore, in line with Bronfrenbenner's ecological model, a woman's experience of pregnancy, birth, and postpartum is influenced by multiple, complex, personal, and systemic factors. For the present research, the individual, family (micro), community (meso), and cultural (macro-

systems) factors, each representing diverse parts of the systems in which women interact, will be considered.

First, individual factors within the mother include attitudes and expectations, body image, mental health and trauma, sense of agency/locus of control, spirituality, and previous perinatal experiences. For example, some women feel better about their bodies and their appearance during pregnancy, compared to how they normally feel (Loth, Bauer, Wall, Berge, & Neumark-Sztainer, 2011), a finding that is significant because body changes due to pregnancy represent a shift away from Western appearance ideals. Women's overall well-being during pregnancy has also been associated with having fewer worries and less anxiety about birth (Biehle & Mickelson, 2011). Women's perception of their birth, including well-being during birth, also shapes their experiences in the postpartum period (Conde, Figueiredo, Costa, Pacheco, & Pais, 2008). For example, women who have a positive perception of their birth have fewer worries about their child's health, increased feelings of well-being about themselves, and a decreased perception of the painfulness of the birth (Conde et al., 2008).

Second, family and microsystem factors (e.g., birthing history, relationship with partner and family) also play an integral role in women's experiences of pregnancy, birth, and postpartum. For example, the stronger a woman's felt bond to her fetus during pregnancy, the stronger her emotional bond will be to her infant post-birth, which is critical to social, emotional, and cognitive development (Rossen et al., 2016, 2017). The presence and involvement of a partner and non-professional support at birth has been shown to provide comfort, meaning, and strength for women, and promotes more positive interactions between a mother and baby following the birth (Kainz, Eliasson, & von Post, 2010). A secure attachment with one's partner contributes to emotion regulation during the period of becoming a parent (Behringer, Reiner, & Spangler, 2011), which ultimately impacts a woman's sense of well-being during child-bearing years. Partners also play a crucial and supportive role in their infant's socioemotional development both uniquely and via their supportive role to mothers, including those experiencing symptoms of depression in the postnatal period (Rossen et al., 2018).

Third, community-level (meso) factors and support also represent important aspects of women's well-being during pregnancy, birth, and postpartum. Factors pertaining to child-bearing women include workplace policies and career trajectories; educational and social services for women; policies and practices in maternal and infant care, and choices in perinatal care. For example, research highlights the significance of how a woman is treated by her care provider, her ability to participate in the decision-making process related to her medical care, and the treatment of her physical body, all contribute to her sense of well-being during childbirth (Carter, 2010; Declercq & Chalmers, 2008; Lawton, Gardner, & Plachcinski, 2011). What actually happens during the singular event of birth is important; for example, vaginal births are associated with a more positive experience of parenting during the postpartum period (Bryanton, Gagnon, Hatem, & Johnston, 2009).

Finally, cultural (or macrosystem) factors also play a significant role in women's experiences of child-bearing. Gender role expectations, cultural views of pregnancy, birth, and motherhood, values influencing the medical system, and media portrayals of pregnancy and birth all play a significant role in shaping women's attitudes and expectations of their child-bearing experience. Research has shown that women are propelled to renegotiate and adjust to cultural changes in gender roles and their roles and expectations of being a mother (Yakushko & Chronister, 2005). More importantly, sociocultural factors influence each system within Bronfenbrenner's (1979) ecological model, often making it challenging to unravel the extent of culture's influence on women's experiences of pregnancy, birth, and postpartum.

Context and Purpose of the Present Research

The present research will examine the interrelated events, and complex factors of women's lived experiences during pregnancy, birth, and postpartum. Specifically, the lived experiences of mothers are needed to understand what factors are most significant in contributing to their well-being in order to provide optimal care for women. This article presents what participants describe as helping and hindering factors in their child-bearing experiences, and what they had wished for during this time. Queries about what helped, hindered, and what women wished for were used to elicit critical incidents about the participants' pregnancy, birth, and postpartum adjustment. The present article addresses the most salient categories identified.

Methods

In this section, we describe the procedure, participants, and the enhanced critical incident technique methodology utilized in the present study. The Research Ethics Board of the University affiliated with the research approved the study before it took place.

Procedure

Postpartum women, between 4 and 12 weeks postpartum, were invited to participate through informational material located in waiting rooms of maternity care providers' offices. This window of time was chosen because it represents the typical time at which a woman's care transitions from her midwife or obstetrician to her primary care physician. Inclusion criteria included women (a) between 4-13 weeks postpartum; (b) with a minimum English proficiency; (c) with a desire and/or willingness to be part of both phases of the research (first interview and follow-up); and (d) a level of comfort with describing their pregnancy, birth, and postnatal experiences. Interested participants were initially contacted by phone to confirm their suitability for the study and to arrange an interview. Participants were invited to choose the location of their choice for the interview.

Compensation for childcare for the participant's older children was offered if needed. All participants chose to have the interviews conducted at their homes. The first in-person interview lasted between one to two hours, and the second interviews (to cross-check the results with the participants) were conducted by phone or e-mail.

Participants

The participants in this study were 13 heterosexual women in long-term, committed relationships. The age of participants ranged from 26- to 36-years old, with a mean age of 30, and a mean annual household income of $89,000. At the time of the interview, just over half of the participants were taking leave from employment, while 46% (n = 6) had returned to work. More than two thirds (69%; n = 9) of the participants were first-time parents while the other third had older children. The sample consisted of 9 participants (69%) who had vaginal births and 4 (31%) who had caesarean sections. The women's births were attended by a range of maternity care providers including midwives (54%; n = 7), obstetricians (38%; n = 5), and a general practice physician (8%; n = 1). One twin pregnancy was represented in the sample, and 2 participants had used in vitro fertilization (IVF) to get pregnant.

Enhanced Critical Incident Technique

The enhanced critical incident technique (ECIT), an adaptation of the critical incident technique (CIT; Flanagan, 1954), was chosen for the present research because it is designed to capture helping and hindering aspects of a specific phenomenon—in this case, women's well-being during pregnancy, birth, and postpartum—from the perspective of the lived experiences of the participants. Also, the ECIT has been expanded to capture "wish list" (WL) items, or what participants wished they would have known or would have had for the experience being studied. Nine additional credibility checks (see Table 1) are included to ensure validity and rigour (Butterfield, Borgen, Amundson, & Maglio, 2005; Butterfield, Borgen, Maglio, & Amundson, 2009).

The ECIT protocol involves a semi-structured, qualitative interview about the experience of interest. In this study, participants were asked to describe what helped them most in pregnancy and what hindered or got in the way of them doing well in pregnancy. Next, they were asked to describe what events or incidents were most helpful to them during their labour and delivery experience, and those which were hindering.

Finally, they were asked to reflect on their postpartum experience thus far, including helping and hindering factors. For each phase of the child-bearing experience, they were also asked to describe "wish list" (WL) items, which represent retrospectively what they think would have been helpful to know or to have during pregnancy, birth, and postpartum. This semi-structured interview protocol focused on the subjective perspectives and insights of the research participants.

Table 1
Enhanced Critical Incident Technique (ECIT) Credibility Checks

Credibility Check	Description
Audiotaping and Transcribing	The interviews were *audiotaped* and transcribed in order to ensure that researchers work directly and comprehensively from the words of participants rather than from inferences or incomplete notes.
Interviewer Fidelity	*Interviewer fidelity* was ensured by using a structured interview protocol, and researchers reviewing each other's interviews periodically.
Independent Extraction	Butterfield et al. (2009) have recommended selecting 25% of the transcripts to give to an independent individual, following which the researcher would normally discuss possible discrepancies and calculate a concordance rate. For this study, the authors enhanced the third credibility check of *independent extraction* by collaboratively extracting Critical Incident (CI) and Wish List (WL), and placing them in categories by consensus with 100% of the transcripts.
Exhaustiveness	*Exhaustiveness,* the fourth credibility check, indicates the point at which no new categories are being identified. This criterion was reached after 13 interviews, after which no other interviews were necessary.
Participation Rates	*Participation Rate* (discussed in the text) does not only provide a minimum requirement for retaining a category but also serves to establish relative strengths of each category.
Placing into Categories by a Judge	In this credibility check, 25% of the CIs are assigned to an independent judge for category placement with a recommended match rate of 80% with the Principal Investigator. This credibility check was modified similarly to the check of independent extraction in that the researchers placed the incidents into categories collaboratively. The researchers achieved 100% agreement through discussion at the time of category formation and coding.
Cross-Checking by Participants	After the participant's results were analyzed and incidents were elicited and placed into their respective emerging categories, participants were contacted to do a second interview (by phone, e-mail, or in-person) and were provided with a copy of their incidents along with the categories that these incidents were placed to confirm whether they had been placed appropriately. This honours participants' voices as the final authorities in representing their lived experience.
Expert Opinion Review	The categories were submitted to two outside experts for an *expert opinion* review. The experts are asked, (1) do you find the categories to be useful? (2) are you surprised by any of the categories? and (3) do you think there is anything missing based on your experience? The categories in this study were submitted to a registered midwife, and a nurse practitioner, who is also qualified as a licensed lactation consultant and is currently working in perinatal care. Both experts confirmed that the categories were congruent with their expertise, and current research in the field.
Theoretical Agreement	*Theoretical agreement* involves reporting assumptions underlying the study and comparing emergent categories with relevant literature.

Note. These nine credibility checks were performed to enhance the rigour of the analysis, according to the guidelines of the Enhanced Critical Incident Technique (Butterfield et al., 2005, 2009), with specific project applications and/or modifications clearly noted under each description.

Data Analysis

A research team was utilized in the present research and comprised one doctoral counselling psychology student, one post-doctoral researcher, and one associate professor of counselling psychology. Inductive data analysis identified each event or aspect of the experience (each called a "critical incident") the participants described. Interviews were audiotaped and transcribed to determine critical incidents (separated into helping and hindering factors) and wish list items. According to the ECIT technique, critical incidents (CIs) and wish list (WL) items extracted are those supported by examples (Butterfield et al., 2009). Two researchers independently formed categories from individual items using inductive reasoning, patience, and the ability to see similarities and differences among the hundreds of CIs provided by participants.

Each CI was placed into a category, either a category which had already been created from previous interviews or by identifying a new category. The researchers made decisions about the exclusivity of the categories, deciding which larger categories needed to be separated or if smaller related categories needed to be merged. This process was conducted one interview at a time until no new categories emerged. A minimum participation rate of 25% was required for category retention (Borgen & Amundson, 1984). Once final categories were established, key themes were identified to summarize and report the results effectively. Incidents which were highly represented and relevant to the counselling psychology discipline were chosen and further detailed in the Results section.

Rigour and validation. ECIT requires nine credibility checks as outlined by Butterfield and colleagues (2005, 2009), which were followed in this study to ensure validity and rigour (see Table 1). To fulfil the first credibility check, all interviews were audiotaped and transcribed. Second, interview fidelity was maintained by reviewing interview protocols and the principal investigator providing supervision of initial interviews and subsequent interview recordings. Third, independent extraction of the CI and WL items took place on all interviews, beyond the recommended 25% of interviews by Butterfield and colleagues (2005, 2009). Fourth, to ensure exhaustiveness was reached, a log of each interview was tracked as its CI and WL items were placed into the emerging categories until new categories did not emerge.

Fifth, the minimum participation rate (percentage of participants that endorsed a category) determined the strength of a category. A minimum participation rate of 25% is the standard established by Borgen and Amundson (1984). Sixth, the ECIT technique suggests an 80% match rate on categories by independent researchers (Andersson & Nilsson, 1964). The present study enhanced rigour by having two researchers conduct data analysis and interpretation together, ensuring 100% agreement across all categories. Coding discrepancies were addressed throughout the analysis and interpretation process between the two coders. Seventh, cross-checking by participants via a second interview, by phone, allowed participants to confirm or review categories.

The eighth credibility check drew on opinions of experts in the field regarding the categories formed. Two experts were considered as part of the research team, and they provided their expertise concerning the data analysis process and provided additional insights about the categories/themes that were extracted. Finally, the ninth credibility check was to attain theoretical agreement for the emergent categories and themes, along with the assumptions of the study, concerning the existing literature. There was consistency between the literature and the assumptions and categories/themes, as elaborated in the discussion.

RESULTS

A total of 933 CIs emerged from interviews with 13 participants. Of the 933 incidents, 486 (52.1%) were found to be helping, 375 (40.2%) were found to be hindering, and 72 (7.7%) were WL items. The 933 incidents could also be categorized by examining when they occurred: 341 (36.5%) were reported during pregnancy; 275 (29.5%) occurred during labour and delivery; and 317 (34.0%) corresponded to the postpartum period. A total of seven themes emerged from the data analysis pertaining to 24 categories. Table 2 provides a summary of the seven themes that emerged as well as examples pertaining to each category within a theme.

Themes and Categories

The following seven themes were identified including: personal factors, interpersonal relationships and support, healthcare resources and information, labour and birth environment and experience, parenting and baby characteristics, community and macrosystem, and personal health and medical factors.

Although all themes (and categories) that emerged in the analysis are important for understanding women's experience during pregnancy, birth, and postnatal, two of the seven most heavily represented themes, and those themes particularly relevant to the counselling psychology profession, were selected for inclusion and further description in this article. The two themes identified as pertinent for discussion in the manuscript were "personal factors" and "interpersonal relationships and support." Correspondingly, the following five categories were identified for further discussion: (a) attitudes and expectations, (b) agency and empowerment, (c) partner relationship, (d) family support and involvement, and (e) community support and involvement.

Categories selected for this study represent individual factors and microsystem factors that are especially relevant to the scope of influence of psychosocial care providers. The authors determined that the category specifically about medical caregivers warranted separate analysis directed toward informing primary medical care providers. The third most heavily represented category, personal well-being, was also excluded for analysis in this manuscript because it represents aspects the authors considered as "givens" (e.g., experiencing morning sickness or preeclampsia) as opposed to factors that an individual can directly influence. The selected categories each have a participation rate of 100%, meaning that all the women

Table 2
Summary of Key Themes and Examples of Critical Incidents for Each Category

Theme	*Categories*	*Example of critical incident*
Personal Factors	**Attitudes and Expectations**	"One of my close friends is a maternity nurse, so she was able to give a lot of insight into what to expect" (helping)
	Personal Well-being	Trouble adjusting to the new body: "I had some struggle with my body image through my pregnancy just like the changes in my body, and sometimes feeling... like out of control" (hindering)
	Agency and Empowerment	Feeling empowered by choices and awareness: "so it was empowering for me too that I took the stance… I said… I really don't want this to happen and I don't want this" (helping)
	Spirituality and Meaning	Seeking spiritual and emotional support: "so I say to my husband come here…you need to pray for me. Like pray for me now" (helping)
	Staying Active	"Not being able to be active on my terms, so not being able to do prenatal yoga or dance, that most of my activity was hauling him around" (hindering)
	Financial Issues	"work was difficult at that point because it was slow, that was a financial stressor." (hindering)
Interpersonal Relationships and Support	**Family Support and Involvement**	Having sister to help around the house: "took care of the kids, and really handled some household stuff… went to the grocery store" (helping)
	Partner Relationship and Partner as Co-Parent	Husband's excitement about getting pregnant: "It felt very unsettling, but (husband) was super excited, and so that helped a lot because he couldn't believe it and he thought it was just great" (helping)
	Community Support and Connection	"We had a lot of support from our community, our friends and our family, and even prayer" (helping)
Healthcare Resources and Information	Caregiver	Lactation consultant advocacy: "she also affirmed that it was definitely my right to go in there and hold my baby whenever I wanted, so that was sort of made me feel more empowered to fight for skin to skin time, and fight for the opportunity to nurse him... that sort of made me feel like I was going to be more comfortable putting my foot down with them" (helping)
	Healthcare Support	"I love that program that they do, they came to my house three separate times, and it was like always like at the perfect time I was always like losing my mind, 'oh my god I wasn't doing something right, or this isn't going right' and they would show up and that was really like I really enjoyed having that service" (helping)
	Preparation	"Feeling prepared for postpartum period from books and then reading ahead too about what was to come was helpful because I felt like I was more knowledgeable and if you know what's coming it's easier to deal with" (helping)

(continued on next page)

Theme	*Categories*	*Example of critical incident*
Healthcare Resources and Information *(continued)*	Information	"I wish I would have had more information about a midwife, and how you don't have to only see a doctor, there are other options, and I didn't know any of them, and I didn't have any information and I just wish I would have had all the information so I could have made the decisions sooner" (wish list)
Labour and Birth Environment and Experience	Labour and Postpartum Environment	Discomfort in hospital environment "I just didn't want to be in the hospital. It was uncomfortable… and I didn't really want the baby to be around the hospital environment" (hindering)
	Labour and Delivery Experience	"It was a long; it ended up being 45 hours, it was a long, long labour" (hindering)
	Non-Medical Pain Management	Labouring at home in the birth pool with cd's: "I came home and things got going along faster... I was in the pool right away, and had the cd's on it was helping, it wasn't pain-free, but it was soo much more relaxed, I think I spent the majority of it with my eyes closed" (helping)
Parenting and Baby Characteristics	Baby's Characteristics	"I think he was a colicky baby, whenever he had a bowel movement, or a burp or a fart, he experienced it really intensely, and he would just cry and cry… as a newborn, he would just cry all the time, and we were bouncing swinging, rocking everything" (hindering)
	Connection with Baby	"It hindered my experience of him in the pregnancy because I wasn't overly connected in the very beginning, I remember like physically I knew I was pregnant but there wasn't that connection" (hindering)
	Parenting	Parenting demands: "having two children who are very different than each other, and having to figure out how to balance that… I think the hardest time is when they're both clearly very needy, when I'm putting him down for a nap and snuggling him, and she's screaming" (hindering)
	Breastfeeding	"They taught me how to pump, they taught me about formula, I got the support with breastfeeding" (helping)
Community and Macrosystem	Workplace Policies and Experiences	Working too much during pregnancy: "I would work sometimes up to 70 hours per week, and then I didn't have daycare… just being very tired and not having time to rest really" (hindering)
	Cultural Attitudes	Feeling judged by others' misperceptions: "they're just going to think of us as just that Christian family that has all these kids, and so being concerned about how other people viewed us, and having another kid" (hindering)
Personal Health and Medical Factors	Medical Concerns	Having so many medical appointments: "I have a prolapsed uterus, so that requires a gynecologist to look at you, and for your family doctor to look at you, and your physical therapist to look at you" (hindering)
	Medications and Interventions	Pain medication (gas) helped rest: "I was so exhausted it just helped me rest" (helping)

Note. The categories examined in this manuscript are presented in **bold** text.

Table 3
Summary of Categories Ranked in Descending Order of Number of Critical Incidents

Category Name	Helping (HE), Hindering (HI), Wish List (WL)	Pregnancy (PR), Birth (B), Postpartum(PO)	Participation Rate	Total Incidents
Caregiver support	HE, HI, WL	PR, B, PO	100% (N=13)	140
Attitudes and Expectations	**HE, HI, WL**	**PR, B, PO**	**100% (N = 13)**	**102**
Personal Well-being	HE, HI, WL	PR, B, PO	100% (N = 13)	89
Agency and Empowerment	**HE, HI, WL**	**PR, B, PO**	**100% (N = 13)**	**75**
Family Support and Involvement	**HE, HI, WL**	**PR, B, PO**	**100% (N = 13)**	**68**
Partner Relationship and Partner as Co-Parent	**HE, HI, WL**	**PR, B, PO**	**100% (N = 13)**	**59**
Community Support and Connection	**HE, HI, WL**	**B, PO**	**100% (N = 13)**	**51**
Pregnancy, Birth, and Postpartum Environment	HE, HI, WL	PR, B, PO	100% (N = 13)	48
Workplace Policies and Experiences	HE, HI, WL	PR, B, PO	77% (N = 10)	53
Spirituality and Meaning	HE, HI	PR, B, PO	46% (N = 6)	29
Healthcare Support	HE, HI, WL	PR, PO	77% (N = 10)	25
Labour and Delivery Experience	HE, HI, WL	B	69% (N = 9)	25
Preparation	HE, WL	PR, B, PO	62% (N = 8)	20
Connection with Baby	HE, HI, WL	PO	69% (N = 9)	19
Parenting	HE, HI	PR, B, PO	31% (N = 4)	19
Information	HE, HI, WL	PR, B, PO	54% (N = 7)	18
Breastfeeding	HE, HI, WL	PO	77% (N = 10)	17
Medical Concerns	HI	PR, B, PO	62% (N = 8)	17
Non-Medical Pain Management	HE	B	46% (N = 6)	12
Medications and Interventions	HE, HI	PR, B, PO	62% (N = 8)	11
Staying Active	HE	PR, PO	54% (N=7)	10
Baby's Characteristics	HE, HI, WL	PR, PO	54% (N = 7)	10
Cultural Attitudes	HI, WL	PR, B, PO	46% (N = 6)	11
Financial Issues	HI, WL	PR, PO	31% (N = 4)	9

Note. This table summarizes all of the categories found, ranked from highest to least number of critical incidents, and indicates whether they represented helping (HE), hindering (HI), or wish list (WL) items, and whether they occurred in pregnancy (PR), birth (B), or postpartum (PO), the participation rate represented in the category, and the total number of incidents. The categories examined in this manuscript are presented in **bold** text.

shared incidents which were coded in each one. In the following section, the number of corresponding CIs for each category will be reported along with a description of the category and examples of representative quotes from the participants.

Theme 1. Personal factors

Attitudes and expectations. This category includes incidents about women's subjective attitudes and expectations towards pregnancy, birth, and the postpartum period including feelings of acceptance, fears, worries, longings, and emotional responses to unmet expectations. A total of 102 incidents were coded in this category, inclusive of helping, hindering, and WL incidents.

Helping incidents were characterized by positive, flexible, and realistic expectations and attitudes, which helped the participants to cope or do well in some way. The incidents in this category reveal that women's ideas about what will happen, and their emotional and cognitive responses to what does happen, are important aspects of their thriving. For example, some participants coped with the challenges of pregnancy, such as exhaustion or nausea, by understanding that these would not continue indefinitely. One first time mom described how watching a birthing video in her prenatal class allowed her to normalize her experience of birth as it was occurring:

> I was feeling confident about going into it, they did show a couple of videos in prenatal class, and one really freaked me out, and I thought 'oh maybe that's not helpful to see what's going to go on.' But at the time, it was helpful because I knew this is normal, this is what happens.

Hindering incidents in this category were women's own personal attitudes towards pregnancy and birth in particular. This included feeling fear or anxiety, guilt, difficulty adjusting to the challenges of their current experience, or having difficulty "letting go" of past or current events which created emotional distress. For several women in the study, their expectations of birth did not reflect their actual experience, making it more difficult for them to cope physically and psychologically during labour.

The hindering experiences in the category of attitudes and expectations were not limited to women's unmet expectations of birth, but also included how they believed their child-bearing experiences impacted those around them. What the hindering attitudes and expectations demonstrated, overall, was that women's actual experience of well-being was negatively shaped by attitudes characterized by fear, anxiety, guilt, and rigidity. This supports the importance of seeing women holistically in their childbearing experience.

Only one woman offered a WL incident coded in this category, describing wishing to have healthier expectations about what is normal throughout the whole child-bearing experience. This new mother describes an experience shared by several of the mothers in this study: feeling worry about her circumstances, the progress of labour, the health of the baby, and the success of breastfeeding, without knowing for certain if what she was experiencing was normal. Through

the helping, hindering, and WL examples of this specific category, it is clear that women's attitudes, expectations, feelings, beliefs, and longings, significantly influenced their experience of well-being during the prenatal, birth, and postnatal period. This area presents a key opportunity for counselling and mental health care providers, as well as primary maternity care providers, to intervene in helping women reframe challenging experiences, have accurate expectations, and think realistically about what is to come.

Agency and empowerment. This category was created to capture the experiences women had of empowerment or disempowerment, agency, and silencing. At times these incidents occurred within the woman herself, either as she felt her strength in the choices she made or what she did, or in not doing or saying what she really wanted to express. Other times, incidents occurred relationally, as women felt silenced or shut out from the decisions that others made on their behalf or empowered to step in and advocate for themselves.

In helping incidents, the participants described self-determination in their pregnancy, birth, and the postpartum period in a variety of ways. This included them advocating for themselves with care providers, for example asking for more tests to be done, declining certain interventions, or telling the care providers or family members what they felt they really needed. Most saliently, women reported feeling that the act of birth itself was empowering and helped them feel like they were participating in something powerful that connected them to other women who had also experienced this both normative and extraordinary event. One participant said simply, "birth is empowering... like wow, I get to push this child into the world… amazing, like, I'm a woman."

Women's stories of embodied empowerment during birth revealed women's potential to have a complex experience, one which is simultaneously empowering and marked with urgency, pressure, and fear. Because of the medical involvement with birth, and the potential for life-threatening consequences, it is important for women to have competent and knowledgeable care providers. Being able to have a voice with care providers and feeling informed and supported by care providers to make autonomous choices was important to all participants interviewed.

The hindering experiences women described included their feelings of being silenced, or the felt sense of being silenced, either by their care providers, the hierarchy inherent within the medical system, or themselves. Although not the focus for this article, participants reported care providers as both a significant contributor to their well-being and their experience of disempowerment. For the women who felt disempowered and unable to fight for what they needed, they addressed this in the WL category. Several of the women wished that they would have been in a more empowering environment, with more collaborative care providers. Others reported wishing to have a stronger voice within that environment, to advocate for what they needed. Because of the discontinuity of care within the hospital system, having nurses change all the time made it difficult for one woman to feel like she could build a secure enough relationship with one nurse to ask for what she needed. She says,

> I would have felt more comfortable voicing my concerns, with the new nurse all the time. I kind of did feel like I should be polite, but if it was someone I felt more comfortable with I do feel like I could have been able to communicate more honestly on my end... there was no relationship.

In her statement, she articulates how both the system, the providers, and herself were all involved in her feeling unsure and disempowered.

The helping, hindering, and WL items demonstrate the importance of agency for women during pregnancy, birth, and postpartum. In many circumstances, women were able to feel empowered to endure difficult situations or were supported by those around them to access their felt sense of strength. Care providers working with women during the pregnancy and postpartum period have an opportunity to support women in being aware of and validating their needs and preferences, attuning to their bodies, making personally congruent decisions, and speaking up for themselves effectively with their care providers.

Theme 2. Interpersonal Relationships and Supports

Partner relationship. For each of the women in this study, their relationship with their partner was a significant influence on their well-being. Helping incidents included emotional support through encouragement and shared joy about the pregnancy, and practical involvement and support, such as preparing meals and caring for other children. Several women reported having difficulty with the physical changes which accompany pregnancy, including their changing weight and shape, and their stretch marks. Several women commented about how their spouses helped them adjust to their new pregnant bodies and changing appearance. One woman described feeling ashamed about her body dissatisfaction and how her husband helped her see things differently. She shared,

> I remember sitting with my husband and just being open, like I feel so shallow, but he was very understanding and listening and I didn't feel judged by him… he kind of again transformed that experience for me through talking and thinking about what it really means to have those changes in my body.

The physical changes also occur postpartum, a time which several women reported feeling cultural pressure again to appear a certain way and return to their pre-pregnancy body. The women's narratives highlight the importance of having a partner during the pregnancy and postpartum period, with whom they can journey together.

Participants also reported hindering and WL incidents about their partners, including wishing for their partners to be more emotionally present or wishing their husbands were home more and did not have to work so far away, or such long hours. Other women mentioned how important it was for them that their husbands read informative books in preparation for birth or attend prenatal appointments. One woman identified how her limited ability during pregnancy, especially with parenting, put extra stress on her husband and her marriage, causing her to feel guilty. WL items included having a partner involved more

in preparation for birth. For example, one woman wished to have been able to practice hypnobirthing skills together with her spouse.

The CIs representing the category of partner relationship reflect how important it is for women to be able to stay connected to their partner throughout the challenges and changes during the pregnancy and postnatal period. The specifically female aspects of the physical elements of women's experiences of pregnancy, birth, and breastfeeding, are juxtaposed with the "we-ness" of couples becoming parents together and being able to share in meeting physical and emotional needs that arise during pregnancy, birth, and postpartum. There are obvious implications in the importance of providing psychosocial support to both men and women in this critical period of a woman's life. Counsellors can proactively involve partners in counselling, with a focus on preparing the partner—both in their understanding and emotional attunement—for shared responsibility and maintained connectedness during this period.

Family support and involvement. Every participant mentioned incidents related to their family's involvement as significant for their well-being. This category includes all family members beyond the partner, such as parents, siblings, stepparents, and in-laws. When listening to women's stories, mothers were spoken of so often we had originally created a specific category, called "mothers," but ultimately collapsed the category of mothers with other family members, who were less frequently referenced. Even for participants whose mothers were no longer living, participants referred to their absence.

Helping incidents pertaining to family involvement spanned pregnancy, birth, and the postpartum period, as family members provided both emotional and logistical support. They helped with babysitting older children, providing encouragement and physical comfort during labour, preparing meals, offering support and guidance with the newborn, talking participants through their fears and worries, and celebrating the positive things which occurred. For one participant, her sister's emotional support was particularly salient. She says of her sister, "She'd come up and sit and talk with me... just having her around is, she makes me laugh more than anyone, she's very passionate, she was so excited about the birth."

Participants described having someone to support and encourage them emotionally was a helping factor. This most often came from mother figures, including their mothers, stepmothers, or mothers-in-laws. They said things like,

> My mom came a lot, she would call and check-in, "How are you doing, what do you need, do you want me to take the kids" or she stayed with me through the night… [my husband] got to sleep and she rubbed my back and helped me count contractions.

Regarding how a mother supported one participant during the challenging postpartum moments, she said,

> My mom came over every day, cried with me when I was having trouble breastfeeding, and I thought I might have to give up on breastfeeding, you

> know crying with people, people giving me hugs, you know, physical stuff is important as well, being comforted by people.

Not all the women had mothers who were physically present, but all felt that their mothers affected their well-being in some way.

Women also spoke about family members when describing hindering incidents. At times, women reported family member's comments or actions being hindering as they felt they needed support and encouragement from those closest to them but did not receive it. Other hindering factors included when family members made judgmental or insensitive comments about their care provider choice, how they were caring for their new child, or when family members were either not available or too intrusive. One participant reported how her mother, although well-meaning, interfered in a way that was unhelpful during labour: "My mom kept telling me I wasn't breathing and I wasn't relaxed, and that was annoying to me because I felt like I was... and I didn't know how to communicate that." One woman's stepfather referred to her unborn child as "another mouth to feed," dismissing the value and significance of this child in the woman's experience.

For postpartum women, the expressed support of their mothers and mothers-in-law was not always helpful. For example, the vulnerability of that period made one woman feel uncomfortable having her in-laws present. Similarly, another woman described how her mother in law's show of concern induced anxiety. WL incidents pertained to wishing for more family support, such as a mother's presence at birth, and establishing clearer boundaries with family members about what was helpful. Overall, women whose family members were most helpful supported the mother to do what she felt she needed and offered guidance and information when requested. While family members are not usually directly involved in counselling services, counsellors can help women and their partners to communicate effectively with family members about their needs and boundaries.

Community support and connection. From an ecological systems perspective, we have presented the categories thus far in the order of proximal to distal factors, starting with individual factors, which were the most heavily cited incidents and closest to one's personal experience, and moving then to incidents within microsystem relationships. The category of community support and connection includes relationships outside of the family which are embedded in contexts such as neighbourhoods or faith communities. Participants reported the felt importance of being supported practically and emotionally in their communities.

The practice in some communities of bringing meals to a woman during the postpartum period was mentioned several times as helpful. One woman said, "Oh, our neighbours have brought us meals, like every other day we get a meal," and another reported, "One of our church members had arranged to make meals for us... I don't think I cooked for the first month."

Women also described the significance of having a sense of belonging in their communities and emotional support with close friends and mentors. Describing the role of community in filling the felt need for a maternal presence, one woman

described how other women from her community supported her, saying, "They were super excited about the baby, and with my mom being so far away, I needed kind of moms around." Another described how helpful her friendship with a close girlfriend was to her in providing emotional support. WL items in this category similarly echoed the significance for women to share the pregnancy and motherhood journey with others.

Hindering incidents in the category of community support and connections referenced disruptions in friendships associated with the pregnancy and new baby, either because they represented a new life focus, which took a woman away from previous friendships, or because it introduced a complicated dynamic with friends struggling with infertility. One woman offered a glimpse at the complexity of maintaining a close friendship bond when one person's joy triggered another's experience of pain and loss, saying "Announcing that we were pregnant to people I know are longing for babies is sooo hard because I don't want to trigger their pain, but I also want them to be a part of it."

Hindering incidents in the category of community support and connections also represented negative comments, attitudes, and uninvited input from others, which devalued the pregnancy or baby. One woman said, "We had several people mention to my husband at the coffee shop [where he works] 'Oh you're having another, a *third* child?' Like oh, your wife is pregnant *again*?" Another woman described feeling that her third pregnancy was trivialized in significance, saying, "Sometimes our babies get downplayed because it's like 'Oh they're just having another' instead of people joining in and being joyful."

In summary, incidents represented in the category of community support and connections reinforced the significance for women to belong, to receive practical help, and to share the emotionally significant experience of pregnancy and motherhood with others. Incorporating psychosocial aspects into group-based maternity care, offering pregnancy and postpartum support groups, and helping women to cultivate meaningful friendship and community connections are all practical ways that counsellors and psychologists can support women to engage social support effectively during the child-bearing period.

DISCUSSION

The rationale for this research was to learn directly from women which factors most significantly shaped their experiences of well-being during pregnancy, birth, and postpartum, to better promote women's and infants' needs. According to Bronfenbrenner's (1979) ecological model, the categories elaborated in this article pertain to individual and microsystem factors, which are clearly embedded in community and macrosystem factors. This highlights the influence of sociopolitical factors such as cultural attitudes about gender role expectations, values influencing the medical system, and media portrayals of pregnancy and birth. The most common areas for direct intervention pertain to the individual and microsystem.

The well-being of women who participated in this study was heavily influenced by their attitudes and expectations. Related to this was their sense of agency and empowerment through the child-bearing period (theme 1). Women's perception of their birth, including well-being during birth, has been found to shape their experience in the postpartum period (Conde et al., 2008). Accurate information can also reduce fear, which has been identified as a predictor of reduced overall well-being (Biehle & Mickelson, 2011). Therefore, this provides encouraging evidence that sharing knowledge and information with women will contribute to realistic and positive attitudes and, as a result, favourably impact how they experience their pregnancy, birth, and, postpartum adjustment.

One of the findings that is perhaps surprising is that "childbirth pain" was absent in the CIs. The physical demands women endure during birth, which may be painful, are not necessarily construed negatively. Pain is clearly less important than the relationship with care providers, support persons, and the experience of personal agency (reported through helping experiences of advocating for oneself or as hindering incidents concerning feeling silenced and disempowered). This finding is significant because it highlights an area that can be directly influenced by psychosocial support. Counsellors can help women prepare for birth and communicate effectively, respectfully, and assertively with their care providers, to know and trust their bodies, and to be able to "let go" of what they cannot control.

Next in the volume of CIs are the categories of social support, exemplified through the relationship with the partner and the partner's role as a co-parent, and the role of the extended family and community (theme 2). The presence and involvement of a partner, including non-professional support, at birth has been shown to provide comfort, meaning, and strength for women, and promotes more positive interactions between a mother and baby following the birth (Kainz et al., 2010). In line with this, a partner's involvement in the whole experience was found to be important in fostering shared responsibility for parental caregiving and to understand how partners can be helpful to the pregnant, birthing, and postpartum woman.

Furthermore, a secure attachment with one's partner has been found to contribute to emotion regulation during the period of becoming a parent (Behringer et al., 2011). This finding was supported in the present research, with several women referring to helping, hindering, and WL factors related to emotional attunement and support from their partners. In addition to facilitating ways for women to cultivate emotional bonds and strong communication between themselves and their partners, counsellors and psychologists can support a woman in reaching out for and receiving care from their practical support systems. The participants in this study represented some who had well-developed support networks bringing meals and helping with daily life and others who felt isolated and like a burden when asking for help. Being aware of the physical and emotional strain associated with the postpartum period can help normalize the importance of receiving help and even proactively hiring extra support, such as a postpartum doula.

Applications for Counselling Psychology Research and Practice

The establishment and increasing acceptance of midwifery care in Canada have offered a growing recognition of the importance of holistic care and well-being during pregnancy, birth, and postpartum. Women have multiple interconnected psychosocial factors influencing their well-being during this period, and professionals have the opportunity and responsibility to gain knowledge and offer services relevant to these needs. Psychologically-informed, collaborative, and interdisciplinary prenatal and postnatal care help to expand resources and promote women's empowerment during pregnancy, birth, postpartum, and motherhood. The following recommendations address broad strategies for providing psychosocial care for women, their partners, and providers, in conducting research with the transformative aim of improving the well-being of childbearing women.

Providing direct care to women during pregnancy, birth, and postnatal is likely the most obvious way for counsellors and psychologists to support women's well-being. Counsellors and psychologists can support women to work with their reactions to the child-bearing experience and support them to choose the narrative she constructs to cope with what occurs during this period.

Counselling psychologists can play an important role in helping women adapt to the demands of their pregnancy and postpartum recovery, and the interrelated events and demands of life, which emerge to create unique and often unforeseen challenges. Direct psychosocial care to women can occur during pregnancy, as preparation for birth and motherhood, and in the postpartum period.

During pregnancy, it is recommended that counsellors work with women to identify and work through factors which negatively influence their birth expectations and readiness. These factors may include personal and familial birthing history; sexual and birth-related trauma (from previous births); working through pregnancy losses; body image; social support needs; psychosocial pain management; and the woman's relationship with her partner, extended family, and community support system. During the postpartum period, counsellors and psychologists can help women make sense of and integrate the positive and negative aspects of their birth experiences, and to adapt to the changes and challenges presented during the postpartum period. These changes and challenges may include breastfeeding, coping with infant sleep patterns, relationship changes, body changes, and maternal identity.

Counselling psychologists are also able to look beyond traditional 1:1 service delivery. They can provide consultation to women and their care providers to promote collaboration and understanding around expectations, roles, decision-making processes, and effective forms of support. Further research with diverse populations and provider types continues to be needed to explore the contributing factors to an optimal growth-enhancing pregnancy and birth experience from an explicitly psychosocial perspective, particularly from the voices of mothers themselves. The subjective experiences of mothers are necessary for informing best practices in maternal psychosocial care.

CONCLUSION

Experiences of pregnancy, birth, and motherhood shape women's lives in many complex ways. Many factors work together to shape this series of significant events in a woman's life. Salient among these factors are the woman's attitudes and expectations about child-bearing, her experience of personal agency and empowerment, and her relationships with her partner, family, and community. The field of counselling psychology, which is concerned with promoting growth, well-being, and mental health of individuals, families, and communities, has a significant opportunity to offer practical and helpful resources to child-bearing women through counselling, consultation, education, research, and health promotion.

References

Andersson, B. E., & Nilsson, S. G. (1964). Studies in the reliability and validity of the critical incident technique. *Journal of Applied Psychology*, *48*(6), 398.

Behringer, J., Reiner, I., & Spangler, G. (2011). Maternal representations of past and current attachment relationships, and emotional experience across the transition to motherhood: A longitudinal study. *Journal of Family Psychology*, *25*(2), 210.

Biehle, S. N., & Mickelson, K. D. (2011). Worries in expectant parents: Its relation with perinatal well-being and relationship satisfaction. *Personal Relationships*, *18*(4), 697–713.

Borgen, W. A., & Amundson, N. E. (1984). *The experience of unemployment: Implications for counselling the unemployed*. Scarborough, ON: Nelson Canada.

Bornstein, M. H. (2014). Human infancy ... and the rest of the lifespan. *Annual Review of Psychology*, 65, 121–158. doi:10.1146/annurev-psych-120710-100359.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments in nature and design*. Cambridge, MA: Harvard University Press.

Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. In W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology, Vol. 1: Theoretical models of human development* (6th ed., pp. 793–828). New York, NY: John Wiley.

Bryanton, J., Gagnon, A. J., Hatem, M., & Johnston, C. (2009). Does perception of the childbirth experience predict women's early parenting behaviors? *Research in Nursing & Health*, *32*(2), 191–203.

Butterfield, L., Borgen, W., Amundson, N., & Maglio, A. (2005). Fifty years of the critical incident technique: 1954–2004 and beyond. *Qualitative Research*, *5*(4), 475–497.

Butterfield, L., Borgen, W., Maglio, A., & Amundson, N. (2009). Using the Enhanced Critical Incident Technique in counselling psychology research. *Canadian Journal of Counselling/ Revue Canadienne de counseling, 43*(4), 265–282.

Carter, S. K. (2010). Beyond control: Body and self in women's childbearing narratives. *Sociology of Health & Illness*, *32*(7), 993–1009.

Chalmers, B., Dzakpasu, S., Heaman, M., & Kaczorowski, J. (2008). The Canadian maternity experiences survey: An overview of findings. *Journal of Obstetrics and Gynaecology Canada*, *30*(3), 217–228.

Chuang, C. H., Liao, H. F., Hsieh, W. S., Jeng, S. F., Su, Y. N., & Chen, P. C. (2011). Maternal psychosocial factors around delivery on development of 2-year-old children: A prospective cohort study. *Journal of Paediatrics and Child Health*, *47*(1–2), 34–39.

Conde, A. A., Figueiredo, B., Costa, R., Pacheco, A., & Pais, Á. (2008). Perception of the childbirth experience: Continuity and changes over the postpartum period. *Journal of Reproductive and Infant Psychology*, *26*(2), 139–154.

Dahlen, H. G., Barclay, L. M., & Homer, C. S. (2010). Processing the first birth: Journeying into 'motherland.' *Journal of Clinical Nursing*, *19*(13–14), 1977–1985. doi:10.1111/j.1365-2702.2009.03089.x

Declercq, E., & Chalmers, B. (2008). Mothers' reports of their maternity experiences in the USA and Canada. *Journal of Reproductive and Infant Psychology*, *26*(4), 295–308.

Flanagan, J. C. (1954). The critical incident technique. *Psychological Bulletin*, *51*(4), 327.

Hart, R., & McMahon, C. A. (2006). Mood state and psychological adjustment to pregnancy. *Archives of Women's Mental Health*, *9*(6), 329–337.

Kainz, G., Eliasson, M., & von Post, I. (2010). The child's father, an important person for the mother's well-being during the childbirth: A hermeneutic study. *Health Care for Women International*, *31*(7), 621–635.

Kwee, J. L., & McBride, H. L. (2015). Working together for women's empowerment: Strategies for interdisciplinary collaboration in perinatal care. *Journal of Health Psychology*, *21*(11), 2742–2752. doi:1359105315586211

Lawton, R., Gardner, P., & Plachcinski, R. (2011). Using vignettes to explore judgements of patients about safety and quality of care: The role of outcome and relationship with the care provider. *Health Expectations*, *14*(3), 296–306.

Loth, K. A., Bauer, K. W., Wall, M., Berge, J., & Neumark-Sztainer, D. (2011). Body satisfaction during pregnancy. *Body Image*, *8*(3), 297–300.

McBride, H. L., & Kwee, J. L. (2016). Focusing on the mother in maternal health care: A literature review of perinatal mental health needs and favourable interventions. *Journal of Psychological Therapies in Primary Care*, *5*(1), 1–25.

Rossen, L., Hutchinson, D., Wilson, J., Burns, L., Allsop, S., Elliott, E. J., ... & Mattick, R. P. (2017). Maternal bonding through pregnancy and postnatal: Findings from an Australian longitudinal study. *American Journal of Perinatology*, *34*(08), 808–817.

Rossen, L., Hutchinson, D., Wilson, J., Burns, L., Olsson, C. A., Allsop, S., ... & Mattick, R. P. (2016). Predictors of postnatal mother-infant bonding: the role of antenatal bonding, maternal substance use and mental health. *Archives of Women's Mental Health*, *19*(4), 609–622.

Rossen, L., Mattick, R. P., Wilson, J., Burns, L., Macdonald, J. A., Olsson, C., ... & Hutchinson, D. (2018). Mother–infant and partner–infant emotional availability at 12 months of age: Findings from an Australian longitudinal study. *Infancy, 23*(6), 893–916.

Sabuncuoglu, O., & Basgul, A. (2016). Pregnancy health problems and low birth weight associated with maternal insecure attachment style. *Journal of Health Psychology*, *21*(6), 934–943.

Seligman, M. E., & Csikszentmihalyi, M. (2000). Special issue on happiness, excellence, and optimal human functioning. *American Psychologist*, *55*(1), 5–183.

Topiwala, A., Hothi, G., & Ebmeier, K. P. (2012). Identifying patients at risk of perinatal mood disorders. *Practitioner*, *256*(1751), 15–19.

Yakushko, O., & Chronister, K.M. (2005). Immigrant women and counselling: The invisible others. *Journal of Counseling and Development*, *83*(3), 292–298.

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