# An Examination of the Knowledge, Attitudes and Perceptions Regarding Perinatal Mood Disorders Among Birth and Postpartum Doulas

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## Abstract

An Examination of the Knowledge, Attitudes and Perceptions Regarding Perinatal Mood Disorders Among Birth and Postpartum Doulas

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**Introduction:** Perinatal Mood Disorders (PMD), including depression, anxiety, obsessive-compulsive disorder and stress disorders, disrupt the mental health of mothers during one of the most vulnerable, challenging periods of their lives, with low-SES women experiencing a greater number of stressors and factors associated with the development of PMD. Doulas are lay health workers who build their entire practice around serving the mother's practical and emotional support needs. Previous research revealed that women who utilize either birth or postpartum doula services have demonstrated positive birth experiences, earlier lactation onset and better breastfeeding experiences, and greater confidence in their abilities as a mother. The presence of a doula providing emotional support, such as listening reflectively to a distressed or frustrated new mother, and practical support, such as ensuring the mother and baby can get into a good sleep routine, might offer one solution for early detection of PMD. To what degree, if any, are doulas trained to recognize symptoms of PMD in their clients, and how would their own knowledge,

attitudes and perceptions regarding PMD impact their relationship with a client whom they suspect may be suffering?

**Methods:** Twelve doulas from the Seattle area were interviewed regarding their level of experience, insights on the preparation and training requirements for new doulas, and experiences with clients suffering from PMD.

**Results:** All of the doulas had been practicing for over one year. Nine of the twelve (75%) felt the training they received in doula certification programs regarding PMD was inadequate for the situations they had experience with clients, and many doulas relied on continuing education courses to learn more about PMD. All twelve doulas reported assisting clients perceived to be suffering from PMD.

**Discussion:** Each of the participants emphasized the supportive role of the doula throughout the perinatal period, particularly in providing emotional support to the mother. The collective attitudes toward PMD were to take action and help clients develop a solution – more sleep for the mother, more time spent outdoors, a referral to a support group, or an appointment with a medical provider or therapist; however, many emphasized that doulas cannot diagnose or treat mental health issues, only empower the client to seek help. Each of the participants identified gaps in the training they received regarding PMD and expressed what they felt was a critical need for more in-depth training, including instruction on the many forms of PMD, any knowledge of recent research on PMD, and how to address PMD with clients and families. The participants in this study spoke confidently about their role in nurturing, guiding, and validating mothers and parents during an extremely vulnerable time – a crucial continuity of emotional support for mothers, especially high-risk mothers.

**Title:** An Examination of the Knowledge, Attitudes and Perceptions Regarding Perinatal Mood Disorders Among Birth and Postpartum Doulas

*Introduction*

Perinatal Mood Disorders (PMD), including depression, anxiety, obsessive-compulsive disorder and stress disorders, disrupt the mental health of mothers during one of the most vulnerable, challenging periods of their lives. Postpartum depression alone affects 10-15% of women.[1] Low-income mothers experience a greater number and degree of stressors and factors that contribute to the development and severity of PMD than middle- to high-income mothers. Low socioeconomic status (SES) and lack of a social support system are two of the biggest contributors to the onset of PMD, particularly depression.[2]

Doulas are lay health workers who build their entire practice around serving the mother's practical and emotional support needs. DONA (Doulas of North America) International, which is the largest doula certification organization in the world, reported over 10,000 members in 2013.[3] The Pacific Association of Labor Support, or PALS Doulas, is a local Puget Sound-based doula membership organization and last reported 170 members.[4] The Northwest Association for Postpartum Support, or NAPS, is a Seattle-area organization providing education, certification and advocacy for local postpartum doulas.[5] In the US, many organizations offer doula services--typically, either birth doulas, who support the mother through her last trimester and the birth, or postpartum doulas, who provide emotional and practical support after the birth of the baby. Few organizations offer doulas who serve as both birth and postpartum supports. Most often, doula services are retained by the expectant parents or by a close member of the parents' community,

such as a family member or friend, as a gift to the couple. Doulas are occasionally contracted through a hospital system, and some are contracted at little or no cost through nonprofit organizations specifically serving low-SES families. Doulas are not currently part of the traditional medical model of perinatal care; however, women who utilize either or both types of doula services have demonstrated positive birth experiences, earlier lactation onset and better breastfeeding experiences, and overall profess greater feeling of self-efficacy and competence as a mother.[6]

Maternal responsiveness (bonding abilities) and feelings of competence have been associated with better cognitive, psychosocial and communicative developmental outcomes in children; however, both responsiveness and feelings of competence can be negatively impacted by the onset of PMD. The presence of a doula providing emotional support, such as listening reflectively to a distressed or frustrated new mother, and practical support, such as ensuring the mother and baby can get into a good sleep routine, might offer one solution for early detection of PMD. To what degree, if any, are doulas trained to recognize symptoms of PMD in their clients, and how would their own knowledge, attitudes and perceptions regarding PMD impact their relationship with a client whom they suspect may be suffering?

*Aims*

This study aims to explore the knowledge, attitudes and perceptions regarding PMD among active doulas. The findings of this project may illuminate opportunities to improve the training and preparation of doulas serving high-risk clients.

*Background*

Prevalence and impact of PMD

Perinatal depression, a term applicable to depression at any stage during (antenatal) and after (postnatal) pregnancy, has an estimated prevalence of 10-15% of all mothers.[1,2,7] Much research has been conducted to examine the risk factors for postnatal, or postpartum, depression, but risk factors and effects of antenatal depression have received less attention.[7] Antenatal depression occurs any time after conception and continues throughout the pregnancy and birth experience.

Recent research has discovered antenatal and postpartum depression share many of the same risk factors, such as low self-esteem, low social support, antenatal anxiety, and low income. In a study of the large pilot National Postnatal Depression Program in Australia, Leigh et al recruited 367 women to complete antenatal risk factor questionnaires and examined the relationships between perinatal depression and "parenting stress," which is the specific concept relating to the parent-child bond or interaction. While studies have concluded that postpartum depression negatively affects the development of the parent-child bond and, ultimately, negatively impacts the cognitive, behavioral and physical development of the child,[8,9] Leigh et al found that the occurrence of antenatal depression is strongly correlated with the occurrence and duration of postpartum depression. Their findings revealed that the key risk factors listed in the diagram below were directly related to the onset of antenatal depression, but not the onset of postpartum depression or, independently, the onset of parenting stress; however, if a mother experienced antenatal depression, she was at a greatly increased risk of experiencing postpartum depression, which would then act as a mediator for the occurrence of parental stress.[7]

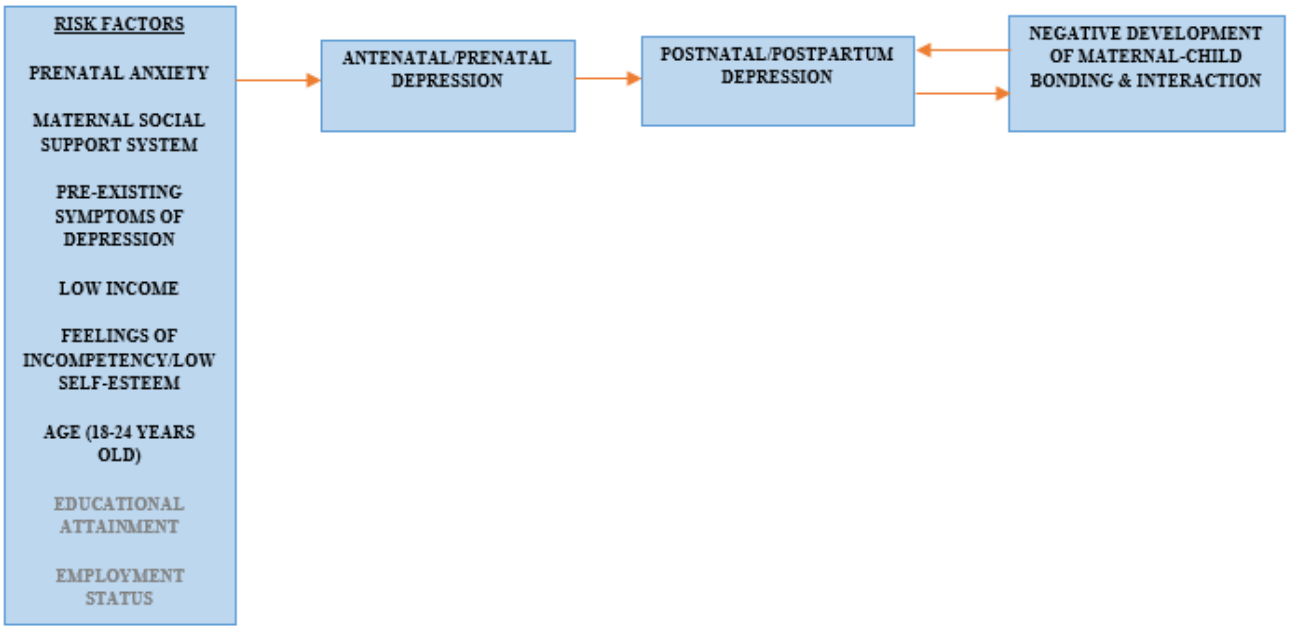



*Diagram of key risk factor effects on the onset of perinatal depression based on the results from Leigh et al.

Key concepts of interest gathered from a review of literature discussing perinatal depression are as follows:

- Onset of antenatal depression significantly influences the onset and duration of postpartum depression
- Key risk factors for both antenatal and postpartum depression include: antenatal anxiety, low self-esteem, low income, low or lack of social support, age (18-24 years old), educational attainment (in some studies), employment (in some studies) and previous miscarriages/abortions[2,10,11]

Recently, investigators have begun to delve more deeply into the causes, prevalence and effects of perinatal anxiety, obsessive-compulsive disorder (OCD), and stress disorders. In a 2017 study, Fairbrother, et al observed a higher incidence of perinatal anxiety disorder among women experiencing moderate- to high-risk pregnancy than those classified as low-risk pregnancies.[12] In an earlier study conducted in Canada, Fairbrother et al screened 310 pregnant

women for perinatal mood and anxiety disorders using a postpartum screening tool. Those with significant scores were interviewed at three months postpartum. The investigators found the prevalence of anxiety disorders (15.8-17.1%) was greater than that of depression (3.9-4.8%). They also observed a greater prevalence of OCD in their sample than among the general population, revealing an increased risk for OCD among pregnant and postpartum women.[13]

A 2016 study by Challacombe et al examined the effects of postpartum OCD on mother-infant interactions and parenting. Parenting stress was measured in mothers clinically diagnosed with OCD (n=37) and mothers without OCD (n=37) at six months postpartum, and symptoms of OCD were observed in both groups of participants; however, the "meanings [of] and responses [to intrusive thoughts]" differed between the OCD and non-OCD participants. The investigators also observed mother-infant interactions in both groups and rated the OCD mothers as "less sensitive" in their interactions with their infants, although the investigators noted this could also be attributed to concurrent symptoms of depression. The mothers with OCD reported lower rates of breastfeeding at six months postpartum, feeling less confident in their parenting and experiencing greater social stressors or a lack of support than the mothers in the control group.[14]

In 2013, Giannandrea et al investigated the risk of postpartum mood disorders, particularly depression and anxiety, associated with mothers who had experienced pregnancy loss prior to a subsequent live birth.[15] Of the 192 women recruited, 49% reported a previous loss through miscarriage, stillbirth or induced abortion, and 52% of women within that group reported more than one loss. The researchers found that women with a prior loss were more likely to receive a diagnosis of major depression, and those who experienced more than one loss were more likely to be diagnosed with major depression and/or post-traumatic stress disorder (PTSD). The study was conducted at an urban pediatric clinic, and the sample was comprised of low-income

women. This population has high rates of pregnancy loss and typically more than one loss, according to the researchers, thus increasing the risk within this population for depression, anxiety, and, potentially, PTSD.[15]

Challenges in the diagnosis and treatment of PMD

Almost every reviewed study discussed the difficulty of assessing the exact timing of onset of PMD. Studies that examined only postpartum depression typically had difficulty determining whether the depressive symptoms began specifically after the birth of the child or if symptoms existed undocumented or unreported prior to the birth of the child.[2,10] Likewise, studies that examined antenatal depression disclosed the limitations of their findings when determining the onset of antenatal depression—whether it occurred specifically after conception, or if the mother experienced chronic, unreported depressive symptoms prior to conception.[7,11] The onset of anxiety disorders were also difficult to determine; however, Challacombe et al observed "intrusive thoughts and compulsions" in both the case (mothers diagnosed with OCD) and control (non-OCD mothers) groups of their postpartum OCD study sample, although the frequency and intensity of these symptoms were greater for the OCD mothers. From this finding, they ascertained that OCD could be "triggered" by childbirth and postpartum parenting stress.[14] Another potential limitation in any study documenting the incidence or prevalence of PMD, particularly depression, may be the self-reporting factor of symptoms and the cultural stigma surrounding mental health struggles, specifically in poorer communities.

In the U.S., current routine prenatal care includes monthly visits with a patient's provider of choice, typically an OBGYN or Certified Nurse Midwife. At about 32 weeks, the patient begins biweekly visits with her provider, then weekly at about 36-38 weeks. Postnatal routine care consists of a single examination between 3-8 weeks postpartum with the patient's provider. The

National Guideline Clearinghouse, which provides guidelines for standard prenatal and postnatal care, recommends administering a depression screening at this postnatal visit, among the numerous other screenings and discussion topics to be addressed.[16] Current standards for postnatal care typically do not allow time for in-depth evaluation of the mother's mental and emotional well-being, as the provider's time with each patient is limited, and there is generally only one visit focused on the mother, six weeks postpartum.

In 2006, Noelle Borders, CNM, MSN, conducted a critical review of literature of postpartum health and found that many of the physical and psychological conditions new mothers described in the weeks following delivery "doggedly persist in a significant number of women beyond one year postpartum."[17] Since routine care in the US provides only a single 6-week postpartum visit that is centrally-focused on maternal health (while the many pediatric visits in the first year focus on the baby), this finding further emphasizes the gap in care and attention given to women postpartum. While birth – and some postpartum – doulas may only provide a limited number of visits up to six weeks postpartum, doulas conduct home visits with clients which often allow for longer, more in-depth discussions and observations than what might be provided in a typical 6-week postpartum medical follow-up. The advantage of more time spent with the client and the client's level of comfort allows for the possibility that doulas could gain insight into the struggles or unhealthy adjustments mothers may experience postpartum and become a frontline in intervention by steering clients to available resources or mental health providers. Many of the studies reviewed revealed that mothers experience "an array of symptoms [beyond six weeks postpartum] which they may never report to health care providers."[17] This could strengthen the case for the use of trained doulas to provide continuity of care to new mothers during the immediate (six weeks) and extended (one year) postpartum period.

Doulas provide important perinatal resources to women and families

Certified birth doulas will typically meet with clients three times prior to the birth, beginning about 2-3 months prior to delivery. During preliminary visits, the doula supports her client as they develop a birth plan based on the mother's expectations, fears and goals. The doula is also trained to listen and emotionally support her client as she prepares for the daunting experience of childbirth and the reality of parenthood. The birth doula remains available to her client throughout the entire birth process as a source of affirmation, encouragement, emotional and physical support. Typically, birth doulas also provide 1-2 visits postpartum during the first few weeks following childbirth. During these visits, the doula observes how the baby has been integrated into the family. The doula again listens to any concerns from the parents and provides resources and emotional support as necessary.[18]

Certified postpartum doulas offer services following childbirth that often extend to three months postpartum. A postpartum doula offers both emotional and practical support during this period, which is often referred to as "the fourth trimester." Postpartum doulas respond to concerns about breastfeeding, sleep patterns and any additional questions the parents might have regarding the new baby. The postpartum doula will provide resources and referrals when necessary. Postpartum doulas often offer practical assistance to parents, such as house-cleaning, meal preparation, and errands.[3]

DONA began a postpartum certification program in 2002 and is the largest certifier of postpartum doulas in the US.[3] During the DONA certification process, aspiring birth doulas log 32 hours of workshop instruction and training, which includes a brief discussion of postpartum mood disorders and symptomatic behaviors the birth doula can identify during postpartum visits.[18] The workshop manual devotes two pages to the topic of postpartum mood disorders,

primarily postpartum depression, including a one-page "Unhappiness after Childbirth" survey the birth doula can administer to clients.[18] According to the DONA website, aspiring postpartum doulas are required to read at least one book on the topic of postpartum mood disorders as part of the certification process.[3]

Doulas' impact on postpartum experience

Both birth and postpartum doulas cultivate uniquely intimate relationships with clients by offering emotional and practical support for mothers. In a randomized control trial, Gjerdingen et al evaluated the benefits of postpartum doula support compared to peer telephone support for at-risk mothers. The 39 recruited mothers were randomized into three groups: those receiving postpartum doula support; those receiving telephone support from a peer group comprised of survivors of postpartum depression; and, a control group. The mothers were surveyed at 0, 3, and 6 months post-enrollment. At the 6-month follow-up, the mothers in the postpartum doula support group expressed greater satisfaction with the quality of support received than those in the peer telephone support or control groups. Participants appreciated both the emotional and practical support from the doulas, while those in the peer telephone support group received only emotional support. The researchers determined that "face-to-face" time is a known preference for support for depressed mothers.[19]

In a 2013 study examining the effects of birth doula support in the promotion of positive mother-infant relationships, Hans et al addressed the "unique opportunity [of birth doulas] to play a role in supporting early parent-child relationships."[20] Birth doulas are present during the highly-emotional, intimate labor and delivery experience. Both birth doulas who include postpartum visits and postpartum doulas acknowledge the struggles of new mothers to integrate a new baby into the family unit and guide mothers in learning, understanding and responding

appropriately to the needs and behaviors of their baby. Community birth and postpartum doulas have the particular knowledge of specific maternal expectations and perceptions of parenthood within the community they serve and can assist mothers with a culturally-competent approach. Hans et al state, "The community doula model relies on a foundation of a strong, trusting relationship between the doula and the mother."[20]

The researchers constructed a randomized trial of a birth doula support intervention for low-income mothers under the age of 22 years, in which 248 pregnant women were assigned to either receive birth doula support or routine care through pregnancy and three months postpartum. Parenting methods and stress were assessed in video recordings and via maternal report at 4, 12 and 24 months postpartum. The study specifically examined the benefits of a community doula program using birth doulas as specially-trained home visitors.[20]

The mothers in the intervention group demonstrated more positive interactions with their babies and were more responsive to the needs of their babies at the 4-month follow-up, results that were statistically significant relative to those receiving routine care. These mothers also reported lower levels of parenting stress than mothers in the control group (p=124). These differences decreased at the 12- and 24-month follow-ups and were no longer statistically significant when compared to routine care. Hans et al discussed the positive impact of the birth doula intervention during the immediate postpartum period (0-3 months) on the parent-infant relationship; however, they addressed the need for additional research on the impact of a community doula program on the extended postpartum period of the relationship development.

In 2010, Wen et al conducted a randomized trial in which 124 mothers participated in a birth doula support program, while 124 additional mothers received routine care during the final three months of pregnancy and the first three months postpartum. All of the mothers were low-income

African-American women recruited from a community health clinic and prenatal clinics at a large urban medical facility. The birth doulas were hired from the same community where the mothers lived and were provided doula training in labor, birth and immediate (0-3 months) postpartum care. The doulas provided weekly home visits during the last three months of pregnancy and the first three months postpartum. The study examined two aspects of the birth doula program: a) the quantity of program contact; and, b) the quality of the mother-doula relationship.[21] Parental involvement in the program was measured using both parent and doula report, while maternal outcomes were measured through interviews and direct observation. The researchers found that quantity of program contact correlated with the quality of the doula-mother relationship as perceived by the mothers.[21]

Campbell-Voytal et al conducted a longitudinal ethnographic study that involved twenty months of observation and interviews with postpartum doulas.[22] The study participants included four postpartum doulas and thirteen families. Participants were observed during six postpartum visits that occurred over a three-month period. Doulas participated in semi-structured interviews at the completion of each family's period of care for a total of 13 family-specific interviews, and each doula also participated in summative interviews at the end of the study.

The findings of the study were organized into two categories: a) doula perspectives on postpartum practice; and, b) personal meaning of being a doula. The doulas described four themes of postpartum practice: 1) supporting women; 2) taking the mother's perspective – empathy; 3) empowering women; and, 4) empowering families.[22] Each of these themes were observed during the home visits with the participating families. Campbell-Voytal explicitly states, "Understanding doulas' beliefs, values and practices will help midwives and others on the health-care team more effectively integrate postpartum doula care, capitalize on doulas' insights,

and anticipate how roles can be structured to maximize respective contributions to the health and welfare of women and infants."[22]

A review of the literature addressing PMD emphasizes a lack of social and emotional support on the development of PMD, which negatively affects the maternal-child bond, and documents the impact doula support can have on the maternal-child relationship. As Campbell-Voytal discussed, doulas can provide invaluable insight and information necessary for health care professionals who aim to support women more effectively and holistically through birth and the postpartum period. Doulas offer a unique approach to serving clients through listening and thoughtful discussion during their in-home visits and can provide referrals for community resources to clients struggling with PMD. Integrating doulas into the health care team during the birth and postpartum periods would allow for greater continuity of care for the mother and child and could foster an "empathetic" and "empowering" birth and postpartum transition for mothers.

By understanding what doulas know about PMD and their ability to recognize signs and symptoms in clients, we may identify opportunities to improve their training and education and better prepare them to advise a struggling client to seek help.

## *Methods*

### A. Design

This was a descriptive study that examined the experiences, knowledge, attitudes and perceptions of PMD from a cohort of 12 birth and postpartum doulas certified by Doulas of North America (DONA), the Pacific Association for Labor Support (PALS) or the Northwest Association for Postpartum Support (NAPS). All participants had, at some time during their career, served low-SES women pro bono via Open Arms Perinatal Services, a local Seattle

nonprofit organization, or independently. The study utilized key informant interviews to gather data regarding training opportunities, professional experiences, personal perspectives and standard responses toward perceived symptoms of PMD in the clients served by the cohort. The data from the interviews was analyzed using content analysis methods.[23,24]

B. Research Questions

The study participants were interviewed individually. The interview outcomes of interest were: 1) participation in PMD trainings; 2) positive or negative experiences in addressing symptoms of PMD with clients; 3) attitudes and responses toward clients experiencing symptoms of PMD; and 4) suggestions for the preparation and training of future doulas regarding PMD (see Appendix for a list of the interview questions).

*Data Collection*

A. Validity/Trustworthiness

Construct validity was the primary method utilized to ascertain which themes emerged from the data and proved most relevant to the study aims. When analyzing the data collected from the transcriptions, the constructs of knowledge, perceptions and attitudes reported in the interviews were compiled into a coding scheme, which was examined by both an external, knowledgeable member of the doula profession, who is involved with the training and certification processes of new doulas, and by the researcher's Committee Chair, an expert in qualitative methods, to prevent the introduction of researcher bias.[25] However, the above-mentioned "member checker" noted during her analysis of the interviews that the researcher did disclose to some participants

her own participation in a birth doula training program. This disclosure could be viewed as an introduction of researcher, or interviewer, bias.

B. Ethical Considerations

This study involved human interaction via key informant interviews and received IRB approval from the University of Washington in June 2016. Doulas were notified of the study through by one of the collaborating organizations or through doula community referral. Given that recruitment occurred through a third party who has no other involvement in the study and is not being compensated in any way for their participation, the risks of coercion were mitigated. The risks of injury or stress to participants was minimal and strictly psycho-social in nature. Some participants might have experienced discomfort during the interview process if traumatic experiences with clients were reintroduced; however, the option to end the interview if the discomfort became too great was explained at the beginning of each interview. To maximize the privacy of the participants' clients, no client names or personal information were disclosed during the interview process.

C. Participant Recruitment

Participants included in this study were certified birth and/or postpartum doulas who had served women of low socioeconomic status. This recruitment requirement was chosen in an effort to expand the diversity of experiences and perspectives discussed in interviews. The previously-discussed review of the literature addressing antenatal depression and its significant impact on the onset and duration of postpartum depression warranted the recruitment of both birth and postpartum doulas. Furthermore, the reviewed research that specifically addressed postpartum depression could not verify the exact point of onset, whether immediately after birth

or if depressive symptoms existed, but were not documented, prior to birth.[2,10] This further validated the recruitment of both birth and postpartum doulas into the study to learn the perceptions, attitudes and knowledge of doulas supporting women during either the antenatal or postpartum periods, or both. The inclusion criteria were the following: 1) experience working with Open Arms, PALS or NAPS; 2) at least one year of experience as a certified birth doula, postpartum doula, or certified in both birth and postpartum practice; 3) must provide clients with at least two postpartum visits as a standard practice (birth doulas); and, 4) at least 20 years of age with no upper age limit. There were no exclusions based on gender, ethnicity, or race.

A request for collaboration was submitted to the Executive Director of Open Arms, the Vice President of PALS Doulas – Seattle, and the Co-Director of NAPS – Seattle. Each organization agreed to the collaboration, and a recruitment email was submitted for distribution through each organization's listserv.

Doulas were asked to indicate their interest in participating by contacting the researcher at her University of Washington email account. Each potential participant received a response further inquiring about the length of their experience as a doula to ensure they met the inclusion criteria, and whether they practiced solely as a birth or postpartum doula or both. To promote diversity within the sample, particularly regarding the type of doula practice variable, some targeted recruitment via referrals from responding doulas or organization staff was necessary. Those who met the inclusion criteria were asked to provide an in-person interview at a location, time and date of their choice.

Subjects were asked to sign a participation consent form and an audio recording consent form prior to interview. Subject interviews were conducted at locations convenient and accommodating to privacy requests for each subject.

D. Risks/Benefits

Due to the methods used for collecting data in this study, risks to the human subjects were minimal. While some subjects found the discussion of their experiences therapeutic, no monetary benefit was offered to subjects.

E. Consent

All participants signed a participation consent form and an audio recording consent form prior to enrollment in the study.

*Analysis Plan*

All interviews were audio-recorded and transcribed. The content of the responses was analyzed using standard content analysis methods.[23,24] Key concepts, phrases and words were identified and labelled using a coding system that included short coded phrases along with clear definitions of each code. The code list and definitions were developed using a priori and inductively-derived constructs. The codes and definitions were drafted in a coding memo and distributed to the Committee Chair and an external member of the doula profession recruited for member checking and coding guidance. The Director of the Simkin Center for Allied Birth Vocations at Bastyr University agreed to participate as external coding reviewer. Atlas.ti was utilized to develop the coding scheme and analyze the data.

*Results*

Twelve doulas were interviewed. Five participants were certified birth doulas, six were certified postpartum doulas, and one was not currently certified but planned to renew her certification within six months of the interview. The uncertified doula actively was practicing as a birth doula despite the lapse in her certification.


The client demographics from this group of doulas varied somewhat; however, the majority served clients aged 30-44 years, categorized as Caucasian and middle- to higher-income, with a post-secondary education.

Participants' perceptions of the doula role

The most-commonly reported purpose of a doula was to "offer support" for the family, followed by "provide knowledge" to the parents and "empower the parents." Overwhelmingly, doulas perceived themselves as sources of knowledge, guidance, support and empowerment for families both antenatally (birth doulas) and postnatally (postpartum doulas).

> **J.T.:** "I believe, really strongly, in the difference it makes having good beginnings, supported beginnings, because it's a crux of society. I believe in that ripple effect."

Four doulas had advanced degrees (biology, nursing, public health, social work), which they felt contributed to their abilities to provide knowledge and expertise. Some doulas specifically claimed to love the job, while others felt drawn to the role from their own experiences with labor and birth. The "empowerment" included the role of the doula as an "advocate," as a "bridge-builder between the client and the medical team." In other contexts, "empowerment" was related to offering "validation" and encouraging the parents to "build confidence" in their abilities to care for a newborn.

> **C.B.:** "It's really not making decisions for them but opening their own eyes to encouraging them and validating them that their decisions are worth – their opinions are valid, their opinions are important to be considered and respected."
>
> **L.U.:** "I think it instills confidence and that confidence builds to 'I can do this' and that builds to 'I don't need you anymore,' which is what you strive toward anyway. In helping to build that [it] then also cultivates your relationship, because you're helping them during a really tough time in their life and giving them the help and guidance are really important things to set them up for the rest of their life. So, to me, that's what being a doula is."

Relationship with client

The most-frequently used word to describe the doula-client relationship was "close." Many doulas also used the words "warm" and "trusting."

> **M. A.R.:** "[It's] striving to build trust and warmth, and I would say that I'm pretty fortunate that that happens, for the most part."

Five doulas discussed the "carefully-asked questions" they put to clients during initial interviews or if they later suspect PMD. One doula created a questionnaire for clients to discuss during the initial interview, and she spent "years" developing a question about client concerns regarding PMD that she felt was respectful yet informative. Two other doulas discussed the intentionally-chosen wording of the questions they ask clients when they suspect PMD –

questions the client "can answer honestly," while still maintaining a respectful rapport with the client.

> **M.J.:** "It's a lot of sitting and listening, then [asking] questions like, 'How was the last hour?' Just trying to ask questions they can answer honestly."

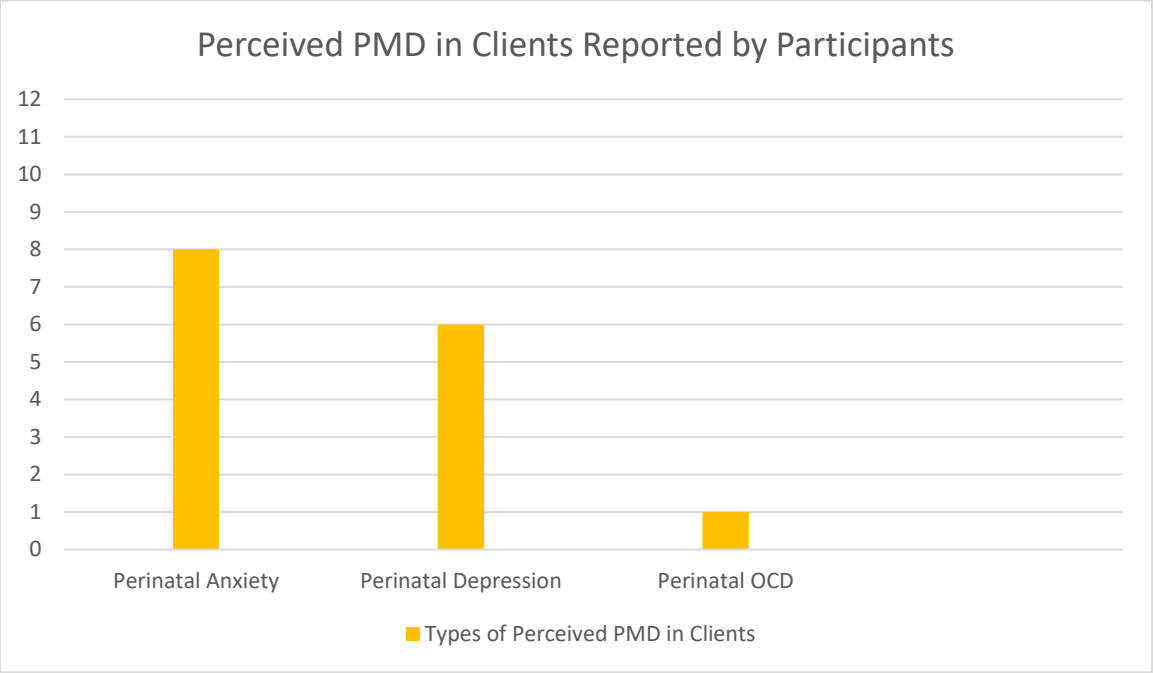
Another doula described asking some "probing" questions in a respectful manner to help determine any boundaries or expectations the client has established for the relationship. Some doulas strove to create a "safe" relationship for their client, and one doula reported feeling that her relationship with a client represented a "holding period," a special nurturing experience during a vulnerable time.

> **M.J.:** "As a doula, you're coming into a really vulnerable time and event, situation, so you want to find somebody you can work with well and trust because that's really what it's about."
>
> **M.A.R.:** "I see this period of time before they deliver as a holding period - spiritually, you're holding them."

Doulas' identification PMD in clients

The most-frequently perceived PMD was antenatal/postnatal anxiety, with antenatal/postnatal depression also often addressed.

> **M.H.:** "Most common is just generalized anxiety – nothing like standard checklist symptoms – just worried, worried, worried."
>
> **L.U.:** "I see a lot of anxiety, OCD – but I think a lot of those might be extensions of their personality prior to having a baby, so it comes out stronger when there is a baby. Not necessarily, but sometimes."




Participants identified a number of behaviors and actions that they believed were indicators of PMD. The most commonly mentioned symptoms focus around clients experiencing "irrational fear or anxiety over baby's safety, health, and development."

> **I.S.:** "The most common things I've had are the anxiety throughout the pregnancy and increased anxiety, I would say, after the baby's born. Sometimes the mother does not feel comfortable leaving the house. Sometimes the mother is uncomfortable with anyone holding the baby."
>
> **M.A.R.:** "Not wanting to hold the baby, not wanting to take care of the baby, being afraid that they're going to hurt the baby."
>
> **J.T.:** "I noticed this behavior of her family having a lot of anxiety – her kids walking around on tippy-toes. Then I noticed she was walking around on tippy-toes, and I still don't know what that's all about. But [I] really felt the anxiety in that home, and her talking about folding laundry at 2AM. This was a very educated mom – she was a PEPS facilitator, so she just couldn't be told. She wasn't going to see it herself and that was really tricky. I didn't know exactly how to help her."

"Trouble sleeping" and "trouble bonding" were also frequently discussed.

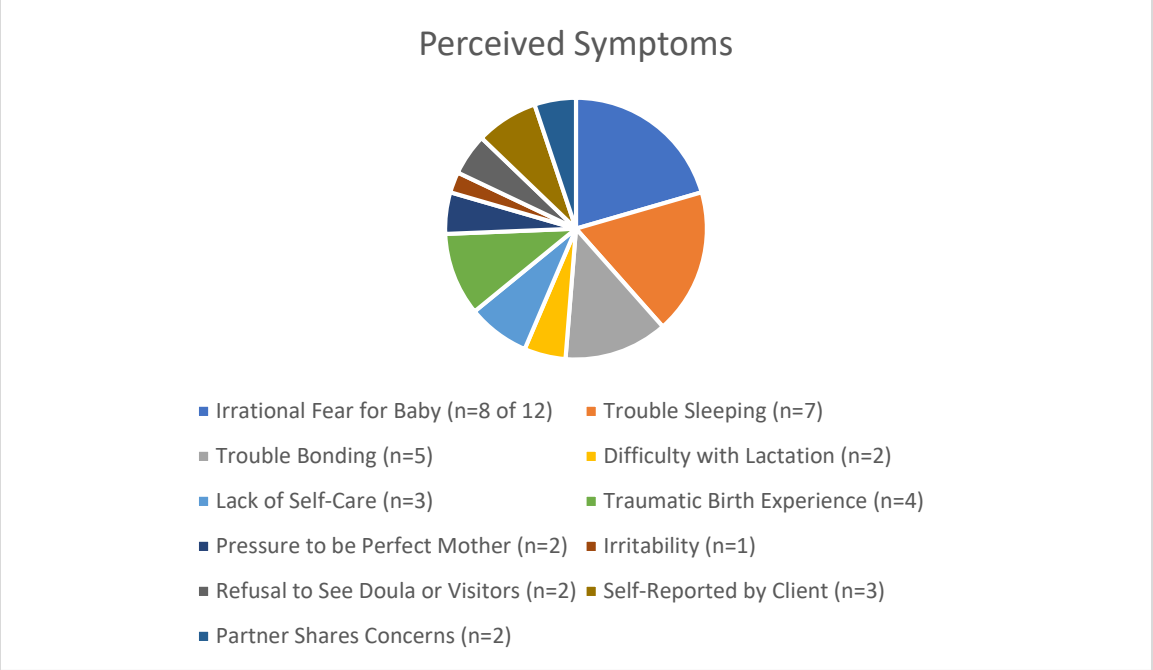
> **A.H.:** "But there's a certain distance between the baby and the mom, even if they're holding it close. It's not just stiffness of uncertainty, it's really hard to describe, but you know it when you see it – where the mom just isn't associating with her baby or wants to have the baby across the room."

Other reported signifiers of perceived struggles with PMD were "difficulty with lactation," "lack of self-care," "traumatic birth experience," and "pressure to be perfect mother." Some doulas identified "irritability," and others noted a client's refusal to "see or talk with visitors, even the doula."

> **I.S.:** "I had a mom who really wanted an un-medicated birth, it was shortly after I became a doula, and unfortunately, she had to reach for pain medication. The reason I say 'unfortunately' is because that's how she expressed herself. And that impacted her birth experience so badly and how she looked back on her birth, that she did not leave her house for seven months and it was pretty hard. Her husband and therapists tried to help her, but she just felt guilt and shame letting her baby down – she thought she failed, so it was really hard."

> **T.G.:** "I went to schedule that two-day check-in, and she made a time, [then] she rescheduled it. I [thought], 'That's interesting.' So we rescheduled it, and then I was already there, I'd already parked, and she tried to cancel it. I texted the husband [and asked], 'Can I just come in?' And he was gone, [so he said], 'Sure, the door should be open.' She was [in] full-on depression, a really bad place. Her nipples were bleeding. She kept rescheduling because she didn't want to deal with it. So now, I've learned that usually when clients don't get back to me or they keep rescheduling, it's a warning sign for me."

Additionally, some doulas stated clients often self-report suspicions of PMD or partners shared concerns with the doula.



Experiences working with client PMD

*Differential access to doulas*

All 12 interviewed doulas had assisted clients perceived to be struggling with PMD. Interestingly, some doulas indicated clients may have "self-bias," meaning a client would be more likely to hire a doula if they anticipate or have a history of PMD.

> **C.M.:** "I think that there's a self-bias toward hiring a postpartum doula if you anticipate or you have a history. A higher percentage of my clients are multiples because more people with multiples realize they're going to need extra help, so I think a higher percentage of my practice are people with these disorders because they're already anticipating because of a history either outside of the perinatal period or a history specifically with previous experiences."

The key to this statement, though, is the ability to "hire" a postpartum doula if a client has a history of PMD, which would seem to exclude low-SES clients with a history of PMD from pre-emptively acquiring postpartum assistance. One doula with extensive experience working with low-SES clients felt that the "most at-risk clients don't seek out doulas."

> **A.H.:** "I think a lot of people who are at-risk for those disorders – and I'm generalizing here, because I know there are upper-middle class people, too, who get them – but, I think that a lot of the people who are most at-risk are people who don't seek out doulas."

*Perceived causes of PMD*

The doulas perceived the most common cause of PMD was a prior experience with PMD or a pre-existing mood disorder prior to pregnancy.

> **C.M.:** "Sometimes it's been a long history that didn't start perinatally. It started in their teenage years – they started 10 years ago or whatever, not around their pregnancy. They also know that, even if they've taken breaks over time, that this is a time they want to be 'on,' not 'off.'"

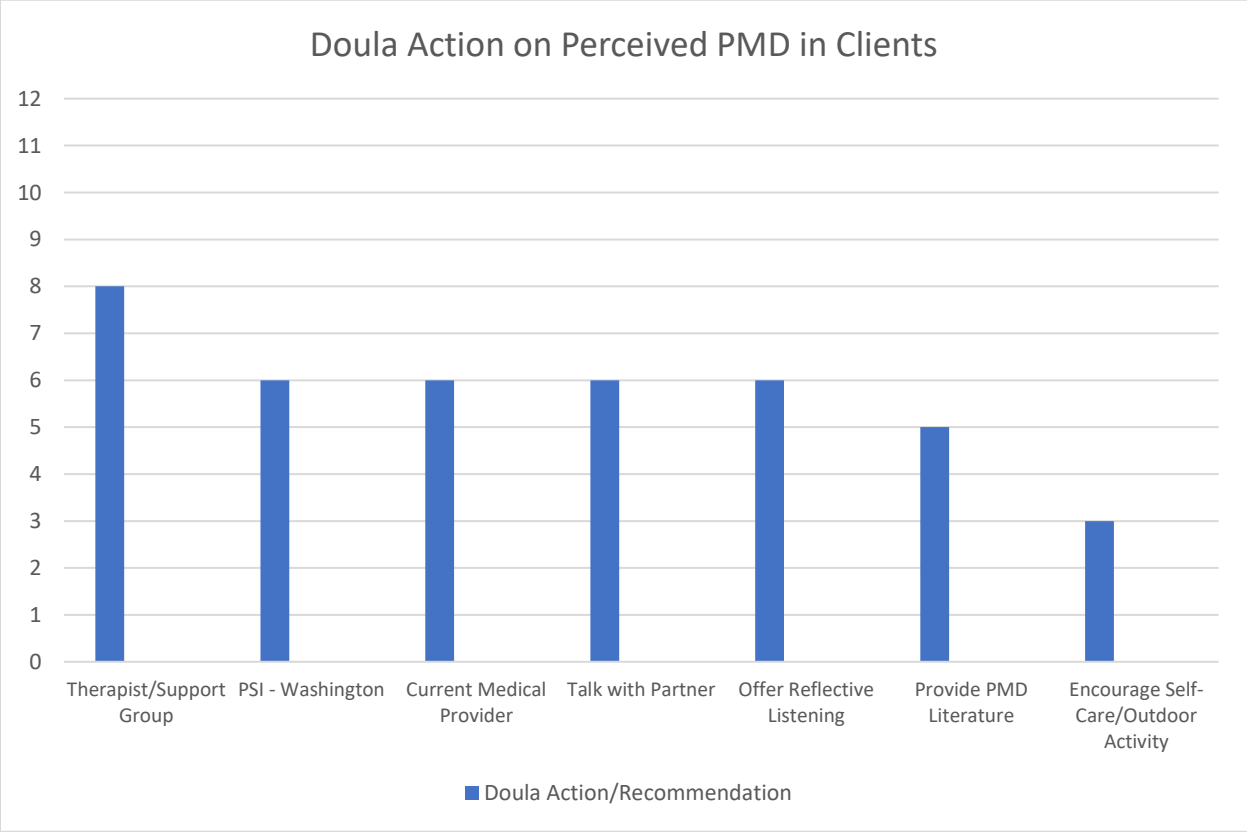
The second most-frequently discussed perceived cause was sleep deprivation, followed by prenatal trauma, such as birth/delivery trauma during prior birth. Some doulas suspected past abuse experienced by the mother could also impact the development of PMD in a client. This perception was based upon experiences providing doula services to adult survivors of childhood abuse.

Doula action on perceived PMD in clients

The majority of doulas reported referring clients struggling with PMD to therapists or support groups. Many doulas made referrals to the local Washington chapter of Postpartum Support International (PSI) or a hotline or talked with the partner or other support person. Others reported practicing "reflective listening" and "providing literature".

> **A.H.:** "[I] just ask about how they're feeling and almost make it possible for them to recognize it themselves. If they're saying things that are really indicative of it, then maybe reflect that back to them – 'Okay, so you're saying that you don't want to look at your baby and that you're not sleeping and you don't want to shower. Does that sound healthy?'"

Others recommended the mother contact her care provider or existing therapist or recommended "outdoor activity" and "self-care."



Reflections on training received on PMD

All participants reported receiving some training regarding PMD in their certification programs; however, nine doulas reported feeling that training was inadequate to prepare them for practice.

> **T.G.:** In the certification program, it was very – I felt – surface level. We had Penny Simkin talk about her development of psychosis and what she did to do that, but I've definitely done more learning since then.
> **M.A.R.:** I would say that you get just the beginning of that training in training – you have to follow up with it to begin to understand what you're looking at.
> **L.U.:** I think in the training it's probably just very little – just things to look for and you might see, but not what to do. I don't want to say "fix it" because you can't fix it. I don't think there was any of that because there's just not time in the classes for [it].

The doulas largely relied on continuing education opportunities and doula conferences to gain additional knowledge regarding PMD. Many doulas reported referring to peer groups both in professional community round-tables and on social media pages for more PMD-specific insight.

> **C.M.:** Talking to people. I haven't gone to one in a while, but we have, NAPS has what they call "Round Tables" where we all get together and talk about what's going on. People will occasionally talk about an issue with a client, just to process for yourself and, professionally, how could I have dealt with that? Could I have done something differently? What would you guys have done in the same circumstances kind of thing? Sometimes I'll learn something from that, you know a situation that showed up a little differently or somebody had a different way of responding that I would've never thought of.

Some doulas read peer-reviewed journals and relied on their own experiences for additional knowledge regarding PMD.

Several doulas indicated a desire for additional trainings regarding "recognizing signs and symptoms," "prenatal/antenatal mood disorders," "addressing potential PMD," "effective communication with partner in recognizing signs and symptoms of PMD," and trainings in "alternative healing" methods to offer clients, such as meditation.

Some participants identified a gap in training to prepare doulas to serve low-SES or at-risk communities. One doula explicitly described the different needs of low-SES clients versus middle- to high-income clients.

> **L.U.:** "Their need is way different than the group I often help, versus the swaddling and validation, they're wondering where the food's going to be coming from, housing, how to get to the doctor's appointment and back – way different."
>
> **L.U.:** "I think that's the difference between our postpartum clientele that pays for it and the folks that can't afford it – [it's about] finding the best way to get them the best help in a short amount of time and to get them over some hurdles and expectations of what's around the corner."

Another doula described the current doula population as a "white" profession and suggested certification and education organizations set aside more funding to assist people of color or members of low-SES communities in completing doula training programs.

Recommendations for educating doulas in the future

The primary recommendation for educating doulas regarding PMD was through participation in "Facebook groups/experiences from other doulas." Several doulas also felt that "continuing education" was very important.

> **M.A.R.:** "I would say continuing ed – PALS has had speakers on depression, and DONA, too, if they wanted to become educated. But they've got a yearly set of speakers – you can order those CDs."

"Familiarize doulas with local resources" was also recommended. Two doulas felt the training programs should be "more extensive and comprehensive," and two others suggested that "DONA/PALS/NAPS should encourage PMD-specific continuing education."

> **I.S.:** "I feel like having something maybe in the training which specifically addresses how to handle scenarios, not extremes, of course, like bipolar disorder or what not, but just basic scenarios, most common scenarios, even just anxiety."

Another doula also addressed the brevity of the current training model and suggested a longer, more comprehensive training program, much like an associate's degree or vocational school, would better prepare doulas for serving PMD clients.

*Discussion*

To our knowledge, this is the first study to examine doulas' perceptions, knowledge and attitudes regarding PMD. Each of the participants emphasized the supportive role of the doula

throughout the perinatal period, particularly in providing emotional support to the mother. They recognized that the support they could offer middle-to high-income clients differed greatly from the support they could offer low-SES clients. The doulas stressed the importance of developing a relationship with clients based on trust. A trusting relationship would allow doulas to delicately ask more "probing" questions if they suspected a client was struggling with PMD. The collective attitudes toward PMD were to take action and help clients develop a solution – more sleep for the mother, more time spent outdoors, a referral to a support group, or an appointment with a medical provider or therapist; however, many emphasized that doulas cannot diagnose or treat mental health issues, only empower the client to seek help. The participants felt the training they received did not adequately prepare them for practice, and many valued the knowledge gained from listening to the experiences of more seasoned doulas or from independent research and education.

The participants indicated perinatal anxiety and depression were the most-frequently perceived PMD presentations in their clients, which validates existing literature. Many of the client experiences discussed by the doulas seemed to follow the pattern of the diagram of key PMD risk factor effects determined by Leigh et al, specifically indicated by the "trouble bonding with baby" reported often by the doulas as a perceived symptom of PMD. Interestingly, some doulas also reported perceived OCD in their postpartum clients, which echoes the findings in the 2016 Challacombe study.[14]

Each of the participants identified gaps in the training they received regarding PMD and expressed what they felt was a critical need for more in-depth training, including instruction on the many forms of PMD, any knowledge of recent research on PMD, and how to address PMD with clients and families.

The doulas discussed the brevity of PMD-specific training in their certification programs and offered many thoughtful suggestions for structuring training programs in ways to better prepare new doulas to face challenges and equip them with tools and resources to offer their clients. Participants also addressed the need for increased diversity within the doula profession and special training in how to serve at-risk or low-SES clients. This was an interesting observation that specifically addressed the aim of this study – to illuminate opportunities to improve the training and preparation of doulas serving high-risk clients – to propose that training more people of color or members of low-SES communities would be a progressive step toward better serving at-risk clients.

Some possible limitations included:

1) sampling bias – the study sample was small and comprised of volunteers. Doulas with an interest in PMD were more likely to volunteer. Additionally, the study sample was comprised of doulas who reside and/or practice primarily within King County, Washington. King County offers several community health programs focused on maternal and child well-being in low-SES communities. King County is also home to a variety of doula training and membership organizations. Thus, the participants from King County may not be representative of the general population.

2) interviewer bias – the researcher unintentionally disclosed to some participants her own participation in a birth doula training program.

As new research reveals more about the prevalence, varieties, and effects of PMD, it is imperative that professionals charged with caring for mothers and families are adequately prepared to address the challenge posed by PMD and offer guidance for treatment. The

participants in this study spoke confidently about their role in nurturing, guiding, and validating mothers and parents during an extremely vulnerable time. Doulas can provide continuity of care from the antenatal through the postpartum period that is absent in our current medical model – they can offer a crucial stop-gap of emotional support for mothers, especially high-risk mothers. This study revealed what doulas strongly believe to be their purpose and what training they deemed essential to preparing doulas to best fulfill that role. Further study to examine the real-world impact of doula care on the mitigation of PMD, particularly in vulnerable populations merits consideration.

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*Appendix*

Interview Questions

1) Are you certified as a birth doula, postpartum doula, or a combination of both?
2) With which organization are you certified?
3) What are some of the primary reasons you chose to become a doula?
4) How long have you been practicing?
5) With which organizations are you affiliated?
6) How would you describe the average demographic of your clientele?
7) What routine services do you provide in a typical client relationship?
8) How would you describe your typical client-doula relationship?
9) What do you do in your practice to cultivate this (#8) type of relationship with your clients?
10) How have your clients responded to your efforts to develop a relationship?
11) How would you describe perinatal mood disorders? When do they generally appear in the perinatal period? How long do they last without treatment/intervention?
12) How common do you feel perinatal mood disorders, such as depression and/or anxiety are in your practice?
13) How would you identify symptoms of a mood disorder in one of your clients?
14) How would you persuade your client to seek treatment?
15) What resources would you recommend for treatment of your client's mood disorder?
16) How much training did you receive regarding perinatal mood disorders in your certification program? Do you feel this was enough to adequately prepare you for practice?