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The Impact of Birth Doulas on Post-Partum Depressive Symptoms: Mothers' Perceptions

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The Impact of Birth Doulas on Post-Partum Depressive Symptoms:

Mothers' Perceptions

by

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. The project is neither a Master's thesis nor a dissertation.

Abstract

The perceptions of mothers of the impact of birth doulas on their post partum depressive symptoms was examined through the lens of role theory and the multi-dimensional framework. With permission, an anonymous, online survey was distributed via email to 67 doulas, all of whom were members of a large organization of doulas in the Twin Cities, MN area. The email included a survey link and a request for the doulas to forward the survey link to their clients who had given birth within the last five years. The 17-question survey asked demographic data and questions regarding role conflict, interactions with their doulas prenatally and postnatally, and experiences with post partum depressive symptoms. Only 14 responses were received, preventing valid statistical analysis. No relationship was found between doula interactions and postpartum depressive symptoms. The study concludes with an in-depth discussion of the reasons for the low response rate with suggestions for improved study design on this topic.

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Introduction

Between 8% and 19% of American women who give birth report frequent post partum depressive symptoms (Ko, Farr, Dietz, & Robbins, 2012). What is colloquially known as "Post Partum Depression" is officially categorized by the DSM-5 as an unspecified depressive disorder with peripartum onset (American Psychiatric Association, 2013). Whether women eventually receive a diagnosis of Post Partum Depression or they experience depressive symptoms commonly referred to as "baby blues", these depressive symptoms have the potential to impact the mother's health and well-being, as well as that of her child and their relationship.

According to the American Psychological Association (2007), risk factors for post partum depression may include: fluctuation of reproductive hormones, personal or family history of depression or anxiety, marital discord, younger age at birth, stress related to the birth or other life events, lack of social support, environmental factors such as pollution, socio-economic status, stress related to having a new child, especially as related to the disjunction between idealizations of motherhood and the reality, and having a difficult infant. The American Psychological Association (2007) states that, if left untreated, post partum depression can lead to mothers' decreased daily functioning, potential diminished capacity to provide adequate care to the infant, and thoughts related to self-harm or harming the child. They also state that children of mothers suffering from post partum depressive symptoms can potentially have negative outcomes, including being "withdrawn, irritable, or inconsolable", "display insecure attachment and behavioral problems", "experience problems in cognitive, social, and emotional development", and

"have a higher risk of anxiety disorders and major depression in childhood and adolescence". Mothers suffering from post partum depression may also perceive their infants' behavior inaccurately, contributing to difficulties with attachment (Orhon, Ulukol, & Soykan, 2007).

Birth doulas are supports for women and have been related to improved maternal health outcomes. In addition to being supports for women during birth, they also often provide both prenatal and postnatal support in the forms of emotional support, psychoeducational support, and advocacy. Because birth doulas often make postpartum visits as part of their services, they are in a unique position, unlike medical doctors who generally do a 6-week medical follow-up and only screen for depressive symptoms, to recognize depressive symptoms and encourage treatment if necessary. Even if doulas do not directly impact a woman's mental health symptoms, they can encourage mothers to be active participants in their medical care (Gilliland, 2002). Doulas have been linked to improved health outcomes, however not much study has been done on doula impact as related to social work (Lee Phillips & Kelly, 2014).

Social workers provide services with mothers and children in a variety of settings, making post partum depressive symptoms, its effects, and its treatment, a relevant issue. Social workers may intersect with clients at all stages of pregnancy, birth, and motherhood. After birth, social workers may be either clinically treating women suffering from postpartum depressive symptoms, or may be working with the mother and family in other ways, such as addressing infant development. Social workers must be aware of the ways in which social work can assist women in moving through pregnancy

and birth in ways that mitigate post partum depression, leading to better outcomes for mothers, infants, families, and the community.

The purpose of this study was to examine the effects of birth doulas on post partum depressive symptoms, as one potential resource for preventing or mitigating post partum depressive symptoms.

Literature Review

Prevention and Treatment of Post Partum Depression

Prevention.

Research on the prevention of postpartum depression has primarily focused on women with specific risk factors, such as histories of depression, and has typically ignored the general population of women who give birth, who could be subject to baby blues or undiagnosed post partum depression. Despite the seeming ease with which prevention efforts could be aimed at post partum depression, considering its distinct onset, research has not proven any effective methods to do so (Battle & Zlotnick, 2005). Prevention efforts have been mainly comprised of various methods of psychoeducation, including support groups, health visitors, and classes. Specifically, receiving health visitors in the prenatal period has not been found to be an effective prevention effort (Morrell, 2006). However, the efficacy of these preventive efforts has not been as supported and replicated in the research as has postnatal treatment (Stuart, O'Hara, and Gorman, 2003; Lee & Chung, 2007; Battle & Zlotnick, 2005).

Client Perceptions of Preventive Efforts.

While studies have not shown the efficacy of prenatal support or preventive efforts, they have identified that clients have perceived these interventions as helpful. For example, one study found that the prenatal support efforts were helpful, but included as part of its discussion that the extent to which the efforts were helpful may have been based on whether the clients perceived the interventions as helpful or not (Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993). To that end, the study authors suggested that individual women have different needs postnatally, ranging from emotional to material, and instead of one particular intervention for everyone, the intervention that meets a woman's unique needs may be the most effective. Morrell (2006) also noted that for one study reviewed, the data did not show an effect but that participants commented that they had found the intervention helpful.

Treatment.

The postnatal period is one during which women are typically either self-motivated to seek treatment or are encouraged to do so by friends and family members (Battle & Zlotnick, 2005). However, some mothers have difficulty admitting that their depressive symptoms are related to mental illness, and therefore fail to seek appropriate treatment (McComish, Groh, & Moldenhauer, 2013; Morrell, 2006).

Research indicates that the treatment of post partum depression is best delivered by health visitors and mental health counselors. After reviewing the literature on post partum depression and treatment, Morrell (2006) found that, contrary to the inefficacy of preventing post partum depression via health visitors, post partum visitors were found to

be effective in both identifying post partum depression and treating it. Both informal and formal postnatal counseling has been found to be effective (Stuart, O'Hara, & Gorman, 2003). One qualitative study identified that simply having someone to talk to about feelings in the postnatal period was more important than anything else (McComish, Groh & Moldenahauer, 2013). Although it is a pervasive treatment, antidepressant medication has not been found to be helpful (Morrell, 2006), and patients have had concerns about the use of antidepressants for this disorder, particularly as it relates to breastfeeding (Henshaw, 2004).

Role Conflict

Research has shown that the issue of role conflict contributes to post partum depressive symptoms. In a metasynthesis of 18 qualitative studies on postpartum depression, Beck (2002) found that four themes emerged: "incongruity between expectations and realities of motherhood", "spiraling downward" amongst many emotions related to new motherhood not just sadness and depression, "struggling to survive" in the day to day, and "reintegration and change" in which mothers came to adjust their expectations and form new identities based on their new roles as mothers. In one study, 80% of new mothers reported difficulty with the discrepancy between what society had told them motherhood would be like, and the reality of it (McIntosh, 1993). Interestingly, this study also found that 68% of its participants admitted that they entered motherhood with expectations out of line with the reality, and the study found a strong relationship between the extent to which a mother had realistic or unrealistic expectations and rates of post partum depression.

Doula Support

Although doula services are most often linked to the labor and delivery process and birth outcomes, birth doulas provide support both prenatally and postnatally in a variety of ways, including emotional, physical, psychoeducational, parenting, and advocacy (McComish & Visger, 2009). Research has shown that women generally find doula support helpful (Koumoultzes-Douvia & Carr, 2006). While research on the impact of doulas on women's emotional lives is limited, there has been emerging research on the impact of doulas for parenting and pregnant teens. Research on doula impact for parenting and pregnant teens identified that the social support provided by doulas was significant, as these mothers were often without effective support systems (Breedlove, 2005; Gentry, Nolte, Gonzalez, Pearson, & Ivey, 2010). For adults, one study in China found that lack of both prenatal and postnatal social support was correlated with having post partum depression, however found that the lack of postnatal social support had a higher correlation (Xie, He, Koszycki, Walker & Wen, 2009).

Research so far has focused on doula impact on the parenting outcomes of young mothers, however this information provides a basis to hypotheses that doulas can impact the parenting outcomes of mothers of other ages, too. For young mothers, who are often challenged by lack of support, education, and resources, doula support prenatally and postnatally led to improved outcomes in mother-infant interactions (Hans, Thullen, Henson, Lee, Edwards, and Bernstein, 2013).

Doula Impact on Role Perceptions

Research has shown that birth doulas impact the role perceptions of new mothers, lending to increased self-esteem and confidence (Manning-Orenstein, 1997). Doulas also help to mitigate unrealistic expectations, lack of confidence, and adjustment to new roles (McComish & Visger, 2009). For the young mothers who have been studied, doula support also increased confidence and perceptions of themselves as being better mothers than they would have been otherwise (Breedlove, 2005). Interestingly, one study of adult women found that, even after receiving only a small amount of training, female friends or family members who acted as birth doulas still had an impact on mothers' role perceptions. The mothers in that study were found to feel more positively about their self-worth and their mothering capabilities, as well as expressing more pleasure about becoming a mother (Campbell, Scott, Klaus & Falk, 2007).

Not all studies have found that doulas impact role perceptions, however. Gordon, Walton, McAdam, Derman, Gallitero, & Garret (1999) did not find any statistically significant differences between women who had used doulas and those that had not on their feelings about their capabilities of motherhood and their feelings of self-worth. They also did not find any differences in mental health outcomes. However, that particular study did not capture the traditional doula experience involving a prenatal relationship and postnatal follow-up. Instead, they provided doulas at the time of admission to labor and delivery, the doulas had received training but were not necessarily experienced, and did not complete any postpartum follow-up.

Conceptual Framework

There are two theories that provided the underpinning for this study's investigation: role theory and the multidimensional framework.

Role Theory

This study proposed that depressive symptoms may arise from the disjunction between role expectations and role realities of motherhood. Role theory supported this notion. The theory, which has its roots in sociology and social psychology, states that roles are learned as part of the social milieu and individuals act in accordance with their learned roles. It is concerned with "patterned and characteristic social behaviors, parts or identities that are assumed by social participants, and scripts or expectations for behavior that are understood by all and adhered to by performers" (Biddle, 1986). Role strain occurs when individuals experience difficulty fulfilling their assigned roles (Goode, 1960). For mothers who experience a lack of alignment between their experiences and the expectations they have come to have through their social education, or whose experience differs from the expectations of those around them, role strain may induce depressive symptoms.

Multidimensional framework

Social work uses the multidimensional framework to understand client lives. It is not a theory, but rather a perspective. The framework views the client as existing in a bio-psycho-social-spiritual arena, with all spheres influencing one another. Because of the many intersection points amongst these spheres, issues in one area create ripple effects in others. Birth is a predominantly physical experience, yet it impacts many other areas of

women's lives. One of the primary impacts is the psychological, which can lead to two areas that this study was concerned with: a woman's mental health and her internal feelings about motherhood. The other significant area where giving birth and becoming a mother is impactful is in the social milieu, wherein others in the world hold expectations of mothers. Therefore, the multidimensional framework is a perfect lens through which to examine the significant and complex changes that occur with giving birth and becoming a mother.

Methods

Purpose and Design

The purpose of this study was to identify what impact birth doulas had on any post partum depressive symptoms, based on the perceptions of mothers who had used birth doulas for a recent birth. This notion had been hinted at in the literature, but the researcher had not found any studies directly addressing this question. The study utilized a quantitative approach to this question in order to generate a maximum amount of data on this under-examined topic. This study employed an anonymous, self-administered online survey to assess how women perceived the impact that their birth doulas had on their postpartum depressive symptoms. Due to the dearth of research in this subject, the researcher was unable to identify any previously validated survey that met the needs of this study topic. Therefore the researcher designed a survey tool based on material in the research about post-partum depression and doulas. The survey, which was administered using Google forms, was not piloted nor tested for rigor and validity.

Data Collection

The survey was created in Google Forms and was available to respondents as a web link. Survey design was based on issues that arose within prior research studies, as well as information about postpartum depression as listed in the DSM 5. Demographic data was collected, including age at the most recent birth when the respondent used a doula, race, present income, and present level of education. The survey asked about role strain, which research has shown to be problematic for women who have given birth. The survey was also designed regarding the types of support that doulas typically offer prenatally and postnatally, as indicated by research.

Sampling Method and Data Collection Process

This study employed convenience sampling as the researcher's time and resources did not allow for a greater scope. The researcher received support and permission from a large doula organization in the Twin Cities area of Minnesota to contact their members regarding this study. The researcher sent emails to all of the doulas in that organization who featured an email address published on the organization's website for a total of 67 doulas. The email explained the project and requested that doulas forward the online survey to former clients who had given birth. The researcher also requested that the doulas forward the opportunity to any doula professional in their network as appropriate. The online survey contained informed consent language, and was taken anonymously.

Measures for Protection of Human Subjects

The study utilized multiple measures to ensure protection of its human subjects. First, the study was approved by the Institutional Review Board of St. Catherine

University. Second, study subjects read a letter of informed consent on the first page of the online survey. As the online survey was taken anonymously, no signatures or signature data was collected. The survey data was kept in a password-protected Google Drive account when it was first received through Google Forms. Once the response was received, it was then transferred to a password-protected flash drive. Third, participation was voluntary.

Results

Sample Demographics

The survey was completed by 14 individuals. All respondents were Caucasian, with one aged 23-25, one aged 26-29, 10 aged 30-34 and two aged 35-40 at the time of the most recent birth when they used a doula. Respondents were not asked their current age because the study was concerned with how age at the time of the birth related to postpartum depressive symptoms, rendering current age irrelevant. At the time of responding to the survey, one individual had completed some college, six respondents had their bachelor's degree, and seven had their master's degree. At the time of responding to the survey, one individual had an annual household income of $0-$50,000, five had an income of $75,001-$100,000, five had an income of $100,001-$150,000, and three had an income of $150,001 or more.

Table 1
Demographic Data

	Age				
	18-22	23-25	26-29	30-34	35-40
Total Household Income					
$0-$50,000	0	1	0	0	0
$50,001-$75,000	0	0	0	0	0

$75,001-$100,000	0	0	0	5	0
$100,001-$150,000	0	0	1	4	0
$150,001 and above	0	0	0	1	2
Highest Level of Education					
HS Diploma or GED	0	0	0	0	0
Some college	0	1	0	0	0
Associate's degree	0	0	0	0	0
Bachelor's degree	0	0	0	4	2
Master's degree	0	0	1	6	0
Doctorate degree	0	0	0	0	0

Depressive symptoms

Five of the 14 respondents had been diagnosed with depression at some point before becoming pregnant, and four of the 14 respondents had been diagnosed with a mental health condition other than depression before becoming pregnant. Only one respondent had been diagnosed with both depression and an additional mental health condition before becoming pregnant.

Three of the 14 respondents experienced depressive symptoms during pregnancy, all of whom had had a diagnosis of depression at some point before becoming pregnant. Of those three, two were treated for their symptoms during the pregnancy.

Six of the 14 respondents reported that they experienced depressive symptoms after giving birth. Of these six, three had had a diagnosis of depression at some point before becoming pregnant, and one had been diagnosed with a separate mental health condition prior to becoming pregnant. Of the eight respondents who reported no depressive symptoms after giving birth, two reported having been diagnosed with depression at some point prior to becoming pregnant, and three reported having been diagnosed with a separate mental health condition prior to becoming pregnant.

Three of the six respondents who reported experiencing depressive symptoms after giving birth stated that they were treated for these symptoms. Two sought treatment on their own, while one woman was prompted to seek treatment by discussions with the doula.

Table 2
Mental Health History and Depressive Symptoms

	Depressive Symptoms During Pregnancy		Postpartum Depressive Symptoms	
	Yes (n=3)	No (n=11)	Yes (n=6)	No (n=8)
Prior depression diagnosis				
Yes	3	2	3	2
No	0	9	3	6
Prior other diagnosis				
Yes	0	4	1	3
No	3	7	5	5

Interactions with doulas

The doula was present at all respondents' births. Prior to the birth, two respondents met with the doulas five times, three respondents met with the doula six times, and three respondents met with the doula four or more times. Respondents spoke with the doula about one or more topics. Nine respondents spoke with the doula about information or education about pregnancy, twelve respondents spoke to the doula about information or education about the birth process, eight respondents spoke with the doula about information or education about mental health, including post-partum depression, ten respondents spoke to the doula about information or education about what to expect after giving birth, three respondents spoke to the doula about the role of motherhood, and four respondents spoke to the doula about a topic designated as other on the survey.

Table 3
Prenatal Doulas Interactions by Respondent Age

	Age				
	18-22 (n=0)	23-25 (n=1)	26-29 (n=1)	30-34 (n=10)	35-40 (n=2)
Number of prenatal doula interactions					
0	0	0	0	0	0
1	0	0	0	0	0
2	0	0	0	4	1
3	0	0	0	5	1
4 or more	0	1	1	1	0
Information Discussed					
Pregnancy	0	1	1	5	2
The birth process	0	1	1	8	2
Mental health	0	1	1	4	2
Postpartum expectations	0	1	1	6	2
Role of motherhood	0	0	1	2	0
Other	0	0	0	2	1

After the birth, all respondents either spoke with or had visits with their doulas. One respondent met or spoke with the doula one time, seven respondents met or spoke with the doula two times, and six respondents met or spoke with the doula four or more times. All respondents discussed at least two topics with the doula postnatally, with 14 respondents discussing the birth experience, 10 respondents discussing their new role as a mother, 10 respondents discussing taking care of the baby, 11 respondents discussing self-care, nine respondents discussing personal and family relationships, seven discussing the baby blues or feeling depressed, and one individual discussing mental health issues other than depression.

Table 4
Postnatal Doula Interactions by Respondent Age

	Age				
	18-22 (n=0)	23-25 (n=1)	26-29 (n=1)	30-34 (n=10)	35-40 (n=2)
Number of postpartum doula interactions					
0	0	0	0	0	0

1	0	0	0	1	0
2	0	1	0	5	1
3	0	0	0	0	0
4 or more	0	0	1	4	1
Information Discussed					
The birth experience	0	1	1	10	2
New role as mother	0	1	1	6	2
Taking care of the baby	0	1	1	7	2
Self care	0	1	1	7	2
Personal/family relationship	0	1	1	6	1
Baby blues/feeling depressed	0	1	1	3	2
Mental health other than depression	0	1	0	0	0

Interactions with doulas and depressive symptoms.

Of the three respondents who experienced depressive symptoms during pregnancy, two met with the doula three times prenatally, and one met with the doula four or more times prenatally. Of the 11 respondents who did not experience depressive symptoms during pregnancy, five met with the doula two times prenatally, four met with the doula three times prenatally, and two met with the doula four or more times prenatally.

Of the six respondents who reported postpartum depressive symptoms, one met with the doula twice prenatally, four met with the doula three times prenatally, and one met with the doula four or more times prenatally. Of the eight respondents who reported no postpartum depressive symptoms, four met with the doula twice prenatally, two met with the doula three times prenatally, and two met with the doula four times prenatally.

Of the respondents without a previous diagnosis of depression prior to becoming pregnant and who went on to experience postpartum depressive symptoms, one met with a doula two times, one met with a doula three times, and one met with a doula four times.

Table 5
Doula Interactions and Depressive Symptoms

	Depressive Symptoms During Pregnancy		Postpartum Depressive Symptoms	
	Yes	No	Yes	No
Number of prenatal doula interactions				
0	0	0	0	0
1	0	0	0	0
2	0	5	1	4
3	2	4	4	2
4 or more	1	2	1	2
Number of postnatal doula interactions				
0	0	0	0	0
1	1	0	1	0
2	1	6	3	4
3	0	0	0	0
4_	1	5	2	4

The sample size was too small to come to valid conclusions, therefore the results of this study can be deemed inconclusive. Regarding the information yielded from this small sample, there did not appear to be any relationship between the number of times that the respondent met with doula and any postpartum depressive symptoms. There also did not appear to be a relationship between the number of the times they met postnatally and the existence of postpartum depressive symptoms. Additionally, there was no relationship between what was discussed, or how many topics were discussed, at the prenatal or postpartum visits and whether respondents experienced postpartum depressive symptoms.

Role expectations

Nine of the respondents reported that their expectations of motherhood matched their experience, while five respondents indicated that there was a mismatch between

what they thought would be expected of them as a mother and the reality of their experience. Four of the five also experienced postpartum depressive symptoms, constituting four of the six respondents in this study who identified experiencing postpartum depressive symptoms. Two of the four were individuals with a history of depression. Only three respondents discussed the role of motherhood with their doula prenatally, while 10 discussed their new role as a mother with the doula postnatally.

Although the sample size was too small to find a valid relationship between the two, it was the strongest association in this sample regarding postpartum depressive symptoms. It suggests that there may be a relationship between the role strain experienced after giving birth and experiencing postpartum depressive symptoms.

Discussion

Discussion will focus on results from the data collected, and reasons for lack of response to this study.

Depressive Symptoms

While the survey did not yield enough results to warrant valid statistical analysis, it can be noted that 42% of the sample reported experiencing postpartum depressive symptoms. This is more than twice that of the national average of 9% to 18% (Ko, Farr, Dietz, & Robbins, 2012). It is unknown to this researcher as to what percentage of the national average includes women who have a previous history of depression, however 35% of this sample had a history of depression before becoming pregnant. Of those five individuals with a previous diagnosis of depression, three went on to experience postpartum depressive symptoms. If those five individuals were removed from the

sample altogether, the percentage of individuals in that sample who experienced postpartum depressive symptoms would be 22%, which is more in line with the national average.

Considering that three of the five individuals who had a prior history with depression went on to experience postpartum depressive symptoms, it is possible that the national average does not represent an accurate picture of the prevalence of postpartum depression. Only three of the six respondents who identified experiencing postpartum depressive symptoms sought treatment. If the national statistic is only able to identify the prevalence of postpartum depressive symptoms based on the number of women who seek treatment, this prevalence of this issue may be drastically underestimated.

Interactions with Doulas

With the small amount of data available to examine the relationship between doula visits and postpartum depressive symptoms, the researcher did not identify a trend regarding the number of prenatal or postnatal visits from the doula in relationship to whether the respondents experienced postpartum depressive symptoms. This is consistent with Morrell's (2006) finding that health visitors during the prenatal period do not impact postpartum depressive symptoms. However, because the survey did not ask about the severity of symptoms, it is unknown whether interactions with the doula mitigated severity for the six respondents who reported postpartum depressive symptoms.

Although this study was an exploratory study, with a larger sample size it would have been interesting to examine if the number of doula visits had an impact on individuals with a previous diagnosis of depression or other mental health condition

compared to those without such a history. Consistent with the literature that doulas can be a source of encouragement for mothers to participate in their own medical care (Gilliland, 2002), one of the three women who sought treatment for postpartum depressive symptoms was prompted to do so by interactions with her doula.

Interactions with doulas and depressive symptoms.

Due to the small sample size, the study was unable to reach any valid conclusions regarding a relationship between topics that were discussed with doulas either prenatally or postnatally, and the experience of postpartum depressive symptoms. It did not appear to matter how many topics were discussed, or what the topics were. This is again consistent with Morrell's (2006) finding that prenatal health visitors do not impact whether postpartum depressive symptoms are experienced. Interestingly, only two of the six respondents who reported experiencing postpartum depressive symptoms indicated that they discussed baby blues or feeling depressed with their doulas.

Role Expectations

This was the most conclusive area of this study. Consistent with McIntosh's (1993) findings that as many as 80% of new mothers struggle with the mismatch between their expected roles as mothers and the realities of their experience, this study suggests that when a mismatch occurred between mothers' expectations of motherhood and the realities of their experiences, postpartum depressive symptoms were likely to be present. Studies have found that doulas help to alleviate role expectations (Manning-Orenstein, 1997;McComish & Visger, 2009;Breedlove, 2005), however only three respondents

reported discussing the role of motherhood with their doula prenatally. This study could not establish a relationship between interactions with the doula and preventing role strain.

However, the study did not ask respondents whether the birth that they were reporting on was a first child or a subsequent child. Role strain related to a first birth makes logical sense, as mothers would not know what to expect. While role strain could still be applicable to subsequent births due to changes in role expectations, it would be less likely to have the same impact as for first-time moms. Future researchers could explore the differences in role strain for first-time versus non-first-time mothers, as well as the impact that interactions with the doulas shaped their reactions to the role change.

Implications for Social Work Practice

Three of the four respondents who reported a diagnosis of depression prior to becoming pregnant also reported experiencing postpartum depressive symptoms. While this sample size was too small to generalize to the greater population, it does suggest that those with a history of depression may be more vulnerable to experiencing postpartum depressive symptoms. Social workers who work with pregnant women should be aware of the potential for those individuals to experience postpartum depressive symptoms, even with doula or other health visitor intervention. Because social workers, like doulas, often deliver psychoeducation, which this study did not find to be effective in preventing postpartum depressive symptoms, social workers will need to be aware that postpartum depressive symptoms may be more influenced by treatment than by prevention, and respond accordingly.

Only half of the respondents who identified having postpartum depressive symptoms sought treatment. There are many possible reasons for this, including that those who did not seek treatment would not have sought treatment for mental health anyway, that they did not have an easy access to treatment during a period of new motherhood, that they were lacking in access to treatment due to lack of insurance or available medical care, or that the severity of their symptoms was not great enough to warrant seeking medical treatment. Social workers must recognize that some women may experience these symptoms and never seek treatment. Social workers who provide home visiting or case management services to new mothers, rather than those who provide psychotherapy in an office setting and are not exposed to new mothers unless they seek treatment, should be aware of the potential for symptoms to exist and for the new mother not to seek treatment on her own, for the variety of reasons mentioned above.

Implications for Policy

Doulas served as a touchpoint for individuals on a number of topics related to the birth process, including psychoeducation about postpartum depression and role expectations of motherhood. Because doulas are involved with women generally before and after giving birth, they represent an excellent way for women to receive psychoeducation and follow-up screening. Policies and laws related to pregnant women and new mothers should acknowledge the role that a doula can play in providing support throughout the pregnancy and birthing process, regardless of whether they have the ability to prevent or mitigate postpartum depressive symptoms. While only one individual in this study who experienced postpartum depressive symptoms sought treatment due to

discussions with the doula, that is one more individual who received treatment who might not have otherwise. Therefore, doulas may provide a service in postpartum screening or intervention that is not taking place through traditional medical services.

Implications for Research

As this study generated only a small amount of data on this topic, it is important that research investigate further how doulas can impact the experience of postpartum depressive symptoms. Future researchers with more time or resources could gain a better understanding of the relationship, if any, between birth doulas and women's experience with postpartum depressive symptoms. Additionally, future research could explore how or whether doulas have an impact on postpartum depressive symptoms for women with a history or current diagnosis of depression versus those without, as there may be an impact for one group but not for another.

The impact of the doula on the severity of postpartum symptoms should also be examined in future research. Postpartum depressive symptoms can range from mild to severe, and while doulas may not be able to prevent postpartum depressive symptoms entirely, they may be able to mitigate them. This study failed to address the issue of severity of symptoms, and future studies could use that to come to a greater understanding of the relationship of the doula to postpartum depressive symptoms.

Future research should also explore how doula intervention could impact experience with postpartum depressive symptoms with first-time mothers versus experienced mothers. While this was not examined in the literature, it is possible that experienced mothers may have a different experience with postpartum depressive

symptoms for a variety of factors. For example, if examining the postpartum experience through the lens of role strain, experienced mothers may have resolved their role conflict issues regarding motherhood, and may be more protected against symptoms for subsequent births.

Lastly, future researchers with more time and resources should expand the scope study to include populations in other geographic areas, include mothers of other races and ethnicities, and mothers of other socioeconomic classes. Although the use of a doula may be limited to those with the resources to afford one, it is possible that there are individuals whose doulas are covered by insurance, or who have access to doulas with sliding scale fees or who provide services free of charge via a non-profit. This would expand the population who has access to doula services, and would make future research stronger and more generalizable.

Strengths and Limitations

Limitations.

The most significant limitation of this study was the lack of a valid survey tool. The original tool was not tested for reliability or validity. After examining the data, the researcher identified areas where the survey tool could be improved to provide greater understanding of the issues. For example, the survey failed to capture details about whether the birth that respondents were reporting on was a first birth or subsequent one, which would have been important in considering whether respondents experienced the role strain of becoming a mother. The survey also failed to capture respondents' ongoing experience with depressive symptoms. The survey asked only if there was a previous

diagnosis of depression and if respondents experienced depressive symptoms during pregnancy, but did not capture whether the respondents were experiencing depression leading up to pregnancy. A previous diagnosis of depression could have occurred in the distant past with no depressive symptoms at the time of conception, which could have a significantly different impact on the experience of postpartum depressive symptoms than for an individual who had an ongoing experience of depression or other mental health conditions.

An additional limitation of this study was its quantitative approach, which prevented the researcher from gaining a deep understanding of the respondents' experience with postpartum depressive symptoms, and their experiences with their doulas. A qualitative approach may have served this study better. Interviews with mothers could potentially capture their experiences in a more nuanced way. For example, if severity of symptoms was to be considered, it would be productive to be able to gain an understanding of how individuals defined levels of severity. An additionally helpful aspect of the doula-client relationship that could be better examined through a qualitative approach would be the strength of the relationship. Although pregnant women and their doulas may have met a number of times or discussed certain topics, this is not necessarily indicative of the quality of their relationship, which could have a further impact on clients' experience with postpartum depressive symptoms. Demographically, which will be discussed further, respondents came from similar socioeconomic statuses and with similar levels of education. These individuals would have likely had access to other information or support which played a role in their postpartum experience. A qualitative approach could help isolate the role of the doula.

Lastly, a significant limitation of this study is that it captured a homogenous sample. All respondents were of the same race. A natural limitation based on the pool of doulas that were solicited for this study was that respondents would likely reside, or have recently resided, in similar geographic locations, most likely including Minnesota or Wisconsin. Socioeconomic status and educational attainment were also similar amongst respondents. While one individual had both less than a college education and an income of $50,000 or less, the remaining 13 respondents were all college-educated and solidly middle to upper-middle class. Increased education and increased income provided these respondents with the potential for more access to psychoeducation, support, resources, and access to treatment. Therefore, the doula may have not had as significant impact on these individuals as they might have had on other individuals without as much support and resources. To gain the best understanding of the role of the doula in relationship to postpartum depressive symptoms, future researchers should include women from varying demographic and geographic pools.

Strengths.

The strength of the study was its investigative nature, exploring a topic that has been under-examined in the literature. Additionally, although a qualitative approach may have served the research better in terms of depth of understanding of this experience, the anonymous survey allowed respondents the freedom to report on potentially difficult topics without concern of the judgment of the researcher. It is possible that respondents were more honest by reporting anonymously than they would have been in an interview through a qualitative approach.

Reasons for Lack of Responses

Although there were not any research conclusions via data analysis, the lack of responses presents an interesting point of discussion. First, it is possible that this method of engagement did not work. The study design aimed to collect anonymous data from women who had used a doula, and the researcher was challenged to reach this population in a short period of time. The researcher also aimed to gather data from the widest selection of women possible, and therefore did not want to utilize an organization that was geographically localized, such as a local hospital or clinic. However, a blind email solicitation to doulas relied entirely on email addresses being correct on the website, the doulas' opening and reading the email, and their time, willingness, and ability to forward the information to clients. Additionally, the researcher was bound by discussions with the doula organization to elicit study participation only once, with no follow-up, which put further pressure on the initial email outreach to the doulas.

Second, as mentioned above, it is possible that the lack of responses was due to a lack of willingness on the part of the doulas to re-engage with former clients, due to a lack of ongoing connection, a lack of interest, or reticence regarding this topic specifically. The doula organization had expressed reservations about approaching new mothers with a survey request due to their desire to let new mothers focus on the first year of motherhood. Although the organization's board agreed to let the researcher contact their member doulas regarding this project, it is possible that the member doulas also embraced this philosophy and did not want to impose on their clientele. Additionally, factors may have been related to the doula-client relationship itself, such as a lack of ongoing relationships with clients once the birth had taken place. Doulas and

clients may have not used email communication regularly, preventing doulas from easily forwarding the survey link, or the doulas may have not retained that contact information after services had been rendered. If the doulas and clients had not had email communication or the doulas had not retained the email contact information, it would have required effort on the part of the doulas to contact former clients and solicit their participation in the study, making it unlikely that they would have done so.

Third, the lack of responses may have been that some of the doulas contacted, although willing to participate, did not have enough of a client base to work with. Three doulas responded to the researcher's email by sending emails expressing their willingness to participate and excitement for the project, but one doula admitted that she had not had many clients yet and therefore would not be able to be of much help.

Lastly, the lack of responses may have been a result of lack of time or willingness on the part of the mothers who received the survey. They may have been too occupied with new or ongoing motherhood to complete the survey, or may have not wanted to revisit emotions surrounding post-partum depression.

Implications for Social Work Practice

Although there was not any data produced by this study that could inform social work practice, some of the reasons listed as possible explanations for the lack of responses could inform social workers interested in working with new mothers or doulas. The doula organization's initial hesitation to participate in the project due to not wanting to bother new mothers could also inform practice, as it hints at two things. One, that the community of doulas and birthing mothers may be protective, and two, that the new

motherhood period may be a time regarded as protected, sheltered, and private. Social workers interested in working with doulas or new mothers may want to consider these possibilities before engaging with these populations.

Implications for Policy

As previously mentioned, the lack of data prevents this researcher from making suggestions for policy. However, the lack of existing data in the literature and this researcher's inability to collect data for this study do suggest that policy makers are challenged to find and develop useful information with which to make policy decisions. Policy makers may want to investigate this topic further before moving forward with policy creation and implementation.

Implications for Research

The lack of existing data and the lack of response rate for this study's purposes suggest that more research is needed on this topic. The low response rate may be informative to researchers in that an anonymous, online survey may not be the best way to collect this type of information. Study on this topic may be better served by a different methodology. Additionally, timing may be important, as doulas and new mothers may not be as receptive to providing information during the mother's first year of motherhood as they would at other times.

Strengths and Limitations

The researcher had hoped that the strength of this study was its ability to generate a maximum amount of data considering the researcher's scope in order to investigate this under-examined topic. This strength was seemingly served by the study design, including

the short, anonymous survey, which seemed easy for new mothers with limited time. However, the lack of responses suggests that this approach did not work. Using doulas as an intermediary relied upon the doula taking the time and effort to contact current or former clients, which, for the reasons outlined previously, may not have been feasible.

The main limitation of the study was its reliance on the doulas as intermediaries between the researcher and the study participants, as well as the use of an email blast to elicit doula participation. One email from the researcher may have not been enough to motivate or engage the doulas to participate. Contact methods were a significant limitation of this study and future research would do well to find a different approach.

Finally, the online survey, although it provided the anonymity the researcher was seeking, failed to capture the complex experience of new mothers and post partum depressive symptoms. The survey tool also had not been tested for validity. The study implicitly had these limitations, and future research may be better served by utilizing a different approach, such as a qualitative design.

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders. (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2007). Postpartum depression fact sheet. Washington, DC: American Psychological Association. Retrieved from: http://www.apa.org/pi/women/programs/depression/postpartum.aspx?item=3

Battle, C. & Zlotnick, C. (2005). Prevention of Postpartum Depression. *Psychiatric Annals, 35*(7).

Beck, C.T. (2002). Postpartum depression: A metasynthesis. *Qualitative Health Research,* 12(4), 453-472. doi:10.1177/104973202129120016

Biddle, B.J. (1986). Recent development in role theory. *Annual Review of Sociology, 12,* 67-92.

Breedlove, G. (2005). Perceptions of social support from pregnant and parenting teens using community-based doulas. *Journal of Perinatal Education, 14*(3).

Campbell, D., Scott. K.D., Klaus, M.H., & Falk, M. (2007). Female relatives or friends trained as labor doulas: Outcomes at 6 to 8 weeks postpartum. *Birth, 34*(3). doi:10.1111/j.1523-536X2007.00174x

Collins, N.L., Dunkel-Schetter, C., Lobel, M., & Scrimshaw, S.C.M. (1993). Social Support in pregnancy: Psychosocial correlates of birth outcomes and postpartum depression. *Journal of Personality and Social Psychology, 65*(6), 1243-1258. doi:10.1037/0022-3514.65.6.1243

Gentry, Q.M., Nolte, K.M., Gonzalez, A., Pearson, M., & Ivey, S. (2010). "Going beyond the call of doula: A grounded theory analysis of the diverse roles community-

based doulas play in the lives of pregnant and parenting adolescent mothers. *The Journal of Perinatal Education, 19*(4), 24-40. doi:10.1624/105812410X530910

Gilliland, A. (2002). Beyond holding hands: the modern role of the professional doula. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 31*(6).

Goode, W.J. (1960). A theory of role strain. *American Sociological Review, 25*(4), 483-496.

Gordon, N.P., Walton, D., McAdam, E., Derman, J., Gallitero, G., & Garret, L. (1999). Effects of providing hospital-based doulas in health maintenance organization hospitals. *Obstetrics and Gynecology, 93*(3), 422-426.

Hans, S.L., Thullen, M., Henson, L.G., Lee, H., Edwards, R.C., & Bernstein, V.J. (2013). Promoting positive mother-infant relationships: A randomized trial of community doula support for young mothers. *Infant Mental Health Journal, 34*(5). doi:10.1002/imjh.21400

Henshaw, C.A. (2004). What do women think about treatments for postnatal depression? *Clinical Effectiveness in Nursing, 8(3-4),* 170-175. doi:10.1016/j.cein2005.03.003

Hutchison, E.D. (2011). *Dimensions of Human Behavior*. Thousand Oaks, California: SAGE Publications.

Ko, J.Y., Farr, S.L., Dietz, P.M. & Robbins, C.L. (2012). Depression and treatment Among U.S. pregnant and nonpregnant women of reproductive age 2005-2009. *Journal of Women's Health, 21*(8), 830-836. doi:10.1089/jwh.2011.3466

Koumoultzes-Douvia, J. & Carr, C. (2006). Women's perceptions of their doulas support.

The Journal of Perinatal Education, 15(4).

Lee, D.T.S., & Chung, T.K.H. (2007). Postnatal depression: An update. *Best Practice & Research Clinical Obstetrics & Gynaecology, 21(2),* 183-191. doi:10.1016/j.bpobgyn.2006.10.003

Lee Phillips, D. & Kelly, C. (2014). Social work should embrace doulas. *Health & Social Work, 39*(2).

Manning Orenstein, G. (1999). A birth intervention: The therapeutic effects of doula support versus lamaze preparation on first-time mothers' working models of caregiving. *Complementary Therapies in Medicine, 7*(4). Doi:10.1016/S0965-2299(99)80014-4

McComish, J. F. & Visger, J.M. (2009). Domains of postpartum doula care and maternal responsiveness and competence. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 38*(2).

McComish, J., Groh, C.J., & Moldenhauer, J.A. (2013). Development of a doula intervention for postpartum depressive symptoms: Participants' Recommendations. *Journal of Child and Adolescent Psychiatric Nursing, 26*(1), 3-15. doi: 10.1111/jcap.12019

McIntosh, J. (1993). The experience of motherhood and the development of depression in the postnatal period. *Journal of Clinical Nursing, 2*(4), 243-249. doi:10.1111/j.1365-2702.1993.tb00171.x

Morrell, C.J. (2006). Review of interventions to prevent or treat postnatal depression. *Clinical Effectiveness in Nursing, 9.*

Orhon, F.S., Ulukol, B., & Soykan, A. (2007). Postpartum mood disorders and maternal

perceptions of infant patterns in well-child follow up visits. *Acta Paediatrica, 96(12),*1777-1783. doi:10/1111/j.1651-2227.2007.00557.x

Stuart, S.S., O'Hara, M.W., & Gorman, L.L. (2003). The prevention and psychotherapeutic treatment of postpartum depression. *Archives of Women's Mental Health, 6*(s2), s57-s69. doi:10.1007/s00737-003-0003-y

Xie, R., He, G., Koszycki, D., Walker, M., & Wen, S.W. (2009). Prenatal social support, postnatal social support, and postpartum depression. *Annals of Epidemiology, 19*(9), 637-643. doi:10.1016/j.annepidem,2009.03.008

Appendix A

[Doula Organization]
[Address]
[Address]
[Address]

January 27, 2015

Re: Statement of Support of Research

The [doula organization] hereby issues this statement of support for the MSW clinical research project of Devon Siegel, examining mothers' perceptions of the impact of birth doulas on post partum depressive symptoms. The student is allowed to contact our members to solicit participation in her project.

[Name], President of [doula organization]

Appendix B

Mothers' Perceptions of the Impact of Birth Doulas on Post Partum Depressive Symptoms
INFORMATION AND CONSENT

Introduction:
You are invited to participate in a research study investigating the role of your birth doula and how she impacted you during and after your pregnancy on a variety of factors, such as post partum depressive symptoms and questions that you had before, during, and after delivery. This study is being conducted by Devon Siegel, a graduate student at St. Catherine University under the supervision of Dr. Pa Der Vang, a faculty member in the Department of Social Work. You were selected as a possible participant in this research because you used a birth doula with one of your births within the last five years. Please read this form and ask questions before you agree to be in the study.

Background Information:
The purpose of this study is to investigate the role of the birth doula and the doula's impact on the mother during and after pregnancy on a variety of factors, such as post partum depressive symptoms and questions that mothers had before, during, and after delivery. Approximately 30-40 people are expected to participate in this research.

Procedures:
If you decide to participate, you will be asked to complete this survey, asking you questions about your prenatal, birth, and postpartum experiences. This study will take approximately 15 minutes to complete.

Risks and Benefits of being in the study:
The study has minimal risks.

There are no direct benefits to you for participating in this research.

Confidentiality:
Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. This survey is anonymous, and so your identity will not be known to the researcher.

I will keep the research results on a password protected flash drive in a locked file cabinet in my home and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 1, 2015. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:
Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with your doulas or St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:
If you have any questions, please feel free to contact me, Devon Siegel, at 773-351-7206. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Pa Der Vang, 651-690-8647, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:
You are making a decision whether or not to participate. Your submission of the completed survey indicates that you have read this information and your questions have been answered. Even after completing this survey, please know that you may withdraw from the study.

By completing this online survey and submitting it to the researcher, I consent to participate in the study.

Appendix C

Survey Questions

The questions on this survey are asking about the most recent time you gave birth when you used a doula.

1. Please indicate the age you were at the most recent birth you had when you used a doula:

-18-22

-23-25

-26-29

-30-34

-35-40

2. Please indicate your highest level of education:

-HS Diploma or GED

-Some college

-Associate's degree

Bachelor's degree

-Master's degree

-Doctorate degree

3. Please indicate your total, gross annual household income:

-$0-$50,000

-$50,001-$75,000

-$75,001-$100,000

-$100,001-$150,000

-$150,001 and above

4. Please indicate your race:

-Caucasian

-African or African-American

-Asian or Pacific Islander

-Native American

-Latina

2. How many times did you meet with your doula before the birth?

-0

-1

-2

-3

-4+

3. If you met with your doula before the birth, what topics did you discuss? Please indicate all that apply:

- Information/education about pregnancy

-Information/education about the birth process

-Information/education about mental health, including post partum depression

-Information/education about what to expect after giving birth

-Discussion about the role of motherhood

-Other

4. Was your doula present at your birth?

-Yes

-No

5. Before becoming pregnant, were you ever diagnosed with depression?

-Yes

-No

6. Before becoming pregnant, were you ever diagnosed with a mental health condition other than depression?

-Yes

-No

7. During your pregnancy, did you experience any depressive symptoms?

-Yes

-No

8. If yes, were you treated for these symptoms?

-Yes

-No

9. How many times did you speak with your doula or visit with your doula after the birth?

-0

-1

-2

-3

-4+

10. What topics did you discuss with your doula after the birth?

-The birth experience

-Your new role as a mother

-Taking care of the baby

-Self-care

-Personal and family relationships

-Baby blues or feeling depressed

-Mental health issues other than depression

11. After giving birth, did you experience any depressive symptoms? These include the following: feeling "down" all or most of the day, loss of interest or pleasure in most or all activities, weight or appetite changes not associated with pregnancy, birth, or breastfeeding, insomnia or sleeping too much, feeling restless or feeling slower than normal, feeling fatigued or without energy nearly every day, feeling worthless or guilty almost every day, feeling less able to think or concentrate almost every day, or thinking about death or suicide.

-Yes

-No

12. If yes, were you treated for these symptoms?

-Yes

-No

-Not applicable

13. If you were treated for these symptoms, did discussions with your doula prompt you to seek treatment or did you seek treatment on your own?

-Discussions with doula prompted

-Sought treatment on my own

-Not applicable

14. After giving birth, did you feel that your expectations of what would be expected of you as a mother match your experience?

-Yes

-No