Midwifery 27 (2011) e214–e221

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Postpartum doulas: Motivations and perceptions of practice

Kimberly Campbell-Voytal, PhD, RN (Assistant Professor)[a,*],
Judith Fry McComish, PhD, RN (Associate Professor)[b], Joan M. Visger, PhD(c), CNM (Instructor)[b],
Carolynn A. Rowland, PhD, RN (Director)[c],
Jacqueline Kelleher, BS, CD(DONA), PCD(DONA) (Certified Birth and Postpartum Doula)[d]

[a] Department of Family, Medicine and Public Health Sciences, School of Medicine, Wayne State University, 3939 Woodward, Ave, #220, Detroit, MI 48201, USA
[b] Department of Family, Community and Mental Health, College of Nursing, Wayne State University, # 258 Cohn Building, 5557 Cass Avenue, Detroit, MI 48202, USA
[c] Maternal Infant Health Services, Detroit Department of Health and Wellness Promotion, 1151 Taylor Street, Detroit, MI 48202, USA
[d] 20 W. Glen Circle, Media, PA 19063, USA

ARTICLE INFO

Article history:
Received 20 October 2009
Received in revised form
24 September 2010
Accepted 27 September 2010

Keywords:
Postpartum doula
Qualitative analysis
United States
Postpartum support

ABSTRACT

Objective: to describe the perceptions of a US cohort of experienced birth doulas who were among the first in the country to be trained to provide postpartum support.
Design: a qualitative, longitudinal study using ethnographic methods; participant observation and semi-structured interviews.
Setting: midwestern, urban, US; postpartum home care over three months.
Participants: four postpartum doulas; 13 families.
Measurements: participant observation during six postpartum home visits per family; 13 semi-structured interviews with doulas at the completion of each family's care; four summative interviews with doulas at the end of the study.
Findings: when describing their postpartum practice, four themes emerged: supporting women, taking the mother's perspective, empowering women and empowering families. When speaking of the motivations, three themes emerged: being 'called' to practice, interest in preventing negative experiences, and career development.
Key conclusions and implications for practice: in the US, new mothers see midwives and doctors sporadically after discharge from the hospital. Postpartum doulas fill this gap in continuity of care by providing support for families as they transition to life with their new infant. Understanding the beliefs, values and practices of these important paraprofessionals will help midwives effectively integrate postpartum doula care into the care of women and infants.

Introduction

Doula care has its roots in the tradition of women supporting other women during labour and birth. In ancient times, this support was typically provided by a family member or an experienced local woman. As maternity care in industrialised countries evolved to become more medicalised, and as families began living further apart, labouring women received less family support and there has emerged a need for support from other caregivers. The doula provides continuous physical, emotional and advocacy support during labour and birth, but does not provide medical or midwifery and nursing care. In the past decade, the role has evolved to include postpartum care, encompassing 11 domains of support (McComish and Visger, 2009).

In 1992, the Doulas of North America (now DONA International) was formed to provide collegial support to doulas, and standardised training and certification of doulas. In 2002, DONA began certifying doulas to provide postpartum care (DONA International, 2006). Although other organisations, including the Childbirth and Postpartum Professional Association (CAPPA), the Association of Labor Assistants and Childbirth Educators (ALACE), Childbirth International, International Childbirth Education Association (ICEA) and others train and certify doulas, DONA is the largest organisation training and certifying postpartum doulas.

As of June 2010, DONA reported that there are 2723 active DONA-certified birth doulas worldwide (2230 in the USA, 308 in Canada and 85 in other countries). In addition, there are 319 DONA-certified postpartum doulas worldwide (290 in the USA, 26 in Canada and three in other countries). Finally, there are 120 doulas that are DONA-certified as both birth and postpartum doulas (100 in the USA, 17 in Canada and three in other countries) (S. Toffolon, personal communication, 14 June 2010). Currently, DONA has placed greater emphasis

* Corresponding author.
E-mail address: kvoytal@med.wayne.edu (K. Campbell-Voytal).

0266-6138/$ - see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.midw.2010.09.006

on increasing cultural diversity among trainers and in the training curriculum, and supporting efforts to develop labour and postpartum support programmes globally (N. Heidbreder, personal communication, 2 June 2010).

Doula care is available in Europe, Central and South America, and Asia. The role of postpartum doulas is similar across settings, although differences in national economies, systems of health care and scope of midwifery practice contribute to variability (Benoit et al., 2005). In Austria, for example, the Government recognises the needs of immigrants and subsidises birth doula services for them. In the Netherlands, the national health-care system has historically guaranteed access to home birth (35% of all deliveries, 50% attended by midwives) and postpartum home care (provided by maternity home care assistants, 'kraamverzorgenden') for all women (Van Teijlingen, 1990; DeVries, 2001; Benoit et al., 2005; Christiaens and Bracke, 2007). Birth doulas are more recent phenomena in the Netherlands and have been certified since 2006. There is no mention of postpartum doulas on the Netherlands national website for doulas (http://www.doula.nl.english.htm). Similarly, in Australia, the Government subsidises postpartum care from domicile midwives for qualifying women (Cooke and Barclay, 1999), shifting the emphasis in doula practice to labour support. Finally, in the UK, approximately 1000 doulas provide antenatal, birth and postnatal services (Chakladar, 2009).

The global trend to organise and standardise doula practice is evident in efforts to create a coalition of European doulas. In 2007, this coalition published 'The European Doula Guide' which addresses doula care in Austria, Belgium, Cyprus, Czech Republic, France, Germany, Ireland, Hungary, Netherlands, Portugal, Spain, Switzerland, the UK, Denmark, Italy, Latvia, Luxembourg, Finland and Sweden (Association Doulas de France, 2007). This is seen as the first step in creating a European doula organisation and formalising guidelines for doula practice across Europe. On the basis of information on this same website, as of May 2007, it was estimated that there were 1060 active doulas and 900 trainees in Europe.

In the USA, with its system of privately funded health care, doula practice primarily takes three forms: doulas are employed by hospitals, work independently, or are affiliated with community-based programmes where they volunteer or receive a wage (Kuczkowski, 2007). In a survey of a nationally representative sample of birth doulas in the USA (Lantz et al., 2005), it was found that US doulas were primarily White, well-educated married women with children. The majority worked in solo practice and provided birth support services to an average of nine clients per year. Few doulas in that sample earned more than $5000 USD per year and only 10% were reimbursed through private health insurance companies. In 2010, US doulas were approved to apply for a provider number, which is the first step to seeking reimbursement from public and privately financed insurers (DONA International, 2009).

Generally, women who receive birth doula services in the USA are only slightly more ethnically diverse than the doulas themselves (Lantz et al., 2005). Woman of colour and/or economically disadvantaged women often receive services through hospital and community-based programmes. Over 100 US hospitals offer doula programmes, including the University of North Carolina at Chapel Hill and the University of California, San Diego (Ballen and Fulcher, 2006). Johns Hopkins School of Nursing offers an undergraduate course preparing birth doulas, and provides doula services to community women without charge (Jordan et al., 2002; Johns Hopkins School of Nursing, 2007). In other communities, community-based doula programmes (e.g. Chicago Health Connection, CoMadres in NC) employ doulas recruited from the community to provide doula services to low- income women. Most programmes are supported by grant funding and many are offered to mothers at no charge (Ballen and Fulcher, 2006). Doula practice in the USA typically involves being on call for the birth, and may involve overnight home stays during postpartum care.

While literature on doula outcomes is growing, to date it has focused primarily on intrapartum outcomes (Kennell et al., 1991; Scott et al., 1999; Hodnett et al., 2007). Evidence from several meta-analyses (Zhang et al., 1996; Scott et al., 1999; Hodnett et al., 2007) supports the effectiveness of continuous labour support. The most recent (Hodnett et al., 2007), which included 16 studies conducted in 11 countries with over 13,000 women from a variety of settings and circumstances, found that continuous intrapartum support decreases medical interventions, caesarean deliveries, and complications of pregnancy and birth, and increases maternal satisfaction. It has been suggested that vulnerable or disadvantaged women may benefit more than advantaged women from birth doula support (Kennell et al., 1991; Abramson et al., 2000; Pascali-Bonaro and Kroeger, 2004), but support for this hypothesis has not yet been published.

Several studies have examined the effect of birth doula support on postpartum outcomes. For example, in the earliest study, Sosa et al. (1980) reported that mothers with a birth doula engaged in more positive behaviours with their infant in the first hour following birth. Others found that mothers who had a birth doula were more likely to breast feed at six weeks post partum and less likely to be depressed at six and 12 weeks post partum than mothers who received standard care (Hofmeyr et al., 1991; Trotter et al., 1992; Wolman et al., 1993). More recently, Mottl-Santiago et al. (2007) reported that women who received birth doula care were more likely to express breast-feeding intent and to initiate breast feeding within one hour of birth. Finally, breast feeding at six weeks post partum was examined among women who received birth support and two home visits within the first 10 days post partum (Nommsen-Rivers et al., 2009). The authors found that, overall, women who received doula support during birth and two home visits within the first 10 days post partum were not more likely than women in the standard care group to breast feed at six weeks post partum. However, women with an existing stressor such as substance abuse, tobacco use, depression or anxiety, or another chronic health condition were two times more likely to breast feed at six weeks post partum.

Five qualitative studies, conducted in the USA, explored birth doula beliefs and values regarding the care of labouring women. Two studies described doula goals of supporting and empowering labouring women as efforts to protect 'birth territory' (Holland, 2009) or to impart 'specialized women's knowledge' (Deitrick and Draves, 2008). Holland identified that doulas were successful because they created a 'relational space' where exchange is balanced and reciprocal as opposed to asymmetrically dominated by medicalisation. In another study (Hunter, 2007), doulas reported that, as educators, they honoured a women's innate knowledge of herself and her body and supported her right to resist technological dominance. In a fourth study, Meltzer (2004) identified that hospital-based doulas engaged in two types of advocacy: action-oriented, where the doula acts overtly or confronts the health-care system to advance the interests of the labouring woman; and passive advocacy, where the doula supports the woman's self-advocacy in silence. Finally, Brandt (2007) explored the spiritual motivations of doula practice. She noted that doulas believed that women have a sacred right to understand and claim their power to give birth on their own terms, and doulas worked to preserve this right. The continuity of perspectives between birth doulas and postpartum doulas has not been explored empirically. Understanding the motives and attitudes of doulas in postpartum practice may assist midwives to more effectively use their services in the future

This report uses ethnographic methods to explore the doula's perspective on the expansion of practice into postpartum care and the effect on views of themselves as doulas. Ethnographic research

explores both etic (outsider) and emic (insider) views on life, and uncovers cultural meanings that help organise behaviour, define relationships and make sense of surroundings (Spradley, 1978; LeCompte and Schensul, 1999). The etic perspective of participant–observers who accompanied the doulas in their home visits complements the emic views of doulas and the women for whom they cared. It is the purpose of ethnography to see the world through the eyes of members of a culture and to document social interactions between members. This study focused on the culture of doula practice with families in the first three postpartum months.

Methods

This study received approval from the Human Investigation Committee of the supporting university, and informed consent was obtained from all participants by research staff. This research was part of a larger study that examined the content and process of postpartum doula care which has been reported elsewhere (McComish and Visger, 2009). This longitudinal study involved 20 months of observation and interviews with postpartum doulas.

Recruitment: doulas

A three-day postpartum doula training session for this study was offered by DONA International. Four certified birth doulas who completed the postpartum training agreed to participate in the study. Although each doula had 30 months of postpartum experience by the end of the study, the care they provided study mothers occurred shortly after they completed training. Thus, this study captured the unfolding nature of an expanded scope of practice for these doulas. Doulas invited women from their practices to participate in the study. Women became aware of their doulas through word-of-mouth, internet advertisement, and referral from a nurse midwife working in a local prenatal clinic. All women who were invited enrolled in the study, except one mother who refused for personal reasons. During the study, two mothers withdrew; one for health reasons unrelated to childbirth and another to return to work. Once interest was confirmed, a member of the research team accompanied the doula on the next prenatal home visit and obtained informed consent. Inclusion criteria for mothers were 18 years of age or older, English speaking, singleton birth, delivery at local hospital, and no known major medical or substance use risks. All mothers were enrolled prior to the birth of their infants. Nine women were attended by obstetricians and four by midwives during labour and birth.

Study procedures

Observer training

The team of seven observers consisted of academic researchers and graduate nursing students at the sponsoring university. Observers attended all the postpartum doula training sessions. Additionally, the observers received training on unobtrusive observation techniques consistent with the ethnographic methods. Guided practice and skill development for field observation and interactional note taking was provided by the study investigators.

Data collection

Home visit observations

Doula care in this study included birth (one or more prenatal visits in third trimester, continuous support during labour and birth, one postpartum hospital visit) and postpartum support (six home visits during the first 12 weeks following birth with telephone calls between visits). An assigned observer accompanied each doula throughout the series of home visits and documented the care provided in detailed field notes.

Interviews: doulas

Two to four weeks following completion of the postpartum home visits, each doula was interviewed by the observer in a quiet location in the community to review her perspectives on the care provided to the mother and family (case interview). Within one month of finishing the study, each doula participated in a final closure interview about the meaning of postpartum doula care in her own life. All interviews were audio recorded and transcribed verbatim. Data reported here are from case interviews and closure interviews conducted with doulas.

Data analysis

Analysis of field notes and doula and maternal interviews used a grounded theory approach in which an understanding of phenomena emerged from the data without a previously identified theoretical framework. Codes were developed by the coding team and became increasingly more conceptual as the phases of interpretation progressed. All observers participated in coding, and iterative cycles of reading and discussion produced the final code list. Final coding was completed in teams of two who reconciled coding differences through consensus. Code categories representing larger themes were traced across transcripts as higher levels of abstraction emerged between and across doula interviews. Trustworthiness of the findings was achieved through analysis by investigators with expertise in maternal child and community health, confirmation by three domain experts, including two experienced postpartum doulas, and prolonged engagement with the doulas and mothers (Morse et al., 2001; Patton, 2001). Finally, the doula interviews were triangulated with observer field notes and maternal interviews to expand and confirm doula reports.

Sample

Doulas

Demographic characteristics of the doulas are summarised in Table 1. As a group, the doulas were married with children, were 30–50 years of age, had some college education and an estimated household income $>$ $40,000. Two doulas were African American and two were Caucasian. Two were working as doulas full-time and were independently employed. The other two had other primary employment and provided doula care part-time. One part-time doula worked independently. During this study, doulas received a stipend for the care they provided each study mother.

The mothers who received postpartum care were ethnically diverse (seven were White, five were Black, one was American Indian), with a median age of 30 (range 19–36, standard deviation 6 years), and had a high school education (10/13). Most were married (9/13), were primiparas (8/13) and had a household income at or below $40,000/year (8/13). Five had full-time jobs prior to childbirth. In all families except one, fathers were involved in family life. For 10 families, the father of the baby lived in the home.

Findings

Findings are presented below under two main headings: 'Doula perspectives on postpartum doula practice' and 'Personal meaning of being a doula'.

Table 1
Demographic characteristics of postpartum doulas (n=4) [a].

Demographic characteristics	Values
Age in years, end of study: median (range)	42.50 (31–53)
Race	
African-American	2
Caucasian	2
Biological mother: yes	4
Education	
Some college	3
College graduate	1
Married: yes	
Beginning of study	3
End of study	4
Estimated household income	
$40,000–$59,999	3
≥ $60,000	1
Certified as birth doula, beginning of study	
Yes, less than one year	3
Not certified[b]	1
Experience as birth doula, beginning of study	
Months: median (range)	20.00 (8–36)
Certified as postpartum doula	
Beginning of study	0
End of study	1
Experience as postpartum doula, end of study	
30 months[c]	4
Postpartum doula work status	
Employed part-time as doula, had other employment	1
Employed full-time as doula, only source of income	2
Volunteer doula only, had other full-time employment	1

[a] Data are reported as frequency unless otherwise noted.
[b] This doula received birth doula certification within one month of study start-up.
[c] All four doulas received Doulas of North America postpartum training as part of study, before data collection began. One doula provided care to new mothers in the community for 13 years prior to study.

Doula perspectives on postpartum doula practice

When speaking of their practice with women and families in the postpartum phase of childbirth, the doulas' perspectives clustered into four themes: supporting women taking the mother's perspective, empowering women, and empowering families. Collectively, these themes reflect the desire to create a positive postpartum experience for the families with whom doulas worked. These themes were closely aligned with the postpartum care that was observed during home visits and with mother's reports of their relationship with their doula.

Supporting women

When discussing their work with specific women and in describing the meaning of their work in general, doulas concurred that they valued the support role and they spoke specifically about four important aspects: presence, listening, protection and translation between parents' expectations and the challenges of integrating a new infant into the family. Quotes from doulas exemplify these aspects of emotional support:

Presence

> The most important thing I believe [that I did for her] was just being there. I let her know, there wasn't a set [time limit]…I wanted her to know that everything she had to say was important. [D#2]

Listening

> Over the course of time I think we finally defined what that problem was through our ongoing talking relationship, and that is usually the case. Sometimes it takes a couple of months of listening and listening to somebody talk and describing what's going on in their family, and then finally it sinks in. [D#4]

Protection

> We talked an awful lot on the phone. She was able to vent, to process and I think that as a postpartum doula, I was able to hear her and be the sounding block. I would like to think that I helped her not go over the deep end with her depression, but to realise that she needed to get somewhere to get medication and support. [D#3]

Translation

> [Mothers] get excited when they read in a book and [see] that their baby is way ahead of schedule, you know. [I] help them to use it as a reference and to just enjoy their baby. You look at milestones as opportunities …and then you can just let go of those milestones… [It is my job] to get them to understand that their child is theirs specifically and their child has [her] own clock. [D#3]

Field observers frequently noted instances of doulas' active listening, following parents' lead during discussions, and encouraging parents to pause, reflect, and take time for themselves. Significant emotional support was provided during the retelling of the 'birth story' where doulas joined mothers in remembering the birth. Observers noted that mothers reflected on how doulas protected them from unwanted advice or intrusion from well-meaning family members. Mothers with other children spoke of how doulas' emotional support helped them avoid guilt and exhaustion when managing multiple competing demands. In these instances, doulas helped mothers translate between feelings, hopes and dreams, and external realities.

Taking the mother's perspective

A second theme in the doula narratives was empathy with the mother. This involved instances where the doula adapted to the mother's perspectives or desires. Doulas put aside their own ways of doing things and viewed things through the eyes of the mother and her family. One doula described it as follows:

> I think that being a doula, it's sort of the flexibility to adapt to what a person needs at that time. The word doula …comes from a Greek word that is basically saying that you have nothing, no opinion, nothing. It's hard to get to that point where you can actually put yourself in the mind set of (the mother). You know this is not your life and this isn't how you would do it …and you have to set that aside and look at what it is that this mother needs. [D#4]

Observational and maternal comments support these perspectives. Observers cited instances when doulas actively adjusted to changing maternal preferences. Plans for breast feeding or expectations for returning to work were common instances where doulas adapted strategies to the mother's changing desires. Regarding empathy, a mother commented:

> …We had this mental connection-thing going on… She understood right where I was emotionally all the time. [M11]

Empowering women

Empowering women was a major theme in all descriptions of the importance of being a doula. For postpartum doulas, empowerment included sharing information and affirming women's values and opinions so that their transition to motherhood was optimal. The following quotes reflect doulas' perceptions of these aspects of empowerment.

Information/self-knowledge

> I think (the most important thing about being a doula is), empowering women and getting information to them so they know the choices they have in child rearing. [D#1]

Affirmation

> I found this woman really guarded and protective over her child and family… She really didn't want anybody in her life that was going to counteract the decisions that she was making as a new mother. I respected that. [D#2]

Choice/control

> When it got time for her to make a choice to go back to work, which she didn't want to do, we had a lot of long talks. Just being able to talk to somebody about that and helping them find the resources and referrals to day care. And encouraging her to go and interview these people by herself was a very good thing. It gave her [the feeling that] this is my child and I want to know how [he's] going to be taken care of and to find the confidence within herself to go back to work.' [D#1]

Observational data confirm these perspectives of postpartum doulas as health educators and supporters of maternal self-efficacy. There was an educative component to each home visit and notes captured evidence of doulas bringing a range of resources to new parents in order to facilitate informed choices. Field notes also captured evidence of doula activities that supported the mother's confidence and efficacy in, for instance, infant care, soothing, feeding, sibling care, and maternal role development.

A common comment from mothers, about what they valued most about doula care was the importance of affirmation. One stated:

> Just coming and visiting and talking, … reaffirming what we were doing was right.. sharing in the excitement…You know, true friendship. [M11]

Another responded:

> She provided me with information to help myself. She helped me take care of me. If I could take care of me, I could take care of my children. [M07]

Empowering families

The final theme that doulas discussed regarding the care they provided was empowering families as they integrate the newborn infant into the family. As the following quote during that critical first hour of this transition reflects, aspects of this theme include flexibility, following family cues, and assisting families to develop parenting skills:

> They are a very strong family unit. It was important that other family members stayed out of the immediate focus within the first hour of birth…They wanted it very intimate, to establish breast feeding right away. It was very important for them to say hello to this baby as a strong family unit. [D#3]

Another stated:

> …the baby was definitely his [the father's] pride and joy …just the fact that we had to schedule our appointments based around him, …that he wanted to be home to participate…was awesome for me. [D#1]

Specific instances of doula efforts to support the confidence and sensitivity of the baby's father were noted by the observers. For example, with fathers who were less engaged during home visits, observers noted the doula's active efforts to draw the fathers into the visit and to support their relationships with their children. During an interview, one father commented:

> …I think she helped us to trust [ourselves], trust our instincts a lot more. She boosted both [of] our confidence. [M04]

In all cases except one, the doula was able to establish an effective relationship with the new parents. In this exceptional case, parents felt that the doula had not clearly explained her postpartum role and they found they were dissatisfied with what subsequently occurred. Personality differences were evident to observers during home visits for this family. Due to an unplanned caesarean section, the doula was not present for the birth. In the closure interview, the doula reported that she felt the family continued to grieve not having a vaginal birth, and this was their major unmet need during postpartum care.

Personal meaning of being a doula

When doulas spoke of their motivations, hopes and expectations for their work as doulas, three themes emerged: being called, preventing negative experiences and career development.

Being 'called'

Doulas differed in terms of the circumstances leading to their doula career. Three doulas identified a sense of being influenced by external forces or powers, and spoke of being 'called' or 'chosen' for the role by influential people (a doctor, a supervisor, another mother) who noticed special talents. These special talents were related to their sensitivity to and ability to connect with childbearing women.

Before she knew about doula care as a career, one doula provided birth support as a volunteer. She stated:

> A doctor (said), 'You come here (to the hospital) so much, you know everything, the policies, etc. You know, people get paid to do this' (laughing). … I didn't really believe him. [D#4]

The doulas spoke with feeling about the power of birth as a transformative force. When asked what being a doula meant to her, one doula stated:

> I feel like what I'm here on this earth to do is be a doula. This is where I'm supposed to be …I just really feel like this is my life's journey. [When] I heard about it, it was just something that struck me in my gut. Like whoa, I have to check this out and it was something that I would really like to do…and I jumped on it. [D#3]

The fourth doula identified an internal desire to start a new career:

> Call it a mid-life crisis. Call it [divine] intervention. Call it,… it was just time to do something. I always wanted to do this, and the time was right, and I had good people to help me on my path. And, once it was chosen, it was easy to become a doula and I'm glad I did. [D#1]

Preventing negative experiences

When talking about motivation for their careers, doulas reflected on their own birth experiences. Two doulas spoke of regrets or inadequacies in their birth or postpartum experiences, and another reflected on positive personal experience as motivation to help other women:

> I tend to be somebody who doesn't have real easy recoveries… My body just doesn't recover. So (when I was pregnant with my third), we were looking for somebody to help us out (and there were no doulas available in the area). Fortunately we had my husband's mother come and she was everything that a doula would be… and I noticed that my relationship with my husband was so much better (than after previous births). [D#4]
>
> I guess I became a doula because I didn't feel I was well supported in my labour and delivery. And I felt like I was (alone) doing my postpartum journey. I wasn't well educated on some of the things…even though my (Mom) was giving me some good advice. I felt like I needed a little bit more one-to-one support. [D#3]

In speaking of her positive birth experiences, another doula shared:

> …I was basically lucky. I have four children and I have never delivered without a bunch of people being there…In my family… you are there and you question the doctors on every little thing they do. And we know that when we walk out that door, they're glad we're gone (laughing). [D#2]

Career development

All doulas described challenges and successes in establishing themselves as postpartum doulas. Key challenges involved meeting the demands of making a living, balancing practice with family life, developing career identity, and personal development.

Making a living. All three independently employed doulas, especially the two for whom doula work was their sole source of income, spoke about their struggle to earn income while providing quality care. One doula stated:

> It's my full-time employment. I feel fortunate that I have been able to devote that type of time into my career. It's important enough for my family that they also encourage my work and support me in that. [D#4]

A second doula commented on her desire that doula services be reimbursed:

> It is really important the women know we are out there … and to have more [reimbursement through] insurance companies and medical care providers. [D#1]

Balancing practice with family life. All doulas talked about how ongoing support from their families made it possible to be a doula, and reflected on the challenges of meeting family and practice obligations. All doulas in this study provided birth and postpartum support to the mothers which necessitated being on call and, at times, providing overnight care. Two doulas described the following experiences:

> There were a couple of holidays that I was away from home [for a birth]. And my family (was) very verbal. They totally didn't like it. But, I'd sit and talk with them… It's not that they were more accepting of what was going on, but they understood it a little more. Then they surprised me, too, because one year I didn't get a chance to cook Christmas dinner. Everything was prepared but hadn't been cooked. And when I got home, like a day and half later, it had been cooked. They had cooked, and I sat down and ate [D#4].
>
> I think the emotional toll that it takes on a doula and her family (is difficult). When you have a practice that you're on call for [a birth] and are gone sometimes day and night, it takes that emotional toll on yourself and on your family. You have to remember to honour yourself and take time off and regroup [D#1].

'Honouring yourself' involved efforts to balance personal and family needs against the needs of doula practice and the obligation to follow the same advice that they gave to new mothers. Time for self, reflection and rest was often in short supply for the doulas.

Role development. The doulas perceived that they had to expend considerable effort to become accepted by members of the health-care team, and described joy when they felt valued as such. One doula stated:

> I think not having recognition from the medical field and other people of the importance of birth and postpartum doulas (is the least rewarding aspect of being a doula). We run into a lot of road blocks in being able to bring our services to the woman of today. [D#1]

Another doula spoke of both the challenges and joy of feeling part of the team:

> I think (some nurses) saw me as getting in the way or coming in and taking over their job, and not knowing that's not my role. (Later in interview) Up at (hospital name) a couple nurses that I had interacted with and who saw my face constantly said, 'Yes, you're here! You're here and I'm so glad!' And that made me feel exceptional, where they let me know that I had arrived. But then I had other nurses, oooooh! [D#2]

At times, doulas felt uncertain about whether they were successfully creating a trusting relationship with mothers. Doulas sought to create an open relationship with mothers and families where both positive and negative feelings could be expressed safely. The doulas reflected on the need to gently probe when observations did not correspond with what the mother reported. One doula stated:

> She can look like it is all together on the surface, but I've spent the night and been in the middle of a full family brawl. [D#4]

When speaking about another mother the same doula stated:

> If you do this for long enough, there are going to be people that you don't connect with 100 percent. I would ask 'How's breastfeed going?' and she would say, 'Oh, good'; and then later I would ask more questions and it came out that, no, they were actually having a pretty big problem. [D#4]

Another doula stated:

> I wish that the relationship we had was even better than I felt it was, because I really think she needed to talk about things a lot more than she did. Again, she doesn't take time to take care of herself and talk about her feelings. [D#1]

Personal development. Doulas described the challenges and successes of personal growth in their work as a doula. One doula eloquently described her journey of growth:

> Being part of the study, I did some personal growth within myself. I'm the type of person who keeps people at a distance. There's no need for you to come into my circle. And I was

surprised at myself that I was able to let them [mothers] come in. I didn't want to ever get pulled in emotionally. But working as a doula, and looking at the women in a different role and seeing…, they need this. I'm ok with this. I can let my guard down. [D#2]

Discussion

A strength of ethnography is the accommodation of 'multiple truths' that exist within a single social world, and it is appropriate for exploring the dynamics of changing caregiver practice with women in the home. This report emphasises the doulas' perspective of their identity and practice as they enter into extended relations with postpartum families. The ethnographic nature of the study allowed the authors to detect what doulas consider meaningful in their world through the analysis of personal reflections and observed behaviours. For example, there were significant continuities between the perspectives of doulas in this study and those in the birth literature regarding the importance of providing support through protection and translation, empowering families, and preventing negative experiences. This study supports views that the social transformation of 'learning to parent' is an extension of the social transformation begun at birth. Lundgren (2008) states that birth doulas are 'mediators of the unknown', and postpartum doulas view themselves as helping families traverse the uncertain landscape of new parenthood.

In the themes of 'taking the mother's perspective' or 'empowering women' there is evidence of the doulas integrating broad social, emotional, and physical factors into care. Illustrations reflect interventions to educate, support maternal self-efficacy and develop the parental role. The importance of teaching as a dimension of labour support is well documented (Campero et al., 1998; Hodnett et al., 2007). In postpartum care, educational support helps integrate home and family factors (social and physical) into care. A recent report found that postpartum doulas integrated educational support as they provided emotional support in three areas: resolution of infant feeding, integration of the new infant into the family, and support of developmental care and attachment (McComish and Visger, 2009).

It is notable that the word 'advocacy', defined as facilitating a new parent's ability to develop skills to overcome barriers and advocate for self or infant (McComish and Visger, 2009, p.151), was not used specifically by the doulas during interviews. However, advocacy behaviours are apparent in several of the quotes under 'supporting women' (e.g. protection) and 'empowering women' (e.g. choice/control). Meltzer (2004) differentiates active or overt advocacy from a 'quiet' advocacy which is more consistent with evidence in this study. Doulas were observed to act as silent partners as they provided resources and referrals, or as they acted as a sounding board as mothers developed the skills they needed to advocate for themselves.

In respect to developing and managing their postpartum role, doulas in this study reported motivations consistent with published accounts of birth doulas (Lantz et al., 2005; Deitrick and Draves, 2008). Similar to those in Brandt's study (2007), the doulas in the present study were motivated by a spiritual-moral frame. Being 'called' to their doula practice, Brandt's doulas recognised birth as sacred and control over birth as a mother's right. Doulas in this study extended this perspective to the postpartum period as they helped mothers transition to the role of motherhood. Similar to Sweetwater and Barney (2009), the present study found that postpartum doulas act as 'buffers', protecting new parents from unsolicited advice from family and friends.

Birth doula concerns with balancing career with family have been reported (Meltzer, 2004; Lantz et al., 2005; Low et al., 2006; Holland, 2009) and are consistent with the data presented here under the themes of 'balancing practice with family life' and 'personal development'. The career challenges experienced by the independently employed postpartum doulas are likely similar to birth doulas in that they require skill in establishing a business and marketing one's services.

This study followed the practice of four, new postpartum doulas over 20 months. The longitudinal nature of repeated observation of postpartum care, followed by in-depth interviews, allowed the authors to capture the evolving practice and perceptions of postpartum doula practice. The study is limited by the fact that it was conducted in a single urban setting in the USA and that it involved a sample of doulas who may not be representative of doulas working in other settings. Postpartum care in the USA is primarily the responsibility of new mothers and supportive friends and family, if any. There is not the tradition of publically or privately subsidised home care, by professionals or paraprofessionals, that is available in other countries. Finally, the novice nature of the doulas' postpartum practice may have impacted the way that they interpreted their practice. Early practitioners can have heightened awareness of critical dilemmas and challenges of practice that can diminish with time. Benner (1984) states, 'Nurses accrue clinical knowledge over time and lose track of what they have learned' (p. 141). It is possible that different perspectives would have been obtained from more senior postpartum doulas.

Conclusion and implications

Postpartum doulas work within a set of core values and beliefs consistent with doulas in other settings. Their focus is the empowerment of new mothers and their families. This is accomplished through supporting women and taking the mother's perspective. In the postpartum period, support involves being present, actively listening, protecting and translating new knowledge into the everyday reality of parenting. Empowerment involves affirmation and helping mothers and fathers to have control and choice in the process of transitioning to parenthood.

Doulas in postpartum practice are similar to birth doulas in the motivations or circumstances that cause them to become a doula. Beyond interests in career advancement, postpartum doulas elaborate on a sense of being 'called' to practice, either by influential people in their lives or by a personal sense of obligation. Postpartum doulas emphasise the desire to prevent negative experiences for families and to ensure parents' rights. Consistent with what is known about the role of lay health providers, career development for postpartum doulas is challenging in terms of earning a living wage, balancing practice with family life, and being accepted by other health-care professionals.

Understanding doulas' beliefs, values and practices will help midwives and others on the health-care team more effectively integrate postpartum doula care, capitalise on doulas' insights, and anticipate how roles can be structured to maximise respective contributions to the health and welfare of women and infants. Currently, in developed countries, most doulas are community-based and many are not affiliated with formal health-care organisations. The independent nature of the practice and its community basis gives the doulas a perspective that stands outside of usual medical care and many mothers value this independence. However, some medical providers have raised a concern about the preparation and lack of formal regulation of birth doulas. To the authors' knowledge, these concerns have not been voiced about postpartum doulas.

These issues pose an important challenge for doula education and practice. Culturally tailored postpartum doula curricula and

training adapted to the context and needs of particular countries and cultures will help doulas sharpen their ability to meet the needs of diverse women living in varied conditions. Postpartum doulas are an important resource for the childbearing family and are a valuable adjunct to midwifery and obstetrical care.

To the authors' knowledge, this is the first study of the perceptions of postpartum doulas regarding their motivations, beliefs, and practice behaviours. In the future, cross-cultural studies will be needed to confirm and extend these findings to doulas internationally. It is expected that this early phase of exploratory research will create the foundation for future examination of postpartum doula outcomes, and ultimately the development of health policy responsive to the needs of childbearing families.

Acknowledgements

Supported by NIH/NINR Grant R15NR08010-01A. The authors thank the doulas who allowed us to enter the world of their practice and acknowledge their commitment to compassionate support of women, infants, and families. We thank the staff, faculty, and graduate students who assisted with data collection and data analysis. Finally, we are grateful for the thoughtful review of our manuscript provided by Carol Hengescht, PCD, CLC, a postpartum doula, and the detailed editorial assistance and support received from Dr. Victoria Neale.

References

Abramson, R., Altfeld, S., Teibloom-Mishkin, J., 2000. The community-based doula: an emerging role in family support. Zero to Three 21 (2), 11–16.

Association Doulas de France, 2007. The European Doula Guide. 2007, PLG Impressions, Paris. 〈http://www.doulas.info/cahier2.php〉 (last accessed 10 August 2010).

Ballen, L.E., Fulcher, A.J., 2006. Nurses and doulas: complementary roles to provide optimal maternity care. Journal of Obstetrical, Gynecological, and Neonatal Nursing 35, 304–311.

Benner, P., 1984. From Novice to Expert: Excellence and Power in Clinical Nursing. Addison-Wesley Publishing Company, Menlo Park, CA.

Benoit, C., Wrede, S., Bourgeault, I., Sandall, J., DeVries, R., van Teijlingen, E.R., 2005. Understanding the social organization of maternity care systems: midwifery as a touchstone. Sociology of Health & Illness 27, 722–737.

Brandt, P., 2007. Nonmedical Support of Women During Childbirth: the Spiritual Meaning of Birth for Doulas. Institute of Transpersonal Psychology, USA. Dissertations & Theses Publication No. AAT 3274206.

Campero, L., Garcia, C., Diaz, C., Ortiz, O., Reynoso, S., Langer, A., 1998. "Alone, I wouldn't have known what to do": a qualitative study on social support during labor and delivery in Mexico. Social Science and Medicine 47, 395–403.

Chakladar, A., 2009. Encounter with a doula: is the NHS failing mothers? British Medical Journal 339, 1316.

Christiaens, W., Bracke, P., 2007. Place of birth and satisfaction with childbirth in Belgium and the Netherlands. Midwifery 25, e11–e19.

Cooke, M., Barclay, L., 1999. Are we providing adequate postnatal services? Australian & New Zealand Journal of Public Health 23, 210–212.

Deitrick, L.M., Draves, P.R., 2008. Attitudes towards doula support during pregnancy by clients, doulas, and labor-and-delivery nurses: a case study from Tampa, Florida. Human Organization 67, 397–406.

DeVries, R., 2001. Midwifery in the Netherlands: vestige or vanguard? Medical Anthropology 20, 277–311.

DONA International, 2006. Position Paper: the Postpartum Doula's Role in Maternity Care, DONA International, Denver, Colorado, USA. 〈http://www.dona.org/publications/position_paper_postpartum.php〉 (last accessed 16 July 2009).

DONA International. 2009. U.S. doulas and third party reimbursement. Insurance coverage for doula services in the US a possibility. eDoula Special Issue, September, 29, 2009. 〈http://www.dona.org/.../Third%20Party%20Reimbursement%20edoula%20090929.pdf〉 (last accessed 9 August 2010).

Hodnett, E.D., Gates, S., Hofmeyr, G.J., Sakala, C., 2007. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 3, CD003766.

Hofmeyr, G.J., Nikodem, V.C., Wolman, W., Chalmers, B.E., Kramer, T., 1991. Companionship to modify the clinical birth environment: effects on progress and perceptions of labour, and breastfeeding. British Journal of Obstetrics and Gynaecology 98, 756–764.

Holland, H., 2009. Relational Spaces in Maternal Healthcare: a Qualitative Study of Young Mothers' Experiences with Community-based Doula Care. Carleton University, Canada. Dissertations & Theses Publication No. AAT MR47544.

Hunter, C., 2007. The Doula as Educator: Labor, Embodiment, and Intimacy in Childbirth. Indiana University, USA. Dissertations & Theses Publication No. AAT 3278464.

Johns Hopkins School of Nursing, 2007. Johns Hopkins School of Nursing—Birth Companions Baltimore, Maryland, USA. 〈http://www.son.jhmi.edu/practice/bc/〉 (last accessed 11 August 2010).

Jordan, E., Van Zandt, S., Oseroff, M., 2002. Educating undergraduate nursing students as birth companions. Nursing and Health Care Perspectives 22, 89–91.

Kennell, J., Klaus, M., McGrath, S., Robertson, S., Hinkley, C., 1991. Continuous emotional support during labor in a U.S. hospital: a randomized controlled trial. Journal of the American Medical Association 265, 2197–2201.

Kuczkowski, K.M., 2007. Doctors and doulas in the labor and delivery suite. Acta Anaesthesiologica Scandinavica 51, 954–955.

Lantz, P.M., Low, L.K., Varkey, S., Watson, R.L., 2005. Doulas as childbirth para-professionals: results from a national survey. Women's Health Issues 15, 109–116.

LeCompte, M., Schensul, J., 1999. Designing and Conducting Ethnographic Research. AltimaMira Press, Walnut Creek, CA.

Low, L.K., Moffat, A., Brennan, P., 2006. Doulas as community health workers: lessons learned from a volunteer program. Journal of Perinatal Education 15, 25–33.

Lundgren, I., 2008. Swedish women's experiences of doula support during childbirth. Midwifery 26 (2), 173–180.

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, 148–156.

Meltzer, B., 2004. Paid Labor: Labor Support Doulas and the Institutional Control of Birth. University of Pennsylvania, USA. Dissertations & Theses Publication No. AAT 3125873.

Morse, J.M., Swanson, J.M., Kuzel, A.J. (Eds.), 2001. The Nature of Qualitative Evidence. Sage, Thousand Oaks, CA.

Mottl-Santiago, J., Walker, C., Ewan, J., Vragovic, O., Winder, S., Stubblefield, P., 2007. A hospital-based doula program and childbirth outcomes in an urban, multicultural setting. Maternal and Child Health Journal 12, 372–377.

Nommsen-Rivers, L.A., Mastergeorge, A., Hansen, R.L., Cullum, A.S., Dewey, K.G., 2009. Doula care, early breastfeeding outcomes, and breastfeeding status at 6 weeks postpartum among low-income primiparae. Journal of Obstetric, Gynecologic, and Neonatal Nursing 38, 157–173.

Pascali-Bonaro, D., Kroeger, M., 2004. Continuous female companionship during childbirth: a crucial resource in times of stress or calm. Journal of Midwifery & Women's Health 49, 19–27.

Patton, M.Q., 2001. Qualitative Research and Evaluation Methods, third edn. Sage, Thousand Oaks, CA.

Scott, K.D., Berkowitz, G., Klaus, M.A., 1999. Comparison of intermittent and continuous support during labor: a meta-analysis. American Journal of Obstetrics and Gynecology 180, 1054–1059.

Sosa, R., Kennel, J., Robertson, S., Urrutia, J., 1980. The effect of a supportive companion on perinatal problems, length of labor, and mother–infant interaction. New England Journal of Medicine 303, 597–600.

Spradley, J.P., 1978. The Ethnographic Interview. Holt, Rinehart, & Winston, New York.

Sweetwater, I., Barney, L., 2009. BC Aboriginal Doula Training-Project piloted in Secwepemc and Gitxsan territory February 2009. The Aboriginal Nurse (Spring 2009) 10–11 (ISSN: 1196-0914).

Trotter, C., Wolman, W.L., Hofmyer, J., Nikodern, C., Turton, R., 1992. The effect of social support during labour on postpartum depression. South African Journal of Psychology 22, 134–139.

Van Teijlingen, E.R., 1990. The profession of maternity home care assistant and its significance for the Dutch midwifery profession. International Journal of Nursing Studies 27, 355–366.

Wolman, W.L., Chalmers, B., Hofmeyr, G.J., Nikodem, V.C., 1993. Postpartum depression and companionship in the clinical birth environment: a randomized controlled study. American Journal of Obstetrics & Gynecology 168, 1388–1393.

Zhang, J., Bernasko, J.W., Fahs, M., Hatch, M.C., 1996. Continuous labor support room labor attendant for primiparous women: a meta-analysis. Obstetrics and Gynecology 88, 739–744.