

2008

Mothering the mother : can a postpartum doula enhance maternal self confidence and maternal empathy in a primiparous mother?

Binda Colebrook

Follow this and additional works at: <http://scholarworks.smith.edu/theses>

Recommended Citation

Colebrook, Binda, "Mothering the mother : can a postpartum doula enhance maternal self confidence and maternal empathy in a primiparous mother?" (2008). *Theses, Dissertations, and Projects*. Paper 1224.

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact elanzi@smith.edu.

INTRODUCTION

This study asks whether a postpartum doula can enhance maternal self-confidence and maternal empathy for a primiparous (first time) mother once she is home from the hospital, and whether the support of a postpartum doula is helpful for primiparous mothers regardless of their socioeconomic status.

In order to frame the research question, this study takes a self-in-relation point of view to understand the postpartum phase from the mother's perspective. In addition, the postpartum phase is examined as a life-changing event for new mothers that warrants added supports as women adjust to their new mothering role. Finally, before defining maternal empathy and maternal self-confidence and examining the relevant literature, the study considers postpartum doula services from a socioeconomic point of view and discusses the utility of such a service for in-home interventions.

Definition of terms

The following chapter will examine the meaning of the word doula, the doula's role and will examine postpartum doula organizations and trainings.

The doula

There are two kinds of doulas: those who support women through labor (labor support doulas) and those who support women after they have given birth (postpartum doulas). According to the Oxford English Dictionary, the word *postpartum* means “after labor or delivery”. It does not define how long this period lasts. The word *doula* comes

from Greek. Raphael (1977), in her classic book *The Tender Gift: Breastfeeding* explores a historical model of supportive care during the pregnancy, birthing and postpartum transition. She states

The word (doula) comes from the Greek, and in Aristotle's time meant "slave". Later it came to describe the woman who goes into the home and assists a newly delivered mother by cooking for her, helping with the other children, holding the baby and so forth. She might be a neighbor, a relative, or a friend, and she performs her tasks voluntarily and on a temporary basis (p. 24).

According to Lim (1992) and Webber (1992) the postpartum doula is "someone who takes care of postpartum women by providing practical and emotional assistance" (p. 3).

Doulas of North America (DONA) (Position Paper, 2007), states that a postpartum doula will spend anywhere from one or two visits to more than three months with a family.

They go on to describe how a postpartum doula's activities vary from day to day depending on the needs of the family. Most of the postpartum doula's work revolves around the education of the mother and family regarding baby care, reading the baby's signs and breastfeeding. A postpartum doula will also spend time making sure the mother has what she needs in order to focus on her baby and learn to care for it. The postpartum doula might prepare nutritious meals, hold the baby so the mother can sleep or simply be with the mother to support her processing of the birth and postpartum experience (Postpartum Doula FAQs, 2007). Raphael (1977) believed that a postpartum doula could be a friend or a family member who has experience with newborns and with breastfeeding. Her book was a first attempt at defining the postpartum doula. Today however, a doula is often a professional who provides a lay service for a fee.

The literature on doulas has primarily focused on labor support doulas. That literature has shown that labor support doulas considerably increase a woman's chances

of a vaginal birth without analgesic drugs and found that women feel more ownership of their experience (Hofmeyr, Nokiden & Wolman, 1991; Wolman, Chalmers, Hofmeyr and Nikodem, 1993; Kennell, Klaus & McGrath, 1991; Klaus & Kennell, 1993; Campero, Garcia, Diaz, Ortiz, Reynoso & Langer, 1998; Manning-Orenstein, 1997). There is less literature on postpartum doula supports, though Raphael (1977) wrote about the importance of the postpartum phase for women and the lack of supports within it in the United States. The few studies that have focused on postpartum doula supports are outlined below.

One study (Altfeld, 2002) focused on teen mothers in Chicago who had both labor and postpartum doula supports. This study found teen mothers to experience less postpartum depression and increased success with breastfeeding as well as increased length of time breastfeeding. Another study (Breedlove, 2005) evaluated the Chicago Doula Project's postpartum doula program as experienced by the mothers themselves. This study found that doulas that come from the same community as the mothers they serve can "increase the power within and among the population in a fragmented community" (Breedlove, 2005, p. 8).

A third study (Kane-Low, Moffatt & Brennan, 2006) examined a volunteer postpartum doula program for at-risk mothers through feedback from the doulas, with the intention of finding strengths and weaknesses in order to improve the program. A fourth study (Barron, Lane, Hannan, Strumpler & Williams, 1988) explored the length of breastfeeding in low-income, primiparous mothers who had a postpartum doula. Barron et al. found that women who did not have supportive others often stopped breastfeeding early. However, those with postpartum doula support breastfed for longer. This researcher

located no studies focusing on the enhancement of maternal empathy or maternal self-confidence by postpartum doulas.

Postpartum doula organizations and trainings

The doula movement is a grassroots movement that emerged as a response to a lack of postpartum care available from traditional care providers (Kendall-Tackett, 1994). Kendall-Tackett observes that in this country, women receive a lot of attention during their pregnancy, but once the baby is born, the mother is often on her own and is expected to know what to do. Meyer, Arnold and Pascali-Bonaro (2001) add that the postpartum doula's "nurturing presence complements the care that laboring women receive from medical practitioners" (p. 58).

There are currently a number of doula organizations that include postpartum doulas in their membership. The oldest one is Doulas of North America (DONA). The DONA website (Our founders, 2007), states that this organization began providing postpartum doulas and labor support doulas from its inception. DONA was founded in 1992 by leading experts in the field of childbirth and newborns. Dr. Marshall Klaus was running the neonatal intensive care nursery at Stanford University in 1967. It was in this context that he observed that many parents of sick and premature infants had difficulty adjusting to their new babies after hospitalization. Along with his colleague, Dr. John Kennell, he began to study bonding. These studies led to allowing parents much more contact with their newborns in hospital nurseries. Their work also led to discovering the importance of continuous emotional and physical support both during labor and in the postpartum period (Our founders, 2007).

DONA membership has increased dramatically in the last 12 years. Beginning with 750 members in 1994, the organization had grown to 6,137 members in 2006. Of those, 2,625 were certified birth doulas and 165 certified postpartum doulas (Member Statistics, 2007). However, in order to be a practicing postpartum doula one does not have to be certified. Non-certified postpartum doulas have usually breast-fed and raised children themselves. As such, their life experience has been their training.

Childbirth and Postpartum Professional Association (CAPPA) is another doula organization that has been in existence since 1998. This organization offers evidence-based training for labor support, antepartum support (pregnancy support) and postpartum support doulas (CAPPA Position Paper, 2007). CAPPA states that while some families don't need extra support in the postpartum phase because they have enough extended family nearby to provide it, there are those who don't have that support and for whom a postpartum doula is a useful option. DONA (Position Paper, 2007) concurs on this point and adds that due to the great distances that often separate families and the need of extended family to continue working themselves, support from the family in the postpartum period is often spotty.

The findings of this study indicate that primiparous mothers found postpartum doula services to be helpful. In addition, postpartum doulas do enhance maternal self-confidence and maternal empathy in first time mothers. Additionally, the mothers in this study confirmed a need to be in-relation during the postpartum phase. The postpartum doulas in this study believed that all primiparous mothers, regardless of socioeconomic status, benefited from postpartum doula services. The results of this study imply that postpartum doula services should be considered as an in-home intervention that, when

tailored to the population it is serving, could benefit new mothers regardless of socioeconomic status. However, in order for this service to be successful, it requires a concentrated number of hours in the first month postpartum as well as an opportunity for the new mother and doula to meet and begin bonding before the baby's birth.

The next chapter will include the existing literature on the postpartum doula movement from a self-in-relation point of view. The next chapter will also describe the birth and postpartum period as experienced by women in the United States today, and compare the process with that of other cultures. A presentation of the literature pertinent to the formation of a new family as a critical period, as well as the current clientele of postpartum doulas, will follow. In addition, the use of postpartum doulas from a socioeconomic point of view will be explored. Finally, the existing literature on maternal self-confidence and maternal empathy will be considered.

CHAPTER II

LITERATURE REVIEW

This chapter will examine the existing literature in the following ways. It will consider the postpartum phase from a self-in-relation point of view. Additionally, it will include an overview of the birth and postpartum phases in the United States, introduce the concept of matrescence, explore the birthing and postpartum phase in developing countries and touch on postpartum depression and the role that a postpartum doula can play in preventing it. The chapter will also explore the formation of the new family by considering birth as a major life transition as well as explore the concept of bonding and attachment as they relate to the postpartum phase. In addition, this chapter will look at the need for a postpartum doula from a socioeconomic point of view by looking at who currently uses a postpartum doula in the United States, the role that socioeconomics plays in the use of the doula as well as existing models of postpartum doula care. Other home-based postpartum supports will also be considered in comparison to postpartum doula supports. Finally, this chapter will define and explore the criteria chosen for this study, namely, maternal self-confidence and maternal empathy, and will explore the relationship between the two. In addition, empathy levels in younger and older mothers will be considered.

Self-in-relation: reframing the postpartum mother's experience

It is useful to frame this discussion in a feminist social construction. Chodorow (1978) re-examined object-relations theory and found that girls and boys follow different

object relations trajectories. Chodorow states that mothers and daughters have a bond that lasts far longer than mothers and sons. Chodorow's analysis showed that because mothers and girls are of the same sex, mothers see daughters as an extension of themselves. This early formative relationship means that girls are preoccupied with relationships, whereas boys are primed for the world of work and have their nurturing needs repressed. Chodorow felt that these social roles and patriarchal norms are internalized and perpetuated across generations. The solution she suggests to this perpetuation of roles is to involve both fathers and mothers in parenting.

Gilligan (1982) examines Kohlberg's (1981) theories of moral development and finds that they do not apply to women. Kohlberg's model states that high morality scores always have a relationship to the law. Women systematically score low on the morality scale in their responses to the Kohlberg questionnaire, which, as Gilligan observes, makes them appear deficient. She notes that this is not because women have lower morals, but because women make moral decisions with an emphasis on relationships, whereas men make such decisions with a focus on justice. In other words, women and men think differently when making moral decisions.

Stiver (1991) explores how Erickson's developmental theory has set its developmental guidelines on a masculine model where independence is the ultimate goal. This leaves women feeling unsuccessful because, fundamentally, they are not striving for separation and individuation. Instead, Stiver and her colleagues at the Stone Center redefine women as relationally oriented and rooted in a need for intimacy.

The Stone Center's writings (Jordan, Kaplan, Miller, Stiver & Surrey, 1991, 1998) coined the term *self-in-relation* to describe the process of understanding the world

through the self, *in relation* to others (Miller, 1987). Instead of stressing separation-individuation, they offer a perspective that stresses relationship differentiation.

Rich (1976) was one of the first feminists to emphasize the potential of motherhood as a source of joy and creativity. She identified two meanings for the idea of motherhood: first, the experience of motherhood as a discovery by women of their powers; and second, the institutions' (the government, the church, the law, the educational institutions) idea of motherhood that kept women in the home with the children and under male control. Thus a tension existed between the two ways of identifying with motherhood. This led in the 1980's to an interest by feminists in the importance of motherhood *to women* (Rogan, Shmied, Barclay, Everitt & Wyllie, 1997) and prompted an array of studies (Oakley 1979, 1980, 1986; Richards 1985; Nicholson 1990; Frydman 1987; Crouch & Manderson 1993) on maternity as women experienced it, not how men saw it. In effect, women reclaimed their own maternal experience.

Following this thread, it is possible to see a link between a feminist social construction and the birth of the postpartum doula movement, which focuses on the idea that women need to be in relation with other women in the postpartum phase in order to be supported and guided as they learn to master motherhood. This is an idea defined by women for women. While the postpartum doula movement did not define itself as a feminist movement, it was one that focused on providing a nurturing relationship in a challenging phase of life. It let women know that it is appropriate and normal for women to be in relation without having to apologize for their dependence during the postpartum phase. As such, the doula movement challenged the patriarchic social structure that devalued social bonds and made women feel guilty for feeling dependent.

Warren (2006), found that when a woman went into labor in Victorian England, another woman would come to the house and take over the running of the household. Men were excluded from the birthing and postpartum rituals. Women would come to visit the new mother and sit around chatting and drinking tea. Men may have felt left out and resentful of these women invading their houses and may not have seen the purpose of sitting around all day chatting and drinking tea with the new mother while she lay in bed with her baby. However, following a self-in-relation perspective, this "useless chatting and tea drinking" served an important purpose in the new mother's life: it allowed her to focus on her baby and nursing. It provided her with the companionship of other women who could relate to her experience and whom she could trust with the running of daily activities while she regained her strength.

The postpartum doula's role: Mothering the mother.

It is important to note that many variables affect the post partum period: (a) the mother's experience of the pregnancy; (b) the mother's experience of labor and birth; (c) whether that experience was disappointing or empowering; (d) whether she had a labor support doula, a home birth, a hospital birth or a birthing center birth; (e) whether she had a vaginal birth or a cesarean section; (e) whether the baby stayed with the mother right after birth; (f) whether the baby had postpartum complications; (g) how breast feeding went in the first days in the hospital, if the mother chose to breast feed; and (h), the baby's temperament. All of these variables as well as the mother's mental health and socioeconomic status will inform the postpartum period. These variables will determine the kinds of supports the postpartum doula will provide as well as the frequency of visits needed.

A postpartum doula's role is one of listener, guide, advocate, resource and caregiver. The work of postpartum doulas has been called a "psychosocial intervention in the home" (Newton & Sprengle, 2000, p. 229) with a focus on perinatal care. According to DONA's position paper "the doula's goal is to facilitate the transition to parenthood" (Position Paper, 2007, p. 2). The postpartum doula is someone who supports parents as they learn to listen to their own instincts. "By modeling a deep respect for the wisdom and decision making abilities of the new parents, she makes clear that supporting them in their own choices will have the best possible results" (Position Paper, 2007, p. 2). The ultimate aim is to help the parents develop their own parenting style. Laing (2000) describes postpartum doula services as "'well baby' psychological services" (p. 227).

Stern and Kruckman (1998), when describing the kinds of supports that women in many developing countries receive, write about the support taking the form of food making, child caretaking and housework. They state that in some cultures this help is minimal but that in most societies many individuals provide a variety of supports. While a postpartum doula is not many individuals, her role is very similar to that of the helpers in those developing countries. Naturally, the supports provided by a postpartum doula are tailored to a modern society, but the basic idea is the same and in fact, attempts to provide a service that invites women to rediscover their connection to other women and to embrace the opportunity for slowing down and reconnecting to herself and her child.

Meyer et al., (2001) state that "the basis of doula care is social support, which includes offering information, tangible physical assistance and emotional support" (p. 57). They reference studies that have shown the reduction in the risk of child abuse and

neglect when there is more maternal support as well as studies that show that home based programs show no risk, only advantages.

Adamakos, Ryan, Douglas and Ullman (1986) completed a study on maternal social support as a predictor of mother-child stress and stimulation. The study included low socioeconomic status mother-child pairs who were assessed prenatally (n=198) and two years later (n= 91). The study found that as welcomed maternal support increases, mother-child stress decreases. This finding is important when considering the usefulness of postpartum doula. However, the authors offer a number of cautions: first the sample size was small; second, there are other variables that may affect this at-risk population, such as depression; third, neither high mother-child stress nor limited stimulation are necessarily going to lead to abuse or neglect. Nevertheless, the authors conclude that to the extent that other factors may play a role, maternal social support may have a positive effect on the mother-child relationship.

Barron, Lane, Hannan, Struempfer and Williams (1988) conducted a study of forty breast-feeding low-income primiparous women. They found that women who did not have supportive others frequently terminated breast-feeding early. However, when a doula was present, duration of breast-feeding increased from 12.3 weeks to 23.4 weeks. In their discussion, Barron et al. state that their findings confirm Raphael's (1976) "doula hypothesis". In other words, when a mother has the support of someone such as her own mother or a postpartum doula to fulfill regular household duties, breast-feeding rates increase because the mother has time to "relax, establish her milk supply and become adjusted to her infant's needs" (p. 12).

A number of studies have analyzed the emotional costs to women in the postpartum phase and have found that women voice a desire for help with basic daily activities such as housework (Pridham, Chang & Hansen, 1987; Fawcett, 1991). Ultimately, the postpartum doula attempts to support new mothers in all the ways that the literature from nursing, midwifery care and attachment theory has discussed. That is, support with practical daily life chores, support with bonding and attachment as well as providing an essential link to the world in this phase that can be isolating. All of this is done within the framework of being in-relation.

The partner or father as a postpartum doula

One might ask why the other parent of the child cannot be the postpartum doula. In some cases, the other parent is not the biological father but is a life partner. In others, the biological father is not a life partner and is not present in the mother's life. Whatever the family makeup or circumstances, if there is a partner in the life of the mother and the newborn, the question remains: why can't that partner be the postpartum doula?

According to Raphael (1977), the introduction of the bottle to the Western way of raising a baby separated the mother from the baby but brought the rest of the family closer. As a result, the partner's role increased in that the feeding of the baby could be shared. Kennell (2002) discusses the inclusion of the partner in the labor of the mother and delivery of the baby as an interesting development. Kennell noticed that the partner was important symbolically to the mother but, especially if the partner is a man, was not essential to the labor. Doulas and birth attendants were much more likely to touch the mother than the father was, unless he was prompted to do so. In the postpartum period,

the fact that the labor is a shared experience is deeply significant to both the mother and father and informs their bond to the baby.

In the postpartum period, the partner can be extremely helpful to the mother and infant, but often, the partner is returning to work and is not able to pick up all the parts of the household responsibilities as well as be there for the mother and newborn (Raphael, 1977). As such, the partner is not the best candidate for the doula role. Additionally, with the doula taking the pressure off, the partner can then also focus on bonding to the baby.

The postpartum period in the United States today

This section will briefly touch on the history of birthing in the United States. The first image that comes to mind is that of labor and birth in a hospital environment. Our modern society provides the best medical care, which is very effective in emergencies, yet, if all goes well, is not necessarily the best place for a woman to give birth (Raphael, 1977). Raphael goes on to say that birth is not an emergency situation and that we have lost sight of that fact in the United States.

The birthing process in the United States

In the 1920s the place to give birth began to shift from the home to the hospital and male physicians entered the birthing room and took over as the ones who delivered babies. Yet women often labored alone, and drugs replaced companions to soothe and calm them. In the 1960s the natural childbirth movement began to reclaim some traditional practices and a woman's need for companionship during labor was recognized. Husbands and partners were brought into the delivery room (Meyer et al., 2001).

According to Stern (1998), once the baby has been born, the woman is expected to rest for one week. This period corresponds with what used to be a typical postpartum

hospital stay. However, it is now no longer than three days. There is some recognition of the need of a woman to rest in the formal social policy called "maternity leave."

However, this leave is not available to every woman.

Today, many maternity wards in the United States have birthing centers that allow women to labor in a more natural way. Nonetheless, for many women the experience of giving birth in a hospital setting is disempowering. Campero, Garcia, Ortiz, Reynoso and Langer (1998) refer to Kitzinger (1990) who argues; "childbirth is a stressful event due to the complex interaction between pain, immobilization, medical interventions and the failure of interpersonal relations within health care institutions" (p. 402). While women continue to be allowed to have their partners in the room with them and attitudes towards labor support from non-medical staff varies from hospital to hospital, women are increasingly likely to have an epidural for pain relief and many women's labors end in cesarean sections. Obstetricians still deliver babies as if they are in control of the labor, and not the laboring woman.

The birth experience of a woman can have a tremendous impact on a woman's postpartum experience. A study conducted in Mexico City in a public hospital by Campero et al. (1998) looked at the most relevant results of a trial to evaluate the effects of psychosocial supports to women during labor. The study interviewed 16 women in the immediate postpartum period. Eight of the women had been accompanied by a doula and eight had not. The interviews showed that the women accompanied by a doula during labor had a more positive childbirth experience. The most important difference was that the women who had had a doula had a sense of control over their experience and had, in short, higher self-esteem. These women felt that they, not the doctor, had given birth.

When this result is combined with that of the positive impact of increased social supports in the postpartum phase, one can see why Kennell and Klaus (1991) advocate for continuity of care from pregnancy through labor and the postpartum phase.

Later in this literature review the criteria for measuring the value of postpartum doulas will be reviewed. It is noteworthy that one of those criteria, maternal self-confidence, was chosen because it is an essential ingredient in a mother's ability to parent her child effectively. The Campero et al. study (1998) illustrates that support can foster a sense of self-esteem, and that support can begin during labor. However, if it does not, it is even more important that the new mother have social supports in place to help develop self-esteem in the postpartum phase.

The postpartum phase in the United States.

The postpartum phase begins after the birth of the baby and, according to the medical model continues for six weeks thereafter, at which point the mother's body returns to its pre-pregnant state, (CAPPA Position Paper, 2007). Raphael (1977) argues that this length of time is culturally bound. She writes that the length of the postpartum phase varies from culture to culture. For example, in Spain, South America and the Caribbean and among Moslems, the postpartum period is thought to be 40 days long. Raphael believes that the postpartum period in the United States is considered to be two weeks long, which coincides more with the typical length of vacations and termination notices in America, rather than the time that the medical establishment defines as the postpartum period.

Typically, a woman who has given birth in a hospital without complications will go home after two or three days. In the United States, birth is viewed as having three

trimesters, (CAPP A Position Paper, 2007). However, CAPP A suggests that there is a fourth trimester in which the family makes an enormous emotional and physical adjustment. Placksin (2000) believes that the postpartum adjustment period lasts well into the first year of the baby's life, making the fourth "trimester" the longest.

The next section of this review delves further into the postpartum phase and its implications for the new mother.

Matrescence in other cultures and in the United States.

This section discusses the meaning of becoming a mother and emphasizes the importance of supports for a mother beyond the labor and birth. The term *matrescence* was coined by Raphael (1977) who wanted a term that would focus on the woman's new phase of life as she becomes a mother. It is a term that emphasizes this important rite of passage. The question that Raphael posed was: when does a woman become a mother? The answer differs from culture to culture. The birth of the baby is not the determining factor, social maternity is. In other words, when does the society consider a woman to be a mother?

In some cultures, for example, matrescence is only achieved after the birth of a son, while in others, not until the birth of a daughter. In another, a woman is not a mother until her baby is considered "human." This humanness is defined by age, and the age usually coincides with a higher likelihood of survival. This strategy prevents the parents from becoming too attached to a baby that might die (Raphael, 1977).

In the United States, (Raphael, 1977) social maternity begins at birth in theory but not in practice. A woman becomes a mother abruptly with little training and little support. Many women are not prepared for motherhood. This is compounded by a hospital

environment where matrescence is hard to achieve because the mother is surrounded by strangers who keep changing with each shift and who do the baby care for her without spending much time teaching her what to do.

Klaus, Klaus and Kennell (1998) refer to a study that examined 186 separate non-industrialized societies. In 183 of those societies, mothers and babies stay together for days or weeks after delivery without any of their usual duties having to be met. None of these cultures have the kind of separation that is standard procedure in hospitals after the birth of a baby. In the United States, it is expected that once the mother is home she will bounce back to normal quite quickly, and the pressure to get back to work is enormous because of the lack of maternity leave available beyond six weeks. The United States has even fewer supports than many other Western cultures. In Britain, daily visits by Health Visitors are standard for the first 14 days after leaving the hospital.

A study using grounded theory conducted in Australia in 1997, analyzed the experience of 55 first-time mothers. Six categories were identified that represented the core experience of becoming a mother. These were: "realizing, readiness, drained, aloneness, loss and working it out" (Rogan, Shmied, Barclay, Everitt & Wyllie, 1997, p. 877). The authors found that these categories sum up the process of change in the postpartum period. They further found that three major factors served to influence or inform how these categories were experienced: "previous experience of infants; social support; and the baby's behavior" (p. 878). Just like the phases of mourning, these categories can be revisited more than once, but the intensity with which they are experienced are mediated by the three factors mentioned above. Women were able to work out how to take care of their babies but not without feeling drained and alone. This

process seems to describe the American mother's experience also as it is defined by the mothers quoted in Kendall-Tackett (1994). It seems that mothers in Australia are also lacking a positive system of social support and could also benefit from an increase in the idea of being "in relation" during the postpartum phase. Rogan et al., point out the huge strength and resourcefulness of women in working it out alone and add that the literature does not sufficiently explore the possibility of providing more support. The authors (1997) also point out that the way the women describe themselves in this study relates to a description of postpartum depression, yet none of the women in the study were diagnosed as depressed and did not describe themselves as depressed. The study concludes by calling for more attention to the social context in which women are living in contemporary Western society and new mothers' social and relationship issues.

In 1976, Raphael (1976) had already noticed the split between the process of becoming a mother and what it used to be. Raphael's research demonstrates that becoming a mother is a learned activity that is passed from generation to generation by other women who are often, but not exclusively, family members. What is interesting is that the woman in the postpartum phase was rarely alone and was not expected to carry out her usual duties or to entertain. All she had to do was focus on her baby, nurse, and let herself be taken care of by other women. Winnicott (1971) states that "the mother's bond with the baby is very powerful at the beginning and we must do all we can to enable her to be preoccupied with her baby at this time – the natural time" (p. 39). What Winnicott points to in this quote is the appropriateness of a mother's absorption in her newborn baby. Kennell (2002) adds that this is not the time to be rushing the mother back onto her feet and back to work.

Rubin (1984) collected data in the 1960s and 1970s on women's experience of the postpartum phase in the United States and found that women often described feeling exhausted. Rubin (1984) believed that the nuclear household contributed to feelings of "disorientation, depression and despair" (p. 97) and concluded that the nuclear household decreased women's contact with the world.

Birth and the postpartum phase in developing countries.

This section will give a brief overview of the literature on birth and the postpartum phase in developing countries. This will serve as a comparison to the United States' more medical model of birth and the lack of ritual around the postpartum period.

Raphael was an anthropologist who looked at the birth and postpartum phase across cultures. She reported in the 1970s that in less modern countries, women still gave birth at home or in the village-birthing hut. The laboring woman's mother or sister or other women surrounded her. Women who had given birth guided her. Once the baby was born, the new mother was not allowed to fulfill her usual duties. Other women cared for her and guided her with newborn care and breast-feeding. The new mother could not cook or clean; in some cultures she was not even allowed to feed herself. In some of these cultures, the rules around a new mother and her infant were very strict (Raphael, 1977). This may seem constricting to Americans who value independence, but the point of the ritual caretaking of women after birth is that it ensures the survival of the newborn. In a culture where formula was not an option, a newborn's survival depended on its mother being able to feed it. A relaxed mother will have much more success with nursing than a tense mother. Raphael (1977) reports that in rural India, although women traditionally live with their husband's family after marriage, when pregnant and close to giving birth,

women go home to their mother's house to labor and give birth, thus insuring a familiar and nurturing environment in which to begin mothering.

Postpartum depression: a case for the postpartum doula

This section will consider postpartum depression as a culturally bound syndrome (Stern & Kruckman, 1983). In their anthropological critique of postpartum depression, Stern and Kruckman observe that childbirth is a universal biological event but it is entirely framed by its sociocultural context. Of relevance to this discussion is Stern and Kruckman's view that

most of the research on postpartum depression has looked to biological and/or psycho-social etiologies such as hormonal shifts, maternal age and parity, psychiatric history, marital relationship etc. Little consideration has been given to the impact of the cultural patterning of the postpartum period as an etiology in postpartum depression – factors such as the structure, organization of the family and social group, role expectations of the new mother and significant other, etc. (p. 1028)

Kendall-Tackett (1994) took Stern and Kruckman's work and asked why women in the United States have higher incidences of postpartum depression than in developing countries. She suggests that a postpartum doula can provide the much-needed social supports that are currently lacking in the United States. Stern and Kruckman and Kendall-Tackett agree that the way the postpartum phase is framed for new mothers in other countries provides examples of social structures that prevent postpartum depression. In the United States women do not currently have the kind of wraparound support that Raphael found in other cultures.

Stern and Kruckman (1983), found that 50% to 85% of postpartum mothers in industrialized nations experience “the baby blues”, and 10% to 20% have a postpartum depression. Bledsoe and Grote (2006) in their meta-analysis on treating depression during

pregnancy and the postpartum phase also put those figures of non-psychotic postpartum depression at 10%. In contrast, in the third world, postpartum blues and depression are practically non-existent.

Yu-Chu and Mathers (2001) completed a study that compared postnatal depression in Taiwan and in the UK to determine whether postnatal depression is biological or cultural. Their findings showed that the same percentage of women, both in Taiwan and the UK, had postpartum depression (18% in UK and 19% in Taiwan). However, they also found that with modernization and a shift from an agricultural to an industrial society, "strong family ties between parents and married children have gradually become weaker" (p. 285). For postpartum women this means that the traditional care from a mother or mother-in-law during the first postpartum month is no longer as available. In fact, in this study only one in three women actually received this kind of support as they were "doing the month". ("Doing the month" is a traditional way of spending the first month postpartum that calls for certain ways of eating and behaving so as to ensure the baby's and mothers' health.) However, 72-95% of the new mothers in this study still carried out the dietary and behavioral taboos that are called for as part of "doing the month" without anyone's assistance, thus adding tasks to an already complex phase of life. The authors conclude that increased Westernization may be a contributing factor to the higher rates of postpartum depression in Taiwan as compared to other ethnic communities. Their findings further suggest that postpartum depression has some important biological determinants as well as cultural and social ones. The Yu-Chu and Mathers study suggests that social supports are an essential aspect of a positive postpartum experience for women, regardless of cultural background.

Stern and Kruckman (1983) proposed that "the negative outcomes of depression and baby blues in the U.S. result from the relative *lack* of: (1) social structuring of postpartum events; (2) social recognition of a role transition for the new mother; and (3) instrumental assistance to the new mother" (p. 1036). Drawing on Stern and Kruckman's work, Kendall-Tackett (1994) defines five protective factors that all these cultures, although quite different from each other, shared: "(a) a distinct postpartum period, (b) protective measures reflecting the new mother's vulnerability, (c) social seclusion and mandated rest, (d) functional assistance, and (e) social recognition of her new role and status" (p. 26). Kendall-Tackett argues for a change in the way that the United States treats new mothers in the postpartum phase. She concludes by stating that the postpartum doula movement is exactly the kind of service that is needed if the high rates of postpartum depression in the United States is to be reduced.

The formation of the new family: redefining the bonding phase

This section explores the moment right after birth and how it impacts the postpartum phase. We have determined that the length of the postpartum period is socially constructed (Stern & Kruckman, 1983; Kendall-Tackett, 1994a). We have further noted that in the United States much attention is focused on the mother while she is pregnant and that the attention shifts from the mother to the baby after she gives birth, leaving the mother with little emotional support and sometimes little physical support. While there is a lack of focus on the emotional supports for a postpartum mother in the United States, much research has been done on the early relationship between the mother and the child both in Britain and in the United States. In Britain the attachment research has led to an awareness of the needs of the mother in the postpartum phase (in a way that

it has not in this country) as can be seen in the systematic ongoing community postnatal care that is available to all women in the UK (MacArthur, Winter & Buck, 2007).

The attachment research begun by Bowlby, Ainsworth and Winnicott has set the stage for the determination that the mother's attunement to her baby is crucial for healthy development. Winnicott (1956), writes about primary maternal preoccupation which he sees as a "special psychiatric condition of the mother" (p. 302) He sees this preoccupation as beginning in the third trimester of pregnancy and continuing for a few weeks after the birth.

The attachment or bonding debate

Bowlby (1969) spoke of attachment as the emotional bond between a baby and its primary caretaker, which the baby displays through proximity-seeking behaviors. The direction of attachment is from baby to mother and develops slowly over time.

Another group of researchers has looked at the period right after birth and called it the bonding phase. According to Myers (1984), this term is "used to describe a rapidly occurring process which occurs immediately after birth and in which the mother forms an affectionate bond to her infant; the direction is mother to infant" (p. 245). Klaus and Kennell (1972) argue that without this bonding, attachment may be difficult because a crucial opportunity for connection has been missed. Bonding is mother-to-infant-directed and is confined to the time close to birth; attachment is infant-to-mother-directed and develops slowly over time. Having said that, it is important to emphasize that both bonding and attachment involve a dyadic interchange and that both the mother and infant are active participants (Myers, 1984).

This discussion is relevant to the work of the postpartum doula and other in-home services because the intention is to support a family, and especially a mother, in their relationship to the new family member and to support their ability to raise a healthy child. If bonding only happens in the first few hours after birth and the hospital protocols dictate that a newborn is not given directly to its mother at birth, what are the implications for the family once they are home from the hospital and how does this affect the postpartum doula or other in-home care providers?

Since Klaus and Kennell (1974, 1972) first published their bonding studies, there has been discussion about the validity of their findings, which state that the bonding period is time-sensitive and crucial for the mother to develop an affectional tie to her baby. Myers (1984), in her review of the bonding research comes to the conclusion that the evidence does not support "the notion that early and extended contact is crucial to the mother-infant bond" (p. 240). Harmon (1981) also expresses concern about the Klaus and Kennell model. His concern is not so much with the notion that early contact, or a lack thereof, can make or break the possibility of bonding. Harmon agrees that the "behavior of hospital personnel, the amount of maternal-infant separation, and hospital practice has a significant and alterable impact on parent-infant interaction" (p. 133). The aspect of Klaus and Kennell's study that Harmon disagrees with is their view of the mother's care by her own mother, her relationship with her husband or partner and family of origin and previous experiences with pregnancy, or this pregnancy, as fixed. Harmon argues that because birth is often a catalyst for the reorganization of past ties, they cannot both be fixed and have a major impact on the mother-infant bond. His experience has shown him

that with the support of psychotherapy, a mother-infant bond can be increased, whatever the initial contact was immediately after birth (Harmon, 1981).

Siegel, Bauman, Schaefer, Saunders and Ingram (1980) studied hospital and home supports during infancy. The study found that the home supports offered in the study did not enhance maternal attachment significantly, nor did they correlate with reports of abuse or neglect. In their conclusion, the study called for the following actions: that the major health professional organizations recommend, "changes in prenatal, labor and delivery, and postpartum practices . . .to promote the positive outcome hypothesized in this research" (p. 189). Those hoped for outcomes were enhanced maternal attachment, a reduction in child abuse and neglect, and an increase in health care utilization. What the authors meant by this was that hospital protocols regarding labor, delivery and postpartum care become more mother centered and respectful of the need for a baby to room with its mother.

Belsky and Benn (1982), when looking at the bonding studies concluded that it is not the skin-to-skin contact per se that is important, but what happens during that skin-to-skin time; "namely, perceptual learning that is fostered by mother-infant interaction" (p. 287). They do not dismiss the bonding studies and are grateful to Kennell and Klaus for drawing our attention to the neonatal period, but they conclude that while the bonding period is a wonderful place to begin the development of healthy infant-parent relationships, it is not the only one. They point to another study by O'Connor, Sherod, Vietzke, Hopkins and Altemeier (1977) that looked at rooming-in (when a newborn spends all its time in the room with its mother and not away in the nursery) as the only intervention and found it made a substantial impact on 143 low income mother-infant

pairs out of whom only one case of subsequent maltreatment was reported, as compared with 9 cases among 158 dyads who did not have rooming-in services.

Given the arguments for and against the bonding phase as a sensitive period, it seems that a postpartum doula's role will be informed by the mother and baby's experience right after the birth. It may be that if there was separation at birth, the postpartum doula's work will revolve more intensely around nurturing that primary maternal preoccupation (Winnicott, 1956). While postpartum doulas are not psychotherapists, they can be listeners who support a mother as she begins to reorganize her past and current ties. She can also be the person who will identify which families could use further psychosocial and psychotherapeutic supports.

Birth as a major life transition

McGoldrick and Carter (2003) have written about the family life cycle and reframed it as a non-linear process. Their model is respectful of all kinds of family structures and does not assume that “family” means a “heterosexual married couple raising their children”. Instead the model uses some “unifying principles that define stages and tasks, such as the emotional disequilibrium generated by adding and losing family members during life’s many transitions” (p. 379).

Following this model one could say that the birth of a first child is a major life transition that warrants extra support. Holmes and Rahe (1967) and Hultsch and Plemons (1979), define a major life transition as a period of time that is stressful and that involves a major reorganization of existing life patterns that includes role re-evaluation (Antonovsky and Kats, 1967), and status change (Myers, Lindenthal, Pepper & Ostrander, 1972). Such role shifts and status changes are from woman to mother, man to

father; and the dual roles of wife and husband to parent. The fact that the addition of a new member is irrevocable is profound and a potential cause for stress and an identity crisis (Belsky & Benn, 1982).

A socioeconomic point of view of the need for postpartum doulas

This section will discuss who currently uses a postpartum doula, whether socioeconomic factors play a part, and whether all mothers could benefit from postpartum doula services.

Women who use postpartum doulas in the United States

Currently in the United States, doulas are mostly used by middle-class women. This fact is largely determined by the fact that health insurance companies do not cover doulas and, as such, doulas can only be used by those who can afford to pay out of pocket. DONA states in its Position Paper (2007) that some insurance companies do cover doula costs but this is the exception rather than the rule. The question remains; if all women could have a postpartum doula, would they want one regardless of class or socioeconomic level?

The role that socioeconomic factors play in the use of postpartum doulas

Are postpartum doula services a useful model across all socioeconomic lines? According to Kendall-Tackett (2005a), postpartum depression is more common in lower-income women than middle-class women. If lower-class women have good support, they are less likely to experience depression. Barnett (1996) conducted a study on depressive symptoms, stress and social support in pregnant and postpartum adolescents. She found that "53% of highly stressed teens who reported low social support compared with 35% who reported high social support scored depressed" (p. 67). Barnett also found that

"social support can have both positive and negative dimensions" (p. 68). While Barnett was looking at support from the teen's mother or from the baby's father, Breedlove (2005) conducted a study that looked at teen parents' own perceptions of social support when using community based labor support and postpartum doulas. The teens that Breedlove interviewed were part of the Chicago Doula Project. The study concluded that doulas who belong to the same community as the clients, can serve a "primary support to disadvantaged teens" through increasing "power within and among the population living in fragmented communities" (p. 8). The young women in this study talk about the doulas being a "somebody" when they have "nobody". In other words, the doulas provide a supporting role that is of primary importance to this population at a time in their lives when they feel they have nobody taking care of them.

Existing postpartum doula models of care

The following is a description of the Chicago Doula Project. With the support of funding, doulas have been made available to teenage mothers in Chicago and there is some indication that this intervention model may be useful in assisting young poor women with beginning the mothering role. In the Chicago model the teen mother is paired up with a doula from the same community, and the doula supports her through labor and up to twelve weeks postpartum (Altfeld, 2002). According to Altfeld, the Chicago doula project's aim was to "integrate intensive prenatal, intrapartum and postpartum support into existing teen parent services through training and employing community women as doulas" (p. 3). The Doula Project was funded by the Harris Foundation and the Robert Wood Johnson Foundation and began in 1996. Evaluation of the project began in 1997 (Altfeld, 2002). In Chicago there were already some early

intervention programs for teens called the Parents Too Soon program. Three existing Parents Too Soon sites were chosen as pilot sites and integrated the doula intervention into their existing programs. It was decided that the design should be flexible so that it could be adapted to each location as needed. The basic outline of doula support is as follows: each participating teen is assigned a home visitor. In the teen's sixth month of pregnancy the home visitor introduces the doula to the participant. In the last trimester the participant takes prenatal classes and the doula accompanies the participant to at least one prenatal appointment. In the final month of pregnancy the doula calls the participant at least once a week. When the participant begins labor, the doula accompanies her through labor, delivery and the first hours postpartum. Once the teen returns home, the doula would "provide services and transition the new mother back to the home visitor" (p. 6). Additionally, in the third year of the program, the FANA (Family Assisted Neonatal Activities) was integrated into the doulas training and presented as a weekly class to the participants while still pregnant, as opportunities for relating to their developing fetus and new baby.

Regarding outcomes of the Chicago Doula Project, mothers who took part in the program had fewer cesarean sections, less anesthesia use and fewer other medical interventions. Eighty percent of participants started breastfeeding and almost 22% of the participants were still breastfeeding at six months. More than half of the participants (50.4%) experienced some depression. Other surveys (Colletta, 1983; Reis, 1987) of young, low-income mothers found that 53% to 67% experienced postpartum depression. Altfeld reports that while the Chicago Doula Project program's numbers are lower on the range of postpartum depression experienced by young, low income mothers than those

found by other surveys, it was still felt that the numbers were high enough to warrant action. All three sites were proactive about offering training regarding postpartum depression and psychosocial supports to their doulas and home visitors as well as securing funding to integrate the knowledge gathered by Altfeld's (2002) study into innovative interventions to address this problem.

The Doula project was also the subject of a documentary that followed one doula, Loretha Weisinger, and some of her clients. In the documentary Ms. Weisinger says, "I nurture them so they can nurture their babies". The outcomes for those teen mothers were inspiring: Of the five followed in the movie, four went back to school. The fifth participant had already had three children and was having her fourth. A year later she was pregnant once more. One of the teens says in the film that Ms. Weisinger is the "first person that helped me". This gives a sense of the powerful impact a doula can have on a woman at this critical life stage.

It is noteworthy that Ms. Weisinger has also been a teen parent, having her first child when she was 16 years old. In the documentary she talks about how frightening that experience was and how little support she was able to find, even contemplating suicide at one point. As such, she is a consumer, supporting other consumers as they interface with the healthcare system, and a mother who knows the power of mothering a new mother because of her experience of not having that kind of support as a teen.

It is interesting to draw a parallel here to support groups run by consumers. It has been found that participants in those support groups find the service more helpful because they feel understood by the group leader (NAMI/History, 2006; Sommer, 1990).

Another program that provides doula supports to socially and medically at-risk women is called the Doulas Care program in Ann Arbor Michigan. This program was started because many women cannot afford the fee-for-service model that is the primary one under which women can hire doulas. The goal of Doulas Care is to "improve the maternal and child health outcomes of at-risk populations by meeting the emotional and physical health needs of culturally diverse populations of low-income women and adolescents with at-risk pregnancies" (Kane, Low, Moffat & Brennan, 2006, p. 3). The major difference between this program and the Chicago model is that the doulas volunteer their time and are not paid for the services they provide. The doula's role is to provide education and support throughout the pregnancy, childbirth and postpartum periods.

Kane et al., (2006) carried out focus groups with the volunteer doulas to find out how to support the program best. The study found that the volunteer doulas were primarily highly educated and well resourced. They took part in the program in order to gain more experience, which is a requirement for becoming certified, and because of a commitment to increasing access to doula supports for all women regardless of available resources. Kane et al. found that a primary concern for the doulas in the focus groups was a fear of failing to meet the unique needs of their clients because of a lack of knowledge about community resources for those living with restricted resources. Another concern was not having experience with "unhappy pregnancies" (p. 5) An additional concern was a lack of skills in supporting new mothers whose life challenges extended beyond the challenges of labor, delivery and the postpartum phase. For example, being a teenage mother or being unemployed. It seems that the difficulties the volunteer doulas

experienced speak to the complexity inherent in working with a population living with complex social and emotional problems, and the additional and specific training that is necessary to support such a population if the volunteers don't have a similar life experience. The Chicago model avoids this to a certain extent by hiring doulas from the same communities as the women they support, thus insuring a certain familiarity with the life situations of their clients and easy access to available resources. This is not a discussion about which model is better, but more about making sure that the chosen model is tailored to the community it is serving and that the doulas themselves have the supports they need to be successful. The focus groups described by Kane et al. attempt to do just that.

At the Cooley Dickinson Hospital in Northampton MA, up until 2006, a subsidized postpartum doula program was available to any woman who gave birth there. In exchange for leaving the hospital after one night, the new mother could access free postpartum doula services for up to 20 hours once the mother and baby went home. Those that chose not to go home early and stay two nights at the hospital did not have the option of postpartum doula services.

The Kaiser Permanente HMO funded this program when they were still in the region. After they left, Cooley Dickinson chose to continue the program because it reduced their in-hospital care costs. The program ended in 2006 because of management changes as well as the lack of proof that the program was cost effective for Cooley Dickinson. However, a new administration is looking carefully at all of these programs and may reinstate them alongside a possible labor support doula program (Thompson, B., personal communication, November, 17th 2007).

The original program offered five 4-hour postpartum doula visits with the option of hiring her for more hours at a fee-for-service rate. The doulas' visits could begin as soon as a mother returned home. For example, if a mother's family was able to support her in the first two weeks, the doula would come after that. It was a very flexible service. The program director found that the focus of the service varied depending on the new mother's affluence and education. For a mother who was less affluent, the doula's focus often became more educational (personal communication, November, 17th 2007).

While the postpartum experience is not the same for an adult middle class woman in financial terms, the experience of isolation that the teens talk about in the Breedlove (2005) study may have echoes in all women's experience of the postpartum phase if no family is available to support her. Myers (1982) speaks to this when she notes that middle-class parents, who are often excluded from consideration for interventions, feel a need for help. According to Meyers, this can be seen in their high level of motivation to improve their parenting skills. Myers recognizes that their needs are much lower than those of high-risk groups, but that they could nevertheless use supports too.

Postpartum doula care and other home based supports

Our earlier exploration of American attitudes to new mothers in the postpartum phase clarified the need for a shift in attitude. Kendall-Tackett (1994) makes it clear that all women could use more supports during the postpartum phase. But how does postpartum doula support compare to other home based supports?

A study carried out by the Cochrane group (Macdonald, Bennett, Dennis, et al. 2007) looked at home based supports for disadvantaged teenage mothers. This study analyzed five other studies that had considered various in-home interventions. None of

them examined doula support, but covered a variety of aids including trained nurses, nurse clinicians, nurse midwives, psychology graduate students and peers of the teen mother who had received some training. The report stated “the evidence suggests that there is only limited support for the effectiveness of home visiting as a means of improving maternal life course, parenting or psychosocial outcomes of teenage mothers or for improving a range of developmental and social outcomes for their children” (Macdonald et al., 2007, p. 2). However, they added that evaluating whether home visiting works is not a simple yes or no, especially when criteria for success were so different from each other from study to study. The authors of the report conclude by saying that they do not believe that home visiting programs are ineffective. They felt that they needed to redesign the study. One question they asked in light of the study was: can one-to-one visits effect change in the face of so many disadvantages? Further, if the answer is yes, even to a small extent, then what does that intervention look like? While the authors recommend looking at the interventions developed by Fields (1980) and Olds (1986, 1988, 1993) this writer suggests that the Chicago Doula Project might be an appropriate model for an intervention that might well be a more effective model than nursing visits.

In 1999 Olds, Henderson, Kitzman, Eckenrode, Cole and Tatelbaum completed a 20-year program of research on the Nurse Home Visitation Program. In this model, nurses visit mothers during pregnancy and up through their child's second birthday. Results of the study suggest that this kind of program benefits the neediest families such as low income unmarried women, but is much less beneficial for the broader population. Nurses were assigned to mothers in the second trimester of pregnancy. The nurse visited

the mother once a week for a month and every other week thereafter until the baby's birth. In the postpartum phase the nurse visited once a week for ten weeks. Thereafter, the nurse visited twice a month until the 21st postnatal month and once a month up until the 24th month. This program emphasized "sensitive, responsive and engaged caregiving in the early years of life" (p. 48). In this way, the attitudes of the nurse seemed to be similar to that of a postpartum doula. However, a postpartum doula is likely to visit a mother in her home every day in the first week or two after she is home from the hospital and as such, provide a more intense continuity of care.

Shaw, Levitt, Wong, Kczorowski and the McMaster University Postpartum Research Group (2006) undertook a systematic review of the literature on postpartum care. Shaw et al., defined postpartum support as an "interpersonal interaction between a postpartum woman and trained individuals or health care professionals." Their study looked at 22 trials that listed at least one of the following outcomes: maternal knowledge, attitudes and skills related to parenting, maternal mental health, maternal quality of life or maternal physical health. Shaw et al., concluded that no evidence was found to support providing universal postpartum assistance as a means to improving parenting, maternal mental health, maternal quality of life, or maternal physical health. However, they did find some evidence that high-risk populations may benefit from postpartum support. Their findings are similar to those of Olds et al., (1999).

Other models that have been researched include first time parent groups (Hanna, Edgecombe, Jackson & Newman, 2002). This model is offered to women in Victoria, Australia, in the early postpartum period and has been found to increase the development

of social networks, enhancing self-confidence and increasing access to child health and parenting information.

The studies reviewed above, while demonstrating some success in supporting the neediest families, do not argue very positively for universal postpartum care programs. The question remains whether postpartum doulas would provide the kind of care that would make a difference for all mothers. If so, such a program would require a doula to work with only one or two mothers at a time for one or two months at a time. Such a program would be expensive.

Research criteria

Having defined and described the role of postpartum doulas, detailed the postpartum period for women in the United States, explored the formation of the new family and enquired into who uses a doula, this researcher will look at the criteria chosen to determine the usefulness of a postpartum doula. Many studies have explored the postpartum phase for primiparous mothers and the various factors that affect this phase in a woman's life. These factors include age, infant temperament, social support, personality traits, culture, race and socioeconomic status (Mercer, 1981). Postpartum doulas provide a type of social support. To measure the effectiveness of such social support, this study will use the criteria of enhanced maternal self-confidence and maternal empathy.

According to the Merriam Webster online dictionary, the word *enhance*, means “to increase or improve in value, quality or desirability or attractiveness.” In the context of this study, this word is appropriate in that it describes the process of increasing the sense of worth a mother experiences as she grows in self-confidence as well as in her ability to feel empathy for her child.

Belsky and Benn (1982) summarize the literature on early parent-child relationships. They state that while the literature is extensive, the results are easily summarized because the results are so consistent. Briefly, optimal development is fostered by sensitive mothering, which can be seen in appropriate responsiveness to infant cues. Ainsworth's research (1973) found that mothers, who are responsive to their child's needs, are nurturing and accept the child's limitations based on developmental level, tend to produce securely attached children. It follows then that sensitivity on the mother's part is "the influential dimension of mothering in infancy" (p. 282).

Webster's Ninth Collegiate dictionary (1985) defines sensitivity in a number of ways: the overarching definition is "the quality or state of being sensitive" (p. 1072). It further defines it as "awareness of the needs and emotions of others" (p. 1072). Given this definition, I have chosen maternal self-confidence and maternal empathy as my criteria for evaluating whether postpartum doulas enhance a mother's ability to sensitively attune to her infant in the postpartum phase.

Earlier in this chapter we looked at a study by Rogan, et al., (1997) entitled "'Becoming a Mother' – Developing a New Theory of Early Motherhood." It is relevant to examine this study in more detail in the context of this paper's criteria. Rogan et al., analyzed the experience of 55 first-time mothers in Australia and saw six phases emerge. These were "realizing, readiness, drained, aloneness, loss and working it out" (p. 877). It is noteworthy that the themes emerging from the focus groups look a lot like the steps taken by someone after any major event. The fact that the first step of this process is "realizing" implies that the primiparous mother can only really understand what it means to be responsible for a newborn after it is born. Oakley (1980) confirms this when she

found little evidence of preparation for the postpartum period. She concludes that if the reality varies from the expectation, it may contribute to the subsequent impact on self-esteem. Another interesting point is that once their baby is born, women in Australia go through a phase of realizing what they are up against and how much they need to learn in order to be successful in the postpartum phase. Women in developing countries who live in cultures unaffected by the West, are not expected to know what to do in the postpartum phase. Those women have communal supports in place as they learn how to mother. Rogan et al.'s study shows that in Australia, women believe that they have to cope on their own and have to self educate. Kendal-Tackett (1994) points to a similar phenomenon in the United States. It is no wonder that depression and reduced self-esteem are widespread.

It has been the experience of this writer that, when talking to pregnant women about the postpartum phase, they are so focused on the impending labor that they have very little psychic space left to consider the postpartum phase. An outcome of the focus groups conducted by Rogan et al., (1997), was that more time needed to be spent in the prenatal classes on parenting issues. As such, it seems that it is important to keep talking about the postpartum phase during the pregnancy but also to acknowledge that even with preparation, women need support in the postpartum phase. It was also noted by this writer that those women who had the foresight to hire a postpartum doula often said things like; "I know that I know nothing about baby care and so I want as much help as I can get." These women often said this with an apology, as if not knowing was not to be admitted too loudly.

Maternal self-confidence

Walker (2007) defines maternal self-confidence as reflecting “a mother’s appraisal of her mastery of the maternal role and grows with experience in the mothering role.” (p. 94). Walker (1986) found that self-confidence is an indicator of perceived role attainment and is the most important subjective measure of sensitive mothering during feeding among primiparous mothers during the early postpartum weeks. Walker further found that for first time mothers, "higher social resources indexed by SES, age and education are related to more sensitive and responsive behaviors during feeding" (p. 355).

Rubin (1967 a, b) and Mercer (1981, 1985) looked at maternal role attainment. Rubin explored the process by which a mother knows her child and knows what to expect from her baby. This process is closely related to maternal self-confidence. Mercer (1981) refers to Thornton and Nardi (1975) who created a role acquisition model that has a number of stages. They are: anticipatory, formal, informal and personal. This personal stage is identified as one in which the mother "experiences a sense of harmony, confidence and competence in how she performs her role" (p. 74). This model parallels the stages found by Rogan et al. (1997) 22 years later. Both studies found that maternal self-confidence was an important indicator of successful mothering. Williams, Jay, Gotowiec, Blum-Steele, Aiken, Painter and Davidson (1987) in a study on adaptation to motherhood, found that parenting confidence was central to adaptation to motherhood.

Davis (1989) found that sometimes mothers could be highly confident but show "low quality of interaction with their infant" (p. 55). Davis concluded that there are two constructs to consider: self-confidence and overconfidence. Overconfidence can result from denial of the complex nature of the mother-infant interaction or naiveté about it. This can be seen in a woman who expresses no concern in her ability to meet her infant's

needs. The author found support for this explanation in the fact that women with more years of college and graduate school were less confident at first in their mothering abilities than less educated mothers. These findings agree with Walker (2007) who found that maternal self-confidence without maternal empathy could lead to difficulties for the child once they get to school age. We will examine this further when we explore empathy.

One of the ways that postpartum doulas help boost new mothers' self-confidence is in supporting their ability to read their baby's cues. Myers (1982) undertook a study using the Brazelton exam as an education tool. The Brazelton Institute defines this exam:

The Neonatal Behavioral Assessment Scale (NBAS) was developed in 1973 by Dr. T. Berry Brazelton and his colleagues. The scale represents a guide that helps parents, health care providers and researchers understand the newborn's language. "The Scale gives us the chance to see what the baby's behavior will tell us," says Dr. Brazelton, professor emeritus, Harvard Medical School. "It gives us a window into what it will take to nurture the baby." The Scale looks at a wide range of behaviors and is suitable for examining newborns and infants up to two months old. By the end of the assessment, the examiner has a behavioral "portrait" of the infant, describing the baby's strengths, adaptive responses and possible vulnerabilities. The examiner shares this portrait with parents to develop appropriate caregiving strategies aimed at enhancing the earliest relationship between babies and parents (<http://www.brazelton-institute.com/intro.html>, January 14, 2008).

Myers found that using the Brazelton exam as an education tool correlated with an increase in maternal self-confidence as defined by being "more sure of self" (p. 466).

This finding confirms the value of explaining what is developmentally appropriate behavior as well as the baby's "positive social interactive abilities" (p. 463).

According to DONA (Position Paper, 2006) postpartum doulas believe that in order for self-confidence to take hold, a mother needs to be listened to, taken care of and supported as she grapples with this major life transition. In the United States mothers get

a lot of attention before the baby is born. After the birth, the attention shifts to the baby, leaving the mother to take care of herself (Kendell-Tackett, 1993). The following quote from a postpartum mother illustrates this well: "I felt like I didn't matter. I felt like they weren't interested in me after I had my baby. My husband said, of course they are not interested. You've had your baby" (p. 3). Raphael (1977) observes that, in America, when a woman is pregnant, the focus is on the pregnancy. Once the baby is born the focus is on the baby, leaving the mother to fend for herself. This need to rely solely on her own resources leads women to feel "depleted and isolated" (Rogan et al. 1997, p. 883) and is compounded by the fact that their social context (Rubin's nuclear family) offers little support. Given this attitude it is easy to understand why self-confidence is compromised in the postpartum phase.

Breedlove's (2005) grounded theory study of postpartum supports for postpartum teens confirms that the support these new young mothers are getting from postpartum doulas increases their self-confidence as mothers. One participant said "the doulas make you a better parent, make you more confident in taking care of your baby. I don't know what I would have done without their support" (p. 5). Another added that "being taken care of is support, and most support you can use in life is knowledge" (p. 5), showing the power of positive role modeling as a way of increasing maternal self-confidence, as well as general self-confidence.

Maternal empathy

Many authors have defined empathy and explored its meaning in the maternal context. It has been called an interpersonal process that originates between mother and newborn (Fromm-Reichman, 1950; Sullivan 1953a). Others have stated that empathy

originates in the non-verbal, skin touching, visual reading relationship between a mother and her infant in the first months of life (Olden, 1953, 1958; Shafer, 1959). It is an interpersonal process (Sullivan, 1953a). If empathy is lacking or faulty it can lead to later difficulties in personality formation (Kohut, 1971; Miller, 1981; Stolorow & Lachmann, 1980). Ainsworth and Bell's (1974) studies of mothers and their babies explored empathy, or a lack thereof, at work. Empathy can be described as a mother's attunement to her infant's cues and her ability to adjust her behaviors accordingly, as well as being able to look at the moment from her infant's perspective and connect with the baby's feelings and wishes. Another principle of empathy is respect for the baby's autonomy as separate from hers.

The present study is using empathy as a measure because empathy in a mother predicts more independent and less demanding behaviors by the time the child is one year old (Ainsworth et al., 1974). It is the quality of maternal interaction and her empathy that affects the infant's development (Weil, 1970). Blehar et al., (1977) found that infants who were securely attached when older, responded more positively to their mothers at three or four months than to strangers. Additionally the mothers of securely attached children were consistently sensitive and responsive to their infant's behavioral signals. In other words, the mother's positive attunement to her baby supported the beginnings of a secure attachment as could be seen in the baby's recognition of its mother at three of four months of age.

When considering the interaction between a baby and its mother, it is noteworthy that babies are born with varied temperaments and abilities to give non-verbal cues (Goldberg, 1977; Korner, 1965). A doula's role can be to support a mother in reading her

baby's cues. This might be one way that a doula could enhance maternal empathy in a first time mother who has no experience in this skill. Additionally, a mother and baby's *goodness of fit* is not always perfect. Empathy plays a large role in a mother's ability to accommodate for her infant's temperament and needs. For example, an empathic mother can draw out a withdrawn baby (Ainsworth & Bell, 1974). A doula could support her in learning how to do this.

Rubin (1984) describes maternal empathy as “the special empathy of mother with child that is characteristic of maternal identity” (p. 9). Rubin adds that the process of maternal identity begins with the child as it begins to move in the mother's belly and show itself in her roundness. In this way there is a "cognitive mapping of the 'I' and the 'you' and a constant reformulation of the 'I' in relation to the concept of 'you'" (p. 9). Rubin (1984) adds that empathy, not instinct, triggers a mother to respond to her child in pain and that it is her own experience of receiving comfort herself that, in turn, makes her able to provide comfort to her baby.

Gordon (2003) defines empathy as "resonating with what another is feeling and seeing things from his or her point of view" (p. 93). Walker (2007) adds that the ability of mothers to be empathic towards their child is especially important for young children who cannot advocate for themselves.

The relationship between empathy and self-confidence

Walker (2007) explores the relationship between maternal empathy, self-confidence and stress, and their relationship to a child's preschool behavior. The study found that “maternal self confidence is associated with the least behavior problems when mothers' confidence in the maternal role and their empathic response to their children are

both high.” (p. 102) However, maternal self-confidence without empathy was associated with more behavior problems in the preschool child (Walker, 2007). Brody and Axelrod (1970) found that some overly confident mothers were low in empathy. Walker (2007) suggests that nurses “may find role-modeling of empathic emotional responses and expressions of child-oriented perspectives to be helpful to parents under stress.

Explaining how a child’s developmental level affects how he or she views the world and responds to it is another tool nurses may use to begin to foster parental empathy” (p. 102). These guidelines could just as easily be applied to postpartum doulas.

Empathy levels in younger and older mothers

Mercer (1986), in her study of three age groups (15-19; 20-29; 30-42) of primiparous mothers found that the age of the mothers had a bearing on acclimation to the new mothering role. Mercer found that the older the woman, the greater her flexibility. The teenage group had lower empathy scores than the 20-29 year old group and the 30-42 year old group fell in between the younger and middle group. It was found then, that empathy is not a developmental construct that increases with maturity. Mercer poses the question: "Could it be that after 10 or more years working at a career or other roles, these older women have become too highly differentiated to take the disequilibrium of pregnancy with the equanimity of the 20-29 year old woman?" (p. 31). In other words, is it harder for them to enter into Winnicott's (1958) primary maternal preoccupation state and could that be contributing to their lower empathy scores? If this is a possibility a postpartum doula could support the older mother in her adjustment to mothering through conversations about what this transition means for her and how it might differ from her "old" life. In other words, the support of an attentive neutral and supportive doula could

facilitate the transition for women of all ages as long as there is an understanding that the experience and needs of mothers at different ages are different.

This study will explore whether mothers feel that their postpartum doula's enhanced their maternal self-confidence and their ability to be empathic towards their babies. Because of the inter-relationship between maternal self-confidence and maternal empathy, it seems important to use them both as measures of effectiveness of postpartum doula supports.

Summary

This literature review has determined that women do best in the postpartum period when they are in-relation. We have looked at the definition of a postpartum doula and the organizations that support them. We have also looked at the postpartum period as experienced in the United States and elsewhere. We have further determined that the birth of a first child is a major life transition for a family and explored the difference between attachment and bonding. Finally we have reviewed who uses postpartum doula's and who needs them. This study plans to consider the postpartum woman's experience of her postpartum doula's support, and asks whether that support enhances the mother's confidence in her ability to mother her child, as well as the mother's ability to develop maternal empathy.

CHAPTER III

METHODOLOGY

This exploratory, qualitative study will investigate the usefulness of postpartum doula support for first time mothers in the postpartum period for women of varied socio-economic status. The purpose of the study is two fold: first, to study the perceptions of postpartum women who received postpartum doula services and how this affected maternal self-confidence and maternal empathy, and second, to study the experiences of postpartum doulas who served a socioeconomically diverse sample of women.

The specific study questions are: does a postpartum doula enhance maternal self-confidence and maternal empathy in a first time mother in the postpartum phase? And, is this true across a socio-economically diverse sample of postpartum women?

The sample will be a non-probability sample obtained by snow-ball sampling using a quota sampling method. To reach a diverse sample, this investigator will attempt to fill predefined sample subgroups. Those subgroups are outlined in the section on Data Analysis. The data collected via interviews, will be analyzed using the grounded method. (Strauss and Corbin, 1990). As the name implies, this method attempts to keep theory grounded in reality (Anastas, 1999). This method allows for "constant comparison" (Anastas, 1999), in which coding takes place in overlapping stages. The data is coded

densely, so as not to miss any possible trend in the data. Further, the data can be analyzed from the start of data collection and trends can be explored for "similarities, differences and degrees of consistency of meaning" (p. 424).

Sample

Postpartum Mothers

The sample will consist of up to 10 mothers who are age 18 or older at the time of the interview, and had a postpartum doula after the birth of their first child. The mother's first child will have to be older than three months at the time of the interview and no older than 12 years. Mothers who have other children at the time of the interview can be included. All participants will have to be English speaking. Additionally, if the mother has suffered from severe mental health problems before the birth of her child, or struggled with severe postpartum depression after the birth of her first child, she cannot be included. Finally, if her first baby had to stay in the hospital for longer than seven nights without the mother, she cannot be included in the study.

Postpartum doulas

The sample will consist of up to 4 postpartum doulas that have worked with at least 10 first-time mothers as their postpartum doula. All participants will have to be English speaking. At least one of the four postpartum doulas must have worked with a socioeconomically diverse population.

Sample design

This sample was designed in order to hear both from mothers about their individual postpartum experience, and from postpartum doulas about working with a number of women of various socioeconomic groups as well as various temperaments.

Thus, the postpartum mothers will have a singular view, and the postpartum doula, a global view.

Contacting postpartum doulas

The snowball sampling process began with an email to postpartum doulas that are part of a doula list serve, some of whom worked through a free hospital Postpartum Doula Program. The purpose was to locate and interview up to four postpartum doulas that have worked with socioeconomically diverse postpartum mothers.

It is clear to this investigator through her own postpartum doula work, and through anecdotal evidence, that postpartum doulas are useful to better-resourced women who can afford to pay for doula services out of pocket. However, it is less clear whether those services are useful to less-resourced women and if so, how. If the postpartum doula agreed to participate in the study, she was mailed a consent form along with a stamped, addressed return envelope. In addition, this researcher requested that the participating doulas contact their former postpartum clients to inform them of this study and to provide them with the pertinent information regarding contacting this investigator.

Contacting mothers

Once a postpartum mother contacted this researcher through the postpartum doula, her suitability for the study was explored. Questions about her socioeconomic status were not included in the inclusion criteria. The hope was that by contacting the postpartum doula first, women who might have taken part in the free hospital program would be included. If not enough mothers had been found in this way, a final question concerned whether they knew of anyone else who might be interested in participating in this study. If the mother agreed to participate in the study, a consent form was mailed to

her along with a stamped, addressed return envelope. In addition, a flyer was posted on Craig's list and Freecycle.

Ethics and Safeguards

The interview questions explored the postpartum doula's experience of being a postpartum doula and asked her to describe the ways that she supported women at this major life transition. Similarly, the study questions explored the mother's experience of having post partum doula services after the birth of her first child. Since the questions may have elicited feelings about their experience, participants had the right to stop the interview at any time and they could skip any question. A list of resources was provided in case the interview elicited some difficult feelings.

Participants were informed that their participation in this study might be helpful in evaluating the services of a postpartum doula for a new mother and her family once she is home with her newborn. There was no compensation for participation in this study.

The researcher transcribed the interviews. The supervisor did not see the data until all identifying information had been coded. Answers were turned into data and the participant's identity remained confidential. Personal information was kept on a separate sheet and was coded as a number for the purposes of the research. All personal information is kept under lock and key for three years as required under Federal guidelines. If the data is needed after three years it will continue to be kept in a secure location and will be destroyed after it is no longer needed. The data was used in this MSW thesis and for possible future presentation and publication. The data was presented as a whole and if brief illustrative quotes or vignettes are used, they were carefully disguised.

Participation in this study was voluntary and any participant could withdraw from the study up until March 30th 2008. Any participant could refuse to answer any questions without penalty. If any participant chose to withdraw, all materials pertaining to the participant was destroyed. Any participant could also call the Chair of the Smith College School for Social Work, Human Subjects Review Committee if she or he had any concerns about this study.

The interview method had been chosen for this study because it might be difficult for a postpartum mother to take the time to answer a survey thoroughly. In an interview setting, the mother could attend to her child if necessary.

Data Collection

In order to gain a broad socioeconomic sample, the researcher attempted to locate postpartum doulas who work with working class populations, teens and working poor populations as well as middle class populations.

The data was collected via interviews of approximately one hour in length. Interviews were tape recorded, transcribed and coded by the author. Interviews were carried out in the home of the postpartum mother or postpartum doula or in any other mutually agreed upon place. If the mother had a young child, being home may have been beneficial. The mother could choose whether to have her child present or not. Field notes were written directly after each interview as an addition to the taped interview.

Data Analysis

The data was transcribed by the author and organized horizontally across the various interview questions as well as across the demographic information, leaving out

identifying information. The data was analyzed manually by being color-coded and visually laid out in order to catch trends, pulling out anything unusual or surprising.

CHAPTER IV

FINDINGS

This study asks whether postpartum doula can enhance maternal self-confidence and maternal empathy in primiparous mothers and whether this is true across a socio-economically diverse group of women. In order to obtain a diverse sample, it was decided that both mothers and doulas would be interviewed. Since doulas would have worked with more women, this increased the likelihood of obtaining a socioeconomically diverse sample of mothers' experiences.

Demographics

The postpartum doula

The original goal was to interview four doulas. It was a challenge to find four who were willing to take the time to be interviewed. Ultimately, three postpartum doulas were interviewed. One has worked for four years in a large city, was trained by DONA and has had 50 clients at the time of the interview. She also works as a labor support doula. The second has worked for one and a half years in a rural area near a number of small towns and a small city, was trained by CAPP and has had 10 clients to date. She also works as a labor support doula. The third doula has worked for seven years in a rural area near a number of small towns and a small city, was trained by a hospital that had a free postpartum doula program and has had 200 clients until now. She is a postpartum doula exclusively.

All three doulas spent an average of between 20 to 30 hours with their clients. However, there is a variance in the way those hours were used. The two doulas who did not work for the free hospital program spent between two to four hours a day with the new family and between three to five times a week in the first week. Thereafter, the number of visits per week reduced to two to three times until the 30 hours were used up. The doula who worked for the hospital program, was more likely to spend four hours once or twice a week for the first two to four weeks depending on whether the family chose to add extra fee-for-service hours onto the free 20 hours allocated by the hospital program.

The mothers

The original goal was to interview eight new mothers. However, nine were interviewed. At the time of their first child's birth, the mothers ranged in age from 26 to 39. The median age was 33. One mother had twins. All the others had singles.

The mothers' annual income at the time of their first child's birth ranged from \$10-30,000 (1); \$30-50,000 (2); \$50-70,000 (3) and 70,000 or more (3).

In terms of race, the sample was as follows: six mothers identified themselves as White/Caucasian; two mothers identified themselves as Multi-Racial and one mother identified herself as Semitic.

All mothers were educated at the Masters level. One was at the Doctorate level and one at the post-Doctorate level. One mother was not working before the birth of her first child. One worked part time. The other seven all worked full time before their first baby was born.

All the mothers were with partners at the time of birth and with the same partner at the time of the interview. Eight of the mothers are in heterosexual relationships and one is in a lesbian relationship.

Interview responses

This section will look at the interview responses in the following order: (a) the mother's experience of the postpartum phase, (b) the role of the doula as seen by the mothers and the doulas, (c) the socioeconomic view of the use of postpartum doulas, (d) the mothers' and the postpartum doulas' views on maternal self-confidence and maternal empathy, and (e) unexpected findings regarding similarities and differences in the mothers' experience of the doulas through the free hospital doula program and those hired independently at a fee-for-service rate.

The mother's experience of the postpartum phase

While it was not part of the thesis question, the interviews gave some insight into the range of experience a mother can have in the postpartum phase. Two of the women reported that the postpartum phase was an empowering and healing experience. They also noted that they had "easy" or "good" babies. These mothers were amazed that they coped so well.

Five other mothers felt that the postpartum phase was intense, but positive, and added that the doula made the difference because she "made life doable". For these women, it was hard to be calm, and the doula modeled that for them. One of the mothers in this group had experienced depression in her life and as a result, was more prepared for the potential pitfalls of the postpartum phase. For her, the doula was invaluable and allowed her to pace herself as she acquired new skills. She also was very focused on

getting enough sleep. All the women in this group felt in control, but still needed practical help and emotional support. For them, it was an intense but positive period. Some of the mothers in this group felt a pressure to keep up the house cleaning and appearances and apologized when they could not keep it up. For the mother of twins, this phase was hard, and her doula was instrumental in making this a positive phase of life. Another mother had been adopted. Having a blood relative for the first time was very emotional. For her, the postpartum phase was full of ups and downs because it was "stirring a lot that I didn't know was there".

For the remaining two mothers, the postpartum phase was very hard and they felt "slammed" by it. The doula did help, but it was nevertheless quite challenging, and they felt set up by the expectation they had of their life with a baby. One mother said "who is in charge of the deception, the good publicity?...you're supposed to be all happy and joyful, you know, ooh, this wonderful maternal feeling. It was not like that for me. It brought a lot of resentment and I just felt alone." The other said "when I actually gave birth I felt incredibly unprepared. As if all of my preparation and mental exercises had been devoted toward pregnancy and the process of birthing." She added that when she imagined motherhood, she skipped the baby phase, and had no idea what it meant to be a mother. For her, it was a huge life change. In her case, the doula acted like a "social worker" that helped her accept her new identity.

The theme of isolation and loneliness came up for quite a few of the mothers, as did the feeling of vulnerability. One mother states, "no one talks about this – the resentment, the loneliness". For many mothers this isolation was accompanied by feeling "brain dead" and "overwhelmed" as well as "unsure" and "nervous". One mother said

"there is no empathy for new mothers. It does seem like everyone around the new mom has forgotten how overwhelming it is" to become a new mother. This same mother felt like all the attention given to her while pregnant disappeared and the focus shifted from her to the baby. Additionally, she felt like the kind of attention given to her was the wrong kind. For this mother, the doula kept the attention on her by providing for her and not making demands, and in so doing, gave her the energy and calm space to focus on her baby.

As mentioned earlier, all mothers in this sample chose to breast-feed. Two mothers also supplemented with formula. While breast-feeding is not a part of the main question of this study, it is a large part of these mother's postpartum experience and informed their emotional and physical state. For three of the mothers, breast-feeding went well from the start. For one mother, it went very well and gave her "wellbeing to do so". For the other two, it took a little practice but went well. For the other six, breast-feeding was a challenge. Responses ranged from "more challenging" to "very painful, miserable, uncomfortable". Some mothers stated that they were confused by conflicting information. Another stated "it was hard in the first week until I got help with it and it evened out". The mother of twins found breast-feeding challenging. Her difficulties with breast-feeding were connected to the small size of her babies at birth. She spent a lot of time "in caucus" with her partner and doula about the situation. Another mother stated that breast-feeding was hard and took up a lot more time than she expected.

What mothers did not realize about the postpartum phase

A lot of the mothers believed that they would need practical help in this phase of life, but they did not know that they would need emotional support. They did not know

how vulnerable they would feel inside. A lot of them did not like the feeling of not being in control or not having command of what they needed and found it hard to allow others to take care of them. Some of them came to the realization that it was profoundly important to be mothered so as to mother the baby. Those who did not have any information before the birth about what a postpartum doula does, found it hard to conceptualize how to use a doula and felt that some more in depth information before the birth might have helped.

The role of the doula

Are postpartum doulas useful to first time mothers?

All the mothers felt that the postpartum doula was useful. They stated that they are useful to mothers with no previous experience with babies or to those with no family nearby. They are also useful for the partner as they establish their role and as they process their experience. They are useful when the mother knows she has a challenging day ahead of her. For some, she can provide a peer/mother relationship. One mother stated that "having a doula felt like a privilege. I remember feeling that this is the most powerful intervention any one could have and that if everybody had this - the way children's lives would start, and the level of child abuse and neglect would so dramatically reduce". Some mothers reported that their doula gave them a break so that they could take a nap or a walk. These mothers appreciated being able to take a moment for themselves.

While all the mothers had positive thoughts about having a postpartum doula, their comments also elucidated some things that doulas must not do. Mothers felt that it is important that they not impose their opinions on the new mother, but must help her find

her own. They also felt that it is important that they not make demands on the new mother's energy.

Some mothers had experiences that were less positive. One felt that the doula did not fulfill her expected role. In this case, the doula did not ask the mother what she needed. One mother who was getting breastfeeding help from her doula wished her doula had confirmed her instincts to feed her baby on demand and not on a schedule. Finally, for some mothers, it was hard to share her with other clients simultaneously, and they wished for more of her time

The role of the postpartum doula as seen by mothers

Mothers thought about the doula's role in several ways. One mother knew that the doula knew more about what they would need in the postpartum phase than she and her partner, and she wanted that wisdom close by. Another added that "I don't know how I would have gotten through it without her". It was also stated by most mothers that the match of mother and doula was important. For some, the age of the doula was important. Some were looking for a grandmotherly type, while others were looking for a peer or a big sister. One mother commented that she projected the idea of "mothering the mother" on what she knew her own mother would have done. This translated for her into a "bustling granny".

Most mothers were clear that they wanted someone who could tune into the mother's needs, and hoped for support in sorting out what is important and what isn't, especially around the paraphernalia that comes with a newborn. The mothers described their experience of the doula's support in a number of ways. Their responses fell into three categories: emotional, physical and informational support.

Emotional support

The doula lessened their anxiety. One mother stated that the doula "headed off a major crisis of confidence". Another felt that she prevented postpartum depression from setting in. Mothers added that the doula helped them to relax and had a therapeutic effect. She supported the mother's choices by encouraging her and not by taking over. She also slowed down mothers who tended to be anxious and helped them to tune into their baby's needs. Her non-judgment was important. For another mother, the doula was a motivating voice and helped the mother to be a problem solver. She encouraged this mother to ask for what she needed.

Mothers felt the need to process the birth and the postpartum phase and what it means to become a mother. Most of the mothers found that this need was satisfied by the doula. She was someone who could relate to this life transition and could normalize it. The doula could "generate normal and minimize drama". Another mother added that "she did bring a good dynamic energy into the house and helped normalize the whole thing". She also was able to serve as an "objective observer outside of the family and was non-judgmental". One mother realized how much support she needed with processing peer pressure and where she was in her matrescence in comparison to her peers. She added that she needed "someone to latch onto".

Physical support

All mothers found the physical help useful. They felt that the doula was helping to keep the household going. Mothers pointed to laundry, dishes, food preparation and snacks as ways in which the doula was helpful. One mother who was doing well emotionally was disappointed that her doula was not more supportive physically with

chores, and had a hard time redirecting her doula towards the kind of support she discovered that she needed. One mother needed the doula's help in the evening most of all, when her baby was at its fussiest. Thus she could focus on the baby while the doula prepared dinner and was on hand if advice was needed. Another mother commented on how the doula would prepare food ahead of time so that when her husband came home, he did not have to make dinner and could focus on his wife and baby instead. Some mothers admitted to finding it hard to ask for this kind of help and that it was hard to be served. For older mothers who had professional lives and who were used to being in charge of their lives, it was especially hard to allow another to take care of them in this way. One mother commented on feeling too "overwrought to give directions", but also felt awkward when she left the doula in the position of always offering to do things around the house. In this mother's case however, she needed her doula to give her emotional support more than anything. Her need to process this phase overrode the need for practical help. From her point of view, more frequent visits for a shorter span of time would have been more useful.

Educational support

All mothers felt that part of the doula's role was to educate them about baby care and newborns in general. One mother stated that she "picked her brains". Mothers mentioned bathing, sleep patterns, soothing of the baby, getting through the night and explaining of baby language as ways in which the doula educated them. Some also added breast-feeding to this list. One mother spoke about how the doula gave her and her husband information about the postpartum phase before the birth which included goals to reach for. These were a guideline as to the baby's sleeping patterns and how long a

mother usually has to sustain interrupted nights before her partner can do one of the feedings with a bottle. This mother found this information enormously helpful, especially when she was exhausted and felt that this phase would never end. It acted a little like a mantra that kept her going. Mothers also found it helpful that the doula kept reminding them to take naps and feed themselves.

The role of the postpartum doula as seen by the doula

All three doulas stated that the overarching goal of the doula is to mother the mother so that she can mother her baby. The doulas stated that the kind and amount of support given to the mothers varied from mother to mother, but that it encompassed the three categories already named by the mothers. Namely, emotional, educational and physical support.

Emotional support

Emotional support includes companionship, nurturing, reassurance and processing of the birth experience. Additionally, the doulas reported that they provide moral support and normalize the emotions that the new mothers might feel. They also encourage mothers to trust their own instincts, and that if those instincts are not coming easily, they nurture them. They added that all mothers need emotional support to some degree, even if they are doing well, and that they need reassurance. The doulas often see mothers who are in an emotional fog, and they believe that their role is to normalize this fog.

Physical support

Physical support includes keeping the house going, food preparation, care of the mother and partner as well as giving the mother a physical break by holding baby while

she showers or sleeps or goes for a walk. It sometimes also involves going places with the mother in her car or going shopping for the mother.

Educational support

Educational support includes guidelines provided to the mother before the birth for two of the doulas. Additionally, for all three, it involves the providing of resources such as mothers' groups. In the list of topics they educate mothers about, the doulas all included newborn care, the need of sleep (and what a lack of it can do) and good nutrition, breast-feeding and bottle-feeding as well as swaddling and soothing. They also added that mothers can be overwhelmed by the amount of gadgets that are now marketed at new parents and that the doula's role can be to clarify what they really need.

The doulas also commented on the idea that the problems of the postpartum phase is a cultural issue and that there needs to be more acknowledgement of what actually happens to a woman in this phase. They add that the mainstream individualistic culture of the United States leaves women thinking that they cannot ask for help and that there is no empathy for new mothers. One doula stated that "it is a set up for them feeling like they are failing". They continue, "mothers don't know that this is a time when they can stop being the hostess, house cleaner and cook". They will sacrifice bonding and nursing for keeping the house going and guests happy. One doula stated that women, even those with financial means ask, "do I deserve this"? (doula care). She added that she often hears new mothers say that they "hate to ask for help". According to the doulas, this leads women to think that they should be able to do it all in the postpartum period. As a result, an educational and emotional part of what doulas do is to let mothers know that it is OK to ask for what they need. As one mother who did understand this put it, "my husband

came home and the house is a wreck and my husband would say, what did you do all day? And I would say, I made a person, how about you?"

A socioeconomic view of the use of postpartum doulas

All three doulas have worked with some mothers of lesser means and with less education. However, most of their clients are college educated.

The doulas stated that all mothers they have worked with share some similarities, including the need for reassurance of their mothering skills, the desire to feel connected to other women in the postpartum phase, and the need for support because no new mother can keep up her usual duties with a newborn. This study also revealed differences in how mothers of various socioeconomic levels responded to doula supports. The following is a breakdown of the findings.

Working poor mothers who are not college educated.

The doulas reported that working poor mothers who are not college educated need supports with basic survival issues such as transportation, paying for diapers, paying the rent and getting nutritious food into the house. These women often use the doula for logistical issues such as getting a ride in the doula's car. One doula spoke about a mother who had no support system. This mother has an infectious disease and no partner. This mother would not have seen any other adult all week unless the doula visited her. The doula found that her role with this mother was to talk and provide companionship as well as a sounding board. She became a therapeutic figure for this new mother.

Another doula spoke about a teenage Latina mother from Ecuador who lived with her working class family in New York City. This mother was very clear that she wanted to breast feed. Her mother had not breastfed. She found a way to get a free doula in

training for both the birth and the postpartum phase. The doula stated that the family was very welcoming of her and that the new mother used the doula well, never hesitating to ask questions and seek out support. Transportation was not an issue for this mother because she lived in an urban setting with good public transport. Her basic physical and emotional needs were being met by her family, and she had the time to focus on learning about becoming a mother on her terms.

Middle class mothers with a college education

Mothers who are middle class tend to be more likely to use the doula as a source of information, for nurturing and for her expertise. One doula stated that, like working class mothers, these mothers are not afraid of hard work because they are used to doing things for themselves. These are the women who find it hard to be taken care of by the doula. They also are more likely to question the need of all the gadgets. One doula felt that the mothers with a college education were often more prepared because they had done the research.

One mother in this group is highly educated but of fewer means. She found it very frustrating that, because of the price, she could not have a labor support doula. Her labor and postpartum experience were very difficult and she felt unsupported, especially by her family. She was not prepared for the postpartum difficulties she encountered. She did have a postpartum doula through the free hospital doula program, who did make a difference, but not enough. When interviewed, this mother had a lot of residual anger about her experience. She also had a lot of frustration with the amount of maternity leave available to her. She stated that her career is very important to her and she feels angry at the societal assumptions she encounters that assume she will stay home with her baby

Upper class mothers

One doula reported that upper class mothers are more likely to treat the doula like a maid or a baby nurse. They attach a lot of importance to having all the gadgets. These mothers are more intent on making sure that they can get their life back to the way it was as quickly as possible. As a result, they often ask about pumping milk and giving bottles as early as possible. One doula noted that these mothers are often less nurturing towards their baby. She added that this is not the case for all of these mothers.

Older mothers who have a career and a college education

Mothers who are older have a harder time accepting not being in control. They have become used to being in charge of their lives. These women sometimes hold high-power jobs. While being committed to their newborns, they also want to keep their careers going. Other older mothers were so thrilled to be a mother at last, that they were ready for their life to shift gears. These mothers were highly empathic, but not always self-confident, in part because of the new experience of not being in control.

Maternal self-confidence

What does maternal self-confidence mean to new mothers?

All mothers agreed that self-confidence is an important aspect of becoming a mother. All mothers had similar interpretations. Namely, it means that the mother trusts herself to know what is right for herself and her baby and that she feels she can care for a newborn successfully. One mother added that a newborn is awe-inspiring and that it should be. Another said that it is "knowing what you are doing, and that you probably won't damage your baby, no matter what you do. It doesn't really matter that you don't

know what you are doing because they are sturdy". For another, it meant two kinds of care: to take care of the baby's needs and to be able to nurture emotionally. She added that a lack of self-confidence around the care of the baby's needs does not mean a lack of loving attention. One mother stated that confidence can mean knowing that "if I don't know how to do it now, I can learn and I'll be able to do it". Finally, one mother who had a sleepy baby and was not initially aware that this could impact his ability to get enough breast milk, felt that self-confidence is the ability to relax while also being able to get proactive when necessary.

The mother's experience of maternal self-confidence, and the doula's support of it.

All mothers agreed that their doula increased their maternal self-confidence. One added "she gave me the tools to get there". Another said that the doula "made me feel more confident, and so I was more confident", and that "her presence profoundly affected" her self-confidence. Some mothers felt maternal self-confidence before the birth. However, those who had experienced depression in the past, were less likely to feel self-confident about mothering before birth, and were surprised at how well they were doing in the postpartum stage, especially with the support of the doula. Those who had no prior experience with children or babies were also less likely to feel maternal self-confidence before the birth.

If confidence was there before the birth, it decreased for some mothers right after the birth as the reality of their responsibility and their lack of knowledge became apparent to them. Those who struggled with breastfeeding saw a reduction in their self-confidence. Another finding was that a really difficult labor does not mean a lack of maternal self-

confidence. Ultimately all the mothers found that it was something that could grow over time.

What does maternal self-confidence mean to the postpartum doula?

The doula defined a self-confident mother as one who believes she will be able to take care of her child. She believes that her instincts are good and will follow them rather than other people's opinions. Another doula felt that it meant that the mother is in charge and trusts what she is doing. She adds that a self-confident mother is one who will not worry about making a mistake and seems more comfortable. One doula stated that some mothers have it at the birth and others don't.

The postpartum doula experience of maternal self-confidence in new mothers

All the doulas agreed that maternal self-confidence is important in new mothers and that mothers are not prepared to be self-confident in our culture. One doula used the term matrescence as a way to talk about a phase that, she believes, deserves more attention as a rite of passage. Additionally, all the doulas agreed that it can grow over time. The doulas observed that self-confidence can revolve around breast-feeding. The mothers ask themselves, "am I making enough milk? Is my baby getting enough?" But, they add that this is not to say that these same mothers cannot be loving towards their babies. It is more that they worry too much about it and don't trust that they can provide enough.

All the doulas agreed that it is part of their job to help a mother's maternal self-confidence grow. They begin this process by acknowledging with the mother that it is very scary to have that kind of responsibility, and that it is a tough job. They add that this process can begin before the birth and that it is done via both education and modeling of

baby care. In addition, they believe that by giving the mother loving attention, the mother in turn, will be able to give the same to her baby. Often, the doula will ask questions that will lead the mother to find the answers for herself, thus boosting her self-confidence. An example of this nurturing comes in the form of telling the mother what an amazing job she is doing. She might say, “you mean you’ve eaten and you’ve nursed already?” Another way that the doula can support the parent's growing self-confidence is by interacting with the baby in front of the parents. In this way, the doula can model how to interact with the baby as well as express what the baby might be feeling in that moment. One doula said that she will “talk to the baby, but for the benefit of the parents, and I show them how to read the cues”.

One doula stated that she has seen overconfidence or a “fear of failure” emerge in women who are used to being in charge and are not willing to take advice. In addition, she has seen mothers push people away. She felt these mothers were sometimes moving towards a postpartum depression.

If doulas do not see self-confidence develop, they believe it is their job to try to nurture it. One doula said “if I see the mom is not yet bonded to her baby, they haven’t connected, and it didn’t feel like the mom could read the baby’s cues yet, this leads the mom to worry rather than action.” In this case, one doula said she will encourage the mother to join a new mother's group because making connections, not isolating herself, and seeing that other mothers have the same thoughts and worries, can be a great relief. They will also normalize the mistakes. She might say, “you know how many people have clipped a finger when cutting a newborn’s nails. Everyone survives. It’s OK”. Another doula stated that she had the mother do more, rather than less, and she will hold her hand

as she does it. For example she will model how to clip a nail once, and have the mother do the rest of them while she supports her. All three doulas stated that if depression is a factor, they will encourage the mother to get mental health support as quickly as possible.

Maternal empathy

What does maternal empathy mean to new mothers?

All of the mothers in the study were able to define maternal empathy and identify it in themselves. All of them agreed that it is a big part of mothering. For them, it meant putting oneself in the child's place and realizing how dependent the baby is and to "really honor that". One mothers stated that it means "nurturing and sensing what he needs, what he is experiencing and feeling, if he is upset, why he is upset, tired, hungry, what to do, how to calm him." Another added that "I know better than him why he is crying".

Another realized that she was "caring for his every need. You are their lifeline and they can't exist on their own". One mother said "with a newborn you have to bring a lot of empathy to the job because they've got no other way to communicate" than to cry. A lot of the mothers were able to put themselves in their baby's place, but some commented that a newborn's experience is so removed from their own that it is a little hard to access. However, if a baby was crying, they were all able to understand that they needed help of some kind and that the baby was not crying just to annoy them.

One mother struggled with feeling empathy in the first three months of her baby's life because she had so much anxiety about the baby getting enough breast milk. It was hard for her not to blame the baby for her difficulties with nursing. Yet she also expressed love for her baby.

The mother's experience of maternal empathy and her doula's ability to enhance it.

One mother felt that maternal empathy is innate. The others felt that it is there but that it can be nurtured along by the postpartum doula. They felt that the doula's tolerance for the mother's mistakes made the mothers more tolerant of their babies. Two mothers commented on the fact that if they were tired and stressed, their reserves of patience were lower and that it was harder to be fully empathic in those moments. Another mother commented that being empathic can be stressful, especially when she could not figure out why the baby is in distress. In those moments, she described a desire to walk away rather than tune in because it was so hard to see her baby in distress. A number of mothers commented on the milk let down (when the breast milk flows without the help of sucking) as a physical manifestation of their empathy, one that is out of their control. For two mothers, the relationship to her partner affected her empathy levels, because they are a team and are able to give each other breaks.

What does maternal empathy mean to the doulas?

The doula's definitions of maternal empathy were similar to the mothers. One said it is "realizing what that person is feeling him or herself". Another gave an example of what empathy might not and might look like. "If I have a screaming baby, and I think, 'will you be quiet, I can't stand this anymore, why did I ever have you?' And the other way, thinking, 'oh, you poor baby, what's wrong, lets try to figure this out so that you'll feel better'". From the doula's point of view, empathy also meant the ability to ask questions in order to figure out what the problem is. It also meant the mother being tuned in enough so that she can learn the little signs that tell her what is going on. All of the

doulas felt that depression could prevent empathy from developing. In this case, they would refer the mother for counseling services.

The doula's experience of maternal empathy in new mothers

All of the doulas agreed that maternal empathy is important in new mothers. Two of the doulas felt that it is innate in most mothers unless something has occurred to turn off the desire to nurture. All three doulas stated that they have seen empathy develop over time, and that some mothers can relate better to a slightly older baby. Doulas support the development of empathy through modeling how to be with a baby, nurturing the mother, and by pointing out to the mother the empathy she IS showing to her baby. Additionally the doula models what the baby might be feeling, giving the baby a voice so that the mother can see the process for figuring out what might be uncomfortable for the baby. One doula said that when the mother is in a postpartum fog, she sometimes thinks of herself as mother's brain. One doula felt that it is important to acknowledge with the mother that mothers don't always feel warm and fuzzy towards their babies, especially when they are functioning with a lack of sleep. She added that "I don't think that I can make them have feelings, but I do think that you can acknowledge where they are and try to figure out different ways to go". The doulas acknowledge that it is hard when they don't see a mother tuning into her baby in an empathic way, "a way that means giving up one's favorite TV show because your child is nursing and is easily distracted." She adds that that is when the doula can help to guide the mother.

The mother's partner in the postpartum phase.

While the partner was not the focus of this study, all of the doulas mentioned the partner as an important person in the postpartum phase, even if they could not always

work with them. All of them spoke about the important role the partners play in the baby's and mother's life. They have seen partners who need a lot of support with developing both empathy and self-confidence in their parenting.

The doulas stated that it is essential for the family system to include the partner in the experience. One doula quoted a father who said to her "how can I get my wife to trust me with the baby?" In this case, the doula said that this father was unusually connected to the doula and often stated that "you are my doula too". In this case the doula felt that it was her role to educate and reassure. The partner in the lesbian couple was at home for a longer time and was intimately involved in the postpartum phase not only as a supporter to the birth mother, but also as a receiver of the doula's support. Few decisions were made without her being present.

The mothers were asked if the postpartum doula was supportive of their partner. Some stated that their partner and doula were never or rarely in the home at the same time. However, for those who had been in the home at the same time, the doula supported the father with baby care and the adjustment to the fathering role. One mother mentioned that even though the doula and father did not meet, she had an impact on his fathering role by preparing dinner in advance so that he would not have to make dinner and would be able to focus on his family instead. The mother mentioned above, whose partner was always involved in the decision making, stated that the doula was as supportive of the partner as she was of the mother.

While the doulas were clear that their role was to include the partner if possible, most of the mothers interviewed attached less importance to this. As a result, it seems that the partners did not always make it a point to spend time with the doula. On a

logistical level, they were often at work very early after the birth and were not in the home at the same time as the doula.

Free hospital program doulas and fee-for-service doulas: similarities and differences

Of the mothers interviewed, five had a postpartum doula through a free hospital postpartum doula program and four had found a doula on their own before the birth of the baby.

The biggest difference between the two groups, is that fee-for-service doulas were interviewed by the family before the birth of the baby. Interestingly, all four mothers in this category hired the first doula that they met. The mothers in this category were more likely to have their doula come in the first week postpartum. The doulas were also encouraging and guiding the mothers about the postpartum phase before the birth. For these mothers, there was also less opportunity for the doula to not be a good match for the family. Trust was established before the birth and the family's priorities and needs were also defined before hand. As a result, the mothers were clearer about what they could ask of their doulas and a little less uncomfortable with asking for what they needed.

For the mothers who received their doula through the hospital program, there was no meeting before the birth. The doula was assigned by the hospital program and an effort was made to match a mother and a doula, but the mothers did not meet the doula until she arrived at their home. Some of the mothers felt it would have been helpful to meet the doula before hand so as to establish a relationship. It would also have helped them to get a clearer idea of the service. Some mothers said this might have made them feel less awkward about having a stranger in their home at this vulnerable time. One mother suggested that even a description of the doula's interests and strengths might have

been helpful. All the mothers appreciated that the service was free and some were amazed that it existed. All the mothers stated that the program was very valuable and some even wished that it had offered more hours, more frequently. Some mothers were clear that mothers need help in this phase, and that the program provided that help, even if it did not meet their needs perfectly.

Among the nine mothers interviewed there were some who felt that a postpartum doula would be even more valuable for a multiparous mother, but this was especially true for mothers who had an easier experience the first time.

Conclusion

Now that the findings are laid out, the next chapter will discuss the results.

CHAPTER V

DISCUSSION

Introduction

The purpose of this qualitative, exploratory study was to determine whether postpartum doula interventions enhance maternal self-confidence and maternal empathy in primiparous mothers. The sample for this study consisted of nine first-time mothers and three postpartum doulas. Four main themes emerged: a) doula intervention includes emotional, physical and educational support; b) women and doulas described increased maternal self-confidence; c) women and doulas described increased maternal empathy; and d) the enhancement occurred across the socioeconomic range of the sample. In addition, there was an unexpected finding regarding differences in services provided by fee-for-service doulas and doulas offered for free through a hospital program. Finally, two additional findings are worth mentioning regarding the partner and the postpartum doula, and the use of doulas for multiparous mothers. Each of the themes will be discussed in detail. The strengths, limits and implications of this study will be discussed and recommendations for future research will be identified.

Findings

Doula intervention as emotional, physical and educational support

The overarching finding of this study is that a postpartum doula intervention increases maternal empathy and maternal self-confidence in a primiparous mother. The mothers themselves, as well as the doulas, felt that the increase in empathy and self-

confidence resulted from the combination of emotional, physical and educational support. Additionally, this intervention was equally effective across a socioeconomic range. DONA and CAPPa define postpartum doula supports that are consistent with those voiced by the participants. DONA and CAPPa add that postpartum doula supports are especially useful for families with no or few relatives nearby. The mothers in this study all mentioned lack of family close by as an initial reason for wanting postpartum doula services. For one mother who did have family help during the first two weeks, the doula did not come right away. However, this mother found her relative's support to be negative and ultimately unhelpful. This is consistent with Adamakos, Ryan, Douglas and Ullman (1986) who noted that support in the postpartum phase has to come from welcomed sources. The mother added that when the doula arrived, she brought a wave of positive energy into her home.

Emotional support

Prior to experiencing doula help, the mothers imagined that doulas would be useful both physically and educationally, but few of them realized the emotional component. The mothers' experiences of the postpartum phase were varied. A majority (5) found the postpartum phase to be intense but positive, in large part because of the doula's presence. She provided them with companionship and emotional support at a time when they felt isolated, vulnerable and overwhelmed. Kendall-Tackett (1994) observes that in the United States, women receive a lot of attention when they are pregnant, but that once the baby is born, that attention refocuses on the baby, and the mother is on her own and expected to know what to do. Two of the mothers echoed this in their interview

and felt very thankful to have had a doula who redirected supportive attention back on them.

Mothers described a range of emotional supports provided by their doula. Overall, they felt that the doula normalized the challenges of the postpartum phase. For one mother, the doula "headed off a major crisis of confidence", and another felt that the doula prevented postpartum depression from setting in. These comments corroborate Kendall-Tackett's (1994) thesis that lack of supports is one of the things that accounts for the higher rates of postpartum depression in the United States, and that postpartum doula services can provide those needed social supports. The five protective factors that Kendall-Tackett found to be present in many other cultures where postpartum depression is not an issue are: (a) a distinct postpartum period, (b) protective measures reflecting the new mother's vulnerability, (c) social seclusion and mandated rest, (d) functional assistance and (e) social recognition of the mother's new role and status (p. 26). The mothers in the present sample often spoke about feeling vulnerable and lonely yet overwhelmed by some of their visitors, wishing that they were less isolated, and disappointed that the loving attention they experienced when pregnant was gone once their baby was born. Their experience echoes the absence of protective factors during the postpartum phase in American mainstream culture found by Kendall-Tackett.

Newton and Sprengle (2000) called postpartum doula work a "psychosocial intervention in the home" (p. 229). The doulas in this study spoke of their work in psychological and social terms too. The doulas stated that their overarching role is to mother the mother so she can mother the baby. One mother called it "mothering the

parent". On an emotional level, this mothering includes reassurance, affirmation, the processing of the birth experience and the beginning of matrescence.

Mothers spoke of feeling vulnerable at this time, and the doulas normalized this feeling by educating them about the enormous life transition that they are experiencing. One mother, for example, felt extreme anger about her postpartum experience and felt set up to fail. McGoldrick and Carter (2003) have written about the family life cycle and reframed it as a non-linear process. They define life phases through "unifying principles that define stages and tasks, such as the emotional disequilibrium generated by adding and losing family members during life's many transitions" (p. 379). Given that American mainstream culture frames the birth of a child only in positive terms, it is no wonder that some new mothers feel "set up" and disappointed when their feelings are less than positive. This experience is in accordance with Raphael (1997) who writes about social maternity. She states that in this country, mothers are expected to walk out of the hospital knowing how to mother their newborn as well as breast feed, and keep up with all her usual duties. A number of the mothers in this study felt unprepared and surprised by the enormous changes that this phase of life brought with it. For example, one mother focused all of her preparation on the labor and birth. She stated that when she imagined motherhood, she skipped the baby phase and had no idea what it meant to be a new mother. As a result, she was unprepared for the challenges of new mothering.

Rogan, Shmied, Barclay, Everitt and Wyllie (1997) conducted a study in Australia analyzing the experience of 55 first-time mothers. Their findings revealed six categories that described the process of change for primiparous mothers. They were: realizing, readiness, drained, aloneness, loss and working it out. For the mothers in this study, these

categories also apply. How much of each they experienced was contingent on a variety of factors. However, because of the doula supports they received, the mothers experienced less loneliness and were not as drained. The mothers alluded to the doula's companionship as essential to making their postpartum experience a positive one. They talked about all the little tips they received that made the learning curve less steep. The doula also provided a sounding board when they were in the realizing stage. One mother mentioned the reluctance among mothers to discuss how hard the postpartum phase was for them, while others talked about the importance of processing the loss of their former lives as well as the difficulty of feeling so "stuck in the house" and the ensuing loneliness and isolation. Those who were encouraged to find a mothers' group found it to be an invaluable forum to express these ideas in.

Physical support

Eight of the nine mothers felt that the physical support that doulas provided kept the household going. However, some mothers felt awkward about asking for this kind of help because they were not used to being assisted in this way. The doulas reassured the mothers that this is a time when they should be served. The postpartum phase as defined by Raphael (1977), is a time that highlights the need in women to be in relation. Raphael stated that this phase is a time when women should not be isolated. She adds that mothering is a learned activity and that women need support so as to learn how to become mothers. Yet 8 of the nine women in this study felt pressure to keep the house clean and guests happy, rather than understanding that they had permission to stop all activity and focus on the baby. Interestingly, some of the women were clear that they only wanted the right kind of company, company that would not be pulling at their

emotional or physical resources. They often defined the doula's company as the kind they wanted. Some mothers found that their doulas had to persuade them gently to let them do more. This too speaks to the tremendous difficulty women have in accepting help, even at this time.

Educational support

All of the mothers appreciated the tips and hands-on support that the doulas offered about baby care. For one mother, the doula's wisdom was profound and welcome, especially as this mother never felt that her doula was taking over or telling her what to do. Instead, she noted that the doula asked the necessary questions that allowed the mother to figure out the answer for herself. This is consistent with DONA's position paper (2007) which states that "by modeling a deep respect for the wisdom and decision making abilities of the new parents, she makes clear that supporting them in their own choices will have the best possible results" (p. 2).

Rogan et al. (1997) recommend an emphasis on the postpartum phase during prenatal classes. One mother felt that her doula was able to prepare her during her prenatal visit and gave her a lot of information both verbally and with references to resources that prepared her for the postpartum phase. This is noteworthy, because it implies that more information about the postpartum phase prenatally, can mean a less overwhelming experience in the postpartum phase and is consistent with Rogan et al.'s suggestion.

However, this same mother had experienced depression in her life and chose to prepare for the pitfalls of potential postpartum depression preemptively. One of the doulas interviewed stated that in her experience, mothers who had lived with depression

were usually more likely to prepare for the emotional aspects of the postpartum phase. The mother mentioned above, stated that the doula gave her timelines to work towards, regarding the baby's sleep patterns and how long a mother usually has to sustain interrupted nights before her partner can do one of the feedings with a bottle. When she was exhausted and struggling, this information let her know that this state of sleeplessness was not forever.

In contrast, another mother (who had no history of depression) stated that her whole focus when pregnant was on the labor and birth. As a result, she was surprised at the challenges she encountered in the postpartum phase. This mother's surprise is consistent with many of the clients I had as a postpartum doula. It may be that focusing the pregnant mother's attention on the emotional vulnerability of the postpartum phase, is a first step toward a positive postpartum experience.

Self-in-relation theory and the postpartum phase

This study confirms that new mothers need to be in-relation in the postpartum phase. This need manifested itself at both the emotional and the physical levels. The literature review has demonstrated that women are rooted in a need for intimacy and are relationally oriented (Jordan, Kaplan, Miller, Stiver & Surrey, 1991, 1998), which means that women understand the world through the self, in-relation to others.

The mothers in this study found it hard to accept the doula's physical support. One mother in this study exemplified this when she spoke about her doula bringing her a meal in bed:

"There was some awkwardness for me maybe around being taken care of and...served. I certainly didn't think of her as a servant at all...It felt like a privilege, I felt sort of privileged,... I remember she and I talking about that, it

made me feel like this is the most powerful intervention any one could have and that if everybody had this, the way children's lives would start and the level of child abuse and neglect would so dramatically reduce".

Because of the mothers' awkwardness at being taken care of exemplified above, the doulas were often re-contextualizing the postpartum phase through a self-in-relation modality allowing the mother to reframe for herself what it means to be dependent at this time and realize that it is not a negative. This finding is consistent with Stiver (1991) who redefined women as relationally oriented and rooted in a need for intimacy.

It is interesting to note that a lot of the women in this study were strongly identified with being independent and struggled with needing to rely on others in the postpartum phase. While the feminist writers of the Stone Center (1991, 1998) see women as being in relation, the mothers in this study still seemed to be strongly identified with being independent. On the other hand, their postpartum doula's support brought them tremendous relief. In effect, the new mothers in this study seemed to be caught between the need to be in-relation and the need to be independent and self-reliant. This tension was amplified by the fact that they were coming to terms with their baby's reliance on them.

Miller (1987) offers a different perspective on Erickson's adult stage and the concept of independence. Instead of stressing separation/individuation, she stresses relationship differentiation. The women in this study seemed to be coming to terms with their newfound identity as mothers. As they came to "realize" and get "ready" (Rogan et al. 1997) for motherhood, they seemed to be leaving their separated/individuated identity and facing their newfound status as being in-relation to their child.

In this respect, a parallel can be drawn between Miller's (1987) relationship differentiation theory and the ideally bonded and attached mother and child. In other words, the mother is attuned to her baby, and the baby is securely attached to his mother so that both can co-exist without overwhelming one another. Might it be, in this phase of life when new mothers go from being separate to being connected, that their desire to be in relation is awakened?

At the emotional level, the mothers in this study were surprised to find such a strong need for emotional support at this time. Most of them were very grateful to receive this kind of support from their doula. The companionship of the doula meant less depression for a number of the mothers. This finding shows that new mothers benefit from being in-relation during the postpartum phase, and derive emotional well-being from it. This is also consistent with Stiver (1991) who saw women as rooted in a need for intimacy. As new mothers go through the realizing phase (Rogan et al., 1997) with the support of a doula, they come to understand that they do not have to become mothers in isolation. Accompanying this is the recognition that women feel comfortable with being in relation. As such, the postpartum phase is an opportunity for women to experience healthy dependency or, relationship differentiation.

Rich (1976) identified two meanings for the idea of motherhood. The first is empowering to women and sees matrescence as a potential source of joy and creativity. Two mothers in this sample experienced the postpartum phase in a similarly affirming and empowering way. For some mothers in this study, however, the postpartum phase was a shock and made the mothers feel vulnerable and isolated. For a few of the mothers,

the presence of a doula provided the opportunity to process this new experience through her relationship with the doula.

Rich's (1976) second meaning for the idea of motherhood is institutional in its view that women should be kept in the home with the children and thus under male control. One mother expressed anger at the idea that she should stay home with her baby and give up her career. In fact, she insisted that she would not give up her career to be with her baby. She also added that she would not give in to the pressure she felt from society to be a stay-at-home mother. This was combined with frustration at the lack of financial supports for new mothers from employers. While Rich talked about women being under male control by being kept in the home, this mother did not identify the control as coming from men. However, the pressures she felt to stay home and the struggle she experienced to keep her career going seem to indicate that the conflicts some women experience in the postpartum phase are similar to those that Rich described in the 1970s.

In conclusion, the presence of a postpartum doula helps women come into contact with an important facet of their womanhood. In addition, the presence of a postpartum doula helps to avert relational problems between the mother and her child, and can prevent depression in the mother as a result of isolation.

Maternal self-confidence

Both mothers and their doulas defined maternal self-confidence similarly. The mothers described it as a mother's trust in herself to know what is right for herself and her baby. Another described it as being able to relax while also being able to become proactive when necessary. The doulas added that a mother who seems comfortable and

does not worry about making mistakes, is a self-confident mother. Both the mothers and the doulas saw self-confidence as something that can grow over time, which is consistent with Walker (2007) who found that self-confidence grows as a mother appraises her increasing mastery of the mothering role.

For some of the mothers, self-confidence was present before the birth, but this did not mean that it remained right after the birth. A number of the mothers found their self-confidence decrease after their baby was born. However, with time and the doula's support, it increased once more. Had the doula not been there, the mothers felt they would still have gained self-confidence over time. Yet, with a doula, it was gained more easily and the mothers did not become as drained as those who took part in Rogan et al.'s study (1997). The mothers in Rogan et al.'s study were able to learn on their own how to mother their babies, but not without considerable added stress.

Other mothers found that their maternal self-confidence was lower before the birth than after. The doulas noted that they had observed this trend in clients of theirs who had lived with depression in the past. Two of the mothers in this study had experienced depression in their lives and, because they did not feel maternal self-confidence while pregnant, had planned for added supports in the postpartum phase. These women did not experience any postpartum depression. One of them attributed this to the support of the doula as well as her ability to set up supports before hand. The other found the birth to be life-changing and empowering. She also noted that she had a "very good baby" which made the postpartum phase less stressful.

All of the mothers in the study agreed that their doula had increased their maternal self-confidence. The doulas agreed that it is part of their job to help a mother's self-

confidence grow. They did this by providing the emotional, physical and educational supports discussed earlier. The doulas agreed that maternal self-confidence is an indicator of successful mothering which is consistent with Thornton and Nardi (1975) and Rogan et al. (1997). If a doula does not see self-confidence develop in a mother, she sees it as her responsibility to nurture it. Two of the doulas are preemptive about this and begin to support and educate mothers before the birth. It is noteworthy that the mother in this sample who was the beneficiary of preemptive supports felt more prepared once the baby arrived, despite the postpartum fog that so many new mothers describe. Unlike the mothers in Rogan et al.'s study, this mother did not go through the "realizing" step. Rogan et al. report this step to mean that the primiparous mother does not realize what it means to be a new mother until her baby is born. Earlier, this discussion noted that prenatal preparation for the emotional pitfalls of the postpartum phase need to be more prominent in a prenatal class. The preparation's focus could be on making mothers realize that they will need help, and to normalize that need, as well as the feelings of vulnerability and exhaustion that are a part of the postpartum phase.

If maternal self-confidence does not develop, one doula stated that she encourages the mother to do more baby care, rather than less. She does this by demonstrating once and then observing and supporting. This correlates with Myer's (1982) finding that using the Brazelton exam as an educational tool increased maternal self-confidence in new mothers. In other words, increasing the mother's ability to read her baby's cues through demonstration boosts her self-confidence.

Another doula added that she encourages the mother to join a mothers' group so that the group can normalize her experiences. This is consistent with a study carried out

in Australia by Hanna, Edgecombe, Jackson and Newman (2002) which found that mothers who attended a group in the early postpartum period had increased social networks, enhanced self-confidence and increased access to child health and parenting information.

Maternal empathy

The mothers in the study defined maternal empathy easily. Their responses were clear and concise, which showed a personal experience of the process. Their descriptions include the ability to put themselves in the child's place and realize how dependent the baby is on them. One mother added that she has to bring a lot of empathy to the job because her baby has such a limited way of communicating. In other words, if she is not empathic, the baby's crying might lead her to blame herself or the baby rather than find the cause of the crying. Sullivan (1953a) described the process of empathy as interpersonal, with the baby and mother communicating with one another. Ainsworth and Bell (1974) describe empathy as a mother's attunement to her infant's cues and her ability to adjust her cues accordingly. One mother's response was congruent with this concept of attunement in that she stated that she knows better than her baby why he is crying. By this she meant that she has learned to read his cues and interprets them in an attuned way.

A number of the mothers stated that it was harder to be empathic when they were tired or stressed. One mother added that if her baby cried and she could not figure out what was wrong, she found it heartbreaking and would have the desire to walk away rather than tune in because it was so hard to see her baby in distress. Yet she also added that this was part of the learning curve of mothering, and that she appreciated the doula's support in processing this new experience of helplessness, which is a part of the parental

experience. As a parent, one cannot always rescue one's child from being upset. One could speculate that, in parents who are particularly perturbed by their baby's distress, echoes of their own early experiences of helplessness are being triggered. This idea is elegantly elaborated by Fraiberg (1975) in her essay entitled "Ghosts in the Nursery".

The doulas in the study defined maternal empathy in similar terms as the mothers. They added that empathy means an ability to ask questions in order to figure out the source of distress in the baby. All the doulas believed that they can support the development of empathy in a new mother through modeling, nurturing the mother and noting for the mother instances when she is being empathic towards her baby. In effect, she is narrating the process for the mother so as to confirm and reinforce it. Goldberg (1977) and Korner (1965) note that babies are born with varied abilities to give non-verbal cues. The doulas spoke about giving the baby a voice by asking out loud what the baby might be feeling so that the mother can correctly attune to her baby's cues. The doulas saw this process as a collaboration with the mother. Ainsworth and Bell (1974) note that an empathic mother could draw out a withdrawn baby. One doula felt that sometimes she can act as the mother's brain when the mother is in a postpartum fog. Following Ainsworth and Bell, this modeling of attunement can support the mother's ability to increase her own.

Some mothers and doulas felt that empathy is an innate quality, which is present at the birth. Two of the doulas added that even when not apparent at first, they have seen it develop over time. The mothers in the study agreed that empathy is present at birth, and that the doula can nurture it along. They added that the doula's tolerance of the mother's mistakes made them more tolerant of their babies. This speaks to the power of the

mothering the mother concept. However, the doulas also noted that the onset of depression could prevent empathy from developing. For the mothers in this study, postpartum depression did not develop. However, for one mother, the postpartum experience was not positive. Yet, despite this, she felt that she was able to be empathic toward her baby. She added that her doula gave her ideas that led to a better understanding of her baby's colic and she learned ways to soothe her baby. In turn, the baby cried less and the mother was a little less stressed. While this mother's overall experience was negative, she did see the doula as a positive force in a dark period of her life even though it was not enough to make a big difference.

The discussion about whether maternal empathy is present at birth could be tied to the bonding debate (Kennell & Klaus 1972; Myers 1984; Harmon 1981). Rubin (1984) describes maternal empathy as "the special empathy of mother with child that is characteristic of maternal identity" (p. 9). Rubin adds that maternal identity begins when the mother feels her baby move in utero, and progresses from there. In other words, Rubin believes that maternal empathy is present at birth. Bonding is described by Myers (1984) as "an affectionate bond" (p. 245) from mother-to-baby that occurs after the birth. It might be that a mother's ability to be empathic towards her baby is enhanced by this affectionate bond and is an important aspect of the development of attachment because it involves attunement to the baby.

The bonding debate asks whether bonding happens over time or only in the first few hours after birth. It is noteworthy that the doulas stated that they have seen a bond grow from the mother toward the baby over time. They report that some mothers do not seem completely bonded to their babies right at birth. For those mothers it is a more

gradual process, which grows into full-fledged bonding (from mother to baby) over time and enables healthy attachment (from baby to mother) to occur. This finding is inconsistent with Kennell and Klaus' (1972) thesis that bonding has a finite time to develop right after birth, but more consistent with Harmon's (1981) thesis that, with the support of psychotherapy, a mother-infant bond can be increased over time. The findings of this present study add that the support of a postpartum doula can also support the increase of the mother-infant bond over time.

Before closing the section on maternal self-confidence and maternal empathy, it is important to examine the connection between the two. Brody and Axelrod (1970) found that some overly confident mothers were low in empathy, which is consistent with Davis' (1989) concept of overconfidence. Davis found that overconfidence can result from a denial of the complex nature of the mother-infant interaction. In her thesis, overconfidence is seen in a woman who expresses no concern over her ability to meet her infant's needs.

One of the doulas in this sample talked about overconfidence. She related overconfidence to a "fear of failure" in the mother, and added that she was more likely to see this happen in women who were used to being in charge. The vulnerability they felt in the postpartum period was destabilizing, and these mothers were less willing to embrace the role of learner. As a result, they were resistant to advice given by the doula. In the above doula's experience, the women who were in this category tended to be older professionals. She found that their fear of failure, which manifested as overconfidence, in combination with the pushing away of advice and support, could lead to a decrease in

maternal attunement to her baby. This is consistent with Ainsworth (1974) who described empathy as a mother's attunement to her infant's cues.

Davis (1989) found support for her explanation of overconfidence in the fact that women with more years of college and graduate school were less confident at first in their mothering abilities than less educated mothers. While this is congruent with the sample of women in this study, it is inconsistent with the older college educated professional mothers who were the clients of the doula mentioned above. However, this doula's experience is consistent with Mercer (1986) who found that the age of a mother had a bearing on the mother's ability to acclimate to motherhood. She found that the teenage group in her sample had lower empathy scores. The 20-29 year olds had the highest empathy scores and the 30-42 year olds had empathy scores that were between the teens and the 20-29 year olds. Mercer asks whether this finding means that older women with more than 10 or more years working at a career have become too highly differentiated to take the "disequilibrium of pregnancy" and the postpartum phase "with the equanimity of the 20-29 year old woman?" (p. 31).

Of the mothers in the present sample, three were 29 or younger and six were 30 or older. All of the mothers in this sample were attuned to their babies and did not display an overconfident attitude as they talked about the first few months with their child. Thus there is a disparity between the experience of the older mothers in this study and the older mothers who were clients of the doula interviewed for this study. It might be relevant that this doula's clients were all living in a large city, whereas the mothers interviewed for this study did not live in a large city.

Whatever the mother's age, if a doula encounters a mother who is overconfident or lacks empathy, it might be even more important that she find a way to bond with that mother. Perhaps one way to bond with the mother is to increase the focus on nurturing the mother. Rubin (1984) stated that empathy, not instinct, triggers a mother to respond to her child in pain and that it is her own experience of receiving comfort herself, that makes her able to provide comfort to her baby. This idea is consistent with the doula's focus on mothering the mother, and is a situation in which nurturing the mother is more important than "role-modeling of empathic emotional responses" (Walker, 2007, p. 102) towards the baby as defined by Walker.

Enhancement occurred across the socio-economic range of the sample

The mothers in this sample were all college educated and within the middle class income range. One mother was still in graduate school and was therefore earning less. This study finds that, for the mothers in this sample, postpartum doulas provide a useful service that enhances maternal self-confidence and maternal empathy. A more socio-economically diverse sample of women could not be found for the study. However, the three doulas that I interviewed had some experience working with mothers from a broader socio-economic spectrum.

The doulas stated that all women, regardless of socioeconomic status shared similarities in their postpartum needs. Namely, the need for reassurance of their mothering skills and the desire to feel connected to other women in the postpartum phase. The doulas also saw the need for physical supports in all women. They added that their intervention enhanced maternal self-confidence and maternal empathy in the mothers they worked with to some degree.

While all mothers need these types of support, the way they use the doula shifts depending on socioeconomic level. The doulas gave examples that are representative of various socioeconomic levels. Mothers who were poorer tended to have fewer resources and supports. For these mothers, the doula served an important role at a physical level, at an emotional level and at an educational level. Often the doula would be using her own car because the mother had no transportation of her own to go and pay the rent or buy needed medicines. For some of these mothers, the doula would be her only visitor. As a result the doula became a therapeutic figure. Another doula spoke of her work with a teen Latina mother who had a lot of family support. In this case, the doula played a more educational role.

Research (Kendall-Tackett, 2005a) has shown that postpartum depression is higher among lower-income women than middle class women and that if lower-class women have good support they are less likely to experience depression. This finding is consistent with the experience of two of the doulas who worked with poorer mothers. In addition, the doula who worked with the teen mother found no depression or risk of it, which is consistent with Barnett (1996) who found that teen mothers with high social support were less likely to be highly stressed. Kane et al. (2006) in their study of a volunteer doula program that offered free doula care to any woman who could not pay out of pocket, found that some of the mothers referred to them had complex and challenging life circumstances. The doulas in their study expressed a fear of failing to meet the unique needs of their clients because of a lack of knowledge about community resources as well as a lack of experience with "unhappy pregnancies". The postpartum doulas in this study found that their job descriptions changed when they worked with a

poorer population with fewer resources, which is consistent with Kane et al.'s findings and implies that the training of the doula depends on the populations they might serve.

The doula's experience of working with middle class and lower middle class mothers was consistent with the sample of mothers in this study. Namely, they used the doula in all three ways defined earlier. However, these mothers also lacked social supports from their community and friends and the doula played an important social role.

One doula worked with upper class mothers and found that they were more likely to treat the doula as a maid or a baby nurse and did not grasp the role of the doula as clearly as the middle class mothers. Namely, that the doula is supporting the mother's ability to become a mother rather than do the mothering for her. These mothers' priorities seemed to contrast with the doula's goal of nurturing the mothering role. Sometimes, the doula felt that these mothers developed less of a bond to their babies. In this case, the doula's emphasis might have to shift and adapt to the situation as if they are working with a mother who is showing less maternal empathy and a degree of overconfidence. As mentioned earlier in the context of maternal empathy and the need to mother the mother, the doula's role might have to emphasize the nurturing of the mother so that she can nurture her baby. Loretha Weisinger, one of the doulas with the Chicago Doula Project, describes her work with teen mothers in the same way. This suggests a parallel in the kind of support that some teen mothers and some upper class mothers might need. Could it be that these mothers share a possible lack of nurturing when they were children themselves?

Unexpected findings

Five of the nine mothers in this study had a doula provided free of charge by a hospital program. The other four mothers paid out of pocket for their fee-for-service postpartum doula's services. There were some differences between the two groups that are noteworthy and thought provoking. The largest difference between the two groups is that those who had fee-for-service doulas met the doula before the birth, began a relationship with her and defined the parameters of the mother's anticipated needs beforehand. Additionally, the doula was able to provide information about the postpartum phase prior to the birth and prepare the mother for the realities of the imminent phase. Of those four mothers, three were very satisfied with the service.

Four of the five mothers who had a free doula, would have liked more hours and wished they had been able to meet the doula beforehand or had the opportunity to read a profile of the doula's strengths and interests before she came. The five mothers in this group also expressed a lack of understanding of what a doula does and felt awkward about asking her to do physical things around the house. While some of the mothers who paid out of pocket also struggled with being taken care of in this way, they did not feel awkward about having a stranger in their home in the same way that the mothers who had not met the doula beforehand did.

These differences are unexpected, and it is important to emphasize how thrilled all the women who had the free service were that the service was available at no charge. They also expressed amazement that it existed as an option for them. Yet the experiences of the mothers in the two groups are different enough to be noteworthy. It seems that doula services that have at least one pre-birth visit from the postpartum doula would be

optimal. In addition, it seems that visits from the doula in the first week, whether the mother has family supports or not, might be useful so that the doula can make sure that the mother is doing well emotionally. It is also an opportunity for the mother to clarify with the postpartum doula what her needs are now that the baby has arrived and whether she still feels that she would like to save the doula's visits until after the family supports have decreased.

In this study the mothers were asked about the usefulness of the doula for their partners. The responses showed a range, which went from very useful to minimally, because the partner and doula were rarely in the home at the same time. However, for those families where the doula did spend time with the partner, the support was significant. From the doula's point of view, the partner plays an essential role in the postpartum phase and needs a lot of support too. While this finding is unexpected, the implications are that more research could be done about the needs of the partner in the postpartum phase from the partner's point of view.

Finally, it is worth mentioning the comments of a number of the mothers regarding the usefulness of a postpartum doula for multiparous mothers. A number of the mothers stated without prompting that they thought a postpartum doula would be even more useful for a mother who is having her second child. One mother who had six children at the time of the interview, had had a postpartum doula for her first four children. She found the support to be invaluable, and stated that most of the support was physical. This was true for a number of the other mothers who had more than one child. They stated that with their second child, they knew exactly what they needed from their doula. That support was physical, with tasks such as cooking, laundry, care of their first

child requested of the doula. This finding implies that while the mothers wanted a doula for their second child, (or had had a doula), the support provided by the doula shifted away from the educational and emotional toward the practical. It might be interesting to do a study of multiparous mothers and their use of the postpartum doula.

Strengths, limits and implications of this study

This study demonstrates that postpartum doulas have an important role to play in the postpartum phase for first time mothers and that this is true across socio-economic lines. It also demonstrates the ways in which a postpartum doula enhances maternal self-confidence and maternal empathy via emotional, educational and physical supports. In addition, it shows that mothers appreciate this kind of a service being free and that more mothers can access the service when it is free. Finally, this study confirms that mothers have a desire to be in-relation during the postpartum phase and experience it as a life-changing event.

This study has some limitations. The sample is small. In addition, I was not able to recruit women who came from a broader socioeconomic spectrum. However, this can serve to illustrate two points. The first, as the literature suggests, is that most of the mothers who use postpartum doulas are middle class. The other raises the question as to whether mothers of lesser means have the time or the resources to respond to such a study solicitation. While the study was posted at a mother's group with a phone number, most of the mothers who responded had received a flyer by email from their doula or had seen the posting online on Freecycle or Craig's List. One might ask whether mothers of lesser means would have access to a computer and were even aware of the study.

In relation to Social Work practice, there are some implications. Postpartum doula services are an in-home intervention. While other in-home interventions reviewed in this study have not proved effective for new mothers, other than the most needy, (Olds, Henderson, Kitzman, Eckenrode, Cole & Tatelbaum, 1999; Macdonald, Bennett, Dennis et. al., 2007) postpartum doulas might be.

A postpartum doula program that is successful is the Chicago Doula Project. It highlights some important elements that need to be in place to guarantee success. In order for postpartum doula services to be successful for all women and their families regardless of socio-economic status or race or ethnicity, they will have to be provided by culturally competent workers who have an understanding of the needs of the population they are working with. For some mothers, postpartum doula services are an opportunity for re-parenting the new mother and are truly a psychosocial intervention in the home. The main criteria of such a service are that the doula meet the family before the birth and be in the home right after the birth as well as consistently for the first month. It may be that the higher the family's needs, the longer she will work with the family. While this service would be expensive given the number of hours it might involve, it may also save costs later as the child might have fewer difficulties in school and might have a better chance of becoming a tax-paying citizen as an adult. In addition, the re-parenting experience for the new mother might lead her to improve her life circumstances emotionally and physically.

Possible future research

This study has established that the supports needed by new mothers can vary tremendously depending on life circumstances. Additionally, postpartum doulas offer an

important service regardless of the new mothers' socioeconomic status. However, whether doula services would be welcomed by all new mothers regardless of culture or ethnicity, has not been answered by this study. One can speculate that any mother regardless of culture or ethnicity needs supports in the postpartum phase, and if she is not receiving them from her own community and family, a doula could be useful. Further study needs to be done to determine whether this is the case. In addition, the kind of cultural competency that a doula would need if she worked with mothers whose traditions were different from her own would also need to be explored. The Doulas Care program in Michigan began to address this by conducting focus groups with the doulas to find out how to best support the program. The Chicago Doula Project addresses this because their model provides doulas from the same neighborhood and background as the new mothers that they serve. This model has proved very effective.

In conclusion, a number of future studies would expand the literature on postpartum doulas. One might examine the postpartum needs of women from different cultural and ethnic backgrounds in the United States and whether they are met by their own support systems. Another might examine and compile a report on existing postpartum doula programs in the United States and abroad. From that data, another study might look at creating guidelines for postpartum doula services with the understanding that all new mothers need emotional, educational and physical support in the home in the first month postpartum. The study could also look at whether the guidelines would need to vary depending on the target population they are written for. Two more studies also come to mind. The first would focus on the partners' experience in

the postpartum phase, and the second would focus on the use of postpartum doulas for multiparous mothers.

REFERENCES

- Adamakos, H., Ryan, K. & Ullman, D. G. (1986). Maternal social support as a predictor of mother-child stress and stimulation. *Child abuse and neglect*, 10, 463-470.
- Altfeld, S. (2002). *The Chicago doula project evaluation, final report*. Ounce of Prevention Fund.
- Ainsworth, M. D. S. (1973). The development of infant-mother attachments. In B. Caldwell and H. Ricciuti (Eds.), *Review of Child Development Research* (Vol. 3). Chicago: University of Chicago Press.
- Ainsworth, M. D. S. & Bell, S. (1974). Mother-infant interaction and the development of competence. In K. J. Connolly and J. S. Bruner (eds.), *The growth of competence*. New York: Academic Press.
- Anastas, J. W. (1999). *Research design for social work and the human services*. 2nd ed. New York: Columbia University Press.
- Antonovsky, A. & Kats, R. (1967). The life crisis history as a tool in epidemiological research. *Journal of Health and Social Behavior*, 8, 15-21.
- Barnet, B. (1996). Depressive symptoms, stress and social support in pregnant and postpartum adolescents. *Archives of pediatrics and adolescent medicine*, 150(1), 64-69.
- Barron, S. P., Lane, H. W. Hannan, T. E., Struempfer, B. & Williams, J. C. (1988). Factors influencing duration of breastfeeding among low income women. *Journal of the American Dietetic Association*, 88(12), 1557-61.
- Bledsoe, S. E., & Grote, N. K. (2006). Treating depression during pregnancy and the postpartum: A preliminary meta-analysis. *Research on Social Work Practice*, 16(2), 109-120.
- Belsky, J. & Benn, J. (1982). Beyond bonding: A family centered approach to enhancing early parent-infant relations. In *Facilitating infant and early childhood development*. Bond, L. A. & Joffe, J. M. Eds. Hanover: University Press of New England.

- Blehar, M., Lieberman, A. & Ainsworth, M. (1977). Early face to face interaction and its relation to later infant-mother attachment. *Child Development*, 48(1), 182-194.
- Bowlby, J. (1969). Self-reliance and some conditions that promote it. In J. Bowlby, *The making and breaking of affectional bonds*. London: Tavistock.
- Brazelton Institute website. (2008). Retrieved January 14th, 2008, from <http://www.brazelton-institute.com/intro.html>.
- Breedlove, G. (2005). Perceptions of social support form pregnant and parenting teens using community based doulas. *Journal of Perinatal Education*, 14(3), 15-22.
- Childbirth and Postpartum Professional Association Position Paper. Evidence-based postpartum doula care. (2007). Retrieved November 3, 2007, from <http://www.cappa.net/position.asp>
- Campero, L., Garcia, C., Diaz, D., 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 & Medicine*, 47(3), 395-403.
- Chodorow, N. (1978). *The reproduction of mothering, psychoanalysis and the sociology of gender*. Berkeley: University of California Press.
- Colletta, N. D. (1983). At risk for depression: A study of young mothers. *Journal of Genetic Psychology*, 142(2dHalf), 301-310.
- Crouch, M., & Manderson, L. (1993). *New Motherhood. Cultural and personal transitions*. Gordon & Breach, Australia.
- Davis, A. L. (1989). *The effects of video self-modeling on maternal self-confidence and mother-infant interaction*. Fuller Theological seminary graduate school of Psychology.
- Doulas of North America Position paper: The postpartum doula's role in maternity care. (2007). Retrieved October 29, 2007, from http://www.dona.org/aboutus/position_paper_postpartum.php.
- Field, T. M., Widmayer, S. M., Stringer, S. & Ignatoff, E. (1980) Lower class, black mothers adn their pre-term infants: An intervention and developmental follow-up. *Child Development*, 51 426-36.
- Fraiberg, S. (1975). Ghosts in the nursery. *Journal of the American Academy of Child Psychiatry*. 14, 387-402.
- Fromm-Reichman, F. (1950). *Principles of intensive psychotherapy*. Chicago: University of Chicago press.

- Frydman, G. (1987). *Mature-age mothers*. Penguin, Ringwood, Victoria.
- Gilligan, C. (1982). *In a different voice*. Cambridge: Harvard University Press.
- Goldberg, S. (1977). Social competence in infancy: A model of parent-infant interaction. *Merrill-Palmer Quarterly*, 23(3), 163-177.
- Gordon, M. (2003). Roots of empathy: Responsive parenting, caring societies. *Keio Journal of Medicine*, 52, 236-243.
- Hanna, B. A., Edgecombe, G., Jackson, C.A. & Newman, S. (2002). The importance of first time parent groups for new parents. *Nursing Health and Sciences*, 4, 209-214.
- Harmon, R. J. (1981). Perinatal influences on the family; Some preventive implications. *Journal of Preventive Psychiatry*, 1(1) 132-139.
- Hofmeyr, G. J., Nokiden, V. C., Wolman, W. L. et al. (1991). Companionship to modify the clinical birth environment: Effects on progress and perceptions of labor and breast-feeding. *British Journal of Obstetric Gynecology*, 98, 756-64.
- Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating. *Journal of Psychosomatic Research*, 11, 213-218.
- Hultsch, D. K. & Plemons, J. K. (1979). Life events and life span development. In P. B. Baltes & O. G. Brim, Jr. (Eds.) *Life span development and behavior*. (Vol. 2) New York: Academic Press.
- Jordan, J.V., Kaplan, A. G., Miller, J. B., Stiver, I. P. & Surrey, J. L. (1991). *Women's growth in connection, writings from the Stone Center*. New York: Guilford.
- Kane-Low, L., Moffatt, A. & Brennan, P. (2006). Doula as community health workers: Lessons learned from a volunteer program. *Journal of Perinatal Education*, 15(3), 25-33.
- Kendall-Tackett, K. A. (1994). Postpartum rituals and the prevention of postpartum depression: A cross-cultural perspective. *Newsletter of the Boston Institute for the Development of Infants and Parents*. 13(1), 3-6.
- Kendall-Tackett, K. A. (1994a). Banishing the "baby blues.": How other cultures prevent postpartum depression. *The Doula*, 28, 26-28.
- Kendall-Tackett, K. A. (2005a). *Depression in new mothers*. Binghamton, NY: Haworth.
- Kennell, J. H. & Klaus, M. H. (1998). Bonding: Recent observations that alter perinatal care. *Pediatric Review*, Jan 19(1), 4-12.

- Kennell, J. H. (2002). *On becoming a family: Bonding and the changing patterns in baby and family behavior*. In J. Gomes-Pedro; J. K. Nugent; J. G. Young & T. B. Brazelton (Eds.), New York, NY, US: Brunner-Routledge.
- Kennell, J., Klaus, M., McGrath, S., Robertson, S. & Hinkley, C. (1991). Continuous emotional support during labor in a US hospital: A randomized controlled trial. *Journal of American Medical Association*, 265, 2197-201.
- Kitzinger, S. (1990). Birth and violence against women. Generating hypotheses from women's accounts of unhappiness after childbirth. In H. Roberts. (Ed.), *Women's Health Matters*. (pp.63-80). Routledge, London.
- Klaus, M. H., Jerauld, R., Kreger, N. C., McAlpine, W., Steffa, M. & Kennell, J. H. (1972). Maternal Attachment: Importance of the first postpartum days. *New England Journal of Medicine*, 286, 460-463.
- Klaus, M. H. & Kennell, J. H. (1976). *Maternal-infant bonding*. St Louis: Mosby.
- Klaus, M. H., Kennell, J. H. & Klaus, P. H. (1993). *Mothering the mother: How a doula can help you have a shorter, easier and healthier birth*. Reading (MA): Addison-Wesley.
- Kohut, H. (1971). *The analysis of the self*. New York: International University Press.
- Korner, A. (1965). Mother-child interaction: One or two way street? *Social work*. 10, 47-51.
- Laing, K. (2000). The home setting for perinatal care In N. A. Newton & K. Sprengle (Eds.), *Psychosocial interventions in the home: Housecalls*. New York, NY, US: Springer Publishing Co.
- Lim, R. (1992). *After the baby's birth: A woman's way to wellness*. Berkeley, CA: Celestial arts.
- MacArthur, C., Winter, H. & Bick, D. (2007). Effectiveness of postpartum support. *Birth*, 34(2) 188.
- Macdonald, G., Bennett, C., Dennis, J., Coren, E., Patterson, J., Astin, M. & Abbott, J. (2007). Home based support for disadvantaged teenage mothers. *Cochrane Library*. 3. Wiley.
- Manning-Orenstein, G. (1997). *A birth intervention: Comparing the influence of doula assistance at birth versus Lamaze birth preparation on first-time mother's working models of caregiving*. Saybrook Institute.

- McGoldrick, M. & Carter, B. (2003, 3rd Ed.) Developmental perspective on family functioning: the family life cycle. In F. Walsh (Ed.) *Normal family processes.*, New York: Guilford
- Mercer, R. T. (1981). A theoretical framework for studying the factors that impact on the maternal role. *Nursing Research. 30*, 73-77.
- Mercer, R. T. (1985). The process of maternal role attainment over the first year. *Nursing Research. 34*, 198-204.
- Mercer, R. T. (1986). The relationship of development variables to maternal behavior. *Research in Nursing & Health. 9*, 25-33.
- Member statistics. (2007). Retrieved October 29, 2007, from <http://www.dona.org/aboutus/statistics.php>.
- Meyer, B. A., Arnold, J. A. & Pascali-Bonaro, D. (2001). Social support by doulas during labor and the early postpartum period. *Hospital physician. Sept*, 57-65.
- Miller, A. (1981). *Prisoners of childhood*. New York: Basic Books.
- Myers, B. (1982). Early intervention using the Brazelton training with middle-class mothers and fathers of newborns. *Child Development. 43*, 462-471.
- Myers, B. (1984). Mother-infant bonding: The status of this critical-period hypothesis. *Developmental Review. 4*(3), 240-274.
- Myers, J. L. Lindenthal, J. J. Pepper, M. P. & Ostrander, D. K. (1972). Life events and mental status: A longitudinal study. *Journal of Health and Social Behavior, 13*, 398-406.
- NAMI/In our own voice. (2006). Retrieved August, 5th 2006, from http://www.nami.org/Template.cfm?Section=In_Our_Own_Voice
- Newton, N. A. (2000). The home setting for perinatal care. In N. A. Newton & K. Sprengle (Eds.), *Psychosocial interventions in the home: Housecalls*. New York: Springer Publishing.
- Nicholson, P. (1990). Understanding postnatal depression: a mother-centered approach. *Journal of Advanced Nursing. 15*, 689-695.
- Oakley, A. (1979). *Becoming a mother*. Martin Robertson, Oxford.
- Oakley, A. (1980). *Women confined: Towards a sociology of childbirth*. Martin Robertson, Oxford.
- Oakley, A. (1986) *From her to maternity: Becoming a mother*. Penguin, Hammondsworth.

- O'Connor, S., Sherrod, K., Sandler, H. & Vietze, P. (1978). The effect of extended postpartum contact on problems with parenting: A controlled study of 301 families. *Birth and the Family Journal*. 5, 231-234.
- Olden, C. (1953). On adult empathy with children. *Psychoanalytic study of the child*. 8, 111-126.
- Olden, C. (1958). Notes on the development of empathy. *Psychoanalytic Study of the Child*. 13, 505-518.
- Olds, D. L., Henderson, C., Chamberlin, R. & Tatelbaum, R. (1986) Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics* 78 65-78.
- Olds, D. L., Henderson, C. R. Jr., Chamberlin, R. & Tatelbaum, R. (1988) Improving the life-course development of socially disadvantaged mothers: a randomized trial of nurse home visitation. *American Journal of Public Health* 78(11) 1436-45.
- Olds, D. L., Kitzman, H. (1993) Review of research on home-visiting for pregnant women and parents of young children. *The Future of Children*. 3(30) 53-91.
- Olds, D. L., Henderson, C. R., Kitzman, H. J., Eckenrode, J. J., Cole, R. E. & Tatelbaum, R. C. (1999). Prenatal and home visitation by nurses: Recent findings. *The future of Children*. 9(1) 44-65.
- Our founders. (2007). Retrieved October 29, 2007, from <http://www.dona.org/aboutus/founders.php>.
- Placksin, S. (1994, 2000). *Mothering the new mother*. (1st and 2nd eds.). New York: Newmarket Press.
- Postpartum doula FAQs. (2007). Retrieved October 29, 2007, from http://www.dona.org/aboutus/faqs_postpartum.php.
- Pridham, K. F., Chang, A. S. & Hansen, M. F. (1987). Mother's problem solving skills and use of help with infant-related issues: The role of importance and need for action. *Research for nursing and health*. 10(4) 263-275.
- Raphael, D. (1977). *The tender gift: Breast-feeding*. New York: Shocken Books.
- Reis, J. (1988). Correlates of depression according to maternal age. *Journal of Genetic Psychology*. 149(4) 535-545.
- Rich, A. (1976). *Of woman born*. New York: Bantam books.
- Richards, L. (1985). *Having families*. Penguin, Ringwood.

- Rogan, F., Shmied, V., Barclay, L., Everitt, L. & Wyllie, A., (1997). 'Becoming a mother' – developing a new theory of early motherhood. *Journal of Advanced Nursing*. 25, 877-885.
- Rubin, R. (1967a). Attainment of the maternal role: 1. Processes. *Nursing Research*. 16, 237-245.
- Rubin, R. (1967b). Attainment of the maternal role: 2. Models and referents. *Nursing Research*. 16, 342-346.
- Rubin, R. (1984). *Maternal identity and the maternal experience*. New York: Springer.
- Seigel, E., Bauman, K. E., Schaefer, E. S., Saunders, M. M. & Ingram, D. D. (1980). *Pediatrics*. 66(2) 183-190
- Shafer, R. Generative empathy in the treatment situation. *Psychoanalytic Quarterly*. 28, 342-373.
- Shaw, E., Levitt, C., Wong, S. & Kaczorowski, J., McMaster University research Group. (2006). Systematic review of the literature on postpartum care: Effectiveness of postpartum support to improve the maternal parenting, mental health, quality of life and physical health. *Birth*. 33(3) 210-220.
- Sommers, R. (1990). Family advocacy and the mental health system: the recent rise of the alliance for the mentally ill. *Psychiatric Quarterly*. 61(3), 205-221.
- Steiner, D. M. (2004). *The social work's student's research handbook*. New York: Haworth.
- Stern, G. & Kruckman, L. (1983). Multi-disciplinary perspectives on postpartum depression: An anthropological critique. *Social Science Medicine*. 17(15), 1027-1041.
- Stiver, I. (1991). The meaning of care: Reframing treatment models. In J. V. Jordan, A. J. Kaplan, J. B. Miller, I. P. Stiver & J. L. Surrey. (Eds.) *Women's growth in connection, writings from the Stone Center* (pp. 250-267). New York: Guildford.
- Stolorow, R., Lachman, F. (1980). *Psychoanalysis of developmental arrests*. New York: International University Press.
- Sullivan, H. S. (1953a). *Conceptions of modern psychiatry*. New York: W.W. Norton & Co.
- Thornton, R. & Nardi, P. M. (1975). The dynamics of role acquisition. *American Journal of Sociology*. 80, 870-885.

- Walker, L. O., Crain, H. & Thompson, E. (1986). Mothering behavior and maternal role attainment during the postpartum period. *Nursing research*. 35(6) 352-355.
- Warren, C. (2006). There should be no limit. *British Journal of Midwifery*. April, 14(4), 222.
- Walker, L.O. (2007). Maternal empathy, self-confidence and stress as antecedents of preschool children's behavior problems. *Journal for Specialists in Pediatric Nursing*. 12(2) 93-104.
- Webber, S. (1992). Supporting the postpartum family, *The doula*. 23, 16-17.
- Webster's Ninth Collegiate Dictionary, (1985).
- Weil, A. P. (1970). The basic core. *Psychoanalytic study of the child*. 25, 442-460.
- Williams, T. M., Jay, L. A., Gotowiec, A., Blum-Steele, M., Aiken, L. S., Painter, S. L. & Davidson, S. M. (1987). Transition to motherhood: A longitudinal study. *Infant Mental Health Journal*, 8, 251-265.
- Winnicott, D. W. (1956). Primary maternal preoccupation. In *D.W. Winnicott: Collected papers*. London: Tavistock.
- Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock.
- 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 Obstetric Gynecology*. 168, 1388-93.
- Yu-Chu, H. & Mathers, N. (2001) Postnatal depression – biological or cultural? A comparative study of postnatal women in the UK and Taiwan. *Journal of Advanced Nursing*. 33(3) 279-287.

APPENDIX A

Consent form for mothers

Informed Consent Form

Please read and sign this form if you agree. Please return it in the self addressed stamped envelope. Thank you.

Dear participant,

My name is Binda Colebrook. I am a Smith School for Social Work student and I am working on my thesis project. This study is a research study about the usefulness of post partum doulas after the birth of a first child for families consisting of one or two parents. I am specifically interested in:

- Whether a postpartum doula can help a mother develop maternal empathy.
- Whether a postpartum doula can enhance a mother's maternal self-confidence.
- Whether postpartum doulas are useful for mothers of varied socioeconomic backgrounds.

I will be interviewing with the help of a tape recorder. The interview will take about one hour and is voluntary. I am happy to come to your house at your convenience or meet you at a mutually agreed upon place. I will be visiting with you once to interview you. It is up to you whether your child is present or not. You are welcome to feed your child during the interview if needed. If you need to tend to your child during the interview that is fine too. These interviews will be held privately if at all possible.

In order to be eligible for this study you must be 18 or older at the time of the interview and you must be the birth parent of one child and had a post partum doula come to your home after the birth of your first baby. Your first baby must be at least 2 months of age but no older than 12 years of age. You must not have been separated from your baby for more than seven days postpartum. This study is not able to include mothers who experienced severe postpartum depression.

The questions I will be asking will be exploring your opinions on the experience of having a post partum doula after the birth of your first child. If the post partum period was difficult for you, the questions may bring back some feelings about the experience. You have the right to stop it at any time. You have the right to pass on any question. I will also be providing you with a list of resources that you can use should this interview bring some difficult feelings up for you.

Your participation in this study will be invaluable in exploring the strengths and weaknesses of the use of a post partum doula for a family that has just brought home a newborn. There is no compensation for participation in this study.

I will transcribe the interviews and no one other than my supervisor and myself will see your responses. My supervisor will not see data until your identifying information has been coded. Your answers will be turned into data and your identity will always remain confidential. Your personal information will be kept on a separate sheet and will be coded as a number for the purposes of the research. I will keep your personal information under lock and key as required under Federal guidelines for three years. If the data is still needed after three years it will continue to be kept in a secure location and will be destroyed after it is no longer needed. The data will be used in my MSW thesis only. The data will be presented as a whole and when brief illustrative quotes or vignettes are used, they will be carefully disguised.

Participation in this study is voluntary and you may withdraw from the study up until March 30th 2008.

You may refuse to answer any question without penalty. If you chose to withdraw, all materials pertaining to you will be destroyed.

If you chose to withdraw please call me at the following telephone number.

1 413 586 5425

You can also call the chair of the Smith College School for Human Subjects Review Committee at the number below if you have any concerns about this study.

1 413 585 7974

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY

TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.

Thank you.

YOUR NAME:

SIGNATURE:

DATE:

INTERVIEWER'S NAME:

SIGNATURE:

DATE:

Consent form for postpartum doula

Informed Consent Form

Please read and sign if you agree. Please return in the self addressed stamped envelope.

Thank you.

Dear participant,

My name is Binda Colebrook. I am a Smith School for Social Work student and I am working on my thesis project. This study is a research study about the usefulness of post partum doula after the birth of a first child for families consisting of one or two parents. I am specifically interested in:

- Whether postpartum doula are useful for mothers of varied socioeconomic backgrounds.
- Whether a postpartum doula can help the mother develop maternal empathy.
- Whether a postpartum doula can enhance the mother's maternal self-confidence.

I will be interviewing with the help of a tape recorder. The interview will take about one hour and is voluntary. I am happy to come to your house at your convenience or to meet you somewhere else. I will be interviewing you once. These interviews will be held privately if at all possible. In order to be eligible for this study you must be a post partum doula who has supported at least 10 women with at least one of them being of a different socioeconomic status than the others.

The questions I will ask will explore your opinions on the experience of being a post partum doula and exploring the ways that you support women at this major life transition. If any of this work was difficult for you, the questions may bring back some feelings about the experience. You have the right to stop it at any time and/or pass on a question. I will also be providing you with a list of resources that you can use should this interview bring some difficult feelings up for you.

Your participation in this study will be invaluable in exploring the strengths and weaknesses of the use of a post partum doula for a family that has just brought home a newborn. Unfortunately, there is no compensation for participation in this study.

I will transcribe the interviews and no one other than my supervisor and myself will see your responses. My supervisor will not see the data until your identifying information has been coded. Your answers will be turned into data and your identity will always remain confidential. Your personal information will be kept on a separate sheet and will be coded as a number for the purposes of the research. I will keep your personal information under lock and key as required under Federal guidelines for three years. If the data is still needed after three years it will continue to be kept in a secure location and will be destroyed after it is no longer needed. The data will be used in my MSW thesis and for possible future presentation and publication. The data will be presented as a whole and when brief illustrative quotes or vignettes are used, they will be carefully disguised.

Participation in this study is voluntary and you may withdraw from the study up until March 30th 2008 and you may refuse to answer any question without penalty. If you chose to withdraw, all materials pertaining to you will be destroyed.

If you chose to withdraw please call me at the following telephone number.

1 413 586 5425

You can also call the chair of the Smith College School for Human Subjects Review Committee at the number below if you have any concerns about this study.

1 413 585 7974

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.

Thank you.

NAME:

SIGNATURE:

INTERVIEWER'S NAME:

SIGNATURE:

APPENDIX B

Recruitment letter for mothers

DID YOU HAVE A POSTPARTUM DOULA WITH YOUR FIRST BABY?

IF THE ANSWER IS YES, WOULD YOU CONSIDER TAKING PART IN THIS STUDY?

Hello, I hope this finds you well. My name is Binda Colebrook. I am currently working on my Smith MSW thesis.

The title of the thesis is:

“Mothering the mother” after birth: Does a postpartum doula enhance maternal self-confidence and maternal empathy in a first time mother in the postpartum phase?

I am hoping to interview mothers that had a postpartum doula after the birth of their first child.

If you are 18 or older; had a postpartum doula after the birth of your first child; was not separated from your child for more than seven days after the birth; did not experience severe postpartum depression; speak English and would be interested in taking part in this study, please email me at appleseedbinda@verizon.net and I can tell you more about it.

The interview would take approximately an hour and I could come and meet you at your home or any other mutually agreed upon place. (If you need to have your child or children there that is fine with me.)

Taking part in this study would add to the literature on postpartum doula supports - which is currently fairly sparse.

I so look forward to hearing from you.

Thanks very much,

With respect,

Binda Colebrook

Recruitment letter for postpartum doulas

ARE YOU A POST PARTUM DOULA?

IF YES, WOULD YOU LIKE TO BE A PART OF THIS STUDY?

Hello,

I hope this finds you well.

My name is Binda Colebrook. I am currently working on my Smith Masters in Social Work thesis.

The title of the thesis is:

“Mothering the mother” after birth: Does a postpartum doula enhance maternal self-confidence and maternal empathy in a first time mother in the postpartum phase?

If you have worked with ten mothers or more and would be interested in taking part in this study please email me at appleseedbinda@verizon.net. The interview would take approximately an hour and I could come and meet you at a mutually agreed upon place.

Taking part in this study would add to the literature on postpartum doulas - which is currently fairly sparse.

If you are interested or would like to know more, please email me back at the address posted above.

I so look forward to hearing from you.

Thanks very much

With respect,

Binda Colebrook

APPENDIX C

Interview guide for mothers

Participant number:
Demographic questionnaire

1: What is your age now?

Age:

2: How old were you when you had your first child?

Age:

3: What was your annual income when your first child was born?

Please check appropriate box

\$0 – \$10,000 per year	\$10,000 – \$30,000 per year	\$30,000 - \$50,000 per year	\$50,000 - \$70,000 per year	\$70,000 or more
----------------------------	------------------------------------	------------------------------------	------------------------------------	---------------------

3a: How do you identify yourself racially?

4: Years of schooling

Please check those that apply:

Schooling completed:

High school:

College:

Graduate:

Doctorate:

5: What year was your first child born?

Year:

- 6: Were you working before your first baby's birth?**
Please check
Yes:
No:
- 7: Were you with someone during the pregnancy and birth of your (first) child?**
Please check
Yes:
No:
- 8: Did you have a labor support doula?**
Please check
Yes:
No:
- 9: In what setting did you give birth?**
Please check
Hospital:
Birthing center:
Home:
Elsewhere: (please describe)
- 10: Did you choose to breast-feed or bottle feed?**
Please check:
Breast-feed:
Bottle-feed:
- 11: If you chose to breast-feed how did you experience breast-feeding in the first days after birth?**
Please describe briefly:

Interview guideline for mothers:

Participant number:

1: I am wondering how you heard about postpartum doulas?

- A: What made you decide to have a post partum doula?
- B: Did you interview doulas before you had your baby?

2: How long did your post partum doula work with you?

- A: I am wondering if she was there everyday?
- B: If not how often did she come?
 - B1: Can you give me an idea of her schedule as she worked with you?
- C: Did she ever come at night?
- D: Over all, how long did she come to see you?

3: Tell me about what it was like to have a post partum doula?

- A: Can you imagine what it might have been like without her?
- B: Did you ever feel overwhelmed by her?
- C: Did she involve your husband/partner too?
- D: How was it to have another woman around?
- E: Did you ever just hang out together?
- F: Did you feel taken care of?
- G: Did you have a desire for companionship?
 - G1: If yes, did the doula fulfill that desire?
 - G2: If no, what could she have done differently?

- H: If you could have changed anything about her service, what would it have been?

4: The next questions are about self-confidence as a mother and your postpartum doula's ability to enhance it.

- A: I would like to begin by asking what maternal self-confidence means to you?
- B: Did you feel self-confident about being a mother before the baby was born?
- C: How did having a baby affect your self-confidence in being a mother?
- D: Do you think that your postpartum doula affected your maternal self-confidence?

5: The next questions are about empathy towards one's baby and whether your postpartum doula enhanced your ability to be empathic with your baby?

- A: I would like to begin by asking what maternal empathy means to you?
- B: Can you imagine what it is like to be a little newborn baby?
- C: What was it like for you to be a mother to a newborn baby?
 - C1: What kind of feelings came up for you?
- D: Does your baby ever cry?
- E: What happens to you when your baby cries?
- F: Do you think that your postpartum doula affected your ability to be empathic towards your baby?

6: Before we end is there anything else that you feel I should know about your experience of having a postpartum doula?

Interview guide for postpartum doula

Participant number:

Demographic information

1: May I ask how long you have worked as a post partum doula?

2: May I ask how many clients you have had?

3: It would be helpful to know how long you spend with a client on average?

Please check:

15 hours:

20 hours:

25 hours:

30 hours:

More: (how much)

4: What is the pattern of your hours with a client?

(example: Everyday for the first week and then two or three times a week for a month.)

Please describe:

Interview guidelines:

Working as a post partum doula:

5: Tell me about what you do as a postpartum doula.

- Do you find that the length of time varies from woman to woman?
- Have you found that women want the same thing from their postpartum doula?
- Does what you do with a woman and her family, vary from household to household?
- Is there a difference between what women ask for and what you feel they might need?
-

7: Do you find that all women, both better and lesser resourced, benefit from postpartum doula care?

- Does what you do with a woman vary from household to household?
- If you see a pattern in what you do, does it coincide with class or culture or anything else?
-

8: Maternal self confidence

- What does self-confidence mean to you?
- Do you think that it is important in new mothers?
- How can postpartum doula care enhance maternal self-confidence?
- If you don't see self-confidence developing in new mothers what does that mean for you?

9: Maternal empathy

- What does maternal empathy mean to you?
- Do you think that it is important in new mothers?

- How can postpartum doula care enhance a mother's ability to be empathic towards her baby?
- Do you see empathy developing in new mothers?
 - What does that look like?
- If maternal empathy is not developing in the new mother, what does that mean?

10: Before we end is there anything else that you feel I should know that is relevant to this study?

APPENDIX D

Human subjects review approval letter

January 8, 2008

Binda Colebrook

Dear Binda,

Your second set of revisions has been reviewed. I am glad that you decided not to send all of those materials to your participants. I do think it will improve your positive response rate. All is now in order and we are glad to give final approval to your project.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your very interesting study

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Starr Wood, Research Advisor