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Domains of Postpartum Doula Care and Maternal Responsiveness and Competence

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ABSTRACT

Objective: To describe the domains of postpartum doula care and illustrate how doulas facilitate development of maternal responsiveness and competence.

Design: Qualitative study using ethnographic method of participant observation.

Setting: Homes of mothers who received postpartum doula care.

Participants: Thirteen women and their infants; 4 postpartum doulas.

Results: Eleven domains emerged: emotional support, physical comfort, self-care, infant care, information, advocacy, referral, partner/father support, support mother/father with infant, support mother/father with sibling care, and household organization. Emotional support was used consistently and in combination with the other domains. Activities in all of the domains were used to facilitate the development of maternal responsiveness and maternal competence with 3 issues: resolution of infant feeding, integrating the infant into the family, and supporting developmental care and attachment.

Conclusions: Data suggest that by using 11 domains of care, postpartum doulas facilitate maternal responsiveness and competence. Development of a long-term relationship, mother-centered care, and education and support related to infant feeding, integrating the infant into family, and developmental care and attachment may contribute to these outcomes.

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Postpartum can be a challenging time for families. Whether the new baby is the parents' first child or joins other siblings, the adjustment may demand skills and knowledge that the family did not previously use. In today's mobile society, extended family members may not be available for support during the postpartum period, and new parents may feel isolated and overwhelmed. A relative newcomer to the postpartum care team, postpartum doulas, provide emotional and physical support that extends into the postpartum period (Kelleher & Simkin, 2006).

Doula is a Greek word that refers to a lay birth attendant who provides non-medical support to women and their partners (Campbell, Scott, Klaus, & Falk, 2007; Klaus, Kennell, & Klaus, 2002). DONA International (DONA), formerly known as Doulas of North America, is an organization that trains and certifies doulas to provide nonmedical support during labor, birth, and postpartum. Postpartum doulas facilitate the transition to parenthood by providing education (evidence-based information on infant feeding and soothing, recovery from birth, and coping skills) and nonjudgmental emotional support for the new family (Kelleher & Simkin, 2006).

In several meta-analyses, continuous labor support by doulas and other support persons was shown to benefit both mothers and infants (Hodnett, Gates, Hofmeyr, & Sakala, 2007; Scott, Berkowitz, & Klaus, 1999). Before the study reported here, no known studies focused solely on postpartum doula care. This article describes findings of a qualitative study that examined the content and process of postpartum doula care. The research questions addressed were

(1) What are the core components (domains) of doula support in the postpartum period?

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(2) Do postpartum doulas facilitate maternal responsiveness and competence? If so, how?

Five domains of support have been identified in labor support literature: emotional, informational, tangible, advocacy, and father/partner support (Hodnett, 1996; Hodnett & Osborn, 1989). Based on earlier studies on intrapartum support and consultation with DONA and childbirth experts, the researchers developed a conceptual model that guided this study (Figure 1). This study addressed two aspects of the model: domains of postpartum care and postpartum doula influence on maternal responsiveness and competence.

Maternal responsiveness is the mother's ability to read her infant's signals correctly and respond to them appropriately, promptly, and effectively (Ainsworth, Blehar, Waters, & Wall, 1978; Eshel, Daelmans, Cabral de Mello, & Martines, 2006; Onunaku, 2005). It is a three-step sequence of events: (a) the child signals, (b) the parent responds in a prompt and sensitive manner linked to the child's signal, and (c) the child experiences that his needs are important and will be responded to in a sensitive way (Eshel et al.; Smith, Landry, & Swank, 2006). In multiple studies and systematic reviews, maternal responsiveness has been associated positively with secure attachment (Ainsworth et al.; Elicker, Englund, & Sroufe, 1992); mother-infant interaction (Donovan, Leavitt, Taylor, & Broder, 2007); children's communication skills (Paavola, Kunnari, & Moilanen, 2005); and the physical, cognitive, and psychosocial development of infants, preschoolers, and school-aged children (Eshel et al.; Smith et al.). Additionally, intervention studies have shown that maternal responsiveness can be facilitated through interventions by professionals and paraprofessionals (Cooper et al., 2002; Eshel et al.; Zeanah, Stafford, & Zeanah, 2005).

Maternal competence involves a mother's self-assessment of her ability to care for her infant effectively and with sensitivity (Hall, Shearer, Mogan, & Berkowitz, 2002). A sense of competency contributes to positive feelings regarding the mothering role (Mercer, 1985), and women who perceive themselves as competent feel more comfortable with infant care (Copeland & Harbaugh, 2004). In a study of 248 first-time mothers, Tarkka (2003) found that maternal competence was lower in mothers who felt isolated from others and concluded that feedback from a social network is important for validating competence.

Mother-centered care is the hallmark of postpartum doula care and is reflected in the consistent use of emotional support in all home visits.

Maternal responsiveness and competence are aspects of parenting needed to facilitate optimal infant cognitive and psychosocial development. This article describes how supportive care by postpartum doulas facilitated these vital aspects of parenting.

Methods

Participants

The current study was conducted in homes of mothers who received postpartum doula care in the Detroit area. Participants were 13 women and their infants and 4 postpartum doulas. All doulas who were approached participated. Of the 16 mothers approached, 1 declined for personal reasons; among those who enrolled, 2 did not complete the study, 1 withdrew (five children, returned to work), and 1 no longer met inclusion criteria after birth (rehospitalization of mother and infant). The final sample of postpartum women was 13 (attrition rate = 13%). Mothers were recruited into the study by the doulas or by nurse midwives at a local public health clinic via a letter from the principal investigator (PI).

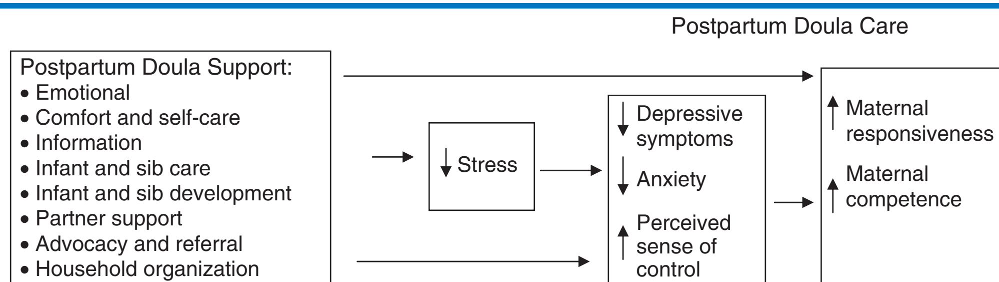

Figure 1. Conceptual model of postpartum doula care.

Postpartum doulas help mothers with three important issues: resolution of infant feeding, integration of infant into the family, and support of developmental care and attachment.

For interested women, a member of the research team accompanied the doula on a prenatal home visit, explained the study, and obtained informed consent. The inclusion criteria for mothers were 18 years of age or older, English speaking, giving birth at a hospital in the Detroit area, singleton fetus, no known illicit drug or heavy alcohol use, not at high medical risk (e.g., diabetes, hypertension), and not planning a Cesarean delivery. Of the 13 mothers who completed the study, 6 were minority women (5 Black; 1 American Indian/White) and 7 were White. Mothers ranged in age from 19 to 39 years ($M = 28$; $SD = 6$). About 70% were married ($n = 9$) and about 60% ($n = 8$) birthed their first child. Slightly more than half (54%, $n = 7$) had an estimated family income of $40,000 or less, with 5 (38%) employed full time and 5 (38%) not currently employed. Three mothers (23%) had used a doula for a previous birth; 1 of them was a birth doula herself. However, no study participant had used a doula during the postpartum period.

Doulas ranged in age from 31 to 53 years ($M = 42.0$ years). Two doulas were Black and 2 were White. All 4 doulas were biological mothers, had attended some college, were married by end of the study, and had an estimated household income >$40,000. All doulas had completed standard DONA birth doula training before the study. For 3 of the 4 doulas, postpartum care was new. The fourth doula had several years of experience as a maternal child health advocate but limited experience as a birth doula. This study was initiated within the first year that DONA provided postpartum doula certification training, and all 4 doulas completed that 3 day training with a DONA-certified trainer as part of study start-up. Doulas also received an additional 2 day session presented by the research team on strategies for assisting mothers to read and respond to infant cues. All training sessions were completed before initiating home visits.

Postpartum Doula Care

In this study, postpartum doula care was defined as care that included both birth doula care (one or more prenatal visits in the third trimester, continuous support during labor and birth, and one postpartum hospital visit) and postpartum doula care (six home visits during the first 12 weeks following birth) with telephone calls between visits. This model allowed doulas to develop a long-term relationship with the mothers. A description of the content of each visit was reported previously (McComish, Campbell-Voytal, & Rowland, 2004).

Data Collection

To obtain richer data, an ethnographic data collection strategy known as participant observation was used in which observers participate as a member of the group (Patton, 2002; Polit & Beck, 2007; Schensul, Schensul, & LeCompte, 1999). Observers were the investigators, graduate nursing students, and a research assistant with a master's degree in social work. Postpartum doulas were observed as they made home visits to mothers and their infants in the first 12 weeks postpartum. Each home visit lasted 1 to 2 hours.

Observers were introduced to the mothers by the doulas, and for consistency, the same observer attended all home visits for a given mother. To avoid influencing doula-mother interaction, participation by observers was minimal (e.g., responding to a family member when addressed). If the father was present, he was included in the home visits and observations with the level of involvement determined by the family. Observers took notes that included conversations between doulas and mothers (recorded as close to verbatim as possible) and field notes about the environment, emotional climate, and interactions with others present. Approval was obtained from Wayne State University's IRB, and mothers provided informed consent before data collection began.

Data Analysis

Home visit transcript data were analyzed in two phases using content analysis with NVIVO software. First, transcripts were analyzed to identify domains of care provided by the postpartum doulas. In ethnographic research, anticipated coding categories may be derived from a formative theoretical model developed before data collection and refined during data collection and analysis (LeCompte & Schensul, 1999; Schensul et al., 1999). The coding categories presented in the conceptual model were initially derived from studies of intrapartum doula care and discussions with consultants. Using constant comparison while data collection was underway, coding categories were refined, new categories added, and decision rules developed through a series of meetings where team members reviewed transcripts, coded data, and

discussed rationale for the categories. Finally, two members of the research team independently coded the data, and coding was finalized through a line-by-line assessment of agreement between coders. Discrepancies were resolved through consensus. In the second phase, using content analysis, the PI and a co-investigator identified the major issues that emerged from the data. These issues were confirmed through discussion and consensus among team members.

Because participants included both primiparous and multiparous mothers and mothers with previous birth doula care, transcripts were reviewed closely to note if there were differences in the three major issues that emerged from the data for these groups of mothers. Although some differences emerged in how the issues were experienced by the mothers, the issues themselves did not differ. Trustworthiness of the data was achieved through prolonged engagement (six visits over 12 weeks), multiple investigators, multiple perspectives (mothers, doulas), and a follow-up survey with participants (member checks) to confirm the researchers' interpretation of findings (Morse, Swanson, & Kuzel, 2001; Patton, 2002).

Results

Domains of Postpartum Doula Care

The conceptual model (Figure 1) proposed that postpartum doulas would engage in supportive behaviors in eight domains. However, 11 domains of care emerged: emotional support, physical comfort, self-care, infant care, information, advocacy, referral, partner/father support, support mother/father with infant, support mother/father with sibling care, and household organization. Each domain is described briefly in Table 1.

Table 1: Domains of Postpartum Doula Care

Emotional support emerged as the most frequently used domain of care and focused primarily on the mother. The predominant feature of this domain was client-directed discussion with the doula actively listening to the mother and her needs. When interacting with the mother, the doula would encourage her to express feelings, process her birth story, and take care of herself by building support networks.
Physical comfort focused on the mother's physical comfort. Examples include assistance with breastfeeding (engorgement, cracked nipples), healing from episiotomy or unplanned Cesarean delivery, or referral related to mother's physical comfort.
Self-care included supportive activities to assist the mother in obtaining adequate sleep, nutrition, hydration, exercise, or other self-care, including encouraging care for postpartum depression and attending the 6 week postpartum care appointment.
Infant care focused on physical care, including facilitation of infant sleep, adequate nutrition, sunlight for bilirubin, play, infant physical development, and safety.
Information included provision of general information (e.g., childcare facilities) that was not included in a more specific topic. For example, the Healthy Start modules on topics like infant care or family planning, or videotapes like *The Amazing Newborn* would be coded under infant care or support with new infant or siblings. Because most information sharing fell into the realm of a more specific domain, this category was not used often.
Both *advocacy* and *referral* included activities to assist the family to obtain needed resources. *Advocacy* focused on facilitating the mother's ability to develop skills needed to overcome barriers and advocate for self or infant with social service or primary care providers. *Referral*s were provided for specific services or resources (e.g., WIC, scholarships for childcare). Referral included doula follow-up to encourage mother to take the action needed. These domains were used by doulas primarily with mothers who were young or experiencing relationship problems within the family.
Partner/father support focused on encouraging the mother to include the father or partner in infant care, and supporting the father/partner or other family members (e.g., grandmother) in their efforts to help the mother.
Support mother/father with infant involved supporting the mother and father with emotional or developmental care and newborn parenting by encouraging activities that facilitated attachment (e.g., soothing techniques, developmental stimulation). Doula activities included modeling,

Doula Facilitation of Maternal Responsiveness and Maternal Competence

Three salient issues for mothers emerged from the home visit observation data: resolution of infant feeding, integrating the infant into the family, and supporting developmental care and attachment (e.g., responding to infant cues, providing appropriate stimulation). Quotes from observation transcripts related to each issue are presented below. The quotes illustrate ways in which doulas used activities in the 11 domains to facilitate maternal responsiveness and competence. For confidentiality, in place of names the letters "M, F, and D" followed by a number (e.g., M1) are used to designate the mother, father, and doula. All initials indicating family member names have been chan-

Table 1. Continued

information-sharing, and reinforcement of parental responses.
Support mother/father with sibling care involved activities such as role modeling, providing information, and reinforcing parental responses related to physical or developmental care, and parenting young siblings. The most common aspects of sibling care with which doulas assisted parents was developmental regression (e.g., bedwetting) and emotional outbursts (e.g., jealousy, temper tantrums, negative attention-seeking).
Household organization was the domain used least often. The activity used most often within this domain was helping mother create "nests" with supplies for herself (e.g., water, snacks), the baby (e.g., blankets, diapers, bibs), or siblings (e.g., toys, books, pillows). Other activities included light housekeeping (e.g., wash dishes, make a snack) while mother took a shower or sitz bath or played with older children.

ged. "HV" followed by a number (e.g., HV1) is used to designate the home visit when the interaction occurred. In most cases, quotes from at least two home visits are included to illustrate development of maternal competence and responsiveness over time.

Resolution of Infant Feeding

Resolution of infant feeding was an issue that emerged early in the postpartum period and was a predominant concern for all women. For primiparas, learning skills related to breastfeeding was a challenge. Doulas provided assistance using the domains of emotional support (listening), infant care (helping with latch), physical comfort (helping set up "nests"), and referral (providing contact information). For example, one mother was determined to breastfeed even if it was uncomfortable. Through emotional support and demonstration of position changes, the doula assisted the mother to breastfeed without discomfort and facilitated breastfeeding competence.

> M4: HV1—first day home from hospital. M: "Sometimes I get sore when trying to breastfeed." D: "I'll show you a side lying (position) next week." (D waiting until mother had healed a bit from unplanned Cesarean delivery to demonstrate position.) M: (referring to a position discussed previously) "Yeah, the football hold is not too bad. It's comfortable for him." (Later in same session) M: "That's what I want now, good positions for him." HV2. D: "I'm glad breastfeeding is going so well. So, are you getting into the flow of his cues?" M: "He hasn't had too many hungry cries, because when he starts sucking, rooting, we feed him. Sometimes he bites my right breast . . . stays on the right longer." D: "Have you thought about using a boppy?" M: "I have one." D: "Try a flat pillow under the boppy so you can guide his head up . . ." (M placed baby on pillow and boppy and positioned breast in baby's mouth.) M: "Yeah, this is comfortable, easy." (M cradles baby's head toward her breast; appears confident in her breastfeeding abilities).

For multiparous women, the decision to breast or bottle feed was complicated by the mother's perception about her previous experiences with infant feeding. Some women felt a sense of failure if they did not breastfeed. Doulas supported women as they coped with these feelings using emotional support and assisting with physical comfort and self-care (e.g., engorgement, nutrition). Two multiparous mothers stopped breastfeeding and grieved the loss of closeness that breastfeeding had afforded. As the following quote illustrates, for one of those mothers, who birthed her fifth baby during the study, emotional support from the doula facilitated competence with both feeding and bonding with her infant.

> M13: HV1. D: "What . . . are you going to decide about feeding?" M: "I really haven't decided. I really want to breastfeed but . . ."(M gave reasons she believed she could not breastfeed successfully: time constraints with 4 other children, newborn difficulty with sucking. D assisted with positioning.) Later in session M: "I really would like breastfeeding to be successful but I have made peace with this . . . I want to nurse her for comfort and at night for sleep . . . don't mind the bottle during the day. It will give me the bonding I didn't get with my first 3 kids." D: "Whatever is best for your family. That is what is important. Breast milk is best, but bottle feeding is fine." HV2. M: "Three days ago she was nursing really well. Then, she refused. I really think I am going to have to go with the bottle. In my last pregnancy I finally got to nurse successfully. The first three I failed. I think mentally I have this feeling that nursing is an extension of pregnancy and now that I am not doing it, she is not mine anymore. Others can feed her." D: "She is your baby, you will raise her by your set of rules because it is your life

and your choice." Later in session D: "You know, you said you were not feeling bonded, (but) I am hearing a lot of bonding in what you are saying. You may have to grieve breastfeeding but I am seeing a lot of evidence of bonding."

Integrating New Infant into Family

Integration of the infant into the family was a challenge for all parents. Doulas facilitated maternal competence using the domains of infant care (education about infants' emerging competencies), self-care (need for flexibility in routines), and emotional support (validating mothers' skills and knowledge). Maternal responsiveness was supported through emotional support (mother-centered discussion, role modeling) and supporting mother/father with infant (reinforcing mothers' ability to read and respond to infant cues). For primiparas and their partners, challenges revolved around developing routines and taking on the new role of parenting. Unrealistic developmental expectations, a dramatic change in schedule, and feelings of inadequacy were problems for one first-time mother, a successful career woman in her 30s. The unrealistic expectations were reinforced by the father. While these postpartum issues are not unique to this family, they were problematic for this couple, perhaps due to lack of local family support and the inexperience of the parents. The doula's support and sensitive interventions in the domain of infant care assisted the mother to develop competence and responsiveness. Development of a trusting relationship was demonstrated by the mother's ability to share her mistakes with the doula.

M11: HV1—Baby 1 week old. M: "We wondered what we could do to get him awake during the day and less active at night." D: "He'll need at least 12 feedings during the day, (or) will be up at night." F: "I read, but am not sure about this. Babies should have this schedule: eat, activity, sleep, and then parents have their time." D: "That schedule actually makes sense for an older baby. As a newborn, this isn't the time to try to get (him) into a schedule. You'll want to get to him within the first 90 seconds when he cries, and it will be easier to calm him." M: "I think that what I am finding is that he is active, but no crying. I don't think he's made it 10 seconds without someone responding." HV2, baby 2 weeks old, mother expressed her continuing frustration with not having a schedule. M: "All I do is feed and change him. I try to get it right . . . He eats about every 3-4 hours." D: "So are you going by his cues?" M: "Somewhat by the clock so that every 3-4 hours I know I'll be feeding him." By HV3, baby 4 weeks old, M is feeling more competent and is beginning to be responsive to baby's cues. D: "I'm proud of you guys, you're doing great!" M: "It doesn't feel that way sometimes." D: "You're a parent!" M: "I had three mommy screw-ups so far." D: "We all have moments like that. We all need to slow down and think more." In HV4, baby 6 weeks old, M was responsive to baby's cues and showing confidence in parenting. F playing with baby. M: "Now is the time of day we overstimulate him!" D: "It's allowed!" M and F share their baby's new "tricks" and behaviors. F: "Mom is the calming influence when Dad gets him riled up." Baby fusses and mother calms him. D: "I'm impressed at how you calmed him."

For multiparas, the challenges focused on balancing care for the new infant with care for older siblings. Doulas assisted by using the domain of support mother/father with sibling care. Because integration of the new infant into a family with other children involves the whole family, a multidimensional approach was needed. Thus, doulas used knowledge of infant and child development as well as problem solving to help mothers integrate the baby into the family. The following quote illustrates a doula's use of knowledge of child development to assist the mother in creating an environment for an older child to interact safely with the newborn while also meeting the desire of her preschooler to be close to her.

M7. HV1. D used educational module on Child Development. D: "I brought this especially for A. (4 year-old). You may find he will demand more of your time because he has not had to share you for some time." M: "I told him, before the baby was born, 'you are not a little brother any more. T (7-year-old) had to share with you, you will have to (share), too.'" D to baby: "You're trying to say something." A, the 4 year-old who was in the room, responded: "The baby's name is S." M: "He (A) scared me to death. He tried to pick him (S) up. Said he wanted to help." D: "What will you do to encourage A to not pick him up?" M: "I'll have him help with laundry, etc." D: "What will you do if he keeps picking him up?" M: "I don't know." D: "You could make a pallet on the floor so A could be near S so he can sit next to him, be near him." M had A sit in a corner of the couch and she moved to sit next to him

so that he could safely hold the baby as well as be close to her.

Supporting Developmental Care and Attachment

Doulas facilitated maternal competence through the domains of infant care (education about infant physical development and care), support mother/father with infant (how prompt and sensitive responsiveness promotes trust and attachment), and emotional support (validation of the mothers' skills and knowledge with developmental activities). Maternal responsiveness was promoted through emotional support (mother-centered discussion, role modeling) and support of the mother/father with infant (reinforcing mothers' ability to read and respond to their infants' cues, and promoting play). For primiparas, this issue was addressed through mother-centered discussion and role modeling related primarily to infant development and parenting. For one primiparous mother in her early 20s, the doula supported the mother's emerging skills in recognizing and responding to her infant's cues using emotional support and information sharing, and encouraged the mother to involve father in infant care:

> M14. HV1. D: "How is she sleeping?" M: "She gets up maybe at 12:00. Her last nap is about 8:00 p.m., and she won't wake until about 11 or 12:00. Then she sleeps a long time." D: "One to three months, she is on target." M: "I feed her then so she won't wake until about 3:00 a.m." D: "So you are picking up on her cues." No response from M so D rephrases: "You can judge what she is going to do." D, reading from module on Infant Development, said: "Walking and rocking helps babies when they are fussy. Have you noticed what soothes her when she is fussy?" M: "Yeah, walking, changing her diaper." D: "You are picking up on her cues, that is great! Try to take care of her needs quickly when she is fussy or crying. Show her you will meet her needs; you won't spoil her. It reinforces the love you give her. Show her that she is a well loved baby." HV3. D uses literature to discuss frustration with infant fussiness: "This (literature) discusses frustration. You want to yell." M: "Yeah. Sometime I rock her; (sometimes) I let her cry . . . come in here to get away from her crying." D: "You know jazz helps them relax." M: "At my house, I keep music on." M stated that infant seemed to calm down with music. HV6. M: "I looked at the brochure about how to keep cool when she was crying a lot. It said how to calm baby down. I rocked her and she went back to sleep." D: "How is dad doing with her?" M: "He's doing good." D: "Men watch you when you are with the baby. It develops his confidence when you show him things. Even if he does (things) in his own order, you may do it in A,B,C, and he does it A,C,B, let him take his time. Let him get his own order. Encourage that time with the baby. There is no such thing as perfect parenting! You pull some from everybody until you come up with your own parenting style."

With multiparas, doulas reinforced sensitive responses by the mother or provided developmental guidance and role modeling about how to read and respond to cues of the older children. For a mother who had 4- and 7-year-old children and birthed her third child during the study, the doula incorporated information about child development along with knowledge of how difficult it is to simultaneously address the needs of three young children. In addition, this mother was recovering from an unplanned Cesarean delivery and another health problem. In several home visits, the doula focused on the emotional needs of the siblings while helping the mother problem solve:

> M7. HV2. M described feeling overwhelmed with trying to coordinate care for two older children and the new infant. M: "I want to put A in a program, but now it's too much. I have to pick up T, get him . . . too much (shaking head and looking tired). They don't have all-day preschool. T is in kindergarten all day." D: "Some schools have all-day preschool. They play . . . teach through playing. Put him on a list . . . Being on list can't hurt." HV3. D followed up to see if M had called about preschool. She had not; they discussed the reasons. HV4. M: "I'm dealing with A's (4-year-old) bed wetting . . . He's so smart. He will strip the bed, change clothes, come out here and sleep on the sofa." D: "Maybe you should restrict fluids earlier. Just don't make a big deal about it, don't make him feel like this (makes finger motion to indicate not to make him feel 'small'). He's caught in the middle. He's got a new brother and a big brother teasing him." HV5. M reported A was doing better.

Discussion

In this study, 11 domains of postpartum doula care emerged, with emotional support the predominant

care provided. When doulas engaged in mother-centered discussion (listening to and addressing concerns of mothers), they were successful in developing a trusting relationship with the mothers. This laid the foundation for mothers to learn about sensitive responsiveness to infant cues and other aspects of infant and sibling care from the information and modeling provided by the doulas.

The three emergent issues that doulas assisted mothers to resolve were similar to those identified in a recent qualitative analysis of written comments of 324 mothers from 10 states on the 2000 Pregnancy Risk Assessment Monitoring System (PRAMS) form (Kanotra et al., 2007). The PRAMS study identified six early postpartum challenges: perceived need for social support, breastfeeding issues, lack of education about newborn care, need for help with postpartum depression, need for extended postpartum stay, and need for maternal health insurance. Most of the quotes in that article highlighted the need for education and emotional support, two strategies doulas in this study used often to help mothers resolve their concerns with infant feeding, integrating the infant into the family, and developmental care and attachment.

While the underlying mechanism that makes postpartum doula care effective is not known, the authors propose that it is the long-term nature of the doula-client relationship and the comforting, supportive presence of the doula in the home that assists mothers to develop maternal responsiveness and competence. Provision of information is an important factor in developing maternal competence (Pridham, Chang, & Chiu, 1994) and engaging mothers in conversations that express care and support enables women to gain confidence in their ability to mother (Fenwick, Barclay, & Schmied, 2001). Cooper et al. (2002) found that maternal responsiveness can be facilitated by paraprofessionals as well as professionals. Results from this study support the validity of that finding. Postpartum doulas are paraprofessionals who can effectively promote maternal responsiveness and competence.

Doulas in this study were with the mother during the intensely emotional experience of birth as well as the transition to parenting. The continuity that exists with this type of care may enhance the doula's credibility, which in turn facilitates the mother's ability to integrate the information and modeling provided. Observation data from this study indicated that postpartum doula care facilitated the capacities of mothers in feeding and integrating the new infant into the family. These capacities were reflected in mothers' continually improving skills that culminated in enhanced responsiveness and competence.

A long-term relationship, supportive presence in the home, and provision of education may be the mechanisms through which postpartum doulas facilitate maternal responsiveness and competence.

The sample of postpartum women in this study included both primiparous and multiparous women and women who had previous experience with birth doula care. Although the three major issues identified did not differ among these groups of women, some differences emerged in how the issues were experienced. What did differ was the need for multiparas to address the complexity of attending to multiple children while getting to know and respond to the newborn. This higher level of complexity in the mothering role would not have emerged without the inclusion of multiparous women.

In the doula care model used in this study, which incorporated both birth and postpartum care, postpartum doulas developed a long-term relationship with the mothers. Studies are needed that examine infant and child outcomes using this combined model versus a doula care model that includes only postpartum care. Randomized controlled trials are needed that examine the influence of postpartum doula care on infant and child development, attachment, and maternal satisfaction.

Limitations

For all 4 doulas, the mothers in this study were the first to whom they provided care as a postpartum doula. Therefore, the results reflect care provided by novice postpartum doulas (Brenner, 1984; Gilliland, 2007). If the doulas had been more experienced in postpartum care, the results may have been different and perhaps even more positive. Also, the recruitment strategy may limit transferability of the findings. The mothers were recruited either by doulas or by nurse midwives at a public health clinic and thus were urban, primarily low-income women. Finally, because this is the first known study to focus exclusively on postpartum doula care, there are no prior studies with which to compare these results. This potential limit to trustworthiness is offset by the fact that participants validated interpretation of the findings through member checks via a follow-up survey.

Conclusions

The number of doulas is growing rapidly as more women seek birth and postpartum doula care and more information about doulas is published (Declercq, Sakala, Corry, & Applebaum, 2007). DONA has provided training for postpartum doula care only since 2002, and has reported that between 2004 and 2006, the number of postpartum doulas rose from 14 to 165, a 12-fold increase in 2 years (J. Robertson, personal communication, September 28, 2007). While there is no standardized model for postpartum doula care in the United States, the model used in this study resulted in 11 domains of care. The study results indicate that postpartum doulas facilitate maternal responsiveness and competence. The mechanisms through which this occurs may be the development of a long-term relationship, mother-centered care, and education and support related to infant feeding, integrating the infant into the family, and developmental care and attachment.

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