Low Income Women's Expectations, Needs, and Desires for Social Support in the Postpartum Period: A Feasibility Study

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Nicolle Marie Uban

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Dedication

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Abstract

The postpartum period represents a significant transition in women's lives. This critical period of adjustment is characterized by physical, emotional and psychological stressors that impact women's experiences, adaptation and health and wellness. Common stressors in the puerperal period include: the transition to motherhood and associated role change and role stress; physical stressors such as hormonal fluctuations, altered sleep, and pain; and, psychological stressors including interpersonal relationship challenges, self esteem and self confidence issues, and postpartum depression (PPD).

Social support has been identified as a factor contributing to women's experiences in the postpartum period (Beck, 2001; Dennis, 2003). Lack of social support is also a predictor of functional status problems in the puerperal period (McVeigh, 1997). There is a body of noteworthy literature examining the association between social support interventions provided by health professionals, and negative affect in the new mother (Armstrong, Fraser, Dadds et al., 1999; O'Hara, Stuart, Gorman, & Wenzel, 2000). Critical gaps in maternal support needs have been identified in the literature and indicate that high risk populations of women might benefit from targeted social support services and interventions (Armstrong, Fraser, Dadds et al., 1999; Dennis, 2003; Shaw, Levitt, Wong et al., 2006).

The purpose of this feasibility study was to examine and describe low-income postpartum women's perceptions, expectations, and desires for social support and the feasibility and acceptability of a postpartum doula as a vehicle for social support services in the postpartum period. This study utilized focus groups, a social support survey and a

socio-demographic survey for data collection. The final sample included a total of 30 participants. First, a pilot test with one participant was conducted to trial the focus group questions and user-friendliness of the social support and demographic surveys. This was followed by three focus groups: Group 1 with nine participants; Group 2 had fifteen participants; and Group 3 had five participants. Recruitment of participants was conducted by a community doula program in the Upper Midwest that has an established priority to serve low-income women.

Four categories emerged during the content analysis process identifying types of support that were most important to participants in the postpartum period and areas where they experienced gaps in support: (1) Functional support; (2) Physical support; (3) Educational/Informational support; and, (4) Emotional support/Presence. The findings from the social support survey confirmed this information, as well as identified deficits in the availability of individuals within their support networks to provide much needed support. Participants in this study had experience with birth doulas and expressed interest in postpartum doula care as a desirable method for providing individualized support to meet their needs and to fill deficits in their existing support systems. The findings from both the focus group analysis and the social support survey reiterate the importance of a broader social support network in low-income postpartum women's lives.

This study adds to the existing body of research by laying out the foundational pieces for designing an effective intervention targeted to meet postpartum women's expectations, needs, and desires for social support in the postpartum period. Furthermore, the information from this study provides those providing support to new mothers with

necessary information to expand current practices in the maternity care model to include targeted postpartum doula support interventions that may ultimately influence maternal outcomes. Additional research is indicated in order to determine the effectiveness of targeted, individualized, in-home social support interventions for women in the postpartum period.

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CHAPTER 1

Introduction

The postpartum period represents a significant transition in women's lives. This critical period of adjustment is characterized by physical, emotional and psychological stressors that impact women's experiences, adaptation and health and wellness. Common stressors in the puerperal period include: the transition to motherhood and associated role change and role stress; physical stressors such as hormonal fluctuations, altered sleep, and pain; and, psychological stressors including interpersonal relationship challenges, self esteem and self confidence issues, and postpartum depression (PPD).

The routine challenges of the puerperal period are compounded in women with low socio-economic status, who have limited access to resources and services (Cook, Selig, Wedge et al.,1999). Furthermore, this population is negatively impacted by financial barriers and system deficits (Abrams, 2008). Research indicates that low-income women have less social support, which results in increased physical, psychological, and transitional stressors (Seguin, Potvin, St-Denis et al., 1999).

Social support has been identified as a factor contributing to women's experiences in the postpartum period (Beck, 2001; Dennis, 2003). Lack of social support is also a predictor of functional status in the puerperal period (McVeigh, 1997). Social support is a multifaceted variable that includes the complex relationships and interactions with one's partner, family, peers, and environment, and is therefore traditionally provided by one's spouse or partner, immediate family, and interpersonal social networks (Hung & Chung, 2001). However, research has suggested that social support can be effectively provided by professionals outside of the individual's familial and social network, indicating that

that this is an appropriate method of addressing critical gaps in maternal support needs. It is essential for these interventions to be targeted to meet a woman's individual expectations, needs, and desire for support (Logsdon, Birkimer & Usui, 2000).

There is a body of noteworthy literature examining the association between social support interventions provided by health professionals, and negative affect in the new mother (Armstrong, Fraser, Dadds et al., 1999; O'Hara, Stuart, Gorman, & Wenzel, 2000). Surkan et al. (2006) examined the relationship between social support, social networks and depressive symptoms in new mothers and concluded that both social support and social networks had a significant influence on maternal mental health and prevalence of depressive symptoms. Lack of social support has been shown to influence maternal coping (Liabsuetrakul et al., 2007). Logsdon et al.'s (2000) descriptive study indicated that it is essential for social support interventions to be targeted to meet a woman's individual expectations, needs, and desires for support, otherwise they report a lack of control and mastery over their situation that can contribute to negative affectivity.

Critical gaps in maternal support needs have been identified in the literature and indicate that high risk populations of women might benefit from targeted social support services and interventions (Armstrong, Fraser, Dadds et al., 1999; Logsdon, Birkimer, Ratterman, et al., 2002; Dennis, 2003; Shaw, Levitt, Wong et al., 2006). Data is lacking regarding the desirability and applicability of targeted postpartum social support interventions, including postpartum doula care, to address the social support needs of new mothers. This gap in the literature provides a meaningful avenue for the exploration and design of contextually relevant social support interventions utilizing postpartum doula support.

The purpose of this feasibility study was to examine and describe low-income postpartum women's perceptions, expectations, and desires for social support and the feasibility and acceptability of a postpartum doula as a vehicle for social support services in the postpartum period.

Conceptualization of Key Concepts

Social Support

The following conceptualizations of the term "social support" guided this literature search. The concept of social support encompasses environment, interpersonal relationships, and functional measures of support (Helgeson, 2003). Maley (2006) describes three primary characteristics of social support, including: emotional support - affective support, reassurance, non-tangible support; physical support – functional support and tangible aid; and, informational support, further defining social support as a mind-body therapy. Social support includes the belief that one is loved and cared for, esteemed and valued, and part of a network of "communication and mutual obligation" (Cobb, 1976). Social support interventions can be provided by professionals, paraprofessionals, and lay people or peers (Dennis, 2003; Ugarriza & Schmidt, 2006).

Social support has long been recognized in the field of nursing as relevant to trajectories of health and illness and maternal outcomes. The Norbeck Social Support Questionnaire (NSSQ) was developed to measure three dimensions, or "functional properties" of support, affect, affirmation, and aid (Norbeck, 1984; Norbeck, Lindsey, & Carrieri, 1981). Social support of new mothers includes: providing care for the infant and other children; allowing the new mother time to rest and heal; meal preparation and other household tasks; and, providing information about mothering and baby care. Postpartum

social support also includes education, advice-giving, emotional and physical support, and affirmation (Breedlove, 2005; Logsdon & Winders-Davis, 2004; Taylor, 2002).

Postpartum Period

The puerperium, or postpartum period, is clinically defined as the "time from the delivery of the placenta and membranes until the return of the woman's reproductive tract to its non-pregnant condition" (Varney, Kriebs & Gegor, 2004, p. 1041). The physiological aspects of this complex transition are usually completed within 6 weeks of childbirth, yet the postpartum period is often described in terms of several months following the birth of a child, and even up until the first year after birth. For the purpose of this study, the postpartum period will be defined as the timeframe from birth to 12 completed months post-delivery to recognize the continuing physical, psychosocial, and psychological changes of the extended puerperal period, and to facilitate the recruitment process.

Doula Support

The foundation of doula support is social support (Meyer, Arnold & Pascali-Bonaro, 2001). Professional doula support is operationalized through emotional, physical and educational support, as well as advocacy, and has been described as "multidimensional presence and support" (Sauls, 2006, p. 36). Historically, doulas have provided pregnancy, labor/childbirth, and postpartum support to women. Doula support is contextual and "fluid" in order to meet the unique needs of each woman. Therefore, the nature of the doula intervention is specifically targeted to meet the individual needs of the mother (DONA, 2002, 2005). The role and scope of doulas certified through Doulas of North America (DONA) includes extensive training on pregnancy, labor and birth,

physical and psychological needs of the new mother, breastfeeding, normal maternal physiologic changes, providing referral information, and explaining normal newborn characteristics. Labor support by a doula has been associated with a decreased incidence of postpartum depression, positive early parenting experiences, higher rates of breastfeeding initiation, and a heightened sense of competence in parenting (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011). Trotter et al. (1992) reported that women who received doula support during labor reported fewer symptoms and indicators of PPD, lower levels of anxiety, and higher levels of maternal self-esteem at 3 months postpartum

Postpartum Doula

Many organizations provide postpartum doula training and certification. DONA International is the largest and oldest certification organizations for doulas in the United States. In response to the growing demand for postpartum doulas, DONA developed and implemented an evidence-based Postpartum Doula Certification (PD-C) program (DONA, 2005, 2002). This includes Standards for Practice and a Code of Ethics. The standards for certification required to become a PD-C with DONA will provide the background for this section. DONA describes the training and certification of a PD-C as a separate, specialized training from that of birth doula. Individuals can be a postpartum doula with or without the birth doula component to their practice.

The role of the postpartum doula. PD-C are non-medical care providers who are trained to provide practical support and to address the psychosocial needs of women and their families through emotional, physical and educational support (Kelleher & Simkin, 2008). It is reasonable to expect the postpartum doula to provide support in identified areas of support, such as: functional support, including household organization and

development of routines; physical support, such as help with breastfeeding techniques and baby care; Educational and informational, including teaching strategies to facilitate bonding and family transition in the postpartum period; and, emotional support and presence such as nurturing and building self-confidence in the new mother and "mothering the mother" through support, praise, and caring affirmations (Kelleher & Simkin, 2008). Postpartum doulas also provide support by listening as the new mother processes her birth experience, as well as role modeling appropriate parenting behaviors (Abramson, Breedlove & Isaacs, 2006). Through the rigorous certification process, DONA clearly defines the difference between the support doulas provide and other providers of postpartum support:

> The role of a postpartum doula is to help a woman through her postpartum period and to nurture the family. Unlike a baby nurse, a doula's focus is not solely on the baby, but on fostering independence for the entire family. The doula is as available to the father and older children as to the mother and the baby. Treating the family as a unit that is connected and always changing enables doulas to do their job: nurture the family (DONA, FAQ).

This definition provides potential clients with realistic expectations for what postpartum doula support is.

The process for becoming a PD-C (DONA) is multi-step. Candidates must attend a certified postpartum doula training workshop. The topics of this workshop and the participant's independent study include the following topics:

> They [Postpartum Doulas] are experienced in supporting families through their postpartum experience…the doula's role is to provide education, non-judgmental

> support and companionship, and to assist with newborn care and family adjustment, meal preparation and light household tasks. Postpartum doulas offer evidence-based information on infant feeding, emotional and physical recovery from birth, infant soothing and coping skills for new parents and can make appropriate referrals when necessary (Kelleher & Simkin, 2008).

In addition, trainees are also required to write essays about various topics to demonstrate an understanding of their role, as well as to clarify important aspects of the postpartum period. They must have positive evaluations from women and families they have served during the certification process. There is a process and requirement for recertification every three years to maintain active status with DONA international.

During a postpartum visit, the role of the doula may include: providing care to the mother, assisting with breastfeeding issues, care-taking of siblings, preparing a nutritious meal for the mother, and educating the family on normal newborn characteristics: "The goal of a [postpartum] doula is to nurture the parents into their new roles. As they experience success and their knowledge and self-confidence grow, their needs for professional support should diminish (DONA 2002, 2005)." Postpartum doulas also advocate for their clients by helping them navigate complex health care systems and social service networks (Kelleher & Simkin, 2008).

Purpose

The purpose of this feasibility study was to examine and describe low-income postpartum women's needs, expectations and desires for a targeted, postpartum social support intervention, and the feasibility and acceptability of the postpartum doula as a vehicle for providing social support. This study utilized focus groups, a social support

survey, and a socio-demographic survey for data collection. The long term objective of this study is to guide future studies utilizing a targeted postpartum doula support intervention.

Significance for Nursing

Nurses and advanced practice nurses (APN) are often at the forefront of providing postpartum care to new mothers. Monitoring the psychological and social well-being in new mothers is an important and often overlooked part of routine postpartum care. Early identification of women with inadequate social support is an important role that nurses and APNs fill. Nurses and APNs must recognize and address the new mothers' need for social support, and acknowledge the doula as a means of providing this critical support. When nurses identify women with inadequate support systems, referral to postpartum doula care and other paraprofessional services should be considered.

CHAPTER 2

Background and Review of Literature

This chapter will provide a more extensive background and review of the postpartum period, key stressors that influence a woman's experiences and adjustment during this transition and social support interventions in the puerperal period. First, an overview of maternal stressors common to the transitional state of the postpartum period will be reviewed, including: psychological stressors such as role change, role stress, issues related to interpersonal relationships, self esteem and self confidence, and PPD; and, physical stressors such as hormonal fluctuations, sleep deprivation, and pain. Next, postpartum social support interventions will be reviewed, followed by a comprehensive review of the use of social support as an intervention to modify maternal mood and PPD. Finally, the concept of postpartum doula care as a vehicle of social support will be introduced.

Maternal Stressors in the Postpartum Period

The postpartum period is often regarded as the transition to mothering. New mothers undergo a significant period of adaptation that is characterized by psychological and physical changes that often contribute to postpartum stress (Leung, Arthur & Martinson, 2005).

Psychological Stressors

A woman's adaptation to motherhood is often complicated by psychological stressors, including: role change and role stress, conflict in interpersonal relationships, threats to self-esteem and self-confidence, and PPD.

Role change. Many women report that role changes associated with motherhood including self esteem and belief in their competence to mother their baby appropriately, contribute to mood lability and stress (Leung, Arthur, & Martinson, 2005). This type of stress leads to a heightened state of arousal and subsequent internalization of expectations for rapid adaptation to their new role, and concern over mastery of these mothering skills (Roman et al., 2007; Beck, 2003; Hung, 2007). Psychosocial stressors increase as the new mother questions whether or not she is adequately meeting the complex demands of motherhood: Can I take care of my baby? Is she getting enough breast milk? What if I don't love my baby enough? Do my friends take better care of their babies? The type of stress associated with role change is punctuated by the individual's struggle to adapt and cope with the new role and demands of motherhood, as well as to integrate new skills; It is often compounded by the perception that others are judging their mothering abilities and is influenced by issues of self-esteem. (Beck, 2003; Hung, 2007; Roman et al., 2007). In the first postpartum year, older women appear to be adapt more easily to the maternal role than women younger than age 20 (Mercer, 1986).

Role stress. Role stress often accompanies role change and is a psychological challenge that postpartum women face. It is characterized by worry and anxiety in response to the complex experiences of the postpartum period. Role stress is related to and influenced by resource and systems deficits, such as: financial concerns and social support; physical and emotional states; health and illness trajectories related to normal postpartum changes; maternal fatigue; maternal self-esteem; education level; mothering experience and perceived capabilities (Amankwaa, 2005; Dennis, 2003; Hardy & Hardy, 1988). Inadequate social support negatively impacts maternal coping in the postpartum

period, contributing to role stress (Liabsuetrakul, Vittayanont, & Pitanupong, 2007). Adjusting to motherhood while maintaining a career is another difficulty new mothers face. The amount of time a woman had off after giving birth and the length of her work day when she returns to work also contributes to mood lability in the postpartum period (Gjerdingen & Chaloner, 1994).

Spousal/partner relationship challenges. Social support provided by one's partner is essential to the woman's successful transition to motherhood (Leung, Arthur, & Martinson, 2005; O'Hara, 1986). Lack of support from one's partner is reported as a major postpartum stressor (Affonso, Mayberry, & Sheptak, 1988). Conflict with one's partner represents a psychological stressor in the puerperal period; Women who reported better relationships with their husbands had a higher functional status (Tulman, Fawcett, Groblewski et al., 1990). Marital disruption has been identified as negatively impacting women's postpartum transitional experience and their functional status; the woman's relationship with her partner can also contribute to her successful adaptation and role change associated with motherhood (Salyer, 2005).

Self esteem/Self confidence. In the immediate postpartum period, many mothers lack confidence in their competence to care for their newborns and adequately meet their needs (Martell, 2001). This dilemma echoes the challenges associated with role change and role stress, particularly as related to maternal self-esteem and perceived capabilities/self-confidence (Amankwaa, 2005; Dennis, 2003; Hardy & Hardy, 1988). Women stated that feeling inadequate in the role of mother contributed to their postpartum stress (Horowitz & Damato, 1999). In addition, mothers reported that mental fatigue contributed to their feelings of uncertainty in mothering (Barcaly, Everitt, Rogan

et al., 1997). The ability to share their parenting concerns with friends and family was identified by new mothers as an important step in building their self confidence in the early postpartum period (Nelson, 2003). Furthermore, mothers who received reassurance from their social networks had improved self-confidence (Cutrona, 1984).

Postpartum depression. When new mothers experience prolonged mood lability beyond the normal adjustment period in the immediate postpartum period, PPD may ensue. PPD is a clinical diagnosis characterized by prolonged symptoms of depressed mood, heightened anxiety, and sleep disturbances. There are three significant indicators of PPD, a) lack of social support, b) role change, and c) physical adjustment. These factors are examples of the complex interplay of the psychosocial, physical, and psychological dimensions in the postpartum period (Corwin, Brownstead, Barton, Heckard, & Morin, 2005). By conservative estimates, postpartum depression (PPD) affects approximately 12-15% of childbearing women, with some studies reporting rates as high as 20% (Declercq, Sakala, Corry, & Applebaum, 2007; Horowitz, Briggs-Gowan, Storfer-Isser, et al., 2007; Leahy-Warren & McCarthy, 2007). Minority and low-income women experience higher rates of PPD than other women. A recent study reported the prevalence of PPD as over 23% in a sample comprised primarily of American Indian and African American women (Baker, et al., 2005). .Emotional issues and PPD have been identified as disruptive to women's transitional experience and maternal functional status in the postpartum period (Salyer, 2005). Seguin et. al (1999) concluded that chronic stressors and inadequate social support had a significant impact on the prevalence and severity of PPD.

Physical Stressors

The biophysical changes and challenges that occur in the postpartum period are multifaceted and include hormonal fluctuations, altered sleep, and pain. These stressors impact a woman's recovery from childbirth, add to the challenges of her successful transition to motherhood, and contribute to her functional health status.

Hormonal fluctuations. The hormonal changes in the puerperal period reflect a shift in estrogen and progesterone levels to the pre-pregnant state. Immediately following delivery, the new mother experiences a significant decrease in estrogen and progesterone levels that can affect mood, sleep, and functional status (Derricott, 2010). Progesterone has known sedative properties and fluctuations in postpartum levels negatively impacts sleep (Swain, O'Hara, Starr et al., 1997). Breastfeeding women experience a sharp rise in prolactin levels that contributes to a sense of calm, relaxed emotional state, and feelings of contentedness; Fluctuations of hormonal levels including estrogen, progesterone, and prolactin during the immediate and extended postpartum period contribute to mood instability, maladaptive coping, and a heightened sense of anxiety (O'Mara, 2003). Furthermore, these hormonal fluctuations contribute to the overall emotional lability, or 'baby blues' that women experience in the early postpartum period (Derricott, 2010).

Altered Sleep. A decrease in progesterone levels in the postpartum period negatively impacts sleep (Swain, O'Hara, Starr et al., 1997). Sleep disturbances such as altered sleep patterns, fatigue, sleep deprivation, and lack of sleep are stressors frequently reported by new mothers (Dennis & Ross, 2005; Gay, Lee, & Yee, 2004). Fatigue is present in the immediate and extended postpartum period, affects maternal quality of life, and negatively impacts the new mother's family (Troy, 2003). Maternal sleep deprivation was associated with new onset depression in postpartum women (Dennis &

Ross, 2005). Women with postpartum depression report poorer quality of sleep than non-depressed women (Posmontier, 2008). Fatigue and sleep deprivation has also been reported to affect a woman's successful transition and overall functional status in the puerperal period (Salyer, 2005). Newborn care requirements such as frequent feedings and infant sleep patterns contribute to sleep disturbances in the new mother (Hunter, Rychnovsky, & Yount, 2009). To offset altered sleep patterns, new mothers attempt to minimize the effect of nighttime waking with increased napping during the day (Matsumoto, Shinkoda, Kang et al., 2003). Lack of social support also contributes to altered sleep patterns in the new mother (Barclay, Everitt, Rogan et al., 1997).

Pain. Discomfort and pain have an impact on new mothers' recovery from childbirth. It is not uncommon for women to experience pain from multiple sources in the puerperal period: afterpains, or uterine contractions caused by endogenous oxytocin that result in the involution of the uterus to its pre-pregnant state; perineal pain related to normal stretching associated with vaginal birth, vaginal or perineal tears, or episiotomy; abdominal incisional pain after a cesarean delivery; and, breast and nipple pain that may be associated with the initiation of breastfeeding, are all common sources of postpartum pain that add to maternal stress (Declerq, Cunningham, Johnson et al., 2008; Derricott, 2010). Women who had a cesarean delivery reported incisional pain as their primary postpartum difficulty; likewise, women who experienced a vaginal delivery reported perineal pain as a significant symptom (Declerq, Cunningham, Johnson et al., 2008). The majority of postpartum women experienced pain symptoms that influenced their functional status and mood, including: backache, fatigue, headache and nausea (Webb et al., 2008). Postpartal headaches are a common cause of pain in new mothers; they are

typically caused by primary headache disorders such as tension headaches or migraines, or as the result of a dural puncture during labor epidural anesthesia (Goldszmidt, Kern, Chaput et al., 2005).

Postpartum Social Support Interventions

Mothers who report adequate social support report fewer symptoms of stress; lack of social support experienced as the result of isolation from family and peers can contribute to stress in the postpartum period (Beck, 2002). This often occurs as a result of women staying home with their infant, resulting in the loss of the work relationships and support system they have relied on in the past. Social support is traditionally provided by one's spouse or partner, immediate family and social network of friends and coworkers (Hung & Chung, 2001). Adequate social support may buffer physical symptoms such as headaches, back pain, cesarean section site or episiotomy site pain, and breast pain (Howell, Mora, DiBonaventura et al., 2009). Social support has been shown to be effective when provided by professionals outside of the individual's familial and social network, indicating that that this is an appropriate method of addressing critical gaps in maternal support needs. Effective social support interventions must be targeted to meet the specific needs of the postpartum population, and must represent contextually relevant, individualized social support interventions (Logsdon et al., 2000; Logsdon & Winders-Davis, 2004).

The appropriate dose of social support interventions is difficult to standardize within and across studies, and includes the timing, onset, frequency, and duration of the social support provided, as well as the domains of support provided. Furthermore, this can vary widely from study to study and from interventionist to interventionist (Lieu,

Braveman, Escobar et. al, 2000; Logsdon & Winders-Davis, 2004). The dimensions of support provided during a visit, including emotional, physical, and/or informational, may also vary, and by the very nature of social support interventions, are often tailored to meet the individual's needs at that specific visit (MacArthur et al., 2002; Norbeck, 1984; Norbeck et al.,1981).

Social Support and Maternal Mental Health Outcomes

There is an existing body of research that provides support for individualized social support interventions initiated in the postpartum period and provided one-on-one, in the home by a health professional show promise as a potentially relevant approach to managing negative affectivity in new mothers. The literature identifies social support as both a predictor of maternal mental health problems including a diagnosis of PPD and as a factor contributing to the incidence of PPD. However, it must be clearly acknowledged that social support is just one piece in the complex inter-play of biological, psychiatric, and psycho-social factors contributing to maternal mood and PPD.

Surkan et al. (2006) found that "both social support and social networks were independently and inversely related to depressive symptomatology" (p. 381). Social support is an important buffer in relationship to the prevalence of depressive symptoms, even in women with a personal history of depression (Howell, Mora, DiBonaventura, & Leventhal, 2009). Lack of social support has been shown to influence maternal coping in the postpartum period (Liabsuetrakul, Vittayanont, & Pitanupong, 2007). Ege, Timur, Zincir, Geckil, and Sunar-Reeder (2008) examined the relationship between social support and PPD and found that participants' overall level of social support influenced the prevalence of PPD and that social support from family, more specifically one's

mother, was a predictor of PPD and also influenced the overall prevalence of PPD. Shaw, Levitt, Wong, & Kaczorowski (2006) concluded that while providing postpartum support as a standard of care to all postpartum women was not evidence based for improving maternal mental health outcomes, there was some benefit to providing targeted postpartum support to women that fall into high-risk categories. A Cochrane review that explored the influence of a much broader range of psychosocial and psychological interventions on maternal mental health in the postpartum period concluded that most women reported a preference for "talking therapies" such as listening visits and individualized, in-home support, over other methods of social support (Dennis & Hodnett, 2007). Liabsuetrakul et al. (2007) conducted a prospective cohort study piloting a screening tool for PPD that assessed anxiety, social stressors, social support and self-esteem and concluded that lack of social support has a negative impact on maternal coping and was also a significant predictor of PPD.

The long term goal of this study was to gather information to design an intervention study utilizing the postpartum doula as a vehicle of social support and to examine the relationship of this support to maternal mental health outcomes in the postpartum period. The following section reviews social support interventional studies with the measurable outcome of PPD using a validated instrument. T*he guiding research question was, "*What one-on-one, in home, multiple contact, social support interventions provided by health professionals have been effective in reducing the incidence of PPD?" Findings are presented according to interventionist.

Nurse or Midwife Support

Targeted interventions delivered in the home by nurses were reported to have positive effects on multiple variables, including: improved maternal-infant relationships; an increase in parenting satisfaction; decreased levels of stress; improved maternal mental health outcomes, and specifically, lower scores on the Edinburgh Postnatal Depression Scale (EPDS) (Armstrong Fraser, Dadds, & Morris, 1999). A home-based nurse visitation intervention resulted in lower rates of depressive symptoms in women receiving the intervention versus the usual care group (MacArthur et al. 2002).

Health Visitor

Health Visitors working with new mothers receive specialized training in the care of postpartum women. This training is focused on providing in-home services to clients with a primary goal of prevention (Health Visitors, n.d). Wiggins, Oakley, Roberts, Turner, Rajan, Austerberry, et al.'s (2005) RCT conducted in the United Kingdom evaluated the effects of two forms of postnatal social support: support health visitors (HV) and community group services (CGS), compared to usual maternity care services on PPD and other maternal and child health outcomes in a population of disadvantaged, inner city women. Participants did not demonstrate a significant reduction In EPDS score, but did indicate a preference for one-on-one, in-home visits from the supportive HV, rather than the CGS. Taylor (1989) examined the influence and efficacy of a HV intervention on the continuation of maternal mood problems and depressive symptoms in a population of postpartum women. The author reported that 24 out of 38 participants responded that they felt that the HV support helped with their PPD symptoms.

Several studies examined the influence of HV trained in Rogerian, non-directive counseling methods, or "listening visits". Holden, Sagovsky, and Cox (1989) found that

there was a significant decrease in EPDS scores in women receiving the HV counseling. Cullinan (1991) reported a statistically significant improvement on repeated EPDS scores in women receiving a HV counseling intervention. Elliott, Gerrard, Ashton, and Cox's (2001) study examined the effects of an HV training program on levels of maternal depressive symptoms in the U.K., as determined by the EPDS and reported a statistically significant reduction in EPDS scores in women whose HV had received the training. Painter's (2005) examined the influence of a HV support intervention and reported a statistically significant decrease in EPDS scores indicating participants had a recovery from PPD as evidenced by a reduction in depressive symptoms.

Telephone Support

Telecare is a modality of social support and psychotherapy for postpartum women delivered via telephone. Dennis (2003) found that women receiving telecare support had a significant decrease in depressive symptoms, suggesting that telephone-based peer support has a positive effect on the incidence of PPD. Ugarizza and Schmidt (2006) also found that a telecare intervention delivered once a week by a nurse therapist (graduate, psychiatric-mental health nursing students) resulted in a statistically significant decrease in EPDS scores.

Therapist

Chabrol, Teissedre, Saint-Jean, Teisseyre, Roge and Mullet (2002) examined the influence of a cognitive-behavioral therapy program delivered in-home by therapists (Master's level psychology students) on PPD, and demonstrated significantly greater rates of recovery in the intervention group. Interpersonal Psychotherapy (IPT) delivered by PhD or PsyD trained psychotherapist for women diagnosed with PPD resulted in a

higher percentage in rates of recovery in the intervention group versus the control group (O'Hara, Stuart, Gorman, & Wenzel, 2000).

Postpartum Doula Support

At the time this project began, no published studies were located examining the influence of a postpartum doula support intervention on maternal mental health outcomes. However, several studies examined the effect of continuous birth doula support during labor and delivery on maternal indicators in the postpartum period such as anxiety, postpartum depression, and maternal satisfaction. One RCT examined the effects of supportive companionship during labor on breastfeeding outcomes. In addition, their findings suggested that support during labor decreased maternal anxiety in the postpartum period, improved feelings of competence and self-esteem, and resulted in lower rates of depression. The author noted that, "events and interactions during labor may have far-reaching and powerful psychological consequences" (Hofmeyr, Nikodem, Kramer et al., 1991, p. 762). Klaus et al. (1993) reported less anxiety and depression at 6 weeks postpartum in women who were supported by a doula during their labor and birth (Klaus, Kennell, & Klaus, 1993). It is evident from theses research findings continuous labor support provided by a doula promotes positive maternal outcomes in the early postpartum period The lack of evidence regarding the impact of postpartum doulas on maternal outcomes during this transitional state clearly warrants research to examine the role of postpartum doulas as a mechanism of social support.

Theoretical Implications

Identifying effective social support interventions for facilitating maternal recovery in the postpartum period is essential. None of the research reviewed tested a theory or had

a theoretical framework guiding the study. Bronfenbrenner's Ecological Systems Theory is one theory that has possibilities for use in guiding future social support research studies.

Conceptual Framework

Bronfenbrenner's ecological systems theory is the guiding conceptual framework for this study, and provides a lens through which to view social support systems. Bronfenbrenner describes an individual's environment as a series of five systems. The microsystem is made up of the individual and their immediate environment including interpersonal relationships between family, friends, and peers. The mesosystem represents the interactions and connections between the individual (microsystem) and the rest of their world. The exosystem is comprised of community-level environments that the individual may not actively participate in on a daily basis, but is ultimately influenced by (ex: the healthcare system or a spouses' employer/office). The macrosystem represents the cultural contexts ad larger entities influencing the individual such as political systems, social and cultural constructs, and the economy. The chronosystem includes socio-historical or environmental events such as the timing of pregnancy and childbirth in a woman's life.

The socio-ecological theory can be used as a guide to social support in the postpartum period, providing a visual clarification of the appropriateness and potential efficacy of targeted interventions provided by one's spouse, family, and friends (microsystem), as well as the extended health care network (exosystem).The nuances between providers and recipients of social support are evident in the direction of support and are determined by the system that generates the support. Reciprocal (bidirectional)

support is more common between peers, family, and friends. For example, a new mother may receive tangible support of a home-cooked meal from a friend, but also provides emotional support by listening to her friend's marital problems when the meal is delivered. Due to ethical concerns, the relationship between health professionals (exosystem) and patients (microsystem) is generally not reciprocal. This type of social support is largely unidirectional, and flows from the health professional (provider) to the recipient (mother**).**

Summary

The complexities of maternal stressors in the postpartum period including the transition to motherhood, accompanied by physical and psychological stressors, contribute to the overall health and well-being of the new mother. Maternal difficulties in any of these areas can negatively impact the mother's return to homeostasis, good health, and her successful adaptation to motherhood. It is important to note that while these stressors are deemed transitional, they have a significant impact on the new mothers overall functional status and mental health (Webb et al., 2008). Adequate social support is one method of addressing these stressors.

There is some evidence that a targeted, one-on-one, in-home social support intervention initiated in the postnatal period may have a positive influence on prevalence and severity of postpartum depression. In addition, there is some data that indicates routine postpartum support to all women is not beneficial, but targeted support in high risk populations may have a positive affect on maternal mental health outcomes. The literature has also suggested that social support can be effectively provided by professionals outside of the individual's familial and social network.

There remains a gap in the literature regarding the desirability and applicability of specific postpartum interventions to address women's complex social support needs in the postpartum period. To date, there are no studies that have examined the effectiveness of a postpartum doula social support intervention targeted to address maternal health needs in the postpartum period. This significant gap in the literature provides a meaningful avenue for the exploration of an additional approach to addressing maternal mental heath using a social support intervention provided by postpartum doulas. Future studies must take into consideration the importance of designing intervention studies that meet the unique and complex needs of the puerperal woman, while meeting key methodological criteria for rigorous trials.

CHAPTER 3

Methods

Design

This study was a feasibility study utilizing data collection methods of focus groups, a social support survey and a socio-demographic survey. The data collection format was structured in 3 parts: (a) participants completed the social support questionnaire and socio-demographic survey; (b) 30 women participated in moderator led focus groups; and, (c) participants were given the opportunity to provide any additional thoughts related to the surveys, discussion, and social support in general. The purpose of this study was to examine and describe low-income postpartum women's needs, expectations and desires for a targeted, postpartum social support intervention, and the acceptability of the postpartum doula as a vehicle for providing social support. The focus group questions were derived from the study's purpose.

Rationale for Choice of Design.

The purpose of this feasibility study was to examine and describe low-income postpartum women's perceptions, expectations, and desires for social support and the acceptability and feasibility of a postpartum doula as a vehicle for social support services in the postpartum period. The focus group format was selected for data collection because focus groups are a semi-structured, moderator led format used to gather information about people's experiences and perspectives related to a specific topic. Focus groups are commonly used for needs assessments, instrument development, and exploration of new ideas (Morse, 1994). The moderator facilitates interaction between group members, asks clarifying questions and helps maintain the focus of the discussion, adding to the richness

of the data (McLafferty, 2004; Sim, 1998). The focus group findings and survey data will help to direct a feasibility intervention study by providing relevant data regarding postpartum women's expectations, needs and desires for support in the postpartum period.

Subjects and Setting

Subjects. The final sample included a total of 30 participants. First, a pilot test with one participant was conducted to trial the focus group questions and user-friendliness of the social support and demographic surveys. This was followed by three focus groups: Group 1 with nine participants; Group 2 had fifteen participants; and Group 3 had five participants. Recruitment of participants was conducted by a community doula program in the Upper Midwest that has an established priority to serve low-income women. The income guidelines used to determine eligibility for doula services are those outlined by the federally funded health and nutrition Women, Infant, and Children (WIC) program. WIC uses a combination of family size and income to determine eligibility, with pregnant women counting as two persons. The eligibility guidelines for the recruitment phase of this study are presented in Table 1. New guidelines were not published in 2010, so the guidelines from the previous cycle, July 1, 2009 to June 30, 2010 were used for July 1, 2010 to June 30, 2011. In order to meet WIC eligibility criteria, gross income before taxes must fall at or below 185% of the federal poverty income guidelines (Gomez, 2009).

Table 1

WIC Income Eligibility Guidelines

Number of Persons in Family	Annual Income ($)

or Household Size Family	
2	26,955
3	33,874
4	40,793
5	47,712
6	54,631
7	61,550
8	68,469
Each Additional Family Member, Add	+$6,919

Setting. The focus group discussions were held at the community doula program center. This site was familiar to the women and easily accessible by car, bus and taxi. The room was well-lit, comfortable, with easy access to restrooms. Beverages and snacks were provided. Participants were encouraged to leave older children at home. However, the center had a designated playroom that was utilized during the discussion as a childcare space and babysitters were available at each session.

Inclusion and exclusion criteria. Additional inclusion criteria for these low income women were as follows: Postpartum women who have delivered a baby within the last year; Received doula services for their last pregnancy/birth; Aged 18 or older; Ability to speak, read, and write in English; and, Willingness to adhere to study protocol (focus group discussion and form completion).

Recruitment Procedures

Women from low socio-economic backgrounds utilizing birth doula services at a community doula program in the Upper Midwest were recruited to participate in the study. The program provides pregnancy, birth, and postpartum services to low income women, as described in the sampling section. As noted in the Sampling section, the program has an established priority to serve low-income women.

The program coordinators recruited clients who had utilized doula services for their most recent birth, using a non-randomized, purposeful, convenience sampling method. Initially, the recruitment process consisted of two approaches, posting of recruitment flyers and a mailing. Recruitment flyers were posted at the program center that briefly explained the study and provided contact information for the Center Directors who were instructed to use the telephone recruitment script for women who expressed interest in participating in the study (Appendix F). This flyer was then mailed to all women who had utilized the programs birth doula services within the last year, asking them to call if they were interested in participating in the study. Women who responded to the postcard or flyer received a follow up phone call to further explain the study and to verify their information in order to determine if they meet the inclusion/exclusion criteria (see Appendix F for telephone recruitment script). In the first mailing, over 70 flyers were mailed with additional flyers posted throughout the center. This process yielded 5 responses. Each of these women met the inclusion/exclusion criteria and agreed to participate. A date was set, and the first focus group was scheduled with 5 expected participants. Reminder calls were made the day before the discussion group. In spite of this, only 1 participant attended the focus group session. At this point, the PI reviewed the recruitment process with the program coordinators and they suggested that calls be place

to each woman who had received the recruitment flyer in the initial mailing. After a modification of the recruitment process was approved by the IRB, this step was added to the recruitment process, yielding more favorable results. Additional flyers were mailed with follow up calls placed. This process continued until 3 focus groups were filled.

Data Collection

Socio-Demographic Data

Prior to the onset of the focus group discussion, participants completed a socio-demographic survey that was developed by the Principal Investigator (PI) (Appendix B). Several drafts were completed before the study version was finalized. After review by the PI, advisor, professional psychologist, community doula program coordinators, and community members, the language used in the survey was modified to be user-friendly at a lower literacy level. Additional questions were added based on feedback from reviewers. The survey was divided into three sections: About You; About Your Baby; and, About Your Birth. Basic information including age, ethnicity, occupation, marital status, schooling and income were included in the first section. The second section focused on pregnancy, baby, and postpartum issues such as infant feeding method and return to work dates. The third section focused on the participants' birth experience with questions regarding mode of delivery and labor/delivery interventions.

Social Support Questionnaire

The social support questionnaire was compiled by the PI with input from her committee members, a professional psychologist, the community doula program coordinators, and community members. To begin the process, the PI conducted a review of validated social support surveys. The purpose was to create a questionnaire that was

user friendly while garnering the desired data from the study participants (Appendix B). From this review, a 21 item social support questionnaire was developed. The initial questionnaire was developed to answer the questions of what type of support women needed in the postpartum period. More specifically, the questionnaire focused areas in which new mothers felt they needed support, and who they had available within their existing support systems to provide this support. This was then reviewed by committee members, a professional psychologist, the community doula program coordinators, and community members and adaptations were made to the questionnaire based on their feedback. The final version piloted and was determined to be user friendly while garnering the desired information from participants. At the request of the community doula program coordinators, two questions were added to the bottom of the questionnaire after the pilot test: (a) Do you have a mother or other female relative who is active in your life providing support? (b) If yes, who? This change was approved by the IRB before utilization.

Focus Groups

The focus groups were held at community doula program center, a location that was well known and accessible to the study participants. In order to minimize disruption from late arrivals, participants were encouraged to mingle and have a snack for approximately 15 minutes before the study procedures were initiated. Prior to the onset of the discussion, the participants were provided with a written copy of the informed consent and given an opportunity to read through it. The moderator then read through the consent form. The Institutional Review Board approved a verbal consent process (Appendix C). After reading the form, participants were asked if they had any questions

or needed any clarifications of the process prior to giving their verbal consent to participate. Once verbal consent was obtained, participants were asked to complete the surveys and then the discussion began. The moderator made it clear that the discussion was being recorded and explained why this was necessary to the research process. The moderator was the Principal Investigator. The focus groups were audio taped and a LiveScribe recording system was utilized as a back-up recording system. Personal conduct rules were established for the discussion, including: not interrupting when another participant was speaking, letting everyone have a chance to speak, being respectful of others and their experiences, and finally, a request to not share confidential information or discussion items with people outside of the group. Refer to Appendix E for the research questions used to guide the focus group discussions. A research assistant was present during the focus group sessions and recorded field notes of verbal responses, non-verbal behaviors, group dynamics and relevant observations. Actual discussion time for each group was approximately 1 ½ hours. After the completion of the discussion, an opportunity was provided for participants to add any additional comments. The recorder remained on during this time. Immediately following the meeting, the moderator and research assistant "debriefed" and discussed the session, including: participant responses, verbal and nonverbal behaviors.

Data Analysis Plan

Qualitative Analysis

The PI worked diligently to enhance analytical rigor throughout the data collection and analysis processes. The focus groups were audio taped and transcribed verbatim in order to validate findings. Cross-checking of the transcriptions in their

entirety was conducted by the PI in order to verify the accuracy of the transcripts. Furthermore, during this process the PI used her field notes and those of the research assistant to fill in gaps or missing data in the official transcript. Descriptive content analysis was used to identify categories from the focus group transcriptions. This process was guided by the methods of Strauss and Corbin (1988) and is described here in detail. Rather than pre-determined categories, the data was analyzed to allow for emergent categories; that is, recurring ideas within the data. While this is a labor intensive process, it allows for the subtleties of the data to emerge. This process is supported in the work of Hsieh and Shannon (2006) as well as Taylor-Powell and Renner (2003).

Implementation of the Coding Process: Content Analysis

The transcripts were reviewed several times by the PI to garner an understanding of the whole text and the quality of responses. The transcripts from the pilot and each focus group were then split up and the responses were regrouped and organized by individual question. An interactive, line by line, response by response content analysis of the focus group transcripts resulted in the emergence of several categories in regards to primary postpartum stressors and desired types of support in the postpartum period. During this process, shared language and commonalities of ideas emerged. Similar responses were grouped together until several categories with shared characteristics emerged and were ultimately extracted from the data. Eventually, the categories were narrowed down to four and analyzed. This process was then repeated by the advisor to the PI with supporting results.

As the categories emerged, additional questions were viewed through the lens of the study's guiding conceptual framework, Bronfenbrenner's Ecological Systems Theory.

This included identifying individuals who helped relieve postpartum stressors as well as individuals that provided overall support to them in the postpartum period. Additional questioning examined which types of support were most important and what supportive characteristics the individuals providing support possessed. Participants were also asked whether or not they had a mother or female relative providing active support. The influence of social support on their postpartum experience was examined as well as their mood since giving birth. The acceptability of the doula as a vehicle for this support was also explored.

Analyzing the Identified Categories

In order to analyze the identified categories, the PI considered the frequency, or number of times a category was mentioned, versus extensiveness, the number of participants who comment on a specific category (Krueger & Casey, 2009). This is an important distinction as it is not uncommon for some participants to revisit a category any number of times during the focus group session. However, it is not only the frequency or extensiveness of a category that is significant, especially when participants are sharing their perceptions and feelings. In this instance, highly emotional topics such as a participant's personal experience with PPD or breastfeeding difficulties may not be shared among multiple participants, but the information provided gives weight to the specific types of social support that may be beneficial to new mothers.

Establishing Trustworthiness of the Data

Trustworthiness of the data was established by measures of credibility, dependability, confirmability, and transferability. Credibility was established through person triangulation, as the focus group format and 30 participants allow the researcher to

"validate data through multiple perspectives of the phenomenon" (Polit & Beck, 2004, p. 431). The focus group sessions were recorded with a hand-held digital recorder and a back-up LightScribe system. In addition, both the PI and research assistant took research notes. A debriefing meeting was held at the end of each session where the PI and RA discussed emerging categories from the specific group, as well as group dynamics, body languages, and other non-verbal cues picked up by the research team. Written notes were taken. The digital recordings were professionally transcribed, and then the PI went through the transcription notes while listening to the recording sessions to fill in any missing text based on the PI and RA notes, as well as the back up recording system audio files. This process was guided by the Krueger and Casey (2009).

Measures to ensure dependability of the data were strengthened by the study design, including: use of scripted focus group questions, a single moderator, and similar condition/environment for each focus group session. Confirmability was enhanced through the description of the data collection and analysis processes, and through the maintenance of an audit trail that included: the PI's field notes, the notes from the focus group observation (PI and research assistant), coding notes, and other relevant data collection and analysis materials (Polit & Beck, 2004). Transferability of findings was somewhat enhanced by the composition of four separate focus groups, representing different women's perspectives at different times in the postpartum period. The sample and setting were adequately described so that transferability decisions can be made by other researchers (Morrison-Beedy, Cote-Arsenault, & Feinstein, 2001). Additionally, Morse (1994) discusses the importance of additional reliability issues, though this term is often not associated with qualitative research. This included issues related to stability,

equivalence, and internal consistency, all of which were addressed in the basic study design. The four focus groups were composed of different women, addressing concerns related to stability. Utilizing a single coder (the PI) and a single moderator enhanced equivalency and internal consistency (Kidd & Parshall, 2000).

Quantitative Analysis

The variables from the socio-demographic form were analyzed using basic descriptive statistics using Excel. The results of the social support survey were calculated by hand, adding up the number of times a "helper/individual providing support" was identified per question.

Ethical Considerations

Institutional Review Board Approval

The study protocol was reviewed by the Institutional Review Board (IRB) at the University of Minnesota. Per the IRB guidelines, waiver of consent documentation was implemented for this study to maintain protection of participants' privacy, and verbal consent process was utilized. This procedure was implemented due to the fact that this study was deemed to have a minimal level of risk to participant and because the consent form would be, "…the only record linking the subject and the research would be the consent form and the principle risk of the research would be the potential harm from a breach of confidentiality" (IRB website--http://www.research.umn.edu/irb/expedited.html). Approval for the project was also obtained from the community doula program directors per their protocol.

All study documents were approved for use by the IRB including: telephone recruitment script, recruitment flyer, socio-demographic form, social support survey, and

the verbal consent form. After the pilot test, changes were made to the socio-demographic form and social support survey and these were resubmitted to the IRB for approval. As noted in the recruitment section, a change was made to the recruitment process after the pilot test and a change in procedure form was completed and approved by the IRB before initiating the new recruitment process.

Risks

There is a minimal level of risk associated with participating in a focus group and this is primarily linked to breach of confidentiality as noted above. Per the IRB regulations, participant names were not recorded on any of the study forms to minimize this risk. However, it is possible that participants may have felt burdened when completing the social support survey or socio-demographic form or when asked to discuss their perceptions, expectations, and desires for social support during the focus group. They may have felt an invasion of privacy by participating in the study because of the sensitive nature of many of the survey questions.

Protection of Privacy

Participant privacy was a paramount issue for the research team. Identifying information was stored in a secure area (locked office and password protected computer) at the community doula program per their usual protocol. Identifying information was only available to the directors of the doula program. The socio-demographic form and social support survey were dummy-coded and did not contain any identifying data. The program directors maintained a list of complete participant names and their assigned numbers. No identifying information was provided to the PI or stored with the data that the PI has access to. All participant information was kept confidential per the University

requirements and the existing protocol of the doula program. The transcribed audio files from the focus group meetings were de-identified and secured by the PI and kept in a locked office on a password protected computer when not in use. They will be destroyed after the dissertation process is complete. The study and procedures were approved by the University of Minnesota Institutional Review Board as well as by the center directors of the participating doula program.

Recruitment of Women and Minorities

By nature of the research topic, the study participants were all women. The target population for this study was low-income, postpartum women, 18 years or older. Recruitment took place in a setting that serves a multicultural, low-income population. Women meeting the needs-based criteria for the existing doula programming as well as the study inclusion criteria were recruited.

Participation of Children

The study population comprises postpartum women aged 18 and above. Women under the age of 18 were not eligible to participate in the study. This decision was made based on the availability of an existing body of research examining social support and symptoms of depression in pregnant and postpartum adolescents (Logsdon, Birkimer, Ratterman, Cahill, & Cahill, 2002; Logsdon, Cross, Williams, & Simpson 2004).

CHAPTER 4

Results

This chapter will present the findings of the study. The sample characteristics will be presented. The findings from the content analysis of the focus groups will be presented and summarized. The social support survey findings will be summarized and discussed. Finally, the findings of the study will be discussed within the framework of Bronfenbrenner's ecological systems theory.

Sample Characteristics

A sample of 30 women participated in the study, though every participant did not respond to each questions (Table 2). These values reported in Table 2 represent the number of women that responded to each individual question, with 30 responses as the maximum number of responses for any question.

About mom. Participant's ages ranged from 19 to 34 years old with the average age of 26.6 years. Participants defined their race/ethnicity as follows: Eight responded white or Caucasian: Three responded black or African American; One responded African American, Native, and White; Seven responded Somali; One responded Asian-American; One responded Asian-Hmong; and Nine chose not to respond. Nineteen participants were married, five were partnered, four were single, and two chose not to respond to this question. All participants received birth doula services for their last birth.

Each participant met the WIC income guidelines meeting criteria for low socio-economic status. Total household incomes ranged from no income from outside employment to $60,000 per year (participant and spouse/partner combined income), with the average participant income $19,093. Employment outside of the home differed within

the sample, with some women not working outside of the home at all, and others working up to 40 hours per week. Of the 20 women that responded to this question, 9 reported no work outside of the home, 5 worked 20 hours or less, 4 worked 21-39 hours, and 2 worked 40 hours or more outside of the home. Occupations included homemaker or stay at home mom, legal assistant, artist, mortgage specialist/accountant, assistant manager at a pizza place, teacher, student, unemployed, house keeper, administrative assistant, customer service manager at large retail store, server, and legal assistant. Participants were asked the highest level of schooling they had completed. Twenty-six responded, and answers varied from: the least amount of schooling, at just 2 years; to, the most, a completed Master's (23 years); with the average amount of schooling 12 to 13 years, or the completion of high school. Eleven women responded that they had a history of depression, 16 responded that they had not had depression, and 3 chose not to answer. Of the eleven women with a history of depression, 5 had received counseling and 3 had taken medication.

About baby. Participants were asked their estimated gestational age (EGA) at the time of delivery: the earliest reported EGA was a preterm delivery at 35 weeks EGA; one woman had a postdates EGA of 42 weeks; the average EGA was 39.6 weeks. Eleven women exclusively breast fed, only one women formula fed, fourteen women used a combination of the two methods, and four women did not respond to the question. The length of the breastfeeding relationship was difficult to quantify as some women were just weeks out from their birth, others were months into the postpartum period, and some did not answer the question about how long they breastfed. That said, the longest duration of breastfeeding was 12 months, and the shortest was 2 weeks. The average length of

breastfeeding was just over 4 months (17 weeks), with the understanding that many of these women were still nursing their babies. Participants were also asked if they had any problems with their infant feeding method. Four responded "yes" and 20 responded "no." All of the four "yes" responses were from breastfeeding moms, who reported problems such as latch issues, lack of milk supply, and mastitis. Twenty-eight women responded to the question regarding how many living children they had: 11 had one child; 8 had 2 children; 4 had 3 children; and, 5 had 4 children.

About birth process. Participants were asked their mode of delivery: 21 reported vaginal births and 3 had cesarean deliveries. Nine women reported using medication during labor while 16 women reported unmedicated births. No women reported an instrumental delivery, either vacuum or forceps. When asked if they had an episiotomy, only one woman responded yes while 28 responded no.

Table 2

Socio-Demographic Data

About Mother		Categories	
Age	Youngest - 19 yrs	Oldest - 34 yrs	Mean - 26.6 yrs
Race/Ethnicity	8 white/Caucasian	3 black/African America	1 Native/White/ African American
	7 Somali	1 Asian American	1 Asian Hmong
Relationship Status	Married - 19	Partnered - 5	Single - 4
Yearly Income	Lowest – None	Highest -$60,000	Mean-$19,093

Hours worked outside the home	Full-time (>/= 40hrs) 2	Part-time (<40 hrs) 9	Stay at Home 9
History of Depression	Yes 11	No 16	
---Counseling	Yes 5/11		
---Medication	Yes 3/11		
About Baby			
Gestational Age at Delivery	Earliest -35 weeks	Latest - 42 weeks	Mean- 39.6 weeks
Feeding Method	Breast - 11	Formula – 1	Both- 14
Feeding Difficulties	Yes – 4	No- 20	
Number of Living Children	Least – 1	Most – 4	Mean - 2
About Birth Process			
Mode of Delivery	Vaginal - 24	Cesarean - 3	
Use of pain medication	Yes - 9	No - 16	
Instrumental Delivery	Yes - 0	No - 24	
Episiotomy	Yes - 1	No - 18	
Insurance Coverage	Yes - 28	No - 1	

Focus Group Findings

The findings from the focus group discussion and content analysis process are grouped according to the focus group questions: postpartum stressors, support, postpartum mood, and the postpartum doula as a vehicle for support.

Postpartum Stressors

Several questions addressed postpartum stressors and available support. First, participants were asked, "What are your primary stressors since having your baby?" Four categories of postpartum stressors emerged during the content analysis process: baby related; functional; physical; and, emotional. Several stressors easily fit into more than one category, but are represented only once in Table 3. Baby related stressors included those stressors that directly involved the newborn. Functional stressors were defined as those stressors that involved activities or tasks the participants needed to accomplish, such as housekeeping or childcare. Physical stressors were defined as related to the participant's physical recovery and adaptation in the postpartum period, such as stress from sleep deprivation. This category also included physical activities of motherhood, such as breastfeeding. Emotional stressors were categorized as those stressors that influenced the participants' emotions, feelings, or internal state of being.

Table 3

Primary Stressors Since Having Baby

Baby Related	Functional	Physical	Emotional
Breastfeeding problems	Not enough time	Sleep deprivation	Lack of adult contact
Finding childcare	Meal preparation	Breastfeeding	Doing it all alone

		problems	
Frequent crying	Job hunting	Starting a new job	Not having support-family out of state
Sibling adjustment	No time for chores, Errands, Meal Prep	Going back to work tired because baby not on a sleep schedule	Isolation-stuck at home alone
Baby's "stuff"	Grocery shopping		
Parenting multiple children	Starting new job: Self and /or partner	Being sick but having to take care of baby	Feeling depressed, unmotivated, "lazy"
Sleep Issues: No sleep schedule Baby not sleeping Night waking	Watching chores pile up while caring for baby	Getting up at night with baby and then having to go to work	"I can't go out and do anything. Being home all day
Juggling work schedules to have one parent with baby at all times	Too many visitors: interrupted bonding; uncomfortable with breastfeeding in front of visitors; needing calm and peace; feeling need to entertain	Needing someone to watch baby so you could nap	Guilty about lack of time spent with baby b/c of other demands (house, siblings, job)
Feeding issues- reflux,	Keeping house clean-	No help at home	"No time that is

swallow, refusal to eat	stress when its messy	after cesarean	strictly mine"-no time for self

Baby related. Many of the participants' primary postpartum stressors revolved around caring for their new baby. Response varied. Some participants spoke of feeding issues such as reflux, poor swallow, breastfeeding difficulty and the baby's unwillingness to eat:

> Breastfeeding. It's getting better, but she couldn't latch onto my left boob until yesterday, so she was only eating out of this one. She sucked blisters onto it and then she sucked them off, so then there were holes. I was crying every time the whole time she was eating. It was so stressful.

Many spoke of sleep related issues such as the baby not developing a clear pattern of sleep, night waking, and poor napping. Sleep deprivation appeared in all four categories as a primary stressor, "For two months, the baby was not sleeping." Others reported stress related to balancing the baby with all of life's other responsibilities. Concerns about mothering multiple children were also voiced. Participants voiced that they felt they had given more time to their older children then they were able to give to their new babies:

> Trying to divide myself between the two of them. I get really stressed out because usually I would just hold her [my toddler] all the time. I was a student; I just graduated before I had her, but I was a student for all that time. I would just hold her and do my homework and everything. Now I feel like I never hold the baby, not nearly as much as I ever held my toddler because I'm always making meals or

> cleaning or playing with my toddler, job applications… There's always something to do, so I feel like I don't give enough attention to the baby. Then I feel really guilty and stressed out about that.

Functional. Functional stressors were largely related to difficulty getting daily tasks done, such as: cleaning the house, cooking, grocery shopping, and laundry:

> Oh god, my biggest stressor is keeping the house clean. I swear, I just look at it and I'm like, you are never clean. I never can do anything.

Additional functional stressors included: Work related issues such as finding childcare or finding time to job hunt; Lack of time to perform self-cares such as showering, grooming, and dressing; and, the general lack of an available support person to watch the baby so that these functional tasks could be accomplished. Adequate bonding time in the early postpartum period was an additional stressor that was mentioned. Oftentimes, family members or partners were present, but were not necessarily a good resource for support:

> I have ten million family members and that was pretty stressful for the first… She's only two weeks old. Today is the second day that I don't have visitors. And even if they are being somewhat helpful it's like sometimes you just need peace and calm, especially when you're just trying to figure out how to do stuff. There are some people that are helpful and some people that are definitely there just to hang out with the baby. That's great and I love my family, but it's hard to accommodate everybody.

Physical. Physical concerns were largely related to sleep deprivation; not enough sleep, baby's night waking resulting in maternal fatigue in the morning when having to

get up and go to work, and not being able to catch up on sleep with naps. Physical problems associated with breastfeeding were a problem for several participants:

> Babies cry a lot. They cry a lot. You can't make them eat. They're hungry, but they don't want to eat. You just can't make them. You just can't make them go to sleep. I don't know. They cry a lot, a lot.

Juggling work and a new baby, as well as managing to care for the baby while sick and sleep deprived, were also mentioned as physical stressors:

> To be honest, the only thing that's really stressing me out is having to do it by myself because my baby daddy works from morning till night, and not being able to sleep. Like right now, I do not feel good and I can't sleep because I have to tend to her. Not being able to sleep is kind of hard. You just try your best to make it through every day. I can't wait till she gets older so she'll sleep more, but that's a long time from now. I'm just going to have to deal with it. That's the worst thing, just not being able to sleep and having to do it by yourself, not having that much support. All my family lives in California; my brother is the only one up here.

Again, a sense of isolation and lack of social support were echoed in several participants' responses.

Emotional. Emotional stressors were linked closely to the other categories. They included: feelings of isolation compounded by limited social contact with other adults; limited or no social support system; no time for self; uncertainty in the role of mother; and, participants spoke of feeling that they were all alone or that they had to do it all by

themselves. Even those with active partners felt as if the bulk of the baby rearing responsibility was on them:

> …but when I went back to work that was challenging because he would sleep later. He was four months when I went back to work and the sleep pattern hadn't developed yet. I had to get up a lot more often and then be up to work. I couldn't get sleep. My husband is supportive, too. It helps, but I still had that burden because we both work.

For the most part, emotional stress appeared closely linked to this overall sense of isolation, including feeling very unsupported as a new mother.

Support

After discussing postpartum stressors influencing the participants' lives, the focus group questions focused on exploring the support systems that women identified as helping them navigate the transitional aspects and challenges of the postpartum period.

Available Support

Participants were first asked, "Who helps you deal with these stressors?" and, "Who provides support to you?" Responses included: Mother-in-law, partner or husband, mom, step-mom, aunt, grandma, sister, sister-in-law, cousin, friend, and dad, as well as: Members of mom's group, therapist, pediatrician, doctor, and birth doula.

Supportive Characteristics

Participants were then asked to describe the characteristics of those individuals identified as providing support and helping them deal with postpartum stressors: "What supportive characteristics do these individuals have?" Mothers in the study responded with a variety of answers. Many cited informational support as very important. This

included knowledge about breastfeeding, child development and basic childrearing. Experiential support was also identified as significant, as mothers and with taking care of babies. As one mother stated:

> I want to know real stories….people that have had children or maybe the same issues, just life experiences.

For some, it was important that the individual had a parenting style similar to theirs and "gave advice that makes sense." Several felt it was critical to have someone who was trustworthy and who cared about or loved their baby. Again, having someone available who was willing to watch the baby so the woman could do self cares, such as: take a nap; take a shower; go to work; get out of the house; or, just "have some me time" was a desirable characteristic that was identified by many. One participant described this as, "He gives me the 'umph' of freedom" to get out of the house without the baby". Others wanted moral and emotional support; someone to tell them they were doing a good job, to encourage them if they were having difficulty breastfeeding, and to be there or to be available to answer questions.

Mother/Female Relative

When asked during the focus group discussion if they had a mother or other female relative who was active in providing support to them, many participants responded yes and described a mother, mother-in-law, grandma, aunt, sister, sister-in-law, step-mom, and cousin as a supportive female relative in their lives. This support included all of the identified categories of support, including: functional support such as preparing meals and doing household chores; support of their physical recovery, including providing time for the new mother to rest and recover and giving the mother a

break by watching the baby; support with baby-related concerns, such as answering questions about normal newborn behaviors and needs; and, emotional support such as encouragement, being present to relieve the sense of isolation many mothers reported, and providing reassurance about parenting skills.

> I don't know what I'd do without her. She's just the perfect mother-in-law. She just helps, like during the day if I'm feeling overwhelmed she'll come and sit with me and talk to me. I call her when [the baby] has a rash or if [my toddler] has bumps on her back or something. She's had eight kids. She's like a baby dictionary. She's so good.

Postpartum Mood

Participants were asked to describe their mood since giving birth and to discuss how the amount and type of support they receive affects their mood. Lengthy discussions ensued in each focus group, providing a rich body of content to review.

Mood

In general, the 30 participants noted a change in their mood after giving birth. This was described as transient, lasting the first two weeks after birth, or more prolonged, lasting several months into the postpartum period. Many participants spoke of feelings of sadness and frequent crying; anger, frustration, and irritability; and, a sense of isolation and lack of support. While this is not a quantitative study, it is compelling to note that out of 30 women, only 3 reported that their mood was unchanged from the perinatal period or could be defined as, "happy."

Many women described feelings of sadness and frequent crying episodes. This was often tied to feelings of isolation and lack of support to help them get through the day to day requirements of mothering a newborn:

> After going through labor you change and you go through some emotions. I need help and nobody is there to help. It's hard and you become sad about that…a baby is depending on me.

The sense of isolation was compelling, and appeared to contribute to several women's postpartum mood issues; "The isolation. It made me feel alone and sad." Participants also described fatigue and prolonged sleep deprivation as resulting in sadness and tears, "Sometimes I cry. I'd like to sleep."

Another frequent response was feelings of anger, irritability and frustration as well as mood lability. Participants most often described these feelings as primarily directed at their partners:

> I tend to snap more. Just little things have irritated me and I'm like, arrrr! Then I'll turn around two seconds later, 'I'm sorry, I'm sorry,' and start to cry and it'll be all fine 10 or 15 minutes later. I notice since I had my son I've been doing that more often. I do it and I've apologized up and down to my boyfriend so many times about it because I'll do it to him most often. It's when I need little things.

Another woman responded, "I was irritated a lot, snappy. It got to the point where I just stopped talking, period, to my husband." Less frequently, feelings of frustration were directed at a baby that would not sleep or was having difficulty breastfeeding; "I was angry when my baby cried. I got angry. He [the baby] was up all night and my husband was going to work a night and day shift." Participants also spoke of diagnoses of

postpartum depression by their medical care providers and how this impacted their postpartum recovery and experience:

> As far as the first six weeks, I was very calm and collected. I just handled everything a lot better than I expected, but then after six weeks, all of a sudden, I went from feeling really great and proud of myself to, all of a sudden, I was really overwhelmed and exhausted and irritable, just not feeling so great. Then I went to the doctor and she said it was postpartum depression. She did put me on a medication. It's only been about two weeks. I do feel a little bit better. I'm sleeping better at night now, but otherwise, again, my therapist helps with that because I have someone that I feel I can say absolutely anything to. But otherwise, I just have good friends that I can talk to.

Effect of Support on Mood

Participants were asked, "Please describe how the amount of support and type of support you receive affects your mood." There was clearly a connection between mothers' reported mood and amount of support received. For the most part, Participant's responded that the more support they had, the better their mood. Many described adequate support in the early postpartum period in the first few weeks after giving birth. This was well received and seemed to provide a protective measure for the participants in regards to their overall mood and coping:

> The first week I had a lot of support around. My sister came and my mom came to visit and my husband was still at home. Then the next week or two or three was kind of hard. I only remember a couple times getting really frustrated before I

learned to tune out. It's fine if he's yelling at me and crying and won't stop. It's OK. I'm just going to keep functioning; it's all right.

Many women described how when this initial support tapered off and they felt more isolated and unsupported, which resulted in irritability and anger, mood lability, and generalized sadness. Several participants reflected on how even small amounts of support helped them get through the day. One woman stated:

> I definitely feel that when I get even 15 minutes in, I'm a way happier person. I've tried to structure the day, because I don't really ever get that help, so that they can have a nap in the afternoon and I can have time where I can take a breather. Otherwise, by the end of the day I just crash and burn. I get more frustrated, especially with the older one because I can't ever get a break, where the baby sleeps on and off throughout the day still. This one never stops. When I get the support it's really significant. You can see significantly how it changes my mood.

This sentiment was echoed by several of the other participants in this focus group session. It appears that even short periods of support provided great relief to the participants. Many women spoke of a lack of understanding from their partners about what their day was like and how much stress they felt caring for a newborn:

> My boyfriend, like all you guys say, he just doesn't get it. You try to explain to him what you go through every day with the baby… Just a couple hours for him, he can barely do that. One night I asked him, 'I'm really tired; I just need one night to sleep. I need you to help me with her.' The second time he got up, he threw a pillow at the wall because he was frustrated and I'm like, really, you're

getting that frustrated? I was so surprised. Oh my god, if it's that hard for you then I'll do it. It just made me feel bad, almost guilty that it was that difficult for him to handle just waking up. I was like, I've been doing it every night for the last nine weeks. I can do one more, even though I'm tired.

While there was a generalized frustration about this, no one spoke of partners that were uncaring, just that they didn't "get it."

Pleasure

Finally, in an effort to further explore women's mood and affect in the postpartum period, participants were asked, "Have you lost interest or pleasure in doing things that used to bring you pleasure?" Again, the responses were almost unanimously "yes!" A few responses suggested symptoms of 'baby blues' and postpartum depression; However, further exploration revealed that rather than a lack of interest or motivation in doing activities secondary to depression or altered affect, many of the women simply felt as if they did not have the time or energy in their day to do the things that they normally did for themselves.

The Postpartum Doula as a Vehicle for Support

The final focus group discussion questions explored the postpartum doula as a vehicle for social support, and included questions regarding the acceptability of doula support, desired types of support, types of support that are most important, length of visits, timing of visits in the postpartum period, when to end visits, and other logistical questions.

Participant Perspectives

Participants unanimously agreed that postpartum doula support would be helpful. Four categories of support emerged during the analysis process identifying types of support that were most important to participants in the postpartum period and what types of support they would need most from a postpartum doula: (1) Functional; (2) Physical; (3) Education/Informational; and, (4) Emotional/Presence (Table 4). Functional support included helping with activities or tasks that participants needed to accomplish, such as housekeeping, cooking, or childcare. Physical support items were those related to the participant's physical recovery and physical adaptation to the postpartum period. Educational and Informational support included many topics related to the newborn, self-care, work and family related topics. Emotional support and Presence included support that influenced the participants' emotions, feelings, or internal state of being. Several measures of support fit into more than one category.

Table 4

Key Types of Support Needed from a Postpartum Doula

Functional	Physical	Educational and Informational	Emotional and "Presence"
Watch kids while I am there so I can get stuff done around the house	Let me nap/sleep- watch baby so I can sleep	Breastfeeding Info	Breastfeeding Encouragement- support when I want to quit
Grocery Shopping – other shopping to restock household	Accompany me to Dr visits for baby	General info: Baby development, sibling rivalry; milestones	Adult contact- Come over just to visit- conversation

Housekeeping: clean, wash dishes, laundry	Breastfeeding- Help with latch, pumping	Schedule of visits for baby and self	Somebody to talk to
Babysit- Watch baby so I have Time for myself-in and out of the house or when I am sick	Feed baby so I can: Run errands; shave both legs; shower; clean house; cook	Info about baby issues: diaper rash, developments, things you should do, vaccination schedule	"On call" help for times of high stress or depression-available on very short notice
Watch kids while we visit so I get a break	Take other kids out for awhile; help with older kids	Help learning to balance baby and the rest of life	Affirmation that I am doing a good job
Cooking, Meal Prep- Prepare meals to freeze	Let me shower or use the bathroom alone	Educating partner about normal PP issues: mood, baby care, stress	Someone to "Mother me"
Get the kids out of the house-take them for a walk, to the park.	Someone to carry the car seat when I go out	Teaching me routines. How to get things done with new baby	Someone to break the sense of isolation form being home alone
Run errands with me	Overnight help	Financial Support	"Comfort me"

Functional Support

Functional measures of support included having someone available to help with household chores such as, doing the laundry, cooking, and cleaning. Many participants

expressed that they were overwhelmed with all of the routine household tasks and verbalized that this was an area in which they most needed support:

> You know how after you go home, having someone to do the laundry and the cooking. I had just had surgery [cesarean section] and I went home and I did all that, the cooking, the cleaning and the laundry. I wish I'd have had somebody doing that for me; making me food in bed where I could sleep. I had to do it all on my own.

Functional support also included helping with older children, taking care of the baby, and managing the baby/children so mother could get chores and self-cares done. Many women simply responded that they needed a support person to watch their babies for a short period of time so that they could get their day to day work done**.** Financial support was cited by several participants as a desirable means of support and one way to ease some of their stress in the postpartum period. Several women indicated the need for additional funds for basic living expenses. Others stated that additional financial support would allow them to delay their return to work, an option that would ease many of their stressors, including: establishing breastfeeding, learning to pump breast milk, and getting their newborn on a workable sleep schedule.

Physical Support

Physical support items included support that helped the participant adjust to her new role as mother and actions that supported her physical recovery. Many women cited sleep deprivation as one of their biggest physical needs and stated that having, "Someone to let me sleep" was the most important type of support desired. Difficulty breastfeeding

was another area of need. Sore nipples, difficult latch, and poor milk supply were all areas in which women needed physical support.

Educational/Informational Support

Participants described several areas in which they felt additional educational or informational support would be helpful. This included baby-related topics such as: normal child development, education about breastfeeding, and information about how to handle sibling rivalry and multiple children. They also requested support in the area of life skills and learning how to balance it all and create daily routines in order to get necessary household task completed. Some women wanted information about how to navigate the health care system in regards to self-care in the postpartum period and timing of follow-up appointments for themselves and their babies:

> In the beginning I was kind of unsure what appointments to make and the procedure to set up vaccination appointments, how often and when, just somebody to help me do that or make a calendar for me to say, at this time he needs to have this. Within this amount of time, you should go in and check this. At this time you need to go in. Because you get so in your own world that you forget that, oh yeah, I have to go to the doctor."

Participants also wanted education and information to be provided to their partners. Many expressed that information coming from and "outside source" might be better received than if it came from them*:*

> What I would really like is just someone to keep reminding my husband that my mood swings are due to, you know, because he takes it personally sometimes. Then that just makes it more difficult. But if there were someone there to remind

him that…this is normal that I just need maybe so more time to myself so that I can recharge and then I'd be able to handle my daughter better and handle things…better at home.

Emotional Support

Emotional support can be somewhat difficult to define. However, many women expressed the need to just have someone available to visit if they were "stressed out." Participants defined adult conversation and socializing as important elements of emotional support; "Adult conversation. I need that socializing." This type of support was noted to relieve the sense of isolation they felt as new mothers.

Schedule of Visits

Timing of visits. This question really addressed two things: at what point in the postpartum period did participants feel postpartum doula support would be the most beneficial; and, at what time of day did they feel they most needed additional support. There were several thoughts expressed about the timing of postpartum doula visits in relation to timing during the postpartum period: on-call for the first few weeks; daily for 4 weeks; every 2 weeks; monthly; weekly for 6 weeks and then every 2 to 3 weeks for at least 6 months; frequent visits early on and then spaced out to monthly visits. Many felt that visits beginning immediately after birth would be a welcome support. Others felt they wanted to have space in the early transitional period, the first 4 weeks, to bond with their baby and family before scheduled doula support visits began. Some wanted daily support, others felt a weekly visit was adequate early on and then monthly. In addition to bonding concerns in the immediate postpartum period, several participants relayed that

they had family support in the early on, but really needed help after family stopped coming:

> In terms of having help from family, the first couple weeks I got a lot of help from family, but then after four weeks or so a lot of that diminished, but I still felt like I needed help. I think having a postpartum doula come in after family is done with visiting and done with helping out, like in weeks five and six and up to week 12 or something would be great."

As for the time of day that visits would be most helpful, responses varied. Some felt it would be helpful just before the craziness of naptime or dinner, while others felt having additional support to ease the transition when coming home from work would be nice:

Length of visits. This question was answered in terms of how many hours the scheduled doulas visits should last. Participants expressed a variety of opinions regarding the length of the "perfect" visit; 1 to 1 ½ hours, 2 hours, 3 hours, 3 to 4 hours, no more than 3 hours, 5 hours, 6 hours, all day, 16 hours, and overnight. A few participants indicated that they felt longer visits seemed as if they would be using the doula as daycare, and they felt uncomfortable asking for this type of support. Several participants commented that shorter visits early on would be nice, and then longer visits as the baby stretched out its feeding times and sleep/wake cycle.

> I guess shorter visits would be better at the beginning of things. Maybe later on when [baby] could go longer without eating and whatever else, then a longer visit would be fine. It depends on the purpose of the visit. If it's to give me a break, then I would maybe need an hour to go get my eyebrows done or something.

Those who mentioned longer visits, 16 hours and overnight, did so in the context of needing an opportunity to catch up on sleep. This sentiment was shared by many participants.

Ending point. Participants were asked how long they would like the visits to continue into the postpartum period. Responses included some very specific schedules: daily for 4 weeks; monthly for at least 6 months; weekly for 6 weeks and then every 2 to 3 weeks for at least 6 months; and, frequent visits early on and then spaced out to monthly visits through the first year. Most felt it would be nice to extend visits well into the postpartum period, even if the time between visits grew longer. They viewed it as something to look forward to as a meaningful means of support:

> In a perfect world, I think I'd look at some of the countries in the European Union that offer substantial help after childbirth. That would be the ideal model. Whether we'd ever get there or not is a whole other thing, but I think they offer it up to a year, if I'm not mistaken. Even if it was just occasionally, once a week that would be fantastic to look forward to; a couple hours every week that you could count on having to yourself.

However, most felt more frequent visits early on would be a welcome relief, and then spacing out visits into the latter postpartum period would be acceptable.

Logistical Questions.

Scheduling visits. Interestingly, in spite of their birth doula experiences, several women expressed that they would feel uncomfortable or unwilling to call the postpartum doula to set up visits. Many asked if it would be possible to have the doula initiate contact and take responsibility for setting up initial appointments. Several indicated they would

like a n “on-call” system, where they could call the doula at short notice and be able to schedule a visit.

Canceling visits. All of the participants were familiar with doula support from their birth doula experiences. They were used to the process by which visits were cancelled, an all of the participants indicated they would be willing to reschedule if a conflict arose. There was an overall tone of respect for the doula and a valuation of her time.

Social Support Survey

The Social Support Survey was a 21 question survey that explored participant’s needs for support and their current social support systems. The goal of the survey supported the purpose of the study, to identify areas of need, participants existing support systems, and areas where participants had deficits of support in order to determine if the postpartum doula was an appropriate vehicle of support to address these deficit areas. Participants were asked to identify “Helpers/Individuals Providing Support” in response to the statement, “I Need…Someone to/Help with/Support in…” The survey findings are presented in Table 5.

Table 5

Social Support Survey Responses

I Need…Someone to/Help with/Support in…	Helpers/Individuals Providing support						
	Spouse/ Partner*	Mother	Friend	Other Family	Doula	Neighbor	No one
Drive me to the store, doctor, church…	17	4	7	5	2	1	12
Take care of the baby to give me a break	22	5	5	7	2	1	5
Help with laundry	17	2	2	2	4	0	11
Cook meals	14	4	3	2	1	1	10
Provide Childcare	13	4	5	7	1	0	10
Help me with breastfeeding	6	2	1	1	12	0	14
Let me sleep	20	3	3	5	2	0	8
Watch the baby so I can shower/bath, eat, have time to myself	21	4	4	5	5	0	6
Explain why the baby has a rash, hiccups, dry scalp…	9	7	4	6	9	0	8
Talk about things the baby should be doing	9	9	5	7	12	0	6
Tell me what is normal for eating, pooping, peeing…	5	10	8	7	12	0	8

Reassure me that the baby is growing	6	7	3	3	5	0	13
Help with the housework/cleaning	14	3	2	4	1	0	10
Tell me I am doing a good job	16	9	8	8	7	2	8
Help me get money for baby supplies, rent, or bills	20	4	2	5	1	0	8
Explain why the baby is crying and what I can do about it	5	5	3	4	8	1	14
Support my ideas and decisions about how to take care of my baby	12	8	4	6	9	0	10
Let me know that it is ok to need help	15	9	7	7	11	2	7
Show me how to take care of the belly button/umbilical cord	7	7	4	3	11	0	12
Help me find a place to get baby supplies	9	5	7	4	10	0	12
Babysit so I can go out with my partner or friends	11	8	6	10	3	2	0

*Respondents may indicate several categories of support per question

In response to eleven questions, participants identified their "Spouse/Partner," as the most common source of support, with "no one" the second most common response to these eleven questions. In response to four questions about functional support, "No One" was the most common response, indicating that women lacked any support in the following areas: (a) help me with breastfeeding; (b) explain why the baby is crying and what I can do about it; (c) show me how to take care of the belly button/umbilical cord; and, (d) help me find a place to get baby supplies.

"Doula" appeared on the social support survey as an option for participants to designate as a "helper/individual providing support" because it is commonplace for birth doulas to provide limited postpartum support to their clients. Typically, the birth doula provides one or two postpartum follow up visits in the immediate postpartum period. "Doula" was identified as a source of support in response to all 21 questions, and was the most common source of support identified in response to 3 questions. "Doula" was also identified as the second most common source of support in response to 5 questions. This is especially relevant data to take into account when considering the appropriateness of the postpartum doula as the vehicle for postpartum support. Only one or two participants identified their "Neighbor" as a source of support in seven of the twenty-one categories. This confirms the social isolation that many participants spoke of during the focus group discussions.

Summary of Focus Group and Social Support Survey Findings

The combined findings from the focus group content analysis and social support survey data provided valuable information in relation to the purpose of the study: to examine and describe low-income postpartum women's needs, expectations and desires for a targeted,

postpartum social support intervention, and the acceptability of the postpartum doula as a vehicle for providing social support.

Postpartum Stressors

Participants identified many postpartum stressors. During the content analysis process, four categories of stressors emerged: baby related, functional, physical and emotional. These stressors contribute to the new mothers coping in the postpartum period and influenced their overall transition to motherhood. Their responses to the questions regarding what types of postpartum doula support are most needed and desirable were clearly influenced by their identified stressors.

Support

The content analysis process of the focus group data revealed 4 categories of support that women reported routine deficits in: functional support, physical support, educational or informational support, and emotional support and presence. The social support survey findings echoed the focus group findings by revealing deficits of support in the same key categories. One difference noted was that the social support survey results indicted that women needed help finding where to get baby supplies, either for purchase or at low/no cost from community agencies. This need was not discussed in the focus groups.

Many women reported their "partner/spouse" as their primary support in response to the majority of the social support survey questions, followed by "no one." The findings reflect that women are often very isolated, with only their partner or spouse providing social support and trying to meet their complex needs in the postpartum period. This was echoed in the focus group data by many participants who felt that outside of their husband or partner, they had limited support available for the day to day functional tasks and physical needs such as showering,

running errands, completing household tasks, and catching up on sleep. The lack of interaction with neighbors evident in the social support survey results is also indicative of the social isolation reported by many in the focus group discussions. However, many of the women in the focus group discussion talked about being able to call on their neighbors in times of real need, just not necessarily for the day to day physical and functional deficits of support.

Postpartum Mood

Participants unanimously reported a change in mood since giving birth. For most, this was a negative change, with lost of interest in doing things that normally brought them pleasure and feelings of sadness and isolation. Most indicated that availability and consistency of support impacted how their mood, and cited an overall lack of support after the initial postpartum period which negatively contributed to their mood.

The Postpartum Doula as a Vehicle for Support

There was an overwhelming affirmative response to the idea of postpartum doula support to address postpartum stressors and deficits of support. The study participants indentified four categories of support that were most important to them in the postpartum period: functional, physical, educational/informational, and emotional/presence. As noted in Chapter 1, these measures of support fall well within the postpartum doulas scope of practice.

CHAPTER 5

Discussion

The purpose of this chapter is to discuss the findings from the focus group content analysis and social support survey. Findings relating to implications for nursing, including a new model of postpartum care utilizing postpartum doulas and the theoretical model, will be discussed. Recommendations for future studies are presented.

Summary of the Findings

The findings from this study add new and valuable information to the existing body of literature. This study adds a postpartum needs assessment that examines the acceptability of the postpartum doula as a means of providing social support to low income postpartum women. The content analysis process of the focus group data revealed four categories that women identified as areas of need: physical, functional, education, information, emotional support, and presence. The findings from the social support survey confirmed this information, as well as identified deficits in the availability of individuals within their support networks to provide much needed support. Participants in this study had experience with birth doulas and expressed interest in postpartum doula care as a desirable method for providing individualized support to meet their needs and to fill deficits in their existing support systems. The four categories of support identified fall within the scope of practice for postpartum doula care according to the DONA standards (DONA 2002, 2005; Kelleher & Simkin, 2008).

The findings from this study support the findings from the literature review in Chapter 2, that identified targeted, one-on-one, in-home social support interventions initiated in the postpartum period are more acceptable to postpartum women than group support or interventions

initiated prenatally. It is evident from the existing body of literature and from the findings of this study that postpartum women experience many stressors that influence their postpartum experience (Amankwaa, 2005; Dennis, 2003; Hardy & Hardy, 1988; Leung et al., 2005); Furthermore, social support is one of the factors that contributes to maternal mood in the postpartum period (Beck, 2002; Logsdon, Birkimer, Ratterman et al., 2002; Corwin et al., 2005). The findings from this study indicate that future studies must take into consideration the importance of designing an intervention that meets the unique and complex needs of the postpartum woman (Liabsuetrakul et al., 2007; Logsdon et al., 2000; Logsdon & Winders-Davis, 2004).

The findings from both the focus group analysis and the social support survey reiterate the importance of a broader social support network in low-income postpartum women's lives. There is a need for additional venues of support to meet postpartum women's expectations, needs, and desires for supp beyond that which is provide by their partners or spouses. It is reasonable to use the postpartum doula as a vehicle of support to address many of these needs, while maintaining the individual's specific desires and expectations for support. This study adds to the existing body of research by laying out the foundational pieces for designing an effective intervention targeted to meet postpartum women's expectations, needs, and desires for social support in the postpartum period

Discussion of the Theoretical Model

As discussed earlier in Chapter 2, Bronfenbrenner's ecological systems theory was the conceptual framework for this study. This theory describes an individual's environment as a series of five, complex systems with interactions within and between systems. During the focus group discussion, participants identified individuals from two of these systems; the microsystem

and the exosystem, as providing support when dealing with postpartum stressors, as well as influence from the macrosystem. The microsystem is made up of the individual and their immediate environment including interpersonal relationships between family, friends, and peers. These are people that the mother has daily contact with. The exosystem is comprised of community-level environments, such as health agencies and Community support groups that may influence the woman, even though she may not have daily contact with these systems or with individuals from within these systems.

During the focus group discussion, participants identified individuals from the microsystem (their immediate environment) and the exosystem (their extended network of support) as providing support for dealing with postpartum stressors. From the microsystem, participants identified partners/husbands, moms, mother-in-laws, sisters, aunts, friends, grandma, cousin and sister-in-law as individuals providing support. From the exosystem, participants identified support from community-based Mom's groups and therapists. Earlier in the discussion, some participants spoke of health care providers, primarily the baby's doctor or pediatrician, as providing support, in addition to their birth doulas. Participants also identified variables within the macrosystem as influencing levels of stress, including the economy and the government. Several participants were experiencing the negative effects of the recession and were looking for employment. Many women had been on the state health plan during their pregnancy and continued to qualify for this coverage. All were WIC eligible and were receiving those benefits. Several discussed the current maternity care practices in Europe including extended physical and financial postpartum support as well as guaranteed employment after a year of paid maternity leave. They expressed support of this model and felt the United States should consider changes

to current maternity care practices. This idea is especially relevant given the current environment of health care reform in the United States.

Utilizing the framework of Bronfenbrenner's ecological systems theory to examine new models of social support in the postpartum period may help identify relevant social support interventions to address the complex issue of postpartum care. By the nature of their relationship with the mother, postpartum doulas fall into the new mothers extended network of support, or exosystem. The postpartum doula also supports others within the new mother's microsystem, or immediate environment, including her infant, partner and other children. Changes at the macrosystem level must occur in order for postpartum doula care to become widely available, including: universal insurance reimbursement for birth doula care as well as postpartum doula care. The Affordable Care Act supports initiatives directed at prevention and public health innovation, providing an excellent opportunity for new directives in maternity care and the implementation of postpartum doula support programs (H.R. 3590, 2009).

Implications for Nursing

The evidence-based findings from rigorous nursing studies can be used as a catalyst for change to the maternal care delivery system in the United States, encouraging the incorporation of postpartum doula support as a routine extension of postpartum care for all new mothers. Nurses and APNS are key stakeholders in current maternity care and are in the unique position to effect change within this patient population by implementing a new model for postpartum care that includes postpartum doula support. Nurses and APNs play an important role in education and postpartum teaching, and can incorporate a social support needs assessments and routine postpartum teaching about PPD into their practice. If deficits are discovered, nurses and APNs

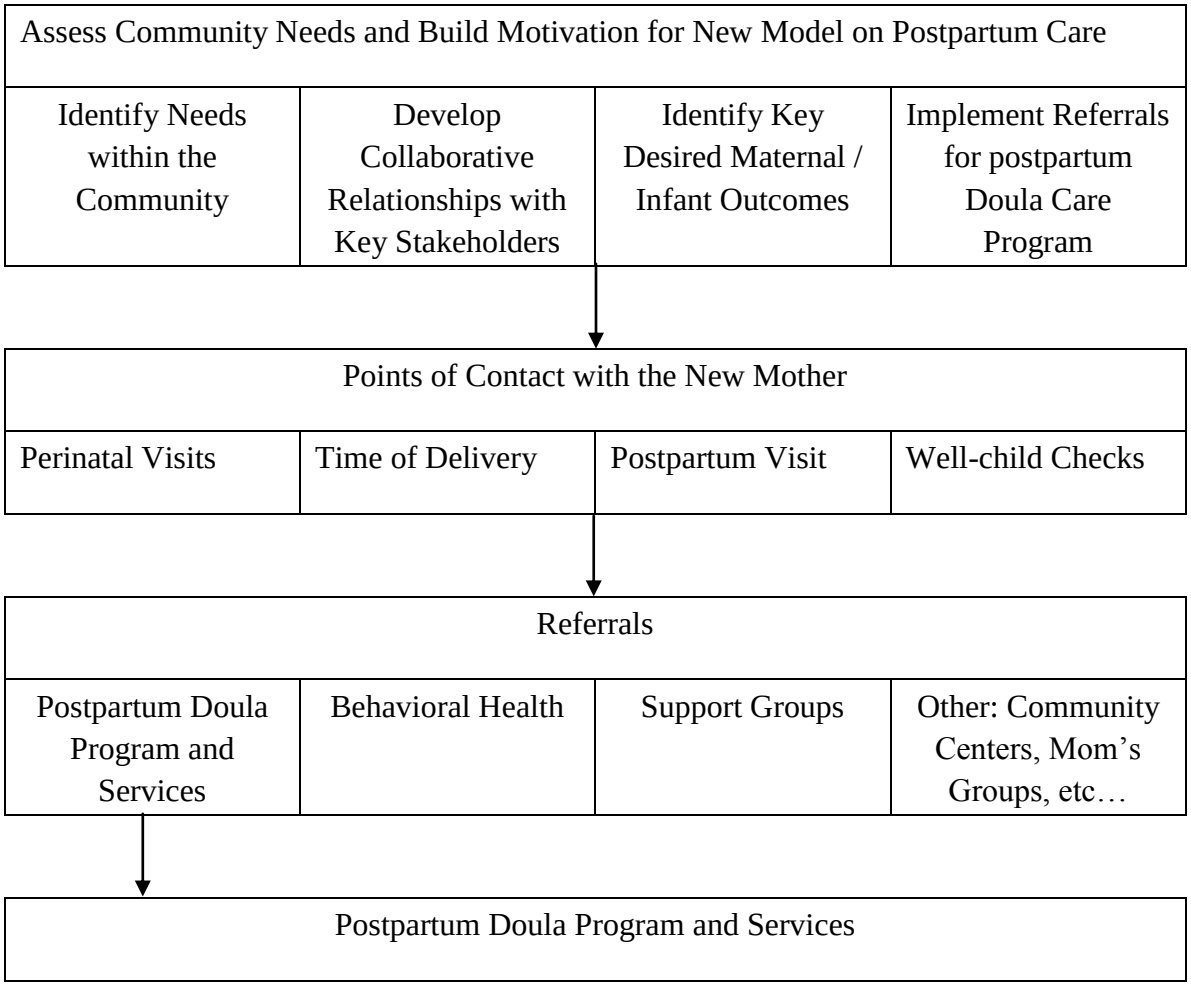
are an appropriate point of contact and a referral resource in directing new mothers to postpartum doula services as one approach to filling identified gaps in social support.

A new model for postpartum support. When reflecting upon the study findings, postpartum doula care emerges as a valid method of addressing deficits of support. As noted throughout the study, it is important to tailor support to meet mothers' needs. This is an important consideration when developing new models of care utilizing the postpartum doula as a vehicle for social support. When considering a new model for care, it is also important to consider several other factors, including: the role of the postpartum doula; points of contact with new mothers within the current care system; identifying areas and deficits of support; and, referrals to appropriate supportive services including postpartum doula services.

Designing a New Model for Postpartum Doula Care. Abramson, Breedlove and Isaacs (2006) developed a community-based doula program. Their program incorporates several key concepts, including: recruiting doulas from within the community being served; promoting extended involvement of doulas with the families served; extensive training and continued education, peer support, "reflective supervision", and quality administrative support. Developing supportive and collaborative partnerships with stakeholders within the community to provide continuity of care and outcomes for perinatal health and parent-infant relationships meet the specific needs of each community of women served, were identified as key components for postpartum doula care (Abramson et al., 2006). The findings of this study together with the identified key components of Abramson et al.'s program have been synthesized into a new model for postpartum doula care represented in Figure 1.

Point of Contact. In the current maternity care system in the United States, assessment of social support needs must be addressed during the perinatal period, at the time of delivery, and at

the routine postpartum visit. Another point of assessment is the well-child visit, as study participants noted they were often more lax in their own follow up care, yet maintained the schedule of well-child checks. It is already a common practice to screen new mothers for depression at their infant's well-child checks as well as at the 6 week postpartum exam (ACNM, 2003). If deficits of support are revealed or the depression screen is positive, mothers should be provided with referrals to postpartum doulas as one approach to addressing support needs by providing needed functional, physical, informational, educational, and emotional support. This would certainly not preclude health care provider referrals to other systems such as behavioral health, mental health support groups, or other resources within the health care system or community.



Functional Support	Physical Support	Informational and Educational Support	Emotional Support and Presence

Figure 1. A New Model for Postpartum Support: The Postpartum Doula

Identification of deficits of support. Both the current maternity care providers within the health care system and the postpartum doula can play a significant role in the identification of deficits of support in new mothers. There are many validated instruments available to identify deficits of support and depression in postpartum women. The Edinburgh Postnatal Depression Scale (EPDS) is widely used at well-child checks and the 6 week postpartum visit to screen for depression. In addition to a depression screen, future studies should consider utilizing a screening tool specific to social support. The Postpartum Support Questionnaire (PSQ) is a tool specific to assessing postpartum support, and measures women's informational, material, emotional, and comparison support. The Perceived Stress Scale (PSS) measures psychosocial stressors. Both would be valuable additions to a postpartum needs assessment. These instruments can be used by APNs to screen for depression and social support and appropriate referrals can be made. While it is not within the scope of practice for doulas to administer these types of screening tools, postpartum doulas are trained to, "help their clients to screen themselves for PPD and will make referrals to appropriate clinicians or support groups as needed" (DONA, 2002).

Screening for PPD is already a part of the routine care of postpartum women in many practices. The American College of Nurse Midwives supports routine screening for depression and PPD in all women as a routine part of primary care, including postpartum visits (ACNM, 2003). In Minnesota, education about PPD is mandated by the state legislature in S.F. 2278,

Article 1, Section 33 which states, “Providers of prenatal care must have information about PPD available to pregnant women and their families; and, Hospitals and other health care facilities must provide new mothers and their families with written information about PPD” (Minnesota Department of Health, 2005-2006).

However, the use of additional screening tools may not be necessary. Simply asking women about their level of social support and their available social support network is likely adequate when assessing deficits of support, and is within the scope of practice of birth doulas or postpartum doulas. Furthermore, making recommendations or referrals based on the information provided by new mothers is within the scope of practice for doulas (Kelleher & Simkin, 2002).

Identification of measurable maternal outcomes. The Abramson et al. (2006) community doula program discussed the importance of key stakeholders within the community determining what measurable maternal and infant outcomes are needed for a community based program. I would suggest that given the lack of postpartum doula research examining the relationship between the postpartum doulas as a vehicle of social support and the influence of such support on maternal mental outcomes, a well designed intervention study examining these variables would be a valuable addition to the research literature on social support and doula care.

Referrals to postpartum doula programs. Recognizing the postpartum doula as a viable option for postpartum social support services is critical to this new model of care. The initial process outlined in Figure 2 identifies the need to include key stakeholders with the community when developing doula programs. Health care providers and other agencies who have contact with new mothers must be sought out to develop collaborative relationships, in order to promote the benefit of postpartum doula care and the unique gaps that this type of support fills within the

current care system. Collaborative relationships between key stakeholders within the community and postpartum doulas would represent a shift in current maternity care practices.

Study Limitations

Issues unique to the focus group method may have occurred. As with any type of focus group discussion, participants are not always comfortable disclosing support perceptions, expectations, and desires in a group format. This resulted in missing data in the verbatim transcripts. There was also missing data in the socio-demographic survey. The social support survey may have been difficult for women to fill out, thus explaining the missing data in response to specific questions. Response bias or social desirability response bias may have been introduced during the discussion and with the surveys. Convenience sampling of women with birth doula experience may have contributed to biased responses regarding the acceptability of a postpartum doula as a vehicle of support. Other issues specific to the focus group format may have occurred, including: censoring of one's responses; lack of contribution to the discussion; and, conformity where participants may have adjusted their perspectives, feelings, or responses to mirror those of other participants.

Recruitment was more difficult than expected. This may have been due to the seasonal timing of the initial groups. Many women did not like to go out with their babies in the winter weather. Recruitment was undoubtedly influenced by the initial recruitment method, a flyer sent in the mail and posters at the community doula center. Many of the women receiving services from the center had transient and unstable housing, so the addresses available in the center files were not always up to date. The sampling method, non-randomized, purposeful, convenience sampling, may have contributed to selection bias during the recruitment process. Finally, the

small sample size, N = 30, affords limited transferability of the findings to other populations of postpartum women.

Recommendations for Future Research

Postpartum doula support was identified in this study as an acceptable method of delivering support to new mothers, and is a largely unexplored method of providing social support. These findings indicate a need for research examining the influence of postpartum doula support on maternal mental health in the postpartum period. This study also confirms the importance of designing interventions that are targeted to meet the expressed deficits and needs of postpartum women, providing support in the manner in which they indicate is relevant, and at the times that it is most needed (Dennis & Hodnett, 2007; Logsdon et al., 2000; Wiggins et al., 2005). The lack of support evident in the social support survey findings and the participants reports of altered mood in the postpartum period, confirms the existing body of literature that indicates that adequate social support or lack there of, affects maternal mood (Beck, 2002; Howell et al., 2009; Liabsuetrakul, et al.,2007). Given the lack of methodologically rigorous trials examining social support interventions and maternal mood, future studies should include the use of validated screening tools to assess social support, maternal mental health and perceived stress.

Conclusion

The data collected during this study Identified stressors and deficits of social support in the postpartum period in a group of low income women. The existing body of research and the findings from this study indicate that effective changes can be implemented to address these deficits in support. The information from this study provides those providing support to new mothers with necessary information to expand current practices in the maternity care model to

include targeted postpartum doula support interventions that may ultimately influence maternal outcomes. Further research is indicated in order to determine the effectiveness of targeted, individualized, in-home social support interventions for women in the postpartum period. With CAM emerging as a viable and appealing treatment modality, it is essential to determine if social support is an effective treatment or adjunctive therapy for use in postpartum women with mental health issues. The information from a well designed, methodologically rigorous study could be used to: (a) influence future studies examining the relationship between social support and PPD; (b) integrate postpartum doula support into routine maternity care practices by implementing a new model for postpartum support; (c) guide intervention protocols for women who are identified as having deficits in social support and/or those who screen positively for PPD; (d) influence nursing practice and standards of cares for postpartum women; and, (e) provide an effective, non-pharmacologic treatment option for women with inadequate social support and maternal mood disorders.

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APPENDIX A

Socio-Demographic Data Form
ID Number:_____

About You
Age (years):
Race/Ethnicity:
Occupation:
    Hours per week you work outside the home:
Are you married, single, or with a partner?
How many kids do you have at home?
What is the highest level of school you completed?
What is your total yearly income?
Have you ever been depressed? Yes/No (circle response).
    If yes, did you go to counseling/therapy? Yes/No (circle response)
    If yes, did you take medication? Yes/No (circle response)

About Your Baby
Baby's date of birth:
Baby's birth weight:
Baby's gender (sex):
How many weeks pregnant were you when you had your baby?
How many times have you been pregnant?
    How many living children do you have?
Are you staying home with the baby (primary caretaker)?
    If no, how many hours per week is your baby in daycare?
How are you feeding your baby? (Breast/Formula/Both)
    If you breastfed, how long did you breastfeed?
Have you had any problems with your feeding method?

About Your Birth
Do you have health insurance?
    Private or MA?
How was your baby born: Vaginal, Cesarean, or VBAC?
Did you use pain medication during labor?
    Type:
Did you have an instrumental delivery (forceps or vacuum)?
Did you have an episiotomy?

APPENDIX B

Social Support Self-Report Survey **ID#_____**

Please put a check mark in the box indicating who provides support to you. You may check more than one box per statement.

Social Support Survey	Helpers/Individuals Providing support						
	Spouse/ Partner	Mother	Friend	Other Family	Doula	Neighbor	No one
I Need…Someone to/Help with/Support in…							
Drive me to the store, doctor, church…							
Take care of the baby to give me a break							
Help with laundry							
Cook meals							
Provide Childcare							
Help me with breastfeeding							
Let me sleep							
Watch the baby so I can shower/bath, eat, have time to myself							
Explain why the baby has a rash, hiccups, dry scalp…							
Talk about things the baby should be doing							
Tell me what is normal for eating, pooping, peeing…							
Reassure me that the baby is growing							
Help with the housework/cleaning							
Tell me I am doing a good job							
Help me get money for baby supplies, rent, or bills							
Explain why the baby is crying and what I can do about it							
Support my ideas and decisions about how to take care of my baby							
Let me know that it is ok to need help							
Show me how to take care of belly button/umbilical cord							
Help me find a place to get baby supplies							
Babysit so I can go out with my partner or friends							

Do you have a mother or other female relative who is active in your life providing support? Yes/No. (circle) If yes, who (mom, grandma, aunt, other…)? _____

APPENDIX C

Consent Form: Women's Expectations, Needs, and Desires for Social Support in the Postpartum Period.

You are invited to be in a research study examining women's expectations, needs, and desires for social support during the postpartum period. You were selected as a possible participant because you received birth doula services through the Everyday Miracles program and are familiar with doula support. Please read this form and ask any questions you may have before agreeing to be in the study.
This study is being conducted by: Nicolle Uban, BSN, RN, PhD_c, School of Nursing, University of Minnesota as a part of her doctoral program.

Background Information
The purpose of this study is to gather information about what types of support women find helpful in the postpartum period. The goal is to find out more about women's expectations, needs, and desires for social support in the postpartum period in order to design a postpartum doula support program.
If you agree to be in this study, you will be asked to do the following things:
1. Participate in **one** focus group discussion lasting approximately **2 ½ hours**. You and the rest of the participants will be asked a series of questions and encouraged to discuss them. The focus group session will be audio taped.
2. Complete a socio-demographic form answering questions about yourself such as; your age, number of children, type of births you have had...
3. Complete a survey about the kind of social support you have in your life.

Risks and Benefits of being in the Study
There are no major risks to participating in this study. However, you may feel uncomfortable with the sensitive and personal nature of questions asked. You may choose not to answer any questions that you do not want to answer during the focus group discussion or on the study forms. Due to the nature of focus group discussions, confidentiality cannot be explicitly guaranteed. Participants may discuss content/information outside of the focus group. There are no direct benefits to taking part in the study.
Compensation: You will receive payment: $20 gift card to Target or Walmart. This gift card will be given to you after you have completed the focus group session and study forms.
Confidentiality: All information gathered as part of this study will be kept confidential by the researcher. Any reports or publications will not include identifying information. Summary information will be shared with Every Day Miracles for the development of a postpartum doula program. Audiotapes of sessions will be erased after transcription. However, it is not possible to guarantee complete confidentiality, as other members of the focus group may discuss content outside of the group.

Voluntary Nature of the Study: Participation in this study is voluntary. If you do not feel comfortable answering a specific focus group, demographic survey, or social support survey question, you do not have to respond. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota or with Everyday Miracles. You may decide to withdraw from the study at any time without affecting those relationships.

Contacts and Questions: The researchers conducting this study are Nicolle Uban, PhD Candidate, 651-303-9693 or ubanx003@umn.edu with oversight by her advisor, Dr. Cynthia Peden-McAlpin 612-624-0449 or peden001@umn.edu . You may ask any questions you have now, or if you have questions later, **you are encouraged** to contact them at the numbers or emails listed above.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

APPENDIX D

Research Questions to Guide Focus Group Discussion [Women's Expectations, Needs, and Desires for Social Support in the Postpartum Period]

Background: Doulas provide individualized social support to pregnant, laboring, and postpartum women.

Birth Doula Experience:

1. What types of support did your birth doula provide?
2. Were there types of support that were more helpful? Less helpful?

Postpartum Stressors:

1. What are your primary stressors since having your baby?
2. Who helps you deal with these stressors?

Social Support:

1. Describe who provides support to you.
2. What supportive characteristics do these individuals have?
3. How does the support you get from your partner/spouse, family, friends, & others differ?
4. Which types of support are most important to you?

Feelings/Affect:

1. Tell me about your mood since giving birth.
2. Please describe how the amount and type of support you receive affects your mood.
3. Have you lost interest or pleasure in doing things that used to bring you pleasure? If yes, please tell me a little more about this.

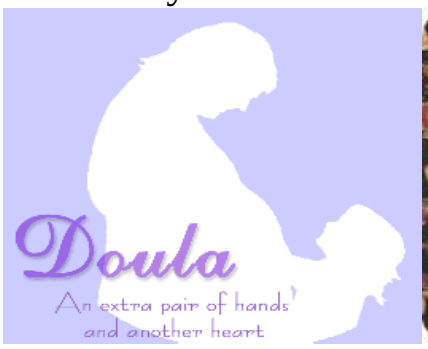
If a postpartum doula came to your house to provide support:

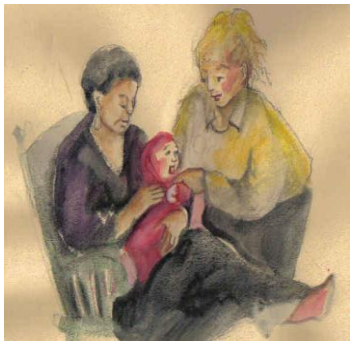
1. What kind of help would you want?
2. When would you like them to come?
3. How long would you like them to stay? (length of visit)
4. When would you want them to stop coming?
5. Would you be willing to contact them if you had to change your visit time? How would you do this?

APPENDIX E

Have you had a baby in the last 12 months?
Did you have a doula at your birth?
Are you over 18 years old?

If **YES**, would you be interested in participating in a focus group study exploring the types of support women need after they have had a baby?



Nicolle Uban, a Midwifery and PhD student in the School of Nursing at the University of Minnesota, is holding focus group discussions to explore women's expectations, needs, and desires for support in the postpartum period. This study is part of her doctoral program and is not associated with the Everyday Miracles doula program or services. Participants will receive a $20 gift card for their time and effort.

If you are interested in learning more about the study, please call **Debby Prudhomme** or **Mary Williams** at **612-353-6293**
The groups will be held at the Everyday Miracles Center.

APPENDIX F

Telephone Recruitment Script for
Respondents to the Recruitment Flyer or Postcard
(Women's Expectations, Needs, and Desires for
Social Support in the Postpartum Period-Focus Group Study)

Name of person:
Phone number: Date/Time called:

Hi [insert name] this is Debby/Mary from Every Day Miracles. I am calling today because you responded to the flyer/postcard expressing interest in participating in the focus group conducted by Nicolle Uban, a Nursing student from the University of Minnesota.

Nicolle is getting together a small group of new moms to get their input on how to design a postpartum doula program. She is interested in learning about your expectations, needs, and desires for support after having a baby. You are being asked to participate in the study because you responded to a postcard you received in the mail or the flyer posted at the EveryDay Miracles center. Your insight and expert opinion about what works and doesn't work about doula care is important to Nicolle.

Every Day Miracles is not part of the research project; their role is independent and separate from the study. Your decision about whether or not you will participate in the study will not impact your relationship with Every Day Miracles.

A focus group is structured conversation where the leader asks a set of questions and participants like you answer them. You don't have to respond to every question, and there is no pressure if you choose not to answer.

The group you will be in will have 5 to 8 women, and will last 2 ½ hours. You will also be asked to fill out a basic form providing information about yourself, a short survey about the types of social support you have, and to sign a consent form saying that you agree to participate in the study.

Snacks will be provided. Because the goal is to have a good conversation, childcare will be provided. Because you will be volunteering your valuable time and sharing your ideas, at the end of the session you will be given a $20 Target or Walmart gift card as a thank you.

Are you interested in joining Nicolle for a focus group session?

No _____ Okay, thanks for your time.

Yes _____ Great. Which date works best for you? Date 1 ____ Date 2 _____ Date 3 ____

You will receive a call the day before the session to remind *you. What is the best number to reach y*ou at? _____

Nicolle looks forward to seeing you at the discussion!