CHAPTER VIII

DISCUSSION

Introduction

At its core, doula support is relationship-based caregiving. Doulas are professionals who provide caregiving to mothers in labor (Lundberg, 2010). This study shows that those caregiving skills are extended to fathers, and are not limited to independent practice doulas. In order to be effective, hospital-based doulas needed to develop several unique skills to provide care in that setting. While hospital-based doulas provided informational support to mothers, this study found that advocacy skills seemed to be unique to independent practice doulas. The next sections of this chapter will examine informational support and advocacy; contrast hospital-based doula care with independent practice doula care; and explore the relationships between fathers and doulas. An attachment perspective (Feeney, 2006) can inform many of these interactions, as they may illuminate the doula's internal working model of caregiving. Additionally, the application of the biobehavioral model of human response to stress (Taylor, 2006, 2002, 2001) may help to further illuminate the relationship between fathers and doulas. Finally, the limitations of the study and future directions for the research will be discussed.

Informational Support And Advocacy

The issue of the dividing line between informational support and advocacy has been difficult to delineate for doulas. Even in the literature of doula organizations, there is no clear dividing line. (The DONA International Scope of Practice and Code of Ethics are provided in Appendix A.) The DONA documents refer to the "primacy of the client's

interests", but there is little clarity beyond that clause. The confusion may exist because the strategies themselves did not seem to differ over much. In this study it was the purpose underlying them that shifted. The dividing line was prompted by the mother's indication that she wanted more options than what the medical staff was offering her. During informational support, doulas and mothers described that explanations were given to alleviate anxiety or give comfort. It was also provided so that mothers perceived a general sense that what was happening to them was similar or dissimilar to other mothers. Once a mother indicated she wanted to know other options in order to possibly make a different choice, participants described that the doula's strategy changed. Doulas then began the advocacy process by soliciting alternatives from medical staff or giving the same information but framed in a different way. In advocacy communications, the emphasis was on giving choices and empowering the mother to choose her own approach. In informational support, the emphasis was on giving information to the extent that the mother prefers.

The advocacy process was identified as beginning when the doula respected that the mother and her birth partner were the primary decision makers about their care. This belief colored the doula's behavior throughout the birth. Therefore, when the mother indicated she wanted more power over her options, it seemed that the doula easily stepped in to make her aware of her choices and involved the nurse or other medical caregivers to provide her with that information. By respecting mothers in the role of active decision maker and modeling their behavior towards her, doulas appeared to be attempting to cue others to view her in that role.

Doula advocacy and patient advocacy. Doula advocacy appears different than other patient advocacy approaches in the medical system. Many patient organizations recommend that people undergoing medical procedures have an advocate. According to the National Patient Safety Foundation (2003), patient advocates are often authorized to ask questions about procedures, remind the health care staff about the patient's medical conditions, confer about treatment decisions, and act on the patient's behalf. Patient advocacy is quite different from doula advocacy as outlined in this study. While the laboring mother may be preoccupied during active labor, she was still viewed by participants as healthy rather than ill. She was considered capable of authorizing consent or refusal for any medical procedures. Whereas doulas offered information to the mother, they stated they did not confer with medical staff independently about the mother's condition. Participants stated that doulas were frequently not fully informed about all of the mother's medical conditions when it was not necessary in order to offer effective labor support.

Power And Advocacy Strategies

For several doulas in this study, the philosophical basis for the advocacy function of doula support was the doula's belief in the possibility of maternal empowerment and personal growth during her labor. Empowerment – the act of claiming one's own influence over a situation and taking responsibility for its outcome (Miller, 1997; Thomas, 1990), could be enhanced or inhibited by the doula's behavior and attitude. This philosophy implied that in order for the mother to exert power in her medical care and choices, the doula needed to believe it was possible for the mother to share power with her nurse and physician or midwife. Midwives are more likely to believe in a shared

power model of medical decision making, but it is not an absolute (Cheyney, 2008; Halldorsdottir, 1996). However, the higher up the medical hierarchy, the more likely it is that a physician will be authoritarian. Thus, a mother with an obstetrician is more likely to experience resistance to her attempts to share power over her care (Johnson, 2008; Street, 2003).

Doulas in this study stated that during the prenatal period they were sensitive to parents changing their desired level of involvement in medical decision-making. They then offered choices and strategies targeted at that level. They said that the doula may be the first person to present a model of shared decision making to the mother, or that the mother may have chosen a doula in order to assist her in this endeavor. Doulas sometimes introduced the idea of switching medical careproviders in order to find a better philosophical match. One doula, Lydia, stated that one third of her clientele changed providers.

Other doula participants taught and prepared their clients extensively for their advocacy role by using role play, scripts, or rehearsing cues. By preparing they hoped to increase the mother and birth partner's effectiveness in getting their requests granted. All of these strategies seemed to be based on the idea of a shared power model. That is, obstetrical environments were seen as inherently paternalistic, where the physician has more power over the patient (Davis-Floyd, 2001). He or she chose to grant patient requests: to opt out of a mandatory IV, to get off the monitor and labor in the bathtub, or to not have an amniotomy. According to doula participants, the mother may have refused these procedures but then might have faced subtle or overt retaliation. Doulas assisted parents in enrolling the careproviders in a shared power model. They recommended that

mothers and their partners share reasons for their requests, frame their requests as simply outside the norm or unusual, and use gentle language. The doulas using these strategies wanted to create an alliance so the nurse would want to help the parents get the birth experience they desire. Many of the doulas' communications were focused towards that end. For doulas in this study, their main power at a mother's birth was their ability to help shape events through their inner attitude towards others and their communication skills. Doulas participants felt they were most effective when their client felt empowered by the doula's presence to speak up for herself.

Advocacy And Female Gender Communication Style

Based on the data collected, the doula's practices of advocacy reflected communication activities. Since the doulas were women, their communications cannot help but be influenced by gendered communication patterns. The sociolinguistic theories of Deborah Tannen reveal that in conducting negotiations, women consider different points of view, elicit the feeling states or others, indirectly posit possible actions, and show a lack of investment in personal status (Tannen, 1990). All of these hallmark patterns were present in the advocacy stories recalled by doulas. Although doulas reported minimal direct verbal interaction with medical staff, they were coaching parents on how to conduct that interaction. Doulas were teaching negotiation skills and influencing those negotiations. This section explores the possible ways that advocacy was influenced by female gender cultural communication style. There was not appropriate data to do any sociolinguistic analysis, however there were sufficient clues present to explore this idea.

Communication rituals of women emphasize negotiation and taking into account the feelings of others when making a decision or posing an issue that requires a decision (Heatherington, 1993; Miller, 1997; Tannen, 1990, 1994, 1997). In conflict situations, women "use language to get what they want while attempting to accommodate the needs of others" (Tannen, 1998, p.174). Women are indirect communicators in this conversational ritual. On the other hand, studies of boys' conflicts show that male culture encourages a "single orientation of pursuing their own self interest without orienting to the perspective of their partner" (Tannen, 1998, p.174). When doulas were explaining advocacy tactics they often took the needs or orientation of the medical staff into account. Recall Lani's explanation about why the nurse said that the epidural medication would not reach the baby. "She was taught that it didn't. So as far as she's concerned, it doesn't. She doesn't know any different." Or Sonia's framing of the hospital's staff reaction to asking for individualized care: "They are a lot of times asking for things that are not part of the normal routine, so understanding that is going to make people just a little nervous. You know in the same way you come to a hotel and you ask for some crazy thing to be in your room; it's going to make people go, "Oh, you know, that's a little odd." Mia discussed understanding the hospital culture with a metaphor of traveling to a foreign country. "If you go to France, think of it as a beautiful country with a lot to offer, and try your hardest to be at all accommodating, it's a terrific place to be." By understanding the point of view of the people on another side of the interaction and accommodating it, the doulas in this study felt that it would increase their client's effectiveness in getting their requests fulfilled.

Independent practice doula participants also realized that they were entering into a medical hierarchy where they had no assigned place and no power to control the situation. Hospital-based doula participants acknowledged their place in the hierarchy was in the lowest rank, but they still felt they had no power over the mother's birth events. Both kinds of doulas felt that a doula's biggest capacity to influence came from how she interacted with her clients and medical staff. These perspectives can be perceived as "frames" or the psychological backdrop for the interaction (Bateson, 1972). The perceived frame influences the metamessage, what is being inferred but not directly stated verbally. In an interaction, participants perceive a particular frame such as, "this is play", or "this is a negotiation". Within that frame, each participant interprets direct and indirect messages. For example, when the doula said, "Did you have any questions about that?", the metamessage implied was "you should ask questions". It was possible for participants in an interaction to begin with or continue to have different frames of interpretation throughout an interaction. This could have lead to conflict or confusion. For example, a physician may enter a laboring mother's room with the intention of stating he was recommending an amniotomy. The physician may have expected the patient to agree and initiated the interaction by indicating to the nurse to prepare the necessary instruments. His frame was that he had the power to initiate a medical procedure as he felt was appropriate, and that his job was to inform the patient of what he was going to do.

In this example, the doula's frame was to empower her client to be involved in her medical care decision-making to the extent that the mother wished. To her, this communication was a negotiation. To the empowered mother and birth partner, their

frame assumed cooperative decision-making. A frame sets up a "structure of expectation" (Tannen, 1993, p. 6) about the roles, people, and course of conversation. In this example, the physician had a different frame and structure or expectation than the doula or the parents. This conflict between frames is not uncommon in obstetrical settings (O'Malley, 2010). However the doula was the person involved in the interaction who was most likely to understand the possibility for conflict between all of their different expectations. In an advocacy situation, she could influence the course of the communication even if she did not have power to offer or implement possible choices. Doula participants accomplished this in several ways.

An initial strategy was rapport building and the creation of solidarity. Solidarity is the drive to be friendly, but it also establishes equal footing between people (Tannen, 1986, p. 101) and thus increased the doula's social power. When doulas interacted in a friendly way with nurses and shared support strategies of the mother, they were building solidarity. The metamessage of this behavior was, "In our own ways we are caring for this mother and her family together." Building solidarity was the beginning of creating an alliance, which gave the doula even greater power in the temporary social structure being created in the labor room. Creating alliances is an important skill in initiating and maintaining female friendships and social networks (Miller, 1997, p. 38; Tannen, 1994, p. 211). An alliance implies cooperation, collaboration, and reliance on one another. While the doula's status within the medical hierarchy was considered to be low to non-existent, her status with the laboring mother and family was considered to be quite high. Mother, father, and doula participants all acknowledged trust, respect, and belief in their doula. Relating to different kinds of people simultaneously was a skill at which the experienced

doula needed to excel at in order to assist her clients in advocating successfully for themselves. The nurse's status was below that of the physician in the medical hierarchy, but she was a stranger to the laboring mother. Thus the nurse could also benefit from a cooperative relationship with the doula, and may use her own rapport building skills.

Another major strategy doulas participants used was indirectness; what linguists refer to as the way people mean what they don't exactly say. Tannen explains the importance of indirectness in human conversation in this way:

> "As we talk to each other about important and unimportant matters, we are always monitoring our relationships to each other, and information about relationships is found in metamessages, which by definition are not spelled out in words but signaled by the way words are spoken. So indirectness, in the sense of metamessages, is basic to communication. Everything must be said in some way; the way it is said sends metamessages-indirectly." (Tannen, 1986, p.68)

People use conversational signals to communicate our metamessages that are separate from the words. These signals include pacing, pauses, loudness, pitch, intonation, and facial expressions. Indirect strategies allow for a pleasurable kind of rapport to be created, when people understand one another implicitly. It also allows for a payoff in self-defense, in that the originator of the comment can state that the listener misinterpreted what was intended – even if the indirect metamessage was interpreted correctly. Examination of advocacy stories revealed that indirect comments allowed the doula to participate in the interaction without making a direct statement. To use Tannen's words, "Rather than blurt out ideas and let them fall where they may, we send out feelers, get a sense of others' ideas and their potential reactions to ours, and shape our thoughts as we go" (Tannen, 1986, p.81). Indirectness also makes it possible to control others or the course of a conversation without appearing to do so. "Did you have any questions about that?" implied that this was an appropriate time for asking questions and

having a discussion, something the physician may not have been expecting. Another indirect question was, "What do you need to know about the risks and benefits before making a decision?" This also modified the conversation and positioned the parents as the decision makers.

Doulas gave several examples of indirect strategies. Jo Ann recalled: "I can say to her, 'You look confused.' I say, 'This is what I see.'…I'm not going to say, 'You look like you need to do...'. I say, 'You look confused, you look unhappy, you look like you did not understand that question." In order to interrupt the physician's automatic action to cut an episiotomy, Lani got his attention. "I will say something like, 'She's stretching very beautifully, isn't she,' as he is grabbing for the scissors." Sonia gave two examples of indirect communication she used in front of medical staff to remind parents to speak up.

> Sonia: 'Now did you…you guys were talking something about that, weren't you?' [Laughs] [Parents respond] 'Oh, yeah, that's right.'
> Sonia: 'Are you sure she wanted an IV? Wasn't, weren't you talking something about that IV?'

Another influencing factor on advocacy interactions is the gender culture of language. According to sociolinguists, men and women use conversation for different purposes. In general women use language to develop connection and affinity, while men use language for self-display and to indicate social status. These differences in purpose influence advocacy interactions even when the physician is female. Physician training and culture are implicitly patriarchal and the attributes of male communication style is inherent in the training of physicians (Apker, 2004; Smith, 1989). Medical culture also emphasizes communication rituals based on status rather than those based on connection and joint decision-making (Davis-Floyd, 1987; McMurray, 2001; O'Malley, 2010).

Research shows that female gender specific communicative skills seem to be the crucial factor influencing patient satisfaction with female patients (Christen, 2008).

Also of interest are the conversational strategies used by men and women. In discussing one man's problem with another male friend, the listener will use conversational strategies to reinforce similarity between the two of them. He will maintain the friend's status, rather than diminish it by acknowledging a weakness (Tannen, 1990, p.60). Men may also use aggression to accomplish affiliation and initiate relationships. In male culture, whoever tells another what to do has the highest status; and status is to be maintained or heightened. Asking questions shows a lack of knowledge and weakness. Men view themselves as problem solvers, and feel most accomplished when they have successfully solved a problem. Conversely, when women discuss a problem, the listener will often display understanding, then reveal a similar circumstance in order to create connection. This reinforces their similarity and encourages the originator to share even more deeply. Symmetry between the two is achieved through empathizing. Connection is most highly valued in female culture, with a preference to avoid direct confrontation (Tannen, 1990, p. 158). Solving the problem is less important than sharing. What is most relevant to our advocacy discussion is that both men and women are interacting from different social structures. From a male perspective, giving orders and getting others to follow them indicates leadership. A command frames the order giver as having more power and creates a hierarchical structure.

In contrast, female social structures are organized in a more egalitarian way with minimal negotiation of status (Tannen, 1990, p. 156). When an individual female

suggests a proposal for the group, she sees compliance as increasing the power of the community not her own individual power. In conflict situations, girls are just as forceful as boys in trying to get what they want. However girls often use language for their own pursuits while also taking into account the needs of others. They may try to convince the other person that what they want is also good for them and meets their needs as well (Tannen, 1998, p. 174). As Tannen writes, "Girls are as intent as the boys on getting what they want, but they find ways of making an argument for what they want while avoiding having one" (Tannen, 1998, p. 176). This is an important skill to acknowledge when examining the doula's effectiveness in indirectly influencing advocacy negotiations. Based on the data collected, doulas, as women, seemed to easily minimize their status if it reduced friction with the physician or nurse or accomplished their client's goals.

In addition, these ideas of gender culture and genderized social structure are brought into play in the advocacy interaction. These frames could have negatively influenced the flow and success of the interaction if they were not taken into account by the doula. Any shift in who is involved in making a decision indicated a sharing of power by the physician or midwife. Women have shown increased compliance with treatment and greater satisfaction when female gender specific communication skills are employed by their gynecologists, even if the physician was male (Christen, 2008). Midwives, who are mainly women, probably bring female conversational rituals and negotiated decision making into the equation (McMurray et al., 2001). However the socialization of maleness and medicine may render making this change difficult for male physicians.

Let us examine more closely what particular strategies doulas in this study employed in these interactions. Women have been socialized to balance their own interests with the person they are interacting with. Frequently they pay a great deal of attention to cues and modify their speech to take into account the impact of what they say on the other person's behavior (Heatherington, 1993). Further, girls learn to temper what they say so as not to sound too aggressive or too certain. Sounding too sure makes them unpopular with their peers. Women are also likely to ask questions of others because it builds rapport. Question asking is seen as weakness by men and among physicians (Tannen, 1994, p. 26). Several doulas stated that when they employed a question asking strategy with a physician or a nurse, they already knew the answer to the question. In this interpretation, doulas might have used the question asking strategy in order to disguise their status with the mother, or to elevate the status of the physician in the interaction by having him provide an answer. Increasing his status may increase his comfort level with his medical orders being considered advisory rather than mandated. The one who waits is considered to be "one-down", especially in medicine where the patient usually waits for the doctor (Tannen, 1994, p. 221).

One example often given by doulas of what they said during advocacy negotiations is termed the "butterfinger buts"[1]. A "butterfinger but" is a self-protective opener that the speaker hopes will help them try to avoid seeming presumptuous. Examples are: "I don't know if this will work, but…" or "You've probably already tried this, but…" This is a rapport building technique taught to novice doulas when they are working with nurses or problem solving a labor challenge with any medical staff.

[1] Linguist Charlotte Baker first identified these types of statements in 1975, using an analogy with the game of hopscotch. A player does not get penalized for dropping a token by accident if "butterfingers" is called out before it reaches the ground.

Similarly, several doulas spoke of phrasing things gently. One of the Florida doulas, Suzy, gave this example, "I've seen other women do this, check with your care provider and see if it's okay…" Camille, from Long Island, stated previously, "Instead of saying, 'What you should do is,' or, 'What I think is,' you can say, 'Many people have found it helpful."

Lastly, doula participants communicated they were invested in creating cooperation and diminishing polarization. A successful advocacy situation meant that the mother and birth partner were able to get their needs for information met and felt a part of the decision making. It also meant that the status and positive self-image of the physician, midwife, and nurse were also maintained. Even if shared decision making was not their usual model of patient interaction, this situation should still have felt good to them. Physicians may have felt personally or professionally challenged when their orders were called into question by a patient. They may also have become invested in winning what they had framed as an argument. Arguments are frequently encouraged in American culture when there is a conflict, but conflict does not necessarily mean an argument (Tannen, 1998, p.5). Conflict implies a difference in perspectives. Therefore the doula participant's stated goal was to create a situation where both parties seek to understand and listen to one another. The individual doula needed to directly facilitate this listening by restating each parties' concerns to the other. Bringing the focus back to feelings shifts the conversation. As Sonia said, "We're going to do things in such a way that's going to keep everybody happy. We never talk about the doctor when they're in the room, we do all these things to keep it really low-key, so that it never becomes us against them."

Among both groups of doula participants and independent practice client mothers, the doulas seemed to implicitly understand the difficulty of shared decision-making for physicians and adopt strategies to assist in its occurrence. However they also felt vehemently that this shared decision-making model was imperative to empowerment of the mother, a model that many doulas seemed to prefer to a physician having power over the mother's health care decisions. Ideally it was up to the mother what decisions she wanted to be involved in and what she wanted her physician or midwife to decide unilaterally, which differed from woman to woman.

Questions needed to be posed in a way that the questioner emphasized seeking information from someone with higher status rather than challenging that status. When recommendations were being questioned, it needed to be done gradually without a direct challenge. Many independent practice doulas in this study considered these communication behaviors critical enough that they taught them to parents prenatally. They also used a series of prompting behaviors during labor to indicate when to use those strategies. The initial and most commonly utilized strategy was asking if there was time for discussion or "if it is a medical emergency". So the questioner knows that the answer to the medical emergency question will be "no". Thus the answer to the initial question was, "Yes, there is time to discuss it", even if the practitioner did not have the intention of discussing his or her medical orders. From there on, the parents can focus on asking about the risks, benefits, and other options. They may then ask for more time to consider the proposed intervention. By asking for more time, parents were not only stalling but may also have been hoping that the labor progressed to a point where the physician's recommended intervention would not be needed.

Since all doulas in this study were women, their communication strategies cannot help but be influenced by female gender style. Women are known for ongoing negotiation beginning with indirect inquiries and that incorporates feelings of all possible stakeholders. Before a conclusion is reached, there is usually much discussion back and forth. In order to be effective in subtly directing advocacy conversations and coaching parents, doulas needed to be aware of the background of these discussions and how they could subtly exert influence using language and nonverbal communication skills. Specifically this brief inquiry recognized the possibility that doulas recognized multiple frames; built rapport to create solidarity; utilized indirect strategies; successfully sent appropriate metamessages; understood male and female uses of language; recognized physician hierarchies and need for status protection; diminished polarization and argument; and incorporated question asking that emphasized information seeking. While a complete exploration of these ideas is not possible without a directed inquiry and perhaps observation in the labor room, examination of these possibilities leads to the conclusion that further inquiry would be worthwhile.

Independent Practice Doula Care and Hospital-Based Doula Care

The majority of doulas in North America practice independently from any organization or medical care group and have their own business. A smaller group of doulas work for hospitals that provided doula services to their patients (Perez, 2009). One of the more interesting areas to examine has been how hospital-based (HB) doula care differed from independent practice (IP) doula care.

Effective labor support models. An examination of both styles of practice revealed that the models of effective labor support (ELS) for independent practice doulas

and hospital-based doulas were different (see Figures One and Four). Both models valued emotional, physical, and informational support as well as cooperative relationships with the mother's birth team. However, the differing models of care also required different skill sets. Among this study's participants, hospital-based doulas familiarized themselves with their patients very quickly. They established a rapport and adjusted their support strategies in service of the mother's goals for her labor. As part of their ongoing responsibilities, HB doulas needed to work collegially with nurses, physicians, midwives, and other hospital staff.

In the IP doula model, "negotiating relationships" included communicating with nurses, physicians, fathers, and other family members. The HB doula model listed these relationships separately. Another difference was that there were several skills in the HB doula model that would be folded into the IP doula model of effective labor support, such as individualizing care, reading cues, and focusing on the patient. When working with a mother that the IP doula knew fairly well, these tasks would be assumed. A major difference was that the IP doula model of effective labor support included advocacy as an equal function to emotional, physical, and informational support. In this study, advocacy was not considered an important component for hospital-based doula labor support to be effective.

Advocacy and empowerment. In contrast to hospital-based doulas, the independent practice doulas in this study knew their clients prenatally. While developing a rapport with their clients, they assisted parents in discovering their preferred philosophical approach towards childbirth. An analysis of both the Midwest mother sample and the IP doula sample revealed that some mothers were more invested in the

decision-making of their labor, while others wanted their doula to focus on emotional and physical support rather than empowerment. The IP doulas explained that unless they were in rural areas, they had little foreknowledge about the medical staff. The doulas felt they needed to initiate competent communication strategies to create a collegial relationship. One of the main differences between independent practice doulas and hospital-based doulas in these samples was the emphasis on empowerment. The HB doulas did not perceive their clients as interested in empowerment, except for a select few who wanted to "go natural". In contrast, empowerment was the main focus of their doula work for many IP doulas. It is important to keep in mind that it may have had more do with the types of mothers that hospital-based doulas support. The eight hospital-based doulas felt that when the patient wanted to know if there were more options, they gave them information. But most of the patients were not perceived as asking for other options.

Comparing the two parent samples, this feeling was substantiated. Many of the mothers in the Midwest sample were very concerned about getting their own preferences met and wanted their doula to help them communicate those preferences. In contrast only one couple in the Lexington sample, April and Noah, expected that their doula would be able to assist in that capacity. Noah expected that advocacy was primarily his role, not their doula's.

It may also be related to the hospital-based doula being an employee of the hospital. Being an employee may mean that the doula felt constrained in explaining that the mother may have additional options or in promoting the mother's interests. In asking the Lexington doulas this question directly, none of them felt that they were restricted in this way. Naomi stated clearly she did not feel this way either. However, Tracy felt

conflicted especially when it came to issues where she would instruct her independent clients differently than her hospital patients.

Patient versus client. One of the stark differences between hospital-based doulas and independent practice doulas was their choice of terminology. IP doulas always used the term "client" when referring to the mother, where the eight HB doulas exclusively used the term "patient". There could be significance to this word choice in a number of ways. First, these terms could exemplify the relationship that the doula had with the mother. In the hospital-based doula world, the mother was the physician's, nurse's, and hospital's patient. Thus she could be seen as the doula's patient as well. The patient in a relationship is "undergoing the actions of another", which implies passivity. Thus the structure of the relationship as set up by the medical system put the mother in a more submissive position. HB doulas and mothers explained that the mother did not have primary choice about who her doula was; she received care from whoever was on call that day. Her doula provided a labor support service as an extension of the hospital. In addition, the duration of their relationship was defined by the hospital – it had ultimate authority over whether the doula was present or not. Once the mother had moved out of the labor and delivery ward, the function of their relationship was over.

In contrast, the independent practice doula was chosen by the mother because she was a good fit. The mother was an active agent in choosing her doula. In this study, the mothers who chose their independent practice doulas explained that they felt safe with her; they "hit it off right away". She "seemed like someone who could meet our needs". The mother had the ultimate authority on their relationship. She could fire her doula or discontinue her services at any time. Conversely, this meant that the doula had the

experience of being chosen. She was selected instead of other doulas to be present at a significant event and to help achieve their goals. They were hired to provide a service, but this feeling of being chosen or special could also influence their doula-client relationship. Further, the duration of their relationship was open-ended. Many doula participants stated they chose to have closure within a few months of the baby's birth. However some doulas and mothers in this sample did not. Thalia and Delia mentioned visiting with "my mothers" for years after being at their birth. For one of the mothers in this sample, Vanessa, her doula became "my new best friend". Two months after the birth, they still talked on the phone almost every day, and had play dates with both of their children.

Rapport. This study revealed that one of the hospital-based doulas' unique skills was the ability to develop rapport with a stranger. In order to be maximally effective in labor support, the mother first needed to invite the doula to assist her in the task of laboring. As HB doulas explained, they supported a wide variety of mothers. Easing the mother into being comfortable with her presence and share that intimacy was no small task. In a Swedish study, 11 student midwives took a doula training and offered continuous support to mothers when they arrived at the hospital in labor (Thorstensson, 2008). They did not utilize any midwifery clinical skills during these births. Establishing rapport was the main theme, with powerlessness and uncertainty resulting if rapport was not established. Rapport was seen as a "connection of affinity" and the student midwife felt it was essential to making her support effective. She was seen as needing reassurance from the attending midwife, which interfered with her ability to be effective in giving labor support. Her preoccupation with her own emotional state impeded her

effectiveness. According to Thorstensson, mothers felt the doula withdraw and lost confidence in their ability to labor effectively. It was not until after they became more experienced and reflective that student midwives concluded their mere presence instilled confidence in the mother.

Like the Swedish student midwives, hospital-based doulas worked to establish rapport and self-reported that their success often depended on the mother's attitude and desire for assistance. However, they had recognized that their presence made a positive difference even if the mother did not want to interact intimately; over half mentioned this during their interview. One doula study offers support for this view. Mothers were randomized into three conditions during labor: continuous doula support, no doula, and a silent woman smiling in the room. Positive outcomes occurred in the silent woman condition where the primarily Latina population felt she was "like a guardian angel" (Kennell, 1998; McGrath, 2008). The ability to establish rapport with a stranger is a skill that comes with experience. However when it does not occur, the doulas in this study did not become preoccupied with their own emotional response. Instead they continued to focus on the mother and display their belief in her ability.

Emotional involvement with clients. Hospital-based doulas and independent practice doulas displayed different levels of emotional involvement with their clients during their interviews. This was communicated in several different ways. First, pain medication was ubiquitous for hospital-based doulas. The vast majority of their mothers chose to have an epidural. This meant that mothers desiring a natural birth were more memorable to the Lexington doulas. They also perceived these births as providing more of a positive challenge to their skills; they felt more effective (which was the main

interview question). During the interview, there was more excitement in their voices when they told stories that were more memorable to them. Overall, HB doulas did not express a personal loss or feeling of failure when a mother had wanted a natural birth but chose pain medication. However, many of the independent practice doulas did. There was some level of anguish present when the mother was not able to fulfill her goal. Even when the IP doula felt that the mother had not set up the situation properly in order to achieve her goal, the doula still expressed an emotional response during the interview.

Besides responses to pain medication, recalling emotional support strategies also differed between hospital-based doulas and independent practice doulas. The two groups of doulas differed in their storytelling style. As the eight HB doulas told their stories, emotional and physical support strategies blended together. Their stories tightly integrated their support strategies, and in the analysis these segments had to be teased apart from within the same sentence. In contrast, in the IP doula stories, emotional support strategies and physical support strategies were often listed separately or told as separate parts of the story. During analysis, they were easier to separate by groups of sentences.

Another difference was in the type of strategies emphasized by each type of doula. When they were asked to tell me about a time they felt their labor support was very effective, HB doulas most often chose stories where their physical support was primary and their emotional support was secondary. With IP doulas, the inverse was true. A third difference was in the level of emotional involvement with the story or client when the story was being told to me. Overall the IP doulas had more emotional involvement with their effective support stories. Their stories also revealed more

complex emotional support strategies (Gilliland, 2004) compared to the hospital-based doulas' stories. Some of them teared up or commented on their own emotional response during the interview. This was likely due to the independent practice doula's emotional support being connected more deeply to the mother as an individual, and reflecting greater personal involvement in the client's life. Overall the hospital-based doulas expressed less depth of emotion when telling their stories. Because of the lack of previous intimacy, the quality and nuance of their stories felt different to me in the telling, in the hearing, and in the analysis. However, experiences with mothers that the hospital-based doula felt bonded to revealed levels of connection and more complex support strategies similar to IP doulas.

These qualitative differences in storytelling may be due to other factors. There may be regional differences in communication style since the Lexington doula sample is from one concentrated area. However these communication differences were also noticed in Minnesota doulas Tracy and Naomi's interviews. It may also be the sheer number of births that the HB doulas attended; many of them had been to over 300 births; Crystal had attended over 500 births. However, in the independent practice doula sample, there were five doulas who had attended over 200 births. Shenise and Serena had attended over 300 and were notable for their emotional engagement and detail in their stories. At this time, the most fitting conclusion is that it is the nature of the work. Hospital-based doula work required less personal investment over an extended period of time with a mother. There was also less depth in their emotional connection. However this should not be construed as meaning that their doula care was not effective or not helpful; clearly that was not the case. Rather each type of doula practice required a

different level of emotional investment over time. During the day(s) the mother was in labor, the total investment of caring and effort was more similar than different.

Client debriefing. A major contrast in interviewing took place during the interviews of mothers who had independent practice doula labor support and mothers and fathers who had hospital-based doula labor support. In asking them to share and reflect on their birth experience with a doula, I was often cast into the role of debriefer with mothers who received hospital-based doula care. If fathers were present, they also seemed to need this but not with the intensity that mothers displayed. Debriefing has been previously defined as "focusing one's attention on the mother in an empathetic way so that she can talk about her feelings and feel listened to" (Gilliland, 2004). Debriefing differs from qualitative interviewing technique in that debriefing is client-led, and is an emotionally centered process that brings the mother to a place of resolution about what occurred. This never happened in the ten interviews I did with mothers who had IP doula care, even when they felt unresolved or upset about labor events (i.e. Natalie, Gail).

HB doula supported parents also sought to understand what had happened and why labor events had unfolded in a particular manner. Some asked me direct questions which I deflected until the completion of the interview. There was a great deal about the functioning of their bodies and labor that these mothers did not seem to understand that the IP doula mothers did. According to the independent practice doulas in this study, their model of care includes the opportunity to discuss the birth and educate the mother and her birth partner postpartum. The doula was available for continuing emotional support during the days and months following the birth, allowing for a more complete resolution. This study revealed that mother participants displayed different levels of

recall, understanding, and emotional resolution during their interviews. This indirectly shows that the IP doula labor support practice model had likely positively influenced the mother's emotional wellbeing eight to fourteen weeks after the birth.

Fathers and Doulas

This study extends what is known about the paternal experience of childbirth in several ways. Many studies reported that men's experience of childbirth was not only stressful but distressing (Chandler and Field, 1997; Johnson, 2002a, 200b; Li, 2009; Nichols, 1993; Vehvilainen-Julikunen et al., 1998). In the current study, fathers described that they most commonly experienced stress when watching their partner in pain or during a long labor. None of the fathers in this study described feelings of distress. They recounted that their stress level was kept from increasing by the doula's presence and knowledge that their wife had the complete attention of a professional trained to assist in meeting her needs. When men wanted to withdraw and take a break, they were free to do so because of the doula's presence. When men became confrontational in response to incidents with the mother's care, doulas described themselves as intervening and calming the father down. What is most important is that no matter what the father's response, both doulas and fathers described being tended to by the doula. Fathers were also concerned about the wellbeing of the mother. When fathers needed to look after their own emotional state, they said that they knew the mother would not go without support. Fathers in this study reported that they found this aspect of doula care very comforting.

Fathers in Chandler and Field's (1997) and Johnson's (2002a, 2002b) studies reported feeling disappointed in themselves and ineffective in their role as labor support.

Swedish fathers reported strong feelings of helplessness (Vehvilainen-Julkunen et al., 1998). No fathers in this study conveyed those feelings. In fact, many of the men recounted incidents where they felt proud of their contributions and their role in supporting the mother in labor. They attributed their ability to positively support their wives or partners to their doula's facilitation and encouragement. No matter what level of engagement they displayed, men conveyed feeling useful and important in their wife's or partner's labor. No mother in either sample of this study reported any dissatisfaction with the father's level of engagement or labor support involvement. Their complaints were minor, such as Sheena's remark that Ryan kept eating in front of her when she could only have ice chips.

In several studies, men reported their desire for a labor guide and were frustrated that the hospital staff was not able to provide that as they expected (Chapman, 1991; Chandler and Field, 1997). Even though it has been almost twenty years since Chandler's study and thirteen years since Chandler and Field's, staffing ratios and nurse's duties have only increased. Work sampling studies confirm the nurse's inability to perform this role for fathers (Gale, 2001; Miltner, 2002). In the current project, doulas successfully fulfilled this role for fathers. Mothers and fathers in both samples unilaterally exclaimed how important the doula's facilitation of his involvement was for both of them. Mothers with both types of doulas described their partner's contributions using praiseworthy terms. Fathers were able to choose which labor support tasks that they wished to engage in, knowing the doula would take care of what did not interest them. They did not experience pressure from the doula to be more involved than they wanted to be, one of the main complaints from men in Chapman's, Chandler and Field's,

and Johnson's groups. All types of informants stated that fathers were allowed to have their labor support role fluctuate throughout the labor in order to suit their own needs as well as the laboring mother's. Men were able to confide in the doula when they wished to share their feelings or concerns. Several doulas mentioned keeping men's emotional responses confidential, even from their wives and partners. In sum, the doula tailored the labor support experience to meet the father's spoken and unspoken needs so that his experience would ultimately be a positive one (at least for events that were within her control).

One result that did correspond with existing literature was the finding of different paternal levels of engagement in labor support. Paternal levels of engagement were primarily based on the father's level of emotional involvement in the process of support: full engagement, less than full engagement, partially engagement, and disengagement. Fully engaged and less than fully engaged fathers also provided physical support for the mother to varying degrees. Partially engaged fathers were intermittently involved. These categories correspond with Chapman's findings of father's who described their preferred role in labor support as coach, teammate or witness (Chapman, 1991). Coaches were fully engaged with the process, providing primary support and suggesting comfort measures and position changes. Less than fully engaged fathers and partially engaged fathers could be portrayed as teammates, who did not want to be the primary support person but were willing to do some tasks to help the mother cope. Disengaged fathers who were present at the labor seemed to fit the witness role. They wished to provide comfort primarily with their presence and have someone else meet the laboring mother's needs.

In this study, doula support during labor addressed all of the known factors leading to paternal distress and stress listed in the literature. Doula care reduced the mother's experience of pain and discomfort, which was the leading cause of paternal distress. Doula care was also focused on fathers, which successfully increased their level of satisfaction. Fathers received guidance, support for their efforts, and assistance in their support activities. In addition, they possessed the knowledge that the laboring mother was the focus of a trained and compassionate professional's continuous care. Because of this, the father was free to focus on his own experience of the mother's labor and his child's birth as he wished to.

Caregiving and Careseeking Behaviors

Doula care provides a unique opportunity to closely examine the caregiving behaviors of doulas. From an attachment perspective, the doula can be seen as responding to the need of another by providing social support and care (Feeney & Collins, 2004). Mothers taking on the challenge of labor can be seen as needing a secure base to rely on during the process. In this study, participants describe events in a way where labor and birth fit the definitions of an exploration-type activity requiring a secure base rather than a distressing event requiring a safe haven. While women vary in their concerns regarding childbirth, in general only a small minority anticipate it as a distressing or threatening event (Soet, 2003). Most women conceive of childbirth as a challenge they will need to meet and develop different philosophies of approach (Davis-Floyd, 2001; Fenwick, 2005; Hauck et al, 2007). Mothers with both types of doulas expressed that their expectations of birth were in alignment with a challenging experience rather than a distressing or

dangerous one. Granted, these expectations were recalled after the birth had been experienced.

Exploratory behavior that requires a secure base involves "going out" from the relationship for autonomous exploration of the environment (Bowlby, 1988; Feeney, 2004). Mikulincer states, "This behavioral system is activated whenever people encounter novel or unexpected stimuli, or conditions that challenge their knowledge, beliefs, or actions" (Mikulincer and Shaver, 2007, p.225). According to Feeney, "the attached person can make excursions into the outside world (to play, work, learn, discover, create, make new friends) knowing that they can return for comfort, reassurance, and assistance should difficulties be encountered along the way" (Feeney & Van Vleet, 2010). Both of these statements offer a frame for the perspective that laboring is likely an exploratory activity for the mother.

The challenges of labor were seen by study participants as difficult tasks but not insurmountable ones. They were stressful but not necessarily distressing. When the laboring mother experienced a setback, the secure base provided a place from which she could gain reassurance and assistance. For example, when a contraction was particularly strong or painful the mother had to initially cope with the bodily sensations by herself. However, once it was over, the doula was available help her to relax, connect with others, remind her of her resources, and refocus to meet the next contraction. Fathers fulfilling the partner role who were fully engaged with labor support also seemed to fulfill this function.

The attachment system is also activated when a person is "frightened, ill or in unfamiliar surroundings" and "seeking protection and comfort" from a person who can

provide a safe haven (Collins & Feeney, 2000). People have different thresholds for when a safe haven is needed (Feeney & Collins, 2004). The safe haven responds to another's significant distress in order to restore felt security and alleviate distress (Feeney, 2004). A distressing event may occur for some individuals during labor that requires a person to respond as a safe haven. For example, a mother who has a medical crisis or fears for her baby's life may feel great distress. During labor, the attachment system of the mother is already activated to seek a secure base. Needing a safe haven would be an acceleration of the attachment system response due to acute distress. The mother's attachment figures, such as her partner or family member, in concert with the doula may provide a safe haven. Overall, the anticipation and commencement of labor fit the definition of an exploratory activity better than that of a threatening event.

Doula's working models of caregiving. Caregiving is a dyadic process that involves one person's careseeking efforts and another person's caregiving responses. Caregiving behaviors that are interpersonally sensitive and congruent with the careseeker's needs can be perceived as supportive, whereas insensitive and unresponsive behaviors are deemed unsupportive (Collins & Ford, 2010). According to Collins, delivering supportive care is dependent on the provider's working model of caregiving. This working model is composed of three factors: the caregiver's skills and abilities; resources; and motives. These factors are thought to be linked, developmentally and behaviorally, to working models of attachment (Collins & Ford, 2010).

This study has helped to reveal the doula's working model of caregiving. In figure three, the hospital based doula model of effective labor support lists the processes involved in providing care. Many of those processes could be seen as examples of the

doula's internal working model. The skills and abilities that fit both criteria are: getting to know the mother quickly; establishing rapport; providing emotional and physical support; and relating to her partner, significant family members, and medical careproviders. Collins defines resources as encompassing cognitive and self-regulatory resources (Collins & Ford, 2010, p. 238). In this way, focusing on the patient, individualizing care, and calm presence may fit into the doula's working model of caregiving. The third component, motive, may be revealed as belief in the mother. Motive is seen by Collins as encompassing altruistic motivations. Many of the hospital-based doulas felt that their doula work was a calling and it met their life's purpose. Many independent practice doulas felt that doula work was what they "were made to do". They made personal sacrifices in order to be a doula. Some stated they wanted to do doula work regardless of whether they were paid or not. These statements expressed altruistic motivations.

Fathers as caregivers during their partner's labor. Fathers usually desire to be present during their partner's labor but may feel pressure to be present or uncertain about their role (Johnson, 2002b, Nichols, 1993). They may not act in accordance with their own expectations or feel challenged to support their wife or partner in the way she most needs (Chandler and Field, 1997). In this study, several fathers revealed they felt uncertain about their ability to meet their wife's needs and were glad the doula was there to guide them. While some fathers were confident in their partner role and fully engaged in the process of labor support, they were in the minority in this sample. Both independent practice doulas and hospital-based doulas agreed that the majority of the fathers they interact with at births lack confidence in their abilities and are not fully

engaged with labor support tasks. This may be the reason why the mothers and fathers agreed to a doula's services, but what is more interesting is to explore the possible reasons behind father's labor support behaviors and emotional states.

Cultural expectation. It has been stated previously that American cultural expectations have changed within the last thirty years. Fathers are expected by the demands of popular culture to provide principal labor support with little preparation to do so and denial of their own emotional needs. Most independent practice doulas in this study concurred about the father's lack of preparation, but they still felt their role was to advocate his primary support role. Some IP doulas in this study called this assumption into question and stated that during the prenatal period they routinely ask men to define for themselves what they want and need. Hospital-based doulas made statements that made clear that they do not hold this assumption; in their experience fathers act in varying levels of interest and involvement with labor support. Fathers in this study affirmed that they felt relieved by the hospital doula's presence and free to choose their role and level of interaction. The doulas felt they accepted his desired level of interaction. So the first explanation for the father's labor support behaviors as not being the primary support person is that he rejected the cultural notion that he ought to.

Paternal attachment style. A second influence on father's involvement in labor support may be his attachment style. In intimate relationships it is a normative expectation that one's marital or significant life partner would provide secure base and safe haven functions. In an exploration of caregiving behaviors and relationship processes, Feeney and Collins (2001) concluded that partner attachment styles directly affect their abilities to appropriately give care to a stressed or distressed partner. In

addition, attachment styles directly affect the ability to seek and receive care from one's partner. Thus, attachment style is a part of an adult's working model of attachment and caregiving. Therefore, fathers who have an insecure attachment style may not provide social support that is consistent with the laboring mother's cues or that is unresponsive or controlling (Feeney & Collins, 2001). Male partners who have a more anxious attachment orientation may desire to be highly supportive but be unable to do so effectively (Simpson, 2010). While there is no direct evidence of paternal attachment style in this study, some fathers were concerned about their caregiving abilities. Independent practice doulas reported that fathers sometimes hired them to care for their partners because they did not feel they could do a good job. In another example, Landon, a father in this study stated, "I don't like taking care of people that are sick. I don't like dealing with ill people. I just don't." This statement reflects his beliefs and expectations of caregiving, which in turn affects his actions. These are components of an internal model of caregiving.

Stress and paternal caregiving. Even if a man has a secure attachment style and an internalized working model of caregiving that would allow him to effectively meet his intimate partner's careseeking needs, he may still have difficulty. His wife or partner's labor is a unique situation. She is having their baby, another person he is uniquely and intimately connected to. Many mothers feel pain in labor which male partners find distressing (Nichols, 1993; Vehvilainen-Julkunen, 1998). He may struggle to alleviate her discomfort and find himself ineffective. Even if the laboring mother is coping well, the father may find the situation stressful and anxiety producing. Because of this, his

own attachment system may be activated. As Collins points out, caregiving may be impaired if a caregiver is feeling insecure.

> "In addition, because an intimate partner is both a target of care and a source of one's own care and security, caregiving behavior may sometimes operate in the service of current attachment needs; and these needs are often incompatible with good caregiving (Collins & Ford, 2010)."

In other words, fathers may act in ways that alleviate their own insecurity and address their own emotional state rather than in ways that attend to the laboring mother's needs. Both hospital-based and independent practice doulas gave examples of fathers who acted in ways that weren't helpful to the mother but that were not necessarily detrimental. As an example, doula Doris mentioned a father who would say, "You're doing great, dear", when it seemed to have nothing to do with what the mother was doing. It may be that it alleviated his anxiety to remind himself she was doing well.

Men also respond differently to stress than women do. When under stress, men often prefer to confront or withdraw (Everley, 2002; Tamres, 2002). These are considered diluted forms of the "fight or flight" response to threat. The response depends on the nature of the stressor. If there is a realistic chance of reducing the perceived threat by confronting it, this strategy is usually employed (Tamres, 2002, Taylor, 2000). In this study, men who were acting in the protector role may have been employing a stress response to a perceived threat. Many of the participant's examples of protector role behavior were connected to situations that could easily be considered stressful by the father. For example, Noah described himself as protective when he and April arrived at the hospital, clearly stating that they did not want a lot of routine interventions. Later when she was eating and drinking during labor, he described the staff as trying to scare

her or intimidate her. He felt that he needed to be very clear that they disagreed with the hospital's policy.

Another common male behavior response to stress is withdrawal. This strategy is more often employed when the circumstances are ongoing and unlikely to change if dealt with directly. Men who habitually withdraw in order to cope with stress and who find the labor stressful may need to be less vital to the laboring mother's coping strategy and take frequent breaks. Lower levels of engagement with labor support may be a withdrawing behavior. Several fathers in the partially engaged group described their feelings of discomfort with being present and desire to withdraw. Although he did give examples of helping his wife during labor, Peyton stated that he felt more comfortable sitting and watching from across the room. In addition, utilizing withdrawal strategies during stress may explain why men who had high prenatal expectations of their involvement in giving support are actually less involved during labor. Independent practice doulas and IP doula mothers both described this particular situation. Men's need to cope with their own emotional and physiological responses of stress may mean that they utilize a familiar coping strategy, especially in the absence of comfort from their partner.

Tending and Befriending During Labor

Female responses to stress are different than male coping strategies. When experiencing stress, women are often more likely to tend to other's needs or to seek out others for support (Tamres, 2002; Taylor, 2000). If possible, women will seek social support from other women (Taylor, 2006). According to Taylor, women are evolutionarily programmed with a biobehavioral response to others in need. They are more likely to tend to their needs and to create social alliances in order to reduce the

careseeker's feelings of stress, in other words to "tend and befriend". Additionally, it does not matter whether the person in distress is familiar or a stranger. If the need is present and the situation is safe, women usually respond in this way.

Tending and befriending behaviors are closely linked with oxytocin and estrogen levels in women but exactly how the mechanism works is unclear (Campbell, 2008; Leng, 2008). What is clear is that women produce oxytocin in response to stress, and oxytocin is also produced when women receive tending behaviors from others in order to alleviate stress. Even in non-stressful situations, oxytocin is produced when people touch one another. Since oxytocin-related processes govern labor contractions and labor progress, the role of oxytocin in labor support interactions becomes even more intriguing. Tending behaviors that involve touch would increase oxytocin levels in both the receiver and the giver. Doula support incorporates many tending behaviors. Doulas soothe, groom, massage, touch, and offer emotional support with their eyes, hands and words (Gilliland, 2004). Comfort measures are designed to reduce pain and tension, which in turn reduces mother's stress. Doulas utilize rapport-building strategies to create relationships where none previously existed. A doula also directs befriending behaviors towards the mother's family and her medical caregivers. These behaviors have the potential to decrease stress for people in the labor room.

The need for tending and befriending may be the initial reason a mother seeks doula support for her labor. Women expand their social networks in order to increase the level of social support resources available to them in response to perceived stress (Taylor, 2000). During pregnancy a mother may be forecasting that she will need tending during her birth experience, and seeks out a doula to befriend her. Alternately, a mother may

arrive at the hospital and request a doula. In this study the reasons mothers gave for having a doula during labor fit their desire to be taken care of. Over half of the mothers positively affirmed the importance of having another woman present "who had been there" or "who could understand what I was going through". HB Doula Sadie commented that a woman's touch is different than a husband's or lover's touch during labor. The mother may "relate to father more sexual than nursing". With the overlapping roles of oxytocin in female stress relief, labor, and lovemaking, her thesis may have some merit. Oxytocin secreted into the brain from one section of the hypothalamus, as it is in response to tending and befriending behaviors between women, causes different behavioral responses than oxytocin released directly into the bloodstream (Leng, 2008; Neumann, 2008). Plasma oxytocin comes from another part of the hypothalamus and takes 30 minutes or more to reach the brain. The father may not have a sexual intention with his touch, but the mother's body may receive his touch differently than the tending touch of the doula.

Doulas may also tend and befriend fathers. When fathers are in the labor room and become stressed, their attachment systems become activated. It is likely that men give off behavioral cues of their internal state. Since part of the doula's internal working model of caregiving is to pay attention and relate to the father, the doula is quite likely to initiate a tending or befriending strategy. Consistently, doulas, mothers and fathers in this study reported that the doula took care of the father's needs during labor. She accepted his responses without judgment and provided emotional reassurance in a number of ways.

The relationship between tending behaviors and oxytocin levels is clear and well substantiated (McDonald, 2010; Taylor, 2006). When the stressful circumstances are reduced the careseeker feels better as a result of the increased oxytocin. The female caregiver may also have increased feelings of wellbeing and a more positive emotional state as a result of her increased levels of oxytocin (Campbell, 2008; Grewen, 2005). Over time, this reward for tending and befriending may become part of the motivational component of a doula's internal working model for caregiving. Even though it is physically and emotionally demanding work, many doula participants focused on the intrinsic rewards of providing doula care.

Taylor makes the point that over time, the oxytocin governed behaviors of tending give way to neuromechanisms that underlie the attachment-caregiving system (Taylor, 2002, 2000). From an evolutionary perspective, displays of tending behaviors in response to stress parallel the behaviors of mothers tending to their infants. Befriending behaviors are considered to have adapted from this system. Because of this, the same neuroendocrine mechanisms are thought to be responsible for attachment related behaviors and tending and befriending behaviors (Taylor, 2000). In Taylor's point of view, these related systems connect attachment caregiving and tending and befriending behaviors.

Moderating Effect

The doula's supportive care of the mother and father during labor may contribute to the mother's perception of paternal caregiving. First, attachment based caregiving has a regulating effect on the emotional state of the recipient (Diamond, 2001; Sbarra, 2008). Mothers and fathers in this study experienced this when they were calmed by the doula's

presence or felt their emotional intensity lessening in response to her actions. Second, when doulas positively facilitated the father's involvement with labor support, they had a direct influence on the amount and effectiveness of his caregiving behaviors. This increase in the amount of effective paternal caregiving behaviors may positively shift the mother's perception of him as helpful and supportive. In the immediate time frame, due to this responsive care the mother may experience a decrease in her stress level and an increase in felt security (Kane et al, 2007; Collins & Ford, 2010, p. 242).

A third way that effective doula support positively shifts maternal perceptions of paternal caregiving is through communicating information about the mother and the events of labor to the father. In a recent study, Kane showed that careseekers are highly attuned to non-verbal signals of their partner's responsiveness during stressful situations (Kane et al, 2007). Careseekers whose needs were tended to effectively used their resources to focus on the task before them. However, careseekers whose partners were neglectful or unresponsive continually monitored their partner for signs of responsiveness which may have "consumed resources needed for the task". Careseekers may also withdraw over time and become anxious. In other words, effective caregiving results in the careseeker being able to focus all resources on coping and completing their task. Ineffective caregiving results in the careseeker continuing to use resources to seek assistance and is diverted from the task, which can lead to a cycle of accelerating stress and anxiety (Collins & Ford, 2010). In the present study, informants stated that when the doula was an effective caregiver and facilitator of paternal involvement, the mother was able to focus on laboring. They described the doula as communicating the mother's needs and emotional state to the father if he was unable to perceive it correctly. In this

way the doula eliminated the burden on the laboring mother to explain how she felt and what she needed, as the doula interpreted this for her. Fathers then expressed that they were then able to indicate their responsiveness, and communicated empathy and understanding of the mother's experience.

Collins also defined "perceived partner responsiveness", which is an internal working model of a specific relationship that defines whether the relationship partner is seen as someone who can be an effective responder in a time of need (Collins, 2010). In this case, mothers who projected that the father might not be as helpful as they needed in labor hired a doula prenatally or planned on having one provided by the hospital. Mothers with both kinds of doula care stated that when they had this perception of their husbands it was a motivating factor in seeking out a doula.

The positive consequences of the doula's labor support effectiveness may be to increase positive feelings of the mother about the father's involvement in labor support. Without exception, the fathers in this study stated that the doula increased their understanding of their partner's experience as well as their effectiveness in helping their wives and partners. Mothers with both kinds of doulas reported that they felt their doula increased their husband's effectiveness. (The only exception was Marilyn, who was having her third child with her husband but with a doula they had never met before.) In this way doula care may have a positive effect on how partners perceive one another and on their couple relationship.

A Theoretical Model Of Doula Support Processes and Effects

Introduction. At the end of the Results chapter, a revised model of effective labor support by birth doulas was presented. It incorporated all of the findings from both my

thesis project and this dissertation. (See Figure 7.) After consideration of the possible theoretical connections made in this discussion chapter, an expanded model has been developed. This expanded model incorporates the ideas of internal working models of attachment, biobehavioral stress, intrapersonal processes, and robust analytic codes that were not included in this dissertation due to time constraints.[2] The model should look familiar, as it overlays new graphic representations to what has already been shown in Figure 7. Because of the increased complexity, this model is displayed in one table and one figure. Table 14 shows the intrapersonal processes of each individual and Figure 8 connects all of the labor support processes, effects, and outcomes into a coherent pathway.

Description of the Model. First, Table 14 shows the Intrapersonal Processes that each person involved in labor or labor support brings to the interaction. At this stage of research, the people identified as involved are the mother, the father (her partner), and the birth doula. The intrapersonal processes of each of these individuals is identified by a unique stick figure. The intrapersonal processes that the mother brings to labor support interactions are her individual internal working model of careseeking and biobehavioral response to stress. These parts of her own personality will influence how she seeks and accepts support from her partner and her doula. The father's intrapersonal processes include his individual internal working models of caregiving and careseeking, plus his own biobehavioral response to stress. These elements will influence his ability to meet the needs of the mother for support, as well as to seek to withdraw or seek assistance if he feels stress or his own attachment system is activated. The doula possesses her own

[2] See the Future Directions section of this chapter.

internal working model of caregiving to support the mother and the father in labor; and her own biobehavioral response to reducing the stress of others. The doula may also feel stress during labor, but will primarily be using this stress relieving system to care for other people. In addition, the doula also brings a philosophical orientation to her labor support which influences her satisfaction with being a caregiver for this family. She also incorporates her own experiential knowledge through the use of implementation strategies. These strategies help the doula to choose the labor support technique

Table 14.

Intrapersonal Processes Influencing Labor Support Interactions

Intrapersonal Processes	*Mother*	*Father*	*Doula*
Internal Working Models	Careseeking	Careseeking Caregiving	Caregiving
Biobehavioral Responses to Stress	Seeking Tending and Befriending	Seeking to confront or withdraw	Soothing by Tending and Befriending
Doula's Philosophical Orientation:			Empowerment or Emotional Support
Individualizing Labor Support Strategies		Knowledge Possible	Implementation Strategies
Individual Processes Represented Graphically:			

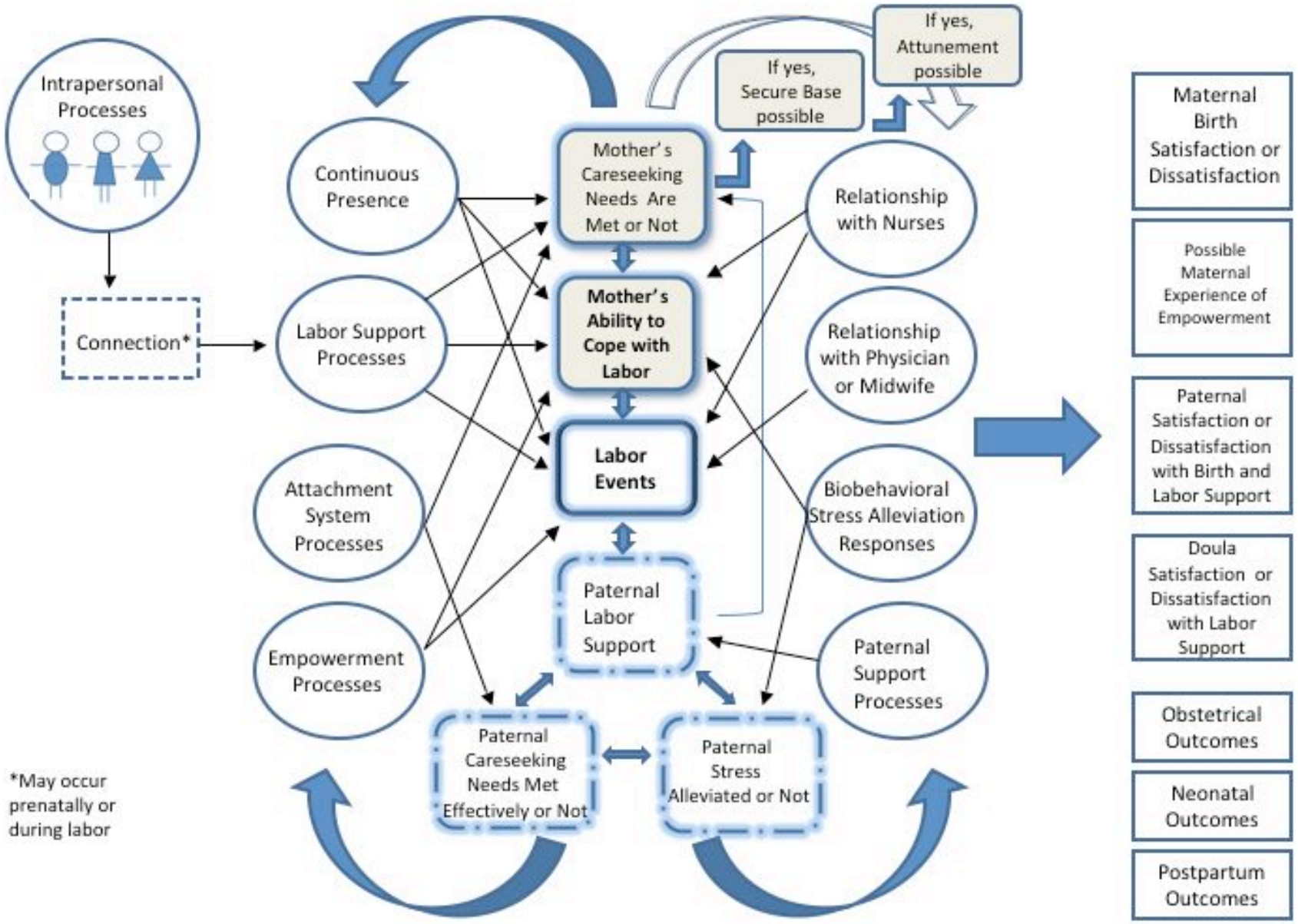

Figure 8. *Feedback Loop of Doula Support Processes and Effects During Labor with Postpartum Results*

that is the best fit for an individual mother.

Another possible influence on internal working models of caregiving and careseeking in individuals is the person's attachment style (Collins and Feeney, 2006). However, data directly supporting attachment style was outside the scope of this inquiry. It is important to emphasize that all of these intrapersonal processes are part of the individual person that he or she brings to the first meeting between the doula and the mother and father. That meeting may occur during the pregnancy or during labor, depending on whether the doula is their regular independent practice doula, her backup doula, or a hospital-based doula. The Intrapersonal Processes of the Mother, Father, and Doula are symbolized as stick figures and are placed on the far left in Figure 8.

These Intrapersonal Processes influence the first meeting and the development of "Connection". Connection is theorized to be the first process involved in effective labor support.[3] At this time, connection is thought to be an interpersonal process between the mother and the doula. It seems to be strongly influenced by the mother's interest in being supported and openness towards the doula. It may be occurring at a range of levels from a feeling of "very connected" to "not very connected" to "unconnected". Connection is thought to begin at the doula and mother's first meeting. If the mother has hired an independent practice doula, it may or may not change during the prenatal process. Connection is also important when a mother and hospital-based doula meet. Currently, it is unknown whether a feeling of connection between mother and doula has a strong or slight influence on the effectiveness of labor support processes. However, connection

[3] Connection arose as a significant concept between doulas and mothers, but was unexplored due to time constraints for this dissertation. More detailed information about connection is supplied in the Future Directions section of the Discussion chapter.

deserves to be included at this time because it was mentioned so often by mothers, fathers, and doulas as part of the labor support experience.

The next sequence of processes is illustrated in a complex feedback loop in the center of Figure 8. On the outside of the loop are eight interactive processes that take place during labor, birth, and the first few hours postpartum. These interactive processes have been identified separately but they take place simultaneously. There is a feedback cycle between the instigating processes on the outside of the loop and the observable effects of those processes on the inside of the loop. Each of the processes are indicated by a separate circle or diamond graphic. They all involve the doula as well as one or more other people, as they are interpersonal processes. When the doula, mother, or father experiences or observes the results, it affects the continuing administration of those processes. These results or effects are indicated by rectangles in the center of the processes. Each of the processes is connected to the observable effect it may have by an arrow. The ongoing influence of the results in the center are indicated by large arrows pointing back to the process circles on the outside of the loop. These processes will eventually cease when the doula leaves the mother and father, usually several hours after birth. The next section explains each of the processes first and then the effects.

Starting on the upper left of the feedback loop, the initial condition for all doula support processes is the doula's Continuous Presence. Being available when needed has been shown to be an important part of providing appropriate caregiving (Collins and Feeney, 2006; Bowlby, 1982, 1969). In addition, continuous presence is one of the only factors involved in the doula's care that has been shown to be reliably responsible for any

positive obstetrical outcomes of doula care.[4] Thus it has the initial location on the process portion of the model.

The next circle is labeled Labor Support Processes. These include the emotional support, physical support, and informational support strategies used by all doulas. It also incorporates the additional strategies identified for hospital-based doulas in Figure 5. In addition, the implementation strategies used by more experienced doulas in deciding what techniques to use with each mother are included (See Figure 1 or 4). Empowerment processes, while a part of labor support for many independent practice doulas, are separate since they are not utilized by all doulas. Labor support processes involve the doula and the mother. The father is involved when he is also engaged in labor support of the mother. If another family member, friend, nurse or midwife is also involved with hands-on labor support, they would also be included in the doula's decision making regarding labor support strategies. In the center effects column, Labor Support Processes influence the Mother's Perception of whether her Careseeking Needs Are Met, the Mother's Ability to Cope With Labor, and Labor Events.

The third circle identifies the Attachment System Processes. These encompass the doula's response to the activation of the mother's attachment system and her desire for support in the exploratory activity of labor and giving birth. This circle indicates the doula's use of her own internal working model of caregiving to meet the Mother's Careseeking Needs. If the father's attachment system is also activated, the doula may also provide caregiving support for him. This is symbolized by the arrow pointing to Paternal Careseeking Needs. If labor support is effective, the mother and father's internal

[4] See also Chapter One: Overview of the Research for a review of continuous support during labor.

working models of careseeking are a good match for the doula's internal working model of caregiving. According to the current elucidation of my theory, if a particular event precipitates a need for a safe haven, the mother is likely to seek additional supportive care from the father who is an identified attachment figure. This circle also represents those processes. It is important to reiterate that all of the circles on the left side of the support loop actually support the attachment system processes. As outlined in Table 3, empowerment processes, labor support strategies and the doula's continuous presence all contribute to the mother's perception of the doula as a secure base, which is an attachment process. Those relationships are implicit by the clustering of these circles on the left side of the feedback loop. The interaction between each of the individuals' internal working models is highlighted by the Attachment Processes symbol in Figure 8.

The fourth circle identifies the Empowerment Processes, which doula organizations usually identify as advocacy. However, the process itself has to do with empowerment of the mother and the parents by the doula. (The term advocacy is not used as an identifier in this model so that it is not confused with more prevalent meanings of the word advocacy from other professions.) The doula, mother, and potentially the father are involved in the empowerment process. Empowerment Processes affect the Mother's Ability to Cope With Labor and Labor Events.

Moving to the right side of the feedback loop, the next two of the doula's processes that contribute to effective labor support are identified as developing and maintaining a collegial Relationship with Nurses and developing a collegial Relationship with the Physician or Midwife. These processes remain an area for future exploration, hence they are outlined in dotted lines. However, all types of participants in this study

acknowledged that these relationships may be an influencing factor on the doula's effectiveness and satisfaction. Participants in this study also alluded that these relationships may positively or negatively influence Labor Events. This process involves the doula and the nurse, and the doula and midwife or physician.

The next processes identified are the Biobehavioral Stress Alleviation Responses. These processes include interactive strategies initiated by the doula to alleviate stress in both the mother and the father if needed. In women, Taylor has identified a female behavioral response to stress of tending to others' needs and seeking affiliation with others, colloquially called "tend and befriend" (Taylor, 2001, 2006). Not only do women tend and befriend when they are feeling stress, but also when exposed to another person's stress responses. Men exposed to stressors of long duration have a strong tendency to withdraw, although they may also choose a confrontational approach (Everly, 2002; Tamres, 2002). The doula's involvement with this process would be to tend and befriend the mother as well as the father. It would also incorporate sensitive support for the father's potential need to withdraw or confront. In this way, these strategies could overlap slightly with the doula's Paternal Support Process and Attachment System Process behaviors. Biobehavioral Stress Alleviation Responses directly affect the Mother's Ability to Cope With Labor and whether Paternal Stress is Alleviated or Not.

The last graphic in the outer process loop is the diamond representing Paternal Support Processes. This graphic encompasses all of the roles, processes, and influences identified in Figure 6, the Diagram of the Father's Birth Experience With A Doula. The support received by the father from the doula directly influences his continuing

involvement in supporting the mother in labor. This is the only direct link to Paternal Labor Support of the Mother.

To review, the outer loop contains graphics representing eight interpersonal processes. Each of these processes is occurring simultaneously. Some of them may overlap, and some of the doula's actions may serve dual purposes. All of these processes are taking place while the doula is with the mother and father during their labor, birth and postpartum experience. All of these processes have effects, and when those effects are observed by the doula, they in turn, then affect how the processes take place. This continuous feedback loop persists until the doula and parents part. The next few paragraphs discuss the center column of effects or results, which are represented by six rectangles in Figure 8.

The primary effect of the doula's efforts is on the Mother's Ability to Cope with Labor. While the Mother's Coping Ability has other influences, it is the central focus of all the doula's activities. The next effect of the processes is on the Mother's Careseeking Needs. Her individual careseeking needs are indicated by the mother's internal working model. What is significant is the mother's own perception of whether her careseeking needs were met or not. There are two possible additional outcomes, each represented by their own graphic. If the mother perceives her careseeking needs as met by the doula, the doula could then be seen as functioning as a Secure Base for the mother during labor. If the doula is serving as a Secure Base for the mother during labor, Attunement may occur. If perception as a secure base or attunement transpires, it then positively reinforces the mother's careseeking needs as being met, which positively affects her Ability To Cope With Labor and Labor Events. This is indicated by another small arrow. Labor Support

Processes, serving as a Secure Base, and Attunement are all parts of the previous incarnation of the Effective Labor Support Model, shown in Figure 1, and in the revised model shown in Figure 7. In the current figure, there are additional support processes that join and elaborate on that revised model. However, the link between effective labor support, meeting maternal attachment needs by serving as a secure base, and attunement remains unchanged.

In the middle of the diagram is the effect box for Labor Events. Labor events include memorable emotional and physical incidents as well as labor progress indicators. One of the main areas of interest fueling this inquiry was to identify the processes that were likely to have an effect on obstetrical and neonatal outcomes. Obstetrical outcomes are the result of labor events and the interventions utilized to treat them. When a doula is utilizing a particular strategy in order to gain a particular effect, it can be considered an intervention (Simkin & Ancheta, 2005). In a common example from this study, if the mother was not progressing in dilation, the doula utilized physical support strategies such as upright positions to encourage progress. So as the doula paid attention to the results on labor events of her initial labor support processes, it provided feedback to further influence those processes. Some doulas and mothers mentioned that the doula's relationship with a physician may be responsible for the physician deciding not to routinely offer medication or break the mother's bag of waters. At other times, empowerment processes may encourage the mother to speak up against another vaginal exam or other procedure. In these ways, different processes affect Labor Events, which may affect overall outcomes.

The next series of three interconnected rectangles portray the effect of the processes on fathers. Each of these effects likely closely influences the other two, hence they are joined in their own small feedback loop. The central effect on father's behaviors is the Paternal Labor Support of the Mother. The current study revealed that his labor support behaviors are based on his chosen roles for himself and a preferred level of engagement with labor support activities. The mother and father's labor support relationship usually started before the doula entered the birth room. Both Labor Events and the doula's Paternal Support Processes directly influence the father's involvement in labor support. His stress level and need for support and reassurance may also have some bearing on his labor support activities. The two remaining results are the Paternal Biobehavioral Response to Stress and the Paternal Need for Careseeking. Either of them may or may not be responded to effectively by the doula independent of the other. At this time, it is unknown whether careseeking and stress are separate or similar processes. For example, when a father feels fear it is likely to elicit a need for careseeking, but fear also causes stress. More research is needed in order to elucidate the differences, if any, between these responses. The last notable relationship is the contribution of Paternal Labor Support of the Mother on whether the Mother's Careseeking Needs Are Met.

This large feedback loop of processes and effects continues to cycle and influence one another until the mother, father, and doula separate, which according to our participants, usually occurs several hours after the baby is born. This brings us to the far right of Figure 8, the Outcomes column. Results for the Mother can be a Satisfactory or Unsatisfactory Birth Experience and the possibility of a Maternal Experience of Empowerment. Mothers seemed to view these experiences separately so they are seen as

separate outcomes. Results for the Father are shown as a Satisfactory or Unsatisfactory Birth Experience and a Satisfactory or Unsatisfactory Labor Support Experience. These two items are listed as separate outcomes because fathers in this study spoke of them separately. While their experience with labor support influenced their birth satisfaction, they did not consider these parts of the experience to possess the same meaning. Results for the doula can be either Satisfaction or Dissatisfaction with her Labor Support Experience, which may depend in part on her philosophical orientation towards labor support and experience as a doula. This area needs further exploration in order to be defined with confidence.

The last three items are Obstetrical Outcomes, Postpartum Outcomes and Neonatal Outcomes. The research question that fueled this inquiry was a desire to outline the labor support processes that likely affected these outcomes and resulted in "the doula effect". Several significant and important processes have been identified in this grounded theory study that are likely contributors to the positive outcomes for mothers, babies, and families. The literature review provided previously used examples of research on each of these outcomes. Obstetrical outcomes might include the use of pain medications, Pitocin augmentation, operative delivery, and cesarean section. Neonatal outcomes might include initiation and length of breastfeeding, and babies' abilities on developmental scales. Postpartum outcomes could consist of satisfaction and confidence in parenting, postpartum depression, and feelings that one's baby is "better than the average baby" (Wolman, 1993). *Discussion*. Figure 7 illustrates effective labor support based solely on findings from this research project. The main changes from that diagram are that this illustration elaborates and adds theoretical information and proposed relationships. This

current graphic displays all of the potential relationships and behaviors that may influence outcomes at our current level of knowledge. It offers perspective on what areas to explore next. The drawback of this diagram is that it does not show which of these intrapersonal processes or intermediate results of the feedback loop are the most significant for a particular outcome. It does illustrate the connections, but it does not show the relative importance of a particular connection.

It is interesting to note that all of the maternal labor support processes can be related to attachment results and outcomes. Another point is that this model keeps perception of the doula as a secure base and attunement within the time period of labor rather than as long-term outcomes. They are seen as results of initial labor support processes that become processes themselves that continue to have an ongoing influence on labor support. Additionally, the model simultaneously connects the father's experience of childbirth to the mother's while also distinguishing it as separate. The father's processes and effects are intimately connected to one another, which co-occurs with the mother's experience of being supported and coping with labor. Lastly, outcomes were reserved for measurable variables that had already been utilized in past research or could easily be incorporated into future research.

However the most significant impact of this model is that all of these processes are instigated and maintained by one person – the birth doula. While birth doulas in this study practiced effective labor support, the deeper meaning of their skill seemed largely unknown to them. For the most part, doulas revealed they were not conscious about why they do what they do. Their actions make sense to them, they are the "right thing" to do in a labor support situation. It is this automatic activity of soothing and speaking calmly,

of touching and smiling, of being alternately indirect and direct yet always appropriate, that actually offers strength for this model's suppositions. According to these theories, appropriate responses to another's stress and appropriate caregiving are automatic responses when the giver has psychologically healthy internal working models. Only effective caregivers would last as doulas, whether they are hospital employees or self-employed business owners. That doulas in this study were unaware of these processes but they were uncovered upon detailed painstaking analysis of their stories, seems to support these ideas.

Limitations of the Study

There are several limitations to the present study. One important limitation is the small sample size, especially for the hospital-based (HB) doulas. Although the eight HB doulas were from two different programs, six of the HB doulas were from one location and one hospital program. Because of the call schedule during the six weeks of participant recruitment, nine of the 16 mothers had care from the same doula (Eleanor). But two of the nine had previous births with a different doula. Further sampling was not done during the axial coding process, and sampling was discontinued before saturation was reached on all pertinent concepts. That was done so that this dissertation could proceed, which allows these concepts to be explored in future research. A diversity of doulas from different programs and regions would strengthen and extend the model of effective labor support.

In addition, there was no corresponding sample of fathers who had chosen independent practice doulas for the mother's labor support care. The voices of these men may further illuminate concepts relating to advocacy, empowerment, and fathers'

experiences of labor support with a doula. Members of the mother and mother-father samples were economically diverse with varied education backgrounds. However, the majority of people in both samples were Anglo-American. Another distinguishing factor is that participants chose to have a doula and were satisfied with their doula support experience. Mothers and fathers in the Columbia, South Carolina sample were recruited by their doula at twenty-four hours postpartum. Parents who chose not to be contacted about the study may be different from those who consented. Of the 27 parents who responded, 11 were unavailable to be interviewed (for various reasons), which may influence the results. Also, IP doula supported mothers were recruited through doula networks, which may create a positive bias. Further, it may be that parents who choose not to have any type of doula care have different perceptions of their needs during labor.

As a condition of inclusion in the study, the mothers experienced normal births without a crisis that threatened their health or their baby's health. Thus, applying the conclusions reached in this study to mothers and fathers expecting premature babies or high-risk labors should not be done. . In addition, doula participants in this study could not use any clinical obstetrical or midwifery skills in their doula practices or other professional or personal roles (e.g. listening to fetal heart tones, taking blood pressure readings, doing vaginal exams to measure cervical dilation). As a result, these findings may not be generalizable to birth attendants who perform these activities.

Another concern may be that the interviews were completed in 2002, 2003, and 2005. This raises the question of whether the conditions under which parents labor and give birth and the processes that doulas use may have changed over time. While this issue was addressed by a historical overview and use of a contemporary review group of

doulas, these conclusions should be interpreted with that in mind.

Future Directions

Connection. During the analysis phase, connection emerged as a robust category with many excerpts from hospital-based doulas and independent practice doulas. Excerpts from mother and mother-father interviews also supported the concept of connection. At this time, concept maps have been constructed for the relationship processes between each type of doula and the laboring mother. Concept maps are an effective technique for positing preliminary ideas during analysis [Maxwell]. A brief synopsis of those maps is provided here.

Connection is currently identified as a relationship process that occurred between the doula and the mother. At this time, the working definition of connection between mother and doula has three components: (a) to communicate successfully, verbally and nonverbally, (b) to feel in harmony with one another, and (c) mothers and doulas feel joined, united or bound together in the common purpose to get through mom's labor in the way she desires.

The process of connection began at the first meeting, whether that first meeting was during the mother's pregnancy or during her labor. The level of connection seemed to be predicated on the mother's emotional openness to the doula as a support person. In turn, this emotional openness seemed to be based on the mother's comfort with her own vulnerability and need for support. When the mother's openness to the doula was low, connection seemed to be minimal. The doula was attentive and helpful, but the doula experienced a low level of emotional satisfaction with the labor support experience. When mothers were more open to the doula's offerings, the doula felt greater levels of

satisfaction.

In addition to doula satisfaction, another outcome that seemed to be related to the maternal-doula connection was attunement during labor. Attunement has been previously defined as "the occurrence over time of a rhythmic, patterned, sequence of events where both the doula and the mother feel a sense of trust, oneness, and communication of sensations and the mother's need during the first stage of labor" (Gilliland, 2004) (See summary in Chapter One). Attunement required the mother to be open to the doula on an emotional and physical level. Without maximal levels of connection in all three components, attunement seems to not be possible.

However, connection does not seem to have any impact on the doula's ability to serve as a secure base for the laboring mother. In the previous examination of the doula fulfilling a secure base function, it was discovered that it was based on the mother's perception of the doula (Gilliland, 2004). This perception was part of the mother's lived experience of her labor, not a measurable exterior event. At this time, it seems that the mother would be in control of the level of connection between herself and her doula. So the mother would most likely set the amount of closeness where it was optimal and comfortable to meet her relationship needs. Therefore, it would be possible for the mother to feel very positive about the doula's support without experiencing a high level of connection.

In contrast, the same level of connection that would be satisfying for the mother may differ from the level the doula may find satisfying. For example, there were several doulas in the both samples who stated they had experiences where they did not feel connected to the mother. They made statements such as, "I felt that I did my job, but I

didn't feel very connected to her." Conversely, doulas explained that the mother expressed that the doula was “wonderful” and that “I could not have done it without you”.

At this time, connection is considered to be a relationship process for two different reasons. One, both the doula and the mother seem to have separate experiences of connection, which may or may not be mutually satisfying. Second, connection is based on the mother’s and the doula’s continuing interactions with one another, which is a communication process. Currently, the concept of connection shows promise for providing the link between the mother and doula meeting as strangers and developing an effective labor support relationship.

Philosophical Orientations. An additional area for future exploration is the philosophical differences between doulas, especially since they may not be predicated on type of practice. The two current philosophies are an empowerment-focused orientation and an emotional support-focused orientation. These philosophies are unrelated to a doula’s support behaviors, but are concerned with the individual doula’s feeling of purpose and meaning about her care work. Several codes from interview data remain unanalyzed that will likely illuminate and extend this model. “A good doula is” and “a good doula is not” have very extensive excerpts. Questions that exist at this time include: Are these philosophies in existence prior to becoming a doula and based on life experiences? Are these ideas dependent on the number of births attended, age of the doula, or level of labor support skills and experience? Do these orientations change over time? Further, it would also be important to extend the sample to include hospital-based doulas from other programs. Other hospital-based doulas may have more of an advocacy

role in their facility. The mothers they serve may also have birth philosophies that include personal development and empowerment.

Relationships with nurses, physicians, and midwives. Doulas, mothers, and fathers all indicated that the doula's relationship to the nurse and medical careprovider were significant contributors to their labor support experience. Analyzing collected data on this topic would further illuminate labor support processes by birth doulas.

Extending the sample. In order to validate the current models of support and extend their application, it is important to extend the sample. Hospital-based doulas from other programs would be an important source. Even more important are the voices of fathers whose partners have hired independent practice doulas. These informants may offer a perspective that has previously not been explored.

Additional Codes. At this time there are several intriguing topics that remain unexplored and are listed in the accompanying tables (see Tables 12 and 13).

Table 15.
Topics For Future Exploration And Data Sources

	Independent Practice Doulas	Mothers with IP Doula Care	Mothers and Fathers with HB Doula Care	Hospital-Based Doulas
Process of Connection in Doula – Mother Relationship	X	X	X	X
Mothers Prefer Doula to Own Mother	X	X	X	X
Nurse-Doula Relationships	X	X	X	X
Pain Medication	X	X	X	X
Memories of Birth and Doula Care: the Role of the Postpartum Visit	X	X	X	X
Prenatal Visits and Maternal and Paternal Satisfaction Outcomes	X	X		X

Table 16.
Additional Codes Not Utilized in Dissertation

Independent Practice Doulas	Code Title	Hospital Based Doulas
X	A Good Doula Is	X
X	A Good Doula Is Not	
X	Challenges: Client Issues	
X	Challenges: Home Life	
X	Challenges: Life Balance	X
X	Challenges: Nature of Work	
X	Connection	X
X	Difficult Outcomes-Death	
X	Doctors	X
X	Experience - Changed over time	X
X	Family Interactions	X
X	Feeling Powerless	
X	Intuition-Spiritual Experience	
X	Learn Doulaing	X
X	Life Changing – For Doula Life Changing - For Others	
X	Meaning of Birth	
X	Midwives	X
X	Moms don't want own Mom	X
X	Money-Fees	
X	Nurses	X
X	Pain Medication	X
	Remembering-Memory	X
X	Running A Business	
	Secure Base – HB Moms	X
	Temporal Distortion–HB Moms	X
X	Type of Mom	X