CHAPTER II

METHODS

Choice of Methodology: Grounded Theory

The grounded theory approach specifies adaptable analytic strategies for building theory that is inductively derived from data (Charmaz, 2000). Exploring social processes and human relationships is well suited by a grounded theory approach (Creswell, 1998; Strauss & Corbin, 1998), and allows for emergent design (Lincoln and Guba, 1985, p. 41). Within grounded theory methodology, there are several methods available to give guidance to the researcher. Some are more unstructured and have different philosophical underpinnings (Maxwell, 2005), whereas others are better suited to certain research questions and settings. Based on my research question and interest in creating a detailed model of relationship processes, my choice was a more structured method, namely that of Strauss and Corbin in their 1998 edition of *Basics of Qualitative Research* (Strauss & Corbin, 1998).

The systematic application of Strauss' procedures is designed to generate complex substantive theory more than other grounded theory methods (Strauss & Corbin, 1998; Charmaz, 2000). Wh there are other approaches to grounded theory, the extensive procedural steps supplied an excellent fit for the expected complexity of the data. Strauss and Corbin's techniques are an organized arrangement of hierarchical levels of analysis and theory creation. Since I desired from the outset to triangulate my sources (originally doulas and mothers) and find participants from multiple settings, their techniques had advantages. They would allow for examination of between group comparisons as well as the development of a theoretical model that could encompass both settings and samples.

In this project, there were eventually four main data sources: independent practice doulas, mothers who received labor support from independent practice doulas, hospital-based doulas, and mothers and fathers who received labor support from hospital-based doulas. Both contributors and receivers of labor support were included. The importance given to actions, attitudes and beliefs of doulas by both types of doulas and mothers and fathers was central to an understanding of the meaning of effective labor support.

Additionally, Strauss and Corbin's techniques allowed for increased generalizability and comparability of the findings. Since meticulous record keeping of decisions and ideas are part of their technique, readers of the findings can judge for themselves on the trustworthiness of the data generated from the inquiry. This final goal was important; I wanted the results of this project to be useful in discerning more details about the doula effect.

In describing the advantages of their structured strategies, it is important to realize that Strauss and Corbin's methods are quite inductive and flexible in nature. The researcher follows the data and the data in turn shapes the inquiry. Purposive sampling, shifting questions within the interview, and intuitive leaps of thinking are all built into their system. Their ideas are not a strict recipe that defines the result. Rather it is more akin to building a house. The order of the construction and the elements of it are the same, but the houses vary tremendously in style, size and room configuration. The next sections will examine the procedures employed in the study: researcher's role, population and sample, data collection, and data analysis.

The Researcher's Relationship To The Topic

As a methodology that explores the construction and interpretation of social reality (Mason, 1996), the researcher has a role in creating the outcomes of the study. Qualitative research is an intimate process, as all of the data collected from participants and other sources is filtered through the researcher. Thus, an understanding of the researcher's background is critical for the reader to understand the analysis presented. In the words of Glesne (1999), "Qualitative researchers are interpreters who draw on their own experiences, knowledge, theoretical dispositions, and collected data to present their understanding of the other's world. As interpreters, they think of themselves not as authority figures who get the "facts" on a topic, but as meaning makers who make sense out of the interaction of their own lives with those of research participants". It is through this "meaning making" process that the categorizing, coding, and outlining of processes important to effective labor support occurred.

I have been a professional doula since 1987, although I attended my first birth unexpectedly in 1981, at the age of twenty. My career has spanned three decades of my life. In 1997, I became a DONA International approved birth doula trainer and have taught 40 three-day basic training workshops with my two partners. I am also one of the few steady providers of advanced doula trainings with a catalogue of over thirty hours of original curriculum. I spent four years as a La Leche League Leader offering peer breastfeeding support, and five years as a childbirth educator. I have also given birth to three children, currently ages 19, 21, and 24.

Conducting research on doulas changed my own independent practice and offered me many insights into effective doula support. After completing my master's thesis,

which focused on this topic, I carried the doulas' stories and the study's conclusions with me to every birth that I attended. I used the doulas' strategies and gained greater insight into my own strategies. Once I paused in my doula practice and focused on research again, my analytical skills were more deeply honed. For the last several years, my life has circled repeatedly through several cycles of data acquisition, data analysis, practice, and teaching. Each phase built upon the other to strengthen my effectiveness and insight into labor support processes.

I have been the recipient as well as the giver of effective labor support. During the interviews, I grasped the understandings that mothers and doulas were trying to convey from the point of view of an insider. Yet I did not forget that my challenge was to draw out the reflections and perspectives from my informants so their words stood out clearly on paper. In my opinion, my position in the doula world was an asset in the scholarly work presented. But it was the scholarly perspective that challenged me to keep asking questions and analyzing to discover what was unexpected, and not just what was easily revealed.

Methodological Process

Sample Identification and Construction

The sample used for this dissertation contains 36 doulas representing a wide variety of locations, practice styles, and experience levels and 26 parents who chose to have doulas support their births. A summary of collected data is available in Table 4. In the previous phase of this project (the 29 doulas who participated between 2002 and 2004 for my master's thesis, Gilliland, 2004), both doulas and mothers served as informants.

Of those 29 doulas, two were hospital-based. Analysis revealed that diversity within the doula sample would extend and strengthen certain concepts integral to the emerging

Table 4.

Collected Data: Types and Times of Sampling versus Types of Participants

	June 2002	June-August 2003	June 2004	June-September 2005	Subtotal	Total
Independent Practice Doulas	(open sampling) 1 3	(discriminant sampling) 1 4	1		28	3 6 Doula Interviews
Hospital-Based Doulas	2			6	8	
Mothers with Independent Practice Doulas		(open) 7 (discriminant) 3			10	26 Mother and Father Interviews
Mothers and Fathers with Hospital-Based Doulas				(mothers only) 4 (mothers/fathers) 1 2	16	

theory. In order to broaden the sample, hospital-based doulas were added as participants for the dissertation phase of the project. All doulas had adopted the DONA International Standards of Practice and Code of Ethics (see Appendix A). Doulas did not need to be certified or a member of DONA, but all followed the guidelines developed by DONA for the doula profession. While there are male doulas, they are quite rare, so they were not included in this study.

Mothers and fathers who chose to have a doula and received doula support during active labor, birth, and the immediate postpartum period were another population for this

study. To be eligible, they also needed to anticipate an uncomplicated labor and healthy newborn. Both mothers who received care from an independent practice doula and mothers and fathers who received care from a hospital-based doula were included in the study.

Theoretical and Discriminate Sampling

The grounded theory approach to research utilizes theoretically constituted samples to gain understanding, generate concepts, and build theory. The aim is to utilize data sources that will maximize opportunities to discover variations among concepts and build categories along their properties and dimensions. Samples are selected in an ongoing and deliberate manner in order to expand developing ideas and discover new concepts. Since theory emerges from the data, this type of sampling serves to "test" the developing theory as it indicates under what conditions the theory holds true (Creswell, 1998).

Theoretical sampling is integral to the grounded theory approach of selecting data incidents based on their relevance to evolving theory. Sampling occurs in three stages, each linked to the first three stages of data analysis. The first stage of open coding utilizes open sampling: the selection of interviewees or observational sites based upon relevance to the research question. After these initial interviews are analyzed and working categories and properties identified, the researcher moves on to the second step of theoretical sampling called axial coding. During the axial coding process, the researcher is looking for incidents that demonstrate dimensional range or variation of a concept. The focus of these "relational" or "variational" sampling techniques is to flesh out and develop categories and relationships (Strauss & Corbin, 1998). Lastly, in the

selective coding process, discriminate sampling is used. The researcher chooses data sources that maximize the possibility of making comparative analyses. During this stage, interpretations and concepts are negated and validated as they were compared to these new data sources.

Sample Description: Doulas

As the main informants of labor support processes, doulas needed to have attended 25 births, be over 18 years old and speak English fluently. In addition, participants 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).

Doula recruitment and interview sites. After receiving approval from the Internal Review Board at the University of Wisconsin-Madison, doulas were recruited through snowball sampling methods. The first round of interviews was conducted in Florida in August of 2002 at the international conference of Doulas of North America (DONA). Access to experienced doulas can be difficult to obtain and conferences are an excellent opportunity to reach a group of regionally diverse professionals. Several messages promoting interest in the study were posted on email list serves. In addition, I also contacted a local doula group that was in driving distance of where the DONA conference was held. This first round of theoretical sampling generated 15 doula interviews.

Discriminate sampling. After the first round of data analysis and coding, a second round of doula interviews was conducted in New Jersey, Manhattan, and Long Island, New York. This second trip generated 13 more interviews and enabled me to

discriminately sample doulas to answer more refined research questions. One additional doula from Los Angeles who was over 50 and served primarily Jewish couples was interviewed when she traveled to Madison. At the time of completion of the first phase of the research project, 29 doulas had been interviewed, 18 of which were analyzed in depth. The doulas were geographically diverse, from ten different states and two Canadian provinces. Two worked for hospital programs rather than independently (Ballen & Fulcher, 2006). Participants came from various economic classes and religious faiths. They ranged in age from 28 to 60 years, and practiced in large cities, small cities, and rural areas (See Appendix D). These characteristics of the sample matched what is known about independent practice doulas in a national survey (Lantz et al., 2005).

Since that time, seven more doulas were interviewed to expand the sample in a discriminate manner. One doula was unique; she was from Halifax, Nova Scotia, and worked independently and as a volunteer in a rural, isolated area. Six doulas worked in a hospital-based program at Lexington, Medical Center in Columbia, South Carolina. I have maintained IRB Approval without a lapse from 2002-2010 so that I could continue collecting data.

Sample description: Mothers-only interviewed (n = 10). To be eligible for inclusion in the study, mothers needed to have had normative labor and birth experiences representative of most women for the study results to be more generalizable. The criteria for mothers included healthy and uncomplicated pregnancies; a lack of life threatening complications during labor for mother or baby; and infants who spent no time in the neonatal intensive care unit. In addition, mothers needed to be at least 18 years old, speak English fluently, and having their first or second live birth. Participants did not

need to be married, however a close family member needed to be present for the entire labor and birth in addition to the doula. The mother's doulas used no clinical skills and attended continuously from the beginning of active labor until several hours after the baby was born. Cesarean deliveries were included in the study as they account for approximately 30% of all U.S. births (Hamilton et al., 2009). Only women who had emergency cesareans for immediate life threatening complications were excluded from the study.

During the first phase of the study, 10 mothers were interviewed. They were from three Midwestern states and lived in cities or rural areas. They ranged in age from 25 to 38 years old. Nine were married; two were multiparous. One of the multiparas had the same doula at both of her births. The father of the baby, with whom the mother had a positive ongoing relationship, attended all of the labors. One mother had a cesarean for non-progressing labor and three mothers had epidural medication. Each mother had chosen her doula during pregnancy and developed an ongoing relationship, although one mother was attended by a substitute doula that she had never met prior to her labor. None of the participating mothers received labor support from doulas included in this study. More information is in Tables 5 and 6.

Sample description: Mothers and Joint Interviews with Mothers and Fathers (n = 16). The same criteria for individual characteristics, birth experience, and timing of interviews that were applied to the Midwestern mother sample were applied to mothers and fathers interviewed in South Carolina. Descriptions of the sample are in Tables 7 and 8. At the time, individual interviews with mothers seemed that they would allow a more

direct comparison to the Midwest sample. To explore father-doula relationships, fathers were included in the joint interviews.

Table 5.

Midwest Mother Sample Demographic Information

Name	Age**	Education Level	Race/Ethnicity	Income Level**	Marital Status	Location
Natalie		College	White		Married	Small City, Wisconsin
Melissa		High School	White		Single	Small City, Wisconsin
Moira		Graduate	White		Married	Large City, Minnesota
Jessie		College	Asian		Married	Small City, Minnesota
Georgia*		College	White		Married	Large City, Minnesota
Jeanne		College	White		Married	Large City, Minnesota
Alicia*		High School	White		Married	Rural Area, Minnesota
Vanessa		College	White		Married	Small City, Illinois
Gail		Graduate	White		Married	Large City, Wisconsin
Keiko		College	Biracial		Married	Large City, Wisconsin

*Alicia and Georgia are biological sisters who gave birth within two weeks of one another in the same state. They lived over an hour apart.
**Due to a computer malfunction, specific age and income information is not available. Mothers ranged from 24 to 38 years of age; income varied from $15,000 a year to $100,000 a year.

Table 6.

Midwest Mother Sample Labor and Birth Characteristics

Name	Type of Delivery (Parity)	Pain Medication	Doula	Knew Doula Prenatally
Natalie	Cesarean	Epidural	Beverly	Yes
Melissa	Vaginal (2)	IV	None, Zoey	Yes
Moira	Vaginal	none	Peggy	Yes
Jessie	Vaginal	none	Peggy	Yes
Georgia	Vaginal	none	Peggy	Yes
Jeanne	Vaginal (2)	none	Peggy, Peggy	Yes
Alicia	Vaginal	Epidural	Reba	No
Vanessa	Vaginal	none	Carly	Yes
Gail	Vaginal	IV, Epidural	Beverly	Yes
Keiko	Vaginal	none	Beverly	Yes

Table 7.

Midwest Mother Sample Interview Characteristics

Name	Interview	Interview Site	Knew Doula Prenatally	Date of Interview
Natalie	Mother Only	Home	Yes	5-03
Melissa	Mother Only	Hom e	Yes	6-03
Moira	Mother Only	Hom e	Yes	6-03
Jessie	Mother Only	Hom e	Yes	6-03
Georgia	Mother Only	Hom e	Yes	6-03
Jeanne	Mother Only	Hom e	Yes	6-03
Alicia	Mother Only	Hom e	No	6-03
Vanessa	Mother Only	Hom e	Yes	9-03
Gail	Mother Only	Hom e	Yes	9-03
Keiko	Mother Only	Hom e	Yes	9-03

Table 8.

South Carolina Sample Demographic Information

Name	Age(s)	Education Level (M, F)	Race/Ethnicity (M, F)	Income Level	Marital Status
Autumn	30	High School	White	15,000	Single
Marilyn	37	Graduate	White	100,000	Married
Neara	25	College	Black	25,000	Single
Whitney	27	High School	White	50,000	Single
Amanda and Cyrus	30/30	Grad/College	White/White	50,000	Married
April and Noah	27/24	College/College	White/White	35,000	Married
Ariel and Justin	31/31	College/College	White/White	40,000	Married
Blair and Lars	34/34	College/Grad	White/White	60,000	Married
Chloe and Landon	34/35	College/College	White/White	not available	Married
Doreen & DeMarco	30/32	H.S/H.S.	Black/Black	10,000	Married
Eden and Huntley	34/34	Grad/H.S.	White/White	75,000	Married
Enid and Fitz	38/32	Grad/H.S.	White/White	50,000	Married
Harmony and Jack	24/28	College/College	White/White	25,000	Married
Jayla and Rafe	34/33	H.S./College	White/White	100,000	Married
Mollie and Peyton	29/31	College/College	White/White	100,000	Married
Sheena and Ryan	30/30	College/H.S.	White/White	75,000	Married

Table 9.

South Carolina Sample Mother and Father Labor and Birth Characteristics

Name	Type of Delivery (Parity)	Epidural (X) IV Pain Medication	Doula
Autumn	Vaginal	IV, X	Sadie
Marilyn	Vaginal (3)	none	Eleanor
Neara	Vaginal	X	Eleanor
Whitney	Vaginal	IV, X	Moselle*
Amanda and Cyrus	Vaginal (2)	X (2^{nd} only)	None, Eleanor
April and Noah	Vaginal (2)	X (1^{st} only)	Sadie, Sadie
Ariel and Justin	Vaginal	none	Eleanor
Blair and Lars	Vaginal	none	Eleanor
Chloe and Landon	Vaginal	X	Eleanor
Doreen and DeMarco	Vaginal	X	Eleanor
Eden and Huntley	Cesarean	X	Linda
Enid and Fitz	Cesarean	X	Eleanor
Harmony and Jack	Vaginal (2)	none	Helen*, Eleanor
Jayla and Rafe	Cesarean (2)	X (both)	Nancy, Crystal
Mollie and Peyton	Vaginal	X	Crystal
Sheena and Ryan	Vaginal	X	Linda

* not interviewed

Table 10.

South Carolina Sample Mother and Father Interview Characteristics

Name	Interview	Interview Site	Date of Interview
Autumn	Mother Only	Home	early 7-05
Neara	Mother Only	Hotel room	early 7-05
Harmony and Jack	Together	Meeting Room	early 7-05
Whitney	Mother Only	Home	early 7-05
April and Noah	Separately: F, M	Home	early 7-05
Chloe and Landon	Together	Home	early 7-05
Doreen and DeMarco	Together	Hotel Room	early 7-05
Amanda and Cyrus	Together	Home	late 7-05
Marilyn	Mother Only	Home	late 7-05
Ariel and Justin	Separately: M, F	Home	late 7-05
Enid and Fitz	Together	Home	late 7-05
Blair and Lars	Together	Home	late 7-05
Eden and Huntley	Together	Home	9-05
Jayla and Rafe	Together	Home	9-05
Mollie and Peyton	Together	Home	9-05
Sheena and Ryan	Together	Home	9-05

Rather than being rigid about format, I decided that flexibility in approach and making participants comfortable was paramount in obtaining a successful interview, consistent with the methodology used. Most men were not interested in being interviewed separately from the mothers. Of the 16 interviews with participants

receiving care from hospital-based doulas, four took place with mothers individually and 12 were joint interviews with mothers and fathers. Two took place with the mother and father sequentially with only two to four minutes coinciding. The remaining 10 interviews took place with both parents simultaneously (See Table 9). Nine couples co-created their birth narrative, with both sharing almost equally in the discussion and spending equal time being interviewed. With one couple, the mother spoke to me for approximately 15 minutes and then the father joined us. Because there was a tendency for mothers to mediate the conversation, having separate questions for the father about their experiences of support proved to be important. All participants were paid 10 dollars for their interview time and parents were given a bottle of Burt's Bees Baby Massage Oil.

Maternal interview sites and recruitment. All mothers were interviewed during the day at their homes in Illinois, Wisconsin and Minnesota, which was their preference. Infants were present at all interviews although some did nap in a separate area during part of the interview. Mothers were recruited through their doulas. Doulas either had not taken their training from me or had done so at least five years prior to this research project. My aim was to exclude any effect of my teaching ideas on the doulas who provided care for the mothers I would interview. None of the doulas who provided care for the mothers in this study were participants in the study. Doulas were contacted through the doula email networks in their communities. Interested doulas who had clients that gave birth during the previous six weeks replied. I sent them an email or letter to be given to mothers, who then contacted me if they were interested. I spoke with each mother over the phone at least once before the interview to answer questions, discuss the project, obtain directions, and confirm our interview time. None of the

mothers knew of me prior to this study. Of the 10 mothers who participated, nine mothers were contacted through their doula. At her interview, one mother, Georgia, suggested that I also talk to her sister, Alicia, who had also given birth during the time frame of the study. Georgia and Alicia were not very close at the time and had not discussed their experiences with one another.

Mother/Father interview sites and recruitment. Mothers and fathers who received labor and delivery care from Lexington Medical Center in Columbia, South Carolina, had their choice of interview sites. Of the 16 sets of participants, two were interviewed in a hotel room, one was interviewed during lunch break at the father's workplace, and thirteen were interviewed at their home. All interviews took place during the day and lasted approximately 60 to 90 minutes. Infants were present during all or part of the interview, although they were usually sleeping.

Parents were recruited by their hospital-based doula during the 24-hour postpartum visit. The purpose of the study was explained to them. It was made clear that parents were only consenting to be contacted about the study, not consenting to be interviewed. (A sample solicitation letter is provided in Appendix B.) The doula filled out an information sheet with contact information, preferred method of contact (email, phone), and which parents were interested in sharing about their experiences (mother, father, both). The information sheets were collected and faxed or mailed to me every few weeks.

Lexington Medical Center (LMC) served patients from a tri-county area, with people traveling over an hour to receive care. Once I had the address data, I marked all possible destinations on a map. For practicality purposes, I screened out four parents

who lived over 75 minutes away from LMC with no other possible interview stops in between. Two of them were also mother-only interview possibilities. (Other parents who lived this distance were included.) Another four parents did not return email or phone messages. An additional three parents made appointments but cancelled due to illness or unexpected schedule changes. Thus, of the 27 parents who agreed to be contacted about the interview, 11 were unavailable.

In the summer of 2005, I made two seven-day trips to Columbia in July, and one five-day trip in September. Approximately one month before my arrival date, parents were sent a letter explaining the study along with a copy of the consent form. Two and a half to three weeks before my arrival date, parents were contacted by email or phone to schedule an interview time and to secure directions. Confirmation calls were made two to three days prior to my visit.

Timing of Maternal/Parent Interviews. A key issue was the timing of mothers' interviews. Three qualitative studies about mother's birth experiences conducted interviews or focus groups two to three months postpartum (DiMatteo et al., 1993; Fowles, 1998; Rippin-Sisler, 1996). Comments and information given by mothers at this time period were organized and reflective. Because of the success of these studies, mothers in the present study were interviewed between 8 and 14 weeks postpartum.

Data Collection

Interviews

The Interview Process

Process refers to the dynamic interaction of understanding that occurs in speaking and listening between people. Coming together as strangers, both interviewer and

participant work to create shared meanings (Mason, 1996). One of the researcher's responsibilities is to ascertain the respondent's context for the information they share (Glesne, 1999). Understanding motives, values, concerns, needs, and thoughts make the information relevant and come alive. Understanding grows when the researcher can see the connection between the contexts held in common with other respondents. Thus the interview questions themselves must be aimed towards revealing context as well as story or experience in order to be effective.

As an interviewer, it is important to set aside preconceived notions about what participants will say. This was especially important for me, since I had done similar work to what I was asking about. However, this was not as difficult as it might be in other professions. As a doula, one works in isolation rather than with other doulas who might validate one's perceptions and experiences at a particular labor. A doula's understanding of labor support for a mother and family is unique to that event; no one else shares this role or is even present for the same length of time. It was not difficult for me to adopt a curious and nonjudgmental attitude since I really did not possess any certainty about another doula's or mother's experience.

In order to gain the level of reflection and information that needed to be ascertained for this project, a loosely structured, open-ended interview technique was used. By starting with basic questions and then repeating descriptive statements unique to each participant, I was able to follow their unique thoughts and reflections. This level of in-depth interviewing was successful in gaining rich descriptions of doula's, mother's and father's experiences, thoughts and feelings.

Context

Both doulas and mothers and fathers were allowed to choose between my hotel, their home, or another quiet place they found convenient for the interview. Of the doulas, four were interviewed in their homes and two chose my hotel room. Two of the mothers and fathers chose my hotel room, one chose his workplace, and thirteen opted for me to visit their home (See Table 5). Infants were present at almost all interviews and parents were encouraged to meet their child's needs. Since parents could choose the time of their interview, babies were often napping part of the time or another family member was present to take care of the baby. There were very few interruptions during any interview. During all of the interviews, we sat in comfortable chairs and couches which seemed to set participants at ease.

Format For Doula Interviews

Doulas were welcomed into the room where the interview was being conducted and were offered a beverage. Each doula had been sent a consent form when possible. We went over the consent form and each of us retained a signed copy. Each doula received a thank you gift of 10 dollars in a white envelope. I explained that I would need to change the tape several times, and that the tape recorder did not have an indicator when the tape was ending. "If you see me looking at my watch, its because the tape is almost up, not because you are boring." This bit of humor seemed to help set participants at ease, and I placed my watch on the table near my notebook. I turned on the tape recorder.

Hospital-based doulas were asked the same questions as independent practice doulas. In addition, they were asked about how they got to know a mother. Questions were arranged on small pieces of paper in a specific order. This enabled me to turn over the papers as questions were answered. If a topic had already been covered, I could remove it from the pile without disturbing rest of the papers. This system worked well for me. Rather than asking questions using the same language with each participant, I asked the questions conversationally as they fit into our discourse.

The first two topics were designed to facilitate rapport as well as focus on a topic of interest. I asked, "How long have you been a doula, and how did you get started?" This was followed by "Tell me a little bit about your practice, who you usually work with, clients, that sort of thing." These topics also helped the participant to focus on doula work and topical memories. My third question was my main point of interest. A review of transcripts shows little variation in the phrasing with each participant. "As you know I am interested in labor support. Taking a few minutes to think about your experiences, tell me a story about a time when you thought you were really effective as a doula. You can include as many details as you wish."

At this point, some participants asked me what I meant by "effective". I replied that the meaning of the word was up to them. This was very revealing as there was great variation in the stories between doulas. After the first story, I frequently asked participants to tell me about another time they "felt their support was really effective". Doulas would then tell me another story where effectiveness was defined in a different way. Most doulas told me two or three stories at this point in the interview. Through these narratives I was frequently able to cover other topics of interest on my cards.

During the interview I took notes on phrases of interest, topics that I wished to return to, and relevant facts about this doula. My notes were a way of keeping track of the path of this interview. I also used my notes in a summary question near the end of the interview. I would repeat key phrases or words that this participant had listed as relevant to doula care and then ask, "You've stated that these things are essential for you as a doula, tell me how did you learn doula-ing?" This worked very well in getting participants to reflect more deeply on their practice and what they valued in their performance.

Almost all of the time, the relevant topics and questions were covered in the interview. If we were reaching the time limit, I would see what was left and choose questions about which I thought this participant might be more insightful. My goal was not to cover all of the questions with each of the participants. Rather I was concerned with getting each participant to elaborate on concepts that emerged as relevant in each interview. Rather than getting systematic comments on every topic, I was more concerned with the quality of the doula's information and reflections. This approach worked very well in accomplishing the goals of this study.

Post-interview notes were recorded after most interviews. Impressions, connections with other participant's statements, and further areas of inquiry emerged at this time and were retained as memos.

Format For Mother And Father Interviews

Upon entering the participant's home, I greeted them and got settled in the interview area. If offered a glass of water or cup of tea, I accepted. These same procedures were followed in my hotel room. Prior to the interview I had mailed each

family a copy of the consent form and eligibility requirements. Previously I had confirmed the parent's eligibility over the phone. Before beginning any formal questions, the consent forms were signed and participants were given a copy. I also gave them a thank you gift of 10 dollars in a white envelope with "Thank you!" on the outside and a five ounce bottle of Burt's Bees baby massage oil. (I was able to get this high quality massage oil for 75% off as the UPC code was misprinted.) I explained that my tape recorder did not have an indicator when the tape ran out so I would be looking at my watch periodically. I reassured the mother or mother and father that they should take care of their baby as needed and that they could stop the interview at anytime. Demographic information was collected at the conclusion of the interview.

The interview schedules of questions for mothers and for fathers are in Appendix B. The opening question was the central focus of the interview and answering it took up most of the interview. In only one instance did the interview begin alone with the father (Noah). However I posed the same initial question. To put the participant at ease I stated the initial question informally: "Okay, so tell me how your birth experience went, and what happened, and you can start wherever you want to start and tell me as many details as you want to. Some people start at the middle, some people start when they're pregnant, wherever you want to start." By phrasing my request in this way, participants were free to start talking without wondering if their answer was "right". During this portion of the interview, I did a lot of listening but took notes on key phrases that seemed indicative of their inner experience. Both mothers and fathers seemed to begin with the beginning of labor and events that were salient to them. All of the participants expended effort to piece together the timeline of events. It was difficult for slightly over half the

sample. Participants seemed frustrated when this did not come easily to them. However, my mission was to focus on their emotions and reflections of their doula's support (or lack of it). An exact timeline was not essential for me to obtain that information. Instead of continuing to discern when an event occurred, I would redirect to focus on feelings or thoughts about it. For example, "So when the midwife came and broke your waters, what was that like for you? What did your doula do then?"

Eight of the thirty-two participants were interviewed alone. Four of the mothers were interviewed alone, and two couples were both interviewed separately. This was their choice and I was not consulted beforehand. Being interviewed alone offered more depth to the narrative and reflective statements. However mothers and fathers interviewed in tandem co-created their birth narrative. They shared their separate reactions and feelings to the same labor event or doula activity. Having both types of interview data enriched the sample.

While the parent or parents were talking I took notes on key phrases, the emerging chronology of birth events, the names and relationships of people present, and themes that emerged. I spent more time listening than I did writing in these interviews. Most frequently I directed the flow of the conversation through short questions that used the language of the participants. Instead of asking, "What did your doula do to support you?", I was able to state, "In what way was she awesome?" In reviewing transcripts, it becomes clear that most of my verbal contribution to the interview was in asking clarifying questions. When parents were interviewed separately, I did not bring up the reflections of the first person interviewed. Instead I started over. The second parent often assumed I knew about significant labor events. To hear their point of view, I would

say, “Tell me more about that.” At other times I focused on their experience, “What was that like for you?”

When mothers and fathers were interviewed simultaneously, I sometimes used the same prompt to get the other partner’s perspective. “What was that like for you?” Often the parents took turns sharing a part of their story and both of their feelings or perceptions. They often felt similarly to a particular event, but not always.

Managing And Recording Data

Each interview was audio taped and transcribed. In some instances, professional transcriptionists have transcribed the tapes and in others, undergraduate students have completed the transcriptions. Because of the possibility of bias and inexperience (Lane, 1996), I have spot checked and listened to the transcribed interviews. Since the majority of parent interviews took place in their homes the recording conditions were not ideal, so checking for accuracy was important. Each of the participants were assigned a distinctive pseudonym and their tapes are kept in my home in a locked cabinet with an electronic back up copy on my computer and additional hard drive.

Procedures During Doula Interviews

Procedures followed during the initial 29 doula interviews have been described in detail elsewhere (Gilliland, 2004). However, those doula interviews initiated a pattern of following the participant’s flow of thought. Rather than interrupting to follow a set pattern of questions, depth in the arena that the participant chose to discuss was more valued. This led to a difference in topics covered when comparing interviews, however the insight and reflection on the topics that mattered to an individual doula outweighed the lack of breadth. In fact, in some cases, doulas did not have much to say on a

particular topic. In the initial group of participants, three doulas in particular did not open up until I asked, "Is there anything else we haven't covered that you'd like to talk about?" One third to one half of the interview time occurred after this question.

Fifteen doula interviews took place in August 2002, allowing time for open coding, memo writing, and development of more focused questions. Two of the participants were hospital-based doulas. Next I interviewed 10 mothers who had received care from independent practice doulas in May and June 2003. Then the next round of 14 interviews with all independent practice doulas took place in July of 2003. (See Appendix D for more details.)

Due to my earlier experience interviewing mostly independent practice doulas, and to be consistent across samples, I decided to use the same interview questions with the hospital-based doulas. Six doulas from the Lexington Medical Center staff of 12 were interviewed in July, August, and September of 2005. I was not sure what would be the same and what would be different in their revelations or reflections. After my first interview with Nancy, I paid attention to what she had focused on as important and what was omitted from her stories. During my next interview with Crystal, she was very detail oriented and practical. Crystal proved to be an excellent informant about the processes involved in getting to know a mother and a couple, but less reflective about the big picture of hospital-based doula care. In this way, each of the six Lexington doulas informed about a different aspect of labor support. They certainly overlapped in their topic choice, however each had a particular area of interest she focused on.

During the same trips that I interviewed doulas, I was also meeting with parents. As I became more educated about procedures and protocols at Lexington Medical Center,

I asked one or two questions about how these policies affected their doula work. Asking about their usual patients and how they became doulas proved to be good introductory topics. When interviewing Lila and Linda, it became clear that these four doulas felt they were most effective with mothers desiring unmedicated births. However that made up less than twenty percent of their patients. Because of this, I asked directly about empowerment – a significant theme for independent practice doulas.

Interspersing types of informants allowed for a depth in perspective. In one day I could hear how both a doula and a parent experienced a similar event, such as meeting the doula for the first time. It enriched my notes and memos, and accelerated my understanding of the processes important to hospital-based doula work. Interestingly, since the timing of the interviews was approximately two months after the births, the doulas remembered some details about a patient who was also a participant. I did not identify any of the parents in my sample to the doulas.

Process And Participant Reactions

Two of the doulas, Crystal and Eleanor, reluctantly agreed to be interviewed. Both told me that they did not like to talk about themselves and did not feel they would have much to tell me. I stressed the importance of their perspective to my inquiry and both eventually agreed. Eleanor's interview had to be rescheduled three times over two trips. My polite persistence and congeniality eventually paid off. Her attitude was very gracious and informative during the interview, but she seemed relieved when it was over. Eleanor was an important informant since 9 of the 16 mother and father participants had received labor support from her (see Table 6). All of the doula interviews took

approximately ninety minutes, and all of them were graciously informative and focused. I also thanked them for recruiting the parents on my behalf.

Procedures During Mother And Father Interviews

Procedures for the mothers interviewed in 2003 has been detailed elsewhere (Gilliland, 2004). Interview questions for Lexington mothers did not change substantially from the 2003 group. The opening question was, "So, tell me the story of your birth experience with *baby's name* and what it was like for you. You can share with me any details about the experience that you wish."

Separate question for fathers were developed, which proved to be valuable. In interviews where the father was not present, some of the questions directed towards the father were asked of the mother. For example, fathers were asked, "So how did you decide to include a doula at your birth? How did that come about? (Follow-up) Is it something that you felt comfortable with right away?" When the father was absent, mothers were asked, "So how did you decide to include a doula at your birth?" (See Appendix B for the question schedule.) When mothers were interviewed alone, they were not asked to comment on their partner's experience of the birth or imagine his perspective. They were asked what they observed about their partner working with the doula, "how they seemed to get along". Mothers were encouraged to speak of their experience with the labor and the doula. The main difference when mothers were interviewed without their partner was the missing voice on his experience. However three of the mothers were single and not living with the father of the baby although he was present at the labor and birth (see Table 3).

After a few joint interviews, it became apparent that each couple had divergent values and differing approaches to decision making during labor. Parents had very different philosophies about childbirth and its meaning in their lives as individuals and as a couple. Some saw labor and birth as a growth opportunity or major life experience. Others saw it as a medical procedure necessary for having a family. Labor events were also dissimilar; some labors lasted two days and some only two hours. Because of these differences, having specific follow up questions was not necessarily helpful. There was a list of topics that I wanted to have covered, and I transitioned into these subjects naturally during the course of their conversation. Some mothers and fathers were more reflective and analytic about their experience. Others were more emotional about what had taken place. Most often I organically followed the course of their storytelling, asking them to reflect on particular events or followed up on interesting phrases. "In what way did you feel your doula was 'an angel'?"

Mother and father interviews took place during all three trips to South Carolina in July and September 2005. Interviews with doulas were interspersed with parent interviews. Except for doulas Eleanor and Sadie, I had already met and interviewed the doula before doing the parent interview. I did not reveal to the parents that the doulas were also participants but acknowledged that we had met. However, doula Sadie and parents April and Noah were in contact with one another and aware of each other's interviews. The crossover between interviewing the doulas and the patients who received care from them created a revealing synthesis during the interview. I had a greater understanding of the doula's challenges when parents described particular labor events or

doula support processes. However I focused on the parent's perceptions during the interview.

Process And Participant Reactions

For the most part, parents enjoyed the opportunity to discuss their labor and birth. A motivating factor for the interview was the opportunity to discuss their doula's care. Only parents who wanted to do that were willing to take the time to meet with me. All mothers and fathers who had doulas that I interviewed were generally satisfied with their doula's care. Of the twenty-six mothers and fathers interviewed, only four were dissatisfied with aspects of their doula's support. Dissatisfaction with their doula was addressed directly in the interview process and approached from a few different angles.

Some mothers and fathers took turns telling part of their story and listening to the other. Other parents interrupted each other or completed each other's thoughts. This seemed to be a continuation of their usual couple conversational style. To minimize the error of not following up on something interesting, I took notes. Sometimes several minutes passed by before I could go back to a previous comment, but very few nuggets were missed. I also perfected the conversational pause. By remaining silent and nodding my head, parents were nonverbally encouraged to initiate another topic or continue talking.

At some point in the interview, most participants asked if I was also a doula and inquired about the purpose of the study. I would confirm my status as a doula and professional trainer without giving further qualifications. Knowing I was a doula seemed to relax parents, it was as if they felt I had a greater capacity to understand their experience. Sometimes, a participant would say, "Well, then you know how it is". My

response was usually, “I don’t know what that was like at your birth. Tell me more about what it was like for you.” This device deflected the tendency to minimize experience or details.

There were three unique aspects to interviewing participants who had hospital-based doula care. First, parents had difficulty reconstructing the timeline of their birth. It often seemed to me that it was one of the first times they had put effort into discerning an order. When parents directed questions towards me asking for help, I repeated a previously mentioned event to assist but not direct their thoughts. “So your mother arrived at noon…” and allowed my voice to trail off.

Second, parents sometimes expressed difficulty in making sense of certain labor events and would ask me to explain it to them. This situation required finesse. On the one hand, I did not want to tip the interview into being a discussion nor did I want to color their perceptions due to my new information. On the other hand, I ran the risk of alienating the mother or father if I seemed unresponsive or uncaring to their inquiry. An effective response was, “We can talk about that more after the interview.” When the interview was complete, our discourse would change from an interview style into a discussion. At this point, I was open to answering their questions, which were usually about fetal positioning and back labor.

Third, sometimes mothers blamed themselves for circumstances that were out of their control. This was usually due to a lack of understanding about their bodies or about hospital procedure. Mothers who felt this way asked me questions during the interview, and I stated that we could talk about that later. This seemed to satisfy them in the moment. It was difficult to hear when I knew I held information that could potentially

positively shift their perspective. At the conclusion of the interview, I offered limited information and emotional support. For instance, Whitney was having her first baby and lamenting the time it took between her cervix fully dilating and having an urge to push. She was blaming her body for its failure, when it was performing normally.

> "Whitney: So it's normal for them to not be at any station at all, when you're ten centimeters?
> Amy: So when you started pushing, it sounds like your body was like, "Oh okay, let's do this now." So that time period when he was still high is just the matter of the uterus getting tighter around his body again.
> Whitney: Wow, I wish I would've know that."

Besides blaming themselves, two of the mothers cried during the interview due to the difficult memories it invoked. (This depth of emotional response was not unique to mothers who had hospital-based doulas, but the self-blame component was unique.) Both Chloe and Eden had difficult challenging labors. Chloe's husband, Landon, met her tears with empathy and affectionate concern. The tears had the quality of an emotional release and Chloe recovered easily. In contrast during her interview, Eden made self-deprecating statements about her lack of progress, level of pain and ability to cope. She felt that she had let her doula down by not being able to cope with the pain. When I followed up on this observation, Eden explained that she did not think her doula really felt that way. But Eden felt that her doula ought to feel that way about her. "I remember earlier in the day, after I got my epidural, I felt like, 'You can go. I know you don't want to be here.' I felt like I had let her down in a way. That she was there to help me do something that I was unwilling to do and I let her down."

Other than diving deeper, I let these kinds of statements pass during the interview except for generally supportive statements, "That sounds like it was very difficult for you." My priority was following the interview protocol. However at the conclusion of

the interview, I began by offering to give Eden and her husband, Huntley, some more information about women's experiences of labor in general, and influences on women's perceptions of labor pain. Based on my training in trauma prevention, I became very concerned about Eden's emotional state. She was expressing overt symptoms of grief and loss, and possibly postpartum depression. I felt that she needed a professional evaluation. I remained another forty-five minutes after the conclusion of the interview, being supportive and gently introducing the idea of seeking more postpartum support. Both Eden and Huntley were very open to the idea as both felt the experience had been overwhelming and had a negative impact on their lives. I commented positively on her interactions with her baby, enjoyment of baby, and the ease in which she nursed him. I have training in postpartum evaluation, breastfeeding and mother-infant interaction, so I could do so confidently. I had prepared a list of referral agencies and professionals in the Columbia area that I left with every participant. Together we discussed the most appropriate referrals for the family and I helped them make a plan.

Completing Data Collection

There is a cyclic nature to data collection and analysis when using grounded theory methodology. Theoretical sampling allows for any relevant source to be included. After open coding, purposeful sampling occurs to develop emerging concepts. The cycle of sampling and coding concludes when a plausible model has been developed and the resulting theory applies in a variety of circumstances. Ideally, the core categories are saturated. In the current project, core categories related to independent practice doulas were saturated and data collection feels complete.

However, concepts related to hospital-based doula support seem saturated in some but not all categories. It would still be advisable to interview hospital-based doulas from other programs, and parents who have received care from doulas in those programs. Not all hospital-based doula programs are alike, with some having different values and resources. Because of time constraints related to this dissertation, I was unable to pursue all of these leads. I have added this information to the Directions for Future Research in the Discussion section.

Additional Data Collection

One of the key distinctions of qualitative data collection is what constitutes data (Creswell, 1998). Informants were not only the participants being interviewed, but also the researcher herself-her thoughts and processes as data are collected and analyzed. In this research project, data came from several sources: the experiences of the researcher as doula, doula trainer, and interviewer; notes taken after each interview of thoughts and impressions; the audio taped interview; analytic memos as the data was sifted through; and conversations and observations with mothers, fathers, and doulas as the research was conducted.

In addition, I became aware of circumstances that framed some of the participant's experiences that were revealed in the interview. Although I did not interview a doula, Peggy, as part of my sample, I did meet with her for dinner. She had arranged for me to interview several of her clients in my 2003 trip to the Twin Cities. She shared with me about one of her clients signing out AMA (against medical advice) when her waters had been broken without labor. The physicians were very angry with their patient and felt Peggy should have convinced her to stay in the hospital. A few days

later, something similar happened with another client of Peggy's; she was afraid of getting a negative reputation based on her clients' actions. (It would have been out of her scope of practice to give medical advice to them.) In the next few days, unbeknownst to Peggy, I interviewed both of these mothers. When the second mother stated that she felt Peggy was pushing her to go to the hospital, I could have validated that feeling but did not. Even though I could not include it as data in my analysis, it enriched my understanding of the complexities of the situation.

During my trips to Columbia, South Carolina, I garnered additional information about the hospital doula program. I was given a tour of the unit and introduced to members of the medical and nursing staff. In addition, I interviewed seven of the obstetrical nurses for another aspect of this project. During my time at the hospital, I took a tour with prospective patients, and observed families and nurses in the labor and delivery area. Between interviews, I was allowed to wait in the nurse's lounge and interact informally with the staff. The doula program director and obstetrical unit director were very welcoming and supportive of my visit, and I received copies of all their program and parent materials. At the conclusion of my visits, I prepared a fifty-page case study based on my memos and notes specifically for them about their program.

Data Analysis

Grounded Theory Approach

Qualitative data analysis is the stepwise process of generating explanations as to why social phenomena occur (Mason, 1996). In the *Basics of Qualitative Research*, Strauss and Corbin proposed four stages for how to approach and examine data from a grounded theory perspective (Strauss and Corbin, 1998). In the first stage of " open

coding", the purpose is to break data apart so it can be examined more carefully and logically, and to allow relationships between phenomena to surface. During this process, clusters of information group together and relationships between these clusters begin a tenuous connection. It may be possible to diagram these relationships.

As more data is categorized, these categories are given theoretical meanings, known as concepts. As analysis progresses, more concepts emerge as data is coded. Each category is further defined by describing its characteristics, referred to as properties and dimensions. For example, as I coded transcriptions of the hospital-based doula interviews, I noticed several concepts that were familiar from the data from independent practice doulas. Namely, there was emotional support, physical support, and informational support. However, certain new concepts also emerged as important: "reading cues" and "individualizing care". Eventually all of these fell under the category of the hospital-based doula's conceptualization of effective labor support. These five concepts represented some of the different properties of effective labor support. A dimension would refer to how well each individual doula was able to carry out each of these aspects.

Open coding was done for all thirty-six doula interviews and twenty-six mother and mother-father interviews. Previous coding of the data from my master's thesis was discarded and each transcribed interview was examined sentence by sentence for emerging concepts. When sentences seemed to contain multiple codes, they were broken down further. First, the 28 independent practice doulas interviews were analyzed for codes relevant to the inquiry. Then transcribed interviews from the ten mothers who received IP doula support were analyzed. The findings were written up for the

informational support, advocacy, and fathers and doulas chapters. At the conclusion of the analysis of these data sets, the six hospital-based doula interview transcripts were analyzed and the results were written. Once that was concluded, the sixteen interviews from parents who received labor support from hospital-based doulas were analyzed and described.

Open Coding

All four groups of informants were coded separately from one another. In other words, categories were allowed to develop from each of the participant groups without a preconceived label or design of what ought to be present. In this way, I was unencumbered by any previous framework and could allow the written and spoken meaning to surface. Granted, since I had been immersed in this data for eight years, I did have some idea of what I might find or hoped to find. But creating new categories with each group enabled me to see the connections within each group's participants. During later stages of analysis I looked for connections between groups.

In beginning the open coding for each group, each line of the interview was examined for meaning. I found the line-by-line analysis effective in my previous endeavors. Focusing at this level of detail allowed the data to speak more fully and without the constriction of only being part of a major idea or theme. Typical questions asked of each line were, "What is being said here? What is the speaker's perspective? What do these words mean? Why this topic? How was this said?"

In this process, Strauss and Corbin state, "The data is not being forced, the data is being allowed to speak" (Strauss and Corbin, 1998, p. 65). Their perspective is that every word, phrase, and utterance has meaning. The researcher's job is to discover the

meaning intended by the participant and convey these multiple meanings into a coherent theory. Sometimes I did find that a particular segment had multiple meanings and coded it in several categories.

Use of Qualitative Software

Throughout the open coding process, Nvivo version 8 software by QSR International was utilized. Initially, the three initial IP doula interviews and two initial IP doula client mother interviews were printed and coded by hand, then those codes were created in the computer program. I did not want my analytical process to be distracted by learning a new program, and inputting codes enabled me to analyze these transcripts twice. Each of the four participant groups was analyzed separately with their own emergent codes. Use of the software enabled the analysis process to advance more quickly. However I did not use any advanced features to make connections between concepts. Rather I used the program as a cataloguing mechanism for the coded excerpts.

Axial Coding

Axial coding reveals the answers to questions such as when, why, how come, and under what conditions. During open coding, data is divided into chunks, and similar pieces from different sources are grouped together. During the axial coding process, these open codes are examined to uncover the relationships that exist between them. Structures emerge between different codes. Structure refers to the conditions that create circumstances under which certain phenomenon occurs. Process denotes the interaction over time of persons and groups in response to certain issues or events. These relationships can take different forms – some of the open codes may be steps in the same process. Other open codes may reveal the functions of that process.

Open coding helps the researcher to create more global concepts, such as informational support and emotional support. In axial coding, the question asked is, "What is going on in this description of emotional support?" Broad categories are refined into smaller and smaller subcategories. Similar incidents from different participants are grouped together. Whenever a transcript seemed to hold a multiple codes in the same excerpt, I would conduct a microanalysis or line-by-line analysis. As part of the axial coding process, I was able to discern whether these multiple codes were actually present. If so, what was the relationship implied by their location in the same line? I spent time with these data segments, teasing them apart, and fitting the theoretical relationships together again into a model.

Discriminate Sampling And Axial Coding

Since I had conducted and analyzed doula and mother interviews for my thesis, both of the Lexington samples represented discriminate sampling. Discriminate sampling is a deliberate technique to purposely choose sites, circumstances or individuals to maximize comparative analysis. My desire was to test my ideas about effective labor support with a sample of hospital employed doulas and parents who had been recipients of their support. Doulaing fathers had also emerged as a significant concept in the 2002-2003 wave of data collection and I wanted to hear the voices of fathers as well.

Making the decision not to have parallel sample groups was not one I made lightly. If I had only interviewed mothers in South Carolina, the only difference between the samples would have been hospital-based versus independent doula care. After weighing the pros and cons, I decided that triangulating the data sources by including fathers as informants held greater potential for strengthening the inquiry. There was the possibility

that I would not get a complete perspective from one member of the couple but only their shared perspective. It was also possible that one partner might overshadow the other. Content analysis revealed that mothers shared more about the actions or activity of birth – the "what happened" part. Both shared equally in their perceptions of the doula and recollections about labor support. In codes that involved the father's experience of birth or relationship with the doula, there were more coded excerpts from fathers than mothers, 54 excerpts from fathers compared to 37 coded excerpts from mothers. The fathers' excerpts were longer and more detailed. Content analysis consisted of counting excerpts, as well as examining the length of the transcript spent on different topics. While there was some variation from couple to couple, there were no joint interviews where one member seemed to dominate.

When I did the South Carolina interviews, I had a base of knowledge to work with. The unique skills of hospital based doulas and the relationships between those skills and the base model became clear. Not only was I examining for additional concepts, but I was also paying attention to what was missing. Most notably, empowerment had emerged as a significant concept in the interviews with IP doulas and mothers. I noticed that few hospital-based doulas spontaneously mentioned empowerment or told birth stories with an empowerment component. In my second doula interview, I asked the doula directly about this concept.

Selective Coding

In the third stage of analysis, major categories are linked and integrated to form a larger theoretical scheme. This is the beginning process of forming a substantive theory. Strauss and Corbin call this theory-generating process of integrating and refining data

selective coding. They offer several methods to assist the researcher at this stage in forming larger links among concepts, and discovering commonalities and contrasts in the relationships between these concepts. They recommend choosing a central category, making diagrams, and writing a story illustrating the theory to assist in this process.

In this stage, the theory is refined until it is ready for evaluation. Poorly developed categories are examined more carefully. More data are obtained through discriminate sampling in order to test certain concepts or strengthen categories. During this stage, I drew several relationship models on white boards with circles and arrows. They changed several times as I connected other categories to the process at different stages. For example, as I categorized the relationship factors between doulas and fathers, data from each sample confirmed the initial framework. Their different perspectives strengthened and expanded the original idea at the same time.

Development Of The Conditional/Consequential Matrix

In the final stage of theory evolution, the categories and their properties and dimensions come together to create a coherent model. Beginnings can be sourced, and conditions for dimensional differences make sense and can be explained. To achieve the matrix level of theory development, the model needs to show the conditions under which the concept occurs, its properties and dimensions, functions and processes, as well as the consequences or outcomes of the concept's presence or processes. Two matrix level models developed in this study. The first is a model of effective labor support by hospital-based doulas. At the conclusion of the analysis of hospital-based doulas and HB doula mothers and fathers transcripts, a strong model emerged. Both perspectives validated and expanded on one another. The matrix, shown in Figure 4, shows that there are three components that

are foundational for hospital-based doula support to be effective. Once they are established, there are eight elements of labor support that doulas enact and parents experience. These eight elements may or may not all be present, but all would be present if the labor support were maximally effective.

The second conditional matrix model is in Figure 5, a model of the father's birth experience with a doula. Another finding, philosophical differences between doulas, needs additional data and analysis before a model can be developed.

Conclusion

Grounded theory allowed for the comparison of data from multiple sources, and creativity and flexibility in coding. While involved in the qualitative process, it is necessary for the researcher to "inhabit" their data. Denzin describes interpretation as an "intimate act" (Denzin, 2000). For the last several years, I have lived and breathed with these doulas' and parents' stories. From the initial interview to checking the transcriptions, making and reading memos, analyzing transcripts, analyzing codes, creating connections and models, and eventually a working consequential matrix, this data has been my world. I have strived to remain quiet so that the patterns will reveal themselves to me. When I felt confused, I did not try and force an answer. Instead I trusted that with time the insight would come, and it always did.

The past eight years of utilizing Strauss and Corbin's methods have trained my mind to work in a particular way. They give a great deal of instruction and guidelines to follow for the novice researcher, but allows for the flexibility necessary to apply to a wide range of social processes. Now that I am no longer a novice, the processes of sorting, analyzing, categorizing, and then feeling for properties and dimensions and functions feel

second nature. I know where I am in the coding and theory development process by what it feels like to be there. It is like unraveling a knotted skein of yarn and then using it to weave a sculpture. The sculpture's pattern feels like it was in the yarn the whole time, but it could not be seen by everyone until it was created.

Procedures For Increasing Trustworthiness And Reliability

There is a great deal of disagreement among researchers regarding how the judgment of quality of research is conducted (Rolfe, 2006). Charmaz states that only a researcher with a belief that grounded theory research can reveal objective verifiable truth sees trustworthiness or verifiability as possible and important (Charmaz, 2000). Several grounded theorists, including Charmaz, value research that is subjective and doubt the possibility of minimizing it. Lincoln and Guba accept the need to create standards for research quality but reject the quantitative research notions of reliability and validity (Lincoln & Guba, 1985). Instead they introduced their concept of trustworthiness and four criteria for achieving it. Trustworthiness is the degree to which the interpretations of the data accurately describe the phenomena under investigation. Sandelowski agreed with their idea but criticized their recommended methods for achieving it (Sandelowski, 1993).

Amongst the backdrop of these conflicts and differences in philosophy, I made my choices. For this research project, I adopted a rigorous, auditable methodology in utilizing Strauss and Corbin's 1998 grounded theory procedures. I also applied strategies derived from Lincoln and Guba's four trustworthiness criteria for judging the soundness of qualitative research: credibility, transferability, dependability, and confirmability. My desire was to create as objective a window as possible on the processes and functions of

effective labor support. I wanted readers to feel they could comprehend and empathize with the experiences of participants and that the analysis created a credible story. Other researchers could follow my procedures and reach similar conclusions. To me, creating a trustworthy interpretation was of significant value.

Transferability estimates the extent to which the results of the inquiry can be generalized to other contexts or settings (Lincoln and Guba, 1985). Credibility is an appraisal of whether the interpretation of the data is plausible and represents participants' original data accurately. Confirmability signifies the degree to which others could corroborate the findings and interpretations. Dependability refers to the idea that the research study could be repeated resulting in the same core findings. It also means that the researcher needs to account for changes that occur within the setting, to the researcher, or social influences that might shift the findings. In other words, a world event or personal experience may shift the meaning or interpretation of the data and need to be accounted for within the analysis.

Transferability

In order for the reader to evaluate whether the interpretation and findings can be generalized to another setting or participants, enough information must be provided. Throughout this research study, thick description that reflects the complexities of the participants and their relationships has been included. Variations between people and settings have been noted. Demographic characteristics of the samples are in the accompanying Tables 4-9 and Appendix D. In addition, the contexts in which labor support occurred have been detailed. With this information, the reader can draw the conclusions about whether the story of the data is transferable to other circumstances.

Credibility

Credibility was addressed through the employment of three different strategies that were applied to different stages in the research process: triangulation, negative case analysis, and member checking. First, the data sources were triangulated in two different ways. In this instance, triangulation refers to the use of multiple data sources to provide corroboration (Creswell, 1998). Participants in both samples included both the givers and receivers of labor support. Doulas and mothers were included in the first sample, and doulas with mothers and fathers interviewed jointly were included in the second sample. In another triangulation of data sources, both independent practice doulas and hospital-based doulas were included as participants. Similarly, mothers and fathers were included as participants. All four data sources are analyzed separately.

Credibility was also enhanced through negative case analysis. In two instances, mothers had experiences that were not in alignment with the findings derived from the existing analysis. Each time, the mother's description of her experiences was examined as a whole as well as in a line-by-line analysis. Examining her narrative as a whole allowed for the examination of themes present in her story. Looking at themes present allowed me to make sure that I was not missing something by focusing on the smaller data segments, referred to metaphorically as "missing the forest for the trees". Line by line analysis allowed for the expansion of the existing codes to include the reality of her experience during the selective coding process. Inclusion of both cases strengthened the findings and development of the theory.

Lastly, member checking was employed to enhance the credibility of the study of the independent practice doula and mother participant findings. Copies of the chapters on

informational support, advocacy, and fathers and doulas were supplied to a focus group of doulas. These doulas were not members of the original sample, however they met all of the criteria for inclusion. Two separate focus group meetings were held, one on informational support and advocacy and one highlighting doulas and fathers. Each meeting took three to three and a half hours. Members were supplied with a printed copy of the chapter two weeks before the meeting. They were instructed to write whatever notes and questions they wished on their copy. During the meeting, the group went through the chapter page by page. I took notes on their comments and questions. Reviewer D was absent from the Advocacy meeting, and Reviewers F and G were absent from the Fathers meeting. Each reviewer supplied written comments before the meeting. At the conclusion of the second meeting, their copies were collected and I retained them as a permanent record of their responses.

I strived for diversity in this group; there is a complete description of the members in Table 10. Members were from across southern Wisconsin and were recruited through doula networks. Two of the members had been introduced to me once (reviewers C and E); I had never met reviewer G. Two of the members had taken a doula training from me; and one is my doula training business partner. This group served to provide critical feedback based on their varied experiences. Between them they had attended 742 births in a doula role.

Overall, group members affirmed my findings and interpretations with strong validation for each detailed category and concept. This group critiqued my work carefully and would often mention specific sentences or phrases that stood out to them. Reviewer C had just completed a novel and was quite critical at times of my

Table 11.

Description of Review Group Members

Name	Age	Location	Number of Births Attended	Year Began Doula Work	Population of Mothers Served	Relationship to Researcher	Other Qualifications
Reviewer A	Over 60	Madison Wisconsin	256	1978	Independent: 151 Volunteer: 105	Long time members of local birth community	Director, Volunteer Doula Program
Reviewer B	53	Madison Wisconsin	184	1990	Mothers with strong desire for natural childbirth, Independent Practice	Doula Co-Trainers	Retired Bradley Birth Educator, Physical Therapist
Reviewer C	35	Waukesha Wisconsin	53	2001	Hospital Based: 15 Independent: 33 Volunteer: 5	None	
Reviewer D	43	Sun Prairie Wisconsin	76	2005	Independent Practice	Took researcher's doula training in 2005	Hypnobirthing Childbirth Instructor Trainee
Reviewer E	31	Madison Wisconsin	25	2009	Mothers with strong desire for natural childbirth, Independent Practice	Took researcher's doula training in 2008	Owner, Maternity Store and Parenting Resource Center
Reviewer F	29	Madison Wisconsin	33	2006	Mothers with strong desire for natural childbirth, Independent Practice	None	Bradley Method Childbirth Educator

organizational and sentence structure. During the meeting, the doulas took the opportunity to tell the story of a birth that was similar to an instance I had excerpted. No one challenged any of my interpretations of the participants' stories or the story that the coding and categories told. Except for one instance, they felt that the interpretation fit the excerpt. In that one instance, Reviewer C took exception to an interpretation however the rest of the group disagreed with her. Once I explained it a bit more, we came to the conclusion that I needed to frame the story more effectively. The category had three other excerpts that fleshed it out which she did agree with. All of the reviewers expanded on the joys and frustrations of doula work. Although each reviewer had different backgrounds and client types, each found herself represented within the data. While an individual reviewer might not agree with a particular stance that a participant had taken, other reviewers in the group did. During the advocacy findings discussion, as I listened to Reviewer E speak on the subject of empowerment, I experienced another "aha moment". The finding on the philosophical orientations to doula support was sparked by her responses.

Confirmability

The importance of confirmability is to ensure that the findings of this study are shaped by the participants and not by the researcher's self-interest or conscious or unconscious bias. This would be especially important in this study since I have such a long history in the profession. The idea of objectivity in this study is impossible. In fact, it is my immersion in the activity of doulaing that brings an exquisite sensitivity to the analysis. My subjectivity is a strength as an analytical tool, but only if I am aware of my own biases and desires throughout the research process.

In order to satisfy any concerns about confirmability in this study, I triangulated my sources and employed a strict audit trail including reflexive notes. During the recruitment phases, I cast as wide a net as possible to find doulas and parents from across North America. My sample is large by qualitative standards, as I have interviewed 74 individuals in 52 interviews. The heterogeneity in the samples and triangulation of sources increased the probability of diversity of experience.

Second, my notes on my research decisions are copious and document my choices throughout the study. Many of them are detailed in this chapter or in my previous master's thesis. The use of a computer program to code my observations assists in providing a trail of my coding decisions. More printed notes show my analytical choices.

In addition, I kept notes on what I expected to find in order to make sure that I was not carrying any expectations that would block my listening during an interview. During research, as in life, it is normal to have expectations. However, in order to increase effectiveness in both it is necessary to continually be aware of and work to dispose of those expectations. My main mantra was to be authentically curious throughout the project. "What would this person tell me? What would be revealed today when I examined my data? Would participants' excerpts cluster or disperse when went further in probing a code?"

It is human to examine other's stories and to respond, "That is like me", or, "That is not like me." However it was especially critical that I be aware of the subsequent thought. "That is not like me or my clients and…" I needed to make certain my experience was contributing to understanding and deeper questioning and analysis rather than blocking it from occurring. I believe that the strength of my data sources,

documented audit trail, and detailed thick description all provide evidence towards meeting the standard of confirmability.

Dependability

Another advantage of cataloguing methodological procedures is that it increases the dependability of the study. Would another researcher following the same procedures and format throughout their study arrive at the same core categories and interpretations? Being precise and noting significant decision making rationales assists in establishing dependability. However additional historical and chronological factors may also influence outcomes and need to be accounted for. There are changes within the researcher, study settings, and cultural influences that require documentation.

Since the dissertation proposal two years ago, I have not been to any births and have immersed myself in the role of a researcher and educator. I have spoken at several conferences about my past research findings and discussed my interpretations with several experts in my field. There are no significant personal changes that merit any bearing on this research study. Within the study settings, labor support practices do not seem to have changed significantly since the data was collected. The Lexington Medical Center Doula Program has changed some of its protocols based on the case study I prepared for them in 2005. I remain active on a doula programs list serve and an international doula list serve with over 800 members. This daily contact keeps me apprised of issues in the doula world. However there have been some changes affecting doula care in the last eight years that are addressed in the next section.

Table 12.

Historical Changes Affecting Doula Care 2002-201 0

Media Exposure of Doula Care Increases	Documentaries illustrating current controversies in childbirth: Business of Being Born (2007) Pregnant In America (2008) Orgasmic Birth (2008) Laboring Under An Illusion (2009) Mainstream Film Mentioning Doula Care: Knocked Up (2007) Away We Go (2009) Television Series on Childbirth that Feature Doula Care: A Baby Story (TLC) Maternity Ward (Discovery Health) Birth Books Written by Doulas: *A Doula's Guide to Childbirth* by Ananda Lowe *A Holistic Guide to Embracing Pregnancy, Childbirth, and Motherhood: Wisdom and Advice from a Doula* by Karen Salt
Cesarean Rate in the United States	Increased from 20.0 % in 1990 to 31.8% in 2007 An increasing number of studies show that this is not the result of increased use of epidurals
Induction Rates in the United States	Show an increasing trend, 22.2% in 2006 from 19.4% in 1998 and 9.5% in 1990
Controversies	Increasing debate over "maternal choice" cesareans Increasing awareness of liability concerns of obstetricians and effect on birth practices

Historical Changes Affecting Doula Care 2002-2010

The changes that have occurred in doula care over the past decade have primarily come from within the doula profession. There is an increased recognition among doulas of the value of labor support. More doula programs are sustaining themselves rather than existing for a few years and then folding (Perez, 2009). The organization *Doulas of North America* has become *DONA International,* with branches in sixteen countries. Most doula organizations have shown increasing membership rates during this timeframe.

Sociocultural changes that have occurred during this period include the increasing cesarean rate in the United States, which reached 31.8% in 2007 (Hamilton, 2009) from 20.8% in 1995 (National Center for Health Statistics, 2010). The cesarean rate is increasing incrementally after a rapid rise from 20% in 1990. The induction rate was 22.2% in 2006, and this has shown a more rapid upward trend to the present time (Ventura, 2007). The rate of maternal morbidity and mortality has been rising gradually since 2000 once reporting techniques improved (Hoyert, 2007). Doulas are practicing in an environment where the use of medical intervention is seen as normal, but there are also increasing complications due to the use of such medical interventions (Block, 2007). These changes are summarized in Table 11. Attendance at childbirth education classes continues to decrease with only 60% of first time mothers attending any type of class (Lothian, 2008; Walker et al., 2009). While the decline has been continuing it has also been gradual, so its impact on doula practice is likely to be negligible.

The other main influences on doula practice appear related to the media. Mothers and their families may watch popular television shows on childbirth and thus they may be

exposed to visual images of IV's, electronic fetal monitors, pitocin inductions, and epidurals. As a result, mothers may become increasingly comfortable with interventions, although this has not been examined empirically. Viewers of the popular media may also be exposed to doulas more now than in previous years. Cable television network TLC's "A Baby Story" produces several episodes a year that feature labor support by a birth doula. One of the doulas in this study, Thalia, has been in four episodes of this show in the past few years. A 2009 documentary film, Laboring Under An Illusion, examines media depictions of childbirth as a constructed false reality. Doula support has also been mentioned or featured in three other documentary movies and two mainstream films. Doulas have also written two general interest childbirth books with the word "doula" featured in the title. Although still not considered mainstream, it appears that doulas are becoming part of the landscape of childbirth in the United States.

None of these changes has appeared to create a shift large enough to influence the main findings of this study. The perspectives of doulas, mothers, and parents gathered from 2002-2005 still appear to be valid in today's environment. The idea that doula care is becoming more acceptable and mainstream alongside cesarean section and acceptable use of technology is quite interesting, although it is outside the scope of this project.