

THESIS

RACE, SEXUAL ORIENTATION, AND CHILDBIRTH: LOCATING IDENTITY IN
THE FRAMEWORK OF SOCIAL SUPPORT

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Bentley Porterfield-Finn

Department of Communication Studies

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Advisor: Meara Faw

Elizabeth Parks
Samantha Brown

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ABSTRACT

RACE, SEXUAL ORIENTATION, AND CHILDBIRTH: LOCATING IDENTITY IN THE FRAMEWORK OF SOCIAL SUPPORT

Social support is a growing field in Communication Studies. Scholars from a variety of disciplines have studied the influence of social support on health, but there is a need for more research which considers how identity factors, including racial identity and sexual orientation, influence supportive interactions. Using the case study of childbirth as a stressful event and investigating the role of doulas as support providers in this context, the present study explores how identity influences both provisions of support and evaluations of support. This mixed methods study, consisting of interviews with doulas ($n = 16$) and a survey of expecting parents ($n = 168$), deepens our understanding of how racial identity and sexual orientation influence how doulas communicate support to birthing persons as well as how these identity factors influence from whom expecting parents report a willingness seek support. Combined findings from these studies illuminate how doulas support birthing persons and the nuanced influence of racial identity and sexual orientation on this support. Limitations and future directions are discussed.

TABLE OF CONTENTS

ABSTRACT	ii
LIST OF TABLES	v
Chapter 1 – Introduction	1
Chapter 2- Literature Review.....	4
Social Support and Health	4
Types of Support.....	5
Negative/Unproductive Social Support	7
Support Gaps and Support Discrepancies	8
Childbirth as a Stressful Event.....	10
Social Support in Labor	12
Doula Support	13
Benefits of Doula Support	15
Doulas and Types of Support.....	18
Theories of Identity and Culture	20
Communication Theory of Identity	21
Identity Negotiation Theory	23
Current Research on Identity and Social Support	24
Racial Identity and Communication	27
Social Support and Sexual Orientation	34
Chapter 3 - Methods.....	39
Positionality	39
A Mixed-Methods Approach	39
Study 1: Interviews With Doulas	40
Participants and Recruitment	40
Procedures.....	40
Analysis	41
Study 2: Survey of Expecting Parents	42
Participants and Recruitment	42
Procedures and Measures.....	43
Racism and Life Experiences.....	44
Perceived Stress Scale	44
The Wijma Delivery Expectancy/Experience Questionnaire	44
Desired and Experienced Support Scales	45
Doula Profile and Implicit Preference	45
Chapter 4 – Study One Results: Interviews With Doulas.....	48
Role of Doulas	48
Advocacy	48
Informed Consent.....	50
Trauma-Informed Care	51
Education and Informational Support.....	52
Emotional Support	53
Respect.....	53

Empowerment	54
Relational Caring	55
Network Support.....	57
Identity and Doula Experiences	59
Medical Racism	60
BIPOC Doula Experiences	61
Relatability	62
Communication.....	63
Hiring challenges	64
White Doula Perspectives	65
Allyship.....	65
Difference	67
Communication.....	69
Sexual Orientation and Doula Experiences	70
Language.....	70
Identity Affirmation	72
Chapter 5 - Study Two Results: Survey of Expectant Parents.....	74
Chapter 6 – Discussion	83
Doulas as Support Providers	84
Models of Care.....	87
Racial Identity	88
Support Provisions	92
Strong Black Woman Collective	94
Theory of Resilience and Relation Load	98
Support Evaluations	99
Sexual Orientation	101
Practical Implications.....	102
Limitations and Future Research Directions.....	103
Conclusion	105
References.....	107
Appendices.....	134
Appendix A: Interview Protocol.....	134
Appendix B: Doula Profiles.....	136
Appendix C: Hypotheses and Research Questions	138

LIST OF TABLES

Table 1: Demographics of Doula Participants47
Table 2: Hired Doula x Familiarity with Doula Support74
Table 3: MANOVA results exploring interactions between race, LGBTQ, and doula profile.82

CHAPTER 1 – INTRODUCTION

Research has established the influence of supportive communication on quality of life (MacGeorge, Feng, & Burleson, 2011); however, scholars have not adequately explored the various ways identity might influence supportive communication in social networks or health contexts. While scholars have developed a strong guiding framework of social support and health communication, the framework stands to benefit from more research including considerations of individual and cultural diversity. Investigations into supportive communication have the potential to be bolstered if scholars center the intersections of identity and supportive communication in their investigations, bridging social support theories with critical cultural theories.

In order to address this gap, the present study seeks to examine the role of identity in the context of doula support. Birth doulas are trained non-medical birth professionals who provide emotional, physical, and informational support to birthing persons prenatally, continuously throughout the labor process, and immediately postpartum (DONA, 2020). Childbirth offers a unique context to explore the mechanisms of social support, especially as they relate to identity because maternal health disparities exist for birthing persons with marginalized identities. For the purposes of this investigation, I focus on two identity factors: racial identity and sexual orientation.

The United States has the highest maternal mortality rate of high resources countries (MacDorman et al., 2016). This is a problem disproportionately impacting women of color, most specifically Black, Indigenous, Persons of Color (BIPOC), and lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals. According to the Pregnancy Mortality Surveillance System, Black women are 3.4 times more likely than non-Hispanic White women to

die due to pregnancy-related causes (Creanga et al., 2017); in New York, they are 12 times more likely to die (Creanga et al., 2015). Compared to straight women, sexual minority women, defined as women who have sex with women, are more likely to report miscarriage or a pregnancy ending in stillbirth; they are also more likely to give birth to children with a low birth weight or to report a very preterm labor (Everett et al., 2019). Further, not much is known about co-mothered families and their experiences of childbirth because they are an understudied population (Darwin & Greenfield, 2019).

The current study examines how racial identity and sexual orientation influence provisions of doula support and expectant parent's evaluations of doula's support potential. The purpose of this study is to critically explore identity as a factor of supportive communication. A mixed methods approach is adopted, using qualitative measures to explore doula's perceptions of how their identities influence the support they offer and their interactions with clients. Quantitative measures are also employed to investigate how identity influences expecting parents' desire for support in labor and their likelihood to seek doula support, specifically from either a Black-identifying or White-identifying doula.

This project argues the imperative of centering critical perspectives of identity in social support research, using the context of doula support in childbirth to exemplify the role of identity in support provisions and support seeking behavior. I begin with a review of the foundational literature on social support. I then offer insight on the rationale of childbirth as a stressful event, followed by an explanation of the current research on doula support for childbirth. Through engagement with theories of identity, I highlight the nature of identity to argue the necessity of considering the unique ways identity influences supportive communication. Specifically, I focus

on research that highlights how racial identity and sexual orientation influence communication. I then move into a description of my methods, and the findings of my research.

CHAPTER 2 – LITERATURE REVIEW

Social Support and Health

People are influenced by their social networks, and guiding frameworks of social support have highlighted the relationship between supportive communication and quality of life. When humans experience both positive and negative stress, they turn to their social networks for support, and the support they receive has an important impact on their wellbeing (Sarason, Sarason, & Gurung, 1997; Goldsmith & Albrecht, 2011). Albrecht and Adelman (1987) define social support as, “Verbal and nonverbal communication between recipients and providers that helps [manage] uncertainty about the situation, the self, the other or the relationship and functions to enhance a perception of personal control in one’s life experience” (p. 19). This definition emphasizes the centrality of communication to social support. Moreover, social support research is fundamentally the study of supportive communication (MacGeorge, Feng, & Burleson, 2011). Humans most often seek social support when they experience situations that result in stress (Sarason, Sarason, & Gurung, 1997).

Academic investigations into social support can be traced back to the 1970s, and these investigations now exist across disciplines (Goldsmith & Albrecht, 2011). For example, research has shown that higher levels of perceived social support result in more positive health outcomes (Floyd et al., 2018; Uchino et al., 1996, 2012), including reduced levels of depression (Dehle et al., 2001) and improved immune function (Cohen et al., 2003). Additionally, social support can act as a buffer against the negative effects of stress, as demonstrated by Cohen and Willis’ (1985) *stress-buffering hypothesis*. This stress buffering function of supportive communication has been observed physiologically in studies which have measured the reduction in cortisol

levels (a hormone released in the body when one experiences stress) that occurs when individuals receive person-centered support in interpersonal interactions (Faw, 2018).

Supportive communication is a fundamental dimension of social support, as social support is a communicative process that is embedded in the structure of interpersonal relationships (Albrecht & Adelman, 1987; Goldsmith, 2004). Supportive communication is a necessary condition for maintaining a good quality of life, whereas lack of social relationships and experiences of social isolation are risk factors for mortality (House et al., 1988). As the social support framework has developed, evolved, and been studied more thoroughly, researchers have found that supportive communication is a complex phenomenon and that not all support is created equal (Bodie et al., 2012).

Types of Support

Various types of social support exist (Cutrona & Russell, 1990; Xu & Burleson, 2001). Xu & Burleson (2001) conceptualize five types of social support: *emotional*, *informational*, *tangible*, *esteem*, and *network*. *Emotional* support consists of attending to another's emotional needs to mitigate feelings of distress. *Informational* support is the giving of facts and advice related to the situation of concern. *Tangible* support is the giving of material assistance, such as goods or services. *Esteem* support involves expressions of respect or validation. Finally, *network* support is generating feelings of connection and cultivating a sense of belonging (Xu & Burleson, 2001). Each of these types of support are examples of behaviors that may be used to communicate support. Different contexts and personal preferences may determine which types of support are most effective at promoting coping in a given situation (Crowley & High, 2019, 2020).

Research has also highlighted the importance of considering how specific types of support influence overall health (Cohen, 2004). *Informational, emotional, and tangible* support are all examples of enacted support, or “what people say and do to help one another cope with stress” (Goldsmith, 2004, p. 31). Enacted support is carried out in conversations and outcomes are influenced by both a support provider’s intention and a recipient’s evaluation of the supportive conversations (Goldsmith, 2004). Studies into enacted support have explored, “the conditions under which communication has beneficial outcomes, including features of interaction that make some attempts more beneficial than others” (Goldsmith & Albrecht, 2011, p. 337). These studies have demonstrated that not all instances of enacted support are advantageous or effective at mitigating negative consequences of stress (Bolger & Amarel, 2007; Gleason et al., 2008). Enacted support leads to effective coping when it meets the demands of the stressor as experienced by an individual, and matches the quality and quantity of support the individual desires (Cutrona & Russell, 1990; Holahan et al., 1997). For example, Zwickert and Rieger (2014) found that obese women seeking support for weight management often received unsolicited advice from loved ones or support that minimized their weight concerns, which led to an increased difficulty in their attempts at weight management or control. Similarly, Gleason and colleagues (2008) established that enacted support is more likely to promote well-being when a supportive conversation leads a support recipient to feel closer with a dyadic partner. These studies build on previous, broader investigations into supportive communication, revealing the need for specificity in inquiries into social support.

Indeed, social support is a complex topic to theorize about because it is not a single, unified construct (Goldsmith & Albrecht, 2011), and scholars are continuing to refine investigations into supportive communication to explore the nuanced mechanisms of support and

how they influence outcomes. Comprehensive investigations into supportive interactions must consider support type, support provider, support recipient, support quality, and support expectations, among other things (Bodie et al., 2012; Davis & High, 2019). Research has begun to more consciously explore instances of undesired social support and supportive communication that result in negative health outcomes. I argue that identity should be considered as a factor that influences the variance in experiences of social support because identity influences communication and some stressors are explicitly related to identity.

Negative/Unproductive Social Support

Despite the generally positive associations that have been found between social support and health, further studies have revealed that some social support may actually cause a support recipient more distress. Some well-intentioned support attempts are not seen as effective or adequate to the person receiving support (L. A. Ford & Ellis, 1998), and support is most beneficial when it is appraised as useful (Heller et al., 1986). For example, an investigation by Brock & Lawrence (2009) found that receiving more support or less support than desired results in decreased relational satisfaction. The same study also found that the cortisol recovery experienced after a stressor is faster when the support a person receives matches the support they desire; this occurrence is called *support-matching*. This finding has complexified earlier frameworks of social support because it revealed that social support is not universally beneficial and that support is most effective at stress mitigation when it meets the needs of the individual receiving support.

Moreover, support networks may actually do more harm than good (Goldsmith & Albrecht, 2011; Revenson et al., 1991). For example, advice can have conflicting outcomes—it can promote caring and closeness, but unwanted or uninformed advice can cause emotional

distress or be perceived as criticism (Goldsmith & Fitch, 1997). Social support scholars must be attentive to the quality and appropriateness of support when making arguments for its importance (Xu & Burleson, 2001; Goldsmith, 2004). Recent literature exploring support adequacy and support discrepancies reveals what can happen when supportive conversations breakdown or when there is a incongruity between the support individuals desire and what they receive (High & Crowley, 2018; High & Steuber, 2014a; Xu & Burleson, 2001). Thus, investigations into supportive communication and support outcomes benefit from specificity and attentiveness to perspectives and qualities of all participants involved in the communicative interpersonal encounter.

Support Gaps and Support Discrepancies

Social support has been found to be counterproductive in the presence of support gaps. *Support gaps* are, “discrepancies among recipients’ perspectives on supportive interactions, including what they need, expect, and receive, across various types of support” (Davis & High, 2019, p. 188). Support gaps exist when support-matching does not occur but goes a step further to consider the perspectives of both interactants and what occurs when they perceive the supportive interaction differently. The greater the degree of the gap, the greater influence it has on interaction outcomes (McLaren & High, 2019; Wang, 2019). Support gaps research adds depth to previous understandings of social support, revealing that individuals have unique preferences for the support they desire and the support they provide, and how experiencing discrepancies in support can lead to negative outcomes. Additionally, support gaps research demonstrates the importance of considering various perspectives in communicative encounters—that of the support provider and the recipient.

There are a growing number of studies investigating support gaps (Crowley et al., 2019; Crowley & High, 2020; High & Steuber, 2014a; McLaren & High, 2019). Recent research into support gaps has established that not all support gaps have a negative outcome (High & Crowley, 2018), as was previously theorized (High & Steuber, 2014a; Matsunaga, 2011). Supportive interactions are complex, and different outcomes result when a person is over-benefitted (receives more support than desired) compared to when they are under-benefitted (receives less support than desires) (McLaren & High, 2019). In the context of infertility, High & Steuber (2014) found desires for support vary by type and relationship. For example, the support an individual seeks from their romantic partner might be different from what they desire from a maternal figure. Additionally, High and Crowley (2018) highlight the importance of seeking support, because people may not receive the support they desire unless they actively seek it. Crowley and High (2020) built on this premise, highlighting the importance of considering both desires and perceptions. Their support gaps framework posits that,

“(a) people generate desires for different amounts and types of support prior to supportive interactions, (b) people’s perceptions of the amounts and types of support they receive are unique from their desires, and (c) people coping with a stressor often desire more support than they receive.... (d) support gaps have implications for people’s personal and relational well-being. ... (e) receivers experience the best outcomes when providers match their desires for support.” (p. 46-47).

Thus, it is important to consider the perspective of both the giver and receiver of support as well as the type of support offered in a given interaction to better understand the outcome. Two individuals might interpret the exact same supportive message differently, and researchers must keep individual differences in mind when conducting investigations into supportive communication (Goldsmith, 2004). As previously mentioned, when individuals experience discrepancies between support desired and support provided, they

may become more emotionally distressed (High & Steuber, 2013; McLaren & High, 2019). The role of preferences and individuality in support outcomes points to the imperative of considering identity in future investigations of supportive interactions.

Further research has begun to investigate the particular dynamics that influence both support seeking and support providing behavior (Burlison & MacGeorge, 2002; Cunningham & Barbee, 2000), but few of these studies have critically considered how identity factors influence support processes and outcomes. It is known, however, that support recipients do base judgements of support quality on characteristics of support providers (Lakey et al., 2002). For example, previous interactions with a particular person influences the support one expects from a given encounter (White, 2015). Social identity influence supportive interactions (Tajfel & Turner, 1986), and High and Crowley (2019) found that the identity-based relationship (in-group versus out-group member) changes the effect of different types of supportive messages, especially when one experiences an identity-based stressor. Investigation into social support explore support related to particular stressor. The present study explores social support in the context of childbirth.

Childbirth as a Stressful Event

Social support is warranted during childbirth because childbirth is an inherently stressful event, as evidenced by various studies which have measured the increased levels of stress hormones (i.e., cortisol, catecholamines) a birthing person's body releases during childbirth, and by birth narratives that describe feelings of disrespect and birth trauma (Alehagen et al., 2005; Beck, 2004; Brownridge, 1995). The level of stress a birthing person experiences during the labor process directly affects the progression of labor (Lothian, 2004). A 2001 study investigating the release of catecholamines and cortisol throughout the birthing process found

that, “mental stress is more dominant than physical stress during labor” (Alehagen, 2001, p. 61). Additionally, certain situational and emotional factors can exacerbate levels of stress during labor, and when excess levels of stress hormones are released in the birthing persons’ body, labor may slow down or stall (Alehagen et al., 2005). Harsh environment theory says that harsh conditions that often accompany the experience of birthing in a hospital (e.g., medical interventions, strangers, bright lights, needles) are difficult to navigate while in a vulnerable state, and that these harsh conditions ultimately may slow down labor (Hofmeyr et al., 1991).

Moreover, hormones released in the birthing persons’ body help orchestrate the birthing process (Childbirth Connection, 2015). Birth is initiated, propelled, and maintained by the continuous release of the “feel good” hormone, oxytocin (Simkin, 2013). Oxytocin is the opposite of stress hormones, and it is released when one feels calm, supported, and loved (Childbirth Connection, 2015). Physiologically, oxytocin slows the heart rate, lowers blood pressure, and even has an analgesic (pain relieving) effect (Gaskin, 2003). When a birthing persons’ labor is artificially induced, they are given synthetic oxytocin (Pitocin) to initiate the labor process (Wei et al., 2010). The specific physical and emotional comfort measures that lead to increased levels of oxytocin vary depending on personal preferences (Simkin, 2013).

Support and perceived safety are crucial dimensions of the childbirth experience (Mukamurigo et al., 2020). When a birthing person feels safe and supported, birth will progress more smoothly; whereas feeling abnormal amounts of stressed or being on high-alert signals to the brain that it is a not a safe environment to birth (Lothian, 2004). Therefore, receiving support that facilitates feelings of warmth, safety, and love is invaluable (Campbell et al., 2006; Kennell et al., 1991). The specific mechanisms of beneficial labor support can look different for different people—quality support during labor is support that causes the birthing person to feel relax and

release more oxytocin; the support provided by a safe environment allows the birthing person to feel more capable of managing labor (Karlström et al., 2015).

Thus, the birthing person must feel like they can trust their care providers and that their choices and wishes are heard and respected (Baker et al., 2005). Stress not only impacts the progression and duration of labor, but excessive stress impacts maternal and fetal well-being (Lederman et al., 1985). A birthing person's perception of their birth matters. Bell and Anderson (2016) conducted a meta-analysis of studies investigating the relationship between birth experiences and postnatal depression, and they found that negative childbirth experiences are associated with an increased risk of experiencing postpartum mood disorders such as postpartum depression.

Social Support in Labor

When people are socially supported in health care contexts, they are better able to make informed decisions and navigate the complexity of the health care system. For example, social support is linked to improved utilization of health care services among people with HIV (Uphold & Mkanta, 2005). Inversely, a history of low levels of social support for laboring women is positively correlated with having a traumatic childbirth experience and an overall negative perception of the birth (Soet et al., 2003), while having adequate support is correlated with better health outcomes for the mother and the baby (Bohren et al., 2017).

For many birthing people, physical sensations of pain are often the primary cause of stress during labor; however, emotional stress can be exacerbated by additional avowed identity factors, such as race, and sexual orientation. A 2018 study investigating Black pregnant, birthing, and postnatal birthing persons at risk for preterm birth in California found, "Participants described *disrespect* during healthcare encounters, including experiences of racism and

discrimination; *stressful interactions* with all levels of staff; *unmet information needs*; and *inconsistent social support*” (McLemore et al., 2018, p. 130). Further, a lifetime of exposure to chronic stress due to systemic oppression contributes to the wear and tear on a Black person’s body, and how that stress affects pregnancy (Latendresse, 2009).

Given what is known about social support, specifically Cohen and Willis’ (1985) stress-buffering hypothesis, social support is a tool that should be utilized in birthing contexts to act as a buffer against the negative effects of stress such as slowed or stalled labor. Doulas are professional support providers whose role is to offer informational, emotional, and physical support to birthing persons and this support can be utilized to ameliorate the stress of childbirth (DONA International, 2020), and the communication of social support plays a crucial role in the quality of doula care provided (Renteria-Poepsel et al., 2018). Research on doula-assisted birthing provides support for the social support framework and how quality support impacts health.

Doula Support

“If a doula were a drug, it would be unethical not to use it.”

~ *Dr. John H. Kennell*

Doctor of Pediatrics and Maternal Health Researcher

Dr. John H. Kennell was a pediatric doctor, with a research focus on maternal-infant bonding. He is also one of the founders the first doula training and certification organization, DONA International, formerly Doulas of North America (DONA, 2020). As evidenced by cultural birth narratives and artistic depictions of birth, women have historically been supported by other women during childbirth (Hodnett et al., 2005). However, the communal aspect of labor is largely absent in contemporary birth experience (De Vries & De Vries, 2007). Instead, birth has become more medicalized, with births being attended primarily by physicians (Cahill, 2001;

Shaw, 2013). Hospital births were not common until the 20th century (MacDorman et al., 2013), and in 2013, 98.6% of birth occurred in hospitals (Martin et al., 2015). As more births happened in hospitals, the use of medical approaches towards birth also increased, including the use of anesthesia for pain management, birth by cesarean section (surgery), and the use of invasive medical technology to assist delivery (Johanson et al., 2002). Hospitals, doctors, the use of interventions (like forceps or vacuum delivery), and episiotomies (a surgical cut made from the vagina to the perineum) are more common now than they have been throughout human history (Lappen & Gossett, 2010; Wertz & Wertz, 1989).

While maternal mortality rates are decreasing internationally, the U.S. has experienced the opposite trend. The U.S. maternal mortality rate increased by 26.6%, from 18.8 to 23.8 deaths per 100,000 live births, between 2000 and 2014 (MacDorman et al., 2016). This number is higher for women of color. According to the Pregnancy Mortality Surveillance System, Black women are 3.4 times more likely than non-Hispanic White women to die due to pregnancy-related causes (Creanga et al., 2017); in New York, they are 12 times more likely to die (Creanga et al., 2015). The pregnancy-related mortality of Black women with a college degree is 5.2 times higher than their White counterparts (Creanga et al., 2017). Given these statistics, the birth community is exploring intentional ways to reverse this trend. More people are having home births, as well as opting for doula-supported births (Dahlen et al., 2011) in an effort to reduce experiences of what is being termed, “obstetric violence” (Cohen Shabot, 2016; Kukura, 2017). Obstetric violence refers to the coercion, abuse, mistreatment, and lack of respect women endure during childbirth at the hands of their health care providers (Kukura, 2017).

Beginning in the 20th century, nurses were tasked with the responsibility of caring for women during labor (Green & Hotelling, 2014). However, it can be difficult for nurses to

provide continuous support to a birthing person given the various other responsibilities they are tasked with during the labor process (Waldenström et al., 2004). According to the leading doula certifying organization, DONA International (2020), a *doula* is a non-medical birth worker whose primary role is to assist parents during childbirth, offering continuous informational, physical and emotional support. As a non-medical member of the birth team, doulas can provide support that nurses are unable to offer (Trainor, 2002). A birth doula is a trained non-medical birth professional who provides continuous physical, emotional, and informational support to parents before, during, and after childbirth to help them have the most positive and satisfying birth experience possible (DONA International).

Benefits of Doula Support

Doulas provide a crucial service to families by providing continuous support during labor. Continuous support lasts from early labor until the baby is born (Bohren et al., 2017). As a 2001 study found, birthing persons reported that most nurses do not provide continuous support during labor. Specifically, new parents expected nurses to spend 53% of their time offering support, but only six to ten percent of the nurse's time was actually spent doing so (Tumblin & Simkin, 2001). While nurses are usually strangers to the family when they arrive at the hospital, parents can meet doulas before childbirth (DONA International). Prenatal meetings provide an opportunity for doulas and parents to form a trusting relationship outside of the birth setting (Amram et al., 2014). Nurses often change shifts every 12 hours; therefore, several nurses may attend to a family with a long labor (Chapple et al., 2013b). Doulas, comparatively, remain with the family throughout the entire labor process (Amram et al., 2014; DONA International; Koumouitzes-Douvia & Carr, 2006).

Despite the valuable role doulas play as members of the birth team, their support is not widely utilized. Master narratives, or “shared, circulating ideologies that shape individuals’ typical understandings of personal experiences in a particular cultural context” (Horstman et al., 2017, p. 1510), reflect cultural notions of what birth and parenthood look like and in the United States, doulas are largely absent from the master birth narrative; this contributes to the under-utilization of their services (Horstman et al., 2017). A 2013 report from the Listening to Mothers Initiative, which surveyed 2400 women in the United States, found that many women do not use doulas or even know what a doula is; among the women surveyed, doulas were only used by 6% of pregnant women (Declercq, Sakala, Applebaum, & Herrlich, 2013). As this report shows doula support is widely under-utilized by birthing persons.

Nonetheless, continuous support is beneficial to parents and babies. Research finds that women appreciate the support given by doulas while in labor and during the postpartum period, and this postpartum support improves health outcomes for mother and baby (Cattelona et al., 2015; Gjerdingen et al., 2013; Koumouitzes-Douvia & Carr, 2006). Additionally, doula-support enhances oxytocin release, which results in decreased stress reactions, fear, and anxiety, and increased contraction strength and effectiveness (Uvnaas-Moberg, 2014). As such, the calming effect of the doula’s presence increases the mother’s own natural pain-coping hormones, making labor feel less painful (Uvnaas-Moberg, 2014). Doulas also act as a buffer against the harsh environment of the hospital by providing support and companionship as well as boosting self-esteem (Hofmeyr et al., 1991).

In 2017 the Cochrane Library, the leading database for systemic reviews in healthcare and home to the Cochrane Database of Systematic Reviews which conducts reviews of research, synthesizing eligible data to answer a particular research question (Cochrane, 2020), conducted a

review comparing birth outcomes for women receiving continuous support with those receiving “usual care.” The 2017 review, titled “Continuous labor support for women during childbirth,” found that women who receive continuous support from a doula experience a 15% increased likelihood of having a spontaneous vaginal birth, a 30% decreased likelihood of having a cesarean birth, a 10% decreased likelihood of needing pain medication, a 31% decreased likelihood of reporting a negative birth experience, shorter labors by 41 minutes, and increased rates of breastfeeding—outcomes all considered to reflect a positive birthing experience (Bohren et al., 2017). Babies born at doula-supported births are also less likely to have low five-minute Apgar scores (a measurement of babies’ health and well-being immediately post-birth; Chapple et al., 2013; Dahlen et al., 2011; Kennell et al., 1991). Each of these outcomes directly link continuous labor support from a doula to improved health outcomes for the birthing person and the baby.

As evidenced by these statistics, utilizing a doula has life-saving potential. Currently, medical interventions during labor are at an all-time high. The induction rate is 44%, the rate of cesarean birth is more than 24%, the rate of artificially rupturing membranes is 55%, the rate of epidural use is 63%, and the episiotomy rate is 52% (Sakala, Declercq, & Corry, 2002). Each of these procedures are expensive and put the baby and mother at increased risk (Jansen et al., 2013; Jordan & Murphy, 2009). While interventions are sometimes medically necessary, doulas can act as a liaison, using their experience with childbirth to increase the quality of patient-provider communication, and reducing the use of interventions when not medically necessary (Akhavan & Lundgren, 2012; DONA, 2020). Doulas are also advocates of informed consent in birthing contexts, encouraging birthing persons to have authority and autonomy over medical decisions (Newnham et al., 2017).

In addition to this life-saving potential, doulas have cost-saving potential. Having a cesarean birth is considered a major surgery, involving physicians, anesthesiologists, and an operating room. As a result, cesarean births can cost twice as much as vaginal births (Kozhimannil et al., 2016). Another study measuring the benefits of doula support observed the rate of cesarean section in doula-supported births to be 40.9% lower than average (Kozhimannil et al., 2013). After analyzing data from 2010, a study conducted by the University of Wisconsin School of Medicine and Public Health found that if a professional doula attended every low-risk birth in-hospital, there would have been about \$29,000 in total savings. The study found that doulas can yield cost savings of \$424.14 per delivery, or \$530.89 per low-risk delivery (Chapple et al., 2013b). Because of the growing evidence indicating that doulas provide significant benefits to birthing individuals and hospital systems, several states have recently pushed for state-funded Medicaid plans to cover doulas (Greiner et al., 2019; Kozhimannil et al., 2016). Currently, Medicaid covers birth doulas in Oregon, Minnesota, and New York (Katy Backes Kozhimannil et al., 2013; Strauss et al., 2016), and this Medicaid coverage has resulted in improved maternal and infant health in Oregon (Strauss et al., 2016). This shows the systemic monetary value of social support in the context of doula support for birthing persons.

Doulas and Types of Support

Similar to other supportive interactions, this doula support can take on different forms. As stated previously, social support scholars have identified five different types of social support: *informational*, *esteem*, *network*, *tangible*, and *emotional* (Xu & Burleson, 2001), all of which are important during the labor process. Professional support in labor is described by Oakley (1994) as having three dimensions: *emotional*, *informative*, and *instrumental*. *Emotional* support is evident when the support providers facilitates feelings of safety for the recipient.

Informative support involves the support provider giving advice when requested. *Instrumental* support involves the giving of practical and tangible services (Oakley, 1994).

A 2011 study by Gilliland analyzing emotional support strategies used by doulas in the United States and Canada identified nine different support strategies used by doulas during labor—five simple strategies and four more complex strategies (Gilliland, 2011). The five simple strategies include: *reassurance*, *encouragement*, *praise*, *explaining*, and *mirroring*. *Reassurance* is verbal acknowledgement of a mother’s feelings while helping her feel less anxious. *Encouragement* is verbal and non-verbal behavior that inspires confidence and courage in the mother as childbirth progresses. *Praise* is an expression of approval or admiration for the accomplishments of the mother in labor. *Explaining* is the expression of ideas in an understandable way to alleviate confusion or anxiety. *Mirroring* involves matching the feelings of intensity expressed by the mother.

The more complex emotional support strategies Gilliland (2011) identified include: *acceptance*, *reinforcing*, *reframing*, and *debriefing*. These more complex strategies used by doula are acquired with experience at multiple births and require a deep level of emotional intelligence (Gilliland, 2011). *Reinforcing* occurs when a doula affirms and encourages the mothers do continue something she is already doing. *Reframing* appears in verbal communication between a doula and a mother and it is a strategy used by doulas to shift a mother’s perception of a situation to be more positive; reframing aids the mother in maintaining a most positive outlook on herself and her abilities. Finally, *debriefing* most often occurs after an experience is over (i.e. a postpartum visit), but it is an emotional support strategy used by doulas which involves active and empathetic listening to the mothers’ experience of childbirth. These

strategies are connected to previously discussed frameworks of social support, as they are forms of informational, emotional, tangible, esteem, and network support (Xu & Burleson, 2001).

The support provided by doulas is beneficial for birthing persons. Doulas influence the quality of healthcare provided during pregnancy and birth (Kozhimannil et al., 2016). While the benefits of doula support have been established, research as not yet uncovered the interaction between identity and support provisions—a vital consider given racial disparities in health outcomes. Further, doulas are largely understudied as a population. To add to this line of research on doula support, I propose the following research questions and hypotheses:

RQ1: How doulas see their role as support providers and how do they describe communicating support to birthing persons?

H1: Expecting parents who are aware of what a doula is are more likely to hire a doula.

Research into doula support is missing the complex considerations of identity in its investigations of how doulas support can facilitate the birthing process. Similarly, development of a pragmatic framework of supportive communication could be strengthened by bridging social support frameworks with critical cultural theories, adding considerations of how identity influences support provision and outcomes.

Theories of Identity and Culture

Supportive communication involves interpersonal interactions, and identity shapes the way people engage in interpersonal exchanges (Kunkel & Burleson, 1999). Identity itself is a communicative process (Collier & Thomas, 1988), and conversation serves as a primary vehicle through which identity is constructed and negotiated (Hastings, 2000). Various theories, including the Communication Theory of Identity (Hecht, 1993) and Identity Negotiation Theory

(Ting-Toomey, 1993), explore the role of communication in identity formation as well as the ways identity influences individual communication patterns. I briefly engage each of these theories to argue the imperative of including considerations of identity in investigations of supportive communication.

Communication Theory of Identity

Identity is a complex phenomenon to study because of its dynamic nature. Identity is based on social roles, social construction, social performances, and which attributes are socially ascribed to individuals (Goffman, 1967), and identities are constructed and performed (Hecht & Choi, 2012). The Communication Theory of Identity (CTI; Hecht, 1993) expands previous definitions of identity to reveal the complexity of studying and understanding identity. The theory says, “a person’s sense of self is part of his or her social behavior and the sense of self emerges and is defined and redefined in social interaction” (Hecht & Choi, 2012, p. 138), and explains the relationship between individuals, relationships, and society in the co-construction of identity (Hecht, 1993). CTI utilizes Baxter’s (2004) concept of dialectics (the experience of tensions) to highlight the dynamic nature of identity and to argue that identity is both a personal and a social phenomenon (Hecht, 1993). CTI conceptualizes identity formation as a communicative process best understood as a transaction (Shotter & Gergen, 1989), and maintains that individuals are constantly negotiating individual, social, and communal elements of their individual identity.

A unique dimension of CTI is the concept of interpenetrating identity frames. The theory outlines four identity frames that collectively influence how identity is constructed and communicated: *personal*, *relational*, *enactment*, and *communal* (Hecht, 1993). The *personal* frame is an individual’s self-image and the way they see themselves. For example, someone who

is newly pregnant says, “I am a mother” is articulating a personal identity. The *enactment* frame refers to how one communicates their identity socially, or identities that are performed in social situations. Taking childbirth education classes, taking maternity photos, or attending prenatal appointment are all examples of enacting a particular pregnancy, or parental identity. The *relational* frame involves individual’s identity in combination with relational partners (i.e. how one identifies within a relationship), for example, avowing the identity of a “mother” or “parent” in relation to the other members of one’s family—for example a romantic partner who may be the other “parent”. Finally, the *communal* frame emerges out of groups and networks and involves the larger collective identity held by a group of people, like the entirety of society who views one as a parent or mother if they have given birth (Hecht, 1993; Jung & Hecht, 2004). These frames are distinct but overlapping; they are not isolated from each other and as individuals utilize communication to manage their identities, the various frames interact and are constantly being negotiated (Hecht, 1993). As Hecht and Choi (2012) argue, “The identity layers can be identified independently but together make up a whole. Thus, identity analyses are enriched if they consider the layers two at a time, three at a time, or all four at once” (p. 143). Considering the various layers of identity in research allows for a more comprehensive view of how identity impacts communication.

Further, CTI, “extends identity beyond individuals and societal constructions to consider interaction and complements the view of social identity located in roles and role theory with identity as relational” (Hecht, 1993, p. 78-79). At its core, identity is both personal and performative. Identity and self-conceptualization are developed through social interactions with others and by cultural socialization, acculturation, and processes of identity transformation (Ting-Toomey, 2005), and identity is constantly being negotiated in conjunction with changing

identity frames. Therefore, tensions are experienced and when the four identity frames outline are competing or inconsistent with each other, identity gaps may arise (Hecht, 1993). This relates to another important theory of identity that analyzes the dynamic nature of identity, Identity Negotiation Theory.

Identity Negotiation Theory

Identity Negotiation Theory (INT; Ting-Toomey, 1993) has also expanded research into identity. INT examines social identity, like social class, ethnic membership, and family role, as well as personal identity, or unique attributes we associate with ourselves, in various communication settings and emphasizes the importance of understanding how individuals navigate identity-specific tensions (Ting-Toomey, 2015). According to INT, the term *identity* includes, “an individual’s multifaceted identities of cultural, ethnic, religious, social class, gender, sexual orientation, professional, family/relational role, and personal image(s) based on self-reflection and other categorization social construction processes” (Ting-Toomey, 2015, p. 418). Further, people’s group memberships, for example racial identity or sexual orientation, contribute to their social identity (Tajfel & Turner, 1986). The two identities central to the present investigation are racial identity and sexual orientation.

Identity is multifaceted, and individuals acquire their identities through their own lived experiences. INT has predominantly been used to examine the tensions immigrants and minorities face in unfamiliar cultural environments (Collie et al., 2010; Toomey et al., 2013), but it is applicable in a multitude of other contexts. INT is similar to CTI in its acknowledgement of various dimensions of identity, including group membership, relationships, and individual self-image. Additionally, both of these theories highlight the importance of considering the various

facets of an individual's identity and how they navigate communicative encounters when they experience identity-related tensions or stressor.

Each of these theories also demonstrate how identity influences communication. Identity is a crucial consideration in research into social support and can add specificity and nuance to the framework, especially when social support literature is being utilized to investigate how the power of social networks can be harnessed to improve health outcomes. Considerations of identity are not wholly absent from social support research, and it is important to consider where researchers have gone before outlining where we hope to go.

Current Research on Identity and Social Support

Some research has investigated cultural differences in supportive communication (Burlison, 2003; Feng, 2015; Kunkel & Burlison, 1999; Mortenson et al., 2009); however, a limitation of the current social support framework is that it does not acknowledge the nuanced ways in which various identity factors might impact how people communicate and receive support. More social support research should adopt a critical perspective, paying particular attention to power and, “bringing to the forefront questions of social justice, equity, participation, and structural transformation” (Dutta, 2010, p. 534). These considerations are particularly important given the current social and political landscape of the United States.

Adopting this critical perspective includes broadening the definition of culture beyond nationality (Moon, 2003). I employ Collier and Thomas' (1988) conceptualization of culture as being formed through interactions and resting upon a, “shared system of symbols and meanings as well as norms/rules for conduct” (p. 133). Thus, cultures can be understood as constituted by gender, ethnicity, nationality, sexuality, or shared experience and people may avow various, sometimes competing, cultural identities (Cho et al., 2013). Within these conceptualizations of

culture, there is a need for more research to center the experiences of those with nondominant cultural identities, including persons of color, members of the lesbians, gay, bisexual, transgender, queer (LGBTQ+) community, and those from a lower socioeconomic background (Orbe, 1998; Orbe & Roberts, 2012). A critical cultural approach to social support research that includes specific considerations of identity allows for an exploration of how those with less societal power express desired support, as well as how their identities influence the support they describe offering to others.

Similar to other lines of communication studies scholarship, the majority of communication studies research that makes comparative claims about cultural difference in supportive communication equates culture with nation-state (Moon, 2013), and compares social support amongst members of generalized *individualist* versus *collectivist* cultural groups. For example, Shankar (1997) investigated how Japanese, Indian, and American cultural components influence breast cancer patients' perception and preferences of their immediate support system. The authors viewed each national culture in isolation and in their findings, they ascribed difference in patients' perceptions of their immediate support system to differences in cultural norms around collectivism, group solidarity, women's adherence to modesty, and assertiveness. Mortenson et al. (2009) examined similarities and difference in how European Americans and Chinese individuals view seeking support as a strategy for coping with stress. They found there were both cultural and sex differences in seeking support, but there was less variety in coping resources. Tang et al. (2016) explored how Chinese culture affects the relationship between social support and postpartum depression, and concluded that the gender roles and family dynamics in Chinese culture prevented women from seeking support for postpartum depression. Finally, Kim et al. (2008) conducted a review of research on culture and social support, also

Asians and Asian Americans to European Americans. They determined that Asians and Asian Americans are less likely to explicitly ask for support from those close to them than European Americans are.

While each of these studies produced important findings about how culture moderates the effects of supportive communication, they each rely on generalizations of cultural differences and dominant American cultural assumptions instead of including critical considerations of other cultural identities or group membership beyond nationality. These generalizations limit the practicality of their findings because immense diverse identities exist within national cultures and focusing on the nation-state as the unit of cultural measurement does not allow for the exploration of experiences of those who do not fit the dominant cultural paradigm.

From a critical perspective, a group of people who share similar identities (i.e. race, gender, age, etc.) can constitute a cultural group (Moon, 2013). Further, being attentive to these identity factors in social support research is crucial because as outlined above, identity and communication are inextricable. Therefore, identity and cultural group membership may influence the support individuals provide, the support they seek, and what constitutes adequate support to them as individuals. Further, research has shown that race and gender influence how individuals engage in interpersonal interactions (Burleson, 2003; Kunkel & Burleson; Orbe, 1988), and language is a mode of expression of group identity (Davis, 2018). People also often connect with and trust people who share similar identities to their own (Tajfel, 1979).

Research into supportive communication and support gaps often investigates interpersonal interactions after experiencing a stressful situation. Examples of stressful situations or experiences that have been studied include unintended pregnancy (Crowley et al., 2019), bullying (Matsunaga, 2011), and marriage (Dehle et al., 2001; Faw et al., 2018; Xu & Burleson,

2001), to name a few. Depending on the severity of the stressor, the experience of a stressor may result in an identity transformation. Palmer-Wackerly et al., (2018) found that when individuals are diagnosed with cancer, they begin to negotiate their illness into their identity and that identity negotiation after a cancer diagnosis influences what treatment options patients choose and the support they desire. In the context of pregnancy, after conceiving a child, a pregnant individual's identity may begin to shift and take on the role of mother (Lang et al., 2011). This relates to both CTI and INT and their suggestions that identity is dynamic and multi-faceted. Palmer-Wackerly et al.'s (2018) study went on to argue that decision-making in health contexts is largely influenced by a patient's identity. The authors advocate for supportive others increased, "awareness of and communication accommodation toward the ways in which patients relate their identity" to their diagnosis (Palmer-Wackerly et al., 2018, p. 1052). This is something that should extend beyond illness identity to include other dimensions of individual's avowed identities. In the case of pregnancy and childbirth, supportive others should be aware of how a birthing persons' identity impacts their desires for support throughout the birthing process.

Racial Identity and Communication

It is important for more research investigations to include considerations of racial identity. Critical Race Theory highlights the imperative of centering considerations of race and advocates for explorations of the ways in which race is both socially and materially constructed (Flores, 2009). Because issues of race permeate society, research that fails to consider race is incomplete. Considerations of race are especially crucial in health contexts, because many health disparities exist in the United States across races (Adler & Rehkopf, 2008; Williams et al., 2010). In their 2013 report on Health Disparities and Inequities, the Centers for Disease Control and Prevention states,

[...] social determinants of health as well as race and ethnicity, sex, sexual orientation, age, and disability all influence health. Identification and awareness of the differences among populations regarding health outcomes and health determinants are essential steps towards reducing disparities in communities at greatest risk (Meyer et al., 2013).

In the United States, racial minorities experience higher rates of chronic disease, and premature death than non-Hispanic White individuals do (National Academies of Sciences et al., 2017). In 2017, 10.6% of Black/African Americans were uninsured, compared to 5.9% of non-Hispanic Whites (Berchick et al, 2018). Further, 80% of Black/African American women are overweight or obese compared to 64.8% of non-Hispanic White women (Centers for Disease Control and Prevention, 2019), and Black infants are 2.5 more likely to die in infancy than non-Hispanic White children (Hauck et al., 2011). Each of these statistics speak to the prevalence of racial health disparities and inequities in the United States.

Additionally, ideas about race and racial difference are socially constructed. Centering race in communication studies is vital because as Davis & High (2019) claim, “Invoking issues of race in studies on close relationships allows scholars to investigate the complexities of supportive interactions in new and socially relevant ways” (p. 209). Social support research that takes race into account is both specific and useful. Racially minoritized groups often encounter cultural marginalization and experience more identity-threatening stressors than members of dominant cultural groups (I. H. Meyer, 1995; Ong et al., 2009). An identity-threatening stressor is a stressor that arises as a result of avowing a particular identity, or a personal or relational issue that damages ones social identity (Thoits, 2013). When one experiences an identity-threatening stressor, this often leads them to feel devalued and social support can be utilized to facilitate coping in these circumstances (Mickelson, 2001). Given this, specific examinations of social support as a vehicle of stress mitigation in marginalized cultural populations may yield

nuanced findings. Research that centers identity must consider the complexity of individuals' identities. In this investigation, I make distinctions between racial categories, while acknowledging that racial identity alone does not constitute an individual in their entirety.

Further, identity and group membership influence the communication of stress. For example, Haslam et al. (2004) developed the self-identity/self-categorization model of stress when they conducted a study to investigate the role of social influence and social identity on the appraisal of a stressful situation. Participants in the study were instructed to complete a challenging task and the task was described to them as either stressful or challenging by an in-group member or an out-group member, in this case someone who was also university student or someone who was not. The study found that when an individual is coping with a threat to their identity, members of their in-group are valued support providers and, "the positive effects of informational support are likely to be limited to those social situations in which the source and recipient of that support share a salient social identity" (Haslam et al., 2004, p. 7). This finding demonstrates how sharing a common identity with a support provider might influence the perception of received supportive communication, and it opens the door for further investigations into social support to consider identity. It is also important to take note of the motivation for seeking support, as support seeking behavior, conceptualized as support marshaling (Crowley & Faw, 2014; Crowley, 2012), may be a result of experiencing an identity-related stressor.

Because identity is dynamic and identity enactment is situational, the context of supportive interactions matter. Most research into social support investigates interpersonal communication in dyads. Race is largely minimized in investigations into supportive communication, but some scholars have begun to include considerations of race in their interpersonal communication research. For example, the Strong Black Woman Collective

(SBWC) developed by Shardé Davis (2015) is an identity-specific communication framework that explores communication between Black women. The SBWC, “advances the idea that Black women construct strength through communal communication practices by imbuing their assembled voices with might and fortitude” (Davis, 2015, p. 20). Davis’ work is attentive to the unique racial-gendered experiences of Black women in the United States, and the SBWC unites the concepts of communication, strength, and race to analyze Black women’s communication behavior. The SBWC highlights how Black women reappropriate the previously stereotypical image of a strong Black woman as a form of resistance to oppression and a way to celebrate their Black womanhood. This particularly relates to social support because it reveals the benefits of Black women associating as a collective—“their ability to resist oppressive forces is increased with the help and support of their Black women counterparts” (Davis, 2015, p. 26). Moreover, the SBWC opens the door for more culturally-specific research on supportive communication.

The SBWC framework outlines four propositions which highlight how Black women’s identities, “shape their unique communication practices and inform the assemblage of their identifiable collective” (Davis, 2015, p. 21). The propositions set forth by the SBWC illuminate how unique communication patterns may emerge for people of particular identities. Specifically, Davis explains the ways in which Black women change their communication patterns when interacting with people of difference racial backgrounds and enact strength when communicating with other Black women (Davis, 2015). She references work Michèle Foster’s (1995) work which revealed how Black women engage in different linguistic practices when interacting with other Black women than when communicating with people outside that community—this is known as code switching. Similarly, Karen Scott (2000) found that Black women expressed living in “two different worlds”: one composed of other Black women and another of people of

different identities. Ultimately, Davis set out to revise research into Black women's communication to be more inclusive of their perspectives and lived experiences, rather than having non-Black women's perspectives driving this research.

The SBWC can be a starting point for an expansion in social support research. Propositions two and four of the SWBC particularly lead to questions about how identity might impact support adequacy. The propositions are: (2) the SBWC consists of an assemblage of Black women, and (4) communication patterns of strength allow the collective to resist oppressive structures but impede vulnerability and emotionality within the group (Davis, 2015). These propositions speak both to the positive aspects of the collective, as well as the potential negatives. Social support in this context can foster strong bonds, but it can also suppress vulnerability.

This finding can have significant implications for social support research, and more specifically for research into racial maternal health disparities (more on this in a later section). Black birthing persons are dying at higher rates than White women (CDC, 2020), and further research exploring the SBWC could examine whether these statistics would change if Black women had access to more inclusive care, and care from Black women physicians. The findings of the SBWC that Black women foster collective strength reveals how, when given the opportunity, Black women can cultivate a safe environment for each other, allowing space to "lament, to process, and to support one another" (Davis & Afifi, 2019, p. 20). Unfortunately, the SBWC is an outlier in interpersonal communication research, most of which lack diverse participants and do not specify the cultural group for which their findings are generalizable to. The SBWC does have limitations, and there is a need for more research into how cultural and identity factors such as race influence the content and outcomes of support. Further research is

needed to explore whether a dyad would suffice to constitute a “collective” in supportive conversations to harness the benefits of the SBWC because supportive conversations usually occur in dyads.

Additionally, the impairment of vulnerability may impact emotional support seeking behavior, even more so in the context of a highly vulnerable situation like childbirth. Burlleson (2003), defines emotional support as, “specific lines of communicative behavior enacted by one party with the intent of helping another cope effectively with emotional distress” (p.552). By adding specificity to investigations of racial identity as a mediating factor of interpersonal communication and including the perspective of those offering support as well as those seeking support, can open to door to richer and culturally-specific research like Davis’ work.

Another study by Davis specifically investigates supportive communication, and social further supports the imperative of including considerations of identity in investigations into supportive communication. In the study, Davis and High (2019) examined differences in evaluations of supportive interactions based on the race of the provider after experiencing an identity-threatening stressor. In an online survey they constructed, the prompt asked participants to recall an identity-threatening stressor, which was defined to participants as, “something that challenges who you are as a person/challenges an identity that represents you” (Davis & High, 2019, p. 194). Stressors commonly identified by participants included financial stress, a health diagnosis, relational infidelity, or family dysfunction. Davis and High then randomly assigned participants to recall a supportive conversation related to the stressor identified with a friend of their same race (Black participant – Black friend; White participant – White friend), or a friend of a difference race (White participant – Black friend; Black participant – White friend).

Considerations of race, and how race influences interpersonal interactions has been absent from previous literature exploring supportive communication, but Davis and High center race and the racial context of interpersonal encounters in this study. The study revealed that women found support from same-race friends to be most beneficial and that, “Supportive interactions are situated within a context of race” and, “People expected and received more of several types of support from friends of their same race than friends of a different race” (Davis & High, 2019, p. 206). This study expands support gaps research and demonstrates that experiences of support are sometimes contingent upon the identity of both the support provider and recipient and, in this context, racial matching of interactants. In the United States, racial identity represents a common historical legacy, especially for marginalized groups who have been oppressed (Omi & Winant, 2014). People trust those who share their racial identity because they often view their social and political environment from a similar vantage point (Tajfel & Turner, 1979). The findings of Davis & High’s (2019) study corroborate conclusions reached by Haslam et al. (2004), which have found that support evaluations are more positive when the support is provided by someone from the same racial group.

The present study seeks to explore the relationship between identity and social support, as it relates to how support is provided, as well as how it influences support seeking behavior. Davis and High (2019) established that the racial composition of a dyad influence support provisions, as women in their study needed, expected, and received more social support from friends of their same race. I seek to extend this inquiry by investigating how the racial-matching of a dyad influences support seeking behavior. Keeping in mind the disparities in maternal mortality between Black and White birthing persons in the United States, it’s crucial to investigate from whom Black birthing persons are more likely to seek support, as this may be a

tool that can be harnessed to promote more health equity. As such, I pose the following research questions and hypotheses:

RQ2: How do doulas perceive their racial identity as influencing their practice and provisions of support?

H2: Expecting parents who identify as racial minorities (BIPOC) are likely to report more fear of childbirth.

H3: White expecting parents will be more likely to hire a White doula than a BIPOC doula, and BIPOC expecting parents will be more likely to hire a BIPOC doula than a White doula.

H4: White expecting parents will perceive a White doula to be more similar to them than a BIPOC doula, and BIPOC expecting parents will perceive a BIPOC doula to be more similar to them than a White doula.

H5: White expecting parents will report higher levels of trust for a White doula compared to a BIPOC doula, and BIPOC expecting parents will report higher levels of trust for a BIPOC doula compared to a White doula.

H6: White expecting parents will perceive a White doula to be more competent than a BIPOC doula, and BIPOC expecting parents will perceive a BIPOC doula to be more competent than a White doula.

H7: White expecting parents will perceive a White doula to be more supportive than a BIPOC doula, and BIPOC expecting parents will perceive a BIPOC doula to be more supportive than a White doula

Social Support and Sexual Orientation

Another salient identity understudied in social support research is sexuality and sexual orientation. Indeed, sexuality remains largely unexplored in communication studies research as a whole (Manning et al., 2020). Recently, several scholars have called for the incorporation of queer perspectives and identities into communication research (see Lannutti, 2013; Li & Samp, 2019; Manning et al., 2020; Suter et al., 2014 for examples). Social support is one such facet of communication studies research that has not yet centered experiences of those with non-dominant sexual orientations in explorations of supportive communication or support outcomes.

The number of terms an individual may use to classify their sexual orientation is growing, but include straight, gay, lesbian, bisexual, queer, and polyamorous, to name a few; and the percentage of adults in the United States self-identifying as LGBTQ+ increased from 3.5% in 2012 to 4.5% in 2017 (Gallup, 2018). Acknowledging the diversity in how individuals self-identify their sexual orientation, this project is specifically focusing on the experiences of sexual minorities (those who avow nondominant sexual identities; Baptiste-Roberts et al., 2017; Everett et al., 2019)—namely, those who identify as queer women. While individuals who do not identify as women (i.e. nonbinary individuals and transgender men) can give birth (Hoffkling et al., 2017; Light et al., 2014), I limited my scope in an attempt to add specificity to my investigation and to not diminish the experiences of non-female identifying individuals.

Master narratives of birth and families, or the dominant cultural ideology that shapes how individuals view and experience the birthing process (Somers, 1994), most often involve heterosexual love and the biological procreation of a child between a man and a woman (Röndahl et al., 2009). Co-mothering families disrupt this dominant script (Darwin & Greenfield, 2019). The twenty-first century has seen an increase in the number and visibility of co-mothered families (Movement Advancement Project, 2011); however, the American medical system, and

more specifically obstetrics and gynecological care, are based in, and rely on, heteronormative language and communication (Röndahl et al., 2009). In the United States, “we have not yet developed shared language in research or practice to adequately describe reproductive histories outside of a cis birth mother’s”(Darwin & Greenfield, 2019, p. 342). Heteronormativity permeates care, and Rondahl et al. (2006) observed this in waiting rooms, on forms and paperwork, in medical journals, and in verbal communication. In the context of childbirth, heteronormative care usually involves the assumption that “parents” implies a man and a woman who biologically conceived a child together (Spidsberg, 2007); however, this is not always the case. Recent estimates found 59% of self-identified bisexual women and 31% of self-identified lesbians reported having given birth (Goldberg et al., 2014).

Similar to racial health disparities that exist in the United States, disparities exist for those with nondominant sexual orientations. Sexual minorities experience high levels of stress as a result of systemic bias, stigma, discrimination, and a lack of providers’ cultural competency in the U.S. medical system (Darwin & Greenfield, 2019; Harvey & Housel, 2014). Members of the LGBTQ+ community often face structural stigma, or “societal-level conditions, cultural norms, and institutional policies and practices that constrain the lives of the stigmatized” (Hatzenbuehler & Link, 2014, p. 2). Emerging research has shown that this structural stigma is a risk factor for poor health (Hatzenbuehler & Link, 2014; Röndahl et al., 2009; Spidsberg, 2007).

Lesbian women are an especially vulnerable group in maternity care situations, and they often report an inadequacy of care, support, and communication (Spidsberg, 2007). Compared to heterosexual women (or women who have sex with men), sexual minority women (or women who have sex with women) are more likely to report miscarriage or a pregnancy ending in stillbirth, they are also more likely to give birth to children with a low birth weight or to report a

very preterm labor (Everett et al., 2019). Queer women also report a lack of social support from family and friends during pregnancy (Yager et al., 2010). Further, not much is known about co-mothered families and their experiences of childbirth because they are an understudied population (Darwin & Greenfield, 2019). Many of the studies which do examine lesbian women's experiences with childbirth focus chiefly on those of White, Christian, wealthy lesbian women (DeMino et al., 2007; Suter et al., 2016). A 2013 study specifically investigating the experiences of lesbian women in the birthing context found they oftentimes encounter homophobia and prejudice, but that small gestures of support and acknowledgment of them as an individual or a family significantly influenced their feelings of care (Dahl et al., 2013). Socially, co-mothers and their children experience stress from heteronormative interpersonal interactions (Suter et al., 2016), and social bias is one of the most pressing issues facing lesbians in the U.S. today (DeMino et al., 2007). For example, co-mothers are often faced with questions comparing them to heterosexual families or questions that directly challenge their family form, such as inquiries about which mother gave birth to the child or people who reject the possibility that a child can have two mothers (Kellas & Suter, 2012). Further, there is a scarcity of social support research that centers the perspectives of lesbian-identifying women.

As previously noted, identity and communication are intimately connected. Identities are asserted, defined, and altered through communication (Jung & Hecht, 2004). Additionally, individuals who experience identity gaps, or a incongruence between how they perform their identity and how society constructs their identity, are better able to negotiate those gaps when they receive social support (Jung et al., 2007). Calls for future research to develop theoretical explanations for how social support influences the relationship between identity and well-being (Palmer-Wackerly et al., 2018) as well as how identity impacts support provisions have largely

been unanswered in the field of interpersonal communication research. This project uses the context of childbirth as situational lens through which to investigate the influence of identity on how support is provided and sought. Further, I seek to explore the relationship between sexual orientation and social support. As such, I pose the following research questions and hypotheses:

RQ3: How do doulas perceive their sexual orientation as influencing their practice and provisions of support?

RQ4: How do combined identity characteristics (race and sexual orientation) influence participants' perceptions of doulas?

H8: Expecting parents will perceive doulas of their same sexual orientation to be more similar to them

H9: Expecting parents will report a greater willingness to hire a doula who shares their same sexual orientation

H10: Expecting parents will be more likely to trust doulas who share their same sexual orientation

H11: Expecting parents will perceive doulas who share their same sexual orientation as more competent.

H12: Expecting parents will perceive doulas who share their same sexual orientation as more supportive

CHAPTER 3 - METHODS

Positionality

As a Black woman, I maintain that research should be more attentive to issues of identity and race, similar to the work of Shardé Davis (2015, 2019). Further as Lisa Flores argues, it is imperative for communication studies research to center race (Flores, 2009). I am also a doula passionate about serving birthing persons of marginalized identities and underrepresented communities. My experience supporting these communities has informed my desire to conduct this investigation. As a Black woman who also works as a birth professional, I aim to use my positionality to explore the unique context of childbirth to enhance frameworks of social support and contribute to research that seeks to improve health outcomes for BIPOC birthing persons. I hope to employ this research explore the ways identity underscores supportive interactions.

Further, being self-reflexive of my positionality, I acknowledge my identity has potentially influenced this investigation. Specifically during the interviews, I acknowledge that my identity may have influenced the way participants communicated with me, specifically when discussing racial identity. Nonetheless, I am committed to letting the data speak for itself.

A Mixed-Methods Approach

This project adopts a mixed-methods approach, consisting of two studies. The first study is a qualitative study and comprises interviews with doulas exploring how their identities inform the way they communicate support to clients. The second study is a quantitative study and entails a survey of expecting parents. A mixed-methods approach is a fitting method for this investigation because it allows for an integration of data to more fully answer my research questions. Further, it allows for an analysis of social support from two perspective—investigating how identity influences provisions of support as well as support seeking behavior.

Study 1: Interviews With Doulas

Participants and Recruitment

Semi-structured interviews were conducted with birth doulas ($n = 16$) who have supported births in the United States. Individuals were eligible to participate in this study if they were 18 years old or older, and if they were a birth doula who has supported at least one birth in the past 12 months. Participants presented a range of experience, supporting between two and 1,300 births. The scope of this study includes exploring experiences of doulas of varying racial identities and sexual orientations. Interviews were conducted with 16 doulas from different geographic regions of the United States. Of the 16 doulas who participated, 62.5% ($n = 10$) self-identified as White, 25% ($n = 4$), as Black, 6.25% ($n = 1$) as Latina, and 6.25% ($n = 1$) as Hawaiian.

Doulas were recruited to participate in interviews through purposive and snowball sampling. Flyers advertising the study were posted on online forums targeted towards doulas and on social media, including the private Facebook group “Doula Talk,” which has over 13,000 members. As a doula, I also reached out to my personal network of birth workers. Given that the literature reviewed and utilized to formulate questions has been largely based in the United States, recruitment for this study specifically targeted participants who have attended births in the United States.

Procedures

This study is conducted from a constructivist, or interpretivist, lens (Lindlof & Taylor, 2019). To answer the research questions, semi-structured interviews were utilized. Conducting interviews allowed for rich qualitative explorations of perspectives on identity, childbirth, and what doulas perceive to be valuable support in the context of childbirth. Each participant detailed

a unique experience and shared their experience as it has been informed by their own social and contextual lenses. The answers to my research questions were informed by the stories told by participants, and their view of the events encompassing their role providing doula support. Participants were asked questions aimed at garnering information about their perceptions of providing social support and how their identities influence provisions of support, if at all (see appendix A for interview protocol).

For this study, a communication narrative sense-making approach was utilized in the interview protocol. Collecting this information through interviews allowed each participant to tell the stories of birth support from their point-of-view. The process of storytelling is linked to mental, physical and relational health, and by asking participants to tell stories, they were able to narratively make-sense of their experience and emotions offering support (Koenig Kellas, 2015). Further, by listening to different stories, I was able to explore how different people make sense of the role of doula support and how identity factors influence their experiences offering support to birthing persons.

Participation in these semi-structured interviews ranged from 14:50 minutes to 85:05 minutes. All interviews were audio recorded with the permission of participants. To protect confidentiality, pseudonyms are used when reporting findings.

Analysis

Once all interviews were conducted, the audio recordings were transcribed. These transcripts were then coded and analyzed for themes to answer my research questions. I engaged a combination of Tracy's (2018) phronetic iterative approach and Braun and Clarke's (2006) thematic analysis. My approach to coding was informed by past knowledge of both social support and identity, with the hopes of extending these theories to include considerations of

identity. An iterative approach to qualitative analysis is informed by questions such as, “What are the data telling me? and What is it I want to know?” (Tracy, 2018, p. 62). Further, thematic analysis allows me to analyze my data in rich detail and as a method, it works to, “reflect reality and to unpick or unravel the surface of ‘reality’” (Braun & Clarke, 2006, p. 81). A combination of these approaches is fitting for my topic. Thus, I coded each interview for themes by iteratively going through two cycles of coding—primary and secondary. Coding occurred question by question and once coding was complete, I utilized this information to answer my research questions. My coding has been informed by previously outlined frameworks of social support, namely the Strong Black Women Collective, support gaps, Communication Theory of Identity, and Identity Negotiation Theory. Additionally, I analyzed the way identity (racial identity and sexual orientation) influence support doula reports providing.

Study 2: Survey of Expecting Parents

Participants and Recruitment

The survey was completed by 168 expecting parents who were currently pregnant in the United States. Individuals were eligible to participate in this study if they currently live in the United States, plan to give birth in the United States, and are 18 years old or older. I aimed to recruit a diverse sample of participants—representing various racial backgrounds and sexual orientations. The majority of participants, 72%, identified as White ($n = 121$). However, 7.1% ($n = 12$) identified as Black/African American, 8.3% ($n = 4$) identified as Hispanic/Latinx, 4.8% ($n = 8$) identified as Native American/American Indian, and 7.1% ($n = 12$) identified as multiracial. In regard to sexual orientation, 92.9% ($n = 156$) identified as heterosexual/straight, 6% ($n = 10$) identified as bisexual, and 1.2% ($n = 2$) identified as queer. The scope of this study

included exploring demographics, emotions surrounding pregnancy and childbirth, support preferences, and implicit bias.

Expecting parents were recruited through purposive and snowball sampling. Digital flyers were distributed to online networks, specifically using social media (Facebook and Instagram). Some doulas who participated in Study 1 interviews (see previous section) also shared recruitment information with current clients. Participants followed a link to the Qualtrics survey, where they completed the survey. The survey contained five scales and took approximately 25 minutes to complete. Participants who completed the survey, and passed attention checks, were compensated \$3 in the form of an electronic gift card.

Procedures and Measures

The survey which participants completed contained a variety of scales intended to measure demographic data, feelings and emotions surrounding pregnancy and birth, life stress, fear of childbirth, desired support during childbirth, and implicit preference (implicit bias). The survey consisted of five distinct scales which addressed these topics.

The survey began with standard demographic questions, including age, marital status, sexual orientation, racial identity, geographic location (state of residence), parity (pregnant with first baby or not), gestation, and whether or not the pregnancy was planned. In addition to scale detailed below, participants were asked about who will be attending the birth (i.e. partner, midwife, OB-GYN), if they are familiar with doula support, and if they have already hired a doula for their birth.

Racism and Life Experiences (RaLES-DLE). Harrell's (1997) Racism and Daily Life Experience (RaLES-DLE; Harrell 1997) scale measures the various dimensions of racism-related stress, or racism microstressors (commonly referred to as microaggressions). The original scale

contains twenty items, or statements about what some people experience on a daily basis. I reduced the scale to ten items to reduce the burden of the scale. The 6-point Likert scale asks participants to rate on a scale from zero to five how often each statement occurs for them “because of race,” from 0 (*never*) to 5 (*once a week or more*). They are then asked to rate on a scale of zero to five how much it bothers them, from 0 (*has never happened to me*) and 5 (*bothers me extremely*). Two scores are then calculated: a frequency score and a microstress (bother/distress) score. Both are calculated as ratio scores by summing the ratings of all items and dividing by 10 (the number of items).

Perceived Stress Scale. Cohen, Kamarck, & Mermelstein’s (1983) Perceived Stress Scale (PSS) measures general perception of stressful situations in participant’s lives over the previous month. It is a self-report measure, consisting of 10 items. Using a 5-point Likert scale ranging from 0 (*never*) to 4 (*very often*), the scale asks participants rate their feelings towards each item. The scale consists of six negatively worded and four positively worded items. It is scored by adding all items, resulting in a score ranging from 0-40

The Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ). Wijma et al.’s (1998) Delivery Expectancy/Experience Questionnaire (W-DEQ version A) is currently the most frequently used instrument to measure fear of childbirth. This self-report scale measures different aspects of fear of childbirth but is considered uni-dimensional. The W-DEQ consists of 33 items on a 6-point Likert scale, ranging from 0 (*do not agree*) to 5 (*totally agree*). To get a score, answers are summed. The total score ranges from 0 to 165; the higher the score, the greater the fear the pregnant women experience. Women whose score is higher than 85 are considered to have a clinical fear of childbirth.

Desired and Experienced Support Scales. Xu & Burleson's (2001) Desired and Experience Spousal Support (DESS) scale, designed to assess of spousal support individuals report receiving and desiring, will be adapted to measure expecting parent's desire for different types of support from their care provider (i.e. obstetrician, midwife), their romantic partner (if planning to attend the birth), and a doula (if they have prior knowledge of the role of a doula or have hired a doula). The scale measures how much of each type of support (emotional, tangible, informational, network, and esteem) an individual desires. There are seven items for each type of support, totaling 35 items. However, to reduce the burden of this scale, I have adapted the scale to include 15 items (3 for each type of support). For each of these 15 items, participants are asked to indicate on a 5-point Likert-type scale how much support they desired from the specified person, ranging from 1 (*don't desire at all*) to 5 (*desire a great deal*).

Doula Profile and Implicit Preference. Finally, I created a scale to measure implicit preference or for doula support from doulas of different identities. The measurement is a 2 (straight, LGBTQ+) x 2 (Black, White) design. I crafted four different profiles representing doulas with different racial identities and sexual orientations. The four profiles include: Black/African American-straight, Black/African American-LGBTQ, White-straight, and White-LGBTQ.

Each participant was randomly be presented with a doula profile, containing a photo of a woman and a short biography explaining herself, her doula credentials, and her support role (see Appendix B). The photos presented were stocks photo of a Black/African American woman and a White woman. The biography remained the same for each profile, with the change of reference to a wife or husband to signal sexual orientation (LGBTQ or non-LGBTQ). Once the participant viewed the profile, they were be asked to provide answers to a series of questions on a 7-point

Likert scale measuring their feelings toward to doula presented, from 1 (*not at all*) to 7 (*extremely*). The measures included perceptions of similarity, competence, trust, and supportiveness. Finally, participants were be asked to answer on a 7-point Likert scale how likely they would be to hire this doula, from 1 (*not at all likely*) to 7 (*extremely likely*).

Table 1: Demographics of Doula Participants

Pseudonym	Race	Sexual Orientation	# births supported	Notes
Anna	White	straight	60	Located in the Southwestern U. S., Anna has been a doula since 2015. She completed her doula trainings through ICEA and HERBAL. In addition to doula work, she is a birth photographer.
Jessica	White/ mixed-raced	straight	1,300	Located in the Southeastern U.S., Jessica has been a doula for over 20 years. She has complete multiple trainings, including DONA, CAPP, and Birth Arts International. In addition to her doula work, she is a doula trainer.
Lisa	White	straight	20	Located in the Western U.S., Lisa has been a doula for 2 years. She is a trauma-informed care provider and completed her doula training through CAPP.
Mary	Black/Indian	straight	5	Located in the Midwestern United States, Mary has been a doula for almost 2 years. She completed her training through DONA.
Olivia	Black/Puerto Rican	straight	40	Located in the Western U.S., Olivia has been a doula for over 7 years and completed training through Birth Arts International. In addition to her doula work, she is a student midwife.
Emily	White	straight	20	Located in the Northeastern U.S., Emily has been a doula for five years. She completed her training through Warm Welcome Births and has previous experience in substance abuse counseling. In addition to her doula work, she does placenta encapsulation.
Lauren	White	bisexual	5	Located in the Western U.S., Lauren has been a doula for almost 2 years. She has completed training through DONA and Birthing Advocacy Doula Trainings.
Devon	White	bisexual/ polyamorous	250	Located in the Midwestern U.S., Devon has been a doula for over 10 year. She has completed trainings through DONA, Ancient Song Doula Services, ProDoula, and Birthing Advocacy Doula Trainings. In addition to doula work, she is a lactation consultant.
Brittany	White	straight	140	Located in the Western U.S., Brittany has been a doula for over three years. She completed trainings through DONA, CAPP, and the Hypnobirthing Institute. In addition to doula work, she is a lactation consultant and offers hypnobirthing classes.
Sarah	Black/African	queer	20	Located in the Western U.S., Sarah has been a doula for over five years. She completed training through International Center for Traditional Childbearing; is an aspiring midwife.
Alexis	White	straight	40	Located in the Western U.S., Alexis has been a CAPP-trained doula for 6 years.
Bailey	Black	straight	10	Located in the Northeastern United States, Bailey has been a doula for six years. She completed her training through Maternity Care Coalition.
Linda	White	straight	20	Located in the Western U.S., Linda has been a doula for three years. She completed her training through Birth Arts International.
Alyssa	Native Hawaiian	straight	40	Located in the Western U.S., Alyssa has been a doula for five years. She completed her training through DONA and is also a babywearing instructor and childbirth educator.
Melissa	White	straight	100	Located in the Southeastern U.S., Melissa has been a doula for eight years. She completed her training through CAPP and is also a CAPP doula trainer.
Carla	Latina	straight	6	Located in the Western United States, Carla has been a doula for almost a year. She completed her training through DONA.

CHAPTER 4 – STUDY ONE RESULTS: INTERVIEWS WITH DOULAS

Overall, this study sought to offer insights into how doulas communicate support to birthing persons (RQ1) and how they view their racial identity and sexual orientation as influencing these interactions (RQ2 and RQ3). This study allowed participants to articulate the value of doula support and the challenges they sometimes face in communicating support. A total of 16 doulas participated in this study, with 62.5% participants ($n = 10$) identified as White and 37.5% ($n = 6$) identified as Black, Indigenous, and/or a Person of Color (BIPOC). Moreover, 87.5% ($n = 14$) identified as straight and 12.5% ($n = 2$) identified as a member of the LGBTQ community (see Table 1).

The Role of Doulas

The first research question explored how doulas see their role as support providers and how they describe communicating support to birthing persons (RQ1). Four themes emerged from the interviews: *advocacy, education and informational support, emotional support, and network support.*

Advocacy

In discussing support provision, ten doulas spoke of the importance of *advocating* for their clients in the birthing space. Specifically, doulas argued that clients' wishes and desires should be respected during childbirth, and unfortunately, this does not always happen. Doulas described supporting clients by ensuring they were listened to and respected during the labor process. Sometimes, this involved stepping in and speaking up for the birthing person's wishes.

Various participants detailed experiences of witnessing their clients be disrespected and disregarded by medical professionals. One doula, Anna, recalled watching a doctor explicitly ignore her client's insistence that she not have an episiotomy (an incision made between the

vaginal opening the perineum). Witnessing the physician's disregard for her client's request infuriated Anna and informed her perspective on the importance of speaking up for birthing parents. She went on to describe that she has gotten "really tired of seeing certain things happen to moms in labor," and that she is not, "going to sit there and be silent when they were being disrespected." Another doula, Olivia, echoed Anna's frustration, "in this medical structure that you're feeling like you're having to fight against just to, to allow people to have informed consent."

Further, advocacy was something that many doulas stated as the reason they decided to pursue birth work. When asked about why she became a doula, Bailey said, "I wanted to be an advocate for other women and really let them know what their rights were when it came to birth [...] you should feel that what you want is most important. You shouldn't feel pressured." The importance of informing birthing persons of their rights is something that came up in multiple interviews. Advocacy also led Lauren to doula work, as she explained:

And one of the biggest reasons why I wanted to be a doula, I think that advocates are so important. And especially for people of color and for the LGBTQ+ community, I think that having an additional person in the room to have eyes on what's happening and to be willing to speak up for them and to help them for themselves is really important.

In this way, Lauren saw doulas as support providers who can ensure that institutional or systematic injustices do not perpetuate health disparities. Taking up this impetus and recognizing how obstetric violence impacts those of marginalized communities most drastically, Brittany said, "I also walk into a birthing space knowing I'm going to fight. I have to fight harder for those people," referring to those with marginalized identities.

Informed Consent. Central to advocacy doula reported providing during childbirth is the concept of informed consent. When asked about something that informs their birth work, Carla said,

The fact that someone knows their options. That's so important to me. That's like what drives me. I think that's a big value is to know your sources, to know that you have more than one option to, know that you can advocate for yourself. And to know that everybody else's opinion shouldn't matter and your own experience, every labor is different.

As doula explained, when birthing people were given all of the information about their options, they were better able to make a decision that they believed to be best for themselves and their baby. Moreover, advocacy provided birthing persons with the opportunity to have the type of birth they desire—an experience in which they feel respected and valued.

Doula sought to educate pregnant parents about their rights as a patient. Multiple doula explicitly mentioned the value of birthing people “knowing their rights.” Speaking to the value of doula in informing parents about their rights, Bailey explained,

Just really getting out there, the importance that just having somebody there with the knowledge can really, really be helpful. Or even if you don't want a doula actually present, going out and getting some of the knowledge so, you know your rights.

She noted that whether or not a person has a doula actually present at their birth, doula can be a great resource for information about birth and individual rights as a patient in the medical-industrial complex.

The informed consent dimension of advocacy is enacted through providing informational support. Doula educated birthing persons on their options regarding medical decisions and interventions. Melissa noted, “I'm very much into, ‘Let's give the resources. Let's give the research and let them decide.’” Similarly, Anna explained,

I do think women need to be more educated about other options, especially for pain relief, because everybody thinks epidural is the only option and that, if you don't get the epidural, it's going to be so painful, when in reality all of the different things that you can do make it not so painful.

As illustrated by Anna's example, one way that doulas support clients is by informing them about the various options for pain management and coping so that clients can make their own decisions about pain management. Lauren echoed this when she said, "So, yeah, I think that being a doula helps to inform the consumer about their options and helps them to have births that are empowering instead of making them feel powerless."

Trauma-Informed Care. Trauma-informed care was an important and unique dimension of advocacy raised by a few participants. Trauma-informed care recognizes experiences of past trauma and how the presence of this trauma might influence experiences during birth. Emily explained that she, "gets a lot of clients who need trauma-informed support." Based off life experiences prior to childbirth, circumstances surrounding labor and delivery can be physically or emotionally triggering to expectant parents (i.e., a mother who is a survivor of sexual abuse). Anna recalled an experience supporting a client, "For her previous pregnancy, she had lost the baby while pushing. The baby had died in labor. So, she was very traumatized and very paranoid about this birth and I felt like the hospital took advantage of that." This mother was paranoid and afraid to move from the bed during labor, and she believed the hospital took advantage of this. She said, "They weren't letting her walk around. They made her lay on her back for almost the entire labor. And I was mentioning to mom, I was like, 'You have the right to move around. This is what you can do.'" She believed the hospital was taking advantage of the client's previous traumatic experience. For doulas, part of being an advocate was understanding how the experiences or life circumstances of a client might inform how they react to the labor process and doing what they can to optimize their experience and mitigate the influence of past trauma.

Education and Informational Support

Another dimension of support doulas reported providing to clients is *education and informational support*. Education was crucial to accomplish the “informed” dimension of “informed consent” mentioned above. Additionally, while childbirth is a natural occurrence, it is an experience that many pregnant people are uninformed about. Doulas in this study sought to fill in these gaps and educate parents about the physiological mechanics of birth.

The manifestation of educational support was demonstrated by doula’s sharing of research and information about the physiological dimensions of childbirth. Four doulas referred to themselves as “evidence-based” practitioners. As Brittany explained, “I really want information that I’m putting out in the world to be backed by actual science.” Melissa noted, “I try my best, I share with them the information, the evidence” on why she suggests certain behaviors.” Moreover, Devon wanted her clients to “feel really comfortable” talking about physical mechanisms of birth. In providing parents this research and knowledge, doulas viewed this support as a source of empowerment.

Doulas explained that not all recommendations made by medical providers are evidence-based or backed by research. Instead, that are often rooted in efficiency, “standard practice,” and expediency. Anna explained, “I think that we overuse technology” in birthing spaces. Similarly, Mary stated, “To me, I think birth is a sacred thing, but to hospitals it’s just another procedure to make money.” In working in this system that does not prioritize the sacred-nature of birth, doulas supported clients by informing them about how their body is built to birth their baby.

Doulas also work to decode and explain the medical jargon that can sometimes leave parents confused. When describing this role, Alexis noted, “And then just being the fly on the wall, being the translator when the doctors are talking about like, ‘Oh, there’s meconium,’ or

whatever, and the parents are like, ‘What?’” When there is confusion, doulas break down that information to make it more comprehensible.

Emotional Support

In detailing the support they provide to clients, doulas described various types of emotional support. Birth is a physical experience, but it is also largely emotional. By supporting the emotional well-being of birthing persons, doulas attend to the needs of expectant parents in a way that medical providers often do not or cannot. In the interviews, three subthemes of emotional support emerged: *respect*, *empowerment*, and *relational caring*.

Respect. One way doulas provide emotional support to their clients is by respecting them. First and foremost, doulas respect the wishes and desires of their clients, whatever that might entail. For example, Jessica respected her clients with the following approach:

Not my baby, not my birth, not my body. The intention there, which is the unspoken part, which it's not my birth, this is her birth. Not my body, this is her birth or their birth. Not my baby, this is their baby. My job as the doula is not to convert them or force them to do what I think they should. It is not a place for me to heal injury that has happened to me in the past. Rather, it is a place for me to take on their goals and intentions as if they're my own and walk the path with them. Not walk it for them, walk it with them

Ultimately, the desires of the birthing person are the most important. In order for a doula to truly support a birthing person, they must understand the wishes of the parent and assist them in achieving the birth they desire. Emily noted that, “as doulas, there's a lot of people with the savior complex” but that she can only help herself and that will allow her to “continue to pass it on.” Bailey explained her role as a doula is, “to make sure that you have the birth experience that you want.”

Another facet of respecting a birthing person occurs when doulas “hold space.” As Brittany explained, “as a doula, we're able to witness but then also create space for the power

of birth.” Thus, part of respecting a person experiencing birth requires giving them the time, space, and opportunity to experience the situation to the fullest extent. Brittany noted how challenging this can be:

I think it's holding that emotional space for all those people and feeling like you're battling with the machine of modern medicine is probably the hardest part of this work because I don't think it needs to be that way, and it gets frustrating.

Doulas open space for the emotional aspects of birth that our medical system does not, and that can be challenging and exhausting work for the doulas themselves.

Empowerment. As support providers, doulas see a vital aspect of their role as empowering birthing persons. Doulas build interpersonal trust with the clients, and they support clients by empowering them to trust themselves. As Jessica explained, “part of the doula’s job is to teach [birth parents] to trust themselves. All I did was give her a little bit of a push, that little bit of reinforcement so that when she tells her story, her story is ‘I chose.’” Doulas do not tell or teach birthing people how to birth, they support clients in understanding and trusting their bodies.

Doulas described birth as “sacred” (Lauren). By inspiring autonomy and individuality, doulas desire for their clients to feel proud and powerful about their birthing experience. Devon explained that there is such a focus on medical outcomes of birth. and, while these are important, she argued, “Yay! I feel so proud of myself!” is the best outcome she hopes for all of her clients. Power was central to discussions of emotional support and empowerment. Specifically, who is given power in the birthing space. As Olivia explained, one of her favorite parts of her work is that doulas “empower people to take back their power.” This language of reclaiming power was echoed by Lauren, who said, “And I think that that's part of what has really made doula work my passion is because I realized that, right now, our system is trying to make birthing people

powerless.” Focusing on the emotional aspects of birth is not something that medical systems often do. Sarah noted:

I value making sure or encouraging folks to be in touch with their own intuition about their experience, which is another thing that I don't think is very present in the medical model, but I encourage them to trust their bodies, to trust what they're feeling, and to respond accordingly. They are the expert in that. I'm there to guide and help shape, but really they're at the center of all of that.

Working within the modern medical system, doulas encourage people to be in touch with their intuition rather than relying solely on medicine.

Relational Caring. A final dimension of the emotional support doulas described providing to clients during birth is relational caring. Birth can move quickly, and it can become easy for birthing persons to feel overwhelmed, anxious, and scared. Doula emotionally support parents by helping them remain calm and ensuring they feel cared for—they build a relational connection with their clients that aids the birthing person in being able to feel safe and relaxed.

In order to cultivate a caring and calming environment for clients, doulas prioritize building relationships with them before the birth and carrying this relationship into the birthing space. The relationship adds a value to the birth team that is often missing with doctors or nurses. As Emily explained, “Yeah. We're not medical. [Medical personnel] know so much more, but we know our client. We have this rapport. We really have the relationship aspect.” Doula may not be medically trained, but they clearly bring a lot of value and power by having built a relationship with the birthing person. Similarly, Sarah said, “in my practice, I hope to be relational.” Thus, doulas value being in relationship with their clients as a facet of the support they provide that a medical team might not be able to.

Jessica told a story of a time she witnessed the power of supporting the birthing parent by helping them feel cared for. She recalled:

I walked in, not knowing what I was walking into. She was African-American. I think her husband was Hispanic, and I walked up to them and I said, 'My name is Jessica and I was asked to come in and help. Can I help you?'
'Yes, yes, yes.'
'Can I touch you?'
'Yes, yes, yes.'
Then Dr. J walks in as I'm starting to talk to the client and she goes, 'The heart rate's irregular.'
I said, 'I just got here, everybody stop. She needs 30 seconds, stop.'
Dr. J stopped, everybody stopped, and I turned to the mom and I said, 'Do you understand what's happening?'
She goes, 'No.'
I said, 'You may have wanted a C-section, your baby wants a vaginal birth, and your baby's having it tonight and we're having it right now. Your baby's getting born.'
Her eyes just bugged out of her head. I said, 'You're fine, you're safe. Your baby is safe. I'm going to stay with you and we're going to meet your baby. How does that sound?'
You could just see her anxiety drop, and as her anxiety dropped the baby's heart rate stabilized. We never had to place the vacuum and we had a birth."

In this instance, Jessica took a moment to calm the energy in the room, explain the situation to the mother she was supporting, and let her know she was not alone. Emotional support involves attending to another's emotional needs to mitigate feelings of distress. This act of emotional support from Jessica allowed the mother a moment to process and recenter, which had the effect of bringing baby's heart rate down, circumventing the need for a medically-assisted birth. Discussing a similar situation, Alexis claimed, "I think birth is so rushed sometimes, like we talked about. I think I just remind people breathe." In keeping the emotional state of the birthing person in mind, doulas offer support by prioritizing the emotional well-being of the birthing parents and reminding them to stay calm and grounded. In promoting the well-being of her clients, Sarah said, "So it should be an experience where we can all wrap our hands around this person and their family to make sure that they have the experience that they want to have."

Childbirth puts physical stress on the body of the birthing person. Doulas work to facilitate pain management through offering comforting touch and guiding birthing persons through different labor positions. In explaining how she support clients, Carla stated:

I'm a very touchy person.... it's how I connect with people. It's how I show my love because, like I said, I just love, you know, the feeling of just touching. And so the fact that I get to do that and I know it helps them progress or just helps them relax.

Physical touch is a way Carla demonstrated care and love to her clients, and she knows this can help release oxytocin, a hormone that propels labor.

Giving birth to a child is a very intimate and vulnerable experience. Establishing trust is a crucial dimension of the doula-client relationship. In interviews, doulas noted the value of relational trust and described how they build trust with clients. Part of gaining trust is earning it. Brittany explained that she is honest and vulnerable with clients in hopes they will reciprocate:

If people are able to be really vulnerable, and I try to be vulnerable with them so that it feels reciprocated. It just helps me be a better doula [...] birth is a vulnerable space, so just that is probably one of the things I try to do with people so they know they can safely be vulnerable with me too.

Doulas are in relationship with the people they provide support to. They are willing to be vulnerable and honest to help build a feeling of safety for their clients to do the same. Ultimately, they want to be able to say to their client what Bailey said, “if you just trust me, I’ve got you.”

Network Support

Doulas inhabit a unique role in that they work for the birthing person, but they also work with co-parents and the medical members of the birth team. In interviews, doulas detailed providing different forms of network support—they facilitate a sense of connection and teamwork among members of the birth team and the birthing person.

One important dimension of network support doulas reported providing was acting as a liaison between the birthing person and their medical care provider. Network support in this context included guiding clients to select the best medical provider for them in the hopes of minimizing the need for advocacy detailed above. Devon explained,

I really want my clients to implicitly trust their medical care provider. They're hiring them for a very specific event. So if I have a client that says, 'I need you to advocate against this provider for me,' it's a red flag and we need to talk about switching care, or them not feeling safe and comfortable. But also, especially for first time mothers, them not understanding why that's so important.

Doulas aid expectant parents in selecting a care provider that is going to provide the type of care they desire.

In navigating their sometimes-peripheral role, doulas work to establish a sense of teamwork and comradery. Doulas technically work for the birthing person, but they also work with medical providers. In an effort to work collaboratively with the medical team, Emily said that she makes sure she is “very respectful” to OB-GYNs or midwives. Moreover, multiple participants described a sense of needing to “stay in their lane” in a hospital setting. Sarah used this phrase, explaining, “I know how to stay in my lane. I know what I bring to my birth experience or to my client's birth experience.” Doulas do not want to replace the doctors or nurses; they seek to cultivate an environment of a team working towards a common goal. As a Black-identifying doula, Sarah added historical contextualization to her desire to collaborate. She described,

Midwives of the rural south during those time periods were eager, in a sense, to collaborate with physicians and nurses from hospitals. They felt as though they could essentially collaborate and work together. If everybody would stay in their lane, then it could be this cohesive and comprehensive model of care for a family.

This historic relationship was important to her. By working with physicians, not against them, doulas facilitate the provisions of more comprehensive, holistic care.

Moreover, doulas explained how they work to get partners involved in the birthing process. Doulas describe their desire for partners to feel valued and integrated in the experience. Doulas intentionally do not replace partners as support providers. This fear of being replaced is something raised by partners. Emily explained, “Most people do not have doulas because of their partner, I feel. It might be a reflection of them not feeling like they're not good enough.” Instead of replacing partners, as Emily went on to say, doula provide space so partners, “can love on their partner. I have everything else covered.” This means doulas actually facilitate the ability for partners to support the birthing person however they want. Doulas bring partners into the network of support by helping them prepare for birth so they will not feel lost or confused about how to support the birthing person during labor. Anna recalled offering this form of support during prenatal visits with birthing partners, “helping dad show some of those comfort techniques [...] we worked together as a team.” Stradling this unique role, doulas deliberately collaborated with partners and medical professionals. They sought to generate feelings of connection and belonging among all involved in the birth so it would feel like a team effort.

Identity and Doula Experiences

The second research question explored how doulas perceive their racial identity as influencing their practice and provision of support (RQ2). To conduct this analysis, I conceptually divided the doulas in two groups: White ($n = 10$) and Black, Indigenous, People of Color (BIPOC) racial identity ($n = 6$). The themes that emerged most directly explore differences between BIPOC doulas' experiences supporting birthing people of color compared to White doulas' experiences supporting birthing people of color. From interviews with BIPOC doulas, three distinct themes emerged: *relatability*, *communication*, and *hiring challenges*. Interviews with White doulas revealed three contrasting themes: *allyship*, *difference* and *communication*.

Before explaining these themes, I am going to highlight the evidence doulas shared about the prevalence of medical racism in maternal health care.

Medical Racism

It is important to highlight why race is a vital consideration in explorations of birth support. Both BIPOC and White doulas recounted witnessing medical racism in the birthing space, and this racism influenced their experiences of providing care for birthing persons. Devon, a White doula, explained her shock at witnessing the inequitable treatment of her clients:

But I feel like when it comes to race and birth, even after all of that, I want to say supposed exposure, it was like ... And I always almost cry. It was like the film got lifted, or sometimes I'll say the gauze came off my eyes, or the light filtering curtain was lifted. My first four clients were white Caucasian couples, married, no big deal. Hard birth, really, really hard birth. And then I did my first birth with a woman of color, whose partner was white. And we're talking like veteran in the military, finishing her PhD. This is somebody who outranks me in life, right? And watching the extreme difference with how she was treated, until her partner came in the room. And anytime he left, she was treated differently. And at one point, when he was napping and she was on an epidural, I went to go get food. And I will regret doing that, because they forced her, after I left, into a Cesarean. She'd been in labor long enough, and you know how your people [sic] can get high blood pressure issues. She was scared for her baby and for her body. She didn't realize that they were grouping her and using systemic racism to free up a room, with a partner who was asleep and a doula who had left.

In this experience, she witnessed a Black woman being treated differently than her previous White clients. Devon went on to say, “in birth work, the inequality that is rampant in our culture just gets magnified.”

BIPOC doulas noted differences in support White and BIPOC clients receive. Explaining this difference, Bailey, a Black doula, noted:

So there has been times when I've been in labor with someone who wasn't of the same racial identity as I am. And, so like their experience went smoother, I guess, or just had a better experience than when I'm with someone of color.

In supporting both BIPOC and White clients in the same hospital, Bailey noticed differences in the way the birthing people were treated.

Many other doulas detailed similar experiences—communicative interactions between providers and BIPOC clients that were starkly different than their communication with White clients. As Brittany explained, “I’ve supported dozens of people of color, and the overarching thing is that they’re not treated the same way across the board.” Beyond this difference in treatment, doulas also noted a stark difference in access. For example, Jessica recalled an interaction with a physician that highlight the inequities in medical access for BIPOC clients.

The doctor initiated the conversation:

This mom in here just showed up in labor. She needs a C-section because she's had five prior C-sections. She has not had prenatal care at all and she's in labor. I go, ‘How do you know she hasn't had prenatal care?’”
She goes, ‘Her staples are still in place from her last C-section [...] She didn't even have postpartum care. She walked around for a year and a half with the staples in her.’
I looked at her and I said, ‘Just for clarity, is this a woman of color?’
She said, ‘Yes.’
I said, ‘Why do you think she didn't have the postpartum or the prenatal care, have we looked into it?’
She said, ‘No, we haven't. I'm just flabbergasted.’
I said, ‘Well, let's look at it really quick.’
We found that where she was living in D.C., she probably had to take like three buses, all the things that we always talk about [...] To walk around with staples in your body and have a life, and take care of children, and have sex, but that's not an issue, because you just don't have time or the capacity to get to your provider. That says something about our system.

This example highlights the systemic inequities that contribute to health disparities between White birthing persons and BIPOC birthing persons. Doulas work directly with birthing persons, but they also work within systems to try to improve outcomes. Racism is not just carried out in interpersonal interactions; it exists in institutions and systems like transportation.

BIPOC Doula Experiences

Relatability. In interviews with BIPOC doulas, they explained how they see their race influencing the support they provide to BIPOC birthing people by creating a sense of connection, relatability, and understanding. For example, Olivia (a Black doula) noted that her BIPOC clients are, “typically hiring me because I am a person of color, and I can understand what they’ll have to go through, especially within the hospital system, systemically. Like, they know that I understand what they’ll go through.” Thus, her clients that share her identity as being a person of color specifically desire to hire her because of their shared experience and understanding.

Related to the notion of having an unspoken understanding, Bailey explained what BIPOC birthing people want in a doula. She stated, “Not someone who is like, ‘Wait, are you, are you sure that’s what they’re meaning?’ And you’re like, yes, that’s exactly how I felt. They’re like, ‘Oh no.’ You know, trying to sugar coat what you’re feeling because they’ve never experienced it.” In this way, Bailey argued that, if experiences of racism or microaggression arise in the birthing space, BIPOC doulas are likely to recognize them rather than doubting their presence like a White doula might. Sarah (a BIPOC doula) explained, “A lot of the clients of color, particularly the Black families that I’ve worked with, have wanted to work with me because I’m a Black doula. It’s been very upfront like that.” This desire to work with a doula illustrates how shared identity can be something explicitly discussed in the hiring process.

When BIPOC doulas support clients who share their racial identity, several participants reported this experience to be more enjoyable. In describing the enjoyment of this experience, Carla (a BIPOC doula) explained,

Black people are very like, ‘Come into my space. You nurture me and we’ll have a really good connection,’ you know? And I felt like I was part of their, I was, yeah. I was part of them, you know, in that laboring room. And I felt very close-knitted to my Black clients [...] like at all times.

This sense of invitation and connection that accompanies supporting another woman of color cultivated a sense of closeness between BIPOC doulas and their BIPOC clients. Similarly, Sarah said, “I absolutely do center Black families and Black pregnant people in my practice” and Olivia stated that it was much easier to feel comfortable and connected to her Black clients. Overall, BIPOC doulas reported the increased connectedness they felt with clients who share their identity. This similarity also influenced their communication.

Communication. An additional way doulas described racial identity as influencing interactions between themselves and clients was through communication. Many BIPOC doulas explicitly discussed race, racism, and maternal mortality statistics with their BIPOC clients. Further, their BIPOC clients raised specific fears surrounding race and childbirth more frequently than their White clients. Olivia (a BIPOC doula) explained,

It’s definitely a fear [...] it’s like one of my clients literally looked at me and said, “I don’t want to die.” And I was so, like, we talk a lot in our prenatal about like, systemically, why, you know, people of color are more likely to die due to childbirth or pregnant- or postpartum-related complications. And so I do a lot of work undoing the fact that it’s not their fault.

By explicitly discussing identity-related fears BIPOC birthing persons have about childbirth, Olivia was able to give them back some agency and hope.

Similarly, another Black doula, Sarah, said she explicitly makes space to discuss these topics. She described making an effort, “affirming to your clients that you understand, to a certain extent, and that you’re willing to, at the very least, be in conversation with them about it, so it doesn’t have to be something that’s swept under the rug.” Ignoring conversations about race and how they influence birth was ultimately, from the perspective of BIPOC doulas, doing their clients of color a disservice. When her clients bring up race-related fears, Olivia said she says,

“Let's talk about why it is the way that it is in what we're going to do to combat that.” They make a plan to address any inequitable treatment to alleviate that fear.

The careful and explicit communication about race with BIPOC clients was juxtaposed with the way BIPOC doulas communicated with their White clients. Sometimes, Black doulas expressed a need to “code-switch,” or change their communication patterns, when interacting with White birthing persons. In comparing working with White and BIPOC clients, Olivia said, “I think the main thing is like with White clients, I feel like I do have to make sure that like I'm worthy of their... Like, I have to let them know, I'm actually really educated on what I'm doing.” She went on to say, “I have to carry myself a little differently” when supporting White clients. Ultimately, Black doulas can sometimes feel a need to prove their competence, worth, and credibility to White clients. This leads to them altering their natural communication patterns to accommodate their clients, in an effort to have their competence recognized and respected.

Hiring challenges. A final unique theme that emerged in discussions with BIPOC doulas was the challenges they face in getting clients. In particular, BIPOC doulas reported experiencing difficulties in attracting White clients. Both in formal doula organizations and in their efforts to seek private clients, BIPOC doulas expressed their sense that White doulas were favored in the hiring process. As Bailey explained, “I do feel like certain programs or certain doula organizations favor women who are not people of color.” In addition to identifying as Black, Bailey also identified as Muslim, and she expressed the belief that her religion also influenced her experiences getting hired. She explained, “Sometimes, I don't know if it's one or the other, or if it's both. But it's something.” Bailey discussed how she sees other doulas who she trained with getting more clients and opportunities than her, and how this experience is

frustrating because of her deep passion for the work and the significant investments she has made in her training and education.

Bailey's frustration was echoed by Olivia. Having been a doula for more than seven years and attended many births, Olivia explained:

I'm a seasoned birth worker. So I did not expect to have to work so hard to get clients in this field. But I have realized because I don't look like majority of the people that live here, I don't end up booking clients as much unless they're someone of color or unless it's someone I know.

Living in a predominately White community, Olivia experienced White doulas getting hired more often, and she attributed that to their identity. Despite her skill and competence, Olivia does not get as many opportunities to support births as White doulas with similar experience. When describing her experiences, Carla expressed that she has never supported a White client. In positing about why this is the case, Carla said, "I'm just throwing that out there, but they don't, they're not attracted to me. If you don't vibe with me, that's totally okay." Although this disparity was something Carla noticed, she also expressed acceptance of this reality because of her personal desire to feel close and connected with her clients—something she might feel more readily with BIPOC birthing parents.

White Doula Perspectives

Allyship. White doula participants also expressed awareness of medical racism and maternal health disparities. This awareness led many of them to want to be allies for their BIPOC clients. Sometimes, White doulas are recognized that they were hired by BIPOC birthing persons specifically to be a source of allyship. White doulas explained how they were hired to "protect" their BIPOC clients from obstetric violence or unequal treatment. For example, Devon explained:

I have numerous people hire me because I'm White, and we talk about that. We talk about how they need me to use my privilege to make sure that they get treated the right way. I've had a number of high academic African-American women of color, some are also mixed race, who are single by choice, who have hired me to be their doula specifically to be by their side. And that is unacceptable. It's unacceptable that they have to do that, that they have to think about that. They have to add this extra layer to their physically-vulnerable, emotional event. It's unacceptable that they need me to stay 12 hours postpartum so that they can have their baby.

BIPOC clients are explicit about their need for an all and recognizing this makes Devon frustrated with how maternal health care operates in the United States. Similarly, when Melissa was hired by a BIPOC expectant parent, she asked them why they wanted a doula. They replied, "I feel like I need you," in reference to her ability to offer potentially life-saving support.

When asked about the value of racial-matching, or sharing a race, between doulas and clients, White doulas offered various answers. Some doulas, like Lauren, believed that racial matching makes a difference, saying that, "in an ideal world," it would be the case that BIPOC birthing people could be matched with a doula who shared their racial identity. Others, like Mary, believed "there are not enough people that are doulas to represent everyone." Lauren saw, "things like accessibility and finances and stuff get in the way of," being able to offer everyone with the best possible match. In the circumstance where White doulas were supporting a client of color, Lauren stated that, "doulas should be making every effort to be informed on what it's like to be a person of color giving birth and how to help foster a sense of safety." In this way, a big part of allyship involved understanding how the system works and doing every possible to ensure the clients feel and experience safety.

In exploring the value of racial-matching and allyship, White doulas acknowledged the potential limits to the support they can offer. While BIPOC doulas expressed an unspoken connection and understanding of racism with their BIPOC clients, White doulas identified a need

to learn how to recognize bias and step in when it takes place. Nonetheless, White doulas often recognized that this training is not equivalent to lived experience, as Brittany noted:

There is excessive amounts of training that a White doula, I think, needs to go through to be able to show up and recognize a lot of things. No matter how much training you get, I can't experience life as a Black person, so there's a lot I absolutely can't learn and connect with that that black doula could. I guess my big picture answer is that I do think racially matching people could have benefits that we may not even be able to put words to yet.

Thus, Brittany recognized that training and learning are not a substitute to the connection offered by sharing a racial identity.

White doulas articulated that representation is valuable, but they still expressed a desire to support the BIPOC community as much as they can. Continuing the conversation on the value of racial similarity between doulas and clients, Jessica stated, “There's a belief right now [...] that women need to be surrounded by women who are culturally the same. I don't know if they need to be the same, so much as culturally sensitive.” This added another layer to the conversation, in that Jessica expressed the belief that White doulas can offer support equal in quality to a BIPOC doula if they are culturally sensitive. Therefore, not all White doulas practice allyship in the same way, nor do they all share the same views on the value of racial matching.

Difference. An important step in enacting allyship was recognizing different. Doulas saw their identity influencing supportive communication with BIPOC clients through the acknowledgement of racial difference. White doulas recognize the difference in their life experience from that of their BIPOC client. For White doulas, one element of being supportive involved recognizing the difference in fears between White and BIPOC birthing people. For example, Devon (a White doula) said the main source of fear for her White clients was whether they would experience a perineal tear. Comparatively, a central fear for her Black clients was, “Am I going to bleed out after?” And for her Asian-American clients, it was, “Is my name going

to be made fun of? Are they going to make fun of us when we bring in our food?” These differences tell us that identity and culture are causes of stress for BIPOC birthing persons. White clients fear inevitable physical aspects of birth, while BIPOC birthing people are concerned with how their identity might influence the quality of care they receive. Emily recounted recognizing fear in the eyes of a BIPOC client’s partner who was “scared that he was going to lose his wife.” In identifying the different ways their clients could experience fear, White doulas spoke about doing their best to alleviate these fears.

When discussing experiences supporting BIPOC clients, White doulas utilized language that affirmed BIPOC birthing bodies as distinct from White birthing bodies. For example, Lauren said, “so, obviously, I am a White person. So that definitely informs things, because I don't fully grasp what it's like to be a person of color, but I am trying.” This aspect of difference and awareness of the inability to truly grasp the BIPOC experience was raised in other interviews.

Sometimes instead of bringing awareness of racial oppression and differential treatment into the birthing space, White doulas learned of disparities by witnessing them. After supporting her first BIPOC client, as noted above, Devon explained, “When it comes to race and birth, even after all of that, I want to say supposed exposure, it was like. And I always almost cry. It was like the film got lifted, or sometimes I'll say the gauze came off my eyes, or the light filtering curtain was lifted.” Although she was previously informed about racial disparities, witnessing the difference in treatment for the first time was shocking.

Moreover, some doulas used language that explicitly signified difference when referring to BIPOC birthing persons. Sometimes this language exoticized Black bodies. For example, Anna noted differences in how a Black client birthed. She said, “I guess, tribal is the best way that I have to describe it. Just her movements and the way that she spoke, her history, and her

moans—that you could feel the history of her heritage kind of in there.” Anna also maintained an awareness of how her support of BIPOC birthing persons might influence how she was perceived in the community. Discussing supporting a Black woman, she said, “I was really glad that it happened before a lot of the racial tension really flared up here, because I didn't want it to look like it was, ‘Oh, I just need to cover my business.’” She did not want it to look like she was supporting a Black woman just to make her business appear more inclusive.

Comparatively, other doulas spoke to the value of honoring and cherishing this acknowledged difference, as Melissa explained,

So that's what I'm looking for and just cultural or religious beliefs, what things do you want implemented into your birth? How can I help you with that or how can I set those up? Are there things like that, that you want to bring in? What makes you comfortable?

As evidenced in her quote, Melissa intentionally invited people to bring culture into their birthing space and did her best to accommodate those different desires so the person felt respected.

Communication. Finally, White doulas explained how race influenced their experiences communicating with BIPOC clients, specifically when having conversations about race and health disparities. Some doulas explained that they explicitly discuss race with BIPOC clients, whereas others indicated that they do not know how to comfortably broach the topic. For example, Lauren said that she is not sure how to discuss medical racism and health disparities, “without scaring people.” On the other end of the spectrum, Devon explained, “I do talk about race when I interview with people prenatally, because it does come up in the birthing room.” Similarly, Alexis explained her approach to prenatal visits, “I feel like we actually had to devote time to like, ‘These are the statistics, and this is what I want you to be prepared for.’” Some doulas described that they do not talk about race in prenatal visit unless their client brings it up.

Expanding on this, Lauren said, “Until I maybe have more training about how to broach that subject without causing further harm, I probably wouldn't say anything about it. But if they brought it up, it would be a topic I would be more than happy to discuss with them.” Thus, she let her BIPOC clients take the lead on initiating conversations about identity. Overall, whether or not a doula raises the topic of racial identity depended on what experiences they have had as a doula and personally, how comfortable they feel talking about race.

Sexual Orientation and Doula Experiences

The third research question asked how doulas perceive their sexual orientation as influencing their practice and provisions of support (RQ3). To conduct this analysis, I conceptually divided the doulas in two groups: LGBTQ ($n = 2$) and non-LGBTQ gender identity ($n = 14$). In interviews with doulas, two themes emerged: *language* and *identity affirmation*.

Language

Language was the primary theme that emerged when discussing sexual orientation with doulas. The majority of the doulas interviewed identified as straight women, and only a handful had experienced supporting a member of the LGBTQ community. Nonetheless, those that had supported an LGBTQ birthing person noted the importance of language in this context. Specifically, they discussed how heteronormative language is often used in the birthing space, and doulas saw an important dimension of their supportive role as ensuring correct language usage by all member of the birth team. This is a manifestation of esteem support, or expressing respect and validation.

Specifically, the language around anatomy, relationships, and parenthood were particularly important in these interactions. For example, Jessica noted, “I've only done a couple of transgender [births]. The big thing is around *chest-feeding* versus breastfeeding.”

In the transgender birthing community, transgender birthing parents often prefer the term “chestfeeding” in place of breastfeeding because of the ways “breastfeeding” has culturally been gendered. Further, Devon explained, “So in my own lactation practice [...] I talk a lot about chest feeding, and I talk a lot about bonding suckling.” By avoiding the gendered term of “breastfeeding” doulas support birthing persons who do not identify as women and validate their ability to feed their child without utilizing a term that might threaten their gender expression.

Another dimension of supporting LGBTQ birthing persons through language was the usage of preferred pronoun. Pronouns are vital in the LGBTQ community, as they are a reflection of gender enactment. Using a person’s preferred and correct pronouns is a way to respect them and validate their gender expression. As Brittany said, “My client that was a trans man, I had to remind people so often. He, he. Him, him. The non-binary [birth I supported], they.” When people received care, doulas recognized the importance of their preferred pronouns being used in a space that was already vulnerable.

Language also came up in conversations about family composition and how to refer to support persons and co-parents in birthing situations. In cases of LGBTQ families, surrogacy, or other non-traditional birthing circumstances, Jessica stated that her biggest role was ensuring correct language usage. When supporting LGBTQ families, she said “language is the biggest thing. And I think that was my biggest role. Similarly, Sarah noted, “the birth space is so heteronormative, and not just in man and woman, but just like the composition of a family or what family is and what it looks like.” Further, when reflecting on her experience supporting a lesbian couple, Devon noticed ways in which they were treated differently when their sexual orientation was revealed. In this instance, Devon explained that the medical team, “treated her wonderfully when they thought she was the sister. And the second she became the partner, it was

like everything became different.” Along these same lines, Jessica described an experience supporting a lesbian couple who was having a baby via a surrogate. Language was very important in this situation, and Alexis explained,

The surrogate mom had had four babies and she was a pro, but I think I came in just reminding like, “This is mom. The birthing person is the birthing person, but this is actually mom and this is also mom.” So just reminding language, because they are like, “Put baby on mom's chest,” and that's not what the plan was. The plan was baby goes on mom's chest, not birthing person chest. So it was just reminding language was pretty tricky.

Given the uniqueness of this situation, Alexis saw her role as a doula to ensure the birth team was reminded of roles and birth wishes. This illuminates an enactment of esteem support, Alexis supported both the birthing person and the mother by validating their roles and identities.

When supporting gay and lesbian births, doulas also reported the importance of reminding the care team about labels. Explaining the frustration of constantly having to correct the medical providers’ language during a birth with lesbian partners, Brittany said, “they kept saying ‘Oh, your husband ... I mean, I'm sorry, wife.’ It's like. Just say partner. It's not that hard.” The highlights another way doulas support clients by being an advocate. Nonetheless, continuously having to correct the language of members of the birth team is something doulas mentioned as a frustration associated with supporting their LGBTQ clients. Sometimes doulas recognized clients trying to situate themselves inside the heteronormative structure. Emily supported a lesbian couple and recalled how the non-birthing parent kept jokingly referring to herself as the father, “there was that undercurrent of her calling herself father, ‘I'm the dad, and that kind of stuff.” She said she could sense this was coming from a place of trying to accommodate the situation and cope. Recognizing this, doulas support client by cultivating a space where parental identities are respected for nontraditional birthing families.

Identity Affirmation

Another way doulas described supporting birthing persons with LGBTQ identities involved making a conscious effort to affirm the identities of their LGBTQ clients. This is another enactment of esteem support. As Sarah explained,

I think that identity is important in general. So in approaching a client that has a non-dominant sexual orientation or a non-traditional makeup of their family, I 100% acknowledge the differences that might exist in their experience, and sometimes the challenges too. Again, it's acknowledging it, and it's creating space to have conversation about it, and it's doing what I can to be supportive and affirming to however they identify, racially, sexually, or as far as their relationship is concerned.

In acknowledging the adversity these individuals might face, Sarah intentionally worked to affirm the importance and value of their unique identities. Similar to BIPOC expectant parents, LGBTQ families can feel ostracized by systemic inequalities. In response, Brittany explained how she makes a conscious effort to affirm the identities of her LGBTQ families:

When I started this business because I had a lot of friends that had different sexual identities, gender identities, that felt really isolated and unsupported in birth, so that's ... I mean, my logo is a rainbow for a lot of different reasons, but one of them is trying to make a safe space for LGTBQ people. One of my first births was actually a trans man and I felt like it was very easy for me to just shift. It's just a man.

For her, making the language shift preferring by her client was easy. However, not all birth professionals adopt this perspective. For LGBTQ clients, the main mode of support is esteem support—it is important to respect and validate the identities of these individuals so promote a safe and comfortable birthing environment.

CHAPTER 5 – STUDY TWO RESULTS: SURVEY OF EXPECTANT PARENTS

The goal of the survey research was to explore how racial identity and sexual orientation influence attitudes towards childbirth and support seeking behavior. Hypothesis one stated that *expecting parents who are aware of what a doula is will be more likely to hire a doula*. A chi-square test of independence was performed to examine the relation between whether expecting parents were familiar with what a doula is (yes, no) and whether they have hired a doula for birth support (yes, plan to, no). The relation between these variables was statistically significant, $\chi^2 = (2, n = 168) = 14.221, p < .001$. Results indicate that pregnant parents who are aware of doulas are statistically more likely to hire a doula to support their birth. Thus, the hypothesis was supported (Table 2).

Table 2
Hired Doula x Familiarity with Doula Support

		Familiar	Not familiar	Total
Yes	Observed	42	5	47
	Expected	33.0	14.0	47
Plan to	Observed	10	11	21
	Expected	14.8	6.3	21
No	Observed	66	34	100
	Expected	70.2	29.8	100

Note: $\chi^2 = (2, n = 168) = 14.221, p < .001$

The second hypothesis stated that *expecting parents who identify as racial minorities (BIPOC) will be more likely to report more fear of childbirth*. To test this hypothesis, an independent samples *t*-test was performed to compare mean fear of childbirth scores across racial groups. In this context, survey participants' race was dummy-coded into a categorical variable, resulting in two distinct groups: White racial identity and BIPOC racial identity. In this analysis, race of pregnant parents (White or BIPOC) was the independent variable with fear of childbirth (using the WIJMA scale) as the dependent variable. The 35 expecting parents who identified as

racial minorities ($M = 95.46$, $SD = 19.98$) compared to the 101 White expecting parents ($M = 84.26$, $SD = 16.66$) reported a significantly higher fear of childbirth, $t(134) = 3.25$, $p < .01$. The hypothesis was supported.

The third hypothesis stated that *White expecting parents will be more likely to hire a White doula than a BIPOC doula, and BIPOC expecting parents will be more likely to hire a BIPOC doula than a White doula*. To test this hypothesis, a 2 (parent race: White vs. BIPOC) by 2 (doula profile race: White vs. Black) analysis of variance (ANOVA) was conducted. In this analysis, race of the expecting parent and race of the doula profile were the independent variables with likelihood to hire as the dependent variable. Results did not indicate a significant interaction between parent race and doula race, with parents of either race reporting to be equally likely to hire a doula of either race, $F(1) = 2.43$, *ns*. Thus, the hypothesis was not supported. However, the data did reveal a significant main effect for parent race, with non-White parents reporting a greater likelihood to hire a doula overall than White parents, $F(1) = 6.00$, $p < .05$, partial $\eta^2 = .037$.

The fourth hypothesis stated that *White expecting parents will perceive a White doula to be more similar to them than a BIPOC doula, and BIPOC expecting parents will perceive a BIPOC doula to be more similar to them than a White doula*. To test this hypothesis, a 2 (parent race: White vs. BIPOC) by 2 (doula profile race: White vs. Black) ANOVA was conducted. In this analysis, race of the expecting parent and race of the doula profile were the independent variables with perceived similarity as the dependent variable. Results indicated no statistically significant differences regarding whether a White or BIPOC expecting parent viewing a Black or White doula profile perceives the doula to be more or less similar to themselves, $F(1) = .23$, *ns*. The hypothesis was not supported.

The fifth hypothesis was that *White expecting parents will report higher levels of trust for a White doula compared to a BIPOC doula, and BIPOC expecting parents will report higher levels of trust for a BIPOC doula compared to a White doula.* To test this hypothesis, I completed a 2 (parent race: White vs. BIPOC) by 2 (doula profile race: White vs. Black) ANOVA. In this analysis, race of the expecting parent and race of the doula profile were the independent variables with perceived trustworthiness as the dependent variable. Results did not indicate a significant main effect for parent race, $F(1) = 3.58, ns$, or doula profile race, $F(1) = 1.73, ns$. However, results did show a significant interaction between parent race and doula race, $F(1) = 5.20, p < .05, \eta^2 = .03$, such that BIPOC expecting parents perceived the Black doula profile as significantly more trustworthy than the White doula profile. Thus, hypothesis five was supported (Figure 1).

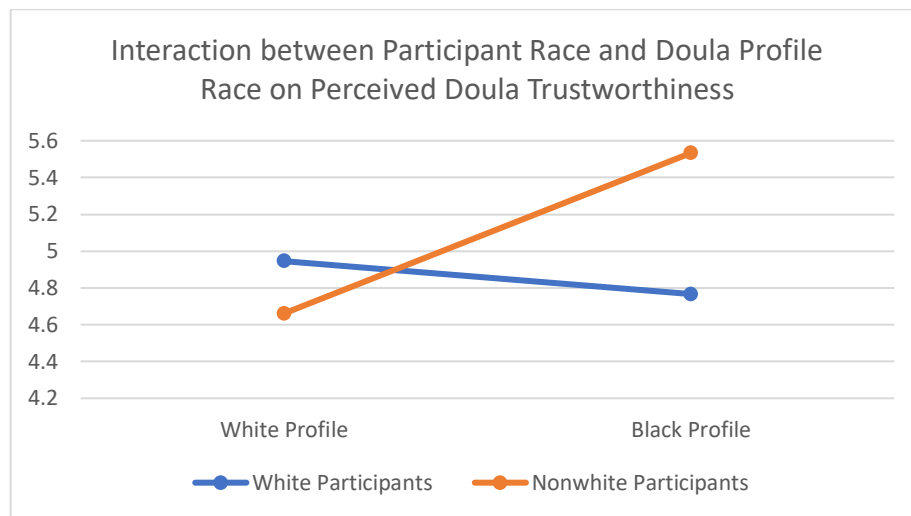


Figure 1: Results of 2 x 2 ANOVA exploring interaction between expectant parents’ race and doula profile race on perceived doula trustworthiness; $p < .05$

The sixth hypothesis posited that *White expecting parents will perceive a White doula to be more competent than a BIPOC doula, and BIPOC expecting parents will perceive a BIPOCO doula to be more competent than a White doula.* To test this hypothesis, I completed a 2 (parent race: White vs. BIPOC) by 2 (doula profile race: White vs. Black) ANOVA. In this analysis, race

of the expecting parent and race of the doula profile were the independent variables with perceived competence as the dependent variable. Results indicated no statistically significant differences in perceived competence when examining doulas of different races, $F(1) = 2.03, ns$. The hypothesis was not supported.

Hypothesis seven predicted that *White expecting parents will perceive a White doula to be more supportive than a BIPOC doula, and BIPOC expecting parents will perceive a BIPOC doula to be more supportive than a White doula*. To test this hypothesis, a 2 (parent race: White vs. BIPOC) by 2 (doula profile race: White vs. Black) ANOVA was conducted. In this analysis, race of the expecting parent and race of the doula profile were the independent variables with perceived supportiveness as the dependent variable. Results did not indicate a significant main effect for parent race, $F(1) = .05, ns$, or doula profile race, $F(1) = .931, ns$. However, results indicated a significant interaction between parent race and doula race, $F(1) = 3.969, p < .05, \eta^2 = .025$, such that BIPOC expecting parents perceived the Black doula profile to be significantly more supportive than the White doula profile and White expectant parents perceived the White doula profile to be significantly more supportive, supporting hypothesis seven (Figure 2).

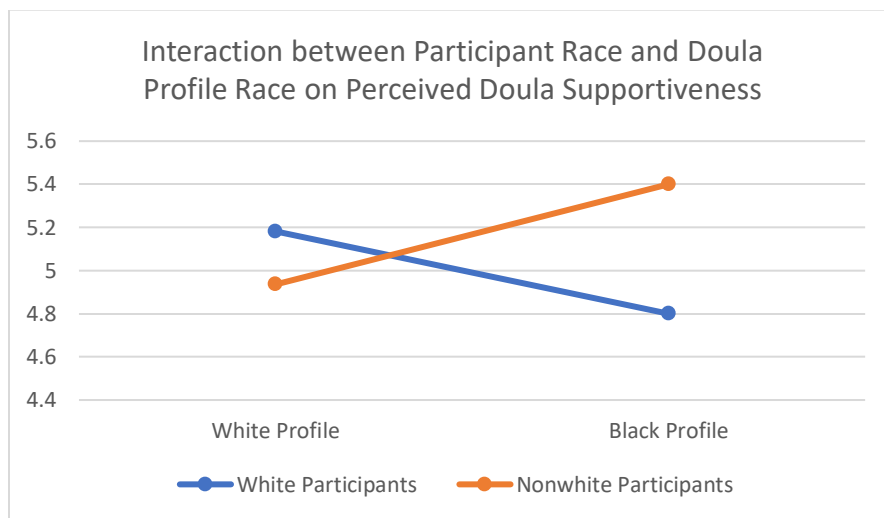


Figure 2: Results of 2 x 2 ANOVA exploring interaction between expectant parents' race and doula profile race on perceived doula supportiveness: $p < .05$

The eighth hypothesis stated that *expecting parents will perceive doulas of their same sexual orientation to be more similar to them*. In this context, participants' sexual orientation was dummy-coded into a categorical variable resulting in two, distinct groups: LGBTQ sexual orientation ($N = 6$) and non-LGBTQ sexual orientation ($N = 157$). Similarly to race, doula profiles were dummy-coded, resulting in two profile types (LGBT and non-LGBTQ).

To test this hypothesis, I completed a 2 (parent sexual orientation: LGBTQ vs. non-LGBTQ) by 2 (doula profile sexual orientation: LGBTQ vs. non-LGBTQ) analysis of variance (ANOVA). In this analysis, sexual orientation of the expecting parent (LGBTQ or non-LGBTQ) and sexual orientation of the doula profile (LGBTQ or non-LGBTQ) were the independent variables with perceived similarity as the dependent variable. Results did not indicate a significant main effect for parent sexual orientation, $F(1) = .002$, *ns*, but did indicate a significant main effect for doula profile sexual orientation, $F(1) = 5.75$, $p < .05$, partial $\eta^2 = .035$. Further, results indicated a significant interaction between variables, $F(1) = 4.152$, $p < .05$, partial $\eta^2 = .025$, such that LGBTQ expecting parents perceived the LGBTQ doula profile to be significantly more similar to them than the non-LGBTQ doula profile, supporting hypothesis eight (Figure 3).

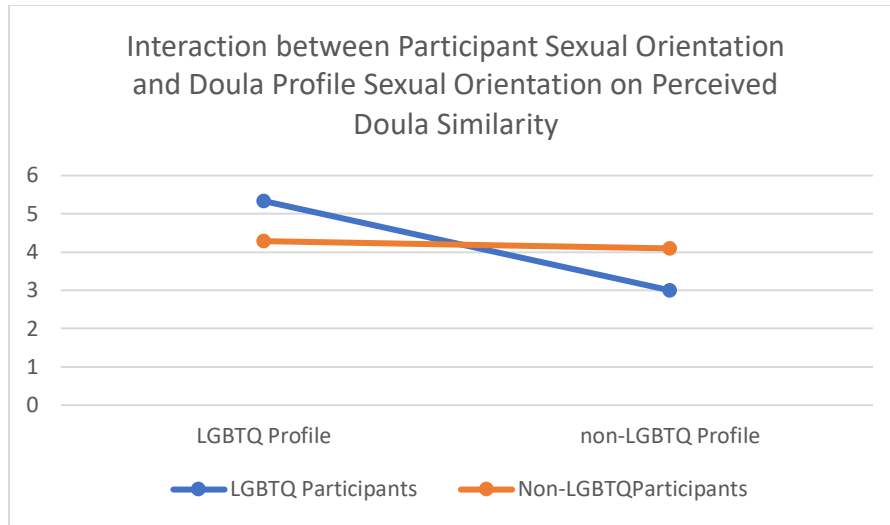


Figure 3: Results of 2 x 2 ANOVA exploring interaction between expectant parents' sexual orientation and doula profile sexual orientation on perceived doula similarity: $p < .05$

Hypothesis nine stated that *expecting parents will report a greater willingness to hire a doula who shares their same sexual orientation*. To test this hypothesis, I completed a 2 x 2 ANOVA. In this analysis, sexual orientation of the expecting parent (LGBTQ or non-LGBTQ) and sexual orientation of the doula profile (LGBTQ or non-LGBTQ) were the independent variables with likeliness to hire as the dependent variable. Results indicated no statistically significant differences in likelihood to hire based on LGBTQ identities, $F(1) = .385, p > .05$. Thus, hypothesis nine was not supported.

The tenth hypothesis stated that *expecting parents will be more likely to trust doulas who share their same sexual orientation*. To test this hypothesis, I completed a 2 x 2 ANOVA. In this analysis, sexual orientation of the expecting parent (LGBTQ or non-LGBTQ) and sexual orientation of the doula profile (LGBTQ or non-LGBTQ) were the independent variables with perceived trustworthiness as the dependent variable. Results did not indicate a significant main effect for parent sexual orientation, $F(1) = .000, ns$, but did indicate a significant main effect for doula profile sexual orientation, $F(1) = 6.08, p < .05$, partial $\eta^2 = .037$. Further, results indicated a

significant interaction, $F(1) = 3.940, p < .05$, partial $\eta^2 = .024$, such that LGBTQ expecting parents reported significantly higher levels of perceived trustworthiness in response to an LGBTQ doula profile when compared with a non-LGBTQ profile, supporting hypothesis 10 (Figure 4).

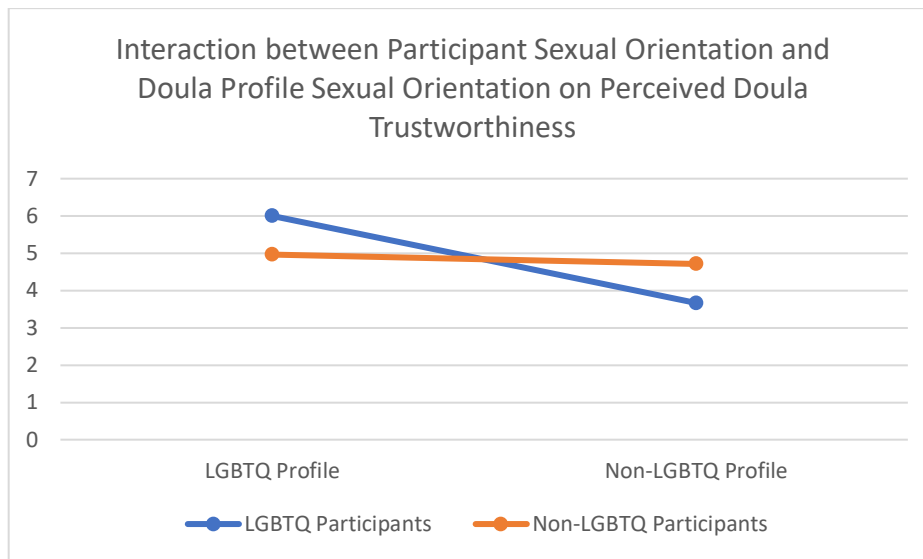


Figure 4: Results of 2 x 2 ANOVA exploring interaction between expectant parents’ sexual orientation and doula profile sexual orientation on perceived doula trustworthiness: $p < .05$

The eleventh hypothesis projected that *expecting parents will perceive doulas who share their same sexual orientation as more competent*. To test this hypothesis, I completed a 2 x 2 ANOVA. In this analysis, sexual orientation of the expecting parent (LGBTQ or non-LGBTQ) and sexual orientation of the doula profile (LGBTQ or non-LGBTQ) were the independent variables with perceived competence as the dependent variable. Results indicated no statistically significant effects, $F(1) = 1.241, ns$. Hypothesis 11 was not supported.

The final hypothesis (H12) stated that *expecting parents will perceive doulas who share their same sexual orientation as more supportive*. To test this hypothesis, I completed a 2 x 2 ANOVA. In this analysis, sexual orientation of the expecting parent (LGBTQ or non-LGBTQ) and sexual orientation of the doula profile (LGBTQ or non-LGBTQ) were the independent

variables with perceived supportiveness as the dependent variable. Results did not indicate a significant main effect for parent sexual orientation, $F(1) = .182, ns$, or for doula profile sexual orientation $F(1) = 2.87, ns$. However, results indicated a marginally significant interaction between parent sexual orientation and doula profile sexual orientation, $F(1) = 3.087, p .081$, such that LGBTQ parents rated the LGBTQ doula as more supportive than the non-LGBTQ doula. Thus, hypothesis 12 received marginal support (Figure 5).

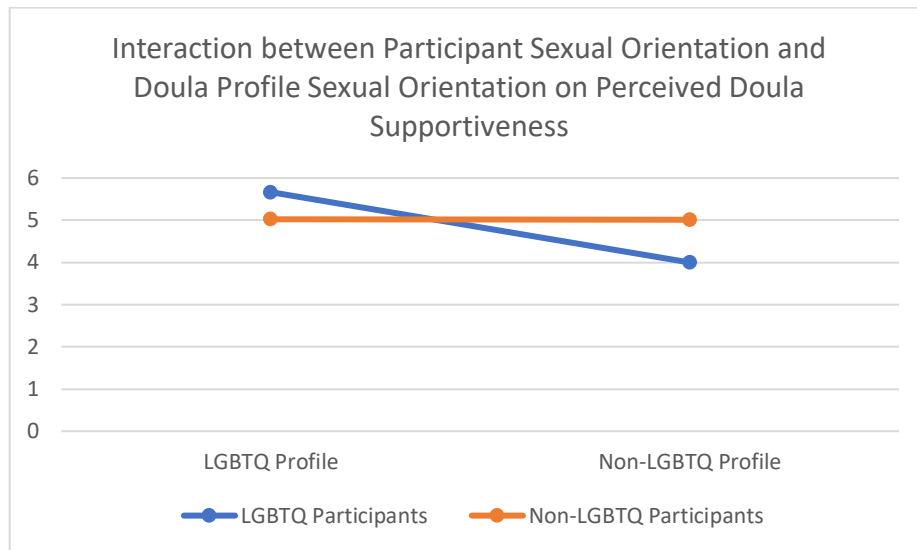


Figure 5: Results of 2 x 2 ANOVA exploring interaction between expectant parents’ sexual orientation and doula profile sexual orientation on perceived doula supportiveness: $p < .05$

The fifth and final research question of this study asked, *How do combined identity characteristics (race and sexual orientation) influence participants' perceptions of doulas (i.e., their perceived similarity, competence, trustworthiness, supportiveness, and likelihood to hire)?* To explore this question, a multivariate analysis of variance (MANOVA) was completed. In this MANOVA, participants' race (White vs. BIPOC), sexual orientation (non-LGBTQ vs. LGBTQ), and the doula profile (straight/White; straight/BIPOC; lesbian/White; lesbian/BIPOC) were included as predictor variables. Outcome variables included participants' ratings of

perceived similarity, competence, trustworthiness, supportiveness and likelihood to hire the doula. Results indicated no statistically significant differences in the model (see Table 3).

Table 3

MANOVA results exploring interactions between race, LGBTQ, and doula profile.

		df	F	Sig
Race	Similarity	1	.011	.918
	Competence	1	.031	.861
	Trust	1	2.01	.149
	Supportiveness	1	.830	.364
	Likely to hire	1	.095	.758
LGTBQ	Similarity	1	.010	.921
	Competence	1	.329	.567
	Trust	1	.001	.973
	Supportiveness	1	.140	.709
	Likely to hire	1	.207	.650
Profile	Similarity	1	.921	.432
	Competence	1	.080	.971
	Trust	1	.906	.440
	Supportiveness	1	.050	.985
	Likely to hire	1	.149	.930

Note: $p > .05$ in all circumstances

CHAPTER 6 – DISCUSSION

The general purpose of this study was to critically examine the role of identity in the context of doula support in an effort to highlight the imperative of including considerations of identity in supportive communication research. Synthesizing the results of the two studies presented in this project reveals nuanced complexities in the way identity impacts supportive communication in childbirth settings. Interviews with doulas, combined with results from a survey of expectant parents, highlight how the specific factors of racial identity and sexual orientation of both parents and doulas impact supportive interactions. This relationship, however, is not linear. Rather, it is multifaceted.

First, outcomes of this study reveal the unique role doulas inhabit as support providers. Birth doulas are described as non-medical birth professionals who provide emotional, physical, and informational support to birthing persons prenatally, continuously throughout the labor process, and immediately postpartum (DONA, 2020). Interviews with doulas contributed additional layers to this description, adding specificity to the ways in which doulas communicate support to their clients. Conversations with doulas revealed that they support parents through *advocacy, education and informational support, emotional support, and network support*. In doing so, doulas provide both personal and professional forms of support.

Second, evaluating detailed experiences of White and BIPOC doulas in conjunction with quantitative measures regarding expectant parents' evaluations of doula profiles highlights the various ways identity influences supportive interactions between doulas and their clients as well as how expectant parents evaluate the supportive potential of doulas of different identities. Exploring the results of the two studies together illustrates that racial identity does influence social support in the context of childbirth, but this influence is complex. Evaluations of

qualitative and quantitative results in this project reveal contradictory findings of how identity potentially impacts supportive interactions.

Finally, LGBTQ families are an understudied population in the context of childbirth (Darwin & Greenfield, 2019) and results from this study reveal a need for more research into this population, as LGBTQ birthing persons (and families) experience marginalization in birthing spaces (Darwin & Greenfield, 2019; Roondahl et al., 2009). The American medical system of obstetrics and gynecological care relies heavily on heteronormative language and communication (Röndahl et al., 2009), and this emerged as an important factor in interactions between doulas and their clients. Doulas of various sexual orientations reported an ability to confidently and successfully support LGBTQ and non-traditional birthing families; however, LGBTQ expectant parents were significantly more likely to hire a doula who shared their sexual orientation. Supporting LGBTQ parents included intentionally providing esteem support, ensuring language is respected, and affirming their identity—resisting heteronormative norms.

The findings from this study offer support for literature on maternal health and identity and extend literature on supportive communication. Each of these outcomes is discussed in greater detail below, beginning with how doulas communicate support.

Doulas as Support Providers

Overarchingly, studying doula support offers substantiation for the health-enhancing mechanisms of supportive communication. Doulas exemplify the *stress-buffering hypothesis* of social support (Cohen & Willis, 1985), and doulas in this study regularly witnessed how their support improved their clients' health outcomes. For examples, doulas interviewed described times they witnessed the power of their care, support, and advocacy in averting the need for medical interventions among their clients. One doula in particular described how her support in

bringing calm to the birthing space helped a mother avoid a Cesarean birth. From what is known about physiological dimensions of birth, the sense of safety and calm doulas bring to the birthing space likely facilitates the release of oxytocin and impedes the release of cortisol, which propels labor (Grewen et al., 2005; Kreuder et al., 2018; Mukamurigo et al., 2020). This health-enhancing relationship is confirmed by previous research which has quantitatively measured how doula support leads to better health outcomes for mothers and babies (Bohren et al., 2017).

Given that doula support is not a highly regulated profession, doulas oftentimes maintain individualized approaches to providing support. Doulas tailor their support to the needs and desires of their clients, and each brings a specialized skillset to their work. For example, one doula in the study described herself as a “physical touch doula,” while others referred to themselves as “evidence-based” practitioners. The difference in descriptive terms reveals diversity in which types of support are emphasized by different doulas. Doulas also adapt the support they provide to the needs of individual clients. Nonetheless, there is consistency in what types of support are provided and what values inform doulas’ interactions with parents. In interviews with doulas in this study, they reported providing support to birthing persons through *advocacy, education and informational support, emotional support, and network support.*

Previous research has argued that advocacy is an important attribute of social support (Whittemore et al., 2000). In being advocates, providers of social support empower and motivate individuals to act on their own behalf through affirmation, encouragement, and validation (Coffman & Ray, 2002; Finfgeld-Connett, 2005; Hupcey, 2001). Additionally, when people are socially supported in health care contexts, they are better able to navigate the complex health care system and make informed decisions (Brashers et al., 2004a). Conversations with doulas illuminated that advocacy is a crucial way they offer support to birthing persons. Informed

decision making is crucial during pregnancy and childbirth (A. R. Braun et al., 2010; Jordan & Murphy, 2009), and doulas supported clients by ensuring they were informed of their rights and that they were listened to and respected during the labor process. Sometimes, this involved actively stepping in and speaking up for the birthing person's wishes. Intertwined in enacting support through advocacy, doulas in this study reported prioritized forming relationships with their clients. By forming relationships they were able to emotionally care for their clients and this care included expressions of love, respect, and compassion (Chang & Schaller, 2000; Coffman & Ray, 2002).

Expecting parents in the United States commonly experience fear around childbirth. Specifically, women and birthing persons express fear of how the structure of the current maternity care system will impact their childbirth experience (Roosevelt & Low, 2016). Many parents who survive childbirth experience emotionally traumatic births. According to recent studies, 20% to 48% of birthing persons report psychologically traumatic births (Beck 2004; Ford & Ayers, 2011), and 30% of women who give birth develop symptoms of post-traumatic stress (PTS; Boorman et al., 2014). This reveals a need for more psychological support throughout the birthing process, and emotional support has emerged as an important strategy in previous studies investigating doula support (Corbett & Callister, 2000; Gilliland, 2011). As noted by Gilliland (2011), "The caring behaviours of doulas are different from the behaviours of other members of the birth team because their relationship to the mother is significantly different" (p. 530). Doulas in this study described providing various forms of emotional support to parents, including *respect*, *empowerment*, and *relational caring*.

Doula support exemplifies a melding of personal and professional provisions of support, and the role doulas inhabit adds value to the birth team, especially when they facilitate network

support. A strong social network is an antecedent for effective and productive social support (Finfgeld-Connett, 2005), and important network members in the context of childbirth include the romantic partner (or co-parent, if present), the medical care team, and the doula. Medical professionals bring knowledge about the birthing body and focus on keeping mother and baby safe. Yet, people often do not get the support needed or desired from healthcare providers (High & Steuber, 2014b; Hupcey, 2001). Doulas can fill this gap, offering types of support medical staff might be unable to, as well as facilitating communication between clients and physicians. Nonetheless, results from this study also spoke to the difficulties doulas sometimes face interacting with medical members of the birth team (i.e. physicians and nurses) and efforts they make to foster a sense of teamwork and collaboration. Doulas noted a desire to have physicians they worked with, not against.

Models of Care

The United States largely adheres to what has been termed the technocratic model of birth, which results in birth being treated like a pathological event and lacking emotional support (Davis-Floyd, 2001; 2004). According to researcher Robbie Davis-Floyd (2004), the technocratic model of birth views the female body as a machine, regarding the birth of the baby as the most important end product and the mother as a secondary by-product. This model is grounded in Western society's values of science, technological advancement, and economic profit. In birth contexts, a technocratic approach emphasizes mind-body separation and a standardization of care, seeing the patient as an object with little personal relationship with the practitioner, is characterized by aggressive intervention (Davis-Floyd, 2001). Essentially, this model does not prioritize attending to the unique emotional needs of each individual mother and approaches birth strictly as a medical event.

Doulas view their primary role as providing compassionate, attentive care to the birthing person to ensure they feel safe, empowered, and respected in the birthing space. Doulas promote and utilize more of what has been termed the humanistic model of birth (Davis-Floyd, 2001). This type of model acknowledges the mind-body connection and emphasizes relationship building between patients and providers. Thus, a dimension of doula support in the humanistic model is network support, or facilitating a sense of teamwork and belonging (Xu & Burleson, 2001). In a more humanistic system, there is connection and caring present in the birth room, as well as a shared responsibility of decision-making (Davis-Floyd, 2001).

Despite the benefits of doula support in promoting a more humanistic approach to birth, doulas are underutilized and have yet to be integrated into the medical model of care for birth in the United States (Declercq, Sakala, Applebaum, & Herrlich, 2013). Moreover, dominant narratives of birth situate families and medical staff as expected characters in the birth story, whereas doulas are absent or liminal characters, at best (Horstman et al., 2017). While research has revealed the cost-saving potential of doula support (Chapple et al., 2013), only three states (Oregon, Minnesota, and New York) have passed legislation to obtain Medicaid reimbursement for doula support (Kozhimannil et al., 2016; Strauss et al., 2015, 2016). Accessibility is an important consideration when discussing the value of doula support, as is identity.

Racial Identity

Considerations of race, and how race influences interpersonal interactions, has been limited in previous literature exploring supportive communication. Scholars such as Davis, High and Afifi have been working to correct this (Davis, 2015, 2018; Davis & Afifi, 2019; Davis & High, 2019), and the present study seeks to add to their line of exploration by investigating the role of identity in a specific context and from two perspectives (doulas and expecting parents).

Moreover, when investigating supportive communication in the context of childbirth, racial identity emerged as a crucial consideration. Combined results from the two studies spoke to the various ways identity impacts communication related to childbirth as well as evaluations of doulas as support providers. Both White and BIPOC doulas explained how they view their racial identity as influencing communication with parents of similar and different racial identities than themselves. The race of doulas also impacted how expecting parents evaluated the perceived supportiveness and trustworthiness of doulas.

The United States' medical system is failing Black mothers, as evidenced by racial disparities present in maternal mortality statistics (Creanga et al., 2017). Beyond the statistics, doulas interviewed reported witnessing differences between how White and BIPOC clients were treated by medical providers. The interview and survey components of this study each add a layer to the conversation of these health disparities and how they influence communication between doulas and clients. Experiences of witnessing medical racism were recounted by White and BIPOC doulas alike. Moreover, survey results showed that Black expecting parents reported a significantly higher fear of childbirth (supporting H2). In seeking doula support, BIPOC expecting parents mentioned this heightened fear, and the fear was often explicitly related to their racial identity. Some of these parents sought support from a BIPOC doula whom they could relate to racially, whereas others sought support from a White doula who could act as an ally and a form of "protection" against medical racism.

Albrecht and Adelman (1987) define social support as, "Verbal and nonverbal communication between recipients and providers that helps [manage] uncertainty about the situation, the self, the other or the relationship and functions to enhance a perception of personal control in one's life experience" (p. 19). The dimension of uncertainty reduction in this definition

is central in the context of childbirth. Previous research has shown that social support is effective at aiding in managing uncertainty (Brashers et al., 2004) and results from the current study reveal that statistics about health disparities and knowledge of medical racism evokes a sense of uncertainty in BIPOC individuals over how they will be treated in the birthing space, and sometimes whether they or their baby will survive childbirth. Doulas in this study supported clients by helping them navigate the medical model of care and experiences of medical racism. Birthing people leaned on doulas to help them make sense of this system, and ultimately to manage uncertainty by translating jargon, advocating for informed consent, and being a liaison between themselves and the rest of the birth team.

Furthermore, because of the racial disparities that exist in maternal health outcomes, it is important to investigate the experiences of BIPOC persons with medical professionals. One way to do this is to examine communicative experiences between BIPOC pregnant and birthing persons and their care providers. A 2018 study investigating pregnant, birthing, and postnatal birthing persons of color at risk for preterm birth in California found that “Participants described *disrespect* during healthcare encounters, including experiences of racism and discrimination; *stressful interactions* with all levels of staff; *unmet information needs*; and *inconsistent social support*.” (McLemore et al., 2018, p. 127). We know that identity and communication are inextricable (Burlison, 2003; Orbe, 1988), and results of this project highlight the various ways racial identity influences supportive interactions between doulas and their clients. Doulas work to supplement, and sometime correct, the support of medical care providers. In doing so, race effects support provision from doulas and influences from whom expectant parents report a willingness to seek support. Results from this study indicate that BIPOC doulas lean on shared

experience and unspoken understanding with their BIPOC clients, whereas White doulas enact allyship.

Davis and High (2019) found that experiences of support can be contingent upon the identity of both the support provider and recipient, as well as on the racial matching of interactants. They established that the racial composition of a dyad influences support provisions, as women in their study needed, expected, and received more social support from friends of their same race. Additionally, racism is an inevitable reality for Black women, and those who are negatively affected by it might feel safest expressing their anger and frustration among same-raced women (Davis, 2019). While support from a racially-similar BIPOC doula was regarded as valuable, this study revealed that support from a White doula may also be desired, especially when seeking support in a medical system rooted in White supremacy.

Adding a critical lens to these outcome, Critical Race Theory (CRT) can be employed. CRT involves, “a collection of activists and scholars interested in studying and transforming the relationship among race, racism, and power” (Delgado & Stefancic, 2001, p. 2). CRT examines races and racism across dominant cultural modes of expression, highlighting the need for diverse individuals to find ways to share their experiences. Since its emergence, critical race scholars like Kimberlé Crenshaw, Mari Matsuda, and Patricia Williams have analyzed the various ways racism is embedded in the fabrics of American society (Delgado & Stefancic, 2001). CRT also encourages scholars to consider class, gender, nation, sexual orientation, and other aspects of identity. Diverse cultural contexts reveal institutionalized inequalities experienced by marginalized cultural groups, such as the maternal health system in this context.

Overall, the value of racial matching, or racial similarity, can be person and context-dependent. Both White and BIPOC doulas posited that racial matching (or racial similarity)

between doulas and clients is valuable, and, in an ideal world, BIPOC birthing persons would be easily match with a BIPOC doula; however, there is a challenge in access to enough BIPOC doulas. Further, some BIPOC individuals specifically desired a White ally. In exploring the value of racial matching, it is also important to consider intersectionality (Cho et al., 2013).

Intersectionality is the notion that individuals' social identities do not exist in isolation and that differences coincide simultaneously (Kroløkke, 2009). As such, in order to really understand a whole person, one must be cognizant of the intersections of their various identities (i.e. gender, race, sexual orientation, age, class, etc.). Therefore, race as an identity factor does not constitute an individual in their entirety, and other facets of individual identities might influence how expecting parents and doulas connect and communicate. Nevertheless, the United States medical system is viewed as a White-dominated space, and, as BIPOC individuals navigate this space, race is top of mind. Additionally, racial identity influences the role doulas can occupy as advocates. Below, I explore how racial identity impacts support provisions and support evaluations, respectively, as both perspectives are important to consider.

Support Provisions

As support providers, racial identity impacts how doulas communicate support; their own racial identity as well as the racial identity of their client influenced interactions described in conversations. From interviews with BIPOC doulas, three distinct themes emerged: *relatability*, *communication*, and *hiring challenges*. Interviews with White doulas revealed three contrasting themes: *allyship*, *difference*, and *communication*. As the findings suggest, this study is an example of how centering race “allows scholars to investigate the complexities of supportive interactions in new and socially relevant ways” (Davis & High, 2019, p. 209). Further, race influences how individuals engage in interpersonal interactions (Burlison, 2003; Kunkel &

Burleson, 1999; Orbe, 1988). While race is a central consideration in doula-client interactions and relationships, I acknowledge that racial identity alone does not constitute an individual in their entirety. This study focused on racial identity and sexual orientation, and future research should explore the how the intersections of these and additional identity factors influence supportive interactions.

Identity is negotiated and constructed through conversation (Hastings, 2000). Across interview participants, doulas detailed a self-awareness of race that influenced interactions with BIPOC clients. In providing support, both BIPOC and White doulas negotiated their identities in conversations with expectant parents as they decided whether to discuss identity-specific topics or not. While BIPOC doulas felt comfortable speaking to BIPOC clients about race, White doulas noted hesitancy broaching the topic, as they were unsure how to raise the topic of race in a respectful, culturally-competent way.

Moreover, there is a co-construction of identity in these relationships (Hecht, 1993). As Feller (2014) argues, “identities are dynamic, co-constructed stories of who a person is rather than states of being that exist independently or, in isolation from others” (p. 341). Through communication, individual’s identities are constructed in relation to each other and against the background of our social relations. Using the Communication Theory of Identity (CTI) framework (Hecht, 1993; Jung & Hecht, 2004), doulas were aware of their individual identities (*personal frame*) in relation to the identity of clients. Many White doulas then adopted an ally *enactment frame* when supporting BIPOC clients, while BIPOC doulas utilized a *communal frame* and employed the value of sharing a group identity with their clients. BIPOC doulas were able to access a communal frame that White doulas could not because of shared experiences and group identity.

Associating as a group is especially valuable for Black women. As Davis (2019) noted, “the supportive communication process for Black women might be grounded in issues of group-level identity” (p. 134). In-group members experience the social world from a similar vantage point and attach similar meaning to communication behavior (Greenway et al., 2016). Both BIPOC and White doulas can support BIPOC birthing persons, but they negotiate their racial identities in relation to BIPOC clients differently. This is a somewhat simplified example, as we know various identity frame are constantly interacting. Overarchingly, racial identity of doulas influenced how they connected with and communicated support to their clients.

Some problematic language arose when discussing race with White doulas during the research interviews. When talking about race, some White doulas employed language that was racist. Even in their denunciations of inequitable treatment, these doulas might actually be perpetuating it. This was reflected in generalizations about race as a risk factor for certain health complications, and the use of language like “tribal” to describe how a Black woman birthed. This language exoticizes Black bodies. The language used in these conversations speaks to the embeddedness of White supremacy in health contexts. These White doulas who speak to the value of allyship and mitigating racial health disparities still perpetuated racist ideology. This revelation highlights a need for more training for White doulas regarding racism and racist language, so they can more efficaciously and productively work to dismantle racist systems.

Strong Black Woman Collective. Findings from this study support and extend Davis’ (2015) Strong Black Woman Collective (SBWC). The SBWC is valuable in that it is an identity-specific communication framework that explores communication between Black women. The theory reveals the value in Black women associating as a collective and “advances the idea that Black women construct strength through communal communication practices by imbuing their

assembled voices with might and fortitude” (Davis, 2015, p. 20). Across interviews, BIPOC doulas developed a communal orientation towards BIPOC clients. Possessing a communal orientation entails cultivating a sense of “we-ness,” and members feeling as if they are “in this together,” “part of a team,” and “here for one another”; it is the ability to think of a relationship as a cohesive unit (Afifi & Davis, 2016, p. 669).

In supporting BIPOC birthing persons, developing this communal orientation was a way for BIPOC doulas to connect with and protect a community they strongly identify with. Sharing the experience of being a person of color specifically led BIPOC parents to desire support from, and hire, BIPOC doulas because of their understanding of racial oppression. Conversations with BIPOC doulas also highlighted that if experiences of racism or microaggression arise in the birthing space, BIPOC doulas are likely to recognize them rather than doubting their presence like a White doula might.

Moreover, speaking specifically of Black doula, in supporting Black birthing persons, Black doulas in interviews explained how they see their race creating a sense of connection, relatability, and understanding. This relationship illuminates the benefits of Black women associating as a collective and as Davis (2015) says, “their ability to resist oppressive forces is increased with the help and support of their Black women counterparts” (p. 26). There is power and value in supporting another Black person. They are also able to communicate messages that affirm the legitimacy and beauty of Black womanhood (Davis, 2019). For BIPOC doulas collectively, supporting BIPOC clients was also reported as more enjoyable to offer. They found it easy to connect with and to feel comfortable with their BIPOC clients. The sense of connection that accompanies supporting another woman of color cultivated a sense of closeness between

BIPOC doulas and their BIPOC clients, and this was deemed valuable in such a vulnerable space.

Comparatively, when supporting White clients, BIPOC doulas in particular described engaging in code-switching, or changing their communication pattern to accommodate White parents, a behavior also explained in SBWC (Davis, 2015). Davis (2015) notes switching, “from standard English to Black English vernacular in the presence of other Black women, is one of the primary features of Black American women’s unique communicative style” (p. 22). Further, in a qualitative study, Karen Scott (2000) suggests Black American women expressed living in “two different worlds”: one composed of predominantly Black American women who share a similar racial and cultural identity, and another world composed of people who share different intersections of race and gender (i.e. White people or even Black men). Scott (2000) explains that Black women negotiate their identities between these different worlds by using certain words and phrases as an “identity marker” to make themselves known in a world where they feel invisible and to mark solidarity with similar others. Conversations with doulas supported these previous findings. BIPOC doulas explained feeling a need to prove their competence, worth, and credibility to White clients. In doing this, they described changing their communication patterns and working hard to prove their intelligence. They altered their natural communication patterns to accommodate their White clients in an effort to have their competence recognized and respected.

Results from this study also expand on some questions left by SBWC, specifically in investigating the role of vulnerability in Black female relationships. Proposition four of the SBWC asserts that communication patterns of strength allow the collective to resist oppressive structures but impede vulnerability and emotionality within the group (Davis, 2015). Thus, in

consistently trying to enact strength, Black women may feel stifled in their ability to express vulnerable emotions to each other. Results from this study found that when BIPOC doulas consciously displayed vulnerability when building relationships with birthing parents, this vulnerability was more likely to be reciprocated. As stated by Davis (2019), “A strong sense of safety might have helped women overcome challenges and build resilience” (p. 151). Black women can cultivate a safe environment for each other, allowing space to “lament, to process, and to support one another” (Davis & Afifi, 2019, p. 20), and shared vulnerability can enhance the emotionally supportive potential of the relationship. Thus, while BIPOC parents may perceive White doulas to be just as competent and may report a willingness to hire them for labor support, results from this study illustrate that BIPOC parents are more likely to trust and feel supported by a doula who shares their experience a BIPOC woman, and the racial and gendered experience that comes with that identity.

Palmer-Wackerly and colleagues (2018) advocate for supportive others to be aware of the way identity impacts patients’ relationship with the diagnosis (in this case pregnancy). Identity and experience are not isolated. In the context of pregnancy, being BIPOC impacts expecting parents’ relationship with the overall experience of pregnancy and childbirth, especially when they are enveloped in a cloud of fear surrounding their care. Given the state of maternal mortality in the United States, BIPOC and White birthing persons should not be supported in precisely the same ways. Compared to White doulas, BIPOC doulas were more readily willing to recognize this and to discuss risks associated with giving birth while BIPOC in the United States, as they viewed this as valuable information to share in preparation for birth. In interviews, BIPOC doulas especially emphasized discussing race with BIPOC clients so they could formulate a plan to navigate racial microaggressions or implicit biases that might emerge in the birthing space.

Comparatively, some White doulas were hesitant to bring up racial disparities, as they did not feel confident in their ability to do this in a culturally-sensitive way. White doulas noted a desire for more training concerning how to communicate with BIPOC clients about the potential of differential treatment. Overall, the SBWC can be a starting point for continued expansion in social support research. As the present study reveals, there is value in utilizing identity-specific investigations in interpersonal communication investigations.

Theory of Resilience and Relational Load. Shardé Davis, the primary author of the SBWC has also contributed to work exploring the Theory of Resilience and Relational Load (TRRL). TRRL could be used in conjunction with Davis' SBWC (2015) to further investigate questions the SBWC left to explore. TRRL examines how relational partners' communal orientation and maintenance of their relationships influence communication during stressful moments and the subsequent appraisal of the stress (Afifi & Davis, 2016). This could apply to childbirth.

In the context of TRRL, dyads can maintain a communal orientation, meaning they work to tackle problems as a team (as noted above). The relationship between doulas and client is initiated before childbirth, and by investing in this relationship before the birth itself, it can pay dividends toward the producing positive outcomes across the birthing experience. This "team" dimension of TRRL could include the birth team as a whole; conversely, the idea of communal orientation could apply more specifically the doula-birthing person dyad. As articulated in interviews with doulas, stress-mitigation is most effective when the birthing person, the partner, the doula, and medical providers are all on the same team working towards a common goal. Moreover, doulas and birthing people must tackle the event of childbirth as a unit working in collaboration, and the identity make-up of the members of this team matters. Interviews illuminated the value in the racial matching among team members. BIPOC women are the only

people who can truly empathize with racial-gendered injustice (Davis, 2015; Davis & High, 2019). Integrating TRRL and SBWC, for example, even if a Black doula is the only other Black woman in the room supporting a Black mother, the dyad can adopt a communal orientation without an entire assemblage of Black women present. Future research should adopt an integrated approach, synthesizing TRRL and SBWC to further explore how BIPOC individuals communicatively cultivate resilience and the implications of embracing a communal orientation as they navigate White-dominated spaces.

Support Evaluations

Racial identity also influenced support evaluations in this study. Previous research has established that identity and group membership influence the communication of stress (Haslam et al., 2004). Additionally, when an individual is coping with a threat to their identity, members of their in-group are valued support providers (Haslam et al., 2004.) The findings of Davis and High's (2019) study corroborate these conclusions, as they found that support evaluations are more positive when the support is provided by someone from the same racial group. Overall, the results from the present study support these findings—expecting parents evaluated support providers (i.e., doulas) of their same race as more supportive and trustworthy, and doulas expressed an enhanced ability to connect with clients who shared their same race on a deeper level. Nonetheless, the survey results from this study revealed nuance in how racial identity influences support-seeking evaluations and decision-making around the birth events.

In the present study, BIPOC expecting parents experienced significantly greater fears of childbirth compared to their White counterparts. Thus, it could be argued that, for BIPOC women, childbirth can be an identity-related stressor (Crowley & High, 2019; Davis & High, 2019). When discussing fears related to giving birth, BIPOC, and particularly Black, birthing

persons raised the likelihood of experiencing medical racism, implicit bias, and even death. This finding was supported by results from interviews with doulas who have supported BIPOC birthing persons. Many doulas recounted experiences of witnessing medical racism against BIPOC individuals and explained race- and racism-related fears BIPOC mothers express to them. Doulas can support birthing persons by mitigating the negative effects of racism (Wint et al., 2019).

Moreover, results from this study show that racial similarity between expecting parents and doulas influenced perceptions of support and perceptions of trustworthiness. However, it did not significantly impact perceptions of competence, similarity, or the reported likelihood to hire a Black doula compared to a White doula. Therefore, regardless of the race of the parent and the doula, pregnant parents evaluated both a Black and White doula as competent, similar to them, and expressed a willingness to hire them. Race did, however, influence the more personal evaluations, like trust and supportiveness. Previous research supports the finding that people often connect with and trust people who share similar identities to their own (Tajfel, 1979). It is interesting that race specifically influenced perceptions of trustworthiness and supportiveness. Stereotypes of Black women perpetuate the image of them as less trustworthy and caring, and this might impact how White doulas evaluate their trustworthiness and supportiveness.

There was also discrepancy in findings from the survey and interviews. BIPOC doulas noted a belief that their race influenced their ability to book clients. Compared to their White counterparts, BIPOC doulas reporting being contacted by fewer birthing persons inquiring about their support services, illustrating biased preferences for hiring White doulas. However, survey results showed no significant interaction between participants' race, the race of the doula, and the likelihood that a pregnant person would hire them. These contradictory findings raise interesting

and important questions about the role of race in doula selection and hiring. Future iterations of this research could ask expectant parents to choose between two doulas of differing racial identities in order to more explicitly capture racial preferences.

Sexual Orientation

Interviews with doulas and surveys of expectant parents showed that sexual orientation played a role in supportive interactions between doulas and their clients. Master narratives of birth and families, or the dominant cultural ideology that shapes how individuals view and experience the birthing process (Somers, 1994), most often involve heterosexual love and the biological procreation of a child between a man and a woman (Röndahl et al., 2009). This heteronormativity is oftentimes reflected in the birthing space, an experience detailed in this study's interviews by several doulas. In interviews with doulas, two themes emerged: *language* and *identity affirmation*. A fundamental dimension of supporting members of the LGBTQ community is ensuring the correct pronouns and family labels are used. In facilitating use of preferred language, doulas supported LGBTQ clients by affirming their identities and the validity of their experiences. This is fundamentally a manifestation of esteem support, or support designed to enhance a person's sense of self and esteem (Xu & Burleson, 2001). Nonetheless, using preferred language with LGBTQ was challenging for some doulas even with good intentions, as heteronormative language is so deeply engrained in cultural narratives and practices around birth (Röndahl et al., 2009).

Although it was predicted that expectant parents would be more likely to hire a doula who shared their same sexual orientation, this was not supported by the data. Overall, expectant parents reported valuing a shared sexual orientation with their doula, but not sharing a sexual orientation did not impede their reported likelihood to hire them or perceptions of the doula's

competence. However, doula sexual orientation was significantly related to members of the LGBTQ community's perceptions of their overall supportiveness, trustworthiness, and similarity. LGBTQ individuals are more likely to feel connected to an individual who shared their sexual orientation (Baptiste et al., 2017), and they may view this shared experience as a tool that will facilitate their ability to support them more adequately than a straight doula could. However a lack of substantial representation of LGBTQ individuals in the doula profession might complicate this finding and its implications. Additionally, the majority ($n = 14$) of the doulas in this study identified as straight, so less is known about how LGBTQ doulas enact support when they share a sexual orientation with a client. Future research should prioritize recruitment of LGBTQ doulas to offer a more in-depth inquiry of how sexual orientation influences birth support.

Practical Implications

From a practical standpoint, this study has various implications for how people engage in interpersonal interactions as well as how to optimize doula support, especially for BIPOC birthing persons. Findings from both studies highlight the value of doula support during childbirth. While there has been an increased recognition of the deplorable maternal mortality and morbidity statistics in the United States and the racial disparities in birth outcomes (Creanga et al., 2017; Howell et al., 2016), discussion of how to realistically alleviate these disparities is rather nascent. Increased accessibility to doula support for BIPOC birthing persons (specifically support provided by BIPOC doulas) might be a part of this health equity solution. People of color report lower satisfaction than White people regarding communication with medical providers (Mottl-Santiago et al., 2020). As established in this study, doulas can act as a liaison between providers and birthing persons, using their experience with childbirth to increase the

quality of communication, as well as advocating on behalf of their clients. Additionally, doulas can assist in care navigation, promote health literacy, and provide culturally competent social support, all contributing to better health outcomes (Wint et al., 2019). Beyond the context of childbirth, the present study reaffirms the value of BIPOC women seeking support from other BIPOC women. However, when navigating White-dominated spaces, and in circumstances where there may be limited accessibility to BIPOC-identifying support persons, BIPOC individuals may seek allyship with White individuals.

When BIPOC individuals seek support from those who share a similar racial identity, they may feel more equipped to face systems steeped in White supremacy. As Davis (2018) notes, communication is a free, functional, and accessible way for Black women to resist embodied representations of oppression across various contexts. Moreover, doula trainings should be attentive to teaching White doulas how to support BIPOC birthing persons in culturally-competent and racially-sensitive ways to ensure they do not perpetuate racist ideology, language, or the othering of BIPOC bodies in their attempts to enact allyship.

Limitations and Future Research Directions

While this study highlights a noteworthy relationship between identity and supportive communication, it is not without limitations. Due to the time frame of the study, the number of participants in both the interviews and surveys was limited. Recruitment occurred over a short period of time and, if recruitment had lasted longer or we had more funds to incentivize participation, we may have had a larger sample of doulas and expecting parents. Additionally, the results are limited by the representation of diverse racial groups and the sexual orientation of participants, as the demographics of participants were not as diverse as we had hoped. Specifically, results of the study would have been strengthened if we had more BIPOC and

LGBTQ participants in both the interview and survey portions. Although steps were taken to ensure the quality and accuracy of results, this small sample size and scope limits the generalizability of the findings. Future research should continue to center experiences of these marginalized communities and continue to explore experiences of BIPOC and LGBTQ doulas and birthing persons.

Additionally, while the interviews allowed for unique insight into how doulas report communicating support, the information collected featured self-reports, which reflect subjective views of support. Our doula participants might have imprecisely recalled the content of interactions or their evaluations of events. Results might have been different if the method of research was different. Future research could seek to observe the supportive interactions between doulas and clients in real time. Research could then explore how identity might influence these interactions and code for instances of implicit or explicit bias as well as the quality and effectiveness of the support provided. Despite these limitations, the findings of this study highlight why it is crucial to consider identity in interpersonal communication research and research on labor support more specifically.

As noted above, there was a discrepancy in findings from the survey and interviews. While BIPOC doulas noted a belief that their race influenced their ability to book clients, survey results showed no significant interaction between race of the doula and the likelihood a pregnant person would hire them. To more explicitly measure racial preference, future iterations of this research could present expectant parents with multiple doula profiles and ask them to identify which one they would be most likely to hire. This approach could more accurately represent the landscape of the doula industry, and potentially explore why BIPOC doulas perceive bias in hiring practices of birthing persons.

Future research should also continue to investigate the role of identity in supportive interactions. Race and sexual orientation are important identities to consider; however, various other identities might influence support seeking, support evaluations, and support provisions—including, but not limited to, age, gender, religion, ability, class, doula parental status, etc. More studies investigating the role of race and sexual orientation in other supportive contexts are also needed. Finally, research that expands upon the current study could investigate outcomes of doula support. Interviews might be conducted with birthing persons who have utilized doula support at their birth. This approach would offer insight into how identity impacts perceptions of support as well as the interactional effects of identity.

Conclusion

Scholars from a variety of disciplines have studied the relationship between social support and health, but there is an insufficient amount of research which considers how identity factors, including racial identity and sexual orientation, influence provisions of support and support evaluations. Using the context of labor doula support, this mixed-methods study extends research on supportive communication by illuminating the nuanced ways identity impacts supportive interactions.

Doulas are a unique population to study, as they offer both personal and professional forms of support. The position they inhabit in the birthing space presents unique challenges as well as unique opportunities as support providers. Nonetheless, each doula maintains an individualized approach to birth. Doulas enact various forms of support, including *advocacy*, *education and informational support*, *emotional support*, and *network support*. Interviews with doulas from across the United States offered insight into how they see their identities, specifically racial identity and sexual orientation, as influencing this support. Comparing the

experiences of BIPOC and White doulas allowed for an exploration of the value of racial similarity between doulas and clients. This is an especially important consideration when taking into account the racial disparities and maternal mortality statistics in the United States.

When supporting BIPOC clients, BIPOC doulas emphasized *relatability*, *communication*, and *hiring challenges* they face. White doulas, on the other hand, described *allyship*, *communication*, and *difference*. When supporting LGBTQ clients, doulas focused on esteem support through *language* and *identity affirmation*. Moreover, quantitative results from a survey of expectant parents illuminated the complex ways identity influenced doula evaluations—specifically their perceived trustworthiness, supportiveness, competence, similarity, and parents' likelihood to hire doulas of different identities. Racial identity and sexual orientation influenced some of these evaluations, but not all of them. Ultimately, this study reveals the unique ways racial identity and sexual orientation influence supportive interactions, especially those between doulas and expecting parents.

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Appendices

Appendix A: Interview Protocol

Background information pertaining to doula work.

1. How long have you been a doula?
2. Tell me about your doula training.
 - a. Are you certified through a particular organization?
 - b. How long ago did you certify?
3. How many births have you attended?
 - a. Hospital births?
 - b. Home births?
 - c. Birth center births?
 - d. Other?
4. Geographically, where have you supported births?
5. Tell me about why you decided to become a doula.
 - a. (if they say their personal birth experience) Tell me the story (or stories) of your birth(s).
6. What are your views on the medical model of care for birth in the United States?
 - a. What are your views on the general approach to births in the United States?

Open-ended Questions

7. What are your favorite parts about being a doula?
8. What have been the most challenging aspects of doula work?
9. Briefly tell me about yourself.
 - a. What parts of your identity are most central to you/ what are your three most salient identities?
10. Have you supported a birthing person with a different racial identity than yourself?
 - a. *Yes*: Tell me about a time you supported a birthing person with a different racial identity than yourself.
 - i. Was race explicitly discussed in prenatal visits, during the birth, or postpartum?
 - ii. How did this experience differ from supporting a birthing person with the same racial identity as yourself?
 - b. *No*: In your opinion, why do you think this hasn't happened?
11. Have you supported a birthing person with a different sexual orientation than yourself?
 - a. *Yes*: Tell me about that experience
 - i. What was new or different about this experience?

- ii. Where there any challenges that arose because of your different identities?
 - b. *No*: Why do you think this hasn't happened?
- 12. Tell me about one of your favorite memories supporting a birth.
 - a. Tell me more about the birthing person.
 - b. Tell me more about the birthing team.
 - c. Why do you think this is one of your favorite memories?
- 13. Tell me about one of your least favorite memories supporting a birth.
 - a. Tell me more about the birthing person.
 - b. Tell me more about the birthing team.
 - c. Why do you think this was one of your least favorite memories?

Value of Doula work

1. Tell me about your doula packages (birth, postpartum etc.). What fee do you charge and what's included?
2. How many hours of direct care would you say you provide for an average birth?
3. What is the lowest fee you would accept for providing birth support?
 - a. Do you offer any sliding scale births?
 - b. Have you ever volunteered doula services?
4. What barriers do you believe prevent parents from accessing doula support?
 - a. Are there certain things you do to try and address these barriers as a doula?
5. Beyond cost-saving benefits, what value do doulas bring to the birthing experience?

Demographics

1. How old are you?
2. How long have you been a doula?
3. Do you have any children?
 - a. If yes, how many children do you have?
4. How would you classify your race/ethnicity?
5. How would you classify your gender identity?
6. How would you classify your sexual orientation?
7. How would you classify your religious identity?
8. What is your highest completed level of education?

Appendix B: Doula Profiles

Black/African-American



White (non-Hispanic White)



Biography:

Sarah is a DONA-certified birth and postpartum doula.

After becoming a mother herself, Sarah became aware of how scary and lonely childbirth and the postpartum period can be. She was terrified and searched for supportive care that could minimize her fear. Her **husband/wife** was a great source of support, but looking back, she wished someone

was there to guide them throughout the process together. After this experience, she decided to dedicate herself to supporting other mothers, hoping they would feel less alone. Sarah has since served as a doula in over 100 births in hospitals, birth centers, and homes.

As your doula, Sarah is committed to helping guide you through your unique journey of pregnancy and childbirth. She offers three prenatal visits, continuous support throughout the laboring process, and assists with chest/breastfeeding immediately postpartum.

The journey of parenthood is diverse. It's winding, and it can be overwhelming. No matter what it is, Sarah is here for you—she will walk with you and be your guide without judgment.

When not supporting birthing persons, Sarah enjoys traveling with her **wife/husband** and their two kids, listening to music, and eating good food.

Appendix C: Hypotheses and Research Questions

Research Questions

RQ1: How doulas see their role as support providers and how do they describe communicating support to birthing persons?

RQ2: How do doulas perceive their racial identity as influencing their practice and provisions of support?

RQ3: How do doulas perceive their sexual orientation as influencing their practice and provisions of support?

RQ4: How do combined identity characteristics (race and sexual orientation) influence participants' perceptions of doulas?

Hypotheses

H1: Expecting parents who are aware of what a doula is are more likely to hire a doula.

H2: Expecting parents who identify as racial minorities (BIPOC) are likely to report more fear of childbirth.

H3: White expecting parents will be more likely to hire a White doula than a BIPOC doula, and BIPOC expecting parents will be more likely to hire a BIPOC doula than a White doula.

H4: White expecting parents will perceive a White doula to be more similar to them than a BIPOC doula, and BIPOC expecting parents will perceive a BIPOC doula to be more similar to them than a White doula.

H5: White expecting parents will report higher levels of trust for a White doula compared to a BIPOC doula, and BIPOC expecting parents will report higher levels of trust for a BIPOC doula compared to a White doula.

H6: White expecting parents will perceive a White doula to be more competent than a BIPOC doula, and BIPOC expecting parents will perceive a BIPOC doula to be more competent than a White doula.

H7: White expecting parents will perceive a White doula to be more supportive than a BIPOC doula, and BIPOC expecting parents will perceive a BIPOC doula to be more supportive than a White doula.

H8: Expecting parents will perceive doulas of their same sexual orientation to be more similar to them.

H9: Expecting parents will report a greater willingness to hire a doula who shares their same sexual orientation.

H10: Expecting parents will be more likely to trust doulas who share their same sexual orientation.

H11: Expecting parents will perceive doulas who share their same sexual orientation as more competent.

H12: Expecting parents will perceive doulas who share their same sexual orientation as more supportive.