

**Negotiating Care: The Role of Lactation Consultants and Doulas in the
Medical Maternity System**

by

Jennifer Marie Closson Torres

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Doctoral Committee:

**Professor Karin A. Martin, Chair
Associate Professor Renee Anspach
Professor Raymond G. De Vries
Associate Professor Lisa Kane Low**

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To my family

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Abstract

This dissertation provides a comparison of two relatively new occupational groups working in maternity care: International Board Certified Lactation Consultants and DONA International birth doulas. Using 150 hours of ethnographic observation and 72 interviews with lactation consultants, doulas, clients, and health care professionals, I examine their role in the maternity care system, including the impact of medicalization on their approaches to creating change in maternity care practices and the meaning and function of their caring labor, as well as the negotiation of paid caring relationship with their clients. I find that, in order to balance their occupation's foundational goals of demedicalization with their role as the clinical managers of breastfeeding, lactation consultants engage in medicalization and demedicalization simultaneously, but some aspects of their medicalization (e.g., medical control) are actually used to demedicalize (e.g., depathologize). This adds the new concept of "medicalizing to demedicalize" to the literature. I also find that lactation consultants and doulas represent more than a simple transfer of care from family to market because of the impact of medicalization on childbirth and breastfeeding. They are taking on an entirely new role - the role of advocates and guides to the medical maternity system, a system that is often difficult to navigate for women who wish to avoid medical interventions during childbirth and breastfeeding. However, despite this need for an advocate and guide, lactation consultants and doulas still have difficulty being paid to care, due to the "hostile worlds" perspective that sees true caring and paid services as incompatible. This creates tension for lactation consultants and doulas between their passion for supporting mothers and their need to earn income for themselves and their families.

Chapter 1

Introduction

The History of Childbirth and Breastfeeding in the U.S.

In colonial America, women gave birth in the home, attended by a midwife. In this model of “social childbirth,” birth was an occasion that brought women together, as female friends and kin “attended and aided each other during birth itself and during the several weeks of ‘lying-in’ that followed” (Wertz & Wertz, 1989, p. 1). When a woman went into labor, the midwife was notified, and then women from the neighborhood were assembled to help. These friends and kin would attend the birth and assist the midwife, as well as tend to household chores and care of the mother during the period of lying-in. However, beginning with the rise of medicine in the 19th century, both childbirth and breastfeeding were transformed through the process of medicalization.

Medicalization is “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders” (Conrad, 2007, p. 4) and move under the control of medical professionals (Conrad & Schneider, 1980; Riessman, 1983; Davis, 2006). When the condition is a natural process, such as childbirth and breastfeeding, a key aspect of medicalization is constructing that condition as diseased or prone to disorder, and this is what occurred in the cases of childbirth and breastfeeding.

As male physicians fought to gain control over childbirth and delegitimize midwives as competent birth attendants, they did so largely by constructing childbirth as dangerous and prone to disorder, and therefore in need of medical supervision and medical instruments, such as forceps. Because women were excluded from medical training, this gave the new medical profession of obstetricians (title coined in 1828) more jurisdiction over childbirth (Wertz & Wertz, 1989). Birthing women also played an important role in the medicalization of childbirth. Many middle- and upper-class women chose doctors as their birth attendants, in part because of the growing status of science and medicine, but also because they wanted to avoid the pain of childbirth (Riessman, 1983; Wertz & Wertz, 1989). As a result, childbirth transformed from a social experience shared among women to a private experience between a woman and her physician, and the use of technology and interventions increased steadily, so that by the mid-20th century, most women were unconscious during their births (Rothman, 1982; Sandelowski, 1984; Wertz & Wertz, 1989).

A similar pattern can be found in the case of breastfeeding. Until the late 19th century, physicians had no authority over breastfeeding, as it was seen as a woman's issue. However, as the new specialty of pediatrician emerged, these men took authority over infant feeding and raised doubts about the quality and quantity of breast milk that women could produce (Stolzer, 2006; Wolf, 2000). Women, believing that breastfeeding was no longer the best way to feed their babies, began to turn to formula, what they and their doctors considered to be the more modern and scientific option. As a result, breastfeeding rates dropped dramatically until reaching their low point in the early 1970s, when the incidence of breastfeeding initiation (giving *any* breast milk at all to one's baby) was around 25 percent (Ryan & Pratt, 1991), and by six months out, only six percent of women were breastfeeding at all (Ryan, Wenjun, & Acosta, 2002).

The natural childbirth movement emerged during the mid-20th century as a response to these changes in childbirth and breastfeeding (Wertz & Wertz, 1989). It was spurred by the publication of Grantly Dick-Read's *Childbirth Without Fear*, and grew through the creation of other organizations, such as Lamaze and the Bradley method, that worked toward women in labor being awake and aware (Rothman, 1982). While the natural childbirth movement is far from one-dimensional, including groups as varied as feminists fighting for women's health and traditionalists fighting for intensive mothering, as a whole, it has fought to reverse the effects of the medicalization of childbirth and breastfeeding (Blum, 1999; Rothman, 1982; Sandelowski, 1984; Wertz & Wertz, 1989).

As a result of the natural childbirth movement and the women's health movement, childbirth and breastfeeding in the U.S. have changed dramatically since the mid-20th century. The once standard practices of cleaning, shaving, purging (with an enema), and putting women under general anesthesia have nearly disappeared, particularly in vaginal births (Declercq et al., 2006, 2013). However, childbirth remains highly medicalized, and other medical interventions have taken the place of earlier ones. For example, 41% of labors are induced (sometimes for non-medical reasons), 67% of women receive epidural anesthesia, 80% of women have electronic fetal monitoring, and 31% of births end in cesarean section (Declercq et al., 2013). Furthermore, 99.1 percent of all births today occur in hospitals and 91.4 percent of births are attended by physicians (Martin et al., 2010).

The medicalization of breastfeeding has also changed over time. While in 1970, only 25% of women initiated breastfeeding (Ryan & Pratt, 1991), today nearly 80% do (Centers for Disease Control and Prevention [CDC], 2013). This is due, in large part, to the increase of medical support for breastfeeding. In fact, breast milk is now often referred to as the gold

standard in infant feeding. However, breastfeeding also remains medicalized. It continues to be defined in medical terms, focusing on the nutritional properties and health benefits of breast *milk*, so that breast milk is becoming a medical product. For example, the American Academy of Pediatrics (AAP, 2012) titled their statement on breastfeeding, “Breastfeeding and the *Use of Human Milk* (emphasis mine).” There is also a growing literature on the ability of breast milk to protect infants from pathogens through its effects on the gut flora (Liu & Newburg, 2013). However, similar to childbirth, breastfeeding continues to be constructed as likely to fail, and therefore, in need of medical management (Dykes, 2005). The AAP’s (2012) policy statement includes a section on “Recommendations on Breastfeeding Management for Healthy Term Infants” that states, “Ensure formal evaluation and documentation of breastfeeding by trained caregivers (including position, latch, milk transfer, examination) at least for each nursing shift” (p. e835). Situated in the middle of all of this are two relatively new occupational groups: lactation consultants and doulas. They are the focus of this research.

Lactation Consultants and Doulas

According to the International Lactation Consultant Association (ILCA), an International Board Certified Lactation Consultant is a “health care professional who specializes in the clinical management of breastfeeding” (ILCA, 2013, n.p.). As certified professionals, they work in a variety of settings, including hospitals, doctors’ offices, clinics and community centers, and as independent consultants, helping breastfeeding mothers with the challenges of early breastfeeding and working to “protect, promote and support breastfeeding” (International Board of Lactation Consultant Examiners [IBLCE], 2012, p. 1).

DONA currently certifies two types of doulas: birth doulas and postpartum doulas. Birth doulas work with women birthing in hospitals, birth centers, and at home, providing them with

physical, emotional, and informational support before, during, and just after birth. Postpartum doulas provide support to women and their families during the postpartum period once the mother and baby are home (DONA, 2005).

Both lactation consultants and doulas find their origins within the natural childbirth movement and efforts to demedicalize childbirth and breastfeeding. The IBCLC credential was created by the International Board of Lactation Consultant Examiners in 1985, with the help of La Leche League International, who supports “natural childbirth, early bonding, exclusive and prolonged mother-child attachment through breastfeeding, and a child-centered family that respects each child’s developmental timetable” (Blum, 1999, p.37). Lactation consultants were developed in order to provide breastfeeding support and education that would facilitate a move away from heavy reliance on formula and a return to breastfeeding as the cultural norm.

Doulas emerged out of a grassroots movement, as women who wanted natural births began to have friends and childbirth educators accompany them during birth for support. The term doula, a Greek word meaning “female helper,” was attached to the women working in these support roles, and doulas began to grow as an occupation (Norman & Rothman, 2007). One of the foundational concepts behind the development of the doula as an occupation was the recognition that labor support was integral to the achievement of natural birth, and DONA International was founded, in part, upon scientific research illustrating the effects of labor support on lowering the rates of medical interventions in birth (Morton, 2002).

One way to view the role of lactation consultants and doulas is as a revitalization of “social childbirth,” because they are providing the labor and breastfeeding support that were lost as maternity care was medicalized. In fact, DONA International makes an explicit connection between doula work and social childbirth:

In nearly every culture throughout history, women have been surrounded and cared for by other women during childbirth. Artistic representations of birth throughout the world usually include at least two other women surrounding and supporting the birthing woman. One of these women is the midwife, who is responsible for the safe passage of the mother and baby; the other woman or women are behind or beside the mother, holding and comforting her. The modern birth doula is a manifestation of the woman beside the mother (DONA, 2012, p. 1).

This comparison draws attention to the care work that these two occupations are performing. England, Budig, and Folbre (2002) define care work as "...a face-to-face service that develops the human capabilities of the recipient" (p. 455). Like social childbirth, care work is often considered to be "women's work," and the qualities of good caring are thought to be a natural characteristic of women, rather than a learned skill (Daniels, 1987; Davies, 1995, 1996; Duffy, 2011; Waerness, 1996). However, unlike the situation of birth in colonial America, lactation consultants and doulas are performing this caring labor within the context of the medical maternity system. Both occupations were designed to work alongside health care professionals, such as Obstetricians, Certified Nurse Midwives, Pediatricians, Neonatologists, Labor and Delivery Nurses and Postpartum Nurses.

The aim of this research is to understand the role of lactation consultants and doulas in the maternity care system. This cannot be accomplished without attending to both aspects of their work - their relationship to medicalization-demmedicalization and their caring labor - as well as how these two impact one another. This is represented in the title of this dissertation. The phrase, *Negotiating Care*, has a triple meaning, referring to how lactation consultants and doulas 1) negotiate positions for themselves on the maternity care team, 2) negotiate medical care decisions for their clients through their advocacy, and 3) negotiate paid caring relationships with clients.

The process by which lactation consultants and doulas negotiate positions on the maternity care team was the subject of an article that I published based upon the interviews with

lactation consultants and doulas that are part of this dissertation (Torres, 2013). I found that lactation consultants are able to utilize a *front-door* entrance to the medical maternity system, entering as lactation specialists and advocates, while doulas use a *back-door* entrance, emphasizing their care work and downplaying their advocacy. This is due to the transformation in the medicalization of breastfeeding described above. Breastfeeding is now considered the gold standard in infant feeding, based upon the nutritional properties and health benefits of breast milk, yet breastfeeding is still constructed as likely to fail. This, when combined with the construction of breast milk as a medical product, leads to a perceived need for medical management. However, most health care professionals receive very little training in breastfeeding, which creates an opening for lactation specialists in the occupational boundaries of the maternity care team.

Doulas, on the other hand, have a much harder time finding an occupational space in medicine as natural birth advocates because their advocacy challenges the occupational boundaries of maternity clinicians. Therefore, they emphasize their care work, the physical and emotional support they provide to their clients, in order to negotiate a position on the maternity care team. As a result of these differences, lactation consultants are able to create more formal changes (e.g., hospital policies), while doulas focus more on creating change “one birth at a time” by helping their clients avoid medical interventions during childbirth and illustrating to clinicians that women can give birth without intervention.

This dissertation builds upon these findings by examining how the different positions of lactation consultants and doulas within the medical maternity system impact their level of engagement with medicalization and demedicalization, as well as how working in this highly

medicalized context impacts their caring labor. Below, I summarize the three articles that comprise this dissertation.

Summary of Articles

The first article, “Medicalizing to Demedicalize: Lactation Consultants and the (De)medicalization of Breastfeeding,” answers the question of how lactation consultants balance their occupation’s foundational goals of demedicalization with their role as the clinical managers of breastfeeding. While the literature on medicalization is voluminous, we have much less scholarship on demedicalization, and even less that looks at how these processes can occur simultaneously (for notable exceptions, see Burke, 2011; Halfmann, 2012; Lowenberg & Davis, 1994). Because lactation consultants are located at the crossroads of medicalization and demedicalization, as individuals who are working to return to breastfeeding as the cultural norm, yet are entering the maternity care system as the medical managers of breastfeeding, they provide an excellent lens on the medicalization-demedicalization process. I find that, not only do lactation consultants engage in medicalization and demedicalization simultaneously, but some aspects of their medicalization (e.g., medical control) are actually used to demedicalize (e.g., depathologize). This adds the new concept of “medicalizing to demedicalize” to the literature.

Despite the fact that lactation consultants are joining the medical maternity team as lactation specialists and clinical managers of breastfeeding, a large part of their work is providing physical and emotional care to women, similar to doulas. Thus, the second and third articles of my dissertation address care work. The second article, “Families, Markets, and Medicalization: The Role of Paid Breastfeeding and Labor Support in the Maternity Care System,” focuses on the question of why certain aspects of care are provided by the market. Some link the commercialization of care to trends of outsourcing family life, warning about the

effects upon those providing care and those outsourcing their care (Himmelweit, 1999; Hochschild, 2003, 2012; Popenoe, 1993). Duffy (2011), on the other hand, points out the complex social and cultural processes at work in the transition of care from home to market, showing that the meaning of care has transformed over time. In this article, I engage with these questions, using lactation consultants, doulas, and the commercialization of breastfeeding and labor support as a context. In doing so, I bring together the literatures on medicalization and care work, which have rarely been in conversation with one another. I find that there are aspects of lactation consultants' and doulas' care work that appear to be a simple outsourcing of care, a transfer of breastfeeding and labor support from family to market. Yet, lactation consultants and doulas are doing more than replacing the village model of maternity support. They are taking on an entirely new role - the role of advocates and guides to the medical maternity system, a system that is often difficult to navigate for women who wish to avoid medical interventions during childbirth and breastfeeding. In this way, they represent a change in the nature of caring within the context of childbirth and breastfeeding support, which can be attributed to the impact of medicalization, both historically and today.

The third article of my dissertation, "Expertise and Sliding Scales: Lactation Consultants, Doulas, and the Relational Work of Breastfeeding and Labor Support," addresses the question: how do lactation consultants, doulas, and clients negotiate the combination of money and intimacy in the context of breastfeeding and labor support? Building upon the work of Viviana Zelizer (2005), I find that, in contrast to a "hostile worlds" perspective, which would see money and caring as corrupting one another, the caring labor that lactation consultants and doulas provide to their clients for pay is performed within the context of a relationship that is compatible with payment. However, both parties must engage in relational work in order to

create an appropriate “relational package,” and this process is highly influenced by the way gender is mapped onto the hostile worlds dichotomy. Because the dichotomy of sentiment/rationality is overlaid with the dichotomies of private/public, woman/man, unskilled/skilled (Daniels, 1987; Nelson & England, 2002), caring is seen as an innate characteristic of women and women are expected to provide care out of love, kinship, or obligation (Boris & Parreñas, 2010; Glenn, 2010). I find that this creates tension for lactation consultants and doulas between their desire to support women and their need to earn income for themselves and their families. This contributes to our understanding of paid caring and provides additional evidence that a “hostile worlds” perspective can perpetuate the devaluing and low pay of care work.

I conclude each chapter by discussing the implications of the findings and suggesting future areas for research and theory development. In the final chapter of this dissertation, I expand these discussions by elaborating upon the implications for medicalization-demmedicalization theory, motherhood, the commercialization of caring, health disparities, relational work, and the relative low pay of care work. I also discuss future research directions, including the role of race and class in breastfeeding and labor support, expanding my concept of medicalizing to demmedicalize, and applying medicalization theory to other transformations in paid caring.

Works Cited

- American Academy of Pediatrics. (2012). Breastfeeding and the use of human milk. *Pediatrics*, 129, e827-e841.
- Blum, L. M. (1999). *At the breast : Ideologies of breastfeeding and motherhood in the contemporary united states*. Boston: Beacon Press.
- Boris, E., & Parreñas, R. S. (2010). *Intimate labors: Cultures, technologies, and the politics of care*. Stanford, CA: Stanford Social Sciences.
- Burke, M. C. (2011). Resisting pathology: GID and the contested terrain of diagnosis in the transgender rights movement. *Advances in Medical Sociology*, 12, 183-210.
- Centers for Disease Control and Prevention. (2013). Breastfeeding among U.S. children born 2000–2010 CDC National Immunization Survey. Retrieved from http://www.cdc.gov/breastfeeding/data/nis_data/index.htm. Accessed February 14, 2014.
- Conrad, P. (2007). *The Medicalization of society: On the transformation of human conditions into treatable disorders*. Baltimore, MD: Johns Hopkins University Press.
- Conrad, P., & Schneider, J. W. (1980). *Deviance and medicalization: From badness to sickness*. St. Louis: Mosby.
- Daniels, A. K. (1987). Invisible work. *Social Problems*, 5, 403-415.
- Davies, C. (1995). Competence versus care? Gender and caring work revisited. *Acta Sociologica*, 38, 17-31.
- Davies, C. (1996). The sociology of professions and the profession of gender. *Sociology*, 30(4), 661-678.
- Davis, J. E. (2006). How medicalization lost its way. *Society*, 43(6), 51-56.
- Declercq, E. R., Sakala, C., Corry, M. P., & Applebaum, S. (2006). *Listening to Mothers II: Report of the second national U.S. survey of women's childbearing experiences*. New York: Childbirth Connection.
- Declercq, E., Sakala, C., Corry, M., Applebaum, S. & Herrlich, A. (2013). *Listening to mothers III: Pregnancy and childbirth*. New York: Childbirth Connection.
- DONA International. (2005). *What is a doula?* Retrieved from <http://www.dona.org/mothers/index.php>. Accessed February 14, 2014.
- DONA International. (2012). *Position paper: The birth doula's contribution to modern maternity care*. Retrieved from

- http://www.dona.org/PDF/Birth%20Position%20Paper_rev%200912.pdf. Accessed February 14, 2014.
- Duffy, M. (2011). *Making care count: A century of gender, race, and paid care work*. New Brunswick, NJ: Rutgers University Press.
- Dykes, F. (2005). 'Supply' and 'demand': Breastfeeding as labor. *Social Science & Medicine*, 60(10), 2283-2293.
- England, P., Budig, M., & Folbre, N. (2002). Wages of virtue: The relative pay of care work. *Social Problems*, 49(4), 455-473.
- Glenn, E. N. (2010). *Forced to care: Coercion and caregiving in America*. Cambridge, MA: Harvard University Press.
- Halfmann, D. (2012). Recognizing medicalization and demedicalization: Discourses, practices, and identities. *Health (UK)*, 16(2), 186-207.
- Himmelweit, S. (1999). Caring labor. *The ANNALS of the American Academy of Political and Social Science*, 561, 27-38.
- Hochschild, A. R. (2003). *The commercialization of intimate life: Notes from home and work*. Berkeley: University of California Press.
- Hochschild, A. R. (2012). *The outsourced self: Intimate life in market times*. New York: Metropolitan Books.
- International Board of Lactation Consultant Examiners. (2012) Scope of practice for international board certified lactation consultants (IBCLCs). Retrieved from <http://iblce.org/wp-content/uploads/2013/08/scope-of-practice.pdf>. Accessed February 14, 2014.
- International Lactation Consultant Association. (2013). *What is an IBCLC?* <http://www.ilca.org/i4a/pages/index.cfm?pageid=3832>. Accessed February 14, 2014.
- Liu, B. & Newburg, D. S. (2013). Human milk glycoproteins protect infants against human pathogens. *Breastfeeding Medicine*, 8(4), 354-362.
- Lowenberg, J. S. & Davis, F. (1994). Beyond medicalization–demedicalization: The case of holistic health. *Sociology of Health and Illness*, 16(5), 579–599.
- Martin, J. A., Hamilton, B. E., Sutton, P. D., Ventura, S. J., Mathews, T. J., Kirmeyer, S., & Osterman, M. J. K. (2010). Births: Final data for 2007. *National Vital Statistics Reports*, 58(24), 1-44.

- Morton, C. H. (2002). Doula care: The (re)-emergence of woman-supported childbirth in the United States. (Doctoral Dissertation). University of California, Los Angeles. Retrieved from Dissertations & Theses: A&I. (Publication No. AAT 3059588).
- Nelson J. A. & England, P. (2002). Feminist philosophies of love and work. *Hypatia*, 17, 1-18.
- Norman, B. M., & Rothman. B. K. (2007). The new arrival: Labor doulas and the fragmentation of midwifery and caregiving. In W. Simonds, B. K. Rothman, & B. M. Norman (Eds.), *Laboring on: Birth in transition in the United States* (pp. 251-281). New York: Routledge.
- Popenoe, D. (1993). American family decline, 1960-1990: A review and appraisal. *Journal of Marriage and Family*, 55(3), 527-542.
- Riessman, C. K. (1983). Women and medicalization: A new perspective. *Social Policy*, 14(1), 3-18.
- Rothman, B. K. (1982). *In labor: Women & power in the birthplace*. New York: Norton.
- Ryan, A. S. & Pratt, W. F. (1991). A comparison of breast-feeding data from the national surveys of family growth and the Ross laboratories mothers surveys. *American Journal of Public Health*, 81(8), 1049.
- Ryan, A. S., Wenjun, Z., & Acosta, A. (2002). Breastfeeding continues to increase into the new millennium. *Pediatrics*, 110(6), 1103-1109.
- Sandelowski, M. (1984). *Pain, pleasure and American childbirth: From the twilight sleep to the Read method, 1914-1960*. Westport, CT: Greenwood Press.
- Stolzer, J. (2006). Breastfeeding: An interdisciplinary review. *International Review of Modern Sociology*, 32(1), 103-128.
- Torres, J. M. C. (2013). Breast milk and labour support: Lactation consultants' and doulas' strategies for navigating the medical context of maternity care. *Sociology of Health and Illness*, 35(6), 924-938.
- Waerness, K. (1996). On the rationality of caring. In A. Showstack Sassoon (Ed.), *Women and the state: The shifting boundaries of public and private* (pp. 207-234). London: Hutchinson.
- Wertz, R. W., & Wertz, D. C. (1989). *Lying-in: A history of childbirth in America*. New Haven: Yale University Press.
- Wolf, J. H. (2000). The social and medical construction of lactation pathology. *Women and Health*, 30(3), 93-110.
- Zelizer, V. A. (2005). *The purchase of intimacy*. Princeton, NJ: Princeton University Press.

Chapter 2

Medicalizing to Demedicalize: Lactation Consultants and the (De)medicalization of Breastfeeding

Introduction

Medicalization and demedicalization have been the subject of sociological inquiry for decades (Conrad, 1975, 2005, 2007; Freidson, 1970; Zola, 1972). Over this period of time, there has been much debate about the exact nature of these processes and how to determine if something is medicalized or demedicalized (Burke, 2011; Conrad, 1992; Davis, 2006; Fox, 1977; Halfmann, 2012; Lowenberg & Davis, 1994). This article adds to this debate by analyzing the complex example of the medicalization of breastfeeding from the perspective of a highly under-researched occupational group that is situated within the center of this context – International Board Certified Lactation Consultants (IBCLCs).

Lactation consultants provide a unique perspective on the medicalization and demedicalization of breastfeeding because they are a relatively new occupation with roots in the women's health and natural childbirth movements and efforts to demedicalize breastfeeding. However, because of changes in the medicalization of breastfeeding, where it is increasingly supported by medical professionals and regarded as needing medical management, lactation consultants have taken the position of lactation specialists within the maternity care system (Torres, 2013). This raises two questions: 1) To what extent, and in what ways, do lactation

consultants work toward demedicalization? 2) How do lactation consultants balance demedicalization with their role as the clinical managers of breastfeeding? By addressing these two questions, I am able to use the interesting and complicated situation of lactation consultants in the domain of breastfeeding to investigate the complexity of the processes of medicalization and demedicalization. Through this analysis, I provide evidence that, not only can these two processes occur simultaneously, but, ironically, medicalization can actually be used as part of a strategy to demedicalize. As I will illustrate, lactation consultants use their position of medical control over breastfeeding to challenge breastfeeding pathology and limit intervention. This stands in stark contrast to our understanding of the medicalization of natural processes, where pathologization and the creation of medical treatments and technologies are the means by which medical control is expanded.

Background

Medicalization and Demedicalization

Medicalization is most often described as “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders” (Conrad, 2007, p. 4). Demedicalization is the reverse: “a problem that no longer retains its medical definition” (Conrad, 1992, p. 224). The medicalization literature is voluminous, and scholars have defined and redefined medicalization, discussing its causes, consequences, and classifications. However, very little attention has been paid to demedicalization in comparison (some notable exceptions include Adler & Adler, 2007; Carpenter, 2010; Conrad & Angell, 2004; Fox, 1977; Wikler & Wikler, 1991).

One trend among studies looking at demedicalization is the discovery that medicalization and demedicalization can operate simultaneously. Lowenberg and Davis (1994) used the

example of holistic medicine to illustrate how certain elements of this area of medicine represent demedicalization, while others represent medicalization. Burke (2011) analyzed Gender Identity Disorder (GID) activism, finding that while some activists fight for the complete demedicalization of GID by removing it from the DSM and medical texts, other activists fight to retain the diagnosis but end the pathologizing of GID. Another example of this type of scholarship is Halfmann's (2012) recent article on American abortion history, where he illustrates how abortion was medicalized and demedicalized simultaneously.

A key contribution of Halfmann's work is that he highlights the limitations of requiring a minimum threshold in order to determine if something is medicalized or demedicalized. For example, he takes issue with Conrad's (2007) statement that birth will not be demedicalized until it is no longer defined as a medical event and is no longer attended by medical professionals, because it obscures many of the changes in birth over time. I agree with his call for a more continuous value of medicalization-demedicalization, seeing each in terms of "an increase or decrease rather than a presence or absence" (p. 189), so that instead of determining whether something *is* medicalized or *is* demedicalized, we can recognize the nuance and complexity of these processes and identify situations where they are operating at the same time.

This article builds upon this literature by examining elements of medicalization-demedicalization in the work of lactation consultants. I do so in a way that considers both the measurement of medicalization in terms of increase/decrease and the possibility of both medicalization and demedicalization occurring simultaneously. However, I extend these concepts by also considering how medicalization can be used as a strategy for demedicalizing in the work of lactation consultants.

Lactation Consultants

The International Board Certified Lactation Consultant (IBCLC) certification is not the only certification in breastfeeding support, nor is it the only certification that uses the term “lactation consultant” (e.g., Advanced Lactation Consultants). However, it is one of the oldest and largest certifications, and the only one offered internationally. Currently, there are 13,292 IBCLCs in the U.S. (International Board of Lactation Consultant Examiners [IBLCE], 2012b). IBCLCs work in a variety of settings, including hospitals, doctors’ offices, clinics and community centers, and as independent consultants, helping breastfeeding mothers with the challenges of early breastfeeding and working to “protect, promote and support breastfeeding” (IBLCE, 2012a, p. 1). Although the IBCLC certification was created in 1985 (IBLCE, 2013), lactation consultants have a rich history in the medicalization and demedicalization of breastfeeding.

The Medicalization of Breastfeeding: Past and Present

During the early 20th century, the quantity and quality of breast milk were constructed as inadequate for infant feeding, and women began to feed their babies formula, which they and their doctors considered to be the more modern and scientific option (Apple, 1987; Wolf, 2001). This was impacted by the growth of “scientific motherhood” – the belief that women need scientific and medical advice to raise healthy children (Apple, 1995). As a result, breastfeeding rates dropped dramatically. With so few women breastfeeding, those who did want to breastfeed had difficulty finding information and support from medical providers, friends, and family members (Stolzer, 2006).

The natural childbirth and women’s health movements emerged during the mid-20th century. There are, of course, important distinctions between these two movements. Most notably, the women’s health movement was spearheaded by feminists fighting for equality, while

the natural childbirth movement was more likely to include traditionalists fighting for intensive mothering (Blum, 1999). Despite their differences, however, they both fought to reverse the effects of medicalization and advocate for natural childbirth and breastfeeding (Blum, 1999; Rothman, 1982; Sandelowski, 1984; Wertz & Wertz, 1989).

Today, breastfeeding advocates have quite successfully moved us beyond the notion that breast milk is inferior to formula, and several health and medical organizations officially support breastfeeding (American Academy of Family Physicians, 2008; American Academy of Pediatrics, 2012; American Congress of Obstetricians and Gynecologists, 2003; American Dietetic Association, 2009; Centers for Disease Control and Prevention, 2011; Surgeon General, 2011; U.S. Department of Health and Human Services, 2008; World Health Organization, 2011). However, this advocacy did not completely demedicalize breastfeeding. It continues to be defined in medical terms, focusing on the nutritional properties and health benefits of breast milk. While this is partially an issue of healthicization, where behaviors and lifestyles are seen as causes of health and disease (Conrad, 1987), it goes beyond this by constructing breast milk as a medical product. For example, the American Academy of Pediatrics (2012) recommends that preterm infants should receive donor milk if the mother's own milk is not available and that, "Practices should involve protocols that prevent misadministration of milk" (p. e831). There is also a growing literature on the ability of breast milk to protect infants from pathogens through its effects on the gut flora (Liu & Newburg, 2013). These construct breast milk as a product separate from the process of breastfeeding and assign it particular properties and medical uses. Furthermore, breastfeeding continues to be constructed as likely to fail, and therefore, in need of medical management (Burns, Schmied, Fenwick, & Sheehan, 2012; Dykes, 2005).

The contemporary medicalization of breastfeeding also has serious implications for motherhood. Despite the existence of a growing body of social science literature that questions the strength of findings regarding the health benefits of breastfeeding (Blum, 1999; Wolf, 2007, 2011), breastfeeding promotion has increasingly emphasized the health outcomes of breast milk, transforming breastfeeding into a moral imperative for mothers (Crossley, 2009; Kukla, 2006; Lee, 2007; Marshall, Godfrey, & Renfrew, 2007; Murphy, 1999, 2003; Wolf, 2007, 2011). The mother who wants to do the best thing for her baby must choose to breastfeed. This reinforces what Wolf (2007, 2011) calls “total motherhood,” where mothers are expected to reduce every risk to their children, no matter how small, and regardless of the impact on mothers themselves. It also ignores many of the social, cultural, and structural barriers to breastfeeding (Lee, 2007; Marshall, Godfrey, & Renfrew, 2007; Murphy, 2003; Wolf, 2011), including those experienced at higher frequency by women in marginal race and class positions, such as unsupportive work environments (Wolf, 2007) and sexualized and suspected bodies (Blum, 1999).

It is within this complex history of breastfeeding advocacy and the contemporary medicalization of breastfeeding that lactation consultants find their origins. The IBCLC certification was created by the International Board of Lactation Consultant Examiners, with the help of La Leche League International (IBLCE, 2013). La Leche League was founded upon a view of breastfeeding as “a relational process, and one in which mother and baby take their cues and habits reciprocally, from each other rather than from outside experts” (Blum, 1999, p. 65). However, the contemporary medicalization of breastfeeding is quite evident in the IBLCE’s description of their history:

In the latter half of the twentieth century, many scientific studies validated the benefits of breastfeeding. At the same time, mother support organizations were developing a significant body of breastfeeding management skills. From this knowledge, a new allied health care profession began to emerge--lactation consulting (IBLCE, 2011, n.p.).

The history of breastfeeding and the emergence of lactation consultants illustrate how hegemonic the medicalization of breastfeeding is. The complete demedicalization of breastfeeding would be much like what Conrad (2007) described as the demedicalization of childbirth – the elimination of both its medical definition and the control of medical professionals – and it is unlikely that breastfeeding will ever be completely demedicalized in these ways. However, as discussed above, viewing medicalization-demedicalization in terms of presence/absence, rather than increase/decrease, misses the nuances of these processes. Lactation consultants provide an excellent opportunity to examine the complexity of the medicalization and demedicalization of breastfeeding, and to rethink our approach to understanding medicalization, because they are positioned at the crossroads of medicalization and demedicalization. In my previous research (Torres, 2013), I explained that the contemporary medicalization of breastfeeding created an opening for lactation specialists in the occupational boundaries of the maternity care system, and lactation consultants filled this position as the clinical managers of breastfeeding. However, they also act as breastfeeding advocates, creating formal change, such as changing hospital policies and practices to be more pro-breastfeeding. In this article, I extend this analysis to provide a deeper examination of the elements of medicalization and demedicalization in lactation consultants' work, as well as the implications for mothering. In order to do so, I identify four dimensions of medicalization-demedicalization that are relevant to the context of breastfeeding, and can be used to examine the complexity of this context.

Dimensions of Medicalization-Demedicalization

I identified the four dimensions outlined below by pulling common themes from the literature on medicalization and demedicalization, as well as social science research on

breastfeeding. Each dimension is a continuum, where more of this dimension represents movement toward medicalization and less represents movement toward demedicalization. The first two dimensions of medicalization-demedicalization that are relevant to the context of breastfeeding are the extent to which a problem is *defined in medical terms* and falls under the *control of medical professionals*. These two dimensions, in combination, are foundational to our understanding of medicalization (Conrad & Schneider, 1980; Riessman, 1983). Both dimensions are present in the history of the medicalization of breastfeeding detailed above, where the ideology of scientific motherhood and the creation of artificial formulas moved infant feeding within the jurisdiction of pediatricians (Apple, 1987; Wolf, 2001). Today, breastfeeding continues to be under medical surveillance and control (Burns et al., 2012; Dykes, 2005) based, in part, upon the construction of breast milk as a medical product, separate from the process of breastfeeding, and with particular nutritional properties and medical uses. Demedicalization within these dimensions would include moving away from a medical definition of breastfeeding (i.e., less emphasis on nutritional properties and disease) and decreasing the involvement of health care professionals and/or increasing women's control over breastfeeding.

The third dimension useful for understanding breastfeeding is the extent to which a problem or process is *pathologized*, or constructed as abnormal or prone to disorder. While pathology is often subsumed under the concept of a medical definition, Burke (2011) points out that it can be useful to distinguish pathologization from other aspects of medicalization. In the context of breastfeeding, this creates a useful distinction between medical definitions that focus on breast milk's health and illness outcomes and the construction of breastfeeding pathology and women's failed bodies. One construction of breastfeeding pathology concerns the quality of breast milk and its ability to be contaminated. In the late 19th century, it was believed that breast

milk could spoil inside of the mother, much like cow's milk left out at room temperature (Wolf, 2000). Today, mothers continue to be given strict rules about their consumption and behavior while breastfeeding, implying that "breast milk is only as 'pure' as the mother who produces it" (Blum, 1999, p. 52; Carter, 1995; Wall, 2001; Wolf, 2011). Another common construction of breastfeeding pathology regards women's ability to produce an adequate quantity of breast milk, which came under question during the late 19th century (Wolf, 2000), and continues to be a dominant concern among breastfeeding women (Dykes, 2005; Kelleher, 2006; Lawson & Tulloch, 1995). Demedicalization within this dimension would move toward constructing breastfeeding as a normal physiologic process and increasing trust in women's lactating bodies.

The fourth dimension used here is the degree of medical treatment, and in particular, the use of *medical technology*. Conrad (2005) identified the role of biotechnology as a major driver of medicalization, and recognized that technology has long been associated with medicalization, such as the medicalization of birth. The primary example of technology in the context of breastfeeding is the turn to infant formula that occurred around the turn of the 20th century (Apple, 1987; Wolf, 2001). Other forms of technology used to manage breastfeeding include breast pumps, nipple shields, feeding syringes, and pharmaceuticals that stimulate the production of breast milk. Demedicalization in this dimension would refer to decreases in formula use and the amount of technology that is used to manage and/or treat breastfeeding.

These dimensions of medicalization are highly interconnected, but each dimension also represents a unique aspect of medicalization that can be useful for analysis. By teasing them apart, I am able to identify when they are not interacting in the manner we would expect. For example, in the medicalization of natural processes, pathologization and medical technology are used as mechanisms for the expansion of medical control (Riessman, 1983). Once a process is

constructed as disordered, medicine can step in to treat it. This medical control is strengthened by the creation of complex medical technologies that requiring training. I will provide evidence that, while lactation consultants may have gained their position of medical control in this way, they are able to use this position to challenge breastfeeding pathology and limit unnecessary medical intervention. First, I describe the methods used to conduct this research.

Methods

The data for this article came from a larger project on lactation consultants and doulas and their roles in the maternity care system that was conducted in Michigan. The findings presented in this article are based upon interviews with 19 IBCLCs, 11 clients/patients, and 9 health care professionals (doctors, midwives, and nurses), as well as 150 hours of ethnographic observation, where I job shadowed three lactation consultants over a period of nine months. Two of these lactation consultants, whom I have given the pseudonyms Lori and Cindy, work in hospitals in the study area. Both hospitals also provide outpatient breastfeeding care, but the outpatient clinic is much more active at Lori's hospital. The third lactation consultant, Sharon, is in private practice in the community.

I conducted lactation consultant interviews between April and July of 2008 and completed interviews with clients/patients and health care professionals, as well as the ethnographic observation, between March and December of 2012. I recruited lactation consultants through contact lists of certified IBCLCs retrieved from two websites: ILCA.org (International Lactation Consultant Association), the professional organization for IBCLCs, and Breastfeeding.com, a website designed for breastfeeding women. I then recruited the three lactation consultants who participated in the observational portion of the research from those

interviewed. I recruited clients/patients and health care professionals during observation and through snowball sampling.

All interviews were semi-structured and audio-recorded, and were conducted either in-person or over the phone. Participants also filled out contact information and a short demographic questionnaire. I compensated interview participants \$20. The Institutional Review Board of the University of Michigan approved this study. All interview participants (lactation consultants, clinicians, and clients/patients) gave written (in-person) or verbal (by phone) informed consent before beginning the interview. Before observation, all clients/patients gave written (community) or verbal (hospital) informed consent.

With the exception of one Black woman, all lactation consultants in this study were white women. While Cindy and Lori worked with race- and class-diverse populations at their hospitals, all of the clients who participated in interviews were white, with a median annual household income of \$100,000-119,999, and all had at least a college degree. Because of this lack of diversity among interview respondents, and because observation was conducted at three sites in one geographic area, caution should be used in generalizing from these data.

All interviews were transcribed verbatim. During observation, I took fieldnotes with pen and paper, noting the interactions of lactation consultants with both patients/clients and health care professionals. Most of the time, I sat or stood quietly in the room, although I was at times brought into conversation by either the lactation consultants or clients/patients. I conducted analysis of interview transcripts and fieldnotes with NVivo through a process of open and focused coding, as described by Emerson, Fretz, and Shaw (1995). First, code categories were identified through systematic open coding. Then, through a process of memoing, these codes were analyzed for patterns and organized into core themes, which were then broken down into

subthemes through focused coding. The quotes and fieldnotes presented here are exemplars that are representative of the data within each theme or subtheme from which they were chosen. All names are pseudonyms.

Findings

In many ways, the lactation consultants in this study were responsible for the medical management of breastfeeding. At the same time, they did a great deal of work to “protect, promote, and support breastfeeding,” in accordance with the IBLCE Scope of Practice (IBLCE, 2012a, p. 1). In the following sections, I present the various ways in which lactation consultants demedicalized and medicalized breastfeeding, and explain how, in some cases, medicalization was used as a tool to demedicalize.

Demedicalizing Breastfeeding

The three dimensions in which lactation consultants in this study worked to demedicalize breastfeeding were pathology, technology, and medical control. In terms of pathology, they challenged doubts about the quality and quantity of breast milk. Doubts about quality often concerned health care professionals’ and patients’ overestimations of contraindications to breastfeeding, many of which revolved around assumptions that milk is easily contaminated. The area of medications, in particular, is one in which the lactation consultants encountered a frustratingly high level of misinformation, as Carol described to me:

We always just crack up because if you just had a baby and you just had a C-section, you’re gonna get morphine, and you’ll get probably some Vicodin, and you’re gonna get Motrin as you get better. Okay, but the same woman who can come in because she’s got kidney stones three months later, ‘You’re gonna have to stop breastfeeding because we’ve got you on morphine.’ And the mothers will say, ‘Oh I’m just pumping and dumping because I’m on morphine.’ Well, three months ago when you had your baby, you were on morphine, were you pumping and dumping then?

As Carol explained here, doubting the quality of milk can cause serious interruptions to breastfeeding, even quitting unnecessarily.

Lactation consultants in this study encountered the second aspect of pathology, doubts about women's ability to produce enough breast milk, quite often. There is a strong cultural belief that insufficient milk is a common problem (Hausman, 2003), and many women receive messages from friends, family, and care providers that instill this doubt. Christine, a lactation consultant client, explained how her mother doubted her ability to produce enough milk for her son:

My family, and including my extended family, nobody breastfed. Um, so my mom still to this day after two children and you look at the size of him (gestures toward her baby), she still said to me just two days ago, 'I don't think he's getting enough.'

Cindy, who worked primarily in the Mother-Baby unit at her hospital, often had to address mothers' concerns about this issue, particularly before their milk came in. The following fieldnote describes one such situation with a patient named Desiree:

Desiree says that she is not sure if the baby is getting anything, and Cindy says that she is getting colostrum, and that Desiree's milk will come in around day 3 to 5. Desiree asks if that is enough for her baby and if she is getting full. Cindy explains that the baby's "tummy is tiny," and shows how small it is with her hands (about the size of a quarter).

Lori used a similar explanation when asked this question, describing newborns' stomachs as "the size of a marble." In situations like this, lactation consultants are challenging the pervasive pathologizing of breastfeeding and doubting of women's lactating bodies, and working to build women's confidence.

These challenges to the construction of breastfeeding pathology served to protect breastfeeding from unnecessary medical treatment and technology that could interfere with breastfeeding and create additional problems, such as "pumping and dumping" or using formula when it is not needed. The lactation consultants in this study, particularly those working in hospitals, spent a good deal of time trying to protect breastfeeding from unnecessary intervention, both through influencing hospital policy/practice and negotiating with care

providers. For example, Cindy and the other lactation consultants at her hospital worked to stop the radiology department from telling breastfeeding women they had to pump and dump their milk after receiving contrast dyes, which is incorrect. Cindy also negotiated the limited use of formula for babies who had low blood sugar, making sure they were not supplemented more than was necessary, which can cause problems with breastfeeding. The following fieldnote describes one of these conversations:

After we leave the room, Cindy sees the patient's Pediatric Nurse Practitioner (NP) in the hallway and asks, since the blood sugar is stable now, can they stop supplementing with formula? The NP hesitates a little bit. Then, she says, "You would probably prefer that right?" Cindy says she would and that she would like to do a trial. The NP says that since the patient has decided to stay another day, they can just go with breastfeeding. She says she will tell her colleague who will be there tomorrow morning.

Another aspect of lactation consultants' work toward demedicalization was their creation of breastfeeding peer-support groups, which challenged medical control over breastfeeding. Sharon, Lori, and Cindy all participated in such groups, but Sharon's was the largest and most active. While there was a lactation consultant present at these meetings, they encouraged women to share their experiences with one another, rather than just providing a question and answer session with the lactation consultants. The following fieldnote illustrates how Sharon encouraged group discussion:

One of the moms explains that she has a white dot on her nipple that hurts when she nurses. Sharon asks if anyone might know what the problem is, and another mom says it might be a milk bleb, which she has read about.

Despite the fact that Sharon already knew this was most likely a milk bleb, she turned the question to the group so the other mothers could discuss their ideas of what the problem might be and how to fix it. This structure challenges medical control by providing a setting that values breastfeeding women's experiential knowledge. Despite all of this work to demedicalize

breastfeeding, lactation consultants still engaged in a fair amount of medicalization, which I lay out in the next section.

Medicalizing Breastfeeding

As explained above, medical acceptance of breastfeeding has grown in recent years, yet it is still considered likely to fail and, thus, in need of medical management. Due to a lack of training in breastfeeding support for most clinicians, lactation consultants have filled an occupational space within the maternity care system for lactation specialists (Torres, 2013). This means that they are often seen as the primary contact for the medical management of breastfeeding, as is indicated by this quote from Dr. Ramón Rios, a family physician:

It doesn't make any sense for me to be the one to do the lactation consulting when we have people on staff that are excellent at that and do that every day and I think that, you know, that's their specialty.

Dr. Rios' statement draws attention to the fact that the very existence of lactation consultants makes breastfeeding a "specialty." Because lactation consultants are becoming the primary point of care for breastfeeding women, particularly those experiencing complex breastfeeding problems, a large part of their work was conducting the medical management of breastfeeding. As a result, they engaged in a fair amount of medicalization. In addition to their position of medical control, the two other ways lactation consultants in this study medicalized breastfeeding were in the dimensions of a medical definition and use of technology to manage breastfeeding.

Lactation consultants in this study reinforced a medical definition by viewing breast milk as a medical product, separate from the process of breastfeeding, with particular health outcomes and medical uses. For example, when asked why she thought women should breastfeed, Louise gave an answer that compared breast milk to formula and emphasized the nutritional superiority of breast milk, including an impact on intelligence, which is highly contested (Blum, 1999; Wolf, 2011):

And, you know, [with formula] they're just set up for allergies and all kinds of infections, ear infections, I mean, when you look at the data and the research that's been done you go through it, you think, oh well why wouldn't they? [...] I mean, smarter babies! Your child is gonna be smarter, you know, there's gonna be better brain and nerve development on a child that is breastfed.

Similar to the AAP statement on breastfeeding discussed above, Lisa told me, "It's so important for premies [premature babies] to get mothers milk. It's like a medicine. It really is, for a premie." I routinely observed Sharon, Lori, and Cindy telling mothers about these nutritional properties and health benefits, especially in reference to colostrum, the type of milk produced during the first 3-5 days after birth. Cindy described colostrum as "very concentrated and full of antibodies and nutrients."

Sharon, Lori, and Cindy also worked hard to make sure breast milk was never wasted. The following fieldnote from Sharon and her client, Ashley, represents how this emphasis on nutritional properties was incorporated into discussions about not wasting milk:

Ashley says she is making very little milk and the baby is not really breastfeeding, but she is giving him pumped breast milk in his bottles of formula. Sharon says to make sure she is only doing that if she knows he's going to drink the whole bottle, because they don't want to waste the breast milk. Ashley explains that even if she can only get a little milk, she wants to give it to him because she thinks it will be beneficial. Sharon enthusiastically agrees with this statement.

Ashley was only able to pump ½ oz. at a time, so she and Sharon were talking about very small amounts of milk. Yet, Sharon supported her belief that even these small amounts would make a difference for her baby. This situation with Ashley also illustrates well the complex implications of the medical definition of breastfeeding for mothers. On the one hand, Sharon's enthusiastic agreement supports Ashley's belief in her body's ability to nourish her baby. On the other hand, it reinforces the moral imperative to breastfeed, no matter how small the amount.

The construction of breast milk as a medical product also manifested in the lactation consultants' practices, particularly the various ways in which they used technology to measure

and manage milk. While they used a variety of technologies (e.g., medications to increase supply, nipple shields, supplemental nursing systems and syringes), the technology most commonly used by the lactation consultants in this study was breast pumps, which were often used to preserve or increase milk supply. The following fieldnote describes Sharon going over the care plan for low milk supply with Nicole, much of which focused on pumping:

Sharon asks Nicole how many times a day she could pump, realistically, and she says she could do a couple more. Sharon says to shoot for six. She says to massage her breasts before pumping, to try using the bigger breast shield [the part of the pump that is placed on the breast] for her pump, and to hand express after pumping. She says that for the next 5 days, Nicole should “move as much milk as possible.”

Breast pumps play a crucial role in the medical management of breastfeeding, because they allow the lactation consultants (and the mothers) to quantify and track how much milk is being produced, as well as set goals for milk production. Often lactation consultants gave mothers a chart to keep track of the quantities they were pumping.

We'll give them their information on pumping, we give mom a pumping chart and, you know, we say, 'A real good goal for good milk production when you have a [premature baby], is, by the time the baby is two weeks old, we want to see you getting about 700 to 750 ml per 24 hours.' (Carol)

Perhaps the most interesting technology used to manage breastfeeding and measure milk was pre- and post-feeding weights, where the lactation consultant measured an infant's weight before breastfeeding and again after breastfeeding in order to measure how much breast milk the child had transferred during feeding. This practice requires the use of a special scale that can measure the baby's weight in very small increments. Paula explained it as, "...a breast milk scale, where you can measure their intake and it's very, very minute. I mean measurements in grams." Because these scales measure in such minute increments, they can be used to calculate very small quantities of milk, down to the milliliter, like in this fieldnote from Lori's clinic: *They*

do another post-weight and find that the baby took 4ml from the second breast, for a total of 21ml [from both].

Not only do these technologies play a crucial role in the medical management of breastfeeding, but they also reinforce the definition of breast milk as a medical product. In the case of breast pumps, the product is literally separated from the process of breastfeeding, which can allow it to take on a life of its own (Blum, 1999). The pre- and post-feed weights add another level to this construction, because the product of breast milk is being abstracted without ever being removed from the mother-baby dyad. It is measured inside of the baby's body.

Given these ways that lactation consultants are defining milk as a medical product and using technology to manage breastfeeding, all as part of their position of medical control, it would be easy to label them as agents of medicalization. However, this would treat medicalization as a category – lactation consultants *are* medicalizing – and would disregard all of the ways they work to demedicalize breastfeeding at the same time. It would also miss the most nuanced aspect of lactation consultants' work – the ways they used medicalization to demedicalize.

Medicalizing to Demedicalize

Lactation consultants' position of medical control over breastfeeding provides them with a certain measure of authority that they can use in their efforts to depathologize breastfeeding and limit medical intervention. This was most prevalent among hospital lactation consultants, because they worked in a medical context where pathologizing and intervention were more common. Their ability to influence hospital policies to be more supportive of breastfeeding, as well as their ability to negotiate care with providers, as described above, came in large part from their position as lactation specialists. They also had the ability to influence hospital policies to

reinforce their medical control, which could serve to limit intervention. For example, Jean, a nurse who worked at Cindy's hospital, explained how the nurses do not have the authority to use nipple shields with patients: "We're not allowed to give out those, uh, nipple shields. [Lactation consultants] are the only ones that are allowed to give those out."

Hospital lactation consultants also had a fair amount of control over breastfeeding education for staff and patients. Several of them reported being responsible for educating nurses and residents on breastfeeding. Also, Cindy, Lori, and the other lactation consultants at their hospitals created/compiled the breastfeeding information that was given to patients and used by nurses to teach new parents. This control over educational materials allowed them to provide accurate information and challenge misinformation that reinforces the construction of breastfeeding pathology (e.g., feeding on cue rather than on a schedule). Additionally, when women experiencing breastfeeding problems were referred to either hospital or community lactation consultants, this gave them the opportunity to provide these types of education and information directly, which these women could use to advocate for themselves.

Holding this position as clinical managers of breastfeeding working to challenge breastfeeding pathology can be a difficult balance. In many ways, the lactation consultants in this study were able to blend together these aspects of medicalization and demedicalization quite seamlessly. However, there were moments when they appeared to experience some conflict, particularly around their use of technology to measure milk. Lactation consultants in this study had to walk a fine line between contributing to anxieties around insufficient milk and measuring milk as a tool to address breastfeeding difficulties. I often observed Sharon either not telling parents how much the baby transferred after a pre-post weight or using general terms, such as

“she took another little bit.” On one occasion, I observed Lori removing a scale from a patient’s room in the Neonatal Intensive Care Unit:

As we leave the room, Lori takes the scale with us. She tells the nurse in the hallway that she does not think the mom needs the scale in there, so she is taking it out. The nurse says someone put in an order for it, and Lori says she is going to talk to them about it. As we walk away, Lori tells me that she thought it would just stress the mom out too much and that it is too early for the baby [who was born at 32 weeks] to go to breast.

This indicates that, while lactation consultants are able to medicalize breastfeeding as part of their efforts to demedicalize, it does require a delicate balancing act.

Lactation consultants in this study also had difficulty balancing supporting breastfeeding with reinforcing total motherhood. Most of the lactation consultants in this study were similar to those in Waggoner’s (2011) research, who were very cognizant of the individual, structural, and cultural obstacles to breastfeeding. Sharon explained her job as, “to make sure that the woman who quits nursing quits because she is emotionally ready to be done with it, rather than she doesn’t know what else to do.” Of course, this is not an easy line to draw when breastfeeding is so strongly attached to good mothering. Lori had a patient, named Brooke, in the outpatient clinic, who was following a routine of breastfeeding, pumping, and supplementing with formula every 2-3 hours. Brooke said she did not want to quit nursing because “at least my baby is getting something,” and Lori replied, “It’s good as long as it isn’t making you miserable.”

Discussion

Lactation consultants provide a unique lens for examining the complexity of medicalization because they are positioned at the crossroads of medicalization and demedicalization. The IBCLC certification originated from a combination of breastfeeding advocacy groups that resisted the medicalization of breastfeeding and the contemporary medicalization of breastfeeding that emphasizes the nutritional properties and health benefits of breast milk. This places them in a position where they work to protect breastfeeding, yet they

have positioned themselves within the maternity care system as lactation specialists performing the clinical management of breastfeeding.

The lactation consultants in this study are actively working toward the demedicalization of breastfeeding by challenging the construction of breastfeeding pathology and working to limit unnecessary medical intervention that can disrupt breastfeeding. Additionally, their involvement in breastfeeding peer-support groups works to place some of the control over breastfeeding back into the hands of breastfeeding women. However, because they have entered the maternity care team through the position of lactation specialists, giving them medical control, they are fully engaged in the medical management of breastfeeding. As a result, they medicalize breastfeeding by endorsing the medical definition of breast milk. They also employ a variety of medical technologies to manage breastfeeding, some of which reinforce the construction of milk as a medical product.

These findings clearly illustrate that medicalization and demedicalization are occurring simultaneously in the context of breastfeeding and in the work of lactation consultants; however, categorizing some aspects of their work as medicalization and others as demedicalization does not capture the true complexity of their role. In reality, some aspects of medicalization can be used to demedicalize. The clearest example of this is when lactation consultants use their position of medical control to challenge breastfeeding pathology and limit unnecessary medical intervention that can disrupt breastfeeding. This stands in contrast to our understanding of the medicalization of natural processes, where the construction of disorder and the creation of complex medical technologies serve to reinforce medical control (Conrad, 2007; Riessman, 1983). Lactation consultants did gain their medical control by these means, but they illustrate

that this process can also work in the opposite direction, where medical control can be used to challenge pathology and intervention.

A close examination of these nuances in the medicalization-demedicalization of breastfeeding also provides insight into the implications for mothers. When lactation consultants challenge the construction of breastfeeding pathology and limit intervention, they also challenge the construction of women's bodies as suspect and prone to disorder. Emphasizing the nutritional properties and health benefits of breast milk can also serve this function, celebrating women's ability to nourish their babies. However, it also contributes to the moral imperative to breastfeed, especially when even small amounts of milk are presented as making a difference in babies' health. This creates a fine line that lactation consultants must walk between supporting breastfeeding women, who may be lacking support from those around them, and reinforcing total motherhood.

Waggoner's (2011) research illustrates that lactation consultants are aware of the structural and cultural context of breastfeeding and, therefore, support women who choose not to breastfeed. This research adds a deeper understanding of this process through ethnographic observation. The transition from supporting a woman in overcoming breastfeeding difficulties to supporting that woman in deciding to quit breastfeeding was far from clear cut, especially when there were rarely objective criteria for when breastfeeding had "failed" or for when women were "emotionally ready" to quit, given the power of the moral imperative to breastfeed. This made it difficult for lactation consultants to discern the turning point at which the breastfeeding support they were providing shifted from being helpful to making mothers "miserable," as in the situation with Lori and Brooke. This is an area that needs more attention, especially in terms of the implications for women in marginalized positions, given Blum's (1999) findings on race and

class differences in breastfeeding experiences and Wolf's (2011) findings regarding the raced and classed dimensions of breastfeeding advocacy.

This study draws attention to the need for an understanding of medicalization-demedicalization as a continuous process (Halfmann, 2012) by illustrating incremental, yet important, changes in the (de)medicalization of breastfeeding. Much of this nuance would be lost in a categorical measure of medicalization. This nuanced perspective also allows for a closer examination of the impact of each dimension of medicalization-demedicalization on mothers, contributing to our understanding of the moral imperative to breastfeeding (Crossley, 2009; Kukla, 2006; Lee, 2007; Marshall, Godfrey, & Renfrew, 2007; Murphy, 1999, 2003) and total motherhood (Wolf, 2007, 2011). This work also builds upon previous research that has illustrated how medicalization and demedicalization can occur at the same time (Burke, 2011; Halfmann, 2012; Lowenberg & Davis, 1994) by providing a case where not only are these processes occurring simultaneously, but medicalization can be used as a tool to demedicalize. This concept of "medicalizing to demedicalize" is a new contribution to the medicalization literature and may be helpful to scholars studying other areas of medicalization or other social actors involved in processes of medicalization-demedicalization.

In summary, this research supports the utility of a continuous value of medicalization. This allows for a more nuanced analysis of medicalization and demedicalization, including the ability to see when both are occurring simultaneously and to more fully analyze the impact of different dimensions of medicalization-demedicalization. Furthermore, it illustrates that medicalization can be used as a tool to demedicalize, adding this new concept to the medicalization literature.

Works Cited

- Adler, P.A., & Adler, P. (2007). The demedicalization of self-injury: From psychopathology to sociological deviance. *Journal of Contemporary Ethnography*, 36(5), 537–570.
- American Academy of Family Physicians. (2008). Breastfeeding: Position paper. Retrieved from <http://www.aafp.org/about/policies/all/breastfeeding-support.html>. Accessed February 14, 2014.
- American Academy of Pediatrics. (2012). Breastfeeding and the use of human milk. *Pediatrics*, 129, e827-e841.
- American Dietetic Association. (2009). Position of the American Dietetic Association: Promoting and supporting breastfeeding. *Journal of the American Dietetic Association*, 109, 1926-1942.
- American Congress of Obstetricians and Gynecologists. (2003). Breastfeeding. Retrieved from <http://www.acog.org/~media/Departments/Breastfeeding/breastfeedingStatement.pdf?dmc=1&ts=20140214T1558161376>. Accessed February 14, 2014.
- Apple, R. D. (1987). *Mothers and medicine : A social history of infant feeding, 1890-1950*. Madison: University of Wisconsin Press.
- Apple, R. D. (1995). Constructing mothers: Scientific motherhood in the nineteenth and twentieth centuries. *The Society for the Social History of Medicine*, 8(2), 161-178.
- Blum, L. M. (1999). *At the breast : Ideologies of breastfeeding and motherhood in the contemporary united states*. Boston : Beacon Press.
- Burke, M. C. (2011). Resisting pathology: GID and the contested terrain of diagnosis in the transgender rights movement. *Advances in Medical Sociology*, 12, 183-210.
- Burns, E., Schmied, V., Fenwick, J., & Sheehan A. (2012). Liquid gold from the milk bar: Constructions of breast milk and breastfeeding women in the language and practices of midwives. *Social Science & Medicine*, 75(10), 1737–1745.
- Carpenter, L. M. (2010). On remedicalisation: Male circumcision in the United States and Great Britain. *Sociology of Health & Illness*, 32, 613–630.
- Carter, P. (1995). *Feminism, breasts, and breast-feeding*. New York: St. Martin's Press.
- Centers for Disease Control and Prevention. (2013). Breastfeeding. Retrieved from <http://www.cdc.gov/breastfeeding/>. Accessed February 14, 2014.
- Conrad, P. (1975). The discovery of hyperkinesis: Notes on the medicalization of deviance. *Social Problems*, 23(1), 12–21.

- Conrad, P. (1987). Wellness in the work place: Potentials and pitfalls of work-site health promotion. *The Milbank Quarterly*, 65(2), 255-275.
- Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, 18, 209-232.
- Conrad, P. (2005). The shifting engines of medicalization. *Journal of Health and Social Behavior*, 46(1), 3-14.
- Conrad, P. (2007). *The Medicalization of society: On the transformation of human conditions into treatable disorders*. Baltimore, MD: Johns Hopkins University Press.
- Conrad, P., & Angell, A. (2004). Homosexuality and remedicalization. *Society*, 41(5), 32-39.
- Conrad, P., & Schneider, J. W. (1980). *Deviance and medicalization: From badness to sickness*. St. Louis: Mosby.
- Crossley, M. L. (2009). Breastfeeding as a moral imperative: An autoethnographic study. *Feminism & Psychology*, 19(1), 71-87.
- Davis, J. E. (2006). How medicalization lost its way. *Society*, 43(6), 51-56.
- Dykes, F. (2005). 'Supply' and 'demand': Breastfeeding as labour. *Social Science & Medicine*, 60(10), 2283-2293.
- Emerson, R.M., Fretz, R.I., & Shaw, L.L. (1995). *Writing ethnographic fieldnotes*. Chicago: The University of Chicago Press.
- Fox, R. (1977). The medicalization and demedicalization of American society. *Daedalus* 106(1), 9-22.
- Freidson, E. (1970). *Profession of medicine; a study of the sociology of applied knowledge*. New York: Dodd, Mead.
- Halfmann, D. (2012). Recognizing medicalization and demedicalization: Discourses, practices, and identities. *Health (UK)*, 16(2), 186-207.
- Hausman, B.L. (2003). *Mother's milk – Breastfeeding controversies in American culture*. New York: Routledge.
- International Board of Lactation Consultant Examiners. (2011). About us. <http://americas.iblce.org/about-us>. Accessed March 27, 2013.
- International Board of Lactation Consultant Examiners. (2012a) Scope of practice for international board certified lactation consultants (IBCLCs). Retrieved from <http://iblce.org/wp-content/uploads/2013/08/scope-of-practice.pdf>. Accessed February 14, 2014.
- International Board of Lactation Consultant Examiners. (2012b) Facts and figures. <http://americas.iblce.org/facts-and-figures>. Accessed June 10, 2013.

- International Board of Lactation Consultant Examiners. (2013) History. <http://iblce.org/about-iblce/history/>. Accessed February 14, 2014.
- Kelleher, C. M. (2006). The physical challenges of early breastfeeding. *Social Science & Medicine*, 63(10), 2727-2738.
- Kukla, R. (2006). Ethics and ideology in breastfeeding advocacy campaigns. *Hypatia*, 21(1), 157-180.
- Lawson, K., & Tulloch, M. I. (1995). Breastfeeding duration: Prenatal intentions and postnatal practices. *Journal of Advanced Nursing*, 22(5), 841-849.
- Lee, E. (2007). Health, morality, and infant feeding: British mothers' experiences of formula milk use in the early weeks. *Sociology of Health & Illness*, 29(7), 1075.
- Liu, B., & Newburg, D. S. (2013). Human milk glycoproteins protect infants against human pathogens. *Breastfeeding Medicine*, 8(4), 354-362.
- Lowenberg, J. S., & Davis, F. (1994). Beyond medicalisation–demedicalisation: The case of holistic health. *Sociology of Health and Illness*, 16(5), 579–599.
- Marshall, J. L., Godfrey, M., & Renfrew, M. J. (2007). Being a 'good mother': Managing breastfeeding and merging identities. *Social Science & Medicine*, 65(10), 2147-2159.
- Murphy, E. (1999). "Breast is best": Infant feeding decisions and maternal deviance. *Sociology of Health and Illness*, 21(2), 187-208.
- Murphy, E. (2003). Expertise and forms of knowledge in the government of families. *The Sociological Review*, 51(4), 433-462.
- Riessman, C. K. (1983). Women and medicalization: A new perspective. *Social Policy*, 14(1), 3-18.
- Rothman, B. K. (1982). *In Labor: Women & power in the birthplace*. New York: Norton.
- Sandelowski, M. (1984). *Pain, pleasure and American childbirth: From the twilight sleep to the Read method, 1914-1960*. Westport, CT: Greenwood Press.
- Stolzer, J. (2006). Breastfeeding: An interdisciplinary review. *International Review of Modern Sociology*, 32(1), 103-128.
- Surgeon General. (2011). The surgeon general's call to action to support breastfeeding. Retrieved from <http://www.surgeongeneral.gov/topics/breastfeeding/>. Accessed February 14, 2014.
- Torres, J.M.C. (2013). Breast milk and labour support: Lactation consultants' and doulas' strategies for navigating the medical context of maternity care. *Sociology of Health and Illness*, 35(6), 924-938.

- U.S. Department of Health and Human Services. (2008). Primary care interventions to promote breastfeeding: Recommendation statement. Retrieved from <http://www.uspreventiveservicestaskforce.org/uspstf/uspbrfd.htm>. Accessed February 14, 2014.
- Waggoner, M. R. (2011). Monitoring milk and motherhood: Lactation consultants and the dilemmas of breastfeeding advocacy. *International Journal of Sociology of the Family*, 37(1), 153-171.
- Wall, G. (2001). Moral constructions of motherhood in breastfeeding discourse. *Gender & Society*, 15(4), 592-610.
- Wertz, R. W., & Wertz, D. C. (1989). *Lying-in: A history of childbirth in America*. New Haven: Yale University Press.
- Wikler, D., & Wikler, N. J. (1991). Turkey-baster babies: the demedicalization of artificial insemination. *Milbank Quarterly*, 69, 5-40.
- Wolf, J. B. (2007). Is breast really best? Risk and total motherhood in the national breastfeeding awareness campaign. *Journal of Health Politics, Policy and Law*, 32(4), 595.
- Wolf, J. B. (2011). *Is breast best?: Taking on the breastfeeding experts and the new high stakes of motherhood*. New York: New York University Press.
- Wolf, J. H. (2000). The social and medical construction of lactation pathology. *Women and Health*, 30(3), 93-110.
- Wolf, J. H. (2001). *Don't kill your baby: Public health and the decline of breastfeeding in the nineteenth and twentieth centuries*. Columbus: Ohio State University Press.
- World Health Organization. (2013). Breastfeeding. Retrieved from <http://www.who.int/topics/breastfeeding/en/>. Accessed February 14, 2014.
- Zola, I. K. (1972). Medicine as an institution of social control. *The Sociological Review*, 20(4), 487-504.

Chapter 3

Families, Markets, and Medicalization: The Role of Paid Breastfeeding and Labor Support in the Maternity Care System

Introduction

In colonial America, childbirth was a social event, attended in the home by midwives and aided by female friends and kin, and nearly all women breastfed their babies for the first year of life (Wertz & Wertz, 1989). The practices of childbirth and breastfeeding have changed dramatically over time, as has the structure of care work surrounding them. One recent development is the emergence of lactation consultants and labor doulas, two occupational groups that provide breastfeeding and labor support. This article examines the roles of these two groups in the maternity care system and the commercialization of care.

Over the last several decades, the care work literature has grown from a focus on social reproduction and drawing attention to the invisible work women did in the home to an understanding of caring within macrostructural forces, such as globalization (Boris & Parreñas, 2010). One dominant theme within this literature is an examination of changes over time in who provides what care to whom and how that care is compensated, with particular attention paid to forms of care that become commercialized. This transition is often characterized as reflective of a general pattern of outsourcing family life or as a move from village to market (Hochschild,

2012). Others have added to this an understanding of the complex social and cultural factors that impact transformations in care, including changes in the nature of caring itself (Duffy, 2011).

This article adds to this literature by examining the caring labor of two relatively new occupational groups, International Board Certified Lactation Consultants (IBCLCs) and DONA International (formerly Doulas of North America) certified birth doulas. Lactation consultants provide breastfeeding support to nursing women and doulas provide emotional, physical, and informational support to birthing women. These two occupations provide an excellent opportunity for examining the outsourcing and commercialization of care because, while breastfeeding and labor support have always existed in one form or another, we now have paid occupational groups specializing in these forms of care.

I will illustrate that the care lactation consultants and doulas are providing today cannot be understood without an examination of the impact of medicalization on childbirth and breastfeeding, both historically and today. By bringing together scholarship on medicalization and care work, two expansive literatures that have rarely been brought into conversation with one another, I am able to illuminate the complexity of the role that lactation consultants and doulas play in the maternity care system and demonstrate that they do not represent a simple outsourcing of care, but rather, a transformation in the meaning and function of a particular kind of care work, breastfeeding and labor support. My findings illustrate the importance of examining the impact of the social and cultural context on the relationship between care and the market, as well as broadening our understanding of care to look beyond physical and emotional care.

Background

Care Work

While there is no single agreed-upon definition of care work, most provide one similar to that of England, Budig, & Folbre (2002):

We use the term ‘care work’ (or caring labor) to refer to occupations in which workers are supposed to provide a face-to-face service that develops the human capabilities of the recipient. By “human capabilities” we refer to health, skills, or proclivities that are useful to oneself or others. These include physical and mental health, physical skills, cognitive skills, and emotional skills, such as self-discipline, empathy, and care. (p. 455).

Given that the majority of caring labor is performed by women, and therefore carries implications for gender equality, much of the literature on care work has been produced by feminist scholars. Early feminist attention to caring came out of a Marxist tradition that called attention to social reproduction (Glenn, 1992) and the invisibility of women’s unpaid domestic labor, which was often not viewed as real work (Dalla Costa, 1972; Hartmann, 1976). Since then, the literature has branched out to examine the multiple sites of reproductive labor, including caring labor, within the home and outside of it, paid and unpaid (Glenn, 1992; Glucksman & Nolan, 2007). Within this growing literature, there are two interrelated themes that are relevant to this article: the care crisis and the commercialization of care, both of which examine changes over time in who provides what care to whom.

There is little disagreement over the fact that we currently have a care crisis and that the number of individuals requiring care outweighs the number available to provide it. There is less consensus on how we got to this point, but most explanations point to the interaction of several factors: as a result of industrialization and urbanization, families are largely cut off from kinship circles and communities; women have moved into the labor force in large numbers; the number of single-parent families is increasing, driven in part by higher divorce rates; and the state provides minimal assistance with aspects of care, such as care for children and the elderly (Braverman, 1974; Glenn, 1992; Dizard & Gadlin, 1990; Hochschild, 2003, 2012). This is where

commercialization enters. All of this has created a “care gap,” and we use the market to fill it (Hochschild, 2003).

The commercialization of care is often linked to the larger trend of the commodification of reproductive labor. Prior to industrialization, both productive and reproductive labor were performed largely within the household. With industrialization, much of the productive labor of goods (e.g., clothing) moved into the market, but reproduction remained in the home. However, during the second half of the 20th century, aspects of reproductive labor, including care, became increasingly commodified (Glenn, 1992). Over time, more and more aspects of family life have become commodities that are bought and sold in the market, rather than provided by household members (Hochschild, 2012; Lair, 2012; Sherman, 2010).

The implications of commodifying reproductive labor are far reaching, especially when examined within the global context (Parreñas, 2000). Additionally, when aspects of family life, including care, are outsourced, there are implications for communities and the individuals who are purchasing these aspects of intimate life. As Hochschild (2012) states, a village mentality of “just do,” where neighbors help one another as part of gift exchange and to create and maintain bonds within a community, is being replaced by a service mall, where we outsource aspects of family life, and along with it, aspects of the self. As more and more is provided by the market, we no longer know how to provide it ourselves (Braverman, 1974), which then reinforces outsourcing, because what you can buy in the market seems better than what the family can do (Hochschild, 2012).

Duffy (2011) provides another layer to our understanding of this process. Through an historical examination of several caring occupations, she illustrates the complex social and cultural processes at work in the transition of care from home to market, which she says cannot

be seen as a simple transfer of care from one to the other. The commercialization of care must be seen alongside the changing nature of care itself. In the case of health care, scientific advances and the creation of specialized expert knowledge transformed the meaning of good care, so that the care that is provided in hospitals and doctors' offices today bears little resemblance to the care that was once provided at home.

In this article, I use the examples of breastfeeding and labor support to engage with this question of why certain aspects of care are provided by the market. These forms of care provide an interesting context for this question, because they represent a form of care that has been provided in a variety of modes over time, including the colonial village model of “social childbirth” (Wertz & Wertz, 1989), but has recently become the specialization of paid occupational groups, such as lactation consultants and doulas. Therefore, they seem to represent a clear outsourcing of these forms of care. However, as I will illustrate, these forms of care were heavily impacted by the medicalization of childbirth and breastfeeding, that is, by the changing nature of maternity care.

The Emergence of Lactation Consultants and Doulas

According to the International Lactation Consultant Association (ILCA), a lactation consultant is a “health care professional who specializes in the clinical management of breastfeeding” (ILCA, 2013, n.p.). As certified professionals, they work in a variety of settings helping to “protect, promote and support breastfeeding” (International Board of Lactation Consultant Examiners [IBLCE], 2012a, p. 1). DONA International currently certifies two types of doulas: birth doulas and postpartum doulas. Birth doulas, the focus of this research, work with women birthing in hospitals, birth centers, and at home, providing them with “physical, emotional, and informational support before, during, and just after birth” (DONA, 2005, n.p.).

As Glucksman (1995) has illustrated, caring labor exists in multiple socio-economic modes simultaneously, and the caring labor surrounding breastfeeding and childbirth are no exception. The reproductive labor of the acts of childbirth and infant feeding can be provided by the woman herself or can be outsourced and commercialized through surrogacy, wet nursing, formal and informal sharing of breast milk, and infant formula. Likewise, care of the childbearing and breastfeeding woman can be provided in many combinations, and these configurations of care have changed dramatically over time. In the “social childbirth” of colonial America, birth was attended by midwives, who were often paid, as well as unpaid female friends and kin, who “attended and aided each other during birth itself and during the several weeks of ‘lying-in’ that followed” (Wertz & Wertz, 1989, p. 1). As childbirth and breastfeeding were medicalized during the late 19th and early 20th centuries, this element of social support for women during childbirth and postpartum was lost.

Medicalization is “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders” (Conrad, 2007, p. 4) and move under the control of medical professionals (Conrad & Schneider, 1980; Riessman, 1983; Davis, 2006). When the condition is a natural process, such as childbirth and breastfeeding, a key aspect of medicalization is constructing that condition as pathological, or prone to disorder. Additionally, processes of medicalization serve to highlight the medical and scientific expertise of doctors, while simultaneously deskilling the public and making them feel uneducated and incapable of making their own health decisions (Starr, 1982; Riessman, 1983).

As childbirth was medicalized, it was constructed as prone to disorder, and thus in need of medical intervention. This transformed birth from a social experience shared among women and attended by a midwife in the home to a private experience between a woman and her

physician in the hospital, and the use of technology increased steadily, so that by the mid-20th century, most women were unconscious during their births (Riessman, 1983; Rothman, 1982; Sandelowski, 1984; Wertz & Wertz, 1989). As breastfeeding was medicalized, it also was constructed as prone to disorder, and breast milk was seen as inadequate. As a result, women began to feed their babies formula, what they and their doctors considered to be the more modern and scientific option for infant feeding (Apple, 1987; Wolf, 2001). Breastfeeding rates dropped dramatically, and, with so few women breastfeeding, those who did want to breastfeed had difficulty finding information and support from medical providers, friends, and family members (Stolzer, 2006). Through these changes, the medical management of childbirth and infant feeding largely replaced the caring labor of social childbirth.

The natural childbirth movement emerged during the mid-20th century as a response to the medicalization of childbirth and breastfeeding, fighting for women to be awake and aware during birth and challenging the high rates of formula use and medical intervention during birth (Blum, 1999; Rothman, 1982; Sandelowski, 1984; Wertz & Wertz, 1989). These changes required an increase in breastfeeding and labor support that, arguably, the medical system was ill equipped to provide. It is within this history that lactation consultants and doulas find their origins.

Doulas emerged out of a grassroots movement, as women began to have friends and childbirth educators support them during natural birth. The term doula is a Greek word that means “female helper,” and it was attached to the women working in these support roles as this form of work began to grow as an occupation (Norman & Rothman, 2007). In 1992, Doulas of North America (now DONA International) was founded, in part, upon scientific research

illustrating the effects of labor support on lowering the rates of medical interventions in birth (Morton, 2002).

Lactation consultants' connection to natural childbirth is not as strong as doulas' because they have worked to present themselves as health care professionals and lactation specialists in order to join the medical maternity care team (Torres, 2013). However, the International Board of Lactation Consultant Educators created the IBCLC credential in 1985, with the help of La Leche League International (IBLCE, 2013), a mother-to-mother support organization that was founded upon a view of breastfeeding as “a relational process, and one in which mother and baby take their cues and habits reciprocally, from each other rather than from outside experts” (Blum, 1999, p. 65). This occupational group was developed in order to provide breastfeeding support and education that would facilitate a move away from heavy reliance on formula and a return to breastfeeding as the cultural norm.

Despite the efforts of the natural childbirth movement, these two aspects of reproduction remain highly medicalized. Childbirth continues to be constructed as pathological and prone to disorder (Rothman, 1982; Simonds, Rothman, & Norman, 2007; Wertz & Wertz, 1989), resulting in a culture of fear surrounding birth, as well as high intervention rates. For example, nearly one third of births are cesarean sections and many women report feeling pressured by care providers to have a labor induction, epidural, or cesarean (Declercq et al., 2013). Medical support for breastfeeding has increased and several professional organizations support breastfeeding (e.g., American Academy of Pediatrics, 2012), yet it also remains constructed as prone to disorder, and thus, in need of medical management (Blum, 1999; Burns, Schmied, Fenwick, & Sheehan, 2012; Dykes, 2005). Also, while hospital support for breastfeeding has been on the rise, nearly half of the women who intend to exclusively breastfeed are given free

formula or offers before leaving the hospital (Declercq et al., 2013). As I illustrate below, this context is important for understanding the meaning and function of lactation consultants' and doulas' work.

Lactation consultants and doulas represent just one form of breastfeeding and labor support. However, these are both rapidly growing occupations in the U.S. and internationally. Currently, there are 13,292 IBCLCs in the U.S. (IBLCE, 2012b) and DONA International has over 5,800 members, including 2,636 certified birth doulas (DONA, 2010). This represents an interesting trend in the commercialization of this form of care work. Therefore, this article addresses the following questions: What role do lactation consultants and doulas play in maternity care? Are these occupations a reflection of the outsourcing of care or something else? What does the existence of these types of paid support illustrate about transformations in care, more broadly? Before turning to the answers to these questions, I first describe the methods used to investigate them.

Methods

The data for this article came from a larger study of lactation consultants and doulas and their roles in the maternity care system. The findings here are based on interviews with 19 lactation consultants, 18 birth doulas, 17 clients, and 18 health care professionals (doctors, midwives, and nurses), as well as 150 hours of ethnographic observation, where I shadowed three lactation consultants over a period of nine months. Two of these lactation consultants, whom I have given the pseudonyms Lori and Cindy, work in hospitals in the study area. Both hospitals provide outpatient breastfeeding care, as well, but the clinic is much more active at Lori's hospital. The third lactation consultant, Sharon, is in private practice in the community.

Two doulas consented to participate in observation, but none of their clients consented to my presence at their birth. However, I was able to observe one postpartum doula visit.

I recruited lactation consultants and doulas through contact lists of certified IBCLCs and DONA doulas available from three websites. I contacted the lactation consultants from ILCA.org, the professional organization for IBCLCs, and Breastfeeding.com, a website designed for breastfeeding women. I retrieved contact information for doulas from DONA.org, the professional organization and certifying agency for DONA International doulas. All lactation consultants and doulas in this study worked for pay at least some of the time. I recruited lactation consultant and doula participants for the observational portion of the research from those interviewed. I recruited clients and health care professionals for interviews during observation and through snowball sampling. All clients interviewed had worked with one of the lactation consultants or doulas in the study. Interviews were semi-structured and all were audio-recorded. Participants also filled out contact information and a short demographic questionnaire. Each interview participant was compensated \$20. The Institutional Review Board approved this study.

The vast majority of lactation consultants and doulas in this study were white, with the exception of one Black lactation consultant, two Black doulas, and one multi/bi-racial doula. While I did observe the hospital lactation consultants working with a fairly race- and class-diverse population, all of the lactation consultant and doula clients who agreed to participate in interviews were white, with a median annual household income of \$100,000-119,999 (for each group), and all had at least a college degree. The participants in this study are obviously not representative of the general U.S. population. However, it is difficult to determine how representative they are of the populations of IBCLCs, DONA birth doulas, and women who work with them, because there is very little data on this topic. One factor that is likely affecting the

class distribution in this study is the cost-prohibitive nature of lactation consultant and doula services. Reported out-of-pocket expenses for lactation consultant appointments ranged from \$40-130 per visit, and doula clients reported paying \$300-1200 for a package that included prenatal, birth, and postpartum care.

All interviews were transcribed verbatim. During observation, I took fieldnotes with pen and paper, noting the interactions of lactation consultants with clients and health care professionals. Most of the time, I sat or stood quietly in the room, although I was at times brought into conversation by either the lactation consultants or clients. These conversations were sometimes about general topics (e.g., the weather), but were often about babies, parenthood, and my experiences breastfeeding my two children. Occasionally, I held babies while the lactation consultants worked with women (e.g., teaching how to use a breast pump).

I analyzed interview transcripts and fieldnotes through a process of open and focused coding, as described by Emerson, Fretz, & Shaw (1995). First, I identified code categories through systematic open coding. Then, through a process of memoing, I analyzed these codes for patterns and organized them into core themes, which I then broke down into subthemes through focused coding. The quotes and fieldnote excerpts presented here are representative of the data within each theme or subtheme from which they came.

Findings

In many ways, lactation consultants and doulas represent an outsourcing of care from family to market. However, I also found evidence to suggest that their work is more than a simple transfer of care, but is instead indicative of a transformation in the nature of breastfeeding and labor support – a transformation that is heavily impacted by medicalization, both historically and today. I begin by describing the day-to-day caring labor of lactation consultants and doulas,

followed by an analysis and discussion of the aspects of outsourcing and medicalization in their work.

The Day-to-Day Caring Labor of Lactation Consultants and Doulas

Both lactation consultants and doulas in this study provided physical support to their clients. Lactation consultants spent a good deal of their time showing women different breastfeeding positions in order to get the baby to latch on correctly and comfortably and stay latched on. The following fieldnote describes a typical interaction of this type with Sharon and Tammie, a woman who was experiencing pain while breastfeeding her baby, Annabell:

Sharon watches Tammie latch Annabell onto her breast and then says, "Okay, that's not bad." She then assists her by turning Annabell's hips toward Tammie's abdomen more. Tammie says that she is still feeling pain, so Sharon tells her to try flipping Annabell's lips out. She does, but it is still hurting, so they break the suction, and latch again. This time, Sharon shows Tammie a different way to do it, putting Annabell's chin on her breast, waiting for her to open really wide, and then pushing the nipple in so she gets more tissue. Annabell readjusts, and Sharon asks if she does that a lot, and Tammie says yes. They break the seal again and re-latch her, getting lots of tissue in her mouth, and Tammie says it feels much better.

Aside from the goal of getting babies to latch onto the breast and stay latched on, as this fieldnote illustrates, positioning was also about making women and babies more comfortable while breastfeeding, which required being able to read the body language of both. In addition to positioning, lactation consultants often assisted women with techniques of expressing milk, including breast massage while nursing, hand expressing milk, and using a breast pump.

While doulas did provide some forms of physical support during prenatal and postpartum meetings with clients, such as massage and basic breastfeeding positioning, the bulk of their hands-on work was during childbirth, when they provided continuous labor support to their clients. This labor support included things like help with getting into different laboring positions, massage, counter-pressure, water therapy, helping them walk around, and holding legs during

pushing. Much of this work revolved around being able to evaluate how a woman was doing and what type of support she needed. Leslie explained how her doula was able to do this: “So she kind of exactly knew what to try and when to try it just by looking at me, which was perfect.” Doulas’ support also included basic elements of care, such as making sure women (and partners) were getting enough to eat or drink or using the bathroom often enough.

Alongside these forms of physical hands-on support, lactation consultants and doulas also provided emotional support, the most common type of which was building confidence and helping clients see how well they were doing - what Tamara, a doula, described as, “just kind of becoming her cheerleader.” Part of building confidence was reassuring clients that what they were experiencing was normal, and not cause for concern. Lactation consultants did a fair amount of normalizing around issues of milk supply. Lisa discussed the types of conversations she had with women about their supply:

Because...and these are, these are direct quotes. ‘I don’t see anything coming out.’ ‘My breasts are still soft.’ Um, ‘I don’t see the baby swallowing,’ which--colostrum--the analogy I use is that it’s like syrup or honey, or a thick milk shake. So, you don’t go, gulp, gulp, gulp. In a few days the baby will do that. But the first few days, they’ll suck three or four times and stop to swallow. And most every mother I tell that to goes, ‘Yeah! That’s what they’re doing!’ And it’s perfectly normal.

For doulas, much of the normalizing they did addressed their clients’ lack of experience with childbirth and was provided as part of their efforts to keep clients calm during birth. When asked which aspects of working with a doula were most beneficial, Gwen, a doula client, replied, “Um, the biggest one was that it was somebody who had already been through it. Um, and so it was just sort of this calming presence to say, ‘Okay, well, don’t—this is not abnormal.’” These aspects of physical and emotional support form the basis of the care work lactation consultants and doulas provide. Next, I address the question of whether or not this work represents an outsourcing of family life.

Outsourcing Breastfeeding and Labor Support

Maternity clinicians, such as physicians, midwives, and nurses, are limited in their ability to provide breastfeeding and labor support, sometimes due to a lack of training (more common for physicians and nurses), but often due to the fact that they do not have enough time for these incredibly time-consuming aspects of care. Private practice lactation consultants in this study spent 1-2 hours during an initial appointment, and even the busy hospital lactation consultants would sometimes spend an hour with a single patient. Doulas provide continuous support during labor, which means they may spend periods of several hours at a time with a laboring woman over a period of several days.

Health care professionals in this study repeatedly indicated that they did not have the ability to spend time with patients, while lactation consultants and doulas did. For example, Tina, a labor and delivery nurse, explained how doulas freed her up to do other aspects of her job:

It just really does help you being able to do the things you have to do as far as charting. I mean as stupid as that is, you know, not that it's stupid, but it just takes time to do it and—and, you know, rubbing someone's back or being with them in the tub or, um, you know, walking around the unit or using the birthing ball or what—all the, you know, anything that you're using, it does just give you that time to, you know, do other things that you have to do as far as the nursing process.

Similarly, Dr. Ashwin, a family physician, explained how lactation consultants are able to provide her patients with the time they deserve:

In my office, I just don't have the time to give people an hour. And most of the time, if I see someone with so—with a breastfeeding issue, if I can get—if I can get a couple of little tips in 15 minutes, I'm good. But most women deserve that hour and that ongoing follow up.

This lack of time creates the need for someone outside of the traditional maternity care team to provide these types of support.

However, many aspects of lactation consultants' and doulas' care work are types of support that could be provided by unpaid family or friends. This begs the question, why do women turn to lactation consultants and doulas, particularly when they are paying for their services out-of-pocket? I found that some of the reasons women worked with lactation consultants and doulas mirrored themes found in the literature on the outsourcing of family life.

While not a universal experience, several of the clients I interviewed mentioned that they did not have friends or family around who could provide support. This seemed to be more common among doula clients, and was also something doulas mentioned when asked why they thought their clients hired them:

Um, others hire doulas because their—their family, you know, we're—we're a transient society now. You know, you—you may have grown up in a small town but you're in a big city now and all family is back in that small town. So they're hiring doulas because they need the extra mom or a sister figure. (Tamara, a doula)

Even though this line of reasoning was more common in interviews about doulas, it was occasionally brought up in discussions about lactation consultants, as well. As Carleen, a nurse practitioner, said, "I think there are plenty of people who aren't lactation consultants who can provide general support for breastfeeding moms and if they don't have even that, then it's more critical that they have the, uh, lactation consultant type support."

In other cases, clients did have family or friends in the area that could help, but preferred to hire an expert. This reflects both a lack in women's own confidence to birth and breastfeed their baby without the help of an expert, as well as a lack of confidence in friends and family, including partners, to provide adequate support.

Uh, I—I knew, um, I think—my husband and I actually took a very—a—a Saturday Lamaze class and, um, I'm sure—and while that was helpful, uh, I'm sure all of that would have gone out the window had we been left to our own devices on the day of, you know, remembering poses and remembering different,

um, things to do. Um, and—and my husband would say—that’s not a criticism to him—it’s just, you know, the reality of it. (Crystal, doula client)

This perception of lactation consultants and doulas as experts relates to the finding above regarding the need to normalize breastfeeding and childbirth for women. Much of this normalization revolved around a lack of knowledge and/or confidence among clients, and this was reflected in their discussions of why they chose to work with a lactation consultant or doula.

While all of these aspects of lactation consultants’ and doulas’ work seem to illustrate an outsourcing of care, the story is more complex. This transfer of care from family to market is complicated by several factors and is highly influenced by the role of medicalization in childbirth and breastfeeding, both historically and today. Examining the role of medicalization sheds some light on why women feel like an expert is needed to do something women did for centuries.

The Role of Medicalization

The support that lactation consultants and doulas in this study provided occurred in the context of medicalized childbirth and breastfeeding, and this must be taken into account when analyzing these types of care work. The processes of medicalization outlined above fundamentally changed the way we understand birth and breastfeeding. Both practices were, and continue to be, constructed as likely to fail and in need of medical management. For example, women’s ability to produce an adequate quantity of breast milk for their babies came under question during the late 19th century (Wolf, 2001), and continues to be a dominant concern among breastfeeding women (Kelleher, 2006; Lawson & Tulloch, 1995) and their care providers, leading to a perceived need for medical supervision (Dykes, 2005). In the case of childbirth, during the 19th century, the emerging specialty of obstetrics constructed pregnancy and childbirth as pathological and in need of medical intervention (Riessman, 1983; Rothman, 1982; Wertz & Wertz, 1989), and this construction has remained relatively stable over time, where risk is

exaggerated and providers often engage in an active management of labor that relies heavily upon the use of technology and medical intervention (Davis-Floyd, 1994; Simonds, Rothman, & Norman, 2007; Wertz & Wertz, 1989).

The medicalized construction of childbirth and breastfeeding as prone to disorder leads to a pervasive doubt in women's abilities to give birth and breastfeed successfully. Many of the participants in this study described how this doubt creates obstacles for women who want to breastfeed or give birth without medical intervention. Some of these obstacles come from family members who are unsupportive, such as Christine's (lactation consultant client) mother:

My family and including my extended family, nobody breastfed. Um, so my mom still to this day after two children and you look at the size of him (gestures toward her baby), she still said to me just two days ago, 'I don't think he's getting enough.'

This helps to explain why some women turn to lactation consultants and doulas instead of family members for support. Obstacles also come from medical providers:

And when they don't have a doctor that walks in who really is supporting all ten of her wishes [on her birth plan], then here I am—we—I maybe helped her create some of those ideas that are written down. Um, at any point the doctor can just wash it and her and I have to regroup. It can be—it can be a little challenging. (Sherryl, a doula)

Within this context, lactation consultants' and doulas' care work often served the function of avoiding medical intervention. Lactation consultants helped women with breastfeeding positions and expressing milk in order to avoid the use of formula. Doulas provided labor support as a natural form of pain management to avoid childbirth interventions, such as epidurals and cesarean sections. In terms of emotional support, the reinforcement and encouragement that lactation consultants provided was, in part, aimed at addressing the medicalized construction of breastfeeding as likely to fail, particularly in terms of a woman's ability to produce an adequate quantity of breast milk. The emotional support that doulas

provided was intimately linked to the construction of childbirth as pathological and dangerous. As Dr. Clark, an obstetrician explained, “I think doulas can help with the fear of the unknown and I think a lot of labor and delivery is—revolves around fear.”

Medicalization not only impacts the nature and function of lactation consultants’ and doulas’ care work, but it also contributes to why many women do not feel competent to birth or breastfeed their baby without the help of an expert. As discussed earlier, the process of medicalization serves to deskill the public and make them feel uneducated and incapable of making their own health decisions (Starr, 1982; Riessman, 1983). As childbirth and infant feeding became defined in medical terms, they moved into the domain of medical professionals. This only increased as more science and technology were applied to each. Currently, there are a number of medications and technologies used during birth (e.g., Pitocin, epidurals, fetal heart rate monitors) and with breastfeeding (e.g., medications to increase supply, breast pumps, supplemental nursing systems), and research on the nutritional properties of breast milk keeps growing.

As childbirth and infant feeding have moved further into the realm of medical professionals, they have increasingly become private events between a woman and her doctor, and many women do not have exposure to other birthing or breastfeeding women. Sometimes they simply do not know anyone who has breastfed or had a natural birth, like a patient of Denise’s (a lactation consultant), who told her “Nobody in my family has ever breastfed. Nobody in my husband’s family.” Women continue to lack exposure to birthing or breastfeeding women:

Um, and while I have support, you know, with my mother and stuff like that and I was calling her during those times [when I was having difficulties] and she breastfed us, you know, times have changed. She hasn’t done it in 30 years, you know. So remembering how to do certain things is—it is difficult (Elizabeth, lactation consultant client)

Each of these factors provides evidence that the role of lactation consultants and doulas is more than a transfer of maternity support from village to market, but instead, reflects a broader change in maternity care. Gwen's statement pulls together the impacts of medicalization I have discussed:

Um, there was a lot of talk about how you get sort of in the system and I was very particular about how I wanted my birth to go. And so it was really clear that, um, because the system gets so big and you get so wrapped up in it, that it was important to have—that it was really good to have somebody who knows the system there with you so to make sure that you didn't end up somewhere that you didn't want to be. Right? So agreeing to something that you didn't either know what it was or you—it wasn't what you wanted because of the pressure. You know, and sort of being pressured into stuff.

Gwen's experience includes a sense of opposition, and a fear of being coerced into unwanted and/or unnecessary medical interventions, combined with a lack of confidence in one's ability to make their own medical decisions and the need for an expert.

However, Gwen's statement also suggests that a fundamental part of her doula's role was to act as her advocate and guide to the medical maternity system. Each aspect of medicalization I have discussed here contributes to the complexity of navigating the medical system, including the medicalized construction of women's birthing and breastfeeding bodies as prone to disorder, the heavy reliance on medical interventions, and the deskilling of women through the use of science and technology. The system is also made complex by broader changes in health care, such as the role of health insurance, the speed-up of health care services, and the creation of specialized health care roles. Within maternity care, these include (but are not limited to) midwives, obstetricians, perinatologists, family medicine physicians, labor & delivery nurses, postpartum nurses, pediatricians, pediatric nurse practitioners, and neonatologists. A significant part of lactation consultants' and doulas' care work revolved around helping clients navigate this system and advocating for their wishes.

Care Work as Advocacy and Guidance

The physical and emotional support that lactation consultants and doulas provided aligns with what is generally thought of as “care.” However, their caring labor went beyond these types of support. An integral part of the care they provided was to serve as advocates and guides to the medical system. The types of guidance that lactation consultants and doulas provided ranged from little tips about hospital resources to tips on navigating the system and getting the help clients needed. On the little end, Lori always made sure that breastfeeding women with babies in the Neonatal Intensive Care Unit knew they could get free food service, even if they themselves were not a patient at the hospital. Similarly, Heather, a doula, always made sure her clients knew which supplies were covered by their insurance, telling them, “You have paid for all of this with your insurance. Make sure you take all of these things home.” Doula clients also mentioned the value of having a doula who knew where things were in the hospital room, to help them feel quickly accustomed to their environment:

But again, like we arrived at the—at the hospital room and she knew where everything was, what everything needed to—what—whatever needed to be done around in the room like how to get food, where’s the bathroom, where do you get, you know, popsicles (laughs). (Maureen, doula client).

Hospital lactation consultants provided guidance on prescriptions and insurance coverage of breast pumps for women who were having breastfeeding difficulties:

Cindy asks the parents if they have a pump and they say they wanted to know what the options were at the hospital. She asks what insurance they have and says she can call in a prescription for a pump and they can see if insurance will cover it. If the insurance will not cover it, they will at least give a discount. They ask if there are any other options, and Cindy says they can rent one from the hospital or from [a local pharmacy].

At the other end of the spectrum, both lactation consultants and doulas helped their clients navigate the large maternity care system and locate the resources they needed. Monica described well the role that Sharon, the private practice lactation consultant, played in helping her navigate:

When I left the hospital, it wasn't clear to me who I was to call if there was an issue. Um, and so I'm not really calling the pediatrician but then not calling my primary care physician and I am no longer really under the care of the ob/gyn so I didn't really know and so it was—it's nice to have that comfort of going to [Sharon's breastfeeding support group] and if there was an issue that Sharon couldn't help me, she would know where to direct me.

Leslie was a doula client who also needed help locating resources. She had a high risk pregnancy but wanted a low-intervention birth. This created a lot of communication problems between her and her doctors, who were specialists, and she felt like they were not able to help her locate the resources she needed, such as alternative therapies. Her doula, Meredith, on the other hand, was able to help. Leslie told me, "I think that her network ended up being like our most important thing and piece of support for us because she could tell us where to go to get the support that we were lacking from our doctors."

Lactation consultants and doulas were not just knowledgeable about the maternity system and where to locate resources. They also played a large role in advocacy, both advocating for clients by acting as an intermediary between clients and the medical team and assisting clients in advocating for themselves. This is one area where there was a clear difference between lactation consultants and doulas. Because lactation consultants have joined maternity care as lactation specialists, and hold a more formal role within the maternity care system (Torres, 2013), they have the ability to engage in direct advocacy, negotiating with care providers. The following fieldnote is an example of the type of advocate role hospital lactation consultants played. In this situation, Lori had a patient, Monique, who was going to formula feed, but decided to breastfeed instead. Before making this switch, Monique's doctors had ordered a Depo-Provera shot, which she was schedule to receive before leaving the hospital. However, this method of birth control has been shown to decrease milk supply if given during the first six weeks after birth. So, Lori took on the task of seeing if she could get the doctors to wait:

After we leave the room, Lori tells the nurse that she is going to go talk to family medicine about the Depo-Provera shot. She is able to locate a resident from family medicine who works at Monique's clinic. Lori asks if it would be possible to delay the Depo-Provera shot, since Monique has decided to breastfeed, and Lori is worried about the shot affecting her milk supply. The resident says that she knows the patient and that she is at risk of getting pregnant because she's had unprotected sex during the pregnancy. Lori asks if it would be possible to just wait at least a couple of weeks, and the resident says she can do that because she will be able to follow up with Monique at the clinic, which means they do not have to worry about her falling through the cracks. Lori tells her that she will go find someone from Obstetrics, because they are the ones who ordered the Depo. She finds a doctor in the hallway, just as she is about to enter a meeting. Lori explains the situation and says that family medicine is fine with delaying the shot and will follow up with the patient. The doctor says that she will let the others in the meeting know, and that she does not think it will be a problem to wait.

Lori's ability to advocate for this patient and support her breastfeeding success hinged on her ability to navigate the medical system, knowing who the key players are in decisions about birth control and how to convince them to wait.

Doulas have not been as formally integrated into the maternity care system as lactation consultants, but they did also advocate directly for their clients on occasion. For example, Danielle described one situation where her client was on her hands and knees and the baby's head was crowning as the doctor entered the room:

So this was one instance where I did step up because, um, so [the obstetrician] came up and she's kind of looking like, 'What do I do?' you know? And the nurse—one—we had two nurses there. One was very natural and one was not and the one that wasn't looked at the doctor and said, 'Well, you need to deliver her—deliver her how you're most comfortable delivering.' And I looked at the doctor and I said, 'She does not want to be on her back to deliver. Absolutely does not.' The deliver—the doctor, uh, delivered her hands and knees.

Lactation consultants and doulas also helped their clients advocate for themselves, most often through providing them with information. For example, when Sharon had clients whose babies had tight frenulums, commonly referred to as tongue ties, she provided them with the latest research and encouraged them to become familiar with it in order to convince their doctor to clip the frenulum.

Sharon asks Ellen if her family doctor will clip tongue ties, and Ellen says that he looked at it and said it was fine. Sharon says it feels like there is a little bit that could be clipped - that you should be able to run your finger through there under the tongue without getting caught, and you cannot. She says that she will show Ellen where to find the research on tongue ties that she has on her website. Then, Ellen can research it herself and talk to her doctor and tell him about the research when asking for it.

Doulas also provided their clients with information in order to help them advocate for themselves. During prenatal meetings, doulas provided their clients with information on birth procedures and interventions to help them determine what procedures they did or did not want as part of their birth, and to help them feel prepared to discuss these interventions with medical staff during the birth. As Christy explained,

I help in that way more before the birth. Between the classes that they've had and the prenats that we've had and I'll go into specific scenarios of, 'This could happen and then you could say this or do this.' Or, you know, 'It is okay to let them know that you don't want the baby taken for the first hour or two as long as the baby is healthy,' you know, we educate on these things so that they can—I don't feel like I have to do a lot of intervening with their communication at a birth.

There was one last form of advocacy that only doulas employed. As I have described elsewhere (Torres, 2013), doulas experience more overlap in occupational boundaries within maternity care than do lactation consultants, which can create conflict. As a result, doulas also employed a method of advocacy that fell between advocating for clients and teaching them to advocate for themselves. They alerted clients to when a medical intervention was about to be performed, creating an opportunity for them to ask questions or to deny that intervention.

If the nurse or doctor suggests something, I might do this (gestures) with my finger and just point to my brain so that they can stop and at that time either the partner or, you know, the laboring person knows enough then to stop and say, "Wait a minute. What are the benefits, risks, alternatives, intuition? And I need time." And so just pointing to my brain kind of reminds them to say, "Wait a minute. We need to talk about this procedure that you're wanting to do." That's my only secret code. I don't have any other ones. Just use your brain. (Brenda, a doula)

When looking at all of these factors together, it becomes apparent that the role of lactation consultants and doulas is more than an outsourcing of maternity support. It reflects a fundamental change in the meaning and function of this type of care work, due, in large part, to transformations in our understanding of, and practices around, childbirth and breastfeeding as a result of medicalization.

Discussion

There are aspects of lactation consultants' and doulas' care work that appear to be an outsourcing of care, a transfer of breastfeeding and labor support from family to market. In some respects, it appears that women pay lactation consultants and doulas to provide these types of support because they are isolated from kin networks. There is also some evidence to suggest that women work with lactation consultants and doulas because they lack the confidence to birth or breastfeed without the help of an expert, or they think the help they can get from the service market is superior to what friends or family members can provide, similar to those in Hochschild's (2012) research. However, the existence of paid lactation and labor support also reflects a much larger issue – a fundamental change in the nature of these types of care work that is impacted by medicalization.

Although there have been changes over time that have contributed to the demedicalization of childbirth and breastfeeding, they still remain highly medicalized, and this is reflected in lactation consultants', doulas', and clients' experiences. This context impacts the care that lactation consultants and doulas provide. It also means that they are not only providing the types of support that were provided during the days of social childbirth, but are taking on an entirely new role - the role of advocate and guide to the medical maternity system, a system that is often difficult to navigate for women who wish to avoid medical intervention in childbirth or

breastfeeding. In this way, they represent a change in the nature of caring within the context of childbirth and breastfeeding support.

This research contributes to the literature on care work by adding complexity to our understanding of why certain forms of care are provided by the market. As Duffy (2011) has pointed out, it is critical that we look at these transitions within the larger social and cultural context, particularly in the ways that the meaning of care changes over time. In the context of breastfeeding and labor support, the meaning of care has broadened to include advocacy and guidance, and this is a key factor in the commercialization of these forms of support. This also indicates the need for a broader understanding of what constitutes care, for it is unlikely that this is the only context within which advocacy and guidance are an integral part of caring.

This article also adds something novel to the care work literature by incorporating a thorough understanding of the process of medicalization. Both the care work and medicalization literatures are voluminous, yet have not been brought into conversation with one another to this extent. Integrating the concept of medicalization into our conversations around care work provides an incredibly useful lens for understanding both the changing locations and meanings of care over time. There are many aspects of outsourced and commercialized care that are impacted by medicalization and could benefit from a more in-depth analysis of its impact (e.g., surrogacy, elder care, home care).

One important future direction for this research is a more thorough analysis of the role of race and class in the commercialization of breastfeeding and labor support. Some have raised concerns about the lack of women of color in these occupations (Kozhimannil et al., 2013; U.S. Department of Health and Human Services, 2011), something that is reflected in my sample, as well, and can affect the cultural competence of care provided. Also, while hospital-based

lactation consultants are usually paid by insurance (for those who are insured), outpatient and community lactation consultant services, as well as doula services, are often not covered, which is definitely cost-prohibitive for many women. One caveat to this is that the Affordable Care Act now requires health plans to cover breastfeeding support; however, it remains to be seen how this will affect access to these services. Given my findings that lactation consultants and doulas act as advocates and guides to the medical system, race and class disparities in access to these services have serious implications for equality in the provision of maternity care, especially in light of existing research that has linked social status, including race and socioeconomic status, to disparities in health and health care through such mechanisms as sense of control (Mirowsky & Ross, 1998) and cultural health capital (Shim, 2010; Dubbin, Chang, and Shim, 2013). According to Shim (2010), cultural health capital, “a specialized form of cultural capital that can be leveraged in health care contexts to effectively engage with medical providers” (p. 3), is stratified by social status and serves to reinforce or even increase health disparities, in part, by assisting individuals in navigating the complex medical system. In a sense, lactation consultants and doulas are providing a boost to their clients’ cultural health capital. Therefore, if these services are stratified by race and class, this can only serve to deepen existing health disparities in maternal and infant health.

In all, this article brings a much needed perspective to the care work literature by incorporating an understanding of the impact of medicalization on formations of care. Through an examination of the caring labor of lactation consultants and doulas, I have been able to illustrate that these occupations do not represent a simple outsourcing of care. Rather, their role signifies a fundamental transformation in the meaning and function of breastfeeding and labor

support within the highly medicalized context of maternity care, so that lactation consultants and doulas are filling a need for advocates and guides to the complex medical maternity system.

Works Cited

- American Academy of Pediatrics. (2012). Breastfeeding and the use of human milk. *Pediatrics*, 129(3), e827-e841.
- Apple, R. D. (1987). *Mothers and medicine: A social history of infant feeding, 1890-1950*. Madison, WI: University of Wisconsin Press.
- Blum, L. M. (1999). *At the breast: Ideologies of breastfeeding and motherhood in the contemporary United States*. Boston: Beacon Press.
- Boris, E., & Parreñas, R. S. (2010). *Intimate labors: Cultures, technologies, and the politics of care*. Stanford, CA: Stanford Social Sciences.
- Braverman, H. (1974). Labor and monopoly capital. *Monthly Review*, 26, 3.
- Burns, E., Schmied, V., Fenwick, J., & Sheehan, A. (2012). Liquid gold from the milk bar: Constructions of breast milk and breastfeeding women in the language and practices of midwives. *Social Science & Medicine*, 75(10), 1737–1745.
- Conrad, P. (2007). *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore, MD: Johns Hopkins University Press.
- Conrad, P., & Schneider, J. W. (1980). *Deviance and medicalization: From badness to sickness*. St. Louis: Mosby.
- Dalla Costa, M. (1972). Women and the subversion of the community. *Radical America*, 6(1), 67-102.
- Davis, J. E. (2006). How medicalization lost its way. *Society*, 43(6), 51-56.
- Davis-Floyd, R. E. (1994). The technocratic body: American childbirth as cultural expression. *Social Science and Medicine*, 38(8), 1125-1140.
- Declercq, E., Sakala, C., Corry, M., Applebaum, S., & Herrlich, A. (2013). *Listening to mothers III: Pregnancy and childbirth*. New York: Childbirth Connection.
- Dizard, J. E. & Gadlin, H. (1990). *The minimal family*. Amherst: University of Massachusetts Press.
- DONA International. (2005). *What is a doula?* <http://www.dona.org/mothers/index.php>. Accessed February 14, 2014.
- DONA International. (2010). *Member statistics*. <http://www.dona.org/aboutus/statistics.php>. Accessed February 14, 2014.
- Dubbin, L. A., Chang, J. S., & Shim, J. K. (2013). Cultural health capital and the interactional dynamics of patient-centered care. *Social Science & Medicine*, 93, 113-120.

- Duffy, M. (2011). *Making care count: A century of gender, race, and paid care work*. New Brunswick, NJ: Rutgers University Press.
- Dykes, F. (2005). 'Supply' and 'demand': Breastfeeding as labour. *Social Science & Medicine*, 60(10), 2283-2293.
- Emerson, R. M., Fretz, R. I., & Shaw, L. L. (1995). *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.
- England, P., Budig, M., & Folbre, N. (2002). Wages of virtue: The relative pay of care work. *Social Problems*, 49(4), 455-473.
- Glenn, E. N. (1992). From servitude to service work: Historical continuities in the racial division of paid reproductive labor. *Signs*, 18(1), 1.
- Glucksmann, M. A. (1995). Why 'work'? Gender and the 'total social organization of labour'. *Gender, Work and Organization*, 2(2), 63-75.
- Glucksmann, M. & Nolan, J. (2007). New technologies and the transformations of women's labour at home and work. *Equal Opportunities International*, 26(2), 96-112.
- Hartmann, H. (1976). Capitalism, patriarchy, and job segregation by sex. *Signs*, 1(3), 137-169.
- Hochschild, A. R. (2003). *The commercialization of intimate life: Notes from home and work*. Berkeley: University of California Press.
- Hochschild, A. R. (2012). *The outsourced self: Intimate life in market times*. New York: Metropolitan Books.
- International Board of Lactation Consultant Examiners. (2012a) Scope of practice for international board certified lactation consultants (IBCLCs). Retrieved from <http://iblce.org/wp-content/uploads/2013/08/scope-of-practice.pdf>. Accessed February 14, 2014.
- International Board of Lactation Consultant Examiners. (2012b). *Facts and figures*. <http://americas.iblce.org/facts-and-figures>. Accessed June 10, 2013
- International Board of Lactation Consultant Examiners. (2013) History. <http://iblce.org/about-iblce/history/>. Accessed February 14, 2014.
- International Lactation Consultant Association. (2013). *What is an IBCLC?* <http://www.ilca.org/i4a/pages/index.cfm?pageid=3832>. Accessed February 14, 2014.
- Kelleher, C. M. (2006). The physical challenges of early breastfeeding. *Social Science & Medicine*, 63(10), 2727-2738.

- Kozhimannil, K. B., Hardeman, R. R., Attanasio, L. B., Blauer-Peterson, C., & O'Brien, M. (2013). Doula care, birth outcomes, and costs among Medicaid beneficiaries. *American Journal of Public Health, 103*(4), E113-E121.
- Lair, C. D. (2012). Outsourcing and the contracting of responsibility. *Sociological Inquiry, 82*(4), 557-577.
- Lawson, K., & Tulloch, M. (1995). Breastfeeding duration: Prenatal intentions and postnatal practices. *Journal of Advanced Nursing, 22*(5), 841-849.
- Mirowsky, J., & Ross, C. E. (1998). Education, Personal Control, Lifestyle and Health: A Human Capital Hypothesis. *Research on Aging, 20*(4), 415-449.
- Morton, C. H. (2002). Doula care: The (re)-emergence of woman-supported childbirth in the United States. (Doctoral dissertation). Retrieved from Dissertations & Theses: A&I. (Publication No. AAT 3059588).
- Norman, B. M., & Rothman, B. K. (2007). The new arrival: Labor doulas and the fragmentation of midwifery and caregiving. In W. Simonds, B. K. Rothman, & B. M. Norman (Eds.), *Laboring on: Birth in transition in the United States* (pp. 251-281). New York: Routledge.
- Riessman, C. K. (1983). Women and medicalization: A new perspective. *Social Policy, 14*(1): 3-18.
- Rothman, B. K. (1982). *In labor: Women & power in the birthplace*. New York: Norton.
- Parreñas, R. S. (2000). Migrant Filipina domestic workers and the international division of reproductive labor. *Gender & Society, 14*(4), 560-580.
- Sandelowski, M. (1984). *Pain, pleasure, and American childbirth: From the twilight sleep to the read method, 1914-1960*. Westport, CT: Greenwood Press.
- Sherman, R. (2010). "Time is our commodity": Gender and the struggle for occupational legitimacy among personal concierges. *Work and Occupations, 37*(1), 81-114.
- Shim, J. K. (2010). Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment. *Journal of Health & Social Behavior, 51*(1), 1-15.
- Simonds, W., Rothman, B. K., & Norman, B.M. (2007). *Laboring on: Birth in transition in the United States*. New York: Routledge.
- Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.
- Stolzer, J. (2006). Breastfeeding: An interdisciplinary review. *International Review of Modern Sociology, 32*(1), 103-128.

- Torres, J. M. C. (2013). Breast milk and labour support: Lactation consultants' and doulas' strategies for navigating the medical context of maternity care. *Sociology of Health and Illness*, 35(6), 924-938.
- U.S. Department of Health and Human Services. (2011). *The Surgeon General's call to action to support breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.
- Wertz, R. W., & Wertz, D. C. (1989). *Lying-in: A history of childbirth in America*. New Haven: Yale University Press.
- Wolf, J. H. (2001). *Don't kill your baby: Public health and the decline of breastfeeding in the nineteenth and twentieth centuries*. Columbus: Ohio State University Press.

Chapter 4

Expertise and Sliding Scales: Lactation Consultants, Doulas, and the Relational Work of Breastfeeding and Labor Support

Introduction

The combination of money and intimacy is a growing area of sociological investigation. While some believe that these two areas of social life cannot be combined without contaminating one another, what Viviana Zelizer (2005) calls the “hostile worlds” perspective, others have argued that they are combined in many ways all around us, and money can actually serve to maintain relationships (Boris & Parreñas, 2010; Zelizer, 2005). One area where the hostile worlds perspective is often applied is that of care work. While there is no single agreed-upon definition of care work, most provide one similar to that of England, Budig, & Folbre (2002):

We use the term ‘care work’ (or caring labor) to refer to occupations in which workers are supposed to provide a face-to-face service that develops the human capabilities of the recipient. By ‘human capabilities’ we refer to health, skills, or proclivities that are useful to oneself or others. These include physical and mental health, physical skills, cognitive skills, and emotional skills, such as self-discipline, empathy, and care. (p. 455).

Those who hold a hostile worlds perspective show concern about the quality of care that is provided for pay (Boris & Parreñas, 2010; Himmelweit, 1999; Hochschild, 2003; Popenoe, 1993; Stone, 2000; Zelizer, 2005). This results from the gendered construction of caring as a natural quality of women and, therefore, something that should be given freely (Daniels, 1987; Davies, 1995, 1996; Duffy, 2011). One outcome of a hostile worlds perspective on caring is that, when

caring is viewed as corrupted by money, this can lead to lower wages for care work as a way to protect the quality of care provided (Boris & Parreñas, 2010; Zelizer, 2005). Research finds that the hostile worlds perspective is, in fact, incorrect, and that individuals can genuinely care for those for whom they are paid to care, yet the belief that money corrupts intimacy creates difficulties in managing the two simultaneously (Stone, 2000; Tuominen, 2003).

I examine the combination of money and intimacy in the work of two relatively new occupational groups - International Board Certified Lactation Consultants (IBCLC) and DONA International (formerly Doulas of North America) Certified Birth Doulas (CD(DONA)). Lactation consultants provide breastfeeding support and doulas provide physical, emotional, and informational support to childbearing women. As care workers providing support within the intimate context of childbirth and breastfeeding, these two groups offer an excellent opportunity for investigating the combination of money and intimacy. Furthermore, while caring, in general, is constructed as women's work, breastfeeding and labor support are forms of care that also occur in the highly gendered context of reproduction. This makes them an especially fruitful site for examining the impact of gender on negotiations of paid intimacy. Also, it is not only lactation consultants and doulas who are affected by the hostile worlds perspective, as clients must also negotiate this relationship and the act of paying for these types of care. Therefore, this article asks the question: How do lactation consultants, doulas, and clients negotiate the combination of money and intimacy in the highly gendered context of paid breastfeeding and labor support?

Background

“Hostile Worlds” and Relational Work

The “hostile worlds” (Zelizer, 2005) perspective is based on separate spheres ideology, which constructs dichotomies of intimacy/economy, sentiment/rationality, family/market. In this

view, these separate spheres need to be kept insulated from one another because their mingling results in contamination. As Zelizer (2005) explains,

Their mixing, goes the theory, contaminates both; invasion of the sentimental world by instrumental rationality desiccates that world, while introduction of sentiment into rational transactions produces inefficiency, favoritism, cronyism, and other forms of corruption (p. 23).

Those who critique the hostile worlds view often point out that money and intimacy are combined in many ways all around us (Almeling, 2007; Boris & Parreñas, 2010; Cook, 2009; Folbre & Nelson, 2000; Haylett, 2012; Hoang, 2011; Nelson, 1999). Zelizer (2005) points to examples such as alimony and child support, children's allowances, wedding gifts, and engagement rings. She shows that, not only does money not corrupt intimacy in these pairings, but it often sustains it. That is because the pairing of money and intimacy is a process of defining social relations and agreeing upon which economic transactions are appropriate for that relationship.

Building upon the work of Charles Tilly, Zelizer labels this process "relational work." A key component of relational work is negotiating a "relational package" that is agreed upon as appropriate by those involved. This negotiation consists of balancing three components: "distinctive interpersonal ties," "economic transactions," and "media" for those transactions (Zelizer, 2012, p. 151). Money is obviously one type of media for economic transactions, but media can also be items such as in-kind goods, or even favors. Zelizer's work has been highly influential, and others have used her concepts to analyze the blending of money, intimacy, and culture in areas of social life as varied as egg donation (Almeling, 2007; Haylett, 2012), art markets (Cosler, 2010), and sex work (Hoang, 2011). When applied to care work, her concepts illustrate that paid caring represents much more than a simple exchange of money and

intimacy/care, and in order to truly understand the impact of commercialization on those involved, we need to examine the context in which it occurs (Boris & Parreñas, 2010).

The Role of Gender

Gender impacts the negotiation of money and intimacy in many ways. From the work of Almeling (2007), supported by Haylett's (2012) findings, we know that egg donation is impacted by cultural understandings of selfless motherhood, constructing it as a gift exchange rather than buying/selling eggs. Sherman's (2010) research on personal concierges illustrates how the construction of domestic work as the unpaid work of wives and mothers impacts concierges' claims to legitimacy as an occupation. In the context of care work, gender plays an important role, due to the way in which it is mapped onto separate spheres, and thus, the hostile worlds perspective. The dichotomy of sentiment/rationality is overlaid with the dichotomies of private/public, woman/man, unskilled/skilled (Daniels, 1987; Nelson & England, 2002). As a result, caring is constructed not only as belonging to the private sphere of the home, but is also believed to be an innate characteristic of women (Daniels, 1987; Davies, 1995; Davies, 1996; Duffy, 2011; Waerness, 1996). As Arlene Kaplan Daniels (1987) explained,

The closer the work to the activities of nurturing, comforting, encouraging, or facilitating interaction, the more closely associated it is with women's 'natural' or 'feminine' proclivities. Such activity is not seen as learned, skilled, required, but only the expression of the character or style of women in general (p. 408)

As a result, women are expected to provide care out of love, kinship, or obligation (Boris & Parreñas, 2010; Glenn, 2010). This can also lead to the belief that the best, most genuine care is that which is provided by the family (i.e. mother), and the market is seen as encroaching upon, or even corrupting, care (Folbre & Nelson, 2000; Nelson, 1999; Stone, 2000; Zelizer, 2005). For example, Popenoe (1993) states that, "the family is by far the best institution" for providing care, and questions the quality of care provided by others (p. 539). Others accept the possibility of

high-quality paid caring, but nonetheless, warn against the complete commodification of caring (Himmelweit, 1999) or the impinging “commodity frontier” (Hochschild, 2003).

Several researchers have shown that genuine caring can be combined with paid employment. Stone (2000) used examples from across a variety of caregiving occupations to illustrate how these individuals strive to provide “good care” similar to that which they would provide to their own kin, even when the rules and policies of the organizations for which they work create barriers to quality caring (e.g., time constraints, encouraging detachment). Similarly, the nursing home staff in Dodson & Zircavage’s (2007) research often regarded residents as fictive kin. Tuominen’s (2003) research on family child-care work emphasized the blending of public and private that happens in this context, where child care is not motivated only by women’s love for children, but is performed as an income-generating activity. All of the women in her study used their income from providing child-care to help support their own families, yet this did not preclude them from developing genuinely caring relationships with the children for whom they cared. Additionally, many of them described their work as motivated by their own personal values and their feelings of responsibility to the community. Tuominen’s research supports Folbre & Nelson’s (2000) claim that childcare markets can be “rich” markets where “the movement of money is only one dimension in a complex relationship” (p. 130).

The blending of money and intimacy into an appropriate relational package does not occur without challenges, however. In Stone’s research, caregivers often had to break the rules of the organizations for which they worked in order to provide the type of care they thought was appropriate, which sometimes created anxieties around losing their jobs. In the nursing homes in Dodson & Zircavage’s study, “family care” was encouraged. However, this often served to exploit the low-paid workers. Similarly, Tuominen found that child care providers were

sometimes exploited by parents of the children for whom they cared, who would pick their children up late, often without providing extra remuneration. Care providers also exhibited a fair amount of flexibility in setting fees, particularly for parents who were having financial difficulties, even when the fees were an important source of income for their own families. Tuominen sees these as examples of the difficulty with combining paid work with caring, given the dominance of separate spheres ideology. This is closely related to another criticism of the hostile worlds view - that it can, often unintentionally, reinforce the low pay of care work.

The Relative Low Pay of Care Work

The fact that care work is low-paid is supported with empirical evidence (England, Budig, & Folbre, 2002). However, there are several theories for why this is the case (for a good review, see England 2005). Some have raised concerns about the impact of the hostile worlds view on caring wages (Boris & Parreñas, 2010; Zelizer, 2005). They reason that, if one believes that money corrupts caring, then the extension of this logic would be that someone who gets paid to care would be less genuine than someone who did it for purely altruistic motives. If one believes that the best care is that which is given freely, this can serve to maintain low wages for care workers. Also, when caring is seen as a natural characteristic of women, it is not regarded as a learned skill worthy of payment (Daniels, 1987; Davies, 1995, 1996; Sherman, 2010; Waerness, 1996). Duffy (2011) has shown that the belief that caring is a natural part of women's character was a key factor in the feminization of caring occupations, such as nursing and teaching. While on the one hand, these occupations were constructed as feminine in order to allow women to move into paid labor while keeping their femininity intact, they were also feminized because tying the requirements for care work to the character of women, rather than to learned skills, was a way to justify lower wages. Also, as can be seen in Tuominen's (2003)

research above, when caring is seen as natural, it can be difficult to get paid for it and care workers can easily be exploited.

This study adds to the literature by examining the caring labor and relational work of two relatively new occupational groups: International Board Certified Lactation Consultants and DONA International birth doulas. Lactation consultants provide breastfeeding support to nursing mothers and “protect, promote and support breastfeeding” (International Board of Lactation Consultant Examiners [IBLCE], 2012, p. 1) in a variety of settings, including hospitals, doctors’ offices, clinics and community centers, and as private practice consultants. DONA birth doulas work with women birthing in hospitals, birth centers, and at home, providing them with physical, emotional, and informational support before, during, and just after birth (DONA, 2013a). The IBCLC certification was created in 1985 and there are currently 26,500 certificants in 96 countries (IBLCE, 2013). DONA International created the birth doula certification in 1992 and they have over 6,000 members across the world (DONA, 2013b). By examining their care work within the context in which it is provided, I am able to illustrate the complexity of the caring relationships that lactation consultants and doulas establish with their clients, as well as the ongoing negotiation of money and intimacy in those relationships through the process of relational work and the construction of relational packages.

Methods

The data for this article were taken from a larger project on lactation consultants and doulas and their roles in the maternity care system that was conducted in Michigan. The findings presented in this article are based upon interviews with 19 lactation consultants, 18 birth doulas, 17 clients/patients, and 18 health care professionals (doctors, midwives, and nurses), as well as 150 hours of ethnographic observation, where I job shadowed three lactation consultants over a

period of nine months. Two of these lactation consultants, whom I have given the pseudonyms Lori and Cindy, work in hospitals in the study area. Both hospitals provide outpatient breastfeeding care, as well, but this clinic is much more active at Lori's hospital. The third lactation consultant, Sharon, is in private practice in the community. I was able to recruit two doulas to participate in the ethnographic observation, but was unable to find a client willing to consent to my presence at their birth.

I recruited lactation consultants and doulas through contact lists of certified IBCLCs and DONA doulas retrieved from websites. The lactation consultant websites were ILCA.org (International Lactation Consultant Association), the professional organization for IBCLCs, and Breastfeeding.com, a website designed for breastfeeding women. The doula website was DONA.org, the professional organization and certifying agency for DONA International doulas. All lactation consultants and doulas who participated in the study worked for pay at least some of the time.

I recruited lactation consultant and doula participants for the observational portion of the research from those interviewed. I recruited clients/patients and health care professionals during observation and through snowball sampling. All clients interviewed had worked with one of the lactation consultants or doulas in the study. Interviews were semi-structured and all were audio-recorded. Participants also filled out contact information and a short demographic questionnaire. Interview participants were each compensated \$20. The Institutional Review Board approved this study.

All of the lactation consultants, doulas, and clients in this study were women (although two male partners did participate in client interviews). The vast majority of lactation consultants and doulas in this study were white, with the exception of one Black lactation consultant, two

Black doula, and one multi/bi-racial doula. The annual household income for lactation consultants ranged from a minimum of \$20,000-39,999 to a maximum of \$160,000-179,999, with a median of \$100,000-119,999. The annual household income for doula ranged from a minimum of \$20,000-39,999 to a maximum of \$140,000-159,999, with a median of \$60,000-79,999. While I did observe the hospital lactation consultants working with a fairly race- and class-diverse population, all of the lactation consultant and doula clients who agreed to participate in interviews were white, with a median annual household income of \$100,000-119,999 (for each group), and all had at least a college degree. The participants in this study are obviously not representative of the general U.S. population. However, it is difficult to determine how representative they are of the populations of IBCLCs, DONA birth doula, and women who work with them, because there is very little data on this topic.

All interviews were transcribed verbatim. During observation, I took fieldnotes with pen and paper, noting the interactions of lactation consultants with both patients/clients and health care professionals. Most of the time, I sat or stood quietly in the room, although I was at times brought into conversation by either the lactation consultants or clients/patients. I developed full fieldnote accounts from my field jottings after leaving the field and returning to my office.

I analyzed interview transcripts and fieldnotes through a process of open and focused coding, as described by Emerson, Fretz, & Shaw (1995). First, I identified code categories through systematic open coding. Then, through a process of memoing, I analyzed these codes for patterns and organized them into core themes, which I then broke down into subthemes through focused coding. The quotes and fieldnote excerpts presented here are representative of the data within each theme or subtheme from which they were chosen.

Findings

Lactation Consultants' and Doulas' Caring Labor

Lactation consultants and doulas provided both physical and emotional support as part of their caring labor. The two main types of physical support that lactation consultants provided were assisting with nursing positioning and expressing breast milk. Positioning entailed helping women and their babies find comfortable positions for breastfeeding and assisting women with getting babies to latch onto the breast correctly and remain latched on. Oftentimes, this was for new mothers who did not have experience with breastfeeding, but it was sometimes also provided for mothers who were experiencing difficulties that they did not have with their previous child(ren). In many instances, lactation consultants spent quite a bit of time working through different positions until they found one that worked for both the woman and the baby, like in this fieldnote with Cindy and Jessie:

Jessie begins to latch the baby onto her right breast using the cradle position, with the baby's head cradled in the crook of her right elbow. She is having difficulty, so Cindy helps her readjust her hands so they are in the cross cradle position instead, with her left hand supporting his neck and head and her right hand supporting her breast. The baby still isn't latching, so Cindy illustrates how to hand express some milk by holding Jessie's breast on both sides, pressing in toward the chest wall, squeezing, and pulling out, but no milk comes out. Cindy then tickles the baby's lips with the nipple and he latches. Cindy explains that he does it by feel, so he needs to get close to Jessie's skin.

This fieldnote also represents the second aspect of lactation consultants' hands-on assistance – teaching various methods of expressing milk. This included using a breast pump, hand expressing (as Cindy did with Jessie), and using breast compression while nursing to increase the amount of milk transferred. Another thing represented in this fieldnote is the intimate nature of the support lactation consultants provided. Not only were they working with women during the early hours and days of parenting a new baby, but they were physically handling women's and their babies' bodies. In this fieldnote, Cindy squeezes Jessie's breast to express milk and then holds her breast, brushing her nipple against her baby's mouth.

Doulas provided physical support to their clients throughout the perinatal period. During prenatal appointments, they worked with women and their partners to practice laboring positions and comfort measures. Some of them also offered prenatal massage services. During postpartum visits, many of them offered basic breastfeeding assistance, such as positioning. However, the bulk of the physical support doulas provided was performed during labor. Doreen described some of the labor support techniques she uses with her clients:

We do warm water showers where we have them on their knees over a big birthing ball and we'll run the hot water—or not the hot water but warm water against their tailbone... We also have counter-pressure, which is, um, when the baby is expanding in the, uh, birth canal and in the pelvic area and you're stretching like this (demonstrates) and that hurts, what we'll do is we'll counter-pressure that.

Other forms of labor support mentioned by doulas included taking their client to the bathroom, massaging, holding a leg during pushing, and walking around with the laboring women. Again, these are very intimate forms of support. Doulas are working with women and their partners during the process of giving birth, providing physical touch and observing intimate parts of their bodies.

In addition to these forms of physical support, both lactation consultants and doulas provided emotional support. Much of this support revolved around normalizing aspects of breastfeeding and labor. As Leslie, a doula client explained:

I think our biggest—biggest thing was just having somebody who knew, um, this is our first child so we didn't really know what to expect. And like I said, we don't have any family here so we kind of wanted somebody who knew what the process was and what to expect and kind of help us know what was normal and what was not normal.

Lactation consultants' often normalized issues of milk supply, especially during the first few days before mothers' milk “came in” and they were producing small amounts of colostrum.

Cindy often explained to mothers that colostrum is “very concentrated” and that the newborns' stomachs are very small (“the size of a quarter”), so they do not need much.

In addition to this normalization, a significant aspect of the emotional support that lactation consultants and doulas provided centered around helping women (and their partners) cope when things did not go as planned. Childbirth and the transition to parenting a new child are, for most, an incredibly emotional experience. When that process was interrupted by unforeseen complications, lactation consultants and doulas worked with their clients to process their emotions and work through the difficulties. For lactation consultants, these were often temporary situations, like needing to supplement with formula to stabilize blood sugar. They also included unexpected complications with the baby, such as needing to go to the Neonatal Intensive Care Unit (NICU), which complicates breastfeeding. Judith discussed working with NICU mothers and babies:

That's our first thing to make sure she has a good milk supply. As the baby is getting better we are going to start working on getting the baby to breast, and sending her away with a plan, because most of our premature babies don't go home fully breast feeding. They have to go home breast, supplement, and pump.

Sometimes, lactation consultants' work included helping women cope with the fact that they would never be able to breastfeed their baby exclusively. In most cases, lactation consultants only worked with women who were experiencing breastfeeding difficulties, so these types of emotional support comprised a sizeable portion of their work.

For doulas, the emotional support of helping to cope with difficult situations most often centered around helping women adjust when their birth strayed from their birth plan. For example, Maureen experienced back labor, which is difficult for any woman, but was especially difficult for her because, as she explained, "I've had, um, issues with my back for like a couple of years so I'll go through like periods of back pain, um, and that just felt like a slap in the face." After 16 hours of back labor, she decided to get an epidural. Afterwards, Maureen processed her

decision with her doula, Meredith, who told her “what you went through is not normal labor,” which helped Maureen deal with the change in her plans:

So just have that feedback that like, everything from your birth plan changed, but like it was based on, you know, it wasn't because I was going back on what I had thought; it was because the circumstances were different and it was really reassuring for me to hear that from someone who knew what they were talking about.

Some women hired doulas because they were afraid of being coerced into medical interventions, and they wanted a knowledgeable birth attendant to help them avoid this situation. So, when things did not go as planned, doulas did a fair amount of processing with women (and partners), talking about the birth and helping them feel like they made the right decision given the circumstances.

For doulas, in particular, one last form of care work they performed was helping to enhance the relationship between a laboring woman and her partner. This form of support falls in between physical and emotional support, because it often entailed helping the partner to physically support the woman. Sometimes this included showing him/her specific comfort measures or labor support techniques that were most helpful at that moment, like Danielle, a doula, explained:

I have had dads who thought that they would not be involved at all and it is a beautiful thing, um, to be able to give the little bit of, you know, hints here and there and they just (snaps fingers) pick right up on it and are the support person that the mom wants them to be. Um, and they never thought that they could be. That's really cool.

This further illustrates the intimate nature of doulas' care work. Not only were they providing physical and emotional care, but they were working to make childbirth an opportunity to enhance the relationship between the laboring woman and her partner.

Having established what the caring labor of lactation consultants and doulas looks like, I now turn to a discussion of how lactation consultants, doulas, and their clients negotiate appropriate relational packages in the context of this form of paid care work.

The Relational Work of Paid Breastfeeding and Labor Support

Much like the care workers in previous research (Dodson & Zinavage, 2007; Stone, 2000; Tuominen, 2003), lactation consultants and doulas cared deeply about their clients and received much personal satisfaction from supporting women through childbirth and breastfeeding. As Gina, a lactation consultant, explained, “I take my job very, um, I guess it-, it’s a passion. And, um, it’s just seeing her succeed, and the look on her face, and watching the baby feed on the breast. I think that’s the greatest thing.” This level of passion coexisted with the fact that the lactation consultants and doulas in this study performed this work as an income-generating activity.

Employment and household financial situations for lactation consultants and doulas in this study varied quite a bit. While some of them performed this work full-time, others were retired, working part-time or full-time in other jobs, or home caring for their children when not working in their lactation consultant or doula capacity. For many of them, the money they earned as lactation consultants or doulas was an important part of their household income, and a few were the sole-earner for their household. Lactation consultants working in hospitals were formal employees of those hospitals, working part-time or full-time (both Cindy and Lori work full-time). Many of the community lactation consultants (including Sharon) and doulas considered their work a business. Janet, a doula explained,

I went to a lot of DONA conferences around the country to get involved with more women that had the same passion I have. So it just fired me up, you know. So then eventually I—I turned it into my own business and started charging for my services.

This illustrates how, in contrast to a situation of “hostile worlds,” where the market corrupts genuine care, lactation consultants and doulas are an example of Zelizer’s (2005) concept of “connected lives.” They and their clients are negotiating a relationship, and in this case, that relationship is compatible with payment. However, lactation consultants, doulas, and their clients

all had to engage in a fair amount of relational work in order to construct this paid intimacy as an appropriate relational package.

In Zelizer's discussions of relational work, she often provides examples where the parties involved must determine the appropriate economic transactions and media for the type of relationship between them. She describes this process in the following way:

For each meaningfully distinct category of social relations, people erect a boundary, mark the boundary by means of names and practices, establish a set of distinctive understandings that operate within that boundary, designate certain sorts of economic transactions as appropriate for the relation, bar other transactions as inappropriate, and adopt certain media for reckoning and facilitating economic transactions within the relation (2005, p. 34).

However, she has also posed the question of how this process might work in the reverse direction by asking "what determines the kind of social relation that people establish for different sorts of economic transactions" (2012, p. 163). I find that the relational packages that lactation consultants, doulas, and their clients construct involve negotiating in both directions. Most of the relational work revolved around the latter - determining appropriate social relations for certain types of economic transactions. However, in some cases, it involved determining the appropriate economic transaction and media for particular categories of social relations. Both types of negotiations are heavily influenced by gender.

Negotiating Social Relations: Experts and Objectivity

A large part of the relational work that lactation consultants, doulas, and clients performed involved differentiating this type of relationship from others, particularly those of family and friends. This process of boundary drawing was impacted by the mapping of gender onto separate spheres. As explained above, when caring is seen as an innate characteristic of women, it is not regarded as a learned skill. Therefore, lactation consultants, doulas, and their clients constructed their care as expert in order to differentiate it from familial care. Clients

described lactation consultants and doulas as experts, as individuals who are much more knowledgeable about breastfeeding and birth than themselves or their friends and family.

Theresa, a lactation consultant client, expressed this sentiment when talking about her experiences with Cindy:

I think that [lactation consultants] kind of play an indispensable role for nursing moms, especially if, you know, like you've never done it before. Lots of my friends are on their second, third or fourth child and they've breastfed all of them so it's kind of all pat, you know. So when I was asking them questions, they were kind of like, 'Well, I don't really remember (both laugh).' Because they—'I don't really remember the first one. I remember the fourth,' you know. Like and so I was like, 'Well, that doesn't really help me.'

Carolyn expressed a similar sentiment when she told me, "I mean having your spouse or whoever, your, you know, familial support person there is all well and good, but realistically, they're not an expert on childbirth."

Another method of drawing boundaries only appeared in the context of doula work, which was the belief that it was beneficial to receive labor support from someone who was not intimately related to the client. This was particularly the case for doula clients who were worried that their family members were "not helpful" or would "freak out" during the stress of childbirth. This is something many of the doulas also mentioned, explaining that their lack of emotional connection allowed them to be objective, which is helpful for clients who are making decisions about whether or not they want certain interventions (e.g., epidurals). Kelly explained it as, "I am the person who is not emotionally attached to this birth. I can step away and have a very objective view of what's happening." Because doulas provided their clients with physical, emotional, and *informational* support, being a non-family member was believed to assist in providing objective information in the moment. However, this framing of objectivity also does the work of constructing the doulas' role as something different from familial support, and therefore, more compatible with payment. Again, this is closely tied to the mapping of gender

onto separate spheres and the dichotomies of family/market and unskilled/skilled. Constructing doulas' care as different from a mother's love provides more opportunity for it to be viewed as skilled, and therefore, deserving of direct payment.

At the same time that lactation consultants and doula care was being constructed as expert and, in the case of doulas, objective, it continued to be seen as women's work. For example, some of the doula clients mentioned doubting their male partner's ability to provide adequate labor support. This was also mentioned by some of the health care professionals who work with doulas, including Eileen, a labor and delivery nurse who told me:

But for a husband the first time or a significant other the first time watches that transition contraction and goes, 'Oh, my gosh.' He then becomes very useless (laughing). Other than the support person, he's standing there holding her hand, because he can't do anything else.

There is an interesting gendered undercurrent here, which was more obvious in Lila's (doula client) statement, "I know I have some friends who just want it to be them and their husband. And I think that's a huge mistake. I don't care who your husband is and how supportive he is; if he's, you know, in touch with his feminine side." Lila implies that the work of labor support is something that women are uniquely positioned to provide. This was not exclusive to discussions of doulas, as it was at times implied that male partners could not provide the most adequate support to breastfeeding women either – particularly emotional support. For example, Molly said, "... my husband's very supportive but he can't come close to understanding what it's like to not have enough milk, you know, for your baby." Thus, the work that lactation consultants, doulas, and their clients performed to construct this work as expert in order to differentiate it from family care did not preclude the fact that it was still viewed as women's work.

These forms of relational work also did not preclude the possibility of seeing these relations as intimate. All parties mentioned becoming very close to one another. Sharon told me,

You know, and my clients become my friends. You know, especially if I have a baby that I'm seeing over and over again... They've made me feel very useful and I've been able to help them get their baby nursing. And so, it's a very personal relationship. When you've, you know, really worked that hard together.

Furthermore, clients discussed the need to choose someone with whom they were comfortable.

Melanie expressed this when she explained her process for choosing a doula:

Um, because her personality clicked. That—that was probably one of the—the, you know, the—it's definitely nice to know that she had the great knowledge base coming into it, but then also, um, if it was with somebody I didn't click with, then it wasn't going to be something I was going to be comfortable having that person, you know, in a very intimate moment in my life, you know, getting to see me naked and, you know, hanging out with me when I feel very vulnerable. Um, I wanted to definitely have someone that put me at ease when I was in their presence.

While clients of hospital lactation consultants did not get to choose who they worked with in the same way as women who were hiring a doula or community lactation consultant, intimacy and comfort were still important. For the few patients who were unhappy with their experiences working with a lactation consultant, their discontent centered mostly around feeling uncomfortable sharing this intimate aspect of their mothering: “Like you're in there and you're sort of like bearing your soul like you're supposed to be able to provide for your child and I didn't feel really supported in that appointment” (Megan, lactation consultant client). These data illustrate that, while there is a lot of work being done to differentiate lactation consultants and doulas from family and friends, this work does not include removing the element of intimacy. Instead, these individuals are working to create an appropriate relational package within a context where money and intimacy coexist.

Negotiating Transactions and Media: Sliding Scales and Working for Free

While much of the relational work of paid breastfeeding and labor support consisted of negotiating a relationship that was compatible with payment, there were instances where transactions and media were negotiated. One such instance was when the lactation consultant or

doula had a pre-existing relationship with a client, such as having worked with that client in the past. For example, Brenda was a doula whose normal fee was \$1000, but told me, “I am doing a birth in June for \$300 that’s her third child with me and, you know, we’re making other exchanges and other things.” Brenda’s sliding scale for repeat clients was not uncommon among the study participants. However, negotiations of transactions and media were not limited to situations of pre-existing relationships. Both lactation consultants and doulas experienced difficulty in determining fees for their services. This was less of an issue for hospital lactation consultants because they are most often paid through a third party, although Lori felt conflicted about her patients who had to pay out of pocket to visit the outpatient clinic where she sometimes worked. Doulas had a lot of freedom in setting the fees for their services, but many of them struggled to determine how much their services were worth. Most often, they set their compensation levels according to their experience and rates of the other doulas in the area. However, they also had to take into consideration the income level of the area in which they worked. Heather, a doula who worked in a rural area, told me, “I know what they charge in [nearby city] and it’s—nobody would even give me a—they would be like, ‘Pft,’ in our area, you know?”

These difficulties in setting fees represent another example of the influence of gendered separate spheres, where care is constructed as something that should be given freely out of love, kinship, or obligation. Similar to the family child-care workers in Tuominen’s (2003) research, both doulas and private practice lactation consultants mentioned feeling some tension between wanting to help and needing to make a living. Sliding scales were a common method of dealing with this, like in Danielle’s (doula) case:

I do have a sliding scale. My straight out fee is \$700. But then I do have a scale so, you know, moms who are, you know, at a lower income level [...] we can fit them in. I try

and work with moms as much as I can. Um, I have done quite a few pro bono births but that gets really tough because, you know, you can only do so many pro bono. I—I mean my heart, I would do everybody pro bono. Um, but unfortunately, I, you know, I do realize, too, that I need to be paid for my time and, you know, there are certain cases that I just can't say no to and I end up doing pro bono.

Like Danielle, other doulas and lactation consultants balanced the tension they felt about being paid to care by doing volunteer work, but this raised the additional issue of how much of their time they could reasonably spend volunteering when they were also trying to bring in income or sustain a business. When I interviewed Sharon, she explained to me that she would sometimes see clients for free if she knew they could not afford her fees, but she was having some difficulty finding a good balance, because she was trying to grow her business.

I want to continue doing that work, but I'm not sure how long I can afford to continue doing it. And especially as I get busier, then it becomes a choice of making money or taking care of this woman, and it will have to be more of a balance.

When I observed her three years later, she was still seeing some clients for free. These data illustrate how the gendered construction of caring as an innate quality of women combines with the hostile worlds belief that money corrupts intimacy, resulting in a devaluing of care that creates tension for care workers who are trying to perform care as an income-generating activity.

Discussion

A large part of lactation consultants' and doulas' work was providing physical and emotional care, including hands-on assistance, normalizing aspects of childbirth and breastfeeding, and helping women adjust when childbirth and breastfeeding did not go as planned. The quality of this intimate caring labor is not corrupted by the fact that they are paid for it, contrary to the hostile worlds perspective. In fact, lactation consultants and doulas are both passionate about the work they do and about supporting women through childbirth, breastfeeding, and the transition to motherhood (or having additional children).

Rather than a situation of hostile worlds, the commercialization of breastfeeding and labor support is an example of what Zelizer (2005) calls connected lives. In this context, intimacy and money coexist and lactation consultants, doulas, and their client are negotiating an appropriate relational package that contains the right balance of interpersonal ties, transactions, and media. However, finding this balance requires work from both parties. Clients explained that they worked with a lactation consultant or doula because they needed the help of an expert, which legitimates the market transactions of this relationship. Also, particularly for doulas and their clients, both parties did quite a bit of work to differentiate the doula-client relationship from that of family or friends by explaining that the objectivity of a doula, who does not love the client, places her in a better position to support the laboring woman's birth plan and decisions during birth.

Gender plays an interesting role in this example of relational work. The gendered construction of caring as an innate characteristic of women results in care being seen as unskilled and as something that should be given freely (Boris & Parreñas, 2010; Daniels, 1987; Davies, 1995, 1996; Duffy, 2011; Sherman, 2010; Waerness, 1996). This is responsible for much of the relational work being done here. Lactation consultants' and doulas' work must be constructed as expert, and in the case of doulas, objective, in order to be compatible with payment. However, the construction of their work as women's work went largely unchallenged, as women were still seen as best-suited for providing these types of care. This contributed to the difficulties lactation consultants and doulas experienced in charging for their services.

Both lactation consultants and doulas felt tension about clients paying for their services, providing some volunteer or low-cost support as a result. On the one hand, they cared deeply about this work, enjoyed doing it, and wanted to help every woman who needed it. However,

volunteer work and flexible payment arrangements also served the purpose of helping lactation consultants and doulas feel like they were performing this combination of money and intimacy “the right way” by not turning away women who needed help but could not afford it.

This research supports the findings of others that, contrary to the hostile worlds perspective, money does not corrupt intimacy (Dodson & Zinzivage, 2007; Folbre & Nelson, 2000; Stone, 2000; Tuominen, 2003; Zelizer, 2005). The caring labor of lactation consultants and doulas is genuine, despite the fact that it is provided for pay. Furthermore, it adds to our understanding of relational work within paid caring relationships. It illustrates how the parties involved work to draw boundaries around social relations in order to distinguish them from other types and to legitimate the combination of intimacy and market transactions. It also illustrates how transactions and media are negotiated in order to match interpersonal ties and to create an appropriate relational package. In doing so, it provides further evidence that the hostile worlds perspective devalues caring and perpetuates the low pay of care work.

Works Cited

- Almeling, R. (2007). Selling genes, selling gender: Egg agencies, sperm banks, and the medical market in genetic material. *American Sociological Review*, 72(3), 319-340.
- Boris, E., & Parreñas, R.S. (2010). *Intimate labors: Cultures, technologies, and the politics of care*. Stanford, CA: Stanford Social Sciences.
- Cook, D. T. (2009). Semantic provisioning of children's food: Commerce, care and maternal practice. *Childhood*, 16(3), 317-334.
- Coslor, E. (2010). Hostile worlds and questionable speculation: Recognizing the plurality of views about art and the market. *Research in Economic Anthropology*, 30: 209-224.
- Daniels, A. K. (1987). Invisible work. *Social Problems*, 5, 403-415.
- Davies, C. (1995). Competence versus care? Gender and caring work revisited. *Acta Sociologica*, 38, 17-31.
- Davies, C. (1996). The sociology of professions and the profession of gender. *Sociology*, 30(4), 661-678.
- Dodson, L., & Zinbavage, R. M. (2007). "It's like a family": Caring labor, exploitation, and race in nursing homes. *Gender & Society*, 21(6), 905-928.
- DONA International. (2013a). *What is a doula?* <http://www.dona.org/mothers/index.php>. Accessed February 14, 2014.
- DONA International. 2013b. *Member statistics*. <http://www.dona.org/aboutus/statistics.php>. Accessed February 14, 2014.
- Duffy, M. (2011). *Making care count: A century of gender, race, and paid care work*. New Brunswick, NJ: Rutgers University Press.
- Emerson, R. M., Fretz, R. I., & Shaw, L.L. (1995). *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.
- England, P. (2005). Emerging theories of care work. *Annual Review of Sociology*, 31: 381-399.
- England, P., Budig, M., & Folbre, N. (2002). Wages of virtue: The relative pay of care work. *Social Problems*, 49(4), 455-473.
- Folbre, N., & Nelson, J.A. (2000). For love or money -- or both? *The Journal of Economic Perspectives*, 14(4), 123-140.
- Glenn, E. N. (2010). *Forced to care: Coercion and caregiving in America*. Cambridge, MA: Harvard University Press.

- Haylett, J. (2012). One woman helping another: Egg donation as a case of relational work. *Politics & Society*, 40, 223-247.
- Himmelweit, S. (1999). Caring labor. *The ANNALS of the American Academy of Political and Social Science*, 561, 27-38.
- Hoang, K. K. (2011). "She's not a low-class dirty girl!": Sex work in Ho Chi Minh City, Vietnam. *Journal of Contemporary Ethnography*, 40, 367-396.
- Hochschild, A. R. (2003). *The commercialization of intimate life: Notes from home and work*. Berkeley: University of California Press.
- International Board of Lactation Consultant Examiners. (2012) Scope of practice for international board certified lactation consultants (IBCLCs). Retrieved from <http://iblce.org/wp-content/uploads/2013/08/scope-of-practice.pdf>. Accessed February 14, 2014.
- International Board of Lactation Consultant Examiners. (2013). *IBLCE exam facts and figures*. <http://iblce.org/about-iblce/iblce-exam-facts-figures/>. Accessed February 14, 2014.
- Nelson, J. A. (1999). Of markets and martyrs: Is it OK to pay well for care? *Feminist Economics*, 5(3), 43-59.
- Nelson J. A., & England, P. (2002). Feminist philosophies of love and work. *Hypatia*, 17: 1-18.
- Popenoe, D. (1993). American family decline, 1960-1990: A review and appraisal. *Journal of Marriage and Family*, 55(3), 527-542.
- Sherman, R. (2010). "Time is our commodity" : Gender and the struggle for occupational legitimacy among personal concierges. *Work and Occupations*, 37(1), 81-114.
- Stone, D. (2000). Caring by the book. In M. Harrington (Ed.), *Care work: Gender, labor, and the welfare state* (pp. 89-111). New York: Routledge.
- Tuominen, M. (2003). *We are not babysitters: Family child care providers redefine work and care*. Piscataway, NJ: Rutgers University Press.
- Waerness, K. (1996). On the rationality of caring. In A. Showstack Sassoon (Ed.), *Women and the state: The shifting boundaries of public and private* (pp. 207-234). London: Hutchinson.
- Zelizer, V. A. (2005). *The purchase of intimacy*. Princeton, NJ: Princeton University Press.
- Zelizer, V. A. (2012). How I became a relational economic sociologist and what does that mean? *Politics & Society*, 40(2): 145-174.

Chapter 5

Conclusion

Research Aims

The goal of this research was to examine the role of lactation consultants and doulas within the medical maternity system, giving special attention to their level of engagement with medicalization-demmedicalization and their caring labor, as well as the intersection of these two areas of their work. It addressed the following questions: To what extent, and in what ways, do lactation consultants work toward demmedicalization? How do lactation consultants balance demmedicalization with their role as the clinical managers of breastfeeding? Are lactation consultants and doulas a reflection of the outsourcing of care or something else? What does the existence of these types of paid support illustrate about transformations in care, more broadly? How do lactation consultants, doulas, and clients negotiate the combination of money and intimacy in the highly gendered context of paid breastfeeding and labor support?

Summary of Findings

In chapter 2, I presented evidence that lactation consultants are not only medicalizing and demmedicalizing breastfeeding at the same time, but that aspects of medicalization in their work actually serve to demmedicalize. As a result of holding the position of the clinical managers of breastfeeding, lactation consultants engage in a fair amount of medicalization. They reinforce the medical definition of breastfeeding and the construction of breast milk as a medical product by emphasizing the nutritional properties and health benefits of breast milk. They also employ a

variety of technologies to medically manage breastfeeding. However, they also use their position of medical control to work toward demedicalizing breastfeeding by challenging breastfeeding pathology and limiting unnecessary medical intervention. Thus, they are medicalizing to demedicalize. This stands in contrast to our understanding of the medicalization of natural processes, where the construction of disorder and the creation of complex medical technologies serve to reinforce medical control (Conrad, 2007; Riessman, 1983). Lactation consultants illustrate that this process can also work in the opposite direction, where medical control can be used to challenge pathology and intervention.

In chapter 3, I illustrated the significant impact of medicalization on the commercialization of caring. While lactation consultants and doulas perform many of the functions traditionally associated with caring (e.g., physical and emotional support), their role as care workers goes well beyond this. Lactation consultants and doulas act as advocates and guides to the medical maternity system, which can be very difficult to navigate, especially when a woman wants to avoid medical intervention in her childbirth or breastfeeding. This difficulty is directly related to the medicalization of maternity, including the construction of women's birthing and breastfeeding bodies as prone to disorder, the heavy reliance on medical interventions, and the deskilling of women through the use of science and technology. Thus, lactation consultants and doulas represent more than a simple outsourcing of family care/life. Similar to what Duffy (2011) has argued about other forms of care work, their caring labor signals a fundamental transformation in the meaning of care, where it has broadened to include advocacy and guidance. This is a key factor in the commercialization of these forms of support.

Finally, in chapter 4, I built upon Zelizer's (2005) theories of "connected lives" and "relational work" in order to show that the "hostile worlds" perspective that money corrupts

caring is not only inaccurate, but serves to perpetuate the devaluing and low pay of care work. Lactation consultants and doulas both care deeply about helping women during the transition to motherhood, and this genuine care is not tainted by the fact that they are paid to do so. However, because of the power of the hostile worlds perspective, lactation consultants, doulas, and their clients must engage in a fair amount of relational work in order to find an appropriate combination of money and intimacy. This is heavily impacted by the way gender is mapped onto separate spheres and hostile worlds, where the feminine characteristics of “nurturing, comforting, encouraging, or facilitating interaction” (Daniels, 1987) within lactation consultants’ and doulas’ work are thought to be the innate characteristics of women, and thus something that should be given freely out of love, kinship, or obligation (Boris & Parreñas, 2010; Glenn, 2010). The result is that lactation consultants and doulas often feel conflicted about charging for their services and end up working for less money, or even for free.

Implications of Findings

There are several important implications that come from this research. My findings regarding lactation consultants’ engagement with medicalization and demedicalization illustrate the limitations of treating medicalization and demedicalization as binary categories. If we were to label lactation consultants as either agents of medicalization OR agents of demedicalization, we would likely place them in the medicalization category, given the many ways in which they reinforce the medical definition of breastfeeding and use technology to medically manage breastfeeding problems. However, this would miss much of the complexity of their work, and would not attend to the many ways that they demedicalize by challenging the construction of lactation pathology and limiting unnecessary intervention.

Using a more nuanced perspective on medicalization-demmedicalization assists in evaluating the implications of medicalization. For example, as I discussed in chapter 2, when lactation consultants endorse the nutritional properties and health benefits of breast milk, they can reinforce the moral imperative for mothers to breastfeed – the belief that in order to be a “good” mother, one must breastfeed her baby. This is especially strong when lactation consultants present even small amounts of milk as making a difference in a baby’s health. However, emphasizing that “breast is best” also challenges the construction of women’s bodies as suspect or inadequate by celebrating their ability to nourish their babies. This is a complete reversal of the initial medicalization of breastfeeding, where formula was seen as superior to breastfeeding. This illustrates how aspects of medicalization, in this case defining breastfeeding in terms of health and illness, can have negative and positive impacts. It also illustrates the key theoretical contribution of this article: the concept of medicalizing to demmedicalize, where medicalization can actually be used to work toward demmedicalization. This concept is applicable to other areas of medicalization, particularly those where it is not clear whether something is being medicalized or demmedicalized. I provide some suggestions of such areas below in the section on future research.

This research also has several implications for care work. First, it illustrates the importance of examining the social and historical context when evaluating changes in caring over time. While the breastfeeding and labor support that lactation consultants and doulas provide shares many similarities with the supportive care of social childbirth, the meaning of these types of support has been transformed over time, as a result of the medicalization of maternity care. Acting as an advocate and guide to the complex medical maternity system is now a key part of supporting a woman through the process of childbirth and breastfeeding, and

lactation consultants and doulas are filling this role. It is important for other researchers studying the commercialization of care to attend to these changes in what it means to provide good care and to keep them in mind when evaluating the impact of commercializing caring.

My findings regarding lactation consultants' and doulas' advocate role also raise important implications for access to these services and equality in health care. Existing research has linked socioeconomic status to better health and health care through such mechanisms as sense of control (Mirowsky & Ross, 1998) and cultural health capital (Shim, 2010; Dubbin, Chang, & Shim, 2013). For example, Mirowsky & Ross (1998) have shown that the sense of control that one gains from education, such as the ability to problem solve and feel like you can master and alter your environment, has an impact on health. Shim's (2010) concept of cultural health capital, "a specialized form of cultural capital that can be leveraged in health care contexts to effectively engage with medical providers" (p. 3), has been shown to facilitate patient-centered care when the habitus of the doctor and patient match (Dubbin, Chang, & Shim, 2013). As I explained in chapter 3, lactation consultant and doula services can be quite expensive. If lactation consultants and doulas are only accessible to those who can afford these services, this can serve to increase existing class disparities in health by providing the class-privileged with yet another resource for navigating health care and getting the best care they can.

Finally, this research illustrates the value of combining gender theory with Zelizer's (2005) theories on money and intimacy. Zelizer's work has been extremely influential, and many scholars have used her concepts of connected lives and relational work to examine combinations of money and intimacy in various aspects of social life. However, there has been very little attention to the role of gender within these processes. Therefore, this research aimed to "gender" Zelizer by incorporating an explicit analysis of the impact of gender on relational work. My

finding that gender impacts the process of relational work in a multitude of ways illustrates the importance of incorporating gender into studies of relational work, and this is not just the case for care work. One of Zelizer's main arguments is that intimacy occurs in all social contexts. Because many characteristics of intimacy, such as nurturing, comforting, and facilitating interaction, are associated with women, gender is an important factor to include when examining negotiations of intimacy and economic activity in any context.

Limitations

The biggest limitation of this research is that I do not have observational data for doulas. I was able to find two doulas who consented to observation, but none of their clients would consent to my presence at their birth. In fact, one of the lactation consultant clients that I observed told me that her doula had asked her and her husband if they would be interested in participating in my research and she said they thought that was "too weird." However, she was perfectly comfortable having me observe her appointments with the lactation consultant. Clearly, she and her husband thought childbirth was a much more intimate event than breastfeeding, and it is likely that others felt the same. In hind sight, it is not surprising that doula clients did not want me at their births. My research shows that one of the reasons why women hire doulas is because they want control over their birthing experience, and thus are not likely to invite a sociological researcher to observe.

While it was disappointing to not have the observational data for doulas, I do not believe it affected the research findings. I did not find large discrepancies between the lactation consultant interviews and the observational data that would lead me to believe I would find such discrepancies for doulas. Also, I have interview data from doula clients and providers that I combined with the doula interviews in my analysis.

Another limitation of this research is the lack of race and class diversity among the patients that I interviewed. While I did observe the lactation consultants (particularly those working in hospitals) working with a race- and class-diverse patient population, the women who consented to follow-up interviews were all white, college-educated, with a very high median annual household income (\$100,000-119,000). I did attempt to recruit women with lower incomes and women of color, but was mostly unsuccessful. This does limit my ability to make race and class comparisons, which are an important area for future research.

Future Research

One area for future research is to give more attention to the role of race and class in breastfeeding and labor support. As stated above, the advocate role of lactation consultants and doulas raises questions about access and equality in maternity care. There are several programs across the country that are focusing on increasing access to doulas and lactation support for low income women, as well as women of different racial and ethnic backgrounds. Some have begun to evaluate the impact of such programs (Kozhimannil et al., 2013), and we need more research in this vain. Another area for this type of research is Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) peer breastfeeding counselors. These are women who have personal experience breastfeeding successfully and provide support to breastfeeding women with WIC.

In my research, the women who had WIC were essentially funneled into a “WIC pipeline” for breastfeeding support after leaving the hospital. Once a lactation consultant determined that a woman had WIC, she put her in contact with the WIC office and sometimes contacted the WIC peer counselor directly to discuss her case. All women who did not have WIC were referred to either an outpatient breastfeeding clinic or a private practice lactation consultant

if they needed follow-up. This dissertation has provided a thorough analysis of this latter pathway for breastfeeding support and future research should examine the WIC pathway. This is especially important given Blum's (1999) findings on race and class differences in breastfeeding experiences and Wolf's (2011) findings regarding the raced and classed dimensions of breastfeeding advocacy.

Another area for future research is to examine the impact of medicalization on caring in other contexts. There are many aspects of commercialized care where medicalization likely plays an important role in the changing locations and meanings of care over time. One example is surrogacy. While Corea's (1985) early analysis of surrogacy focused on medical/male control of women's bodies, more recent scholarship has focused mainly on questions of morality, gender, and motherhood (Markens, 2007; Pande, 2010; Wilkinson, 2003). For example, one branch of the surrogacy literature focuses on surrogate women's engagement with the social identity of mother, drawing primarily upon theories of gender and cultural constructions of motherhood (Berend, 2010; Goslinga-Roy, 2000; Ragoné, 1994; Teman, 2010). However, the medicalized construction of mother and fetus as separate patients (Wertz & Wertz, 1989) is also an important factor in this process. As Rothman (1992) has explained:

The history of Western obstetrics is the history of technologies of separation. We've separated milk from breasts, mothers from babies, fetuses from pregnancies, sexuality from procreation, pregnancy from motherhood. And finally we're left with the image of the fetus as a free-floating being alone, analogous to man in space, with the umbilical cord tethering the placental ship, and the mother reduced to the empty space that surrounds it.

Linking surrogacy to these other forms of separation could provide an important perspective on the identity processes involved in surrogate relationships.

Finally, future research should focus on applying the concept of medicalizing to demedicalize to other contexts. This concept is especially helpful for areas where it is unclear

whether something is being medicalized or demedicalized. One possible area would be complementary and alternative medicine (CAM). CAM treatments fall outside of traditional biomedicine, and many challenge traditional biomedical approaches to treatment. However, they are increasingly constructed as medicine and are often framed within a biomedical discourse, such as this statement from the National Center for Complementary and Alternative Medicine (2013) on spinal manipulative therapy (such as that performed by a chiropractor):

Findings from the largest and most rigorous, randomized dose-response study of spinal manipulative therapy (SMT) for chronic low-back pain suggest that 12 sessions (SMT) may be the best “dose” for people with chronic low-back pain (n.p.)

This is very similar to the case of breastfeeding, where lactation consultants are reinforcing the construction of breast milk as a medical product, yet they are doing so in large part to challenge perceived breastfeeding pathology and unnecessary medical intervention. Applying the framework of medicalizing to demedicalize to areas such as CAM provides a more nuanced perspective that allows for closer examination of the impact of medicalization and demedicalization in such contexts, where it is not so clearly “good” or “bad.”

This dissertation represents six years of research and writing. However, as this section on future directions illustrates, it does not mark an end, but rather a beginning. I began this research with questions about the role of lactation consultants and doulas in maternity care and how their work is impacted by the medicalization of childbirth and breastfeeding. As I worked to answer these questions, I developed many new ones. I look forward to following these new lines of inquiry and building upon the foundation that this dissertation provides.

Works Cited

- Berend, Z. (2010). Surrogate losses: understandings of pregnancy loss and assisted reproduction among surrogate mothers. *Medical Anthropology Quarterly*, 24, 240-262.
- Blum, L. M. (1999). *At the breast: Ideologies of breastfeeding and motherhood in the contemporary united states*. Boston: Beacon Press.
- Boris, E., & Parreñas, R. S. (2010). *Intimate labors: Cultures, technologies, and the politics of care*. Stanford, CA: Stanford Social Sciences.
- Conrad, P. (2007). *The Medicalization of society: On the transformation of human conditions into treatable disorders*. Baltimore, MD: Johns Hopkins University Press.
- Corea, G. (1985). *The mother machine: Reproductive technologies from artificial insemination to artificial wombs*. New York: Harper & Row.
- Daniels, A. K. (1987). Invisible work. *Social Problems*, 5, 403-415.
- Dubbin, L. A., Chang, J. S., & Shim, J. K. (2013). Cultural health capital and the interactional dynamics of patient-centered care. *Social Science & Medicine*, 93, 113-120.
- Duffy, M. (2011). *Making care count: A century of gender, race, and paid care work*. New Brunswick, NJ: Rutgers University Press.
- Glenn, E. N. (2010). *Forced to care: Coercion and caregiving in America*. Cambridge, MA: Harvard University Press.
- Goslinga-Roy, G. (2000). Body boundaries, fiction of the female self: an ethnographic perspective on power, feminism, and the reproductive technologies. *Feminist Studies*, 26, 113-140.
- Kozhimannil, K. B., Hardeman, R. R., Attanasio, L. B., Blauer-Peterson, C., & O'Brien, M. (2013). Doula care, birth outcomes, and costs among Medicaid beneficiaries. *American Journal of Public Health*, 103(4), E113-E121.
- Markens, S. (2007). *Surrogate motherhood and the politics of reproduction*. Berkeley: University of California Press
- Mirowsky, J., & Ross, C. E. (1998). Education, personal control, lifestyle and health: A human capital hypothesis. *Research on Aging*, 20(4), 415-449.
- National Center for Complementary and Alternative Medicine. (2013). *Determining the optimal number of spinal manipulation sessions for chronic low-back pain*. Retrieved from <http://nccam.nih.gov/research/results/spotlight/111413>. Accessed February 14, 2014.

- Pande, A. (2010). Commercial surrogacy in India: Manufacturing the perfect motherworker. *Signs*, 35(4), 969–992.
- Ragoné, H. (1994). *Surrogate motherhood: Conception in the heart*. Boulder, CO: Westview Press.
- Shim, J. K. (2010). Cultural health capital: A theoretical approach to understanding health care interactions and the dynamics of unequal treatment. *Journal of Health & Social Behavior*, 51(1), 1-15.
- Riessman, C. K. (1983). Women and medicalization: A new perspective. *Social Policy*, 14(1): 3-18.
- Rothman B. K. (1992). *Plenary Address*. Midwives Alliance of North America Conference, New York, NY.
- Teman, E. (2010). *Birthing a mother: The surrogate body and the pregnant self*. Berkeley: University of California Press.
- Wertz, R. W., & Wertz, D. C. (1989). *Lying-in: A history of childbirth in America*. New Haven: Yale University Press.
- Wilkinson, S. (2003). The exploitation argument against commercial surrogacy. *Bioethics*, 17: 169–187.
- Wolf, J. B. (2011). *Is breast best?: Taking on the breastfeeding experts and the new high stakes of motherhood*. New York: New York University Press.
- Zelizer, V. A. (2005). *The purchase of intimacy*. Princeton, NJ: Princeton University Press.