

Deciding on a Doula:
Pain, kinship & the resurgence of woman-supported birth
in the United States

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Table of Contents

Acknowledgements	3
Chapter 1 <i>An Introduction</i>	5
Chapter 2 <i>Literature Review</i>	26
Chapter 3 <i>“But it hurts!” Is a person the best drug you can get?</i>	37
Chapter 4 <i>Family & Space Dynamics: Kin & U.S. Birth</i>	66
Chapter 5 <i>The “in” thing to do? Final remarks & the future of doulas</i>	96
References Cited	112
Bibliography	123

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Chapter 1

An Introduction

Historically, women have long been assisting other women in childbirth. This social and emotional assistance disappeared during the twentieth century as biomedicine changed the way women give birth in the United States. With recent birthing movements in the U.S. which challenge a hyper-medicalized birthing structure, the possibility of using of a doula, or childbirth companion, counters how many hospitals and health care providers are choosing to educate women about birth. My thesis aims to investigate how doula usage during labor is changing the way women experience birth in the United States. This study explores how doula support is redefining pain perceptions and kin relations through doula-to-client interactions, both physically and relationally. By exploring cultural factors and motivations of mothers who have used doulas during childbirth, I suggest that doulas — who have been shown to have positive influence during labor — are part of a resurgence of woman-centered and -supported childbirth in hospitals and homes across the country. Before addressing these issues, I will first discuss what a doula is and how a doula works.

What is a doula?

To define “doula” based on how a doula’s role is perceived today in the U.S., I am borrowing a definition from *The Doula Book* (2002):

Doula is a Greek word whose definition has come to mean a woman who helps other women. The word has further evolved to mean a woman experienced in

childbirth who provides continuous physical, emotional, and informational support to the mother before, during, and after childbirth.

The Doula Book, written by medical doctors Marshall Klaus and John Kennell and social worker Phyllis Klaus, was one of the first publications about doulas. Originally titled *Mothering the Mother*, the book explains the social impacts doulas have and the medical impacts associated with their support. These three researchers have worked in childbirth studies and advocacy for decades, examining mother-to-infant bonding and woman-to-woman labor support. Along with other childbirth experts Penny Simkin and Annie Kennedy, they founded DONA: Doulas of North America in 1992, the first organization for doulas and for promoting doula care (DONA 2005c). In 2004, DONA changed its name to DONA International to better represent its members. In 2009, there were over 200 members from 42 countries other than the U.S. and Canada, mainly in Europe. In addition, there are 5,800 members from the United States and 900 members from Canada (DONA 2005b).

The word “doula” means servant in Greek, particularly a woman’s servant. In choosing “doula” as a word for childbirth helper, DONA founders and other childbirth educators acknowledged the unique ability of a doula to be with a woman in a serving yet intimate way. This “mothering the mother” mentality is at the backbone of doula work and of DONA’s standards of practice. The definition of doula has transformed, though; as one doula described it, doula means “to be with woman” but her job is “to be with family.”

There are two types of doulas: birth doulas and postpartum doulas. This study focuses exclusively on birth doulas. Birth doulas attend between two and three prenatal sessions with clients, offer phone or e-mail support, stay through the entirety of a mother’s labor, and make one or two postpartum follow-up visits. Some doulas provide a written birth story with their services, chronicling the birth as a gift to the family. Postpartum doulas work with the mother

after the child is born, visiting the family's home for between one and three weeks after the birth. They are available as emotional and physical supports, offering a sympathetic ear along with practical services including laundry, cooking, and cleaning. Postpartum doulas can also assist with breastfeeding and watch for signs of postpartum depression.

There are also public and private doulas. Private doulas usually work with contracts that detail all services covered by their fees. These fee-for-service doulas charge anywhere from \$400 to \$750 per birth in this area, though some doulas are said to make upward of \$1200 to \$1800 per birth in larger metropolitan areas like Manhattan. The fee covers all services detailed in the contract, which usually includes two to three prenatal appointments, the birth, and one or two postpartum appointments. Public doulas work as volunteers in community programs or in hospital-based programs. Volunteer doula services exist in several areas, including in Ann Arbor. Hospital-based programs nationwide employ a certain number of doulas on staff at all times, providing "on call" services at the facility. This paper mainly considers fee-for-service doulas, though several doulas mentioned working as volunteers prior to charging a fee.

Who are doulas?

Doulas come from all types of social and ethnic backgrounds. Almost all doulas are women, but there are no restrictions that say doulas must be women. At least one man in Ann Arbor has completed doula training in the past year. In this study, all doulas are women and they tend to refer to doulas as only women. As such, I will refer to doulas as women while acknowledging here that there are exceptions.

Anyone can become a doula by undergoing training. DONA-certified programs are the most attended doula programs nationwide. In Ann Arbor, they are taught at the Center for the

Childbearing Year. DONA trainings start with a 2-day weekend training session that is the core of doula education, and the certificate received after this session is the bare minimum needed to practice as a doula, especially as a volunteer (See “Doulas Care” below). To become a certified DONA birth doula, a person must complete multiple assignments¹, including the training workshop, required reading, attendance and evaluation at three births, a written essay, proof of some lactation training, and character references (DONA 2005h). Certification must occur within four years of the initial training workshop. Because certification can be a lengthy process, several doulas opt not to complete certification but still practice.

Why doulas?

Doulas are underrepresented in childbirth literature, both in the social sciences and medicine. In general, “alternative” birthing trends or movements — meaning those not considered part of mainstream culture — are underrepresented, too. My study of doulas began with my interest in childbirth education as I investigated ways to be involved in the childbirth sphere without having giving birth. There is no age requirement or birth prerequisite for doulas, though many are parents. For me, doulas represent a bridge between women who have yet to experience childbirth and those directly involved in it. It is a mutual learning opportunity, as doula clients reap knowledge from trained professional doulas, but doulas also have the opportunity to learn about birth, people, and different stages of the life cycle.

Doulas fascinate me as a potential trend. Ann Arbor residents come from all types of religious, cultural, and socio-economic backgrounds to make up the city’s population of about 114,300 people. One group might be considered alternative or “hippie,” embracing Earth-

¹ For a complete list of steps required to becoming certified by DONA, see http://www.dona.org/develop/birth_cert.php.

friendly practices, shopping at local businesses, and choosing holistic remedies. Another group is much more affluent. These residents tend to live in Ann Arbor's wealthier downtown neighborhoods, send their kids to private pre-schools, and shop at upscale grocery stores like Whole Foods Market. Because the University of Michigan is in Ann Arbor, many faculty and staff reside in and around the city, too, bringing a large population of highly educated people into both the affluent and alternative groups. Doulas are described as being part of an alternative culture, but those with wealth are more able to afford them. Sometimes the affluent hire doulas without understanding the social support they provide, resulting in a negative doula birthing experience (Paul 2008). Though this paper does not explicitly tackle this issue, the intersection between desire to use a doula and means of acquiring a doula is of interest since those who have alternative lifestyles are often not those with abundant economic means. There is a mix of alternative and mainstream lifestyles represented in this study, but almost all are of greater economic means.

Finally, DONA has seen a large increase in member growth and doulas certified in the last ten years. In 1999, DONA had 1,034 doulas registered, and by 2009, 2,636 doulas were registered. Additionally, DONA membership² has skyrocketed: with almost 7,000 members in 2009, the organization gained more than 1,500 members between 2004 and 2009 and has grown almost 150 percent in the past decade (DONA 2005b). These numbers indicate a greater awareness or understanding of doulas by society at large. More research is needed to account for such organizational growth over such a short period of time.

Birthing Terms: Getting to know childbirth discourse

² Membership refers to anyone from the medical, doula, or childbirth educator community that supports DONA's mission.

There are many medically and socially constructed terms used to talk about childbirth. Here, I define a few of the more frequently used terms as they pertain to this paper. Because there are not universal definitions for some of these terms, it is essential to understand how they are used in this work and thus how to apply them within the context of this discussion.

Types of childbirth: “natural” & medicalized

There is no universal definition of “natural” childbirth. Childbirth is inherently social, as women in different cultures have learned about childbirth through other women, the media, education classes, etc. Considering any form of childbirth “natural” is almost impossible, but women frequently refer to “natural” childbirth as opposed to medicalized or “unnatural” childbirth. People in this study use the term in different ways and with reference to different contexts. For practical purposes, the term “natural childbirth” will be used here to refer to birth without the aid of any medical or pharmacological intervention, i.e. labor inducing drugs like pitocin, pain-reducing drugs like epidurals or spinal blocks, delivery with the help of forceps or episiotomy, or surgical procedure such as cesarean section. These are considered interventions because womens’ bodies are biologically designed to give birth, and all of these things seek to augment, or sometimes interfere with, that process. For example, for women who have longer labors, pitocin can induce contractions which then become quicker and usually more painful, something that would not have happened had pitocin not been administered. Interventions are not inherently good or bad, but they can increase risk of complication for mother and baby. In this thesis, I tend to talk about interventions negatively, mostly because people — in this case, doulas — have been found to help women in birth avoid certain interventions, maintaining a “natural” and low-risk birth environment.

Some women in this study refer to natural childbirth only in terms of pain medication. For them, giving birth naturally means giving birth without any type of pharmacological drug or by cesarean section, as no interviewee considered a cesarean section — a surgical birth — natural. There are also people outside this study who refuse to call birth natural within a hospital setting. Although many of the women in this study claimed that birth seemed more natural while at home, no one explicitly said birth in a hospital is unnatural. Some women expressed the desire for intervention-free birth, avoiding the term natural and instead referencing the desire for a lack of medical intervention as described above.

Medicalized childbirth refers to the predominant system in the United States that regulates, manages, and negotiates childbirth within a biomedical arena. Since birth can almost never be entirely natural and removed from social influences in the United States, medicalized birth is how most people think about birth. Aside from interventions like those listed above, birth is medicalized through the discourses used to talk about birth, the perceived danger some people associate with birth, and childbirth education materials³ which emphasize what could or will go wrong during birth without equally emphasizing what is normal about birth. This is also found in how some people discuss birthing women, considering pregnancy a sickness or treating pregnant women as fragile. Dr. Marsden Wagner, an obstetrician-gynecologist and World Health Organization consultant, uses this WHO quote to illustrate how birth medicalization has become the dominant form of childbirth discourse today:

By medicalizing birth, i.e. separating a woman from her own environment and surrounding her with strange people using strange machines to do strange things to her in an effort to assist her, the woman's state of mind and body is so altered that her way of carrying through this intimate act must also be altered and the state of the baby born must equally be altered. The result is that it is no longer possible to know what births would have been like before these manipulations.

³ “What to Expect When You’re Expecting” (2008) is an example of a childbirth education book that emphasizes negative childbirth aspects instead of positive ones, as cited by several women in this study.

Most health care providers no longer know what “non-medicalized birth is. The entire modern obstetric and neonatological literature is essentially based on observations of ‘medicalized’ birth is.” [2001:25]

Medicalized birth is what most people consider normal. In seeking “natural” birth, women in this study seek birth away from this medicalized structure, even if they birth in the hospital.

Low-Risk & At-Risk

Low-risk refers to a mother who has a healthy, normal pregnancy without complications which could affect labor and birth. Conditions that could cause complications include gestational diabetes, a history of heart problems or other disease, previous miscarriage, previous cesarean section, or age. If a woman has any of these complications or the potential to develop them, she is considered at-risk. Women can start as low-risk and end at-risk depending on their health during pregnancy. In this study, for example, Elaine began her pregnancy low-risk but developed gestational diabetes in her seventh month placing her at-risk. She was able to give birth without interventions at the hospital, however, even lacking an IV. Most women are low-risk, and interventions like cesarean sections are usually considered unnecessary. The WHO estimates that about 15 percent of cesarean sections are necessary (1985). In this paper, all discussions occur under the assumption that conditions are low-risk unless explicitly said otherwise.

Home birth & Home birth Transfers

A home birth is any birth that takes place in a residence as opposed to a birthing center or hospital. Planned home births happen in Michigan because certified professional midwives are legally allowed to practice within the state. A home birth transfer occurs when a midwife recognizes a potential problem during labor that could harm the mother or child or when the

birthing mother requests intervention — such as an epidural or induction — that the midwife cannot provide. Women transfer for a variety of reasons, and transfers often are necessary to save lives. In general, home births are not recommended for women who are at-risk during their pregnancies due to the potential for complications. Additionally, the American Congress of Obstetricians and Gynecologists issued a statement in 2008 reinforcing its opposition to home births. The statement concludes that the goal of any birth should be a healthy and safe outcome, and that, “Choosing to deliver a baby at home, however, is to place the process of giving birth over the goal of having a healthy baby” (ACOG⁴ 2010b). ACOG submitted a request in 2008 to the American Medical Association for the group to also reiterate its opposition to home birth. The AMA endorsed ACOG’s statement, further opposing home birth (AMA 2008). Interestingly, this cry to re-oppose home birth came just months after Ricki Lake’s film, *The Business of Being Born*, was released. The film, discussed later in this paper, shows benefits of home birth and the negatives of a hyper-medicalized birthing system in the United States (Epstein 2008). The AMA’s oppositional statement names Ricki Lake as a celebrity who fails to acknowledge the dangers of birth, and the ACOG final statement mentions the need for childbirth decisions to not be made based on “what’s fashionable, trendy, or the latest cause célèbre,” referencing a “rosy picture painted by home birth advocates” that could turn into a life-threatening situation (ACOG 2010b).

Health Care Providers

There are five types of health care providers involved in childbirth. In a hospital setting, obstetricians, family physicians, and nurse-midwives are trained to deliver babies. Obstetricians

⁴ ACOG is the American Congress of Obstetricians and Gynecologists, self-proclaimed as “the nation’s leading group of professionals providing health care for women” (ACOG 2010a). ACOG used to be the American College of Obstetricians and Gynecologists, and as such, some materials are still copywritten under this name.

or obstetrician-gynecologists are licensed medical doctors who have completed medical school, finished residency, and specialized in the obstetric field. Family physicians are also medical school-trained doctors, but they have not specialized in obstetrics or gynecology, thus very few family or general practice physicians deliver babies. Certified nurse-midwives also deliver children, and while they generally work in a hospital, they work in different types of settings. Nurse-midwives are nurses who have either done extended midwifery study after receiving some type of registered nursing degree or enrolled in a second career certified nurse-midwifery program. Nurse-midwives tend to be women, but men occasionally work in this field.

Alternately, there are certified professional midwives — or lay midwives — who do not undergo formal medical training and are not licensed by a medical organization. These midwives learn their job through apprenticeship, working with experienced midwives for several years prior to joining or starting a private practice. Certified professional midwives attend home births and help women give birth in an environment of their choice. These midwives usually have back-up doctors at local hospitals in the event of a needed home-to-hospital transfer.

Only nine states currently legally allow lay midwifery by judicial interpretation or statutory inference, including Michigan (MANA⁵ 2009). Lay midwifery is legally prohibited in 12 states, including neighboring Indiana and Illinois, and four states do not prohibit or endorse the practices through law, including Ohio (MANA 2009). There are also several states that regulate midwifery licenses or issue a North American Registry of Midwives exam to midwives wanting to practice.

Frameworks & Models of Birth

⁵ MANA is the Midwives Alliance of North America. As one of the most prominent midwives organization in North America, the group promotes the midwifery model of care (described below) and partners with other organizations including the North American Registry of Midwives to promote midwifery care and unite practicing midwives.

There are three frameworks of childbirth described in the literature today (Wagner 2001:26). The first, medicalized or high-tech birth, relies on doctored-centered and midwife-marginalized birth. This model is described somewhat through the various interventions detailed above. Medicalized birth is marked by technology dominating women's bodies and their abilities to birth babies. This has been described as a technocratic model of birth and combines technology and male-influenced obstetric practices to devalue women's labor experiences (Davis-Floyd 2003:51). The majority of women that give birth in hospitals are subjected to unnecessary interventions through this medical model that make birth more complicated and more dangerous than it should be (Davis-Floyd et al. 2009:14). Thus, the dominant medicalized birth model is found in the United States as well as Ireland, Russia, and France. Another framework for understanding childbirth is the midwifery model. This is more human-centered, is less technological, and has lower intervention rates while practiced predominantly in Scandinavia, New Zealand, and the Netherlands. The third model combines biomedical and midwifery practices and is practiced predominantly in Britain, Canada, Germany, Japan, and Australia. In these developed countries, biomedical practices are in place but midwifery practices also thrive. Additionally, standard hospital care in these countries tends to be low interventionist. The U.S. may be moving to a more combination model of birth, but with cesarean sections now being the most common surgery performed (Menacker and Hamilton 2010:6), it seems unlikely that hospitals will internally embrace midwifery and medicalized models together.

Birth in Ann Arbor/Ypsilanti

The Ann Arbor-Ypsilanti area has a variety of resources available to pregnant women and new mothers. The area also has its own birthing culture, which many women describe as

more liberal or alternative to mainstream birthing education. Several of these locations are frequented by many of the women in this study, and each of the locations is known to appeal to certain groups of people. A general understanding of each venue will help when reading through women's stories. I begin with two major hospitals followed by two major childbirth education centers in Ann Arbor.

University of Michigan Hospital

The University of Michigan Hospital delivers over 4,000 babies every year and houses both an obstetrician-gynecology practice and a nurse-midwifery clinic. There are nine nurse-midwives that work in the clinic, which is separate from the general obstetric practice of about 250 doctors, residents, and medical students each year. The obstetric practice and the nurse-midwifery clinic share nurses, however, and nurses are expected to know and be able to shift between protocols used in either practice. UM Hospital offers no birth education classes but refers women to the Center for the Childbearing Year, the Lamaze Family Center of Ann Arbor, and Birthing From Within⁶ instructors. These referrals will be described below. The two childbirth experts interviewed work out of UM Hospital, and six of the seven interviewed mothers who used doulas gave birth at the hospital at least once, all with a doula present.

St. Joseph Mercy Hospital — Ann Arbor

St. Joseph Mercy Hospital is on the border of Ypsilanti and Ann Arbor. It has an obstetric-gynecological practice as well as a nurse-midwifery practice with three nurse-midwives on staff. St. Joe's is part of a larger health system throughout Southeastern Michigan and has certain options that UM Hospital does not, which includes birth classes. Classes such as infant

⁶ Birthing From Within is a birthing philosophy discussed further in Chapter 3.

care, daddy boot camp, and childbirth preparation are offered in multiple hospital locations multiple times a month. These classes are also advertised on an Ann Arbor radio station. Only one mother in this study gave birth at St. Joe's, and thus there will be less discussion of this hospital and its practices.

The Center for the Childbearing Year

The Center for the Childbearing Year offers a variety of childbirth education and information for women and men. Classes including childbirth preparation and infant care along with play groups and support groups provide families informational and social support. All DONA-approved doula trainings are run through the Center, and doulas meet there for social and professional reasons, fostering social ties among other doulas and learning new childbirth information. Other activities, including belly casting, belly mapping, and massage, happen at the Center, too. The Center houses the Breastfeeding Center of Ann Arbor, a separate business that provides lactation support and information.

The Center is a place where local midwives, doulas, and other health professionals advertise their services and meet potential clients. There are business cards and pamphlets in one part of the Center, right next to the public lending library of birth materials. There are also stores through the Center and the Breastfeeding Center where patrons can purchase childbirth education information, breastfeeding supplies, and other materials. Once a non-profit, the Center for the Childbearing Year now exists as a for-profit business.

Almost all women in this study have a connection to the Center. Every doula underwent training there, several mothers who used doulas took birthing classes there, and one woman was provided with two free doulas through the Center. Women who do not use the Center often find

classes at the Lamaze Family Center of Ann Arbor, a resource described more as mainstream than the Center for the Childbearing Year.

Lamaze Family Center of Ann Arbor

Lamaze International is a well-known childbirth education organization that offers services from “pregnancy to preschool.” The Lamaze Family Center of Ann Arbor was established in 1967 by a group of nurses (LFCAA 2010). The Family Center developed from the teaching of Dr. Ferdinand Lamaze, who introduced new childbirth practices in 1951 that focused on relaxation and breathing techniques. Though Lamaze International no longer focuses on breathing techniques, the Ann Arbor Family Center retains Ferdinand Lamaze’s concepts that stress the normalcy of birth and women’s inherent ability to birth their own babies.

The Family Center offers a variety of classes and workshops for women, men, women and partners, and siblings. These classes include childbirth preparation, infant care, new mom support groups, sign language classes, and breastfeeding seminars. There are also a variety of classes for older kids including toddler playgroups along with specialized classes like those on cesarean sections and infant CPR.

At least two women in this study took Lamaze classes — one at the Family Center of Ann Arbor, another elsewhere — and one of the doulas interviewed is a childbirth educator there. The Family Center is a non-profit organization and tends to attract more “mainstream” people to its classes (Danielle). Because Lamaze is an internationally known childbirth education method, Danielle believes more business professionals and professors are attracted to it versus “alternative” people. She said while doulas are discussed in the Lamaze childbirth preparation classes and several families do go on to use them, the difference between Lamaze and the Center

for the Childbearing Year is that people go into Lamaze not knowing what a doula is while people go into the Center's classes already knowing they are going to use a doula. The Family Center does not directly recommend doulas, but four of the six childbirth educators on site are doulas. Doulas are also well known at the Family Center because of its connection to Doulas Care, a volunteer doula organization and childbirth resource.

Doulas Care

Doulas Care is a community-based doula organization that provides volunteer doulas to families with low-income status. The volunteer doulas provide similar services to private doulas, including prenatal visits and phone support. Doulas Care doulas currently work in eleven Michigan counties. In its first three to four years, the program worked with about 40 families (Doulas Care 2005a). In 2009, the program served 214 families (Doulas Care 2010b). Doulas Care is currently staffed with about 50 volunteer doulas (Doulas Care:2010a). Aside from birth and postpartum services, Doulas Care will soon launch a "Dial a Doula" program through UM Hospital, providing on-call doulas to families when requested. Doulas that work with Doulas Care do not need to be certified through DONA but do need to have taken DONA training.

Part of Doulas Care's mission is to serve populations with limited resources. By serving these populations, which includes Latino families and other ethnic minority families, doulas find women who would make great doulas and thus have an impact in their own communities. Doulas Care sponsors several scholarships for low-income or limited resource women to go through doula training and volunteer with the program that may have helped them. The group receives referrals for potential clients through pregnant women themselves but also through social workers and prenatal care providers.

Doulas Care now offers options for families that do not qualify for free doula services but cannot afford private fee-for-service doula care. Families can pay a set fee of \$350 for birth services and refer to a sliding scale for postpartum services. Fees charged do not go to the doulas but instead to the organization because Doulas Care is a non-profit organization currently housed within the Lamaze Family Center of Ann Arbor. Though originally created as part of the Center for the Childbearing Year, the group transferred to the Family Center in 2009 after the Center for the Childbearing Year changed from non-profit to for-profit in 2008. Doulas Care is not directly a part of the Family Center but does share an office.

Additional Birthing Classes

There are other birthing resources available in Ann Arbor, including classes from Birthing From Within instructors, Bradley Method⁷ instructors, and infant massage therapists. Women have the option of taking prenatal yoga and working with postpartum doulas or new mother support groups, too. Businesses like The Little Seedling offer classes about baby preparation and cloth diapering in addition to selling baby care items. Because Ann Arbor has a diverse population and many people from surrounding areas drive in to the city, multiple businesses focused on birth exist as options for new and pregnant mothers.

Participants & Methods

Over the course of four months, I carried out 13 in-depth interviews lasting between 30 minutes and an hour and a half. Of those interviewed, four of the women are doulas, seven of the women are mothers who used doulas during birth, and two people — one woman and one man — are childbirth experts, meaning they are medical professionals who work in the childbirth

⁷ Bradley Method is another birthing method, discussed further in Chapter 4.

field both as health care providers and as academic researchers. I also talked informally with other academic researchers, childbirth educators, and doulas, drawing on ideas and pursuing themes based on their insights and experiences. I interviewed no husbands of women who had used doulas. Except one woman, all women were married at the time they gave birth, and each of these husbands was present with their wives during labor. I will refer only to partner figures as husbands in this paper unless citing a study that uses the term “partner” instead. Many women use doulas while unmarried or with female partners, which is why “partner” is often used in studies. There was one woman without a husband, Carrie, who has four children and has never been married.

Methodology

I sought out interviewees through flyers, personal references, and formal organizations. I posted flyers around the Ann Arbor area in grocery stores and childbirth education centers and shared the flyer electronically with several local doulas and health care providers. I also utilized websites, including UM Hospital’s and the Center for the Childbearing Year’s, in order to identify potential interviewees. In the case of the Center’s website, I personally e-mailed several doulas whose information is posted on the site. Many of the doulas I spoke with passed my information to their clients, expanding my subject pool.

Interviews took place in a variety of settings, but the majority occurred in participants’ homes. Because almost all those interviewed have children, it was important for them to feel comfortable and for me to adapt to their busy schedules. Many times, their children were present for the interviews. All informants live in or around the Ann Arbor-Ypsilanti area. By meeting with informants in their homes, offices, or places of their choosing, I was able to gather

information about their lifestyles or preferences based on the objects they surround themselves with or the types of places they enjoy. Interviewing people in environments of their choosing allowed me special access into their lives through non-verbal cues, helping me better understand who each of them are. In this thesis, all informants are referred to using pseudonyms.

Study Limitations

There are many limitations to this study, even though this research offers a framework for future research concerning mothers and doulas. One major limitation was time. I first had to obtain Institutional Review Board approval, which took about two months. Due to my senior thesis research and writing schedule, I conducted research, analyzed my findings, and wrote my conclusions over a period of about six months. I was limited by the number of women I was able to interview, the amount of time I spent recruiting mothers and doulas, and the diversity of participants I was able to secure. However, I am satisfied with my sample of 13 and feel that it is a good base on which to build further research.

Because of the small study size, my conclusions cannot be applied generally or to other geographic areas since all participants live in the Ann Arbor-Ypsilanti area. Furthermore, this sample lacks diversity. The women interviewed are middle- to upper-middle class economically, with the exception of one woman who qualifies for free doula care based on her low economic standing. There is little ethnic diversity in the women interviewed: the majority of participants are Euro-Americans. There were some immigrants, including one mother and her husband from Romania. Another woman is married to a man from Nepal but is not Nepalese herself. Of the doulas interviewed, none are currently working as volunteer doulas, which means their clients are paying women of middle- to upper-middle economic means. At least two of them have

worked as volunteer doulas, though, and thus can make comparisons between their volunteer clients versus their private clients. Doulas are not exclusively women, either. There are men who have undergone doula training. DONA does not discriminate doula candidates by sex, but there are very few male doulas. No male doulas are referenced or interviewed here, which affects the discussion of gender dynamics. One male doula-like figure is referenced and is referred to as a husband's doula, but he has no doula training, just a background in therapy. This particular man symbolizes the potential for male social support in the birthing room, as this husband-doula attended the birth explicitly to support the soon-to-be father socially.

This study does not include women who have had poor experiences with doulas. In advertising for women who used a doula in childbirth, I expected responses from women who had very good or very bad experiences. No respondents had negative experiences, though. There is also a lack of health care professionals and their interpretations of doulas and the women who use them. Cases of poor mother-doula relationships and doula-care provider relationships exist, especially in newspaper accounts (Paul 2008), but none are reported in this study.

Paper Outline & Conclusion

This thesis consists of five chapters. After this brief introduction outlining the thesis's main themes, I provide a literature review in Chapter 2 that examines existing research on doulas. Social scientists and medical researchers have investigated doulas very little. The literature highlights the many positive effects of doulas as explored by social scientists and medical scholars. Most literature explores doulas in terms of medical effects, and few researchers focus on doulas as social support. Based on this existing work, my thesis aims to supplement social research by looking at doulas from a mother's perspectives.

In Chapter 3, I explore the role of social support and perceptions of pain in doula work. Support is an abstract term, and in this chapter I define doula support, placing it in the context of birth. The presence or absence of support also affects how pain is experienced. Doula use is a way to decrease perceived pain during labor (Emad 2003). Women who use doulas recognize doulas' abilities to help them manage labor pain, regardless of their desires for medical interventions. Though women also rely on figures like mothers or husbands, birthing mothers in this study attribute pain management techniques to doulas.

Chapter 4 focuses on kin relations, looking specifically at how doulas are part of shifting kin dynamics during labor. Husbands and partners have changing roles in labor due to a doula's presence. Partner support combined with doula support has seen positive outcomes (McGrath and Kennell 2008), but partners still must navigate another person within the birthing space. Birthing mothers' mothers have historically been resources to their daughters, but doulas offer informational and emotional support that may be favored over mother support. Doulas are also becoming kin as a result of the intimacy of the labor experience. This transformation of doula into kin forces us to reconsider how kin ties are formed within a birthing context.

In the final chapter, I examine how doula use could be considered trendy and what consequences doulas have for the future of American childbirth. The media has been fascinated with childbirth in recent years and usually reflects the dominant birthing structure. Although doulas have yet to be featured in movies or on television shows, they have the potential to break into popular media in the future if their usage moves into the mainstream. Doulas also have the opportunity to dispell standard notions of birth in the United States. I conclude that doulas are an opportunity to counteract the hyper-medicalized, technocratic birthing structure that exists in most U.S. hospitals today. In exploring aspects of support, the experience of pain, and kin

dynamics, I have found that doulas show the potential to affect women's birth experiences as a non-medical intervention, one that relies on social support as opposed to technological support. In this thesis, I show the relevancy of doulas and how their emerging roles as social supporters in childbirth could spark a movement back to woman-centered birth.

Chapter 2

Literature Review

The literature on doulas has primarily been written by doula advocates like DONA founders John Kennell, Marshall Klaus, and Penny Simkin. Other research on doulas, their meaning, and what they do is limited. Most studies have been published in obstetric and gynecological journals, birth journals, or other medically-focused publications. Although more and more doulas are being trained, there is little or no data gauging what the mainstream public thinks or knows about doulas. More research on doulas needs to be done to better understand their evolving role in U.S. childbirth.

Clinical Trials

To date, at least seventeen published randomized clinical trials have been run testing the positive or negative effects of social support during labor. These trials compare doula-assisted or social supporter-assisted labors to controlled labors that lack the same type of support person. In most early trials, researchers studied other people providing continuous support including nurses or relatives, many of whom were trained for the purpose of the study. Trials involving professional doulas, or those trained by an organization like DONA, did not start until the last decade. All trials focused on nulliparous women — those giving birth for the first time. An unreleased study from China completed in 2009 focuses on nulliparous women and multiparous women using doulas as behavioral interventions (Clinicaltrials.gov 2010).

Clinical doula trials began with Dr. John Kennell, a pediatric researcher from Case Western University, and Dr. Marshall Klaus, a neonatal researcher at Stanford University. The two men studied infant-maternal bonding together in the latter part of the twentieth century, slowly looking at alternative birthing options and finding doulas. These trials began overseas but soon were run in the United States and Canada.

Overall results from clinical trials show shorter labor times, decreased cesarean sections, and a reduction of negative feelings about the birth experience by the mother and the partner. Additionally, all studies tend to show benefits of having continuous support during birth provided by a doula, nurse, or family member, resulting in birthing mothers that feel more secure about birthing, have greater success in breastfeeding, and have fewer incidences of postpartum depression. Though some trials were run in North America — Campbell et al. (2007), Gagnon et al. (1997) and (1999), Hodnett and Osborn (1998), Kennell et al. (1991), Kennell and McGrath (1993), (1999), and (2008) — several trials have been run worldwide within different medical systems such as Klaus et al. (1986), Langer et al., (1998), Madi et al. (1999), and Sosa et al. (1980). Furthermore, several international doula trials studied intermittent support versus continuous support during labor, including Breart et al. (1992), Hemminki et al. (1990), and Hofmeyr et al. (1991). Though each trial differs slightly, they all show the same result: continuous social support by someone other than a care provider yields better birth outcomes, which means fewer interventions and more positive experiences as reported by the mother.

In place of professionally trained doulas, Campbell et al. (2007) found that female relatives trained as labor doulas during two-hour sessions prior to birth resulted in more positive prenatal and birthing experiences as reported by birthing mothers in the U.S. At six to eight weeks postpartum, women who had used these friend or relative doulas reported more positive

impressions of their hospital care and had more positive self-reported breastfeeding experiences than women without these helpers.

Clinical trials tend to focus on a specific practices and how they differ among control and test groups. All continuous support trials used a control group lacking this type of support. Nurses and other medical staff do not qualify as continuous support persons, unless they are in the birthing room the entire duration of labor. For example, McGrath and Kennell (2008) looked at the effect of doulas on cesarean rates while Sosa et al. (1980) looked at the effect of a supportive companion on perinatal problems and labor lengths. In McGrath and Kennell's study, cesarean section rates decreased with the use of a doula in labor (2008), and Sosa et al.'s study showed fewer perinatal problems when a doula was used during labor in addition to more positive mother-infant interactions immediately after labor (1980).

More continuous support trials need to be administered. Fewer trials have been done in the past decade, indicating a decrease in doula research by clinicians although the certification and general awareness of doulas is on the rise. Researchers aside from Kennell, Klaus, and a few others with whom they've collaborated, have not explored doulas in depth and have not invested time into designing studies about doulas. In future research, clinicians could benefit from the application of sociological and anthropological concepts to trial designs, recognizing cultural differences, environments, and social support systems when examining the perceived effectiveness of doula support.

Anthropological Research

Little anthropological research focuses on doulas. Anthropologist Dana Raphael first used the word "doula" to describe individuals who offered psychological encouragement and

physical assistance to new mothers in the Philippines. Raphael (1973) applied this term to women she observed helping new mothers breastfeed, choosing doula as a word with a nonmedical connotation.

The only anthropological study explicitly focused on doulas is a study out of Tampa, Florida. This study evaluated doula support provided through an inner city program that offered services to impoverished women during pregnancy and birth (Deitrick and Draves 2007). Through surveys of doula clients and through interviews with doulas, doula clients, and labor and delivery nurses at two local hospitals that accommodate the program, the authors found 129 of the 142 women surveyed (91 percent) credited doulas with enhancing their birth experiences and 124 of the women (87 percent) indicated that they would use a doula again during birth if available (Deitrick and Draves 2007:400). From the interviews, doulas were identified as providing four types of support: physical comfort, physical assistance, socioemotional, and verbal. This research adds to doula literature by recognizing cultural factors involved in using doulas but is not associated with a larger research body and is not published in an anthropology journal⁸.

Nonetheless, there is a growing body of literature on childbirth and anthropology. Several scholars, especially those who are a part of the Council on Anthropology and Reproduction, have explored American birthing practices that are slowly including doulas. The Council is comprised of anthropologists that study women's reproductive issues. Several scholars consider doulas in other countries, such as in Brazil (Jones 2009), or examine doulas as a way to control pain (Emad 2003).

⁸ Deitrick is a medical anthropologist and ethnographer, but her work is not associated with a university, and she works out of a hospital. Draves has a professorial appointment through St. Leo University in Florida but specializes in psychology.

Robbie E. Davis-Floyd's *Birth as an American Rite of Passage* (2003), a foundational work of childbirth theory, identifies the technocratic model of birth, a framework focused on male hierarchy and technology from which the majority of American birth practices are now shaped. This volume also discusses key issues in birth, such as hospital policies and family practices, all of which have been affected by technology. Davis-Floyd identifies ways in which women learn about and experience birth as mediated through technology. Pregnancy is confirmed through ultrasound images, labor is confirmed with fetal heart monitoring, and babies are born with the aid of hospital instruments. By looking at birth as an American rite of passage,⁹ Davis-Floyd forms new ideas for anthropologists to explore, including the use of doulas as a counter to the technocratic model.

Other foundational anthropological works include Emily Martin's *The Woman in the Body: A Cultural Analysis of Reproduction* (2001) and Brigitte Jordan's *Birth in Four Cultures* (1993). These works provide some of the first cultural investigations of birth following changes in medicalized birth from the mid-twentieth century, especially in the United States. Martin argues production and machinery metaphors are applied to women's bodies and cultural stereotypes intersect with biology, as processes including childbirth are not exclusively biological. Jordan uses ethnographic research from Sweden, Holland, the Yucatan, and the United States to explore childbirth as a cultural event that is biomedically mediated in many parts of the world. Jordan uses the concept of authoritative knowledge as a way of analyzing the information that is the most trusted or relied on by pregnant and birthing women. She further discusses how authoritative knowledge varies among cultures in its acquisition, how those with it

⁹ Rites of passage were first discussed in the mid-twentieth century by van Gennep (2004). A rite of passage involves three stages: separation, transition or liminality, and integration. For American women, Davis-Floyd describes pregnancy as the first stage through which women are separated from others, labor as the liminal second stage during which women are neither pregnant nor mothers, and the birth of a baby as the final stage when women become mothers, fully transforming from an individual without child to a mother.

become trusted, and how it intersects with power in the birthing room. Her study shows how views of biomedicine and its role in childbirth are inherently social.

Cross-Cultural Studies

Doulas have not been professionalized in other countries as much as in the United States, and doulas are not as prevalent in places outside North America. Studies have been done on doulas specifically in Mexico (Campero et al. 1998) and on partner labor support in Turkey (Gungor and Beji 2007) and the United Kingdom (Somers-Smith 1999). All of these studies found positive outcomes and impressions of social support as interpreted by mothers and partners. Other works have examined social assistance by traditional midwives. In areas of Nigeria, traditional birth attendants assume their roles as village midwives based their social and community standing, not by medical skill or training (Itina 1997). In some Malaysian villages, midwives are essential in helping women complete a rite of passage while protecting the child from negative spiritual forces (Laderman 1983). Although midwives often fulfill social roles during birth, the World Health Organization has launched numerous programs to train traditional birth attendants in several countries, helping women add medical knowledge to their cultural understandings of their communities.

There has been a large amount of research published recently concerning cesarean sections, especially through efforts of the World Health Organization to survey large geographic areas. The most recent survey indicates cesarean rates of about 27 percent in nine Asian countries¹⁰ (Lumbiganon et al. 2010). Additionally, analysis of the survey data showed China as having the highest cesarean rate at over 41 percent; not only were a quarter of these cesareans

¹⁰ The countries surveyed were China, Cambodia, India, Japan, Nepal, the Philippines, Sri Lanka, Thailand, and Vietnam.

done without need for medical intervention, but 62 percent of the hospitals interviewed cited financial incentives¹¹ for increasing cesarean births (Chong and Kwek 2010:440-41). Similar surveys have been done in Latin America and have shown that high rates of cesarean sections do not result in better mother and child outcomes and can increase harm (Villar et al. 2006). This data has caused scholars to issue warnings about the harm of unnecessary cesarean sections for women's health and children's health (Victoria and Barros 2006). Private hospitals in countries like Brazil have reported cesarean section rates up to 90 percent (Jones 2009, Victoria and Barros 2006). Unlike in the United States, scholars in the international medical community are finding ways to intervene and fight for cesarean decrease. Althabe et al. (2004) found a small percentage of cesareans could be avoided in Latin American countries if hospitals enacted a mandatory second opinion policy in which the birthing mother consults two doctors about her birth options and does not only adhere to the first doctor's recommendation. This study found no changes in outcomes or in mothers' perceptions of care. Cesarean sections have increased in the United States since the mid-90s, reaching a 32 percent cesarean rate as of March 2010 (Menacker and Hamilton 2010). The World Health Organization advises a 15 percent cesarean rate (1985), one that none of these studies finds present in these increasingly biomedical countries. This data adds to cross-cultural childbirth studies by providing statistical bases for social research.

Social Science & Medical Research

¹¹ Financial incentives refer to the increased revenue hospitals make from cesarean procedures. According to Lumbiganon et al. (2010), a cesarean costs an average of £1200 (approximately \$1900 U.S.) more for a cesarean section than a vaginal birth in the United Kingdom due to the increased need of drugs, personnel, and equipment. The gap is much larger in the United States at more than \$5,000: in 2005, a complication-free vaginal birth cost \$6,973, a complication-free cesarean cost \$12,544, and a cesarean with complications cost \$15,960 (Childbirth Connection 2008). These figures do not include additional anesthesia and other costs. In low-resource countries, increasing cesarean sections without medical need also increases hospital revenues (Lumbiganon et al. 2010).

Little social science research has been carried out on doulas, and the majority exists in publications aimed at medical professionals. Interest has increased, however, based on three dissertations written on doulas in the past seven years. In 2003, Christine Morton from the University of California at Los Angeles published her sociology dissertation titled, “Doula care: The (re)-emergence of woman-supported childbirth in the United States.” Her dissertation draws from her personal experience of being a doula along with qualitative interviews of dozens of doulas about what they do, how they practice, and why they’ve chosen to do so. This work draws heavily on sociological theory concerning doulas as part of social networks and only focuses on the doulas, omitting input from mothers who have used doulas and health care professionals who interact with doulas. The paper identifies many conflict-ridden issues doulas constantly must negotiate, including financial gain, emotional availability, and professionalism. Prior to Morton’s work, little if any academic work was devoted to social issues surrounding doulas. Other works exploring the doula’s professional or semi-professional role are Gilliland (2002) and Lantz et al. (2005).

In 2004, Bari Meltzer published her dissertation in sociology, “Paid labor: Labor support doulas and the institutional control of birth.” Again, Meltzer’s sociological background allows her to draw on institutional and structural issues faced by doulas, including how doulas are an opportunity to bridge gaps between midwifery models of birth and obstetric models of birth. Through extensive interviews with 30 doulas and several follow-up interviews, Meltzer identified these structural issues in American birth and how doulas — by negotiating a personal and professional role during labor — challenge the current biomedical systems in place.

Following studies focused on doulas as an occupational group, Heather Holland (2009) looks at community-based doula programs as opposed private doula practices. In eight

interviews with doulas and mothers who were clients of the doula program, Holland found an improvement in maternal care through the creation of relational space between young mothers and doulas. These interviews revealed that an increase of accessibility to doula programs could improve social support for mothers during pregnancy and birth and also create a greater sense of control over their birth experiences. Holland comes from a social work background and conducted these interviews in Canada. Her conclusions emphasize intervention and activism, but her discussion of space and support reveal important social concepts to pursue further.

A key piece of social research used in my study is a survey conducted by Childbirth Connection, a New York-based childbirth advocacy group. Listening to Mothers II is a survey developed by Childbirth Connection, Boston University School of Public Health, and Harris Interactive with support from Lamaze International (Declerq et al. 2006). The survey was administered by Harris Interactive — a national market research group — and consisted of 200 telephone interviews and 1,373 online surveys of mothers. Only women with one child were included, and the child must have been born in a hospital in 2005. Phone interviews were conducted in January and February 2006. Using national demographics and efforts to reach ethnic minorities, the survey population resulted in a representative sample of the U.S. population. Since the majority of women in this study gave birth in a hospital along with the overwhelming majority of U.S. women¹², this survey is utilized for statistical data in many sections of this thesis. Childbirth Connection first conducted a Listening to Mothers survey in 2002 (Declerq et al 2002). The organization followed Listening to Mothers II with a survey looking at postpartum issues, New Mothers Speak Out, in 2008 (Declerq et al. 2008).

Other social research combines medical outcomes within social contexts, particularly low-income situations. Hospital-based doula programs have been the topic of studies including

¹² Less than one percent of births happen outside the hospital (Martin et al. 2009:5).

Gordon et al. (1999) in Northern California and Mottl-Santiago et al. (2008) in Boston. These studies, and several others, target the effects of social support for women in low-income or urban areas. Lashley (2008) explores low-income adolescent black mothers' birth perspectives, including those on doulas, and Schroeder and Bell (2005) find positive responses from incarcerated women who had doula assistance during birth. Dundek (2006) reports positive results from a hospital-based doula program in Minneapolis designed for Somali women, reducing the number of cesarean sections among Somalis and increasing nurses' comfort levels in working with Somali women. Newspaper articles highlight low-income or multicultural doula work, including doulas helping Somali women in Minneapolis prior to Dundek's study (Halvorsen 2004). Articles also feature doulas helping Hispanic women in Florida (Hutcheson 2008) and teen moms in inner-city Chicago (Fields-Meyer 2005). Similar to social science research, journalists find themes in their stories of disadvantaged women learning from or being empowered by doulas, such as incarcerated women (Spencer 2009).

Medically-based scholars have looked at doulas through several lenses but each involve social context. Nurses have examined nurse-doula interactions and suggested ways for the two groups to interact better during labor (Ballen and Fulcher 2002); continuous and intermittent support strategies have been compared, revealing that continuous support is better for the birthing mothers' outcomes and feelings about birth (Scott, Berkowitz and Klaus 1999); and benefits of the doula have been documented by doctors using patients' personal stories as evidence of their positive results (Kennell, Fulcher, and Stein 2004). As medical researchers write about doulas, social scientists need to join them to create more holistic studies within medical contexts.

What most of these studies lack is the mother's perspective — how do birthing mothers feel about doulas? What is it about the doula that creates these beneficial outcomes and creates more positive birthing experiences? Though scholars are using surveys and statistics to show mothers' satisfaction with doulas, this paper aims to contribute more personal accounts of how and why doulas are endorsed by birthing mothers. By beginning to fill this gap in the literature, I aim to stimulate more discussion about mothers' motivations to use doulas and how the presence of doulas at birth is part of a greater cultural change in U.S. childbirth.

Chapter 3

But it hurts! — Is a person the best drug you can get?

I would have never made it without any medication had I not had a doula, for the first child, especially. My goal was to do natural childbirth with both my kids, and there would have definitely been a time during the first one when I would have melted down and succumbed to the drugs if I hadn't have had my doula there.

Jill, mother of two, doula
present at both births

People are not drugs, but some local families — namely birthing mothers and their husbands — are choosing people instead of or in addition to medically administered drugs during childbirth. In seeking an explanation for why a person would be a preferred labor intervention over pharmacological options that reduce pain or laboring time, pediatric researcher John Kennell has pointed to doulas' positive effects in lieu of intravenous remedies that are standard in most hospitals. Kennell, called the father of the modern doula movement, is cited in multiple interviews and printed works as saying, "If a doula were a drug, it would be unethical not to use it" (Young 1998¹³).

Birthing women in U.S. hospitals today are offered a variety of medical interventions for pain relief, two of the most common being epidural analgesia and spinal blocks. Epidural analgesia, also called an epidural block, numbs pain and is administered at the lower back, just below the spinal cord (ACOG 2004). An epidural cuts off feeling from the waist down, though dosage strength determines how much feeling is lost. Epidurals begin working 10 to 20 minutes

¹³ This quote is cited in multiple places and used numerous ways. However, the origin of the quote is obscure at best. Based on the literature, it is inferred that Kennell said this at DONA's annual conference in 1998.

after being administered. A spinal block is also injected into the lower back, bringing immediate but temporary pain relief that lasts only an hour or two. A smaller needle is used and a much lower dosage of medication is administered, numbing the regions below the waist.

Regardless of prevalent usage, there are many risks associated with these pain relief interventions including headache, soreness, and loss of blood pressure. If medication enters a vein, this could alter the woman's heartbeat or result in dizziness. Additionally, if the injection site is not properly watched and prepared, medication could find its way to the chest muscles, making it hard to breathe (ACOG 2004). Though these blocks relieve pain and often allow mothers with longer or more intense labors to rest, they can also make pushing more difficult because women are unable to feel contractions that tell them to push. Although drug dosages can be adjusted to gain some feeling for the contractions, labor can be prolonged as a consequence of high doses of pain medication. Still, the majority of American births are medicated in some way: eighty-six percent of women use drug-induced pain relief nationwide, and over three quarters of women are administered an epidural or spinal block (Declerq et al. 2006:31).

Despite the prevalence of pain-relieving drugs, there is a lack of detailed knowledge about drug interventions for pregnant women seeking this information. For example, the American Academy of Pediatrics' website has a health topics section. Within this section, the user is able to choose a developmental stage for relevant health information. When choosing "Prenatal to 1 Year," all following links contain no information about prenatal health, labor and deliver, or pregnancy. The site instead lists questions about circumcision, development milestones infants should reach, and infant hearing screenings. Additionally, an alphabetical search guide on the same page lists health topics relevant to women and children. "Childbirth" is not listed, and "Birth Control" followed by "Birth Defects" are the only birth-related topics. The

AAP's sister website, healthychildren.org, features a prenatal section with two topics: "Decisions to Make" and "Delivery and Beyond" (AAP 2010b). The only birth-related decision concerns care provider, and the delivery section's pain information features definitions of pain medication without a list of risks or alternatives (AAP 2010a). Over half this page is dedicated to medication needed when having a cesarean section — a relevant page since 32 percent of births nationwide are by cesarean section, the twelfth consecutive year the rate¹⁴ has increased and a 57 percent increase from the decade prior (Menacker and Hamilton 2010). In the state of Michigan, rates have increased 50 percent, from 20.2 percent in 1996 to 30.4 percent in 2007 (Menacker and Hamilton 2010:5). The new addition to the C.S. Mott Women's and Children's Hospital as part of the University of Michigan Health System has been designed for a 50 percent cesarean rate (Susan).

A recent documentary, *The Business of Being Born*, explains the intervention domino effect used in many U.S. hospitals (Epstein 2008). This film is an exception to other childbirth education materials that fail to explain to pain medications. Instead, filmmakers interview obstetricians, medical anthropologists, and certified nurse-midwives who explain the connection between pitocin, epidurals, and cesarean sections in U.S. hospitals. Based on the interviews, experts agree that some cesarean sections credited for saving women and their babies are only necessary after rounds of other medications severely hinder a woman's ability to give birth.

Women interviewed in this study, however, suggest that a doula can act as a preferred substitute for drug intervention in pain relief and comfort, or, as some women explain, as a type of human intervention that helps them give birth in the ways they want. As Jill explained above, it was her doula that kept her from sacrificing her desire for natural childbirth during more painful moments in labor. More than just preventing interventions when mothers desire to do so,

¹⁴ The cesarean rate is the number of cesarean births per 100 live births (Menacker and Hamilton 2010).

doulas provide support — support for the mother, for the couple, for their decisions, and for labor pains. Almost all the women talked about how choosing a doula was a way for them to regulate the administration of pain medication that hospitals routinely use. In using a doula, women from this study make informed decisions based on their understanding of American birth. This chapter explores what doula support is and how doulas' drug-like effects are empowering women to re-assess the birthing experience.

Doula Support

What is support? According to women in this study who have used birthing doulas, a doula *is* support. The Greek translation means servant, but servant has transformed into supporter for American birthing experiences. A doula's continuous, encouraging presence works to support a woman's birthing experience by reflecting the birthing mother's calm side while the more wild, out-of-control side physically handles the birth process (Dara). A doula can prevent women from sacrificing their birthing desires and support them through their decisions. Concurrently, she can physically symbolize a part of the birthing woman by reflecting calm in her demeanor toward someone feeling the opposite.

As part of support, doulas are considered by their clients to be the calm, knowledgeable presence during the birth process whereas the partner — sometimes the husband, but not exclusively — is often described as a different type of support, often going through the emotional roller coaster of birth along with the woman. This is especially true of first time dads who oftentimes have no frame of reference for what birth looks like, even if they've been active during pregnancy and attended prenatal appointments as all fathers in this study did. Without knowledge about birth, partners can increase anxiety for the mother if they are not comfortable

with watching or participating in labor. Calm, supportive presences in the birthing room have been recognized as key components of alleviating perceived pain for birthing women because they create a more pleasurable and less anxious birthing environment (Lowe 1996).

In a nationwide survey conducted in 2005, only three percent of women were supported by a doula during labor in over 1,500 mothers interviewed (Declerq et al. 2006:30). However, all women who had access to and utilized a doula during labor felt they had been fully supported during labor (2006:31). Obstetricians, however, attended 79 percent of women, but only 34 percent of respondents felt obstetricians had been supportive during labor. The study authors point out, too, that though doulas provided support to the smallest percentage of women surveyed, doulas were the support caregiver that received the highest care rating of “excellent” which came from 88 percent of the respondents who had used them.

It is hard to grasp what doulas do without using one or knowing one personally. Many women described their excitement about using a doula before giving birth even without having a concrete understanding of what the doula would be doing in the birthing space. Jenn and her husband were friends with a doula for years before giving birth to their first child. Even after knowing her on a personal level, Jenn was still unsure about what a doula actually did: “I didn’t have a great understanding beyond that a doula was someone who came to the birth to support the mother.” After two births, one in the hospital and one at home, Jenn recognized that a doula was the socially supportive system she needed:

A doula is someone who provides the support that you need before, during, and after childbirth. And for me, it was a lot about processing what kind of birth we wanted, what were our fears ... a little bit like therapy, processing birthing expectations or goals or wishes, and issues that we were concerned about. And then during childbirth, just incredible support for not only me but my partner and taking breaks and [being] physically supportive and emotionally supportive and afterward just being an incredible caregiver.

Jenn describes support as a layered activity, one that involves being mentally, emotionally, and physically supportive, not just for her but for her and her husband. For Jenn, this type of support was a need, a large part of which involved verbally processing the birth before and after labor. As opposed to technological or biomedical support, social support met Jenn's needs in the ways she needed. Jenn also recognized the need for feeling safe to talk about birth with someone willing to respect the wishes of the family. Health care providers, especially in a hospital setting, are not required to talk through birthing wishes and desires with a mother in depth, much less after the birth. Obstetricians, especially, are usually on call and attend births of women who are in labor during their shifts as opposed to working with the same woman for nine months before labor. UM Hospital nurse-midwives have a similar system, but with only nine midwives and changing midwives during prenatal appointments, the chances of getting a nurse-midwife you know are higher than a woman getting an obstetrician she knows in the general labor and delivery practice. Nurses are often thought to attend laboring mothers, but paperwork, other patients, and clinical duties often prevent them from continuous time with a birthing mother (Ballen and Fulcher 2006). After labor, postpartum doctor visits tend to verify physical health of the mother and child as opposed to mental and emotional health. A doula acts as an available outlet, fulfilling a family's need by being present for the event but also being involved to a great enough extent that allows her to be emotionally available for the family following the birth.

Prenatally, doulas support the mother through two or three sessions during which the doula gets to know the family, understand their birthing knowledge, talk about questions they might have, and discuss their desires for the birth. Some doulas recommend that their clients make birthing plans — written details about what they desire to happen during labor —

regardless of what information the birth plans actually contain¹⁵. Each doula's prenatal sessions vary in how they look, too. Some doulas will offer massage services, pampering the expectant mother while also accustoming the mother to the doula's touch since many doulas offer massage during labor. Leah is certified in Reiki, a Japanese form of relaxation and healing, which her clients will often request during prenatal appointments. Doulas interviewed for this study cited information transmission as one of the most important parts of prenatal appointments. The birthing family often seeks specific information about labor, infant care, or hospital policies, which the doula is able to present to them and talk through with them. By talking through important information like this, the doula learns about the family's needs and desires for the birthing experience — before, during, and after — and thus learns how to better support the birth by knowing the people whom she is supporting. Prenatal sessions are ultimately intended to develop a relationship between the family and the doula, cultivating a relationship through which labor support can happen.

Labor Support

What support looks like changes for every labor. Doulas describe their support for mothers in labor on a case-by-case basis, recognizing that each labor is unique and each mother will need different types of physical, mental, and emotional support. For Samantha, a birth doula who became a doula after using one during the birth of her first child, her role as a doula during labor is an essential presence in the birthing room, one that she describes as “holding space:”

I feel like there is a piece of support that is a little harder to talk about, and it's almost like being an anchor holding a space during the birth, where it includes things like encouraging the mom, rubbing her hand, holding her hand — it's really more about holding a really strong space so she can labor feeling like she

¹⁵ Birth plans are frequently created by birthing mothers or families during prenatal appointments. These are discussed further in Chapter 4.

has something to anchor to. I don't really know how else to describe it, but I feel like it's a really important part. You've got nurses coming in and out and that's their job, but to have one person who's just there, who's present, who's able to say, ... 'you're doing great' — I feel like that's a really important part of support that's really hard to put into words.

Holding a space, as Samantha puts it, encompasses the three dimensions of doula support as outlined by Jenn. Based on the more spatial purpose Samantha feels herself to have, Jenn's description of her doula's physical support as "superficial" seems somewhat appropriate, deeming it the most visible layer of support but also the least important. Under the surface, there is a more purposeful, impactful reason for having a doula present and having a non-biological family member active at the creation of a new family. A doula's "encouraging words, encouraging looks, encouraging touches" (Jenn), have a greater importance during labor than the mother's immediate physical relief. Along with a doula's listening ear after labor, these non-tangible support services are actually the most salient characteristics of doula support, both of which happen while the doula is holding a space that only she can hold.

DONA International defines a doula in a very similar way: "A birth doula is a person trained and experienced in childbirth who provides continuous physical, emotional and informational support to the mother before, during and just after childbirth" (2005d). Without citing the formal description, Jenn was able to piece together a definition almost exactly matching the ideal doula as cited by the largest doula organization in the world, through which her doula was certified. Jenn's doula reflected the mission of DONA through her methods of support without needing to be verbally explicit.

A doula's support can also translate to creating space for the couple, finding a place for them to step back from the laboring experience and talk. During labor, there is rarely a moment that some type of medical staffer isn't in the room, and with each person comes options for

intervention. Samantha says her role is often to find a safe space for the family: “What can I do to give the family a little bit of time to talk about [a decision] without a nurse or a doctor staring them in the eyes, waiting for a response?” Samantha frequently recommends that her clients seek the bathroom for privacy — a space lacking monitors, health care providers, and nurses. During prenatal appointments, she talks to the birthing family about the importance of having moments of alone time and seeking those moments out, even if it means retreating to the restroom.

During normal labor, use the bathroom — go in and shut the door. Sometimes they need to, sometimes they don’t. But it’s quiet in there, and sometimes if things are just a little bit overwhelming, I might even say, ‘Would you like to go to the bathroom and just go take care of business and come back out and get a fresh perspective?’ And so it sounds very much like, ‘Do you need to pee?’ but we’ve already talked about it [meaning], ‘Do you need a little break?’ I’ll send the partner in, because she’ll probably have a contraction while she’s in there, it’ll be nice for the partner in there. But sometimes it can be a nice way for them to step out of what can seem like a lot of pressure. [Samantha]

Samantha uses an alternative physical space to create mental and emotional separation from the birthing environment for the woman and her partner by utilizing a removed physical area, away from birthing space defined by medical staff and limitations of the actual hospital room. In this way, Samantha’s doula role is as a space manager: mediating how people are interacting within a space in multiple dimensions, reading their reactions and emotions at any given time, and making recommendations for how best to use space at any given moment.

Samantha currently works as a private doula, but as a new doula she volunteered with Doulas Care serving low-income families. Samantha explained that many of the women she was paired with as a volunteer doula didn’t have a lot of social support locally, meaning women who lack someone to fill the role of a close friend or family member. For these women, Samantha became a multi-faceted support system during birth, playing the roles of partner, friend, and educator.

Carrie is a recipient of free doula services. She has four children, all with different fathers. Due to Carrie's broken ties with her family members — who also live at least 100 miles away — and with few friends in the area, her maternal infant support worker at UM Hospital recommended a doula when Carrie became pregnant with her third child. Carrie sought the services of a free doula through the Center for the Childbearing Year. The Center sent her two doulas each for her third and fourth births, though only one doula was able to attend her fourth birth. Without partner or friend support, Carrie found each doula essential. Her doulas even drove her to the hospital for her third birth. To her, a doula is, “A comfort, and a friend, and the best thing there is. I would honestly say that it made my childbearing experience wonderful.” Carrie's first word to describe her doula experience was “supportive.”

Across incomes and lifestyles, doulas create a culture of support in the birthing room. This support translates to physical, mental, and emotional space, not just for the birthing woman but for all players involved — including health care providers if they are around. Instead of an advocate, a doula acts as a mediator between space and the woman, mediating how spaces are used and how they could better be utilized for the mother's comfort and the birth experience as a whole. By expanding on this role, a doula fully enacts support in the laboring room.

Pain & Relief

Pain has been cited as the most culturally salient part of childbirth in the United States (Emad 2003). Pain, however, is a cultural construction (Good et al. 1992; Morris 1991; Scarry 1985). Because the medical community has found biological determinants of pain, people treat pain as a problem to be dealt with through medical means as opposed to a socially and culturally experienced feeling. By ignoring the social context of pain, people fail to understand the

meaning behind the pain they perceive. It is only when, “we recognize that the experience of pain is not timeless but changing, the product of specific periods and particular cultures” that it is possible to “*act* to change or influence our own futures” of pain experience (Morris 1991:4). Pain chances for every person depending on context, which means reactions to pain must change per context, too. Pain is linked to suffering in medical history and in literary texts, and scholars recognize the need to examine pain in historical and cultural contexts in order to understand how people experience it (Good et al. 1992; Kleinman 1986; Morris 1991; Scarry 1985). The experience of pain in U.S. childbirth needs to be understood in relation to the cultural factors affecting birthing women as well as those affecting medical personnel trained to deal with women in pain.

Many Americans dwell on labor pain, teaching classes on how to overcome it and creating popular media images of exaggerated or comedic pain within film and television. After the Lamaze Method was introduced in the 1950s, the birthing technique was misunderstood as a way to achieve painless childbirth (Lamaze International 2010). Unlike Western images of seething, screaming pain, not all cultures ascribe to this experience of labor. In South India¹⁶, for example, women seek labor inductions using pitocin because the drug mimics oxytocin, the naturally occurring chemical that regulates contractions (Van Hollen 2003). These women believe pain is a necessary part of childbirth and that it has larger implications than physical discomfort, including the bringing about of visions. By using pitocin, these visions can more easily come about since the drug increases contractions and thus the pain of labor. In reality, the pain experience is different for every woman. It is this individualized pain that necessitates a constant support attendant during labor; with someone monitoring the mother and interpreting

¹⁶ In other areas of India, women are shamed and sometimes humiliated among family or friends if they make any noise at all during childbirth (Jeffrey, Jeffrey, and Lyon 1989:115-116). As with the United States, pain experiences cannot be generalized in other countries.

her perception of pain with her, a support person can make suggestions for pain relief that take into consideration the specific labor experience of the mother (Lowe 1996:82). The pain experienced during childbirth, however, is pain that many women say they've never felt anywhere else and have a difficult time describing. Dara describes fear of pain before each of her births, even before her third birth. For Dara and her husband, having "somebody who can maintain calm and trust in birth in the face of lots of pain and what looks like suffering" was essential.

Doulas are a non-pharmacological response to pain relief because their supportive role creates a calm social environment during birth. In having the ability to stay with the mother constantly through labor and having knowledge of non-medical pain management techniques, doulas are in a perfect position to reduce the birthing mother's negative psychological reaction to pain (Simkin 2007:169). Clinical trials have shown continuous doula support in labor to produce positive physical and mental outcomes, including among low-income and middle-income couples (McGrath and Kennell 2008). Trials in which a female friend or close relative was minimally trained as a doula-like support system also resulted more positive incomes than non-supported births due to their continuous presences (Campbell et al. 2007). A positive outcome is usually characterized by the mother's impression of labor afterward, a lack of medical intervention or flexibility by the family for intervention, and a lack of in-labor complications resulting in cesarean sections. Other health care providers are unable to interact one-on-one during labor — including nurses — which places them at a disadvantage for administering what hospitals might consider alternative pain relief methods (Simkin 2007). These methods include hot and cold stimuli, position changes, massage, acupuncture, and hydrotherapy, each of which takes time and careful monitoring of the mother (Simkin 2007). Doulas are able to help the

mother and her husband manage pain during the birth with these methods while being continuously present for consultation, encouragement, and other help.

Speaking Relief

By acting as pain negotiators, doulas take the mother's cultural expectation of pain and find ways for the woman to draw words onto her body that focus on empowerment versus bodily failure (Emad 2003:22). When coming from nurses, who are perceived to be experts in the birthing room regardless of their interactions, this type of encouragement has been cited as having narcotic-like strength in easing pain for birthing women (Simkin 2007:196). When contractions happen, for example, doulas offer different types of verbal responses for getting through them. Jenn's doula posted encouraging phrases around her delivery room at the hospital, showing her and Jenn's husband words to say when Jenn needed encouragement or help. Though visual cues, the phrases become verbal messages transferred from doula and father to the mother and the mother's body. Jenn cited these phrases for helping her stay calm as well as for her husband who could look at a visual reminder of calm when needing encouragement for himself and his wife. Doulas have also been known to repeat encouragement mantras with mothers during contractions, to lead singing through and between contractions, and to feed the partner encouraging words he can say when he may feel speechless. Sophia's doula meditated while Sophia labored at home in a tub¹⁷. From across the room, Sophia remembers feeling peaceful, even through her intense contractions, because she "really felt her [doula's] calming energy" reach her.

¹⁷ Some women choose to labor in birthing tubs because the weightless feeling of the water can help manage contractions. Women laboring in water do not necessarily have water births, though. Tub is used in some home births but are also available in some hospital settings, especially those that encourage low-interventionist births.

Pain, brain, & body

Ultimately, pain negotiation starts in the mother's brain, and medical anthropologists recognize the importance of the cultural construction of the mind/body dichotomy. The relationship between mind and body is not uniform among all cultures, and how a person experiences pain challenges how the mind and body work together. The relationship between mind and body is strained in Western cultures: the mind and body are separate and do not function as one. Other cultures view the two as functioning holistically. Though typically discussed when describing sickness, the body's reaction to pain or perceived malfunctions, such as childbirth, is a form of communication "through which nature, society, and culture speak simultaneously" (Scheper-Hughes and Lock 1987:31). By this, Scheper-Hughes and Lock (1987) refer to how the social structures around us influence how our physical bodies respond to stimuli and show this response in a culturally appropriate manner: it is the body as an individual, as a vessel reflecting relationships within society, and as an tool under social and political control. Social histories are essential in shaping how bodies are taught to react to pain (Morris 1991; Scarry 1985). As such, the mind and body function within a contradiction — they are separate entities but are both influenced by social and cultural forces. The body may physically suffer due to an illness or disease, but social forces also cause suffering based on societal reaction and treatment of that body. Suffering is social, and the process of pain becomes one of social mediation and transformation (Kleinman, Das, and Lock 1997:xix). Southern Indian women experience this mediation following labor, as the extent of their pain and the power of their experiences during it impact their social lives among family and friends (Van Hollen 2003).

For a birthing woman, the pain she feels is only as bad as she perceives it, but her bodily experience is still real (Lowe 1996:85). Doulas, health care providers, and support partners are

constantly seeking ways to help mothers reorient their minds on something aside from what they are conceiving as pain by interacting with them psychologically. The multiple verbal encouragement techniques, for example, are all focused at the brain, but their messages are often linked to a body reaction, too, like, “you can do it, just one more push” or “breathe through this contraction, then relax.” Valerie said she works with mothers one contraction at a time in her capacity as a doula, helping them see beyond the pain of a single contraction and instead verbally encouraging them until it has passed. She said women avoid or delay pain medications because of this encouragement since their minds are temporarily distracted from the physical sensation. Implicitly, support players including doulas recognize the relationship between mind and body.

Medical scholars have explored pain and its connection to the brain, discussing what is actual, physical pain versus a person’s perception of painful experiences. There is an association, for example, between the anticipation of chronic pain and it exacerbating the experience of that pain (Ploghaus et al. 1999:1979). If women perceive childbirth only as painful, they will have an experience focused on the negative, fulfilling their own pain-in-childbearing prophecies. Chronic pain is defined by its persistence, marked by the firing of pain signals in the nervous system for an extended period of time (NINDS 2009). Childbirth is not true chronic pain because its duration is confined (to days at most) as opposed to ailments lasting weeks or years. The other medical classification of pain, acute pain, is defined by its “normal” nature that “trigger[s] in the nervous system to alert you to possible injury and the need to take care of yourself” (NINDS 2009). Childbirth by low-risk women produces a normal, routine type of pain — but labor pain is not alerting you of possible injury. This reinforces the idea that pain is culturally constructed because childbirth pains are experienced by women worldwide but cannot easily fit into either category uniformly. Anthropological discussion of chronic pain tends to focus on the duration of

pain but also accounts for important elements that can be applied to childbirth: namely, the necessity to examine the social environment in which chronic pain is experienced (Good et al. 1992; Kleinman 1988:180). In the context of childbirth, the environmental factors that could influence pain experienced during labor are not necessarily in the delivery room but more so experienced during pregnancy. Because pain is so often associated with childbirth, it can come up when interacting with health care providers and family members but also with friends, media outlets, neighbors, the teller at the bank, the cashier at the grocery store, and a host of others who may expand on the distress of childbirth, thus creating a social context for chronic, negative pain to exist. In discussing this thesis with mothers not interviewed for the study, almost all of them immediately referred to the pain of childbearing versus those interviewed who focused on the overall experience. Scheper-Hughes and Lock conclude that the structure of individual and collective sentiments — as simple as the “feel” of one’s body or how natural someone feels in their physical position — is a social construct (1987:23). This means that an overarching social atmosphere can supplement how women physically perceive themselves during childbirth. Doulas, most often deemed a solely positive addition to birthing rooms (Declerq et al. 2006; McGrath and Kennell 2008), directly combat this pain structure with methods of mediating that pain before, during, and after birth with continuous support techniques. It is also essential to acknowledge childbirth pain as continual in order to apply these techniques, which take time to exercise and may need to be repeated often. This type of pain mediation is possible because psychologically, there are also two types of pain: withering pain and strengthening pain. The former is marked by its destructive nature while the latter is “apt to enhance the endurance, strength and immunity” of the person experiencing it (Kinget 1999:306). There is a need to take care of your self, but as opposed to pain caused by non-normative events like breaking a bone or

rupturing an appendix, childbirth causes no immediate danger for low-risk women. Conquering childbirth pain can be liberating or empowering instead; Jenn feels as if there is not challenge her body can't handle having gone through childbirth naturally.

Pain can also be thought of in context of illness or sickness. Through biomedical practices, pregnancy has sometimes become a treatable condition, similar to an illness or sickness that temporarily harms the body's normal functioning (Martin 2001; Davis-Floyd 2003). By choosing to label pregnancy as a malfunction of the body as a machine, the labeler ignores pregnancy as a natural human process and immediately seeks ways to fix the supposed problem (Davis-Floyd 2003:51-59). This view stems from what Davis-Floyd calls the technocratic model, a structure that places technological intervention and male hierarchy as the backbone of the birthing process (2003:47). Though pain can be dangerous to the mother based on its unexpected, immediate nature, childbirth has transformed from a normative human process to that of a harmful process through intervention. Davis-Floyd contends that modern obstetrics was created to "develop tools and technologies for the manipulation and improvement of the inherently defective and therefore anomalous and dangerous process of birth" (2003:51). The Western world prefers to see the body on level a symbolically equal with machines, having transformed the body into a commodity following the modern theories of labor and modes of production from early twentieth century thinkers including Karl Marx (Scheper-Hughes and Lock 1987:22). If the female body is a machine and birth causes it to malfunction, the body would need drugs administered immediately to counteract the pain, even when labor is progressing normally. Non-pharmacological techniques like those above — many of which doulas routinely engage in — can only be used if pain is experienced as necessary and temporary, and the body is not seen as broken. If the body is functioning normally, health care providers do not need to seek immediate

ways to fix it. Pain unfortunately indicates distress, even though pain is an understood part of labor.

Furthermore, childbirth is an anticipated pain, and most women know it's going to be painful. Popular media images of childbirth often focus on the pain, including those in film and television. The television show *Gilmore Girls*, for example, features the main character, Lorelai, recounting her daughter's birth at several points each season, referencing her immediate need for Demerol¹⁸ and describing her birth experience as including screaming, swearing, and "pelting the nurses" with ice chips: "And while some have called it the most meaningful experience of your life, to me it was something more akin to doing the splits on a crate of dynamite" (Anderson 2000). Though a comedic take on childbearing pain, this is an accurate reflection of how media shapes pain anticipation for birthing women. Pain management is an oft-cited topic on women's health blogs and magazines, too. Parenting Magazine's website offers many articles on what "childbirth is really like" that deglamorize birth and instead focus only on contractions as opposed to the overall experience. One article details the mother's experience passing through the stages of labor. Each step details the amount of pain the mother will feel on the biological side of birth, failing to include information about how birth experiences are not just about pain (The Parenting Group 2010). This article also includes phrases about how your water "will probably break or be ruptured by your obstetrician" and how "your doctor may perform an episiotomy." As such, this "premier magazine for mothers" reaches over 10 million women each month¹⁹ endorsing messages concerning pain anticipation with a technologically-influenced twist.

¹⁸ Demerol — also called meperidine — is a narcotic sometimes administered during labor that provides moderate to severe pain relief. It is also sometimes given to people undergoing surgery.

¹⁹ (Bonnier Corporation 2010)

It could be inferred that anticipation of this pain is one reason why women are undergoing elective cesareans. A 2007 study found obstetrician-gynecologists acknowledging an increase in elective cesarean on maternal request though doctors recognize the risks of the cesarean procedure outweighing the benefits of pre-planned birth (Bettes et al. 2007:57-66). The media has picked this trend up, too. *TIME Magazine* ran an article in 2007 titled, “Choosy Mothers Choose Cesareans,” highlighting one woman’s elective cesarean (Park). The article contains almost no information about the risks associated with surgery that a cesarean entails but does feature commentary about the medicalization of birth and the change in cultural understandings of labor and delivery. A commonly misunderstood medical intervention is the epidural block. Epidurals numb pain but are also known to slow contractions. If contractions slow too much, health care providers may recommend and administer pitocin as a way to induce labor, creating stronger contractions that yield more pain and could result in another epidural. As this cycle repeats itself in hospitals, labor fails to progress and doctors recommend emergency cesarean sections. The woman interviewed for the *TIME* article cited a fear of an emergency c-section as a primary reason for her decision to plan one instead (Park 2007). Elective cesarean sections (and non-elective cesareans), however, eliminate immediate pain by numbing the mother and thus creating “painless” childbirth with the intervention of medical aid.

Childbirth Pain Management

How does anticipated pain translate to childbirth pain management? In recognizing childbirth as chronic pain, doulas and birthing mothers have found ways to cope with pain that would be impossible if the pain was strictly acute. The natural rhythms of the body aid pain

management, since contractions tend to increase over time, giving the mother an opportunity to understand how contractions work and how she can react to them.

Jenn relied on her husband and her doula, Leah, during her contractions. She recognized the uniqueness and specialness of the childbirth experience, feeling “the incredible contracting of your uterus” but also learned how reacting and handling the continual pain of birth required mental focus. For Jenn, it was all about “bringing it back to your brain.”

I could definitely tell when I was focusing on the pain every time. It was [as if] my whole body was like “oh my gosh” and I was tightening up instead of letting my body go through it, kind of letting it pass through, and Leah would be there reminding me to breathe, or reminding me to use low sounds, because there would be points where I would be like really high pitched which was just my whole body tightening up as opposed to me just working through it ... [Leah] could read me and tell through my body language when I wasn't dealing with it effectively to help me progress for my own benefit and the baby's benefit.

For Jenn, getting through contractions — the painful part — was all about focus. This focus was all mental, not physical, recognizing the power of the physical contractions but not allowing them to dictate how she was reacting to them. With her doula and husband by her side, she was constantly encouraged and reminded to use mental processes during her birth experience, which included the use of sounds as focus points to combat her body's physical tightening. Low sounds are effective in promoting a more open feeling because they require a more open mouth to produce them. For brass players in a band, low tones are made on their instruments by lowering the jaw within the mouthpiece, giving air as much room as possible to move and create the low tone. Concurrently, the longer the instrument, the lower the tone it makes. In thinking about the body, the lower the tone the mother can focus on and make, the more air she is inhaling and exhaling and the more open she can imagine her body, thinking about herself as longer and more fluid as opposed to tight and twisted. Leah was able to see this physical tightening, too, and encouraged the lengthening of Jenn's body through focus exercises such as low tones. Leah

verbally negotiated Jenn's physical pain, bringing in vocal focus points that help Jenn apply a sense of calm and empowerment to her contracting body.

Many mothers and doulas call this type of interaction pain management, looking at labor as an opportunity to mediate pain. This mediation directly connects back to brain function and focus.

When I went through the Birthing From Within²⁰ class, we had a couple things that we did where we held ice cubes, I don't know if anybody talked about when you hold ice cubes in your hand and see how long you can hold them, and I think going through that you realize how difficult it is to detach your mind from pain. So I think that was something that made me think about how am I truly going to manage this experience when this is the first time for me, so I think that was a big part of it, because you know it's going to hurt, you just don't know how you're going to manage that in that moment. [MariBeth]

MariBeth's exercise involving ice cubes is a tangible experience connecting brainpower to pain power. Detaching the brain from pain, especially when it is anticipated, is not easy. Ice cubes are cold; if you hold an ice cube, your hand will become increasingly colder and the nerves in the skin will consistently send stronger and stronger messages to the brain concerning the cold feeling it is experiencing. At the same time, the person holding the ice cube recognizes that it is cold and expects it to become colder and colder as time goes on. Not only is pain experienced, but it is also anticipated by the nature of the pain instigator in question. MariBeth learned this mind-body connection through this exercise and went into labor drawing on this exercise while Jenn went into labor drawing on verbal encouragement.

The childbirth experience has a level of anticipated pain attached to it. In this case, however, the pain instigator is a child, something not feared or dangerous but considered special

²⁰ "Birthing From Within: An Extra-Ordinary Guide to Childbirth Preparation" is a book by Pam England, a certified nurse-midwife, and Rob Horowitz, published in 1998. The book sparked a movement in the childbirthing community, recognizing the experience of birth as supreme over its potential negative aspects. Classes are taught by certified instructors nationwide in conjunction with the values of the book. In this case, MariBeth read the book first, ascribed to its philosophy, and sought out a class by a Birthing From Within instructor.

or precious. In low-risk births, especially, pain is not considered harmful; concurrently, interventions such as epidural blocks or other pharmacological methods could negatively affect the baby (ACOG 2004). As such, there is a disconnect between what a natural reaction to pain management would be: in the case of the ice cube, the first reaction is to drop the ice cube. In the case of childbirth, the needed reaction is to manage that pain and be rewarded with something more precious than the situation from which you started. Pain is a necessary condition, and without pain “things generally regarded as pleasurable — good food, sweets, play, love, praise — could not be *felt* as pleasurable (Kinget 1999:304). Under this framework, pain is essential to fully enjoy the resulting child after having the capacity to endure.

Samantha uses visualization to help her clients talk about pain. She likes to think about childbirth in terms to mountain climbing. About three quarters of the way up you feel like you can't go any further, she says, but you know you have to get to the top. And when you persevere and make it to the mountain's peak, the pain of the journey becomes nominal compared to the view, which is then that much more incredible having gone through the experience to see it. Many doulas use other visualization techniques, including that of rushing waves, when talking about contractions. The image, from Ina May Gaskin's book *Spiritual Midwifery*, came up at a social doula gathering at the Center for the Childbearing Year. The women present agreed that they all prefer using Gaskin's terminology, speaking of “rushes” instead of contractions (Gaskin 2002:331). In using words like “rushes” or “waves,” doulas remove medical connotations from women's bodies, helping them focus on what their bodies are doing and not what medicine says is happening to them.

Pain, however, is not the focus of childbirth for many women but rather a necessary experience requiring less preparation when compared to dealing with the exhaustion of long

labors or unwanted interventions that may result, including cesarean sections. Exhaustion was cited as a more pressing concern to many women interviewed. Long labors can result in adverse effects for mother and baby and tend to concern hospital staffs for liability reasons. For some doctors, it is easier to induce a birth or perform surgery, i.e. a cesarean section, than potentially lose or harm a baby when surrounded by hospital technology that could prevent it. Hospitals also sometimes have policies concerning how long a mother is allowed to labor normally after her water breaks; MariBeth was told her labor would be induced if she did not progress after 24 hours. It is exhaustion, not pain, that led all the women in this study who were administered medical intervention to seek the aid of an epidural or the administration of pitocin during labor. Additionally, long labors allow the medical staff more time to offer pharmacological alternatives to the immediate pain and exhaustion. During her sister's labor, MariBeth watched as nurses came in more frequently as time went on, continually asking if MariBeth's sister was ready for her epidural yet. Birth plans were cited by some mothers and doulas as a way to avoid this, but the hospital setting can tempt mothers on the edge of choosing drug intervention (see above discussion of pitocin and epidurals). Samantha describes this as the grayest of areas. The women who concern her — and other doulas — are those who say that they would really like to try not to have an epidural. To Samantha, it's like working in a candy store and giving up candy for Lent. The temptation is always there.

It's really hard when your nurse can be pro-epidural, the whole medical system is pro-epidural, you've already signed the consent form because you have to when you check in and it's just dangling in front of you, it's really hard to not. That's when I feel like it's hard for families to make their own best decision. Is it really time or is it time because...it's a constant temptation. And you've already given yourself permission to do it if you want to and that's when I feel like sometimes women are like "well I don't know if I should or if I shouldn't" — it's confusing. And I don't have any problems if they want to or not, I just want families to feel like they're making their own decisions. And it's not that a doctor's coming and

saying, “oh, ready for your epidural now?” and they hear, “you’re doing a bad job, you’re not handling this well... let’s do something different.” [Samantha]

Samantha brings pain back to auditory encouragement and understanding. From her perspective, those encouraging words and auditory focus points are the keys to holding out through painful periods or times of exhaustion. Women have described the birthing experience as something that takes you out of reality to some extent — including Elaine and Jill from this study — which may include interpreting things around you differently than you would without the physical and emotional pressures happening inside you. Unlike the twilight state²¹ some women experienced during births in the mid-twentieth century, this out-of-mind state without drugs occurs because women are unable to focus in the moment how they would normally (Jill, Carrie, and Dara).

The Birth Environment: Intentions & Intervention

Valerie, a local doula, also recognizes the difference between intention and execution of natural birth based on setting. As a professional midwife in training, Valerie sees many women transfer from home to the hospital for a variety of reasons. Transfers happen when low-risk women are reassessed and considered high-risk or at-risk by their attending midwives. Maternal fevers, illness, preeclampsia, gestational diabetes, fetal distress, and long labors are just some of the reasons why a midwife might recommend or insist on a home-to-hospital transfer. Aside from needed transfer, women laboring at home might electively transfer from fear, exhaustion, or something else. When women transfer, Valerie believes, “they’re not really planning a natural

²¹ The “twilight state” refers to the use of morphine and scopolamine to put the mother in a semi-conscious, pain-free state for birth. This was considered a feminist issue for a while, emancipating women from the pain of childbirth, but was then determined oppressive. This was recently explored on a 2009 episode of the television series *Mad Men*, in which a main character, Betty, gives birth to her third son in the hospital. Betty enters a twilight sleep that the producers call “The Fog,” which is also the name of the episode (Abraham 2009). During this time, Betty acts in a dream sequence and remembers nothing of her birthing experience after the fact while her husband sits in a daddy waiting room. These conditions are still referenced as a negative thing by mothers today, including MariBeth who indirectly referenced these types of birthing conditions when describing her sister’s birth: “They kicked us all out of the delivery room when my sister had her son. I thought that was so like 1950, you know?”

birth anymore.” Though many women plan for natural hospital births, home birth women tend to be more decided about their births based on their choice of having them away from biomedicine. These women often make this decision on the basis of the home setting creating a more “natural” birth, but there is tension in this choice: these are no longer natural birthing bodies but postbiomedical bodies that make decisions about natural childbirth against a backdrop of medical intervention options, implicitly acknowledging the safety net of intervention within their home birth choices (Klassen 2003:804). Home births create a physical environment free of intervention temptation in which women can be more relaxed and comfortable, though. Sophia said laboring at home was essential to her labor progressing as it did because she was comfortable and relaxed the entire time. This environment also allows the family to have whomever they wish to be present, which sometimes is contrary to hospital policies. Both St. Joseph Mercy Hospital and UM Hospital sometimes enforce policies prohibiting children under the age of 16 from being present at births, though some families want their younger children to see their siblings born. Jenn was excited to birth at home for her second baby so her toddler daughter could be present, even though timing made it so that her daughter was asleep during the birth. It was still comfortable, though: so comfortable that after the birth, her doula helped them take care of logistical things with recovery and settling in at home, which included ordering a pizza for dinner.

An intervention-free zone is breached when circumstances beyond birthing mothers’ control result in a transfer. With this transfer of location and space comes a transfer of belief frameworks. The hospital represents a new space the mother and doula must navigate. Doulas are particularly valuable in the event of a transfer because they understand the hospital setting the woman is entering and are able to help her and the family in coping with the new environment.

This coping process often results in choices that do not necessarily reflect the mother's preference toward intervention-free birth. Valerie watches more clients transfer than other doulas in her capacity as a certified professional midwife in training. "Sometimes a person planning a natural birth in the hospital will feel like a doctor or nurse is really pushing something on them that they don't want whereas the home birth transfers usually, even if they didn't exactly want it, [accept intervention because] it's what they're asking for [by transferring]," she says. "So that's kind of a subtle difference." There is a subtle difference in her role as a midwife, too. When clients transfer while she is in the capacity of the midwifery practice, she almost always takes on a doula role at the hospital, switching gears from biological and medical caregiver to physical and emotional caregiver. This location change can also be traumatic for mothers who cannot set what Valerie considers "realistic goals:" "It makes me nervous when someone is talking prenatally as though they can have total control over their outcomes because none of us can. It's a big red flag for me." Home birth is a way women attempt to have control, but as many women have experienced, this doesn't always work out. It's also not the popular thing to do: less than one percent of women deliver at home in the United States (Martin et al. 2009:5). However, research suggests that birthing women perceive pain as significantly higher in hospital births than in home births (Morse and Park 1988). This indicates that with intervention options dangling in front of them like the candy Samantha describes, hospital environments perpetuate the illusion or experience of heightened pain through their constant offerings of pain-reducing drugs. By not having the option to reduce pain instantly, home birth pain is not compared as often to pain-free births since the pharmacological option does not exist at home. Women birthing at home are more likely to find relief through alternative methods of pain easement, including social support. This environment also puts doulas in a position to dispel myths that

they will or will not make decisions for the mother if the temptation is too much for them during labor. “Sometimes I think that women assume that I’ll be able to be able to take over for them to a certain extent ... that I’ll be able to say no to a doctor when they feel like they can’t say no or something like that” (Valerie). At home, however, the doula doesn’t need to take on this role. Instead, she can focus on more positive negotiations of pain and experience, such as massage or verbal encouragement.

Sophia attempted home birth twice and transferred to the hospital both times. The first time was for an emergency cesarean, as she ran a fever during labor and the midwife found inconsistencies in fetal heartbeats. This transfer was necessary, and Sophia recalls relief over delivering a healthy son after complications. The second time, Sophia transferred due to exhaustion and received an epidural after mentally “hitting a wall” at hour 34 of labor.

I was just afraid that I was going to end up with a c-section, so I needed something to help me relax and manage the contractions, so I decided to go to the hospital and get an epidural, even though I was totally against that, but I was also really willing to be flexible during the birthing process. So that’s kind of what felt OK for me at the time.

Though home birth was what she and her husband wanted, Sophia was more concerned with avoiding a second c-section than staying at home and risking complication. Her doula came with her to the hospital, supported her decision for an epidural, and stayed with her throughout the birthing process. Even with trying to maintain an intervention-free environment, Sophia and her husband needed to seek aid for the first birth and chose intervention the second time, thus altering their initial birthing framework. In both instances, their doula — who was different for both births — supported them fully. Doulas in this study who have experienced home-to-hospital transfers said their roles do not change too much at the hospital.

Sophia's story shows how she and her husband attempted to fit into a birthing framework that they believed to be best for them and their children. Regardless of their ideal living situation, however, they fall short at reaching their preferred living style in several ways, including with birth. Sophia and her husband seek to contradict a typical American family structure by adhering to more alternative childrearing practices, which include co-sleeping, breastfeeding through toddler years, and attachment parenting²². Though their son is too old now, Sophia and her husband are trying to get their infant diaper free, which means the couple is attempting to learn their daughter's sounds and movements that indicate the need to relieve herself before actually doing so, avoiding the use of diapers entirely²³. Sophia is also interested in moving from their upper-middle class home in East Ann Arbor to a cooperative family living environment. She can't point to a specific reason for why she and her husband feel these are better practices than those of other families she knows, but she says they feel right and make sense to them. After immigrating to the United States from Eastern Europe, her family has adopted family practices contrary to both Eastern European and American structures. Ultimately, though, Sophia's birth story shows her and husband's willingness to be flexible and adapt to life as it comes, believing in their ideal frameworks for living while also embracing the type of lifestyle they are actually able to live. When considering birth, Sophia's example of flexibility is essential for pain relief and management when considering the health and safety of the mother and child. Regardless of how setting and belief structures create an ideal birth in theory, the mother and child's wellbeing is the most important part of managing labor pain and intervention.

²² Attachment parenting is a parenting style based on eight principles that endorse positive, nurturing parenting skills based on psychology. The aim of attachment parenting is to nurture empathetic children who have strong, emotional connections to their parents (API 2008).

²³ There is a diaper-free philosophy found in Western cultures, but this type of lifestyle is more commonly found in less developed countries. For example, a Peace Corps worker describes the women listening to their children's bodies while their children were tied to their backs all day in "Monique and the Mango Rains" (2007).

Pain is an essential part of childbirth. Mothers learn about pain in different ways, and thus experience pain based on the paradigms through which they learn mind-body strategies of dealing with pain. The cultural contexts in people experience pain continue to change (Morris 1991:267) and adapting to them in childbirth is essential for women who seek positive birth experiences. Popular media tends to focus on the physical manifestation of pain, though doulas offer a non-pharmacological route to pain management. Through continuous support, it may be possible to redirect paradigms of pain that move away from anticipating negative pain and perceiving increased labor pain as a result. Mediating pain through social support before and during labor is an essential step to fighting against the technocratic model in childbirth and reaffirming the need for continuous, woman-centered labor support. By using social forces instead of medical interventions, women have the opportunity to respond to the American construction of labor pain through the social culture they create in the birthing room.

Chapter 4

Family & Space Dynamics: Kin & U.S. Birth

Doulas often have the opportunity to interact with more than just the birthing mother; in fact, most doulas rarely attend to one birthing mother exclusively. U.S. hospitals are legally required to let the birthing mother bring whomever she desires into the birthing room²⁴, and restrictions on fathers, family members, or friends have been banned for over two decades (Allen 1999; Annas 1989). With formal doula certification through DONA beginning in the 1990s (DONA 2005a), doulas have had the chance to form support-related relationships with family members apart from the mother and with medical staffs.

Based on study interviews of doulas and mothers who have used doulas, women agree that it is the soon-to-be mother who advocates for the use of the doula, even if the decision to use one is mutually decided upon by them and their husbands. However, doulas acknowledge that fathers need to be comfortable with doula support during labor. Valerie and Danielle will not take a birthing mother as a client if the partner or husband is not in favor of their participation. All doulas in this study mentioned how many fathers are apprehensive at the idea of a relative stranger possibly supplanting them during labor. They also agree that there is a difference between a hesitant, yet willing, father and one who is obstinately against the doula.

²⁴ The mother can bring whomever she desires, but some hospitals limit the number of people allowed in the birthing room.

Most doulas have a first interview with a family, which can be over the phone or in person, during which time the potential client asks the doula questions²⁵ about her practice methods and the doula gets an idea of what the client is looking for in a doula. This interview helps both parties get a feel for each other. A family has the opportunity to hire or not hire a doula, and a doula has the option of accepting or rejecting a family if she feels it is or is not a good fit for her. Many times, how the father interacts with the doula during this interview is a large part of the doula accepting or rejecting a potential client. Danielle described meeting a family at a local coffee shop for a first interview. After talking with them, she said that because of the father's extreme hesitation and skepticism, she "just knew we couldn't work together." Danielle described how "red flags were flying" for her internally, indicating that this family would not be a good fit: "If at any point a red flag goes up for me, any 'uh oh' feelings, I will not take that client on." To her, the father was not interested at all in her services and attempting to work with such a family would only create problems as opposed to cultivating a team environment before, during, and after labor.

This cooperative environment was discussed by many mothers, and many women write birth stories in popular media and scholarly research. It can consist of a multitude of people, including health care providers, nurses, friends, husbands, doulas, extended family, older children, and can sometimes include the birthing mother's mother. Doulas in this study all said it was rare to interact with a soon-to-be grandmother, but that it happened on occasion. Doulas can replace what is perceived as the knowledge of the mother's mother, drawing from experience that might otherwise be provided by this mother figure to her daughter (Leavitt 1986:97). In this

²⁵ DONA's website lists sample questions that many women refer to when interviewing doulas (DONA 2005e). Though partners are not specifically mentioned, all the questions refer to "we" or "us" as a birthing unit that needs support, implying a couple or family, versus questions aimed at how the doula only interacts with the mother.

way, relatedness among those in the birthing room becomes blurred or crossed as the doula may compete with or replace knowledge given by the mother's mother.

By looking at how doulas interact with particular family members, it is possible to see how doulas may or may not come to be considered kin through the birthing process. However, for some there is a constant tension between acting as kin in the birthing room and acting as kin outside the birthing room. Two dilemmas affect doulas primarily. They first must negotiate being a trained professional and a caring woman. Second, they must handle “pricing a priceless service” through placing a monetary value on their time and attention within an emotional context (Morton 2002:13-16). As a paid care provider, doulas are monetarily compensated for their time but are also expected to provide a certain abstract level of emotional support, something requiring a personal connection to the mother and possibly the father or other family members. In this way, a personal connection is forged with a family but is also bound by a contract²⁶ detailing how these interactions will take place. Some doulas strive to maintain friendships with their clients; others follow DONA's guidelines that recommend a professional relationship that does not extend beyond the scope of the final postpartum visit. However, some mothers and doulas describe a connection between each other, resulting in a family-like bond that can occur through the experience of the birthing room. As kinship is “steadily reinventing itself” in a “perpetual makeover” through theory and practice, the inclusion of doulas within kin structures becomes more possible and recognizable (Franklin and McKinnon 2001:6). Some doulas may be invited to enter this intimate family space and potentially form these bonds,

²⁶ Doulas generally work with client contracts that outline payment, provided services, and their expected roles during pregnancy, labor, and the postpartum period. It is through a contract that doulas are able to draw boundaries with clients who desire extended emotional support through additional appointments or phone conversations, outlining fees for sessions outside the scope of the contract. Furthermore, contracts create a means through which money can be exchanged, since doulas generally act as independent contractors, personally handling their own payments and work relationships.

whereas blood relatives including to-be-grandmothers can be kept out of this space purposely (see Jill's story and Dara's story below). Other players move through the birthing room, too, including nurses, obstetricians, and nurse-midwives. These actors are less likely to take on such kin affiliation, however, and their connections to birthing mothers and doulas vary. It is these issues that are explored in the following section, looking at how doulas support partners, interact with or as mothers, and are now being negotiated into kin roles, placing them in the context of a changing kinship structure determined by the context of the birthing room.

Doulas & Dads

“Oh no no no, midwives and doulas are for when the husband is clueless or doesn't want to be involved, and I'm neither of those things. I'm really looking forward to being involved.”

Burt Farlander, played by John Krasinski
*Away We Go*²⁷

“There's a stereotype out there that if you have a doula, you don't need the dad.”

Samantha, a local doula

Doulas are not dads, and they don't pretend to be. Partner support is crucial in the birthing room, and doulas are not meant to supersede that support in any way but instead supplement it. For the women in this study, all but one of them had husbands present at the birth.²⁸ Each of them discussed the importance of their husbands being emotionally and physically available and how their doulas were of a different type of importance but one that directly influenced their husbands.

²⁷ (Mendes 2009)

²⁸ Carrie is the only unmarried mother participant in this study. Carrie's four children each have a different father, and the last two children were born with two doulas present at each birth. The doulas were provided for free by the Center for the Childbearing Year based on Carrie's economic status.

Samantha recognizes the role of the partner beyond taking up space in the birthing room. To her, the father is also going through a life-changing event, experiencing an event that will ultimately leave him changed. This experience will take him as a childless man to a father, from dad-to-be to actual dad. In a national survey, eighty-two percent of women had a husband or partner present as a support during labor; seventy-six percent of women without husbands or partners had a friend or other family member present (Declercq et al. 2006).

Regardless of conception beliefs surrounding whether or not a fetus is a child in utero, men talk of “going to be a dad” before birth while they recognize that they “are dads” after birth. Furthermore, this generation of fathers who were born in the late 1960s and 1970s recognizes childbirth as a transformative process for them. After birth men have the opportunity to become caring fathers versus the father-in-the-waiting room image of the mid-twentieth century (Reed 2005:4). Dads need help, too. Studies both in the United States and abroad chronicle fathers’ nervousness or anxiety prior to birth concerning labor and postpartum baby care (Fletcher 2008, Gungor and Beji 2007, Li et al. 2009, Reed 2005). However, most fathers want to be involved: even when hospital policies restricted fathers in the mid-twentieth century from being active in the birthing room, fathers were finding ways to coach their wives and involve themselves with birth (Leavitt 2003). Doulas offer an alternative to constant anxiety and creative involvement by being an emotional and informational resource to fathers. Danielle said how she interacts with a father changes at each birth, and a father’s desire for involvement is a significant indicator of how involved she needs to be.

Unlike husband-coached childbirth options like the Bradley Method that solely rely on the father for support during labor (AAHCC 2009), doulas act as reassuring, informational helpers, providing all types of support to both partners during labor. By using a doula, couples

have an opportunity to embrace and use a family-centered support system emphasizing support of the birthing team versus just the birthing mother.

Dara & Stephen: A Case Study in Dad Doulas

Dara and her husband have three children. The first two were born in what Dara calls “beautiful home births.” During her third pregnancy, Dara and her husband Stephen planned another home birth which resulted in a home-to-hospital transfer and an emergency cesarean section at UM Hospital.

Dara is a doula and had attended several births prior to the birth of her first child. Both she and Stephen are passionate about socially supported childbirth, but Dara said Stephen wasn’t sure they needed a doula for their own births. After much conversation and several informal meetings with doulas, Dara and Stephen had no doula before the birth of their first child. Their home birth midwife contacted them about two weeks before Dara’s due date to tell them about a doula who wanted to experience home birth. Dara spoke with the doula on the phone briefly but she and Stephen had not decided to hire her. Since midwives focus on the medical issues at a birth, they often are unavailable for as much social support as some families desire. When Dara’s water broke two weeks early, she remembers e-mailing this doula in the middle of the night, telling her she was hired if she could show up right then. The doula did, and Dara said her doula’s support was essential during her labor.

Dara’s first birth experience taught her and husband the value of doula support in labor, even with an involved father present. Dara said that, “[Stephen] had no idea how to comfort me,” remembering that Stephen, her sister, and her best friend, all of whom were present, only reflected Dara’s panic back to her. Dara said her doula reflected a calmer image, reminding her that she was fine and everything was normal. Before the second birth, she and Stephen knew

they needed help: “The second time around, we were like ‘we’re not doing this alone, and you’re [Stephen] not my doula”” (laughter).

After having the chance to reflect on her birth experience, Dara realized Stephen needed support, too. Dara’s doula helped her stay calm and encouraged others present, but Stephen lacked a constant support system similar to Dara’s. Before the birth of Dara and Stephen’s third child, the couple decided it was time for him to experience doula support: “We got a doula for me and then we invited his friend who’s a therapist to be his doula. That’s what we called him, [Stephen’s] doula,” she said with a laugh.

The first time around I don’t think I really understood what his experience was, but the second time around it became clear to me that Felix was also panicked during labor and nobody was telling him, ‘Calm down, everything’s OK.’ So this third time around we were like, ‘oh yeah, you need someone for your emotional support.’ And that was I think very helpful.

The third birth was more difficult and traumatic than the first two, I had a c-section, and I think having someone designated as Felix’s support person was really helpful not just at the labor but at those early postpartum days. . . . It was his job to help Felix through, and if we hadn’t designated someone for that then Felix would have been responsible for two children, . . . a wife in a hospital who’s like drugged up (you know I don’t even remember the first day), and . . . getting me . . . support in the hospital, and it would have been all on his shoulders had no one taken care of him. So thank God we had a doula in place for him. [Dara]

Dara and Stephen’s story shows the importance of social support for all members of the family, including fathers. Fathers are often called upon to be support systems for birthing mothers but may not have the emotional composure to handle being that support system. Fathers also may not understand what’s happening, even with childbirth education classes or other knowledge.

Stephen originally thought he could be Dara’s social support until experiencing labor firsthand. Fathers have social support needs, and these cannot be overlooked. Friends — like Stephen’s therapist friend — or family members could meet this need. Ultimately, Dara and Stephen’s story illustrates the potential need for maternal and paternal social support and how there are

options for getting that support so the husband can be the best birthing partner possible for his wife.

Doulas Supporting Dads

The father provides understanding and support that doulas cannot always provide, but as Dara and Stephen illustrated, dads need support, too. Jenn said she relied on her husband primarily because, “We’re married, we’re partners, and we know each other best.” Because Jenn’s husband understood how his wife responded under pressure and in emotional situations, he was able to help the doula and the care provider understand Jenn’s emotional state. Partner support during labor has been cited as positive for birthing mothers’ experiences (Somers-Smith 1999), but little has been done to understand how partners feel or don’t feel supported themselves.

Doulas help the father during the birthing process by being as much of an emotional and physical support to him as to the mother. During labor, the doula-to-dad dynamic changes slightly, as the doula acts as what Jenn calls the “second line” while her husband is the “first line.” This relationship allows the father take breaks, make mistakes, and be emotional flexible through using the doula as the constant calming presence in the birth. Studies have found that as supportive as partners can be during labor, they often need support due to the stress surrounding their role in childbirth²⁹ (Somers-Smith 1999). DONA claims that doula support helps fathers stay more involved with their partners rather than pulling away due to stress or anxiety during labor (2005e). Doulas, through their experiences, can act as this support and step in for the father

²⁹ In Turkey, a controlled study found that fathers attending births yielded more positive outcomes by their wives than women who birthed without their husbands; interestingly, the study also found that mothers and fathers supported by a third party such as a health care provider resulted in the father taking a more active role in labor (Gungor and Beji 2007).

periodically while also helping him know what to do. Jenn's doula whispered encouraging words into her husband's ear when he was at a loss for words, providing him with verbal support for his wife. Overall, Jenn and her husband's use of a doula doubly benefited their family, giving Jenn the help she physically and emotionally needed while providing her husband with additional help, too. Jenn stood for the majority of her labor, and she said her doula Leah allowed her husband to physically rest from the pressure of holding Jenn up:

Leah was there as a support for [my husband] much of the time to help him and see how he was doing, giving suggestions for taking care of his body when I was really hanging on him and being hard on him. She was kind of like the person who, she was helping me but Jason was first. So Jason was first line and then she was helping Jason and then if he needed a break then she would come in and be first line, first caregiver.

This third-party support system allows the doula to "hold space"³⁰ in the room until she is needed. By meeting with the family in prenatal appointments, the doula is able to gauge the birthing mother's needs but also the father's needs for support, tailoring her involvement in the birth to the specific family situation. This also creates an environment where the doula helps the father be as involved and effective as he wants to be. This holding space idea was discussed by doulas at an informal doula gathering at the Center for the Childbearing Year. It was unanimously agreed among the doulas present at this meeting that holding space at births was essential as to allow the father to step in as much or as little as he desired. Danielle described this arrangement as something akin to a "security blanket," seeing the fathers she works with realize they have the ability to be with their wives in labor but also that they have security of someone with greater knowledge and experience to step into their space whenever needed or wanted.

Another way doulas interact with fathers is by recognizing possible emotional strain or shock that fathers experience while seeing his wife in labor. The family transformation process is

³⁰ Holding space is also discussed in Chapter 3. However, its discussion here is only in reference to fathers.

shared when the father is present, since the woman is becoming a mother and the man is becoming a father. Women in the doula group also discussed this issue at a recent meeting, recounting the many different types of dads they've worked with during childbirth. Due to emotions or apprehensions over his wife's safety and child's safety, fathers can either be very supportive or too supportive, becoming micro-managers or over-zealous about birth. The doula group talked especially about the strain birthing women can experience from certain over-involved fathers that must be reminded to eat, use the bathroom, or take a break. One doula talked about the problems this can cause since the birthing mother should not have to redirect her maternal energy on her husband, just on birthing the baby. Doulas act as a way to negotiate the father's role, however, and have the ability to act as that reminder for the dad, making sure the mom is comfortable but also that the dad is taking care of himself, too.

Being emotionally involved can also be an issue in the moment. Valerie acts as a less-attached person in the birthing room, helping the father remember the pre-discussed details of a birth when faced with decisions in stressful or fast-paced moments:

In the middle of birth it can be hard to remember [things the couple talked about beforehand]. Recently there was a situation where a baby was separated from the mother, and the father was kind of looking at them both and I was like, 'go with the baby,' and he's like 'oh, ok' so that can be helpful too. I usually keep a clearer head than somebody who's emotionally attached.

The dynamic between dads, doulas, and mothers needs to be mutually agreed upon before heading into labor. The moms and doulas in this study, agreed that if any hard feelings existed from a dad because of the use of a doula, a doula would simply not be used. Any type of competitive or argumentative relationship between father and doula would ruin a positive birthing environment, resulting in possible stress for the mother and for health care providers. Doulas are taught how to maintain boundaries, and one of their jobs is to accept or reject clients

based on how they will click. Danielle said she spends a lot of intentional time assuring the father of his role in labor and reassuring him that she is not there to supplant him. If a father is not cooperative or supportive of the doula following this encouragement, the doula will most likely refuse the client in question. Overall, good doula-dad relationships are essential for fostering positive experiences by laboring women³¹. Though doulas may create initial unease by intruding upon an established marriage or other kinship dynamic, fathers in this study and in others have expressed find doulas helpful and supportive through labor. In fact, based on the need for social support for fathers, fathers may need their own support persons to enable them as birth partners with their wives.

Moms & their Moms: Changing kinship roles in birth

In listening to me explain what a doula is, a friend of mine said, “Oh, like a mom.” While doulas do not explicitly take the role of the mothers in some families, the absence of close family — emotionally, geographically, or both — motivates some couples to choose a doula.

Jenn and her husband used a doula for the birth of their first child and also had Jenn’s parents at the hospital with them. Jenn described her mom being at her labor as “an unexpected presence there,” one that she had not planned on having but one that was appreciated because she and her mom shared a close bond. Due to her mom’s diagnosis of cancer just a few weeks

³¹ Studies have also shown how partner support and doula support combine to create positive birthing experiences, especially concerning the encouragement of partners (See Chapter 3). One randomized clinical trial found a reduction in cesarean sections saw through the continuous use of a doula (McGrath and Kennel 2008). The trial was only conducted among middle-class couples, emphasizing the need for male partner support along with continuous support of both partner and doula. McGrath and Kennel report findings of “unequivocal...positive opinions” from both partners of laboring with the support of a doula (2008:92). The study also found that partner-only support was not as successful in positive outcomes or in the reduction of cesarean section rates; as the authors discuss, men who attend the births of their children do not always have a specific, well-defined role, even though they attend the majority of births among middle-class couples (2008:96).

earlier, Jenn did not anticipate her mom staying at the hospital through the night when she went through triage at 7 p.m. on a weeknight, only to labor all night long.

We didn't get a chance to talk about what it might look like or what she would want or what I would want [with my mom there] and it ended up being fine. I think it ended up being fine, her being there. I'm very glad that she was there even though I think it was torture for her because she said to me at the end, 'Would you *please* use drugs next time'" (laughter). [emphasis spoken]

Jenn's mom had an epidural at each of her births and had long labors similar to Jenn's first birth experience. As such, Jenn recognizes that it was difficult for her mom to experience birth with her daughter while her daughter was birthing without the aid of pain-relieving medication. Jenn was also induced with pitocin due to the length of her labor, which increased the frequency and intensity of contractions and thus created additional pain that Jenn's mom witnessed. Even though Jenn's mom wasn't included in any of the prenatal discussions of how labor would look with husband, doula, and birthing mom, the outcome was still positive because Jenn and her mom's relationship was positive. Though Jenn doesn't think her mom's experience informed her choice to attempt a birth without pain medication, she does believe having a doula there was important to calm her nerves and keep her confident with her decision to stay drug-free in labor. Yet Jenn's mom was still helpful. In addition to the emotional meaning of having her present at the birth, "She was just there," Jenn said. "She helped with giving me water sometimes but for the most part she was there as kind of an observer and, you know, giving me encouraging words every once in a while."

Jenn's mom passed away before the birth of Jenn's second child. For this birth, Jenn and her husband gave birth at home to mentally and physically distance themselves from the use of medical intervention at the hospital. Jenn resisted pain medication during her first birth but was given pitocin, something she wanted to avoid the second time around. She hired the same doula

again, but this time she used her doula to talk out what the birth would look like without Jenn's mom present. Jenn said her doula Leah helped her verbally and emotionally process her mom's death in light of her second child's birth. Through prenatal sessions with Leah, Jenn said she realized that not having her mom there the second time did not need to bring thoughts of losing her mom to the surface again. To honor her mom instead, Leah helped Jenn set up an altar for Jenn's mom: "For me, her presence was very real, even though she wasn't physically there, her presence was very real during the birth and more so after [my son] was born." Jenn said this element helped turn her birth into "a more spiritual experience beyond just the natural" one of home birth.

Not all mothers' mothers have the same positive interactions with or understandings of doulas. Jill's mother felt having a doula was superfluous, though Jill and her husband flew a doula friend of theirs out from Washington for the birth of their first child. Jill said that having a doula brought a more positive energy to the birthing room versus the energy of her mother, which was more negative. Jill's mother wanted to be present while her daughter gave birth, but Jill refused, stating that, "her energy didn't match mine." As a practicing Buddhist, energy in the birthing room was incredibly important for Jill. Even through her attempts to keep her mother out, a nurse snuck Jill's mom in while Jill was in labor. Because Jill stood or squatted for most of her labor, Jill said she didn't see her mom come in and did not know she had attended the birth until after it was over, something she is thankful for. This could be considered a form of anti-kinship, in which blood ties are rejected or downplayed. In Jill's case, a doula replaced her mother's influence over her labor while also reinforcing distance in the relationship between Jill and her mother during Jill's pregnancy and birthing experience.

Elaine was conflicted about her mother's role in her birth, unlike Jenn and Jill who had strong opinions about how involved they wanted their mothers to be. Elaine's mom gave birth to her and her two siblings with an epidural while Elaine's dad was in the room, though Elaine does not know whether or not the epidural was by choice. Elaine said she and her mother spoke frequently during her pregnancy, and that giving birth is a "rite of passage" within her family.

Geography separates this mother and daughter: Elaine and her husband moved to Michigan a few years ago, while Elaine's mother still resides in California. Her mom visited a few times while Elaine was pregnant, but the family recognized it wasn't feasible for Elaine's mother to time her visits in order to be present at her grandchild's birth. Elaine said she wished her mom could have been there, but at the same time was relieved that distance prevented her presence:

[Deciding whether or not I wanted to have my mother at the birth] was...somewhat stressful, because I know she wanted to be here, and I didn't necessarily know if I wanted my mom to be here, you know? ...Whether or not the type of support they offer during labor is actually helpful support or more stressful sorts of support is another sort of thing. And then when someone comes from faraway to try to be at a labor when you don't know when they're going to be coming that's a whole other type of stressor to try to have the baby during that visit which may or may not even happen.

Elaine desired her mom's presence, but also saw the advantages and freedom of not having her immediate family there, resulting in an evaluation of the type of support they would offer. Elaine realized that support from a non-family member would be less burdensome than a family member. Families bring stress, as she said, and a calm environment became more important to Elaine than maintaining close cross-generational intimacy in the birthing space. In this way, a doula was a better fit for her and her husband. Because she couldn't be there, Elaine's mom sent Elaine a small amount of money to offset the cost of a doula. Elaine said her mom was very

supportive of Elaine and her husband using a doula and wanted to contribute since she couldn't be there herself.

Conversely, Dara adamantly refused to have her mom present at birth:

I think people either tend to have a great relationship with their mom or a horrible one, so it's like you're not going to have a middle-of-the-road one. I have a pretty bad relationship with my mother. I disagree with lots of things that she's done as a mother and with her own life. So I *really* was clear I did not want her at any birth of mine. I would love to have any of my sisters at the birth but I never wanted her to be there. [emphasis spoken]

Dara is the oldest of seven. She remembers her mom being pregnant while she was growing up, and she also remembers the medical environment her mom created for their family. Dara's mother's "extreme trust in medicine and surgery and pills was a very negative influence" in Dara's life, inspiring a drug-free birth environment for her own births as a sort of "rebellion" against the medically-oriented childhood she had. Her mom delivered all seven of her kids in the hospital. Dara was born while her mother was in a twilight sleep³² and forceps were used. Dara believes this was an awful and traumatic experience for her and has felt a need to not replicate this type of experience in her own births³³.

With conflicting views on medicine and birth along with the tensions of a poor mother-daughter relationship, Dara was adamant about not inviting her mother to her births. However, Dara invited her sisters, and her youngest sister did attend her first birth. Because her sister was only 15 at the time, Dara's mom ended up driving Dara's sister to New York from Virginia. A plan was made by Dara and her husband Stephen to relocate Dara's mom upon arrival, putting her up with friends across town so she wouldn't be present for Dara's home birth. It wasn't until later that Dara learned that her mom had stayed for the birth, sitting quietly in the hallway

³² Twilight sleep is defined in Chapter 3.

³³ Dara's six siblings were born with the aid of spinal blocks for the pain, and she remembers her mom going to a specific hospital because they were able to administer spinal blocks versus epidurals.

outside Dara's apartment door until she heard the baby cry, verifying that her daughter and granddaughter were safe.

I feel like birth is such this pivotal event, and it does have something huge to do with your relationship with your parents, and I don't have words for it. Me having a home birth, she was just so worried I was going to die, and she couldn't imagine doing it without all that medical intervention. [Dara]

Relationships between family members do change with birth, as seen through Dara and her mom. There isn't just a rebellious daughter at stake anymore but a grandchild and a hope for a new relationship between generations. Dara's birth contradicted the cultural framework of birth that her mother was comfortable with, and as such put both Dara's life and the child's life in danger in Dara's mother's eyes. By subscribing to a different model of birth, Dara created a cross-generational clash of medical worlds, attaining her ideal birth situation by consciously excluding her mother from it. Dara felt this was necessary, and for her, the stress her mother would bring to the birthing room was not worth her mother's presence, similar to the way that Jill felt about her mother's intrusive energy in the birthing room. Though Elaine and her mother have a positive relationship, the same possibility of mother-induced stress stopped Elaine from finding ways to make her mother's presence at birth a reality. Instead, both women had husbands and doulas as their social support systems during labor.

Mothers and doulas are not enemies or equivalents; instead, they each play a specific role in their daughters' lives concerning birth. Some women value their mothers' experiences, using their stories to affect their own birth experiences. Others value their mothers' presence, desiring them to be involved in their journey to motherhood. Regardless, the mother-doula dynamic in itself is not necessarily a tense one. Rather, tension arises from renegotiation of desired or perceived roles of knowledge and support during pregnancy and in the birthing room. Mothers must learn the extent to which their daughters want them involved and daughters must learn how

they want to involve their families. Doulas play a part, too, stepping in during a time historically reserved for the women closest to the mother (Leavitt 1986). It is also a time of family creation. As the birthing mother's actual mother steps out of the spotlight, the doula watches a birthing woman become a mother, thus witnessing the creation of new kin. Mothers used to watch their daughters become mothers, but now they often are excluded from this event while a doula shares it with the new family instead.

Doula as kin

Doulas usually are not related to their clients. Some doulas report acting as doulas for family members, sometimes for pay and sometimes not, but most doulas are hired independently of prior connection. Because families directly hire them, fee-for-service doulas bypass the medical arena's complex system of insurance and health care provider options by being a care provider without institutional strings attached³⁴. DONA recommends that doulas keep their personal distance from clients, severing ties with them following service (DONA 2005g). Birth doulas are paid participants in labor, meaning though they interact within an emotional, family setting, they are still performing a service as opposed to doing a friend a favor. As such, the line between emotional support person and professional caregiver become blurred: how does a doula maintain professional composure and practice while also being emotionally involved with soon-to-be parents during what some consider one of the most intimate or emotional experiences of their lives? In the case of married couples,³⁵ a doula enters the life of the family unit at a time in

³⁴ Consequently, families of middle or low incomes are unable to afford doulas. Some insurance companies are now accepting doula care as a medical expense, and doulas have a code families can give to their insurance companies for potential compensation.

³⁵ This example is being used because all the couples in this study are married and were married at the birth of their first child and subsequent children is applicable. By using the marriage illustration, a connection can be made between legal bounds and bloodlines.

which it is transitioning from a two-person, legal relationship to a three (or more) person unit. By producing a new family member through sexual intercourse, the parents create a new kinship structure by bonding each other through the shared blood of their child (Schneider 1980). Though the notion of blood being “thicker than water” in U.S. kinship (Schneider 1984; Holy 1996) has recently been challenged as an anthropological theory, blood still represents a biological connection between the mother and father of the child. No one else in the birthing room shares a genetic substance with the child unless other kin relations are also present. By attending births, doulas can become a temporary or adopted family member. By inhabiting space historically filled by others with closer, more long-term ties to the birthing mom such as mothers, sisters, or friends (Leavitt 1986:97), doulas don’t replace the husband but instead add another personality to the room. It is only through their close proximity to a biological event that that formation of kin ties can be considered.

According to Ladislav Holy:

The anthropological concept of kinship is...built on links established in the process of engendering and bearing children, that is, on the basis of immutable natural facts which are given and can be seen as preceding the activities and processes through which a particular cultural expression of these natural facts is elaborated. [1996:143]

Essentially, kinship is defined by such “natural” facts in U.S. society, those being the blood ties between people that are created through childbearing. This view has been challenged and refuted by many scholars — Holy mentions Schneider 1984, Strathern 1992a, Strathern 1992b and Bouquet 1993 among others — but has a different contextual application concerning childbirth. These scholars challenge biology as the basis of kin ties, looking at contemporary society and the contextual situations that create kin-like ties among non-kin peoples. Schneider (1984) acknowledges that much of the United States still functions under the assumption of natural facts

as determining kinship, but that this lacks understanding of cultural and social context. If kin ties are created through the process of childbearing, can doulas become family through the same process?

Doulas share an emotional connection to a birthing mother and often father, unlike other health care providers who are unable to stay with the family at all times. Elaine said this was a large part of why she wanted a doula at her birth since she and her husband anticipated needs for increased emotional support during the birth of their first child. This connection can result in friendships, which Samantha often forms with her clients, or with deeper, kin-like relationships.

When asked what a doula is, Sophia responded with this:

A member of the family, really. An amazing person who, you know, you share something really intimate with that person. It has to be, there has to be a connection, a higher level...intuition, spiritual, whatever people call it. When we interviewed both our doulas we felt a really strong connection so that was the main reason for choosing them. And because we see birth as such a powerful experience and so intimate, we really want someone who we feel really comfortable with and who we could consider part of our family later on, more than a friend...I do really see the professional relationship, I understand that, but we, we wanted to extend that and extend her into our family.

For Sophia, each of her doulas³⁶ has become family to her. Birth is a process of creating new kinship structures through natural facts, but it also has the ability — and for Sophia, an inherent ability — to create kin links with those who may not share bloodlines. Doulas, then, could serve as a reinforcement and counterexample to anthropological kinship theory of the mid- to late twentieth century. Bearing children results in kinship relations with the birth of a child but can also create a different type of kinship through social support.

³⁶ Sophia and her husband used one doula at the birth of their first child and a different doula at the birth of their second child due to scheduling conflicts with the first doula. Though they very much liked the first doula, Sophia said the second doula was a better fit for her and her family, and that the relationship with the second doula continues six months after the birth.

Current kinship theory emphasizes relationships and systems that transcend bloodlines in creating kin. Due to a range of assisted reproductive technologies, there is “increasing contemporary uncertainty surrounding ideas about kin relatedness” and how biology and sociality intersect (Franklin and McKinnon 2001:6). Theorists are also attempting to examine intersectionality among factors of kinship in many different locations and within different arenas (Franklin and McKinnon 2001:7), though the birthing room is not one that has necessarily been re-examined. This could be because the birthing room reinforces ideas about biology creating life and reproducing it in a medical setting. Instead, these theorists focus on issues of advanced technologies if discussing childbirth, including the impact of infertility (Cahn and Michie 1997; Thompson 2001), biogenetics (Green 2007), and reproductive technologies including in vitro fertilization (Andrews 1999; Edwards 2000). Through this transformation, ideas like those of David Schneider are understood but bypassed, seeking an alternative view of what scholars have considered natural facts without recognizing the emphasis placed on biology in American society. Doula twist conventional understandings of procreation through an alternative site of kinship making; doulas are not present at conception, but they are present at family creation through their work during a biological event.

Doula-as-family could also result from the perceived intimacy and power of the birthing experience. Thousands of women submit birth stories to magazines, online databases, and books each year, chronicling every moment of their labors. With titles like “Birth Stories: Mystery, Power, and Creation” (Dwinell 1992) and introductions emphasizing the profundity and emotion of the labor experience as a universal rite among women (O’Brien 2005), the importance of birth is chronicled through women’s accounts of this thought-to-be intimate process. The title of an upcoming birth story collection captures the perceived positivity of birth from the pens of some

childbearing women: “Belly Button Bliss: A Small Collection of Happy Birth Stories” (Mann 2010). Doulas often write birth stories for their clients, and produce a copy for them as stipulated in their contracts following the birth. Danielle does this for her clients, and finds that the women appreciate reading through their birth stories during Danielle’s postpartum follow-up appointments. Other doulas or midwives might encourage the family to write their own birth stories, and several doulas, nurse-midwifery practices, and certified professional midwifery practices post birth stories from their clients on their websites.

Birth stories can cultivate the intimacy and emotion of birth, demonstrating that many women and men recognize birth as a transformative process. Having a doula may or may not affect this intimacy: by inviting a doula to experience birth with them, birthing mothers or couples may be inadvertently inviting doulas to form these kin-like ties to them. Even if these types of links aren’t made, having the experience together could join the doula to the family in an alternative way, similar to the alternative creation of family in how support groups for families whose children carry a specific genetic disease feel kin ties between members (Rapp, Heath, and Taussig 2001). Here, families share an on-going experience through their children and through genetics in greater society, but birthing parents and doulas also share an experience within the social construction of birth space. Health care providers also recognize this shared experience of the birthing room team. Susan, a nurse-midwife at a local hospital, says she meets doulas when they come in as “part of the family unit.” In this way, doulas can be seen not as separate from the family but part of it, based on the social context — not the medical context — in which they function.

Danielle is constantly “in awe” over her inclusion as part of a family during labor:

To me what I find intrinsically weird about being a doula is I only know [the family] for a short period of time in their life, but it’s so intense and so

emotionally deep at the birth itself that I find it sometimes perplexing that they even would want me in that world with them. You know, it's like, 'What gives me the right to be a part of this intimate process with them? And how is that they can trust me that deeply during a very revealing part of who they are?' I mean, you really learn a lot about people during labor because it brings out a little bit of everything about you. And I walk away from each birth feeling blessed and honored that I was allowed to be a part of that process and to bear witness to what I've just seen them do which is transform into a family.

Watching them transform into a family may also result in her transform into part of their family, even if it is only temporarily. Danielle makes a standard practice of not befriending her clients unless there is an especially unique connection between she and them. Samantha, however, strives to connect with each client through the building of a friendship which she hopes will somehow continue after the professional relationship ends. She said she and several of her former clients stay in contact through e-mail. Other former clients get together with her family and their kids have play dates. For Samantha, relationships formed through the birth process are special enough to maintain years after the doula-client relationship has ended.

Medical Professionals: Family or Functional?

The same care-provider-as-family modality can occur among families and midwives or nurse-midwives. However, hospital settings can impede this occurrence and the creation of kin-like ties that doulas have the ability of forming with their clients, as can the lack of time some care providers spend with their clients. The labor and delivery wing at a hospital rotates dozens of nurses, nursing techs, nurse-midwives, obstetricians, technicians, and support people in and out every day. Unless delivering at home, a laboring family has very little choice in what support staff will be present during the labor process, even if they've chosen a specific health care provider to attend the birth.

Doulas and nurses

Doula tasks are often confused with those of nurses, who are assigned to particular mothers and do not have the same medical responsibility that a midwife or obstetrician would have. Nurses, however, are not as available as many women may perceive them to be, and families do not know who of the nursing staff will attend them in labor based on shift schedules and indeterminate labor lengths. Furthermore, nurses come from different trainings and backgrounds; at UM Hospital, the same nurses share nursing duties between the nurse-midwifery clinic and births overseen by an obstetrician. Though a nurse may prefer to work in one area or another, staffing or shift assignments could see a nurse comfortable with physician-directed births complete with routine IVs and fetal monitors attending a woman opting for a drug-free birth and vice versa.

Elaine is a nurse and has worked in labor and delivery. Part of her push for using a doula was her own experience knowing how little nurses emotionally and physically support birthing mothers. “There is so much paperwork the nurses have to do,” she said. “There are so many other things they have to keep on their mind to keep you safe...it’s hard to do that and provide good labor support at the same time. So I wanted someone else besides the nurse there to support me.”

Nurses have varied labor and delivery experiences that shape their willingness to work with a doula. UM Hospital does not differentiate between labor and delivery nurses and midwifery clinic nurses. Because these two units follow different protocols, nurses tend to prefer one or the other and may have trouble transitioning between a hyper-medical environment and a less-interventionist environment. One study pointed out the need for teamwork between nurses and doulas: “the goal of the nurse is to ensure a safe outcome; the goal of the doula is to ensure

that the woman feels safe and confident” (Ballen and Fulcher 2006:305). By embracing that nurses and doulas serve different functions that both help the woman, nurses could foster a more supportive environment while easing possible tensions or miscommunications between doulas and medical staff. Though experienced nurses have generally attended a higher number of births, an experienced doula has observed more continuous hours of labor than many nurses or providers (Gilliand 2002). With these differences of experiences, it is imperative that medical staff and doulas recognize the differences in their roles and how they each fit into the birthing family’s environment. There are nurses who do an excellent job of attending to women more continuously, and all doulas in this study cited at least one experience with an excellent nurse.

Birth Plans

One way to cultivate a team environment at the hospital is through the use or creation of a birth plan. A birth plan is a list of goals or ideas that are either written or verbally discussed that concern labor, delivery, and postpartum care. Birth plans can also include information about older siblings and their care during labor, plans in case of a medical emergency, or directions for infant care by health care providers. Birth plans vary in content and length, but all contain decisions that birthing parents have discussed and should share with their health care providers.

Birth plans have positive and negative reactions from doulas and mothers, but most people in this study agree it is important to at least talk about some decisions that would be included in a birth plan so health care providers understand the family’s desires or goals for birth. According to unpublished UM Hospital statistics, nurse-midwives practices saw 29 percent of their birthing mothers come into the hospital with birth plans in 2009.

Calling a birth plan a “plan” is problematic for some people. Danielle avoids this terminology and instead opts for “Wish List” as a way to describe this piece of paper. By discarding “plan,” she says long, arduous birth plans are avoided and communication is instead promoted between parents and providers. Similarly, Valerie does not endorse birth plans because she wants to emphasize communication between parents and care providers. She will help families who want birth plans edit them or discuss aspects of them, however, because her experience as a doula and aspiring midwife has helped her see many birth plans and understand what makes a good birth plan from a bad one. Leah comes from a similar mindset, too, refusing birth plan endorsement but working with it if the parents want one.

Samantha is the only doula interviewed in this study that openly supports birth plans. She does promote communication among all parties, but she endorses birth plans as a means of empowerment within hospital settings for the birth parents. It doesn’t matter what’s on the paper, she says, but bringing a plan to the hospital and walking in with it up front shows the confidence the couple has in their ability to achieve their ideal birth: “Show up with a piece of paper so you are stacking the deck to increase the chances of getting a nurse who really wants to be involved in the birth process. Some nurses are really great about that and some nurses, that’s not their strength,” Samantha says. Creating a birth plan and bringing it to the hospital could be one way to combat any negative nursing interactions for a family while also soliciting assistance from a nurse willing to join a family team versus attend a patient sporadically.

Doulas & Medical Staff: Happy family?

While doulas are legally allowed to be present in hospitals and clinics, their relationships with medical staffs can be friendly but can also be difficult. Mothers in this study did not

remember any negative interactions between doulas and medical staffs, and doulas have almost no negative experiences while working with laboring mothers in hospitals.

I've always had really positive interactions. I really look at the person's care providers as people they've chosen for their own good reasons and I don't want to interfere with that relationship and I also look at them as people to collaborate with and I really go in with the assumption that they have their patient's best interests in mind. [Valerie]

In Valerie's experience, she has had few if any negative interactions with medical staff.

However, medical students who are not official labor and delivery staff, have created problems for one of Valerie's clients:

I can think of a time when there were some medical students who were having an inappropriate conversation in the room while a woman was really in intense labor and I said to her, 'is their talking bothering you?' and she was so much caught up in what she was doing that I think that she hadn't even been able to express that but when I asked her she was like, 'yeah, get out of the room'.

In her role as a doula, Valerie is able to understand all medical and non-medical persons in a space, including those who may not belong. As a birthing mother and even as an involved or apprehensive father, it may be difficult to exercise power in a hospital environment or know if that is an option. Because Valerie has the ability to act on behalf of the family but also understand how hospitals and medical staffers work, she was able to recognize an inappropriate conversation and exert power in asking the students to leave. Valerie, in her role as a doula, can act as a bridge between family and health care providers and can manage birthing space when needed.

Limits on what a doula can do

Doulas are not family member or medical staffer replacements. They instead exist to support the birthing mother physically, emotionally, and informationally, which means there are

limits to what they can do. For example, doulas claim no medical authority even though they advise pregnant women and birthing mothers. Valerie said she finds her doula clients asking questions that should be asked of a health care provider but which clients are embarrassed or afraid to ask them. She said she answers them the best she can but usually points them to other sources of information, including books or articles.

Private doulas limit their practices through contracts. These contracts outline the services any one doula will provide for the fee they charge. By detailing the extent of prenatal appointments, phone and in-person availability, and postpartum check-ups, doulas establish client-doula boundaries. Samantha said her contract is an essential piece of her doula practice. As someone who becomes emotionally invested in people, she needs limitations on her client availability. Because doula support can be “emotionally demanding work,” Samantha said these limits help her have enough left to support her family at the end of the day. Doula contracts usually list prices for additional services, including extra prenatal or postpartum appointments which clients sometimes feel they need.

By marketing themselves as contractual workers, doulas enter a legal framework that has them exchange their services for monetary compensation. But what if something goes wrong? If doulas can also form kin ties with clients or develop friendships with them, legal accountability is called into question. Though I can find no record of a lawsuit brought against a doula, the possibility of one could exist if a doula does not fulfill what is outlined in her contract. Just as a patient could sue a health care provider for poor medical practice, could a doula client sue a doula for poor support? And if doulas do create kin-like ties with clients, do these ties alter the quality of support given or the perception of support received? One could argue that you would not sue your mother for bad advice, meaning you also wouldn't sue your doula for bad advice

either. Even if doulas become like kin, they still work and are paid within the contractual functions of a business-client relationship.

Kinship and the American legal system have a long history of relying on bloodlines. Wills and other legal documents appoint blood relatives as heirs and guardians. Legal battles are fought weekly over who has a right to custody, objects, or inheritance because “next of kin” is a phrase often used without considering the context of kin relations. With the advent of assisted reproductive therapies including sperm and egg donation and surrogacy, kin lines become blurred with legal jargon and court battles. The hallmark custody case over Baby M brought surrogacy to the public spotlight in 1998. After William and Elizabeth Stern employed a surrogate to carry and deliver their baby, the surrogate, Mary Beth Whitehead, decided to keep the child. William Stern was the biological father, but Whitehead was the biological mother after being impregnated with Stern’s sperm. The Sterns brought case against Whitehead for breaching the surrogacy contract. Ultimately, the New Jersey Supreme Court ruled the contract invalid, naming Stern as biological father but also Whitehead as biological and legal mother, rejecting Elizabeth Stern’s adoption of the baby (*In the matter of Baby M, A Pseudonym for an actual person*, 109 N.J. 396 [1998]). The court ruled that the contract breached New Jersey law and policy which prohibits a person from waiving their parental rights by contract; in this case, Whitehead was unable to waive her right as a mother for the child she bore. Ethical debates raged across the country concerning the case. Biology overruled other social considerations in this matter, reinforcing an American reliance on biological factors to determine kinship

As contractual workers, doulas legalize the abstract nature of emotional support. What support looks like changes for each family, and doulas are unable to legally outline what their support could look like in labor. Valerie said her emotional support varies from client to client

and that much of it is just “instinctive.” DONA does not list guidelines on what emotional support looks like because it changes for every birth. This also applies to befriending clients. Danielle avoids this practice, but Samantha embraces it. She enjoys supporting her clients as a doula and as a friend, although she recognizes that every client may not want friend support: “I feel like I am able to know inside myself whether or not it’s going to work or whether it feels like it’s a two way friendship or whether it’s not.” If a client prefers professionalism from her doula and is not seeking friendship, Samantha could be limited in how she interacts with the family. However, since the majority of her doula clients come from referrals by former clients, the connections she makes to her clients must be special enough that women send their friends to her for support.

Samantha also mentioned the importance of strong kinship ties for doulas. With two small children, Samantha said she can only maintain a doula practice with the support of her husband. Aside from doula work and some freelance photography, Samantha is the primary parental care taker because she stays at home during the day. If she is called away on doula work, her husband has to take the kids regardless of where he is or what he is doing. Though she has friends who also help out, having strong, established support systems is vital for her to be a social support system for a woman in labor. Many other doulas have children, and finding alternative child care when with a doula client is only possible if social support networks exist.

Regardless of how doulas and clients relate to each other, doulas are beginning to challenge conventions of kin and medical space. Women can bring whomever they like in the birthing room with them³⁷, regardless of blood relation. As spaces become more medicalized and

³⁷ There are restrictions to this policy. Both St. Joe’s and UM Hospital have previously restricted hospital visitors under the age of 16. During warnings for H1N1, UM Hospital instated this policy, restricting older siblings from attending their younger siblings’ births. This policy also makes assumptions about who comes to the hospital. During Fall 2009, a 15-year-old pregnant girl came for a scheduled appointment at the nurse-midwifery clinic. She

families become more emotionally and physically distanced, doulas provide a way for mothers and fathers to experience a caring, supportive relationship during birth.

brought two friends with her as emotional support at the appointment, both of whom were also 15. When the three girls entered the hospital, the two friends were not allowed to pass through security and were stopped at the entrance because they were under 16. The security guard enforcing the policy did call the midwifery clinic about the girls since they were accompanying another 15-year-old.

Chapter 5

The “in” thing to do? Final remarks & the future of doulas

Women supporting other women during labor is not new (Leavitt 1986), but the use of the term “doula” is. After first being used by an anthropologist to describe mothers’ postpartum helpers in the Philippines (Raphael 1973), the word all but disappeared in academic research until clinical trials focusing on social support during birth began in Guatemala in the 1980s (Sosa et al. 1980). “Doula” is used today to mean “an experienced labor companion who provides the woman and her husband or partner both emotional and physical support throughout the entire labor and delivery and, to some extent, afterward” (Klaus, Kennell, and Klaus 2002).

The majority of women giving birth today have mothers who would not have had access to doulas. All of them were born before the word “doula” was transformed from an anthropological concept to a specific term, meaning a woman providing social support in U.S. childbirth. The women interviewed in this study who used doulas are between 31 and 38 years of age, placing their birth dates in the 1970s. Several women referred to how their mothers gave birth during that decade and how medicalized birth seems when their mothers talk about it (Dara, Elaine).

History reveals trends or movements in American childbirth. Hospital birth, for example, did not become standard until the mid-twentieth century. Approximately half of all U.S. births occurred in a hospital in 1938 but jumped to 95 percent by 1955 (Leavitt 1986:269). Cesarean sections also saw rapid growth and change in the twentieth century with the development of new

techniques and drugs, including penicillin³⁸. The modern cesarean section was developed in 1915, and the rate of cesarean deliveries was 2.5 percent in 1930. However, with the move of most births to the hospital mid-century, cesarean sections became more frequent and accessible for more women. Though the rate was just 5.5 percent in 1970, each decade following saw significant increases in cesarean delivery rates. The rate was 16.5 percent in 1980, 22.7 percent in 1990, 22.9 percent in 2000, and now about 32 percent in 2009 (Menacker and Hamilton 2010:1). Between 1996 and 2006, the cesarean delivery rate increased by 50 percent (Martin et al. 2009:2). A recent National Institutes of Health panel discussed this rise in cesarean, citing too many barriers for women to achieve vaginal births in biomedical settings as a reason for this rise (Grady 2010).

In addition to hospital-based changes, grassroots organizing has affected several birth-related issues. A group of women launched the postpartum depression movement in the mid-1980s on the tailwinds of second wave feminism (Taylor 1996). This movement used woman-led and -managed support groups in person and over the phone to unite women suffering from PPD and draw media attention to the condition. Years later, there was a spike in PPD press coverage when actress and model Brooke Shields spoke about her battle with PPD publicly and wrote a book about her experience, “Down Came the Rain: My Struggle Through Postpartum Depression” (2005). Women also advocated for vaginal births after cesarean sections, or VBACS, in the late 1980s and early 1990s. Statistics point to an increase in attempted VBACs between 1989 and 1996, followed by a steep drop in attempts (Martin et al. 2006). Medical literature focused on risks associated with VBACs in the mid-1990s and may be one reason for a dropout in VBAC attempts.

³⁸ The discovery and subsequent usage of penicillin drastically reduced infection during and after cesarean sections (Leavitt 1986).

Childbirth movements have appeared worldwide, too. The maternal reform movement in Australia empowered women to change the technology-dominated birth scene of the 1950s and 1960s and advocate for more family-friendly, mother-centered maternity care through feminism in the 1970s (Reiger 2001). Home birth in the Netherlands has maintained strength as a social trend in the face of Westernized health care and technological standards in other Westernized countries³⁹ (DeVries 2005).

Is it possible that doulas are just another American trend that will fall out of fashion? Doulas could be trendy for a time, but how women talk about their doula experiences points to a resurgence of woman-centered social support instead, something present in birth until male-dominated, physician-influenced techniques and practices rose to the forefront of childbirth practice (Davis-Floyd 2003; Leavitt 1986; Martin 2001; Wagner 2001). Birth had been constructed as a social event complete with female relatives, neighbors, and friends prior to limits on the number of people in the birthing room and directives put in place by physicians trying new birthing techniques (Leavitt 1986:87-8). By examining a doula's role as it relates to media and technology, this final chapter shows that doula-supported childbirth is a movement toward the resurgence of socially-supported, woman-centered birth set against the backdrop of American medicine.

Media: How doulas get a good (or bad) rap

Few scholars have explored how childbirth is portrayed in U.S. popular media (Emad 2003; Kline 2007) but a recent increase in birth-focused films, television shows, and plotlines in mainstream media reinforces medically influenced messages that audiences are hearing about

³⁹ About a third of births in the Netherlands happen at home. The government manages health care nationally and supports midwife-assisted home births as what DeVries calls "a pleasing birth" (2005).

birth. Visual and print media materials help us understand how many women have misconceptions about the birthing process. As Danielle points out, doulas often act as birth knowledge referees, helping clients sort out what should be a concern and what shouldn't:

I think there's a greater awareness of the doula, but I think there's also a greater awareness because...we're so saturated with information in this society that I think women read about all the things that can go wrong in a birth, and so there's a greater sense of worry about the what ifs — What if they make me do this, what if. So a lot of my support is going through and you know helping them get through their fears of their labor. And so I think with that higher sense of awareness, people seek support and resources to kind of allay those fears.
[Danielle]

A recent documentary attempts to allay many of these fears by exploring the different discourses surrounding childbirth today. *The Business of Being Born* (2008) is a film produced by Ricki Lake, a former daytime talk show host. Along with director Abby Epstein, the film explores U.S. childbirth by featuring home birth midwives and contrasting midwifery and biomedical models of birth. At least two doulas cited this film as something that is helping women learn about less medicalized childbirth because it has “reached the mainstream” in a way that other low-interventionist childbirth education hasn't (Leah). Though initially released to a limited market, the film is now widely available. Lake and Epstein also collaborated to create “Your Best Birth,” a book about natural childbirth options (2010). Similar to the film, the book emphasizes low-interventionist births.

Mainstream Popular Media

In contrast to woman-centered information like Lake's film, popular media and childbirth education is saturated with an abundance of risk-related language and discourse in the Western medical world (Possamai-Inesedy 2006). This language is evidenced in books, pamphlets, and magazines outlining risks and problems associated with birth. For example, many movies and

television shows portray characters with problematic births versus more normal ones or capitalize on the uncertainty or scandal of birth, like TLC's *I didn't know I was Pregnant* and MTV's *16 and Pregnant*. These reality programs dramatize birth as a dangerous event among women (in the former) or a dramatic one among teenagers (in the latter).

Entertainment media often focuses on birth because of its potential for humorous situations. The industry has benefited from an interest in birth in the past few years with films like *Baby Momma* and *Away We Go* and television shows like *The Secret Life of the American Teenager*. With *Secret Life*, writers began with a storyline focused on the challenges of a pregnant teenage girl in suburban America but have created a teenage soap opera revolving around high school romances and dramas. While creating humorous or dramatic plotlines, writers do not explain the reasons behind decisions characters are making and instead perpetuate a biomedical model of birth. In *Knocked Up*, Kathryn Heigl's character heads into labor and says she does not want pain medication without an explanation of why. Immediately before the baby's head is visible, she demands an epidural — which is no longer available based on her labor progress — and proceeds to scream uncontrollably until the baby is born (Apatow 2007). *Knocked Up* has a childbirth premise but is ultimately about everything in a character's life except the actual labor. Similar themes are repeated in films like *Juno* and *Saved!* and on television shows like *Friends*, including birth experiences by *Friends* characters Carol, the lesbian; Phoebe, a surrogate for her brother's twins; and Rachel, an unmarried, unplanned mother. On *The Office*, Pam, played by Jenna Fischer, recently gave birth on the show. Instead of showing the birth like many other comedies, *The Office* writers instead showed unrealistic hospital scenarios in an effort to create humorous situations. These included Pam's boss periodically entering the birthing room during Pam's 16-hour labor and Pam accidentally

breastfeeding the wrong baby (Ramis 2010). By creating plot lines around pregnant characters, writers and producers use birth as marketable entertainment without explaining anything about birth. The women in each of the examples above give birth in hospitals in the lithotomy position, a difficult position to labor in for the woman but an accessible position for the physician delivering the child (Davis-Floyd 2003:121-25). This visual perpetuates the dominant medical model of birth while ignoring choice or alternative birthing options. Writers base their storylines on dominant themes, though, meaning that until doulas and other alternative birthing options become more common, they cannot be reflected through popular media. Because U.S. birth is marked by fear, humor in birth media is a way to counteract a scary or dangerous event.

Midwives are written in comedic shows as misrepresentations of the midwifery model, instead reinforcing a medical model. Because midwives are uncommon and viewed as “hippie” or weird, they are easily transformed into objects of mockery. In looking at episodes of three separate shows — *Gilmore Girls*, *Dharma & Greg*, and *Girlfriends* — Kline concludes that midwife-attended births appear as an irrational choice, portray the midwife as a “controlling bitch,” and affirm the need for medicine, especially for pain (2007). Kline also mentions an episode of *ER* in which a home birth goes wrong and needs intervention. If midwives are depicted in such a negative, domineering way, doulas might be portrayed like this, too, if they can find a way into popular entertainment. There is hope, though: Kline omitted an episode of *Judging Amy* from her study because it differed so greatly from the other television shows. The *Judging Amy* episode showed a home birth in a better light, enforcing many of the positive aspects of the midwifery model of care.

Mainstream Print Media

Doulas are seemingly invisible in visual media but can be found in print media.

Newspapers and magazines not associated with birth — including *The New York Times*, *Crain's New York Business*, and *People Weekly* — run stories about doulas, often in lifestyle or human interest sections instead of health sections. In a brief content analysis of six articles featuring doulas, I found a generally positive impression of doulas with one exception. In an article written by Pamela Paul, “And the Doula Makes Four,” published in *The New York Times*, the author details the negative aspects of doula use, especially among more upper-class women (Paul 2008). This is the only article I have found with such negative sentiments toward doulas. The article opens with Paul telling the story of a disgruntled mother whose birth experience using a doula is poor. Within the first quarter of the story, only “servant” is used to define what a doula is, and only the mother’s infuriated comments indicate what the doula’s duties entail: “The doula was supposed to be my advocate at the hospital and help us carry out our birth plan” (Paul 2008). No other duties are listed nor any indication of how doulas function before or after birth is referenced. Without a third-party definition from a doctor, birth expert, or from a doula organization’s website, the reader begins the story without fully understanding what the doula should be doing except acting as a “servant.” Located in the Fashion and Style section of the *Times*, Paul’s article highlights key cultural reasons for choosing a doula. Her opening sentence indicates that women who are “contentious, organic-fruit-buying expectant mothers” seeking “natural” or “unmedicated births” are turning to doulas (2008). In this study, Leah noted that, “Some people seek out doulas because it’s a trendy thing to seek natural birth.” Based on this article, Leah’s statement can be applied to some women seeking doulas without understanding what a doula is.

How “doula” is defined is an issue in many articles because the Greek translation of “doula” as the word “servant” has a culturally negative connotation in today’s social context. Each story aims to define what “doula” means, recognizing that “doula” is a foreign word to those not familiar with birthing culture. Writers usually take time to explain the Greek meaning of the word, mostly using the word “servant” with some modifier. Jaffe (2008) uses “servant” and the synonym “helper” to clarify the type of serving doulas do, while *People* magazine opts for “birthing attendant.” *People*, boasting a readership of 1.43 million, writes a less fact-driven, more inspiring story focusing on a woman in a low-income area helping out pregnant teens (Fields-Meyer 2005). There is no way to determine, though, if the absence of “servant” relates to the author’s attempt at writing a more moving story. Two articles specify translations as “woman’s servant,” recognizing that doulas aid mothers-to-be (Hutcheson 2008; Jaffe 2008). Hutcheson needs to add more clarification, though, as she cites doulas as “somewhere between a midwife and a doctor” (2008). In reading the rest of the article, doula duties are understood, but none relate to direct medical knowledge, which is what midwives and doctors practice. Because doulas do not perform any medical duties, this definition could be misleading to less educated readers. Many articles fail to provide a concise, colloquial definition of a doula, leaving the reader to interpret the text as he or she desires. Print media is disadvantaged because writers cannot always express what a doula does in words. As seen in Chapter 3, doulas and birthing mothers have a hard time expressing it, too, not finding a concise or inclusive definition of doula support.

Some print journalists cover doulas who are part of hospital- or community-programs. These articles highlight the positive effects of social support in inner-city communities (Fields-Meyer 2005), minority communities (Halvorsen 2004; Hutcheson 2008), and prisons (Spencer

2009). These stories often include personal stories from women that have benefited from doula support and pleas for continued community support and awareness. By highlighting programs versus individual fee-for-service doulas, the print media justifies doula practice among specific peoples while failing to mention how doulas can help individuals, too. It is important that newspapers continue publishing about such programs, though, if doulas are to be supported by the mainstream public and through financial contributions, as many volunteer programs run exclusively on donations.

Doulas Today

The majority of doulas are certified through DONA. In advertising their services, doulas who have gone through DONA training and completed the other steps of the certification process put “CD(DONA)” behind their names. Certified doulas are also listed on DONA’s website by geographic location, simplifying the find-a-doula process for women seeking a certified doula.

Only six doulas out of at least an estimated 25 to 30 doulas in the Ann Arbor-Ypsilanti area are listed on DONA’s website, and none are listed in Ypsilanti. Twelve doulas are listed on the Center for the Childbearing Year’s website, and only two of them are listed on the DONA website. Only two doulas on the Center’s birth doula directory advertise that they are certified. Many other doulas use business cards, personal websites, and word-of-mouth referrals to gain clients. There is no way to know the actual number of practicing doulas in the Ann Arbor-Ypsilanti area, but I have been unofficially told that the Center for the Childbearing Year trains more doulas every year than any other DONA-certified training location in the United States. Women drive in from elsewhere for training, but having this training site in Ann Arbor points to a large local population of doulas.

While doulas vary in how they advertise their services, a root issue in how doulas advertise is certification. The majority of doulas I've met in the past year are not certified through DONA, but all have gone through DONA doula training. There is no overarching system that requires certification among practicing doulas, though programs like Doulas Care require a copy of a doula's DONA training completion certificate.

Nonetheless, the number of doulas registered with DONA has skyrocketed in the past ten years, and this increase brings up questions about why. Rather than representing an increase in doulas, childbirth experts and doulas point to the need for certification among doulas as the main reason for this increase. As Susan put it, we — the medical community, the Ann Arbor area, and the United States in general — are “all about certification.” Valerie said prospective clients sometimes ask if she is certified, but she doesn't think certification has ever been the difference between being hired or not being hired: “I think our society really values certification and pieces of paper that say, you know, someone else is vouching that I'm what you're looking for.”

The value of certification is subjective because certification is not required for practice. However, everyone tends to “march to the step of DONA” as Susan said,

I think we've always had informal networks of social support and ways in which women have worked together, it just hasn't been recognized. So as you're seeing the professionalization of that role occur, you're seeing the rise in the number of certifications.

Susan is unsure if certifications are rising because there is an increase in the number of people working as doulas or if those who have been doulas are getting certified as a way into health care careers. Only two of the four doulas in this study are certified, even though the other two have each been practicing as doulas for over five years. For them, certification is a formality that is not worth the hassle. Additionally, certification must occur within four years of the initial doula training weekend. Because many doulas

practice intermittently for several years, many of them would have to re-take the training weekend class at an expense of several hundred dollars. Doulas counter U.S.

biomedicine's construction of birth, and by rejecting the notion of certification, some doulas counter another aspect of mainstream culture that values official accreditation.

Susan is a childbirth educator and sees certification as an opportunity for women to enter the childbirth education field. Susan said certification helps women expand their opportunities to work with families and that about a third of women who become doulas do so as a pathway into other health care careers. As health professions become increasingly competitive and more women undergo doula training, certification could become mandatory for doula practice. Doulas are different because they work in medical fields while acknowledging their lack of medical knowledge. Certification may be a way to justify their place in the birthing room in the future, but U.S. law allows birthing mothers to bring whomever she desires to her birth (Allen 1999; Annas 1989), thus doulas are permitted in birthing rooms regardless of their certification or kin status.

Considerations for future research

As evidenced by lack of media and academic attention to doulas and their social impacts on women's childbirth experiences, there is a need for continued research on doulas. For example, it is important to get a better estimate of the number of practicing birth doulas in the United States. Further anthropological study is needed to understand the circumstances surrounding doula use and the people using them, putting medical findings in a social and cultural context.

This thesis is the first known attempt to understand why mothers are choosing doulas and what about doulas remains salient to mothers after birth. Doulas appeal to birthing families for specific reasons, and this thesis should not be the last attempt at understanding what those reasons are and what themes can be drawn from them. The ways in which women learn about doulas needs to be understood. Researchers also need to examine how social networks impact a woman's decision to or not to use a doula. Several of the doulas in this study said their clients find them after being referred by friends of theirs who have used the same doula. However, several of the women who have used doulas said they have few if any friends that have used doulas in birth. Because doulas are not prominent in mainstream media, understanding these social networks is imperative to understanding how women understand what doulas do and their importance as perceived by other women.

Biomedical research points to medical benefits of doulas without considering social context. Although continuous support is shown to produce better outcomes than intermittent support in randomized trials, there is little understanding of what continuous support entails. Medical researchers must consider the social aspect of continuous support among medical personnel and non-medical personnel, including doulas. Within this discussion, future researchers could examine what constitutes support and how this support is similar to or different from that of medical personnel or partners. Because doula support has been cited in reducing medical intervention like pain medication, having a better understanding of how doulas promote non-interventionist births could increase understanding of why some doula clients attribute natural births to doula support.

Kin relations must be considered in future research, too. Fathers relate to doulas differently than birthing mothers, but the ways in which doulas interact with fathers have not

been explored. Birthing mothers in this study often referenced how imperative having a doula was for their husbands, but without talking to husbands, this information was unable to be explored in great detail. If women are partially hiring doulas because they perceive their husbands having a need for support during labor, researchers should speak with husbands about their experiences with doulas before, during, and after labor. Studies examining the roles of birthing mothers' mothers and roles of doulas are needed, too, since some birthing women in this study chose a doula's presence in labor over that of their mothers. Investigating these kin issues could help explain how doulas may become kin through the birth process and contribute to discussions of evolving American kinship.

There is much room for extended social and cultural study of doulas. Because this study interviewed people of similar socio-economic standing and focused on a particular geographic area, issues of race, ethnicity, class, and gender were not explored as they could be among other communities or groups. With an increase in social research in relation to childbirth over the past decade, collaboration between the medical and social science communities is the next step to better understanding the potential doulas have to change childbirth in the United States.

In the face of technology: doulas and the American medical system

Doulas are a direct consequence of women taking a stand against hyper-medicalized birth in the United States. Just as the medical community introduced epidurals to respond to women's perceived pain, women are choosing doulas as a response to needed continuous social support during labor. By promoting fewer interventions and relying on support techniques including massage and verbal encouragement, doulas offer something technology cannot: personal touch. Doulas tailor their care to their clients' wishes, which could include interacting with fathers,

mothers' mothers, or friends. Unlike most medical staffers who do not remain with the family and may never have met them before, a doula provides nonmedical support in a medical setting that health care providers cannot.

Furthermore, doulas are a bridge between social and medical support. By having some childbirth knowledge and health system experience, doulas can guide women and their husbands through hospital birth or home birth in a way that others cannot, especially if the couple is having their first child. All women who paid for doula care in this study chose a doula for the births of their first children. For those with more than one child, they continued hiring doulas for subsequent births. Without many close family members nearby and a perceived need for father support, women actively pursued doula support for additional comfort, knowledge, and husband help. The relationships formed through the intimate experience of birth have the ability to continue after the client-doula relationship is gone, too.

There is no formal tracking system for practicing doulas in the United States. Because several doulas practice without certification and others practice intermittently, there is no way to understand how many doulas there are and what impacts they are having on specific communities. Doulas in this study believe awareness of doulas is increasing. When Danielle began working as a doula almost seven years ago, she remembers that there were few doulas in the area and few women knew what doulas did. Now, however, she sees “a greater awareness of what the doula is and how valuable that can be for some families” within the community, sometimes resulting in too much business:

Right now the market is not even saturated. I mean, there's many times when I'm turning clients away because I'm booked or the other doulas are booked in our practice. And we think that's a good problem, that there's just enough awareness that women want to hire doulas. [Danielle]

The awareness Danielle refers to is reiterated by doulas Samantha and Leah. Before having her first child, Samantha researched what doulas do and learned about their benefits. After using one at her oldest child's birth, she underwent doula training and began practicing. For her, doulas stand against what she considers the standard hospital routine:

Doulas are getting a lot more popular. The awareness of having a doula at your birth is becoming more prevalent. It's included in a lot of childbirth education classes now, even Lamaze talks about having a doula now...what used to be mainstream childbirth education is now much more proactive in terms of, "let's not have routine medical intervention, let's not have medical intervention be routine but use it when it's necessary, not routine." [Samantha]

By working against what biomedicine dictates as routine, doulas embody the importance of social support for women during childbirth. Childbirth is not a disease, and based on mothers' comments in this study, women should not be treated with routine procedures similar to those that sick patients undergo. Social support matters, and women are sharing the news:

I think more and more...people are having doulas and telling their friends about it. And having positive experiences and really whatever...kind of experience you have, having a doula present is going to help that process, even if you don't end up having a natural birth, even if you end up having an elective cesarean, having someone there supporting you is going to make a difference. [Leah]

Still, doula awareness may be limited to the immediate geographic area. MariBeth said she does not think "there's very much of an awareness out there about what [doulas] do and what the value is. Most people don't even know what a doula is." She described Ann Arbor as "kind of a weird place" when people would be more likely to know what a doula is and have social networks connecting them to doulas.

Yet others, such as Richard, an obstetrician and researcher at UM Hospital, have a different opinion from the women in this study over the potential doulas have to impact future

births. He believes doulas are no longer “in fashion” and that they have already faded out, having peaked in popularity and numbers a few years ago. He does not interact with doulas on a personal basis as often as other medical personnel, but he has overseen a large number of births at UM Hospital over the last 30 years. His insight is valid based on his experience and expertise, but he does not have the same perspective as several women in this study do. For Leah, doulas will persist over time. Doulas are more than a trendy birth option because social support is catching on and “women [are just] being more empowered in their bodies.” It is “strong women,” she said, who can influence the resurgence of social support in the birthing room and have the potential to impact birthing women for generations to come. If doulas can be the people who “maintain calm and trust in birth in face of lots of pain and what looks like suffering” (Dara), doula support has a future in American childbirth.

Doulas are a response to the hyper-medicalized standard in American medicine today. As technology undermines women’s empowerment in the birthing room, women have an opportunity to regain power over their birth experiences through use of a doula. Women who decide on a doula make a stand against dominant biomedical discourse that relies on technology and protocol instead of people. It is my hope and belief that doulas will remain in birthing rooms for years to come, re-establishing woman-supported childbirth in American biomedical culture.

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