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The Labor of Labour Support:
How Doulas Negotiate Care Work

A dissertation submitted in partial satisfaction of the requirements
for the degree of Doctor of Philosophy

in

Social Sciences
(Sociology)

by

Amy A. E. Moffat

Committee in Charge:

Professor Nella Van Dyke, Chair

Professor Paul Brown

Professor Laura Hamilton

Professor Lisa Kane Low

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University of California, Merced

2014

Dedicated to my mom and women everywhere
who birth new ideas, new paradigms, and new life

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List of Abbreviations

C-section	Cesarean section
CAPPA	Childbirth and Postpartum Professional Association
CEU	Continuing education unit
CNM	Certified Nurse Midwife
DONA	DONA, International (formerly Doulas of North America)
IRB	Institutional Review Board
VDP	Volunteer Doula Program (a pseudonym)
WHO	World Health Organization
WIC	Special Supplemental Nutrition Program for Women, Infants, & Children

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- Moffat, Amy, ed. 2010. *2020: Visions for the Central Valley*. Berkeley, CA: Heyday Books.
- Kane Low, Lisa, Amy Moffat, and Patty Brennan. 2006. "Doulas as Community Health Workers: Lessons Learned from a Volunteer Program," *Journal of Perinatal Education* 15(3):25-33.
- Kane Low, Lisa and Amy Moffat. 2006. "Every Labor is Unique: Call When Your Contractions are Three Minutes Apart." *American Journal of Maternal and Child Nursing* 31(5):307-312.

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Abstract

The Labor of Labour Support:
How Doulas Negotiate Care Work

by

Amy A. E. Moffat

Doctor of Philosophy in Social Sciences

University of California, Merced, 2014

Professor Nella Van Dyke, Chair

Doulas are specialized caregivers who provide emotional support, information, comfort measures, and advocacy to women during their childbearing year, with a focus of continuous companionship during labour and delivery. This dissertation is a sociological study of the emergence of birth doulas as an occupation seeking legitimacy within maternity care. Findings are drawn from in-depth, semi-structured interviews conducted with twenty birth doulas from the same Midwestern metropolitan area in 2012-2013. Doulas in this sample, both volunteer and paid, ranged in certification status, birth experiences, and encounters with medical staff. An interview was also conducted in 2011 with two key informants from the largest doula membership organization.

This study addresses a gap in the literature on professionalization to account for the expanding doula occupation seeking legitimacy. The findings demonstrate many ideological tensions and paradoxes of how doulas strive to establish themselves as professionals. I find that the demands of professionalization may contradict the very essence of doula work. This creates tension between pursuing legitimacy while still desiring autonomy and self-regulation. Another paradox is how doulas need support in order to give support. Inadequate theories of worker emotion management provide an opening to discuss doulas' needs for peer support. I find that although doula work is mostly solo and isolating, there persists a strong need for collegiality. Doulas especially find benefits to debriefing with other doulas or birth workers when they are no longer with a client. I expand Goffman's concept of teammates, who co-operate on stage in performance and gossip back stage, to include doulas need for such support when they are not working in order to be successful caregivers.

Clinical research has found the presence of a doula is associated with more positive birth experiences and outcomes. However, very little is known about which types of social support that doulas provide contributes to improving health outcomes. I analyzed a sample of 198 clients who received one of 85 volunteer doulas in 2005-2007. I ran logistic regression to demonstrate that when volunteer doulas of similar training provide massage and visualization/relaxation, women have a significantly lower risk of having an unexpected c-section.

Chapter One

INTRODUCTION

[T]he challenge to society is not only to provide help and care where these are needed but also to offer the opportunity to contribute and care for others.

(Bateson, 2010:8)

Doulas, also known as labour¹ assistants, help pregnant women and their families achieve their goals of having an easier, healthier, and more empowering birth experience. Based on key informant interviews with volunteer and entrepreneurial doulas in a mid-sized Midwestern region, this research analyzes the doulas' efforts to care for and care about their clients, while focusing on the strategies doulas employ in their professional and personal (back stage) lives. This introductory chapter provides an overview of the purpose and focus of this research by first introducing doulas, why they are significant, and how they contribute to professional knowledge and practice. I also detail how the research was conducted and the organization of the subsequent chapters.

¹ A note about my use of the distinction "labour" versus "labor." Although the same English word "labor" has been used since the fifteenth century to describe both the effort of women during childbirth as well as what men and women do in producing things for use and exchange in the home and the market (Martin 1992), I purposefully try to distinguish the two. Throughout this research I use the spelling "labour" to refer to the physical, mental, and emotional work by pregnant women in bringing forth children, while I use the spelling "labor" to refer to the activities one is doing, making, or performing as an occupation. However, my definition of labor is not contingent on whether those activities are paid for in the marketplace, as it has historically been defined. This allows housework and volunteer work to be included in the field of labor. It is nevertheless significant that the term "labor" as we use it in everyday language means both definitions simultaneously, especially in a society where the realms of home and work are usually sharply divided. It provides a sense of validation to the effort involved in expelling a baby from one's body, with the accompanying sense of accomplishment. Yet, as Martin (1992) illustrates, the Western medical metaphor used to describe women's labour gives credit only to the mechanical parts of the woman's body, giving objects (instead of the whole woman) the credit for the work.

INTRODUCING THE DOULA

Like the wise elder woman of the village who was called to the birth, in addition to the midwife, doulas provide the emotional caring that nurses and doctors no longer have time for in contemporary institutional settings. Labour support is care that is intended to ease a birthing woman's anxiety, discomfort, loneliness, or exhaustion, assist her in finding her own strengths, and ensure that her needs and desires are known and respected (Simkin 2002). Doula care, such as emotional support, informational support, physical comfort measures, and advocacy, mostly consists of invisible and specialized knowledge and care work crucial for household, family, and individual well-being, which is typically done informally by women on an unpaid basis. Facing a public unfamiliar with paying for these services, doulas seek legitimacy for both their product and themselves as providers (Sherman 2010), though the essential product they are selling is themselves (Joinson 1992).

Doula services emerged in the early 1990s in the United States and are typically offered by women running their own small businesses, volunteering in non-profit or community programs, or staffing hospital-based doula programs. The doula's role is to provide physical, emotional, and informational support to mothers and their partners before, during, and just after childbirth (Klaus, et al. 1993). During pregnancy doulas assist families in gathering information about the course of labour and their options. Subsequently the doula accompanies the woman in labour and offers continuous emotional support, information about labour progress and advice regarding coping techniques, and physical comfort measures during childbirth (Hodnett et al. 2011). Information also includes explanation and discussion of practices and procedures and

assistance in acquiring the knowledge necessary to make informed decisions about her care and helping the woman articulate her wishes to others (Hodnett et al. 2011). The doula advocates for the client's wishes as expressed in her birth plan and doula-client conversations, helps the mother incorporate changes in the plan if and when the need arises, and enhances the communication between client and health care providers. Immediately after the birth and up to a few months postpartum, the doula provides additional support in regards to mother care, breastfeeding, and infant care. Since the doula's role encompasses the non-clinical aspects of care, doulas can be present with their clients in the entire range of birth settings, from a scheduled or emergency cesarean section, to unmedicated home births (Gilliland 2002).

Doula work is paradoxical much of the time. They have to leave their families in order to support other families. They need the support from their own family and networks in order to be able to provide support to others. They volunteer as novices and are assigned clients who have more or different needs than other clients, thereby gaining much-needed experience by supporting very challenging, demanding and difficult births. They work independently without an apprenticeship, yet rely on and value any chance to be connected to other doulas.

In a 2012 nation-wide survey, only six percent of women who gave birth in the United States said they used a doula (Declercq et al. 2013). This number is low, given the medical research and clinical trials on labour support confirming that doulas benefit women by assisting in positive outcomes during childbirth, both physically and psychologically (e.g. Hodnett et al. 2011). In Morris's (2013) book on the epidemic of c-sections in the United States, she concludes that not only should women hire doulas, but

there should also be a public health initiative to publicly fund doula programs along with health insurance companies recognizing the positive financial outcomes. So far health insurance reimbursement is sporadic at best, but community-based doula programs like Health Connect One are growing throughout the nation. Health Connect One relies on grants from foundations for funding and is just one model of recruiting, training, and providing community-based doula care. The Volunteer Doula Program (VDP), a community-based volunteer doula program in the Midwest, is another example of a model for providing access to women who would not be able to afford the private cost of a professional doula. Regardless of the benefits shown in research and the strong support from researchers, “doula” is still not a mainstream word. For the most part, doulas are attempting to commodify tasks that have not previously entered the market.

SITUATING DOULAS AS CARE WORKERS

First, it is important to define care work in the context of this discussion. Traditionally, social scientists have defined caring labor as those occupations that provide services for dependents – children, the sick, and the elderly. More recently, scholars have clarified terms more deliberately. Before, “reproductive labor” had been used to describe the unpaid work women did in the home and was an essential categorization of household tasks needed to bring such invisible work into the discourse of Marxist economics (Duffy 2007). Hochschild’s (1983) study on flight attendants introduced “emotional labor,” which suggests that workers are paid to have and act out emotions they do not really feel. Later, England (1992) created a broader category of work, referred to as “nurturant work,” to include other face-to-face service workers who also have clients or customers

such as waiters and sales workers. Folbre and Weisskopf (1998) use “caring labor” to denote work that provides care services and is motivated by caring attitudes, e.g., a sense of affection or concern for others. Caring is the verb to signify the act of helping (“caring about”) and being compassionate (“caring for”) that presumes an intimate relationship with another person (Zelizer, 2005). I will mostly use “care work” to refer specifically to caregiving occupations dominated by women (Abel & Nelson, 1990) in which all kinds of labor tasks – mental, manual, and emotional – are integrated.

Distinct from reproductive labor which was specifically unpaid labor in the home, care work can exist in different institutional contexts, e.g. “it can be given away, traded among family members or friends, or sold in the labor market” (Folbre & Weisskopf, 1998:172), and is not limited to one place. Doula work falls into care work because doulas 1) have individual clients, 2) are motivated by altruism and intrinsic enjoyment (usually referred to as “passion”), 3) perform tasks that are directly related to reproduction and indirectly related to historically invisible tasks that are now being commodified, 4) can be unpaid (volunteer) or paid (entrepreneur) or a combination of both, and 5) are subject to work structures similar to other kinds of healthcare work (with the sick), such as being on-call. Ultimately, care work definitions are useful simply for the fact of revealing and calling attention to gender inequality and being able to categorize work to show that women do such a significant majority of paid and unpaid care work (England, 2005).

Historically, family relationships and the labor market have been seen as separate, dichotomous domains, but care work, which has traditionally been a female activity in the private, behind-the-scenes sphere, has increasingly demanded market valuation as it

moves from the private to the public market place. Commodification is a process in which something, a task or product, enters into the realm of sale. As Nelsen and Barley (1997) maintain: “Work becomes a commodity when audiences deem a formerly unpaid activity worthy of remuneration.” (p.619). Some scholars have voiced concern about this process because they believe that caring cannot be reduced to a market exchange model (Fisher and Tronto 1990). How could one operationalize love, for instance? Also, many scholars deplored the movement of activities away from families into more formally organized work, as has been the case with modern and urban industrial societies and economies (Coser 1994), because they believed something would be lost since care exchanged in the familial system is understood to be based on reciprocity and morality (Knijn 2000).

However, recent research has engaged in the debate about the commodification of intimacy, directly challenging the “hostile worlds” notion that care work and compensation are incompatible (Folbre & Nelson, 2000; Himmelweit, 1999; Stone, 2007; Zelizer, 2005). This is in response to Parsons and the functionalists’ (Parsons and Bales 1955) ideas that such categories are unchanging, universal, and descriptive of past, present, and future. England (2005) calls this conceptual framework in the care work literature the “love AND money” perspective, which rejects the idea that genuine caring can only be found in families, communities, nonprofits or the state, making it impossible to move to the labor market or to stay the same once it is being paid for. Other scholars working within these and other care work theories (Cancian 2000, Nelson 1999, Zelizer 2005) have challenged such dichotomous constructs and argue that conceptual dichotomies usually used to distinguish between types of labor (e.g. family obligation vs.

profession; caring about vs. caring for) are false ones. They assert that care and profits can exist simultaneously without hostility. These authors address the past assumption that markets are saturated with selfishness and corrupt motives, an idea which lacks empirical support. The love and money framework argues that it is possible to provide fair pay for workers who combine the values of love and money and provide quality care services for clients in a capitalist market sector.

Fisher and Tronto's (1990) compelling argument states that care work crosscuts these direct opposites and we need to have a new vocabulary that can "emphasize caring as a process and points to contradictions resulting from the lack of integration between phases of caring" (p.56). Feminist analyses have tried to make the labor side of the dichotomy more visible, but have not challenged the dichotomy itself. But recognition alone does not increase value or automatically reduce the pay inequity, and may even reinforce the status quo that caring is women's work (Fisher and Tronto, 1990). It is in this context that I consider doulas as a case study for care work that is trying to seek legitimacy – namely prestige and respect – through a process of professionalization.

PURPOSE OF THE STUDY

The fact that doula work is a caring profession creates challenges and the need to negotiate contradicting demands in two areas of women's lives: 1) at work, having to balance caring – providing a high level of care centered on women's values – with professionalism and strategies for gaining legitimacy, and 2) at home, having to balance the demands of work with family responsibilities, necessitating a supportive family and network of peers in order to structurally and emotionally provide care to others. Doulas

occupy a challenging social position, over and above the fact that their work requires them to be on-call like some medical care providers. The purpose of this research is to use doulas as a case to consider how individual struggles for occupational legitimacy are distinctive when it involves care work.

This dissertation research addresses the following research questions:

(1) What are the individual and collective strategies for occupational legitimacy? How do internal considerations contribute to or weaken the success of overall goals for professionalization? The goal of Chapter Two is to describe individual attempts at occupational legitimacy and investigate the points of tension in the emerging professionalization of doula work. I draw from the literatures on professions and occupational legitimacy to examine how doulas negotiate this social context, and how they manage to provide a high level of emotional care in a unique work structure.

(2) Which specific domains or combinations of doula care (information, emotional support, physical comfort measures, and/or advocacy) make a significant positive difference in birth experiences and outcomes? I hypothesize that one or multiple groups of doula tasks will reduce the rate of unexpected c-sections. The goal of Chapter Three is to statistically test the effect of doula tasks on the method of childbirth delivery (c-sections).

(3) What are the individual and ideological factors that influence how doulas are able to provide social support, while paradoxically needing similar social support themselves? I hypothesize that the emotional tasks required of doulas may sometimes lead to burn-out, but do not have such severe outcomes as stated in the psychosocial consequences of emotional labor literature (e.g. Wharton 1995, 1999; Hochschild 1983,

1997). The goal of Chapter Four is to describe how doulas negotiate the tension between front stage and back stage (personal-life considerations) to have their own social support needs met.

REVIEW OF LITERATURE

The following paragraphs will provide only a brief summary of the literature more thoroughly discussed in subsequent chapters. In Chapter Two the relevant literature includes professions and the process of professionalization. Literature on professions assumes that a new occupation will without a doubt strive for professionalization through traditional strategies of legitimacy and therefore should have all their members engaging in the highest credentialing and continuing education available. This may be a function of the fact that most research on professions has examined professions with some longevity, and has not looked at consequences of occupations that chose not to take that route. I question the assumption that all members of an emerging profession, whose skills and tasks are now becoming professionalized, will partake in whatever they can to establish legitimacy and that there are limited costs individually and collectively in doing so. This research could suggest new theoretical frameworks in women's strategies in negotiating institutional, family, and personal barriers to work. Because they work in an institutional setting like a hospital, where women-centered care continues to need development and support, doulas provide an example of the struggles women who perform informal and unpaid work encounter as they attempt to gain legitimacy for their services. This study adds to the conversation of professions by analyzing how doulas directly reconcile competing personal and professional ideologies and negotiates the

points of tension between their individual and collective values with the demands of professionalization.

In Chapter Three, I review a significant body of medical research demonstrating the value of doulas in reducing the number of c-sections, reducing the use of medication and having fewer complications for both the mother and her newborn. In more than 21 randomized, controlled clinical trials, conducted in over 15 countries, medical researchers examined the effect doulas made in helping with the complexities of pregnancy, childbirth, and motherhood (Hodnett et al. 2011). There is a range of stressful feelings and experiences that mothers undergo when giving birth (DeMatteo et al. 1993). About 56 percent of the total population of women (68 million) aged 15-44 in the United States have given birth to a child (Martinez et al. 2012). Because of the vast proportion of the population that goes through childbirth, it is important that we explore how women can have positive birth experiences, both physically and emotionally, so they are more able to sufficiently bond emotionally with their babies and reduce maternal morbidity and mortality. One strategy to create positive birth experiences is to lower the rate of c-sections (e.g. Lobel and DeLuca 2007, Morris 2013). The current c-section rate in the US is 31.3 percent (2009-2011, not including twins or more) (Osterman and Martin 2013), and yet it is often an unnecessary medical procedure with known risks. Even with the surge of elective c-sections, more research has come out recounting the risks to the mother and baby when undergoing this surgery (as compared to spontaneous vaginal births), including higher maternal morbidity and mortality and fetal mortality rates (Morris 2013).

Thoits (2010) reviews numerous sociological research studies on stress in the last 40 years which find that social support is a buffer that moderates the effects of stress on health outcomes. However, sociologists are still attempting to discover and understand the processes or mechanisms that underlie the relationships between social support and health outcomes (House et al. 1988). I explore what few social support studies have addressed – the actual behaviors and actions that labour support persons engage in when giving support during birth, and the types of support that are associated with changing birth outcomes. This study is unique because no one has attempted to disaggregate the doula's tasks to see which specific methods are effective. The practical clinical and program benefits will derive from empirical data that specifically identifies which caring tasks are effective to produce change in health outcomes. Uncovering which specific actions doulas take that are most effective will have the potential to make this non-medical intervention more effective, and contribute to literature on how social support may reduce the impacts of stressors on health and well-being for new mothers and their infants.

In Chapter Four, I consider Goffman's *The Presentation of Self in Everyday Life* (1959) and his dramaturgical model of social life. Since then, researchers like Hochschild (1983) have built on the Goffman's framework of being on a theatre stage during work, using examples such as flight attendants and other service workers. Hochschild offered a theory on the commercialization of feeling, where workers are paid to act out emotions they do not really feel, and therefore need to manage the tension between those feelings. In more contemporary literature mostly represented by mental health professionals and nurses, the cost of caring experienced by caring professionals is

characterized as “compassion fatigue” (Figley 1995). This literature emphasizes the need for offsetting stressful work situations with play and rest to “remain grounded in various aspects of our complex identities” (Pearlman 1995:54). The focus is not the emotional tension within the self when being on front stage, but rather concrete activities that individuals use to cope more effectively when off stage. This is important for the structure of doula work, in isolation and with physical demands for being on-call. I am interested in determining what structures create a positive experience and promote professional longevity. For instance, “research on caring occupations, such as nursing or midwifery, shows how changes in the structure, practice, and professional norms guiding these fields have the potential to increase or diminish workers’ positive experience of caregiving” (Wharton 2009:154). Even though Goffman recognized “actors” need for back stage camaraderie of teammates, Hochschild and subsequent sociological theorists have neglected the back stage metaphor.

RESEARCH DESIGN

The research is comprised of a mixed method design from three sources, including both qualitative and quantitative data. The qualitative data encompasses qualitative interviews with volunteer doulas and key informants, and the quantitative data comes from evaluation documents filled out by doulas and clients of a volunteer doula program.

I conducted in-depth, semi-structured interviews with twenty doula ($n=20$), at least 20 years old, who provide services in a mid-sized Midwestern metropolitan statistical area. Half the sample currently volunteers through the Volunteer Doula

Program (VDP), and the other half are entrepreneurs. VDP is a separate non-profit 501(c)3 organization that consists of a community-based volunteer doula program serving communities throughout its metropolitan area. I recruited the volunteer doulas using word-of-mouth through the VDP organization and snowball sampling. The entrepreneurial doulas were recruited directly from access to their marketing materials online and also by snowball. This purposeful sample had a range of certified doulas: those who were certified, currently pursuing certification, or “lay” doulas who were not certified. I conducted interviews with the volunteer doulas in 2011 in the homes of the participants and lasted approximately two hours. I conducted interviews with the volunteers using a semi-structured interview guide (see Appendix A), which I later modified and condensed when interviewing the entrepreneurs. For the entrepreneurial doulas, in 2013 I conducted interviews over the phone, which lasted about one hour. During the interviews I asked participants about their demographic background, reproductive background, personal views on childbirth, becoming a doula, training, volunteering, doula practice and structure, who makes a good doula, costs and payments, with an additional open-ended question at the end. All references to individual doulas in this research are made with pseudonyms. Data analysis consists of theme and content analysis of interviews, and explores how individual practitioners define doula work and how multiple audiences consider where doula works fits in and around well-established professions

Qualitative data collection also included an interview in 2011 with two key informants, Anne Kennedy and Penny Simkin, two co-founders of DONA, International, the largest U.S. doula membership organization. As key decision makers in the

beginning development of doulas, their experiences provide a broader picture of the structure of doula training and professionalization, which in turn provides a foundation to better understand individual doulas' experiences. See Appendix B for the interview guide.

Additionally I obtained survey documents from VDP, which constitute the quantitative data. The VDP dataset includes variables on the scope of services provided by the doulas and client health outcomes. Clients in this sample were enrolled in the program 2005-2007. Clients are the unit of observation and all the clients in the sample are unique, but the doulas could have provided services to multiple clients. A total of 85 doulas in this sample provided services to 198 clients. The quantitative analysis includes a binary regression model on c-sections by treatments (different tasks) performed by doulas.

ORGANIZATION OF THE DISSERTATION

The dissertation manuscript is organized into five chapters. This chapter includes a broad introduction, as well as the research questions and common thread linking the three middle chapters. Chapters Two, Three, and Four are meant to be self-contained. Because each chapter is written as a separate paper, there is some repetition of key concepts. Each chapter is comprised of its own abstract, introduction, literature review, methods, findings, discussion or analysis, and conclusion. Chapter Five, the conclusion, summarizes the findings from the previous three chapters, recommendations, and questions for further research.

Chapter Two

STRATEGIES FOR LEGITIMACY IN A CAREGIVING OCCUPATION

ABSTRACT

The emergence of doulas as a new form of work began in the US in the early 1990s. These specialized caregivers for expecting mothers have operationalized labour support into a defined role, which includes emotional support, information, comfort measures, and advocacy. Membership organizations have also emerged with associated standards of practice, training, and certification processes. With a growing popularity over the past decade comes a concerted effort for professionalization. This study addresses a significant gap in the literature of professionalization to account for this expanding occupation seeking legitimacy outside of the medical profession. Findings are drawn from in-depth, semi-structured interviews conducted with twenty birth doulas from the same Midwestern metropolitan area. The respondents ranged from having achieved certification or currently pursuing certification to “lay” doulas who were not certified, as well as those with a range of experience and encounters with nursing staff and doctors. An interview was also conducted with two co-founders of the doula organization, DONA International. This paper discusses the paradoxes of how doulas strive to establish themselves in their formative year as professionals, attempting to demonstrate legitimacy while still desiring autonomy and self-regulation.

STRATEGIES FOR LEGITIMACY IN A CAREGIVING OCCUPATION

The appearance and growth of doulas in the United States since the early 1990s offers a rare opportunity to observe an occupation as it emerges in real time. Doulas, also known as labour² assistants, help pregnant women and their families achieve their goals of having an easier, healthier and more empowering birth experience. Doulas are a specialized group of care workers; their role encompasses the non-clinical aspects of care during childbirth, such as providing emotional support, information, physical comfort measures, and advocacy. Doulas emphasize that during labour and delivery women need consistent, continuous reassurance, comfort, encouragement and respect based on their circumstances and preferences. This is in addition to safe modern obstetrical care and the love and companionship a woman's partner provides. Clinical research has shown that doulas can improve maternal and infant health outcomes without performing any medical interventions (e.g. Hodnett et al. 2011).

For the most part, doulas are attempting to commodify tasks that have not previously entered the market. These tasks consist of invisible and largely miscellaneous knowledge and care work crucial for household, family, and individual well-being, that are typically done informally by women on an unpaid basis. Facing a public unfamiliar with paying for these services, doulas have strategies to seek legitimacy for both their product and themselves as its providers (Sherman 2010). The current literature focuses mostly on the client's satisfaction with doulas and justifying the benefits of doulas. Little has been written on the rise of the doula in contemporary North America from the doula's

² Throughout this research I use the spelling "labour" to refer to the physical, mental, and emotional work by pregnant women in bringing forth children, while I use the spelling "labor" to refer to the activities one is doing, making, or performing as an occupation.

perspective. Examining the work of doulas in an institutional setting like a hospital, where women-centered care continues to need development and support, doulas provide an example of the struggles women who perform informal and unpaid care work have encountered as they attempt to professionalize their services. As they attempt to garner legitimacy from various audiences and move toward influence and prestige while keeping autonomy, there is the possibility that the traditional path of professionalization creates a dilemma for doulas as they attempt to provide the best care for their clients.

The goal of this chapter is to describe individual attempts at professional legitimacy and investigate the points of tension in the emerging professionalization of doula work. With rich qualitative interview data from highly experienced as well as novice doulas, this research helps illustrate a set of processes underlying the emerging professionalization of doula work that remains underdeveloped in the literature. The analysis will include how individual practitioners, as well as a macro-level organization case, are defining doula work and how multiple audiences consider the work. I will be advancing such a description of the first generation of doulas that has already been skillfully started in two salient sociological dissertations a decade ago (Morton 2002, Meltzer 2004) and continues to develop with contemporary research (Morton and Clift 2014, Torres 2014). I will be adding to the conversation by analyzing how doulas directly reconcile competing personal and professional ideologies and negotiate the points of tension between their individual and collective values – such as the primary goal of support for all women in birth – with the demands of professionalization. This research will contribute to the literature on professions and the process of professionalization by questioning the assumption that all members of a new profession

will partake in whatever they can to establish legitimacy, and that there are limited costs individually and collectively in doing so.

This chapter begins with a description of doula services, what doulas do, and the boundaries of doula work. I then review the literature on professions, specifically occupational emergence and legitimacy, and examples of occupations that strategize to address obstacles to their professional legitimacy. I present my argument of the case of doulas as an emerging occupation. Subsequently I identify my data and methods, and present qualitative findings on strategies for doulas' strategies for occupational legitimacy, specifically 1) intellectual evidence that doulas matter, 2) overcoming difficulties in working with the medical healthcare team, 3) certification and credentialing, 4) work and personal experience, 5) entrepreneurship and marketing, 5) compensation, and lastly 6) the doulas' vision for the doula profession in ten years. Finally, I discuss and conclude that doulas will have to reconcile the goals of their profession to have doula work integrated, mainstreamed, valued, and available for all birthing women, while keeping their role of advocacy and emphasis on women-centered care.

INTRODUCING THE DOULA

Even though doulas emerged in the 1990's, they are not a common household name. This next section is comprised of defining what doulas do, results of previous clinical research trials on doula support, how they are trained and credentialed, and then later how they fit as birth support in hospitals.

DEFINING DOULA SERVICES

The word “doula” is a Greek word meaning “woman’s servant,” “handmaiden,” or “mothering the mother” and refers to an experienced woman who helps other women. Anthropologist Dana Raphael was the first to use this term to describe traditional labour support. She was investigating the idea that if breastfeeding was to be successful, there had to be another woman around to provide care to the mother during the immediate postpartum time of transition.

“One day I was describing this pattern to a friend of mine who politely translated our conversation to her eighty-five-year-old Greek mother-in-law. The woman interrupted us to explain how in her day in Greece a *doula*, usually a female relative or a neighbor, came to the home of the new mother, washed up the dishes, gave the other children a bath, and encouraged the mother, telling her how plump the baby was. Since there is no word in English to describe a person who performs this service, from then on I called that helper ‘the doula.’” (Raphael and Davis 1985:7).

In a review of anthropological data about birthing practices in 128 non-industrialized societies, it was found that all but one had support from another woman (Zhang et al. 1996). The initial meaning of doula referred only to help given during the postpartum period, but has now been adopted by others who have subsequently expanded its meaning. In this research, a doula refers to an experienced woman who helps other women during the childbearing year (pregnancy, childbirth, postpartum), who is not a friend, loved one, or kin, and who is professionally trained. There is a distinction between birth doulas and postpartum doulas (including separate certifications), where postpartum doulas teach concrete skills to new mothers to nurture their baby. However, I will not be making any assessments between birth and postpartum doulas, so when I refer to “doula” in this research I am implying birth doula.

The doula's role is to provide physical, emotional, and informational support to mothers and their partners before, during, and just after childbirth (Klaus et al. 1993). Labour support is care that is intended to ease a women's anxiety, discomfort, loneliness, or exhaustion, assist her in finding her own strengths, and ensure that her needs and desires are known and respected (Simkin 2002). During pregnancy doulas assist families in gathering information about the course of labour and their options. Subsequently the doula accompanies the woman in labour and offers continuous emotional support, information about labour progress and advice regarding coping techniques, and physical comfort measures during childbirth (Hodnett et al. 2011). Information also includes explanation and discussion of practices and procedures and assistance in acquiring the knowledge necessary to make informed decisions about her care and helping the woman articulate her wishes to others (Hodnett et al. 2011). The doula advocates for the client's wishes as expressed in her birth plan and doula-client conversations, helps the mother incorporate changes in the plan if and when the need arises, and enhances the communication between client and caregiver. Immediately after the birth and up to a few months postpartum, the doula provides additional support in regards to mother care, breastfeeding, and infant care. Since the doula's role encompasses the non-clinical aspects of care, doulas can be present with their clients in the entire range of birth settings, from a scheduled or emergency cesarean section, to unmedicated home births (Gilliland 2002). Table 2a illustrates the major activities that doulas provide during the prenatal, intrapartum, and postpartum periods.

Table 2a. WHAT DO DOULAS DO?

<i>Prenatal</i>	<ul style="list-style-type: none"> • Establish a relationship between pregnant woman, doula, and woman's partner (if any) • Provide evidence-based information and education • Discuss preferences and concerns before labour – never to persuade the client to give birth using any particular method
<i>Intrapartum (Labour & Delivery)</i>	<ul style="list-style-type: none"> • Continuous presence • Provide emotional support, reassurance, praise • Be kind, respectful, and nurturing • Offer information • Provide physical comfort measures (comforting touch, massage, warm baths/showers, promoting adequate fluid intake & output, relaxation and visualization techniques) • Suggest positions that facilitate fetal descent and rotation • Engage women's husband/partner, as desired by the couple • Advocate (helping the woman articulate her wishes to others) • Facilitate positive communication between the woman and her caregivers to insure informed consent
<i>Postpartum</i>	<ul style="list-style-type: none"> • Provide breastfeeding instruction, guidance, and reassurance • Provide information on recovery and infant care • Light household chores

Since the care that doulas provide is not formulaic and sometimes solely contingent on the client's needs, the categories of potential doula tasks have been operationalized in different ways. I emphasize the categories of tasks here and in the next chapter because doulas have struggled with explaining to potential clients and the general public what their services consist of, commonly being mistaken for midwives, who are medical care providers. The concentrated effort to explain, describe, and defend a new role and its boundaries is a typical hindrance for emerging occupations.

Doula work has its own scope of practice, which defines boundaries of the care. This scope of practice has been defined relatively recently, even though doulas are stepping into work that the village matriarch, wise woman, or female elder traditionally performed. DONA International's Standards of Practice (2008) establishes doula care as

the following: accompanies woman in birth, provides emotional and physical support, suggests comfort measures, and provides support to the partner. Gilliland (2002) presents five consistent aspects of the doula's role: 1) labour support, 2) guidance and encouragement, 3) team building, 4) communication, and 5) assisting mothers to cover gaps in their care, all the while being responsible primarily to the mother whom she serves. While doulas do more than just suggest position changes during labour or holding the mother's hand, this type of care may be the most important part of what they do (Morton 2002).

Another definitional strategy is to create boundaries by conveying what a doula is not. A doula receives no medical training and has no responsibility for the medical health and well being of the pregnant woman or the fetus/infant (Morton 2002); she is neither a midwife nor baby catcher. Doulas do not perform any clinical or medical tasks such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care.

A nurse's role includes starting infusions, checking vital signs, administering medications, attaching and adjusting electronic fetal heart monitoring instruments, and documenting the progress of labour on the patient's chart (Rosen 1991), all of which a doula does not have the responsibility or expertise to perform. In most hospital labour and delivery rooms, the nurse is the support person who encourages and assists a mother through her labour. Nurses and medical care providers can give the patient considerable psychological support, but this attention may be diverted by their many responsibilities and other patients (Rosen 1991). For instance, technology allows nurses to monitor patients without being there in person. "While the technology introduced during the last

40 years has assisted doctors in monitoring the mother and fetus and has improved patient outcomes, it has moved the medical profession away from hands-on care” (Rosen 1991:2236). Thus, in the current health care structure with unresolved nursing staff shortages, nurses and doctors cannot provide *continuous* support by remaining by the labouring women’s side from time of admission to a few hours after birth; this is the niche doulas fill.

A doula is present at a birth in addition to a midwife, nurse, and/or medical doctor and emphasizes a team approach. Since a doula is not a medical care provider, doulas do not “prescribe” treatment; instead they are trained that when they do offer suggestions or information they do so by advising their client that she check with her primary care provider before employing any advice of the doula (DONA International 2008).

An abundance of medical and academic research demonstrates the benefits of doula care and maintains that there are no known risks (Hodnett et al. 2011). This is an extraordinary context that makes the emergence of doulas far ahead in their professional legitimacy than many other new occupations. The research of Marshall Klaus, MD, Phyllis Klaus, and John H. Kennell, MD (e.g. Klaus et al. 1986) spurred the use of doulas in the US, and they were principle actors in the subsequent founding of the first doula membership organization, Doulas of North America³ in 1992. Additionally, other health organizations with expert authority have given credibility to the labour support person.

³ Doula of North America later changed their name to DONA International, and will subsequently be referred to as DONA.

BOUNDARIES OF DOULA WORK

What defines a doula as opposed to a friend attending birth is the specific training and credentials that give doulas access to an emerging specialized role. During the past two decades, the option for certification through various doula associations in North America has emerged. Whereas certification is not a strict requirement to call oneself or be hired as a doula, it represents an individual's effort to professionalize her services and may increase public perception of the validity of the doula's role.

A system of training recruits is one of the conditions for an occupation to acquire jurisdiction. Most doulas participate in a classroom training course or program which emphasizes a wide range of topics, such as anatomy and physiology of labour and birth, the stages of labour, comfort techniques, and when and how to refer the woman to outside resources. They may also learn about routine interventions, medical terminology, pain medications, and cesarean surgical procedures so they can speak the same language as the mother and medical care providers. Because of the diverse organizations and individuals that offer training throughout the world (there are too many for me to list here, but Meltzer (2004) provides an initial list), there is no single way for doulas to get training, but it usually takes place over a long weekend (Friday night through Sunday evening). The following Table 2b is an example of doula training curriculum.

In the United States there is a distinction between certified doulas and lay doulas. Certification is not required in any state to practice as a doula. But there is the choice to pursue certification, which typically requires approved classroom training (as discussed above), additional coursework such as childbirth education classes, required reading, birthing experiences, and written essays. Requirements for doula certification,

recognition, or registration are widely varied depending on the organization and country.

Certification programs vary in their cost of training, length and quality of training, number of births required, time limit, required exam, required childbirth education classes, and continuing education.

Table 2b. TYPICAL CURRICULUM OF DOULA TRAINING

- | |
|---|
| <ul style="list-style-type: none"> • Role and scope of practice of doula care: prenatally, during labour, and in the postpartum period • Anatomy and physiology of pregnancy, labour, and birth • Overview of the labour and birth process • Ways in which a doula should be prepared to support the emotional and psychological needs of women and their partners in labor • Comfort measures and natural pain management techniques, including hands-on practice • Massage techniques and acupressure points for labour • Support strategies for normal and challenging labours • The first hour of life, including the doula's role involving the newborn and the initiation of breast-feeding • Referral sources for situations that fall beyond the doula's accepted scope of practice • Value clarification and the meaning of "support" • Essential communication and mediation skills • How to facilitate informed decision-making • Review of certification requirements, ethics, and standards of practice |
|---|

Adapted from Meyer et al. (2001)

Working towards certification benefits individual doulas and the doula community but also poses more personal and professional hurdles for the doula – hence the recognized process of “torment” to complete a rite of passage and come out the other side a professional. This socialization of moving from one role to another, as they become insiders of the occupation, is how information and values are transmitted from the group level to the individual (Van Maanen and Schein 1979) and is the subject of study of social scientists researching organizational culture (Saks and Gruman 2014). At

this point certification may be the only channel to regulate behaviors of doulas, making sure they are not stepping outside of their scope of work or failing to adhere to an organization's code of ethics by including those agreements in certification requirements. Though, Kane Low, Brennan, and Moffat (2006) identified a need for establishing evaluating mechanisms to assess how a volunteer doula is doing. As my findings will demonstrate, self-regulation and autonomy are highly valued by the doulas, but certification and individual assessment are not.

THE PROCESS OF PROFESSIONALIZATION

The word "profession" has been used in many different ways and is today occasionally interchangeable with occupation, vocation, job, career, and work. However, sociological theory refers to professions specifically as occupations that have a unique position of power, prestige, and autonomy in the labor force of industrialized countries (Wilson and Oyola-Yemaiel 2001). Sociologists have written extensively about professions, especially historical accounts of medicine and law where professional status has already been gained (see Parsons 1939; Freidson 1970; Elliott 1972; Larson 1977; Abbott 1988; Macdonald 1995). A functionalist list of attributes (e.g. control over access, training, credentialing, claims of specialized skills based on theoretical knowledge, a service ideal) that make an occupation also a profession is now thought of as an outmoded theoretical framework (Saks 1983). More contemporary sociological literature on professions emphasizes the process in which an occupational group strives towards professionalism, in which strategies highlight control over certain labor niches (e.g Hirshkorn 2006; Johnson et al 2006; Sanders and Harrison 2008; Sherman 2010).

“Strategic” theorists see such key characteristics of established professions as rhetoric new occupations use to acquire legitimacy and justify professional status (Cant and Sharma 1996).

The concept of legitimacy has been discussed within studies of industry change over time, such as the evolution of organizations (e.g. Aldrich and Ruef 2006). Essentially, legitimacy is about how much prestige and respect society gives to an occupation (Cancian 2000). While there has been a shift in focus from some measurable outcome of professionalism to studying the process in which the struggle for legitimacy is carried out, the assumption is still that occupations (with the exception of blue-collar labor) automatically strive for professional status. The literature has not considered that establishing professionalism may be at odds with doing the work in the most effective and beneficial way. My argument is that legitimacy is of primary importance, with professionalism as a consequence of that action. In effect, by seeking legitimacy, doulas may be re-defining professional values. For instance, prestige may not be of utmost importance but directed so that more women can get the care they need.

Scholars have noted that certain new occupations were “hived off” from older occupations where the original occupation maintains a higher status and simply delegated more routine (less appealing) tasks to the new occupation (Nelsen and Barley 1997). The process of hiving off tasks helps to create a hierarchy of care in which doctors have a disproportionate amount of power. It is easy to hypothesize that hiving off is what happened with doulas as hospital administrators and doctors structured nurses’ work to be more clinical, valuing medical interventions over emotional support and effectively devaluing the woman-centered caring tasks. However, in contrast with the literature, the

tasks that doulas picked up from nurses were considered the more personally satisfying tasks for individual care workers (besides the difficult part of never leaving the labouring mother's side). As many doulas and health professionals have observed, this hierarchy of care tasks for nurses where emotional support became a low priority happened prior to the arrival of doulas. Researchers of childbirth, and specifically labour support, saw that emotional support had been dropped off from the nurses' scope of work, thus they created the doula to fill that niche. Nonetheless, doulas face a dilemma of trying to gain legitimacy while also providing the labour support which ultimately helps women and their infants and which clients value the most.

Midwifery is good example of three different possible occupational configurations (Macdonald 1995) that involve the balance of power with doctors. It is interesting how the profession of medicine reacted to the belief that midwives were encroaching on the jurisdiction of doctors, and took "usurpatory and exclusionary" actions (Macdonald 1995:146). In the first configuration, which happened in some parts of the US, midwifery was completely usurped by doctors and abolished, even though the doctors then had taken on a large proportion of low status tasks, which risked a reduction of the status of the doctors' profession as a whole. In other parts of the US, midwives had to be registered and their practice supervised and controlled by doctors. This allowed low status tasks to be relegated to lower status workers that doctors then oversaw. Doctors had to believe that by taking over control of obstetrics, it would not cost them financially or decrease their status. Still, in order to establish autonomous control over their own affairs, such as having a statutory board, midwives had to show they had a distinct area of practice. And the legal credentials of certified nurse midwives had to

guarantee market control by restricting access of potential practitioners into the profession (Macdonald 1995). Finally, as occurred in Britain, doctors responded by completely abdicating what they saw as the time-consuming and boring tasks associated with midwifery. Thus, midwifery would remain entirely outside of medicine.

Another possible professionalization model to consider is a personal concierge (a.k.a personal assistants), with an emphasis on service, legitimacy and entrepreneurship. Sherman (2010) provides personal concierge entrepreneurs as an example of an occupational approach where aspects of a particular labor arena, in this case traditionally unpaid household and family labor tasks, were hived off to form a new group of labor; but they hived off the more enjoyable tasks. The direction of hiving is the opposite of high status to routine, in this case undervalued to valued. The concierges used rhetorical strategies to make their work appear more valuable in terms of both money and professional status, specifically distancing themselves away from the traditional labor and especially gender associations. They emphasized competence (e.g. educational credentials), autonomy, entrepreneurship, and their ties to the marketplace, because tasks that were perceived as “women’s work” were seen as obstacles to their professional legitimacy. With a focus on social implications, “concierges try to distance themselves from the gender connotations of their work, representing their product and themselves as gender neutral as much as possible” (Sherman 2010:82). The concierges drew strong practical boundaries between traditional domestic labor and their tasks, such that many of them refused to do any cooking, cleaning, or food preparation. Additionally, they drew symbolic boundaries by locating themselves as outsiders of the family, because of the

belief that work would be corrupted by intimate relationships (that dichotomy between love vs. money).

Doulas are similar to concierges in that they picked up tasks that were traditionally undervalued and then created rhetorical strategies to make their work appear valid, authentic, and justifiably considered work. However, I hypothesize that doulas cannot make a boundary about gendered language and work. The concierge model does not fully translate to doulas, in that gender boundaries are less flexible. The majority of doula tasks are gendered because they are dealing exclusively with women's bodies and birth processes, and they would expect those tasks to continue to be associated with women. Because doula work is virtually exclusively women's work, they have a more difficult mission to legitimize than concierges do. Given the historical framework of the formative years of an occupation (e.g. midwifery), doulas will need to be aware of institutionalized male power, demonstrate respectability, while also distancing themselves from medicine (doctors and nurses) in order to keep their professional autonomy.

As my findings will demonstrate, doulas themselves present their role as overlapping and complementary to – yet distinct from – those providing clinical care (Morton 2002). Doulas provide the emotional caring that nurses and doctors no longer have time for in contemporary institutional settings. Morton (2002) found that when working with medical staff, doulas need to show that they are accountable to them, are competent in their discourse, respectful of their authority, have no claim to their domain (e.g. medical knowledge and responsibility), and do not antagonize them. However,

while this is what the doulas may be trained to do, it is not necessarily the reality of their actions.

Torres (2013) found that doulas experience occupational closure (restricted boundaries) among maternity care professionals. Torres compared certified doulas with lactation consultants in terms of gaining entrance to the medical maternity care team and whether they could establish change in birth and breastfeeding practices in the institutions. Torres concluded that lactation consultants were able to create more formal change by influencing hospital policies and practices and gained more credibility and status for their occupation compared to doulas because breastfeeding has been accepted as a medically necessary component to infant health. Because doulas emphasize their care work boundaries and downplayed their advocacy, they create change only informally by exposing medical providers to non-medical ways of giving birth (Torres 2013).

The tension between the medical team and the doula is an element that influences the doulas' strategy for occupational legitimacy, which includes medical rhetoric to "prove" the benefits of doula care on women and infant health outcomes. Doulas may not be clinical actors, but the majority of their time is spent within the clinical scene. The medical team in hospital institutions includes a variety of healthcare professions, such as obstetricians (doctors), certified nurse midwives (CNMs), pediatricians, neonatologists, labour and delivery nurses, and postpartum nurses (Torres 2013). CNMs were especially in attendance in the Midwestern town in which this research is situated, but their rate of attendance may be different from other states in the U.S. Doulas, however, are not in an authoritative position to educate nurses and doctors on the scientific literature on birth (especially natural childbirth), and have difficulties advocating for their clients for fear of

being labeled a “bad doula” (Norman and Rothman 2007). As my findings will demonstrate, doulas must walk a fine line of being committed advocates for their clients, understanding evidence-based medical interventions and their consequences, while remaining “in line” with the medical staff and supporting decisions that are not theirs to make.

And yet, “institutional standards of behavior and normative power structures shape doulas’ professional practices” (Meltzer 2004:viii). Doulas cannot get away from being part of the system – even if their values are different and they have a strong distaste for the medical model of birth – if that is the location of their work. As Meltzer observes, doulas have become part of the system. To some extent, doulas cannot do what they want to do effectively, or do what they believe is their role, given the restraints and restrictions of the intersections of their tasks within the organizational structure of the hospital. For instance, a doula can be asked to leave the labour and delivery room if she disagrees with the health care providers decisions or openly questions the medical staff (Norman and Rothman 2007). Therefore, doulas overtly emphasize their physical support and comfort measures because they are “severely limited in their ability to act as advocates for their clients who want a natural birth” (Torres 2013:927). Meltzer asserts that this role restriction is not unique to doulas, and can also be seen in child welfare workers and home health workers, for example. The barriers of obtaining the credentials that might help them negotiate hospital structures reduce the doulas’ effectiveness and legitimacy and yet function as alternative professional pathways to provide the care women really need.

The World Health Organization (WHO 1985) recommends reducing negative outcomes of birth by providing enhanced support and preventing mothers from being unattended during labour. The WHO's Reproductive Health Library also includes a video that can be easily accessed through YouTube, entitled "Labour companionship: Every woman's choice" (www.who.int/rhl accessed 2014). The Medical Leadership Council (1996) report on reducing c-sections, as well as the American College of Obstetricians and Gynecologists (ACOG and Society for Maternal-Fetal Medicine, 2014), the Society of Obstetricians and Gynaecologists of Canada (SOGC et al. 2008) and the Association of Women's Health, Obstetric, and Neonatal Nurses (2011) have formally recognized the benefits of continuous labour and delivery support, also noting that is probably underutilized. The most recent Cochrane Review on labour support (Hodnett et al. 2011) maintains that all women should have support throughout labour and birth. A more thorough discussion of medical research on continuous labour support is included in the next chapter.

METHODS

I conducted in-depth, semi-structured interviews with twenty doulas (N=20), at least 20 years old, who provided services in a mid-sized Midwestern metropolitan statistical area. Ten doulas were actively participating in the Volunteer Doula Program (VDP, a pseudonym) in June 2012. Recruitment also included interviews of an additional 10 entrepreneurial doulas from the same geographic area who had similar training and volunteer backgrounds. Interviews of the entrepreneurs took place by phone in October 2013. This purposeful sample had a range of certified doulas: those who were

certified, currently pursuing certification, or “lay” doulas who were not certified. The two main groups (volunteers vs. entrepreneurs; certified vs. lay doulas) also covered two other dimensions: (a) range of doula experience (attended ≤ 10 births vs. > 10 births), and (b) personal birth experiences and motherhood (have given birth themselves vs. never given birth).

A major strength of the sample is that all the volunteer doula informants shared participation in the DVP program; a baseline requirement of training and program orientation was constant. The majority of the entrepreneurial doulas also had the same or very similar training sponsored by DONA or the Childbirth and Postpartum Professional Association (CAPP). Birth doula training entailed a weekend course, usually three full days, delivered by a DONA- or CAPP-certified trainer. The DVP program orientation consisted of approximately three hours as an extension of the DONA doula training, covering the volunteer program procedures as well as dealing with the unique needs of low-income and/or minority clients. For the volunteer doulas the interviews were conducted in the homes of the informants and lasted approximately two hours. They were recruited using word-of-mouth through the DVP organization and snowball sampling. For the entrepreneurial doulas, interviews were conducted over the phone which lasted about one hour, and were recruited directly from access to their marketing materials (e.g. having a website showing they served the same geographic area as the volunteers, or listed on the DONA website for the same town), and then eventually by snowball (informal doula networks). After obtaining consent following IRB guidelines, I conducted interviews with the volunteers using a semi-structured interview guide (see Appendix B), which I later modified and condensed when interviewing the entrepreneurs.

All references to individual doulas in this research are made with pseudonyms. See Table 2c for a summary of the demographics of the doulas who participated in interviews.

Table 2c. AGGREGATED DEMOGRAPHICS OF DOULA RESEARCH PARTICIPANTS

<i>Race/Ethnicity (self-identified)</i>	Caucasian	16
	Non-Caucasian (Asian-American; “Mixed” Black & White; Native American & White)	4
<i>Age Range</i>	Min	20
	Max	60
<i>Certified by an Organization</i>	No	10
	Yes*	10
<i>Doula Experience (Total # Births Attended)</i>	3 – 10	10
	20 – 300+	10
<i>Biological Mother (Gave Birth)</i>	No	8
	Yes	12

* Certification answer “yes” includes two doulas who had submitted their certification packet/application but had not yet received an official acceptance.

I conducted an additional semi-structured interview in March 2011 with two co-founders of DONA, Penny Simkin and Anne Kennedy⁴ (see Appendix C for interview guide). The interview took place in Penny Simkin’s home in Seattle, Washington and both were present at the same time.

Interview recordings were transcribed verbatim. Analysis of the qualitative data included theme analysis (Strauss and Corbin 1990), content analysis (Miles and Huberman 1984), and life history narrative theme analysis (Luborsky 1993). Analytic categories identified from previous research (closed-coding) were used, as well as

⁴ Since both Simkin and Kennedy are associated with the founding of DONA, it would have difficult to ensure confidentiality. They both agreed to have their full names utilized for this research.

categories that emerged (open-coding) in reading the interview texts, and were organized in NVivo (v10) software.

FINDINGS

The following narratives show a range of experiences by the doulas in terms of how they have used medical research to gain respectability, worked with staff as part of the medical healthcare team, and how training, experience, and claiming to be an entrepreneur helps legitimacy. They also generate a clear vision for the doula profession in ten years, which provides an interesting framework for future legitimacy efforts. This is interwoven with DONA co-founders' reflections on how they made decisions two decades ago, birthing an occupation that had yet any legitimacy or professional status. As doulas attempt to garner legitimacy from various audiences, this act is in tension with desired autonomy. Some doulas have expressed conflict related to the limitations of pursuing certification (in scope of services) and providing comprehensive care (to emphasize the conflicts).

EVIDENCE THAT DOULAS MATTER

Doulas are made familiar with the variety of clinical research that has found the presence of a doula is associated with more positive birth experiences and outcomes. There is a significant body of medical research demonstrating the value of doulas in reducing the number of cesarean births, reducing the use of medication and having fewer complications for both the mother and her newborn (e.g. Klaus et al. 1986, Kennell et al. 1991, Madi et al. 1999, Gordon et al. 1999, Campbell et al. 2006, Hodnett et al. 2011). Doulas are exposed to this literature to some degree in their training and use it when

speaking or providing marketing materials to potential clients about their specialized role. Having this evidence-based information to back-up the argument for the effectiveness of doulas is remarkable and may be useful in gaining credibility. On the other hand, it is not the only variable in legitimacy that will produce the desired result of “every woman who wants a doula to have one” (DONA International 2014b). Even with clear acceptance as to the benefits of doula care, the struggle continues for acceptance within the medical community.

WORKING WITH THE MATERNITY HEALTHCARE TEAM

Doulas use a variety of strategies to try to establish legitimacy with medical staff, such as using visual cues, being attentive to first impressions, and being friendly, to gain a perceived layer of credibility. The doulas’ formal recognition by doctors and nurses would likely make it easier for them to work within the maternity healthcare team.

In the interviews, some of the doulas had stories about how medical staff were overtly hostile to them. Brooke felt that sometimes she was asked to defend why she was there. Penny Simkin told a story of a nurse who said to her, “You are taking the best part of our job away!” Gina said, “Doctors just blow you off... like you’re a crazy hippie person.” At the same time, many of the doulas talked about very welcoming nurses who said the doulas made their jobs easier. In this sense, it really depended on the doctors’ or nurses’ personalities. However, it created stress for the doulas if they did not know whether they would get care providers who were antagonistic and unfriendly, or not care what the doulas were doing, or be welcomed like a team member. For instance, Kelly described her experience with hospital staff:

“The part that’s sometimes not easy for me is the emotional part of the reception in hospitals. What I mean by that is there are some hospitals where you walk in the door and because you have ‘doula’ on your name tag, people are super skeptical of you. You’re probably evil. You’re just on eggshells and you feel defensive and there’s territorial stuff with the nurses. . . . That kind of reception, being seen as a bad person, really wears me out.” (Kelly)

They felt that if their role had more legitimacy, they would be welcomed more often.

When the interview participants were asked about how they portray themselves professionally, especially when going to a birth at a hospital, there were mixed responses. Many doulas mentioned their clothing and said they wear medical scrubs, such as nursing uniforms. One doula made a point that if she were wearing scrub pants, maybe the nurses would assume she has some sort of medical background and that she can be trusted a little bit more. In contrast, Jessica said, “I don’t want to look like I’m hospital staff, but I’m not going to wear my jeans or sandals. So I wear comfy clothes.” Another doula said she picked out purple scrubs because they are comfortable with a stretchy waist, but she deliberately tried not to wear the same color as doctors, such as green or blue. Mostly the doulas chose their clothing and shoes out of utility, like being comfortable and following hospital rules (such as no open-toed shoes). One of the most experienced doulas said she was personally against doulas wearing scrubs because it confuses the doula’s role, especially because she is clear that she is not a medical provider.

Some of the volunteer doulas mentioned the VDP nametags in the discussion about portraying themselves professionally. The majority of the volunteer doulas said they never wear their nametag, and cited multiple physical reasons, such as getting in the way of providing physical comfort measures, and getting in the way when wearing the required hospital [visitor] badge. On the other hand, Felicia said she always wears her

VDP nametag or her university work ID when she's with her private clients, especially if she is at the university hospital. Jessica had not received a nametag, from VDP or from being certified from DONA yet, but she would wear it because she believed she would get a different attitude from nurses and clients. One doula wears her VDP nametag and waits for the doctor to ask her who she is, whereas a different doula also thought that the nametag was a good opening piece for nurses who would be interested in hearing about the VDP program. Robin, an entrepreneur, says she wears an ID badge but most of the doctors don't look at it anyway; she feels that they just don't care.

The doulas also discussed how they present themselves professionally beyond just their appearance, such as how to make a first impression with medical staff. Many doulas talked about being open and friendly with the nurse on duty right away and giving their "best face" by acting helpful and supportive. Another doula contradicted that tactic by saying that she does not offer to shake hands because she believes the focus should be on the mother. The dilemma is that the health care providers do not know who the doula is, may not have even heard of a doula, and may not understand her role. Therefore the doulas have to provide on-the-spot justification and promotion in the labour and delivery location in order to establish the legitimacy of their place there.

In the interviews, doulas were asked if there were anything they would like to change if they could. One doula commented that she thought the (hospital) system was not really ready for doulas. Both Penny Simkin and Anne Kennedy commented that the doula is still trying to figure out where she belongs in the hospital. My findings uncovered that the doulas are clear where they fit in the medical setting and have been remarkably proactive about having a standard of practice and promoting the role of the

doula, how the doula and the partner work together, how to meet the nonmedical needs of the client while being a member of the maternity care team, research findings and the structure of their costs and services. It is the medical care providers who have not figured out how to embrace doulas (or may not ever want to).

However, doulas have not focused on medical care providers or the hospitals as institutions as audiences to whom they should demonstrate their legitimacy; doulas had to be probed just to talk about clothing and first impressions. The lack of focus on doctors as a target for seeking legitimacy is noteworthy and points to the doula's primary responsibility to her client (DONA International Code of Ethics, 2008). More focus has been made on educating clients for formal recognition (discussed in more detail below) and illustrates the course in which doulas have chosen to seek formal recognition. Paradoxically, however, while doulas are appearing to achieve an alternative women-centered occupation that lies outside the traditional sphere of professional groups (e.g. medicine), they still desire to be accepted by them and have access to professional resources and rewards (Reid and Garcia 1989).

CERTIFICATION

Half the doulas in this sample were not certified, while the other half were certified or had submitted their certification packets to a certifying organization but were awaiting final recognition at the time of our interview. The following interconnected themes emerged from the in-depth interviews regarding certification. The certification topics include the clients' value of credentials, a personal sense of professionalism, the medical staff and community at-large taking credentials seriously, and the improving doulas' reputation. Conversely, the theme that individual doulas do not want to be

limited by specific professional boundaries is incorporated. Additionally, four barriers to earning certification are discussed: the difficulties of 1) obtaining enough births that count towards certification, 2) obtaining evaluations, 3) having the paperwork processed by certifying organizations, and 4) the expense.

Professional Ideologies: “I have a lot of faith and trust in the organization.” – Kelly

Since certification is not a requirement, there is a choice as to where doulas can go for their credentials and which organization they want to be associated with. About half of the doulas in the sample were members of DONA. DONA International has over 6,500 members in the USA and internationally, as well as certifying over 10,000 birth and postpartum doulas. In 2013, DONA processed 786 new certification and 459 recertification applications⁵ (DONA International 2014a). Laura said that DONA was the only organization she even considered, especially because she knew that Penny Simkin was a founding member. She thought Penny was the “rock star of the birthing world... She’s kind of the gold standard of everything for me... So I feel like if Penny’s on board, [DONA] is a good place to go.” Then again, many of the doulas chose DONA because the training they completed was by a DONA-certified trainer (and therefore counted towards DONA certification) as that was the only training available in their area.

Kelly, the most experienced doula in this sample, had involvement with other organizations such as Birth Works International, but chose DONA because she felt the organization was “definitely the organization to take the doula profession to the next level.” It was important to her that DONA was organized around the practice, the scope of work, and had position papers. Also, she highly valued the responsiveness of those in

⁵ The number of applications include both birth and postpartum doulas.

the organization: they answered her calls, paperwork was returned promptly, and the leaders of DONA were excellent role models and mentors. “I felt that DONA is big enough, professional enough, and structured enough that you have some real support behind you” (Kelly). Kelly shared examples of calling DONA for advice during situations where she wondered about her responsibility as a doula, and received prompt help. Kelly also believed that Birth Works had extraordinary women leaders, as well as a strong philosophy, materials, mindset and knowledge base, but was not positioned as well as DONA with a national presence and effective marketing. Ultimately, DONA’s scope of work was most important to Kelly; she was upset that other organizations were certifying doulas and encouraging them to perform vaginal exams, for instance.

Personal Ideologies: “I just wanted to feel accomplished...” – Melissa

For some doulas, going through the certification process was a personal accomplishment and opportunity for reflexivity. Angela appreciated the chance to write essays about her reflections on each birth and what she learned from them. She also felt that it was a way to get more rigorous with her doula experience and valued the process even though she eventually chose not to get certified. Melissa felt a sense of accomplishment by completing the training and fulfilling the certification requirements and “now I have this piece of paper that says I’m certified.” This is similar to what Meltzer (2004) found with her research, where the doulas in her sample placed just as much importance on their credentials – contributing to their own sense of professionalism – as the consumers or potential clients. For many of the doulas, the process was worth the effort whether they eventually received their piece of paper or not; this was especially true from the ones who chose not to get certified even though they had been working

towards the certification requirements. This is dissimilar from what Meltzer (2004) found, where the doulas in her sample felt that since they received recognition by a certifying organization, then they must be qualified. None of the doulas in this sample mentioned that particular notion.

Collective Values: "It sounds professional." – Erica

The choice to attain certification also stems from the perception of potential clients, and having letters at the end of the doulas' name provides some external legitimacy. For instance, if a birth doula is certified through DONA, she could present herself as Jane Doe, CD(DONA). However, there are conflicting views about the difference certification makes to clients. Some doulas remarked that being certified gives them the ability to present themselves to potential clients from "a bit stronger perspective" (Angela). It shows that the doula is serious about her work and is equivalent to other professions, especially if clients are finding doulas from a website. Jessica thought that having the title would help people in her community "take it a little more seriously." Nancy was clear that in her particular community, where many academics work and live, people care about the letters behind their name. And additionally for Nancy, clients found her listed on the DONA website (which lists only certified doulas), but she emphasized that those were clients who were specifically looking for certified doulas. On the other hand, Danielle's view was that potential clients in her community do not know that doulas can be certified and therefore do not know to ask if their doula is certified. Brooke agreed with Danielle, stating, "In reality no one really besides the doula knows about the certification." Either way, none of doulas in the sample chose to certify solely on the basis of clients wanting or expecting credentials.

Clients are not the only ones who expect a certain level of professionalism that is implicit in credentials. Felicia expressed that she was pursuing certification because it would lead to better relationships with hospital staff, and that she would be granted more respect because health care professionals are used to respecting letters after names. And yet she did not find it necessary with her home birth clients. Jessica brought up the perception that certification could potentially be a way for families to get assistance with hiring doulas, such as payment through their health insurance. Although this might not be the actual way insurance companies make decisions, her perception that it might help was important in her determination to get certified. For both Felicia and Jessica, the notion that certification would help their clients and families was the tipping point in pursuing it.

Individual Values: “So many things about the process [of certification] made me mad because it just didn’t seem very ‘doula-y’” – Brooke

Major perceived barriers to gaining certification, specifically (but not exclusively) to DONA, include: 1) the requirement that the doula must be present with her client and begin her doula services before the laboring mother reaches 4 cm dilated, 2) gaining medical staff evaluations of the doula, 3) having the certifying organization processing paperwork in a timely manner, and 4) the expense. For the majority of the doulas in this sample, they were either current volunteers with VDP, or had volunteered in the past before starting their own business. Even for the entrepreneurs, their first birth clients were crucial to gain certification requirements and many had volunteered in order to gain clients for certification purposes. DONA requires continuous labor support throughout active labor, meaning support must start before active labor, which is defined as 4 cm.

As a volunteer with VDP, the organization's policy is that doulas cannot attend labors at home and must meet their clients at the hospital. However, doulas are trained to tell clients to stay home until they are in solid active labor and to even call the doulas for support over the phone while they are home. This creates tension between what is best for the clients, what is best for the volunteer organization regarding liability, and what will count for the doulas.

Five doulas specifically cited VDP's policy as a barrier to their certification process. For instance, Isabel had only one qualifying birth after attending eight births.

As Jessica stated,

“The hardest part of the certification process when doing volunteer VDP births, due to their liability agreement we, as doulas through VDP, cannot go into the woman's home during her labor at all. But ironically, or paradoxically, the doula's role is to encourage and support the woman to labour as long as possible at home, [such] as to when [to go] to the hospital [to] avoid any opportunities for unnecessary intervention when things don't happen in the doctors' time. The biggest obstacle is getting the requirements that DONA wants for certification, like you have to be with women from 4 cm, and sometimes a woman doesn't go to the hospital until she's like 7 cm, so it doesn't qualify.” (Jessica)

Brooke explicitly explained the conundrum, stating that she would never tell a client “I really want this birth to count so can you please go in [to the hospital] at early labor and get checked in.” Moreover, only one c-section can count towards the three qualifying births and even so labor support must be continuous. It was a rare occurrence when the doulas in this area were allowed to accompany their clients into the operating room during a c-section surgery. Even if the hospital allowed a loved one in the operating room, if the labouring mother was accompanied by her husband or partner then she would most likely pick her partner to be present during the c-section. Given these

circumstances, doulas participate in about 8-10 births to complete the requirement of three certifying births.

The second major barrier is the difficulty in obtaining one-page evaluations (filling out a form with closed-ended and open-ended questions) from the client's primary care provider and if that care provider is a physician, then an evaluation must also be obtained from the nurse. These evaluations are in addition to the client's evaluation, which none of the doulas had a problem receiving. However, trying to get busy doctors and nurses to fill out the form was problematic. Many doctors are only in the delivery room to catch the baby and nursing shifts change, OB and LND nurses can leave to go home during active labor.

Doulas described the evaluations as a "weird process," "awkward," "frustrating," and "complicated." As Brooke illustrated, "I'm not going to ditch mom and like run down the hallway to find you." Some doulas had good results by mailing their forms to the doctor's office and having them sent back completed. Others dropped off forms or mailed them and never received a response. Other doulas, who knew they were green and inexperienced, said that asking for an evaluation of themselves as a doula was uncomfortable. Erica stated, "I just didn't feel comfortable the first few times asking them to evaluate me because I was brand new and I don't feel comfortable about me being here so I didn't ask until I felt comfortable with myself." Robin also declared that she would feel completely ridiculous asking a doctor whom she's never met and maybe worked with for ten minutes to take time out of his busy schedule to review her. Robin believed that the client review, not the doctor's, was far more valuable and far more telling of whether or not the doula met her responsibilities.

When asked about the evaluation forms specifically, Penny Simkin did acknowledge the tension but stated that the evaluation form was meant for “more good than harm.” For her, the bottom line was to make sure that doulas could demonstrate that they function well in the hospital:

“We have to recognize our place which is the lowest person in the [medical] hierarchy and we are there because we are not doing harm, that they think we are not doing harm, and that we may be doing good in their eyes, that they can tolerate us. But if they think we’re making life difficult for them, we’re out of there. . . . My motto was one doula in the room is worth 500 out in the hall or out of the hospital.” (Simkin)

The third major barrier to certification was the difficulty of getting paperwork processed by the organizations. Both DONA and CAPPa were cited as not getting back to doulas after they submitted their certification paperwork in an expeditious manner, which just added to the obstacles and complexities of the entire process. Because of the close network of doulas in the area, word would get around about the organizations’ lack of response and it distressed them even if that had not been their personal experience.

The fourth major barrier was the cost. Brooke had taken six months to complete all her certification requirements and then when she could have sent in her completed packet decided it was not worth the expense for certification and the required annual membership renewal fees. DONA doulas are required to re-certify after three years. Additional CEUs required to keep certification was not listed as a hindrance, as much as the cost of the continuing education courses. Felicia was also concerned that there were potential wonderful doulas out there who could not afford the cost of membership and certification, which was affecting the supply of doulas. Melissa felt paying for the

certification was just the conclusion to all the time and money she had already invested in, such as training.

Limitations of Professional Boundaries: “[I]f you use any of those [other holistic modalities] in your practice, you’re no longer allowed to call yourself a doula.” – Crystal

All the doulas interviewed were all very clear about the standards of practice, the boundaries in which doula care is practiced and where the ethical lines are drawn to say that one is a doula. This includes a scope of work, the continuity of care, as well as the training, experience, and certification. However, this awareness made some doulas make an informed decision not to pursue certification because they knew they wanted to practice outside DONA’s scope of work.

For Crystal, she wanted to broaden her education in holistic modalities and was looking at other organizations besides DONA to get her doula certification that would allow her to practice things like cranial sacral massage and herbal medicine. “My not being able to melt two practices together to create a more holistic experience for a patient or a client because I’m not a doctor, seems ridiculous to me – that I’m not allowed to be a birth worker because I am also a cranial sacral therapist” (Crystal). Brooke also did not want to be limited by DONA’s scope of work. She did not feel she went outside the scope very often (e.g. aroma therapy, placenta encapsulation, belly mapping), but was aware that she did practice in a sort of “grey area” and so decided to not get certified. Melissa had friends who were doulas that did essential oils and homeopathy who chose not to certify as a doula because they did not want to be stuck under the rigidity of the organization. Felicia acknowledged that some doulas wear different hats and even

childbirth educators who may fill multiple roles with their clients have some complexities when they are under multiple certifying boards.

In spite of how certification might help them establish legitimacy and some doulas are choosing not to pursue certification, DONA's goal to educate and provide standardization of care by doulas may be considered successful. All the doulas had clarity about the ethical boundaries and the organization had effective transparency about the doula's role.

Personal Choice vs. Collective Ideologies: "Anybody can call themselves a doula." – Teresa

Many of the doulas in this sample remarked that certification is not a guarantee to result in a "good" doula⁶, whereas training and experience may be more important. There are many differences between doula personalities as well as effectiveness, but the interviewees felt these differences were not entirely mitigated by certification. A common remark was that not all doulas should be certified. However, the interviewees recognized that there is a risk with non-certified doulas because they are not committed to working within the bounds of the scope of work. The doula reputation hinges on the actions of all workers who call themselves doulas, whether they are certified or not. Uneven preparation and training can complicate outcomes: "We get a bad rap if a doula does things she is not supposed to do, [like] if there is a doula who starts performing medical tasks, because she is unaware that doulas do not do that. That reflects negatively on us as a whole" (Felicia).

⁶ Definitions of "good" and "bad" doulas are based on whether the doulas stay inside the established scope of work and how they are perceived by clients and medical staff.

Ultimately, the doulas have a personal choice about whether to pursue certification and with which membership organization or training business to certify. The benefits of certification consist of personal achievement of having a higher level of training and education, clients giving legitimacy to the credentials and therefore increasing the demand of certified doulas, gaining more respect from hospital staff, and the prospect of helping out clients whose health insurance may recognize the credentials and hence have a better chance at reimbursement. However, many barriers exist in gaining certification, even for those individuals who choose to pursue certification in the first place. Finally, there are reasons beyond the certification process in which doulas choose not to obtain certification, frequently feeling like they cannot do what is best for their client if they are bounded by a specific scope of work or role defined by an outside organization. These findings about certification are interesting given the supposition that doulas as a whole are striving for legitimacy and therefore should all engage in the highest credentialing available.

EXPERIENCE

Besides credentials, experience is also a major component of claiming legitimacy. Even with the copious positive comments about the trainings, many doulas were still not confident to call themselves an official or professional doula immediately after the training. More than a third of the doulas I interviewed said they did not call themselves a doula to others until after attending their first birth after training. Just under a third of the sample doulas said they considered themselves a doula directly after completing the training, while the other third of the doulas in the sample called themselves a doula after becoming certified or after more than one birth experience. Even though the trainers

clearly stated during the training that those attending could call themselves a doula directly after, interviewees still felt that training itself was not enough and that birth experience was needed even more. Paige remembers her trainer saying, ““You guys, you walk out of here as professional doulas. And then once you get certified, then you’re certified professional doulas.”” Yet it still took Paige experience with three births before she would call herself a doula, professional or otherwise. When hiring a doula, many times the potential client will ask for references from previous clients. Gina disclosed that references and previous birth experiences were more important to her clients than certification.

As Morton (2002) fittingly points out, the structure for doulas learning their skills does not include an apprenticeship, which would be typical in other professional care work occupations (e.g. nursing, social work, counseling). Other professions also have an internship phase, and that may be why the doulas are intuitively waiting until they have birth support experiences to call themselves a doula. As covered in the previous section, certification attempts to standardize the training, education, and experience of a birth doula.

Although motherhood is not a prerequisite to being a doula, many doulas are mothers themselves and have personal experience of childbirth. However, there is much internal debate about whether having gone through childbirth makes a doula more legitimate. The doulas on a whole do not believe it necessarily makes them more effective than doulas who are not mothers themselves, but they do acknowledge that clients think motherhood experience is important. Angela said, “I know that all my moms have asked about my birth experiences. I think that gives me some street credit.”

A few of the doulas articulated that the birth experience provides them with a sense of empathy for what the labouring mother is going through, but that empathy as a skill does not have to be learned solely from one's own personal experience; just by being a woman a doula has empathy. Melissa, one of the youngest doulas in the sample, stated,

“I think that really all it takes is an understanding of the female experience and empathy, you know. I haven't actually gone through the act of birth, but I'm capable of it. And being a woman, I have that connection with what they're... going through. And I feel like I have an enormous capacity for empathy, which I think is really important.” (Melissa)

In the end, the doulas understand that they have to give what clients want. However, they personally feel that what should be valued for is their training and experience as a doula, not their own experiences of what labour feels like.

ENTREPRENEURSHIP AND MARKETING

Two additional themes that emerged here are that being an entrepreneur helps legitimacy, as well as knowing who to market one's services to. In both of these customary legitimacy strategies, the doulas revealed a good deal of ambiguity. For instance, Kelly and Robin, the most experienced doulas in the sample, are the only ones who clearly feel comfortable calling themselves entrepreneurs. For Kelly “it makes me feel a little more legitimate,” while for Robin she thinks of herself as an entrepreneur because of the structure of the work; she's in control of her own schedule and has the freedom and flexibility to continue to be a full-time mother. The perception that there is a disconnect between having a “business” and doing the caring work of a doula, is widespread. Melissa said,

“I do see myself as a business woman, entrepreneur, and very kind and loving doula. It just sounds strange with all of it being in the same sentence... I don’t know [if there is a better word for it]. I guess it hasn’t been invented yet... I’m not sure if there’s a word that includes [everything].” (Melissa)

Laura stated, “I guess I don’t think of myself as an entrepreneur. That sounds like more work than what I do. That sounds like a lot of work. I guess I just consider myself self-employed. It’s got a different connotation, to me, anyway.” And Paige stated, “I don’t see myself as an entrepreneur. ... I don’t really have that, like, business mindset... I would say I see myself more as, like, a community support person.” Nancy mentioned that although she does business work like making business cards, websites, and contracts with clients, that part of the work does not come naturally to her. Other doulas said they do not do their doula work for the money, they do it for fun or as a service, and therefore the label “entrepreneur” does not fit for them. It is interesting that self-identifying as an entrepreneur is not in alignment with having passion for their work.

Teresa also made a striking point that although she has her own LLC company with its own website, people do not hire her, say by word-of-mouth, under her company name; they are looking for her, Teresa, as an individual they hire. “Other doulas in the community don’t say, ‘Oh, you need to call [name of business].’ They say you need to call Teresa.” This concurs with Sherman’s (2010) findings that the new entrepreneurs, like concierges, have to show legitimacy for themselves individually as providers of a service.

Another boundary the doula community asserts is that doula care is distinct from what many husbands and partners do as “coaches” in the delivery room. As Penny Simkin narrated, some men said in the beginning of the doula movement, “We do that,

what's the big deal?" Doulas affirm that they are there in addition to the partner, not in place of, but that they bring a different set of support and advocacy skills than the partner. When asked who they considered to be the primary client, the mother or the mother and her partner, most of the doulas in this sample responded that it depended on the level of involvement the partner preferred. "It's their dance, and they know how to work it together," stated Jessica about a particular client couple. Again, this points to the notion that it can be difficult to describe and market doula services when they are tailored specifically for the client.

REGULATION

Since there is no law to require credentialing, nor a board to regulate doula activities, any person can say they are a doula, even without basic training or experience. When I specifically asked Penny Simkin if certification should be required, she declared, "I don't know that we have reached the level where the law is looking at us [to require certification for doulas] and I hope we don't." She argued for self-regulation, not legal control. Robin mentioned that because this is not a regulated profession, there are doulas who do not understand their scope of practice, who "overstep and do things that they shouldn't and make the medical community regard them as a nuisance in the delivery room rather than a benefit."

Intriguingly, self-regulation is one of the characteristics of a privileged social and economic position granted to professions in the old functionalist model. Doctors, especially in Great Britain recently, have been under examination for the effectiveness of their self-regulation, which is partially defined as being able "to undertake the proper regulatory action when individuals do not perform competently or ethically" (Irvine

1997:1541). While doulas also have many parallels with the values and desire for autonomy and self-regulation, the consequences are considerably minor compared to incompetent or unethical doctors.

When asked if they had ever received negative feedback from a client, it was only in the context that the client was disappointed with her birth outcome (e.g. a c-section) but not disappointed with the doula herself. I expect the doulas themselves do not talk about the potential risk of breaking protocols and the need for mitigating interpersonal conflicts because they cannot see themselves in that position. But it is interesting that at this point the only tangible regulation is client input, where it is necessary to gain positive client referrals in order to secure more clients.

COMPENSATION

Economic rewards are another way to gauge the status, and therefore legitimacy, of a profession. Conversely, the traditional definition of a profession includes workers performing expertise for the greater good – service rather than reward oriented. Doulas also wrestle with this contradiction.

At no time in the past has there been a set rate established by any organization or institution for doula work. Penny Simkin, in her interview, said that they (the individual founders and the organization of DONA) never told new doulas what to charge, though they did ask them to consider being willing to take nonpaying clients because they wanted to make doulas available to every woman who wants one. “And doulas have been really good about that [volunteering], I think, and even the ones that are trying to make a living at it will still do births, you know, marking their fee down or even doing it [for free]” (Simkin). Of the 15 doulas in this sample who have established their fee (the

other five were volunteer doulas who had not yet charged for their services), they charged an average of \$640, ranging from \$450 to \$1,200 per birth. When asked if they thought their pay reflected the value of their work, the majority of doulas considered that the level of their fee does not demonstrate the time, energy, preparation for prenatal visits, answering emails, as well as continuous support during long births, in addition to the investment in their education, training, books, birth bag supplies, and certification application.

But the doulas also said that they do believe that they charge what the economy can sustain and they base their fees on the level of their experience. For instance, many doulas will increase their fee after their first year of experience, and/or after they get certified. Melissa said, after giving an example of a couple who tried to talk her down in price but then after the birth were so appreciative of her services they gave her an extra tip, “I do think that the monetary value shows... how much they value what I do, and how much they value their birth experience and investing in that.” A couple of doulas also argued that many doulas undercharge, maybe because they are not certified or they are nervous about charging. However, clients are not aware of this distinction and low fees affect the reputation of all doulas.

A FUTURE VISION OF THE DOULA PROFESSION

When asked to envision what the doula profession would look like in ten years, the doulas were clear across the board and consistent with their values previously stated. First, the doulas would like to see the reality that every woman who needs a doula, gets one, no matter their financial situation or insurance coverage. As Teresa pictured, “For every woman who wants a doula, whether you can afford it or not, there’s someone

available to you.” Second, they would like doulas to be more mainstream, where they would no longer have to explain what a doula is. In Laura’s vision, “people know what [a doula] is, and don’t think twice about choosing to have one.” Paige compared the future access of professionally trained doulas to the current supply of labour and delivery nurses, where they would be just as available for any woman who is giving birth. Third, the doulas envisioned future doula work as being valued, “not just for what they do, but also monetarily” (Melissa). And finally, they want to see doulas more integrated with the medical system. Doulas would be legitimately recognized as part of the healthcare system, although not necessarily run by anyone else. But, as Kelly pointed out, “I don’t want [doula work] to lose the magical things that it is in that transition [to be more an integrated practice in the medical system].” They would be legitimate, integrated team members, but not at the expense of losing autonomy.

DISCUSSION

The general social organization of doulas is based upon the values of providing social support in institutions where traditional woman-to-woman support is absent. However, doulas are now facing the same dilemma as lay midwives, also traditionally seen as women’s work, in that the demands of professionalization may contradict the very essence of their work. For instance, research (Hodnett et al. 2011) demonstrates that doulas have a greater impact on improving obstetric outcomes when the doulas were not clinically trained (nurses, midwives, or students) and were not an employee of the hospital. The authors of the Cochrane Review also advise that although *continuous* support during labour is what makes the difference, it is not effective when the

continuous support is done by nurses or midwives in clinical settings. This evidence-based research supporting the argument that what doulas do is distinct from husbands (Bertsch et al. 1990), provides some recognition, but it is not enough to be fully integrated into the medical setting. In order to gain respect, doulas have to get approval by those in power inside the institutions (e.g. doctors, midwives, nurses) to fulfill certification requirements. Such a paradox has already been seen with certified-nurse midwives who are not accepted as employees in some hospitals and the status of lay midwives where their practice is illegal in some states.

What happens when there is conflict between the main values of a profession? In the case of medicine, the professional values are expertise (specialized knowledge), ethics (boundaries of practice), and service (providing aid for the greater good). For doulas, service may seem in conflict with established scopes of practice. Some doulas are choosing to protect their individual autonomy by deciding not to get certified. Not only does the process of certification go against their doula values (the certifying organizations themselves become institutional rather than personal), but in order for them to provide the most comprehensive care to their clients, some of the doulas do not want to be bound to what they believe is a strict scope of work.

While the doulas in this sample clearly understand and appreciate the doula's position and responsibilities, they want to be able to do more. They feel they have to choose between clashing priorities: either legitimacy of the profession or the best care for the client. However, literature on professions assumes that a new occupation will without a doubt strive for professionalization through strategies for legitimacy and therefore should have all their members engaging in the highest credentialing available.

This may be a function of the fact that most research on professions has examined professions with some longevity, and has not looked at the consequences of occupations that chose not to go that route, possibly because those occupations which have not followed a traditional path to professionalization are no longer in existence, or maybe doula work is unique because it cannot detach from gendered work.

Doulas also express the desire that their work will eventually be mainstreamed. The objective of membership organizations, especially those established for new occupations, is that they raise awareness of public knowledge about this new activity, with the goal that people will take it for granted (Aldrich and Ruef 2006). For example, DONA provides resources and information about research on labour support, as well as “widely respected” training and certification (www.dona.org). If doula services were more normalized, they could spend less energy defining, explaining, defending, and discerning what they do and how it is different than other services. They would no longer be mistaken as midwives and their value would be reflected in their pay and prestige.

This initial study features an individual unit of analysis to translate experience into a broader process of legitimacy that influences levels of professionalism. While I did use DONA as a case for institutional strategies, it would be prudent to also look at the many other certifying institutions that have cropped up since the doula movement began and look at them as a whole. Currently, individuals have choices about where to go for training and certification.⁷ And institutions have choices about what they emphasize and

⁷ In the beginning, it was Penny Simkin flying around the country and striving to train as many new trainers as she could.

provide to individuals, and how they market their benefits. Meltzer (2004) provides a list of certification requirements and costs across four different organizations (including ALACE, Birth Works, CAPP, and DONA), but there are now many more offerings and a (possibly) wider range of beliefs as to the doula's scope of work.

An examination of the larger doula "community," nationally and/or internationally would provide salient findings on the future trends of doula work and whether or not doulas will be successful at providing birth support to every laboring woman who wants it. I also would like to investigate in greater depth the concept of social entrepreneurship, where entrepreneurs are more interested in creating social value and are less interested in gaining personal profit (Abu-Saifan 2012).

With regard to individual volunteer doulas and the requirements of the VDP program, this research illustrates some tension between the individual volunteer doula needs and the requirements of the VDP program. However, this is not an assessment of the effectiveness of the VDP program. Shade (2011) has compared three community-based doula programs using HealthConnect One's organizational model, which is a nationally replicated and federally funded and evaluated initiative. However, there are alternative programs out there like VDP that have strengths that have yet been recognized. VDP is special in that it exclusively uses volunteers (with stipends when funding allows). It would be indispensable to conduct a systematic comparison and evaluation of the different community-based models in practice. Such an assessment comparing programs could help with finding sustainable structures for providing doulas with training, experience, and compensation, as well as serving the maternal and infant population that is currently not being served.

Eventually, doulas will have to reconcile the best way to structure their professional trajectory so that they can support more women in their child-bearing years. They can either use credentialing as a way to limit access to the work so that only trained workers can call themselves doulas, therefor limiting “bad” doula scenarios. Or they can use certification as a cultural signal of professionalism to consumers (clients) and medical staff. Since there is not an overwhelming demand for services, certification will most likely continue to be optional and used as an gauge for expertise.

CONCLUSION

In a 2012 nation-wide survey, only six percent of women who gave birth in the US said they used a doula (Declercq et al. 2013), which was an increase by one percent since 2002 (Declercq et al. 2002). Given that there were 4.02 million births in the US in 2002 (Martin et al. 2003), we can approximate about 201,000 women received doula care at birth in one year. Similarly, for 2012, approximately six percent of all registered births indicates 237,000 women received doula care (Martin et al. 2013). This number seems low given the medical research and clinical trials on labour support confirming that doulas benefit women by assisting in positive outcomes during childbirth, both physically and psychologically. But this is where doulas stand: in the middle of knowing they make a difference, but still trying to prove it. In Morris’s (2013) book on the epidemic of c-sections in the US, she concludes that not only should women hire doulas, but she also recommends that there should also be a public health initiative to publicly fund doula programs, much like the Volunteer Doula Program, as well as health insurance

companies recognizing the positive financial outcomes. Change needs to happen at the institutional-level, as well as at the client/patient level.

The emerging model of doula is a fascinating opportunity to look at an occupation in its formative years, their strategies to set themselves up in a unique position, and what is working and not working to create institutional change. There are some tensions in that there are portions of the process of gaining legitimacy that go against women-centered values. It's a double standard that doulas must be certified for medical staff to take them seriously but they are still deemed less important than a lactation consultant, for example. Doula will have to reconcile the goals of their profession to have doula work integrated, mainstreamed, valued, and available for all birthing women, while keeping their role of advocacy and women-centered care.

Chapter Three

LABOR SUPPORT PROVIDED BY VOLUNTEER DOULAS: THE EFFECT OF COMFORT MEASURES ON C-SECTIONS

ABSTRACT

Doulas, also known as labour assistants, help pregnant women and their families achieve their goals of having an easier, healthier and more empowering birth experience. Clinical research has found the presence of a doula is associated with more positive birth experiences and outcomes, such as reducing the rate of cesarean surgery (c-sections). C-sections are associated with increased newborn and maternal health complications, including higher maternal morbidity and mortality and fetal mortality rates. Very little is known about which types of social support that doulas provide actually contributes to improving health outcomes. Thus the question, which specific domains or combinations of doula care – such as emotional support, physical comfort measures, information, and advocacy – make a significant positive difference in birth experiences and outcomes? Using data from a non-profit volunteer doula program located in a mid-sized city in the Midwest, different types of doula support were explored to reveal a difference in unexpected c-sections through logistic regression. The sample includes 198 clients who received assistance from a volunteer doula in 2005-2007. These doulas were not employees of the hospital, but part of a separate community-based program. Clients for whom doulas reported they provided massage and visualization / relaxation had significantly fewer unexpected c-sections. The findings about specific physical comfort measures are consistent with previous literature that massage and relaxation can be a stress buffer through labour physiology. Professional doula trainings should continue to emphasize physical comfort measures. Further research is needed to examine explicit forms of other types of doula support, such as emotional support.

LABOR SUPPORT PROVIDED BY VOLUNTEER DOULAS: THE EFFECT OF COMFORT MEASURES ON C-SECTIONS

Durkheim ([1897] 1951) recognized that mortality and morbidity are significantly higher among those who are socially isolated. Thoits (2010), in an article summarizing sociological research on stress in the last 40 years, describes numerous studies which find that social support is a buffer that moderates the effects of stress experiences on health outcomes. Because of the varied ways scholars measure social support (e.g. structural measures assessing the existence of social relationships vs. functional measures, considering perceived and actual receipt of support and particular resources), it has been difficult evaluating theories that link social support to health outcomes (Uchino 2004). However, sociologists are still attempting to discover and understand the processes or mechanisms that underlie the relationships between social support and health outcomes (House et al. 1988).

Doulas can improve the birth experience and health outcomes for both mothers and infants by reducing stress and the need for medical interventions such as c-sections. DiMatteo and colleagues (1993) illustrated the stressful feelings new mothers experience when giving birth. This stress is compounded by a lack of adequate support from husbands and nurses, loss of personal control during the birth process, unexpected physical pain, feelings such as disappointment and sadness, and added stress from financial considerations (DiMatteo et al. 1993). Because of the vast proportion of the population that goes through this experience, it is important that we explore how women can have positive birth experiences, both physically and emotionally, so that we can

reduce maternal mortality and morbidity, reduce fetal mortality, and increase mothers emotional bonding with their babies.

Doulas, also known as labour⁸ assistants, help pregnant women and their families achieve their goals of having an easier, healthier and more empowering birth experience. Clinical research has found the presence of a doula is associated with more positive birth experiences and outcomes (Hodnett et al. 2011), however we know very little about which types of social support doulas provide that actually contribute to improving health outcomes. Thus the question: Which specific domains or combinations of doula care – such as emotional support, comfort measures, informational support, and advocacy – make a significant positive difference in birth experiences and outcomes?

In this chapter, I explore what few social support studies have addressed – the actual behaviors and actions that labour support persons engage in when giving support during birth, and the types of support that are associated with changing birth outcomes. Uncovering which specific actions doulas take that are most effective will have the potential to make this non-medical intervention more effective, and contribute to literature on how social support may reduce the impacts of stressors on health and well-being for new mothers and their infants.

DOULA CARE ~ WHAT DO DOULAS DO?

The word “doula” is a Greek word meaning “woman’s servant,” “handmaiden,” or “mothering the mother” and refers to an experienced woman who helps other women.

⁸ Throughout this research I use the spelling “labour” to refer to the physical, mental, and emotional work by pregnant women in bringing forth children, while I use the spelling “labor” to refer to the activities one is doing, making, or performing as an occupation.

In this research, a doula refers to an experienced woman who helps other women during the childbearing year (pregnancy, childbirth, and postpartum), who is not a friend, loved one, or kin, and who is professionally trained. Labour support is care that is intended to ease a women's anxiety, discomfort, loneliness, or exhaustion, assist her in finding her own strengths, and ensure that her needs and desires are known and respected (Simkin 2002).

Doulas do not perform any clinical or medical tasks such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care. Since the doula's role encompasses the non-clinical aspects of care, doulas can be present with their clients in the entire range of birth settings, from a scheduled or emergency c-section, to unmedicated home births (Gilliland 2002). Since most doulas volunteer or charge on a fee-for-service basis, they refer to women and their families as clients.

Doula care is different than the support providing to mothers by their significant partners. Results from studies (Klaus et al. 1992, Kennell and McGrath 1993) distinguish the support given by fathers versus doulas, especially in the behavior of fathers during times when a doula was present compared to times when the father was the sole companion. They all concluded that doulas and fathers together can foster a team approach because they provide complementary, but different, labour support. But what is it that doulas do that fathers do not?

The Cochrane Review (Hodnett et al. 2011) summarized common elements of doula care, which I have utilized here when categorizing doula tasks: emotional support, information, comfort measures, and advocacy.

Emotional support provided by the doula includes attending her client continuously during labour and delivery, while offering reassurance and praise (Hodnett et al. 2011). Establishing a relationship between the client, doula, and woman's partner (if any) during the prenatal period can help establish an intimate foundation for care. Gilliland found in the literature that nurses provide four groups of emotional support: 1) encouraging verbalization of fears, concerns or needs, 2) reassurance, encouragement and praise, 3) being with a woman, keeping company; and 4) social conversation with a woman (Gilliland 2011:526). Gilliland then expanded the main labour support strategies by interviewing doulas and operationalized five additional emotional support categories that doulas perform that are not performed by nurses and husbands: 5) mirroring, 6) acceptance, 7) reinforcing, 8) reframing (content and context), and 9) debriefing (using active listening skills). Some of these strategies included verbal and non-verbal responses, such as acceptance. From both qualitative research like Gilliland's (2011) and the quantitative work medical researchers (reviewed later), scholars have determined that the emotional care doulas provide is different from, yet complimentary to, support which is provided by other support people.

Informational support includes explanation and discussion of practices and procedures and assistance in acquiring the knowledge necessary to make informed decisions about the client's care and helping the client articulate her wishes to others (Hodnett et al. 2011). During pregnancy, doulas assist families in gathering information and providing education about the course of labour and their options. During labour, the doula can convey "information about labour progress and advice regarding coping techniques" (Hodnett et al. 2011:3). Doulas can provide up-to-date evidence-based

information to mothers who may not have access to such information elsewhere.

Immediately after the birth and up to a few months postpartum, the doula provides additional education in regards to mother care, breastfeeding, and infant care.

Comfort measures refer to a group of tasks in which the doula provides tangible support in the form of physical touch or suggestions to facilitate relaxing the body and making the physical part of labour less painful. According to Hodnett and colleagues (2011) comfort measures also include “comforting touch, massage, warm baths/showers, [and] promoting adequate fluid intake and output” (p.3). Doulas can provide natural pain relief by suggesting changing labour positions to lessen discomfort, using techniques such as patterned breathing, massage, and/or aromatherapy, offering food and fluids as desired, assisting the labouring mother into the shower or bathtub (hydrotherapy), and creating a calm environment for visualization and relaxation.

Advocacy happens when the doula advocates for the client’s wishes as expressed in her birth plan and doula-client conversations, helps the mother incorporate changes in the plan if and when the need arises, and enhances the communication between client and caregiver. Doulas advocate for their client’s wishes by trying to make sure their client’s best interests are being met and that they receive the best care possible. Meltzer (2004) maintains that “*Mediated advocacy* is a form of advocacy most commonly practiced by doulas” (p.110), in which the doulas’ power and voice are bound by institutional norms. The doula also acts as an advocate by helping the woman and her family navigate the healthcare system, ensuring that decisions made for the labouring woman respect her wants, needs, and preferences, and assisting with any information needed to participate in her health care decisions. The doula discusses the client’s preferences and concerns

before labour – never to persuade the client to give birth using any particular method. This also includes using the doulas’ social capital to help their client navigate the health care system and make referrals to additional resources, such as a medical office, WIC, social services, the local Public Health Department, a social worker, or domestic violence shelter, if needed. While doulas are trained not to speak for the client, the doula can enhance communication and understanding between the woman or couple and the medical staff (DONA 2008). Doulas do not have the same negative career consequences as nurses for speaking up (Hanks 2008), especially if doulas are employed outside the hospital institution.

Any of the above categories of doula tasks can be constrained by institutional barriers that make it hard for doulas to do their jobs. I created the domain of “barriers” to include any institutional policies that prevent the doula from providing the any of their support activities. The care that doulas provide presume that they are working in an institutional environment that allows for them to play the role they have been trained for. But many hospitals have existing policies that may prohibit or prevent the doula from performing certain tasks or roles. However, there is tension since doulas working in the hospital setting have to respect the medical providers’ authority and endeavor not to antagonize them (Morton 2002; see also the role of doulas in Chapter 2).

LITERATURE REVIEW

The ensuing review of literature develops from the following framework: Previous research on continuous labour support has found the presence of a doula providing support during childbirth is associated with more positive birth experiences and

outcomes, such as reducing the rate of c-sections. C-sections are associated with increased newborn and maternal health complications, including higher maternal morbidity and mortality and fetal mortality rates, and therefore the World Health Organization and other organizations call for a reduction of unnecessary c-sections.

Doulas provide different types of support, but those groups of tasks have not yet been tested as to which specific types of support make a significant on birth experiences and outcomes. Sociological literature, as well as research from other social sciences, medicine, and nursing, provides varied theories in what ways direct social support is connected to physical health. And finally, this section concludes with a critique of the generalizability of the research on doulas when their roles, training, and interventions (tasks) have not been controlled for or made explicit.

CLINICAL RESEARCH ON CONTINUOUS LABOUR SUPPORT

Despite the fact that doulas do not receive medical training and have no responsibility for the medical health or well-being of the pregnant woman or the fetus/infant (Morton 2002), the use of this non-medical intervention during birth has been found to improve maternal and infant health outcomes (Hodnett et al. 2011). There is a significant body of medical research demonstrating the value of doulas in reducing the number of cesarean births, reducing the use of medication and having fewer complications for both the mother and her newborn. In more than 21 randomized, controlled clinical trials, conducted in over 15 countries, medical researchers examined the effect doulas made in helping with the complexities of pregnancy, childbirth, and motherhood (Hodnett et al. 2011). The World Health Organization (WHO), the American College of Obstetricians and Gynecologists and Society for Maternal-Fetal

Medicine, the Medical Leadership Council, and the Society of Obstetricians and Gynaecologists of Canada (SOGC), have formally recognized the benefits of continuous labour and delivery support (WHO 1985; ACOG and Society for Maternal-Fetal Medicine 2014; Medical Leadership Council 1996; SOGC et al. 2008). A summary of the differences in maternal and infant birth outcomes as a result of labour support compared to a control group are listed in Table 3a, including more likely to have shorter labour time, more likely to have a vaginal birth, more likely to have satisfaction with their birth experience, and more likely to have healthy baby Apgar scores five minutes after birth.

Making a difference during birth is obviously not as simple as just adding an optional doula to the maternity care team. Research has identified significant birth outcomes when a doula is used; however, little is known about what doulas do that make such a difference. There is no detailed information on the specific training topics nor itemized accounts of the activities of the support that generates the measured significant differences. Hodnett and colleagues (2011) conclude their Cochrane Review on continuous labour support that future clinical research trials on different models of training labour support “would help to inform decision makers about the most effective models in the context of their settings” (p.15). My research is attempting to address this gap in the literature by providing more specific information about one specific model of volunteer doula care.

THE RESEARCH RATIONALE TO REDUCE THE RATE OF C-SECTIONS

Childbirth accounts for the most frequent reason for hospitalization in adult woman, ages 15 to 44, in the United States (Hall et al. 2010). Furthermore, cesarean

surgeries (c-sections) as a method of birth have received much attention in recent years as the United States reached its highest rate ever reported – 1.3 million c-sections, which constituted 32 percent of all births in 2007 – with this rate continuing to accelerate (Menacker and Hamilton 2010). In 2011, the rate of c-sections in the U.S. was 32.8 percent (Martin et al. 2013). A c-section is defined as the extraction of the infant, placenta, and membranes through an incision in the maternal abdominal and uterine walls (Menacker & Hamilton 2010). The World Health Organization acknowledges that c-sections put women's lives at risk and therefore recommends a country's c-section rate should not be higher than 10 to 15 percent (WHO 1985).

Although much debate continues over the short- and long-term risks and benefits to both mothers and infants, c-sections are known to increase newborn and maternal health complications, including higher maternal morbidity (injury) and mortality (death) and fetal mortality (death) rates (Villar et al. 2006). Deneux-Tharoux and colleagues (2006) found that maternal mortality associated with c-sections was 3.3 to 3.6 times higher than vaginal births and there was no difference between emergency or planned c-sections (whether the c-section was done during labor or before labor started) (Deneux-Tharoux et al. 2006). C-sections have also been associated with a significantly increased risk of rehospitalization 30 days postpartum after a planned c-section because of medical issues, such as wound complications and infection, and 76 percent higher hospital costs and 77 percent longer hospital stays (Declercq et al. 2007b). Additionally, this procedure has also been associated with decreased rates of healthy psychological measures; for example, women who had c-sections felt the birth process was more distressing and less fulfilling (Salmon and Drew 1992). There has been no evidence that c-sections improve

the health of newborns, as research has shown that all types of hospitals with high c-section rates do not have better neonatal outcomes than hospitals with low c-section rates (Glantz 2011).

Researchers are not suggesting that we abolish c-sections, because there are circumstances where c-sections can save lives (e.g. placenta previa, maternal heart problems), but rather that we look at the reasons why the c-section rate is so high and reduce the rate of unnecessary surgeries (Morris 2013).

The decision to deliver by c-section is purportedly related to clinical indications, but the use of c-section also varies by non-clinical factors. Research in the last 25 years has illustrated the relationship between socio-demographic characteristics of the mothers and whether they gave birth vaginally or by c-section. The following factors are important (e.g. Stafford 1990; Peipert and Bracken 1993; Bravemen et al. 1995;): 1) maternal age, 2) race/ethnicity and nativity, 3) parity, defined as the number of children previously given birth to, 4) single fetuses (not twins), 5) gestational age of fetus, 6) type of insurance or payment source, 7) the timing of prenatal care initiation, and 8) the characteristics and established policies and procedures of the hospital. For instance, the likelihood of a c-section for women aged 40 to 54 is 49 percent, which is more than twice that for women under the age 20 (Martin et al. 2013). Many of these characteristics, including the rate of obesity – a highly significant factor leading to maternal complications during birth – are confounded with socioeconomic status. Recognizing the factors, like socioeconomic status, that correlate with c-sections is essential when using c-sections as a dependent variable in the subsequent statistical analysis, as previous research points to feasible control variables.

TYPES OF SOCIAL SUPPORT

Now that the high c-section rate in the US has been assessed, we can turn to an examination of doula work and how different categories of social support, as operationalized here, have the potential to reduce c-sections. The following is a general review of the literature in each of the four different categories of social support – emotional support, information, comfort measures, advocacy – and the barriers to such support.

Emotional support is defined as offering empathy, concern, love, trust, reassurance, affection, intimacy, encouragement, or the non-instrumental aspects of caring (e.g. Cohen 2004; House et al. 1988), with the goal that the client feels cared for, feels respected as an autonomous person, and has increased confidence. Emotional support in the sociological literature, however, is often conceptualized loosely and fused with social support, with little attention given to the different forms in which it may be displayed. For example, Seeman and Berkman (1988) measured whether the recipients felt like the emotional support they received was available and adequate, such as someone to talk over problems with and help to make decisions. Gilliland (2011), as previously noted, described in detail the specific emotional support techniques that nurses and doulas provide to labouring women, but very few studies that include emotional support outside of nursing have explored the operationalization of this concept.

Informational support is typically defined as providing information at a time of stress or finding things out for the client that assists with problem-solving (House 1981). For example, patients usually do not know the risks and benefits associated with different modes of treatment and let their medical providers affect their choice (Bernstein et al.

2012). Specifically, as “maternity providers push decision-making responsibility onto patients [thus transferring the risk of the decisions from the provider to the patient], most women’s sources are biased and not evidence-based, and few women understand the risk of interventions and c-sections...” (Morris 2013:146-7). Even when women and couples participate in childbirth education classes, they only receive information that is outdated. When childbirth education classes are provided by hospitals they tend to normalize interventions and c-sections (De Vries and De Vries 2007) and the classes are used to provide information about the procedures of a c-section, rather than empirical evidence about risks and how to prevent such interventions.

In the social support literature, comfort measures are referred to as instrumental support and include tangible aid, concrete assistance, and the delivery of physical support (Langford et al. 1997). Physical comfort measures for people who are ill are usually associated with pain management and meeting physical needs to provide physical ease. Comfort can also refer to meeting psychological needs for security and peace of mind (Lowe 2002). Field and colleagues (1997) found that massage reduced pain and stress during labour, such as self-reported lower levels of depressed moods and decreased behavioral anxiety. Teixeira and colleagues (2005) found that “active” guided relaxation exercises in pregnant women, distinct from passive/self relaxation, significantly reduced maternal anxiety and heart rate. While the actual physical mechanisms of massage and relaxation are still not clear (e.g. manipulation of cortisol levels), the benefits of such comfort measures have conveyed longer-term effects, such as shorter labour times, shorter hospital visits, and less postpartum depression (Field et al. 1997). These

techniques may ease the pain of labour directly or indirectly and can reduce the need for narcotic analgesia or anesthetics (Simkin and O'Hara 2002).

Advocacy is a domain that is not traditionally seen as part of social support, but something different and separate, and possibly much larger. Kohnke's (1980) definition of advocacy in nursing is the "act of information and supporting a person so that he can make the best decisions possible for himself" (p.2038). Health advocates, as well as peer health advocates using their social networks, have been used in many public health interventions. In a broader sense, advocacy is part of social relations, recognizing the interests (or agendas) of other people who make up an institution or social system and trying to make change from within. In the hospital settings, nurses are usually thought of as ideal patient advocates, but advocating for patients can have consequences on their careers and hence is considered a risk-taking behavior (Hanks 2008).

Institutional barriers can limit the amount of advocacy (or warrant an increase in advocacy), therefore Hodnett and colleagues (2011) caution that the effectiveness of labour support may be influenced by policies and practices in the birth setting, as well as by the relationship between the labouring woman and her care provider. For instance, hospitals may limit food and liquid intake during labour as a precaution for the risk of aspiration of gastric (stomach) contents, and subsequent pneumonia, after having general anesthesia during a c-section surgery. Even though general anesthesia is now used in less than five percent of c-sections in the U.S. and U.K. (Afolabi and Lesi 2012), policies are still in place for outmoded practices, where doulas do not have the authority or control to make change. A Cochrane Review (Singata et al. 2010) on restricting intake of food and drinks during labour found that there is no justification for this practice, especially

women at low risk of complications. Yet, many hospital policies are not revised in a timely manner when evidence-based information is made available.

METHODOLOGICAL PROBLEMS OF PREVIOUS CLINICAL RESEARCH ON DOULAS

There are many gaps and issues with past clinical research trials. To begin with, the literature is not consistent as to what is meant by a doula intervention. Each of the randomized controlled trials used different criteria regarding the experience of the labour attendants, such as the culture, background, and training of the women used in the experimental intervention (Zhang et al. 1996). Some doulas were mothers themselves, some were not. Some already had additional training in assisting with childbirth, such as a Lamaze teacher, midwife, midwifery student, or nursing student, while others were laywomen. Some were given additional doula training as part of the trial, and some had already obtained a wide variety of doula training (or none) before the experiment. This is more important than semantics, such as whether the labour support was called a doula or labour attendant or something else. For instance, those involved in the intervention varied from being a Lamaze childbirth teacher and mother in Texas (Cogan and Spinnato 1988), midwifery students taking shifts or laywomen as support persons (Hemminki et al. 1990), to doulas who were drawn from the same community as participants but were strangers (not previously known to the participants) in South Africa (Hofmeyr et al. 1991).

One variable that has shown significance is whether the doula was a part of the medical or nursing institution (e.g. an employee or student of the hospital) or someone from “outside.” The Cochrane Review (Hodnett et al. 2011) concludes that using a doula

who is not paid by the institution is more effective than using a hospital employee, such as a nurse or student. Cohen and colleagues (2000) also make a different, but equally important, distinction between credentialed professionals and lay persons, specifically in their review of home visitation programs for health issues. They determined that credentialed professionals were more effective as sources of emotional support because of their authoritative knowledge and wide experiences, even though a lay person from the person's network of natural associates could have been trained to deliver the same information.

Another chief critique of the medical research on doulas is that the results from the previous trials in other countries, like Guatemala, cannot be generalized to North American birth environments because of the difference in practices and cultures and the different backgrounds of the mothers receiving the intervention. However, Hodnett and Osborn (1989) concluded that their study in Toronto demonstrates that a North American population with different sociodemographic characteristics, including prenatal education, could still receive a positive difference in labour and birth outcomes by using a doula. Most of the doula studies, nevertheless, research young, socially and financially disadvantaged women who would have been labouring alone, without any partner, family or friends (Keenan 2000) and do not make any arguments as to the strength of translating their findings to other populations. When another study (Gordon et al. 1999) tried to address the sample population issue and conducted a doula trial with women enrolled in a prepaid group-model health maintenance organization, who had also received some formal instruction in childbirth preparation, and were expected to have a spouse or other support person with them during labour, they were not able to reproduce significant

results in rates of birth outcomes (e.g. cesarean, vaginal, forceps, vacuum delivery, oxytocin, breastfeeding, postpartum depression or self-esteem measures).

Another critique of previous research is that there was no consistency as to when the studies enrolled the mother into the doula intervention, except that the labour support persons were unknown to the mother before they started providing support. In many of the studies the mother enrolled into the experimental group as she was admitted to the hospital at whatever standard that particular institution used for admittance, usually the measurement of cervical dilatation (however even that criterion differed across hospitals). As Hodnett and colleagues (2011) concluded, labour support in early labour (which is typically before the mother is given instructions to present at the hospital) makes more of a significant positive difference. In fact, the continuity of doula care provided through the entire childbearing year – from pregnancy, through childbirth, including postpartum – has not been addressed whatsoever, as the clinical trials have only focused on labour and delivery. Where some studies have included support during pregnancy (Manning-Orenstein 1998), the preliminary results have been very positive.

A further critique of the previous clinical trials is that the mothers in the studies usually had a “normal” pregnancy without any medical risks in order to control for physiological differences. However, obstetrical risk status can also be associated with social and economic factors. Gordon and colleagues’ (1999) lack of results needs to be examined further, but it points to the main concern that the social and economic – in addition to health – background of the mother is vital information that should be taken into account and reported. For instance, it makes sense that the trials were originally arranged to provide support to those in most need, such as women who would have been

otherwise labouring alone. But currently the trend in North America is that women who can afford to hire doulas are women with husbands and/or other supportive kin in attendance, are able to afford private health insurance, are more highly educated, have completed some formal instruction in childbirth preparation, are familiar with a hospital setting, and are older (Lantz et al. 2005). One of the paradoxes of doula work is that those who do not have financial access to hire doulas possibly are the ones for whom doulas can make the most difference.

The lessons from the previous clinical trials are important to incorporate in this research. The four essential points kept in mind when seeking an acceptable dataset include: 1) the doulas should be consistently trained, 2) the doulas should not be paid by the hospital institution, 3) the doulas' care should start in pregnancy and continue through birth and post-partum (what is often referred to as the childbearing year), and 4) there should be some measure of socio-economic status of the client. The following dataset contains volunteer doulas who are considered "outsiders," drawn from the same pool, and were expected to provide the same scope of services during the childbearing year (prenatal visits, labour and delivery, and post-partum). Although the dataset used in this research may not be easily comparable across studies, it is remarkable that within the dataset all the volunteer doulas attended birth doula training led by the same trainer or her apprentice, and the same volunteer orientation. The dataset also takes into account methodological issues by including a number of control variables, specifically a measure of the client's socio-economic status (discussed below).

The research question addressed in this particular quantitative research design is: What are the specific tasks (inputs) that doulas provide that make a positive difference in

birth experiences and outcomes? This research tests the effect of doula treatment tasks – emotional support, information, comfort measures, and advocacy – on the method of delivery (c-section).

METHODS

DESCRIPTION OF DATASET

In order to explore the doula tasks that influence health outcomes, I obtained quantitative data from the Volunteer Doula Program⁹ (VDP) located in a mid-sized city in the Midwest. VDP is a separate non-profit 501(c)3 organization that consists of a community-based volunteer doula program serving communities throughout its metropolitan area. Since forming in 1999, VDP's purpose is to improve maternal and infant health outcomes and reduce health disparities by promoting access to doulas for women who are socially and/or medically at risk and in need of extra support and who are least likely to have the resources to pay a fee for doula services. Women can refer themselves to the program or are referred by social workers, health care providers, WIC, Catholic Social Services, community members, and others. This grant-funded program provides a DONA-trained volunteer doula to provide birth doula services. Since the program is not situated within a hospital, the doulas can attend births in any local hospital or in the client's home. More recently, as grant funding has significantly decreased, the program offers doula services for a reduced fee (\$350) or on a sliding fee scale,¹⁰ more

⁹ VDP is a pseudonym for the purposes of this research.

¹⁰ The doulas do not know if their clients are paying the VDP or are getting their services for free.

extensive postpartum doula services have been added (also sliding-fee scale), and stipends for the doulas have been eliminated.

The VDP dataset includes variables on the scope of services provided by the doulas, client and baby health outcomes, and satisfaction with the VDP services¹¹. These data were collected as an on-going program evaluation. The data come from multiple sources in which the “client ID” matches the information across all the forms (see Appendix D for codebooks). The first source of data is an ACT database of new clients from a survey that is filled out by the program coordinator during the first client intake conversation. It includes basic information, such as referral date, due date, demographics, health background (e.g. number of previous births), and other information needed to make an assignment to a doula. Clients in this sample were enrolled in the program between January 2005 through August 2009. For my research, the intake registration data was used for the client’s self-reported ethnicity and income level (lower, middle, or upper/higher).

The second source is a ten-page survey of closed- and open-ended questions that doulas are asked to fill out during their prenatal visits with the client and after the birth. The doulas completed surveys on clients who gave birth from January 2005 to December 2007. The doula survey includes a checklist of treatments the doula provided during birth, from breathing strategies to massage. While this form has the most important information for this study of doula tasks, the program staff acknowledges that it is the most difficult information to obtain and have in the past provided a \$50 stipend to doulas

¹¹ There were over 183 variables in the original VDP dataset.

when they submit their survey. The clients are matched from the intake registration to the doula survey with a unique client identification number.

SAMPLE DESCRIPTION

Clients are the unit of observation, and all the clients in the sample are unique, but the doulas are not. Thirty-six doulas (18 percent of the sample) are associated with only one client. There are a total of 85 doulas who provided services to the 198 clients. While c-sections are independent across clients, they are not necessarily independent by doula designation.

The original data collected from the doula survey included 263 clients, but there was a large amount of missing data, which is somewhat typical of self-reporting paper-and-pencil surveys. Sixty-five cases were dropped for missing the dependent variable or missing the doula identification number (which is necessary for clustering) resulting in a sample of 198.

Clients who had an unexpected c-section were 18.3 percent of the sample, which includes one planned VBAC (vaginal birth after cesarean) that resulted in an unexpected c-section. Almost 82 percent of the remaining clients in the sample had spontaneous vaginal births ($n=145$). One planned c-section and eight VBACs were grouped with not having an unexpected c-section. There is only one client with multiple gestations (twins). The average client age is 26 years old with a range of 14 to 41 years old ($\sigma=5.3$). In terms of socioeconomic status, 71 percent of the clients identify as lower income, compared to 28 percent middle- and less than one percent upper-income. The ethnicity of the estimation sample is 57 percent white (not Hispanic), 22 percent African

American, 12 percent Hispanic, about two percent Asian, and almost eight percent grouped in an “other” category (such as Arabic, Jewish, and Native American).

The average week of pregnancy in which the clients sought their first prenatal care appointment was 9.2 weeks, with a range of 0 to 27 weeks; in other words, the majority of clients (92 percent) sought prenatal care in their first trimester, eight percent in their second trimester, and none in this sample waited until their third trimester. The majority of clients gave birth in a hospital (96 percent) and the remaining (4 percent) at home, with the most common hospital associated with the local university (34 percent). The employment statuses of the clients are 45 percent unemployed, 15 percent part-time workers, 22 percent full-time workers, and 18 percent students.

When compared to the larger sample, the only disparities were in ethnicity, income level, and employment status, where more whites, middle-class clients, and full-time workers were in the larger sample of 263 cases. Losing the more privileged respondents was a function of missing data from the doula surveys. This could cause bias and not be truly representative of the population being studied; in this situation, women who used volunteer doulas. However, in 2004, VDP¹² reported the ethnicities of their clients from that year were 55 percent white and 45 percent from minority ethnic backgrounds ($n=128$), thus I am fairly comfortable that the estimation sample of 198 from 2005-2007 is representative of the clients who would normally use the volunteer program.

¹² I was able to reference basic descriptive statistics (not the raw data) from a 2004 VDP program evaluation report that was written for program funders.

MEASURES

Dependent Variable

In the analyses presented below, the primary dependent variable is whether or not the client had an unexpected (emergency) c-section. Using c-section as the primary outcome indicator of doula success is useful for a couple of reasons: it is easy to measure as a binary variable and accurately collected. However, with the new trend of vaginal births after c-sections (VBACs) and repeat c-sections, as well as increased consumer demand for elective c-sections (e.g. Behague et al. 2002), this measure has become more complex. Therefore, I chose to focus on unexpected c-sections by consolidating the original categorical variable into a dichotomous variable where c-sections are counted only if they were unexpected (not planned) or occurred when a VBAC was desired but not successful.¹³

Independent Variables

The next section details how previous conceptual areas of tasks were operationalized in this research, given the availability of data. I chose independent variables based on the theory that certain domains of tasks could be operationalized into the four domains found in literature about doulas (emotional support, informational support, physical comfort measures, advocacy), plus barriers, medical interventions, and demographics controls. Table 3b is a summary chart of the dependent and independent variables: unexpected c-sections, total time with doula, information, massage, visualization/relaxation, and referrals. Most variables have been coded to be

¹³ I would have preferred to keep the original categories of method of birth which would have emphasized the differences between vaginal births, VBACs, planned c-sections, and unexpected/emergency c-sections, and consequently run a multinomial logit regression. However, the sample size was too small in some of the categories, and therefore I chose to use a binary format.

dichotomous (yes/no) variables. Some variables have been generated into an index, by summing individual dichotomous scores where each item is given equal weight. To test reliability of the indices, Cronbach's alpha (α) statistic is reported to demonstrate inter-item correlation.

Total time with doula: The length of time the doula spends with the client during labour is important in this study because another aspect that distinguishes doula care from that provided by other care providers, such as nurses and doctors, is that the labour support is continuous. The length of time the doula spends with the client creates a larger or deeper bond between doula and client, where intimacy and trust may be amplified. Unfortunately, there were not any other variables in the dataset that could be used to operationalize emotional support.

Information: The point of providing information, specifically evidence-based information, is that clients can subsequently have realistic expectations, understand their choices, and make informed decisions about their medical care. In this dataset the specific topics of information were itemized. Doulas had a check list of informational topics that may have been covered with clients during prenatal visits, such as information on breastfeeding, baby care, circumcision, emotional recovery, physical recovery, communication with their care provider, community resources, post-partum depression, and patient rights. The index used here only incorporates information given during the prenatal visits that pertains to labour and delivery, as this specific information may have made a difference during birth: 1) birth plan, 2) comfort measures (non-drug methods of pain relief), 3) episiotomy, 4) positions for labor, 5) preterm labor, and 6) role of the doula.

Massage: Massage is one of many possible variables to measure complementary and alternative approaches of pain relief in labour. I chose this one because of previous literature that massage has been shown to reduce pain and stress. The variable used here is whether the doula reported she used massage or not.

Visualization / Relaxation: As with massage, visualization and relaxation belong to a larger group of physical comfort measures, or complementary and alternative measures, for providing non-medicated pain relief. The variable used here is whether the doula reported she used visualization/relaxation as a physical comfort measures. Visualization and relaxation could theoretically be conceptualized separately, however the data collected in this sample was a checklist where the doula confirmed that she used “visualization/relaxation” as a technique during labour support.

Since massage and visualization/relaxation theoretically belong to the same larger domain of physical comfort measures, they could possibly be combined into an index to represent comfort measures. When combining the two variables, though, Cronbach’s alpha is not high enough to justify the combination of the two variables. Hence, I consider that massage and visualization/relaxation are not measuring the same construct.

Advocacy: Advocacy is not captured as a direct concept in the sample dataset; the doulas were not asked a direct question whether they provided advocacy to the client during labour and delivery. Therefore, the variable used here is the number of referrals made to the client during prenatal visits to measure the amount of outside support and healthcare navigation the client needed. The index used here incorporates referrals the doula made to client for outside support during prenatal visits with client: 1) WIC, 2)

medical office, 3) social services, 4) health department, 5) social work, 6) domestic violence shelter.

Control Variables

When using c-sections as the primary indicator for doula success, a number of control variables must be included.

Barriers: In this research, a control variable used to capture the barriers to doula care is an index of the following dichotomous variables doulas thought had a negative effect on their ability to provide care or facilitate the client's wishes (e.g., what was included in their birth plan): 1) hospital policy, 2) medical complications, 3) woman's refusal, 4) prevented from providing comfortable environment, 5) prevented from providing comfort measures (bathtub, shower, walking, positioning, etc), and 6) prevented from providing client's food preferences. If the doula thought she could not provide these services, then this variable would mediate positive effects of four different types of tasks.

Medical interventions are indicators of the cascade of interventions where one intervention can lead to more interventions, which could lead ultimately to a c-section. Doulas have been shown to reduce seemingly innocuous medical practices, therefore leading to fewer c-sections. The index for medical interventions from this sample includes: intravenous line (IV), induction using Pitocin, augmentation of labour contractions by administering Pitocin, epidural, episiotomy, intrauterine pressure catheter (IUPC), internal fetal scalp electrode, and amniotomy (deliberate breaking of the membranes) to induce or accelerate labour.

The other control variables that were available in the dataset were measures of age, ethnicity, and income category. Age is measured as a continuous variable.

Ultimately, the ethnicity variable was transformed into a dummy variable for white only because of small cell size in some of the ethnic categories. Income was originally collected as three categories that were then transformed into a dummy variable for low-income. See Table 3c for a summary of the control variables.

The sample mean and dispersion of each variable used in the model are summarized in Table 3d. For example, the average number of referrals of .31 is relatively low given it is an index that extends to 6, so this is useful to take into account. In this instance, only one in three clients is being referred to at least one (out of six) outside community resources.

MODELING TECHNIQUE

Let Y_i denote the binary variable of a potential c-section outcome of individual i if she were to receive doula support. The c-section outcome is a function of (A) doula tasks, (B) institutional barriers that may prevent a doula from providing certain treatments, (C) client health, such as medical complications and interventions, (D) client demographic characteristics, and (F) doula experience and demographics.

$$Y_i = f[A, B, C, D, F]$$

The research hypothesis is that if a significant result is found in the logistic regression, it will show that specific doula tasks, A, will have an effect on Y, and it is expected that they will have a negative effect. For instance, if massage is conducted by the doula and added to the equation, the c-section rate will decrease. Unfortunately, there is no non-doula group to compare to the doula treatment group, as occurs in traditional treatment

effect analysis, such as previous research using randomized controlled trials which compared doula groups with non-doula groups. What is being compared here are the tasks themselves within a population who all received care from a doula. And although included in the hypothetical model, this dataset does not contain information about the doula herself, such as whether she is experienced (and thus knows when to use specific tasks for specific birth complications) and whether she comes from the same cultural or demographic background as the client.

To analyze the rate of c-sections within the group of clients that received a doula, I used logistic regression¹⁴. The log odds of the outcome is modeled as a linear combination of the predictor variables. An OLS regression is not used here because I have a binary dependent variable and the errors from the linear probability model violate the homoskedasticity and normality of errors assumptions of OLS regression, resulting in invalid standard errors and hypothesis tests (Long 1997). The modeling strategy for this research generated a series of models that sequentially introduce variables to test whether they mediate or confound the relationship between key independent variables and the dependent variable.

I generated two models, first by only including doula tasks, barriers and medical interventions (Model A), then demographic control variables (Model B). It was more appropriate in this strategy to keep independent variables regardless of statistical significance rather than to pursue a parsimonious model (Miller 2005) to allow a comparison using this model in future studies. I checked all the variables for collinearity by looking at the VIF of all the variables together (mean VIF 1.24), as well as the single

¹⁴ The statistical software used for this analysis is Stata v9.2.

variables, of which none had a VIF over 1.58, so all the variables are appropriately included in the model.

With the possibility that some doulas may be more effective in preventing c-sections than others and are therefore not independent across clients, the logistic regression was run with a cluster option to specify which doula each observation is associated with and to adjust the standard error accordingly. Table 3e presents the results of two logistic regression models using clustering¹⁵.

RESULTS

The first model, Model A, shows that the variables measuring massage and visualization/relaxation during the client's labor and delivery are significant in reducing the likelihood of the client's birth outcome of a c-section. This is consistent with previous literature regarding massage and guided relaxation exercises. Receiving massage reduces the odds of birth resulting in a c-section by 0.552. In other words, receiving massage from a doula reduces the odds of a c-section by 44.8 percent. Similarly, if the doula provided visualization/relaxation techniques, the odds of a c-section are reduced by 57.2 percent. The effect of these variables remains consistent with the addition of control variables (see Model B), except the odds of receiving a c-section are reduced even more (58.6 percent) by massage when controls are included.

¹⁵ Because means substitution was used on missing cases for control variables, the regression was run with "missing" dummy variables for medical interventions, age and white, but are not shown in the table. Missing lower income was not included because there is no variation in dependent variable – they all did not have a c-section – so Stata was dropping the lower income missing from the total N.

The barriers variable in which the doulas perceived limitations to their ability to provide support and advocacy was also included in Models A and B. Contrary to expectations, the coefficient is negative, suggesting that when the doulas recognized there were barriers in the institutional environment, the c-section rate was still reduced. For one unit increase in barriers, the odds of a c-section are reduced by 27.5 percent (Model A). The odds change only slightly (28.6 percent) when the demographic controls are added in Model B. This is puzzling as my original hypothesis suggested that as barriers increased, doula support decreased, and therefore c-sections would rise. However, there is reason for caution here since the p-value of barriers in both Models A and B (.081 and .099 respectively) are significant if only using a significant level of 10 percent.

It is possible that those doulas who are attentive and responsive enough to know that they are in an environment that officially limits their role, may have found effective work-arounds, or are experienced enough to know how to deal with such restrictions. Again, maybe it is not getting the food/drink or music that the client thinks she wants, but performing the tasks that make the most difference (such as visualization/relaxation) no matter how unfriendly the birth environment. It is quite possible as well, that those institutions that have stricter policies are providing care at a level that changes the overall c-section rate, which seems most likely given controls for time, information, and advocacy. And yet, doulas are actually present in these hospitals even if they consider the environment unfriendly to doula care; the doulas are still being allowed to be in attendance and therefore the barriers must not be so severe or debilitating.

Model B adds controls including the ethnicity variable (white versus all other ethnicities), age, and lower income. The positive significant effect of the ethnicity

variable is not consistent with the literature, which shows that in the general population non-white women have more c-sections. When basic frequencies are run between ethnicity and c-sections, white women in this sample have a higher percent (21.5 percent) than non-white women (14.6 percent) in their rate of unexpected c-sections. It is possible that the sample is unusual in that more white women are having c-sections.

Medical interventions do not appear to be significant, and the negative direction of the relationship with c-sections does not support my hypothesis that more interventions would produce more c-sections. However, it is possible that doulas have to do more tasks to counter each intervention and are in fact working harder. It is possible that decisions to provide physical comfort measures are based on more interventions, as the correlations between medical interventions and massage, and medical interventions and visualization, are both positive.

DISCUSSION

Although research has shown that doula care reduces the likelihood of a c-section, until now research has not examined what doulas do that makes a difference. This research demonstrates that when volunteer doulas of similar training and program orientation provide massage and visualization/relaxation while they are providing continuous one-on-one support during childbirth, women have a significantly lower risk of having an unexpected c-section. The result remains when controlling for age, ethnicity and income level. This form of care appears to give important benefits without having risks that are commonly associated with routine obstetrical interventions (Mc Nabb et al. 2006). The findings regarding massage and non-touching visualization and relaxation

techniques contribute to the gap in the literature on labour support that shows the ability of doulas to act as a buffer against adverse aspects of medical interventions and unfriendly birthing environments (Hodnett et al. 2011). The results also support previous research on social support that specific techniques can buffer the effects of stress experiences on health outcomes.

This quantitative study is unique and worthwhile because no one has attempted to disaggregate the doula's support to see which specific actions are effective. This research contributes to the literature on labour support by showing that both physical (touch) and psychological (no touching) measures matter and that it may be both mechanisms in play at the same time. Even if we do not discover why doulas make a difference, this quantitative research focuses on what specifically is effective and the qualitative research (see previous and subsequent chapters) illustrates how individual doulas make caring work valuable for themselves and childbearing women. The effectiveness of doulas providing massage and visualization/relaxation for reducing c-sections is important to discover, as this makes available a piece of the puzzle that social support is successful, and can indicate how to make changes to improve the health of women and babies.

The strengths of the sample used in this research are fourfold. First, the doulas have consistency in their training, their expectations, and their role as a volunteer doula. Second, the doulas are all part of a community-based volunteer doula program, so they are considered outsiders and not a hospital employee, thereby giving them more space for advocacy. Third, the doula services started during pregnancy and provided a continuity of care for each client throughout their pregnancy and birth. The doula was not a stranger when the client arrived at the hospital, thereby affording more intimacy and trust.

There are also some limitations to the data that must be acknowledged. The VDP program outcomes are likely differ in numerous ways compared to clinical research or randomized control trials. First, the clients who choose to have a doula through the volunteer program are not randomly selected. They may choose to have a doula because they already belong to a sub-group of the population that values natural birth or has a strong aversion to c-sections, for instance. While some demographic data were collected on the clients, it is still limited. It is possible that single mothers or women who do not have family nearby are more aware that they need additional social support and therefore self-select to participate in the program and receive doula services. However, all the mothers in the sample chose to use a doula and I am comparing outcomes among them.

Second, while these data come directly from doulas, it was collected by questionnaires; the data are not directly observed. This means that questions answered by the doula about prenatal visits with the client and the client's birth outcomes were answered after the birth, and it is not clear how long after the birth the doulas completed the form. However, these results are consistent with previous clinical control trials that had similar limitations.

Third, at this time the VDP dataset does not include characteristics of the doulas themselves, which may create some selection bias. For instance, the doulas' demographic characteristics (age, ethnicity, number of children) as well the level of their doula experience (number of births previously attended) may contribute to their knowledge of what tasks to perform and when they may be individually more effective in preventing c-sections than other individual doulas. No matter, the fact that the doulas from VDP are required to have completed similar birth doula training and volunteer

program orientation workshops and are required to follow the same scope of practice (work standards), as well as the adjusting the model by clustering the doulas, gives this research a clear foundation.

Future research could examine whether there were certain variables that matched between doula and client, as well as to test if more experienced doulas (as operationalized as the number of previous births attended as a doula) had an effect on the dependent outcomes. I recommend using the VDP's doula and client surveys, with some adjustment and revisions, such as reducing the number of variables that are redundant or trivial. Other variables that have been identified to be included in future research, but are not included in this program dataset are: 1) the amount of support from other caregivers, 2) the quality of relationships with caregivers, 3) the extent the client is involved in medical decision-making, and 4) whether the client has high expectations or had experiences that exceeded expectations (Hodnett et al. 2002). Additionally, the positive or negative experience of the woman, separate from whether she ended up with a c-section or not, is an important outcome. For instance, a woman's labour may have concluded with surgery, but if she believed she was given adequate time to labour on her own and was included in the decision for a c-section or felt otherwise empowered, she may rate her overall birth experience positively.

CONCLUSION

The special types of social support that doulas provide to childbearing women appear to be providing a significant buffer to the stress of childbirth, and thereby moderating stress and lessening negative birth outcomes. The contributions of this

research are a significant piece of the puzzle about what specific types of support are linked to a health outcome. It also offers a valuable and important avenue for developing objective insights about doula work and how to advance the doula community's professional niche. The findings that physical comfort measures provided at birth, in the form of relaxation and visualization techniques and massage, reduce the likelihood of a cesarean section in a community-based volunteer doula program, have implications for practice and are applicable for designing training and certification programs and for social and health policy. Practical clinical and program benefits will derive from this empirical data that specifically identify which caring tasks are effective to produce change in health outcomes.

Table 3a. Summary of Clinical Studies on the Benefits of Continuous Support During Childbirth

<i>Labour Events</i>	<p>More likely to have shorter labour time^{a-f}</p> <p>Less likely to use epidural analgesia^{e,g,f}</p> <p>Less likely to use other analgesia or anesthesia pain medication^{h,i,j}</p>
<i>Birth Events</i>	<p>More likely to have a spontaneous vaginal birth^{f,j}</p> <p>Less likely to have an operative vaginal birth (use of tools such as vacuum extraction or forceps)^{f,j}</p> <p>Less likely to have cesarean surgery^{b,e,j,k}</p>
<i>Immediate Maternal Outcomes</i>	<p>Less likely to have dissatisfaction with or negative views of the birth experience^{d,g,l-o}</p> <p>Less likely to perceive difficulty in coping with labour^{i,g,p}</p> <p>Less likely to perceive low levels of control during labour^{h,q}</p>
<i>Baby Outcome</i>	<p>Less likely to have a baby with a low 5-minute Apgar score^{c,d,r}</p>
<i>Citations</i>	<p>a. Sosa et al. 1980</p> <p>b. Klaus et al. 1986</p> <p>c. Cogan & Spinnato 1988</p> <p>d. Hemminki et al. 1990</p> <p>e. Kennell et al. 1991</p> <p>f. Hodnett et al. 2011</p> <p>g. Gordon et al. 1999</p> <p>h. Hodnett & Osborn 1989</p> <p>i. Hofmeyr et al. 1991</p> <p>j. Madi et al. 1999</p> <p>k. McGrath & Kennell 2008</p> <p>l. Tarkka and Paunonen 1996</p> <p>m. Campero et al. 1998</p> <p>n. Bruggemann et al. 2007</p> <p>o. Campbell et al. 2007</p> <p>p. Wolman et al. 1993</p> <p>q. Langer et al. 1998</p> <p>r. Campbell et al. 2006</p>

Table 3b. Summary of Dependent and Independent Variables

Domain/Category	Variables/Coding	Description
Health Outcome <i>Maternity health outcome</i>	Unexpected c-sections (1 = yes)	Was the client's method of birth an unexpected c-section or repeat c-section after attempting a VBAC? As opposed to spontaneous vaginal delivery, vaginal birth after previous c-section (VBAC), and planned c-sections.
Emotional Support <i>Continuous presence of doula during birth</i>	Total time with doula , (categorical, recoded at mid-point)	Total time doula spent with labouring mother, number of hours
Informational Support <i>Info regarding labour progress</i>	Information (max = 6; $\alpha = .72$)	Information given to the client at prenatal visits on the following six topics (index): Birth Plan, Comfort Measures (non-drug methods of pain relief), Episiotomy, Positions for Labor, Preterm Labor, Role of the Doula
Comfort Measures <i>Comforting physical touch</i>	Massage (1 = yes) Visualization/Relaxation (1 = yes)	Comfort measures or labor support techniques doula used with the mother: Massage Visualization / Relaxation
Advocacy <i>Helping the woman navigate health & community resources</i>	Referrals (max = 6; $\alpha = .75$)	Referrals doula made to client for outside support during prenatal visits with client (index): WIC, Medical Office, Social Services, Health Department, Social Work, Domestic Violence Shelter

Table 3c. Summary of Control Variables

Domain/Category	Variables/Coding	Description
Controls		
<i>Environment unfriendly to doulas</i>	Barriers (max = 6; $\alpha = .69$)	Were you [the doula] prevented from performing any comfort measures or desired birth plans due to ...? (index): Hospital policy, Medical complications, Woman's refusal, Prevented from providing comfortable environment, Prevented from providing comfort measures (bathub, shower, walking, positioning, etc), Prevented from providing client's food preferences
<i>Medical Interventions</i>	Medical Interventions (max = 7; $\alpha = .72$)	Medical interventions, including pain medication, as reported by the doula (each dichotomous combined into index): Use of epidural (first transformed from categorical to binary), Internal fetal scalp electrode, Intrauterine pressure catheter (IUPC), Intravenous line (IV), Amniotomy (AROM) artificial rupture of membranes, Pitocin induction, Pitocin augmentation
<i>Demographics</i>	Age (continuous) Lower Income (1 = yes) White (1 = yes)	Maternal (client) age Income level: 3 categories lower, middle, upper/higher which were recoded into a dummy of lower income = 1, middle & upper = 0 Ethnicity (5 categories) recoded into a dummy variable of white only

Table 3d. Summary Statistics of VDP Variables

Variable	Mean	Stan Dev
Unexpected c-sections	.18	0.39
Total time with doula	10.68	7.17
Information	3.43	1.66
Massage	.72	.45
Visualization/Relaxation	.42	.49
Referrals	.31	.87
Barriers	1.00	1.38
Medical Interventions	2.37	1.87
Age	26.30	5.34
Lower Income	.71	.45
White	.57	.49

N = 198

Table 3e. Logistic Regression Coefficients Predicting Unexpected C-Sections

	Model A: Without Controls	Model B: With Controls
Total time with doula	0.00371 (0.0330)	0.00284 (0.0348)
Information	0.0918 (0.0948)	0.0837 (0.0977)
Massage	-0.595 ⁺ (0.346)	-0.881* (0.375)
Visualization/Relaxation	-0.848* (0.338)	-0.849* (0.367)
Referrals	0.0322 (0.141)	0.0459 (0.154)
Barriers	-0.322 ⁺ (0.185)	-0.336 ⁺ (0.204)
Medical Interventions	-0.201 (0.134)	-0.204 (0.152)
Age		-0.0479 (0.0444)
Lower Income		0.871 (0.595)
White		0.877* (0.361)
Constant	-0.524 (0.532)	-0.132 (1.527)
<i>N</i>	198	198
Pseudo <i>R</i> ²	0.095	0.134

Standard errors in parentheses
⁺ $p < 0.10$, * $p < 0.05$, ** $p < 0.01$

Chapter Four

THE EMOTIONAL LABOR OF LABOUR SUPPORT: DOULAS' OWN NEED FOR BACK STAGE TEAM SUPPORT

ABSTRACT

Doulas, also known as labour assistants, are specialized caregivers for pregnant and labouring women and their families. They provide emotional support, informational support, comfort measures and advocacy to women during their childbearing year. Childbirth can be intensely emotional and physical for these care providers, and thus, I explore the paradoxes of how doulas need support in order to do what they do. Findings are drawn from in-depth, semi-structured interviews conducted with 20 birth doulas from the same Midwestern metropolitan area. An interview was also conducted with two co-founders of the membership doula organization, DONA International. Doulas in this sample, both volunteer and paid, reported about specific strategies for managing issues of doing work in isolation, the unique demand of being on-call and having to leave their families to support another family at any time of day or night, and the lack of apprenticeship or collegial cohesion. Goffman's dramaturgical model of social life is discussed in regards to the back stage of the performance, where doulas need other team members who may not necessarily be performing on stage at the same time, but debrief and problem-solve back stage between births.

THE EMOTIONAL LABOR OF LABOUR SUPPORT: DOULAS' OWN NEED FOR BACK STAGE TEAM SUPPORT

Doula services emerged in the early 1990s in the United States and are typically offered by women running their own small businesses, volunteering in non-profit or community programs, or staffing hospital-based doula programs. Like the wise elder woman of the village who was called to the birth, in addition to the midwife, doulas provide the emotional caring that nurses and doctors no longer have time for in contemporary institutional settings. Labour¹⁶ support is care that is intended to ease a birthing woman's anxiety, discomfort, loneliness, or exhaustion, assist her in finding her own strengths, and ensure that her needs and desires are known and respected (Simkin 2002).

Doula care, such as emotional support, informational support, physical comfort measures, and advocacy, mostly consists of invisible and specialized knowledge and care work crucial for household, family, and individual well-being, which are typically done informally by women on an unpaid basis. Facing a public unfamiliar with paying for these services, doulas must seek legitimacy for both their product and themselves as providers (Sherman 2010), the essential product they are selling is themselves (Joinson 1992). Based on interviews with volunteer and entrepreneurial doulas in a mid-sized Midwestern region, this research analyzes the doulas' efforts to care for and care about their clients, while focusing on the strategies doulas employ in their professional and personal (back stage) lives to care for themselves.

Studying doula work is important for our understanding of work, and specifically women's work, in two ways. First, the emergence of doulas in the past two decades

¹⁶ A note about my use of the distinction "labour" versus "labor." Throughout this research I use the spelling "labour" to refer to the work that pregnant women do in bringing forth children, while I use the spelling "labor" to refer to activities one is doing, making, or performing as an occupation.

offers a rare opportunity to research individuals working in an emerging occupation in real time (rather than having to use historical methods) and to examine their struggles and strategies for legitimacy while still embracing women-centered values (see Chapter 2). Second, doula work and their specific strategies for managing issues of doing work in isolation, the unique demand of being on-call and having to leave their families to support another family at any time of day or night, and the lack of apprenticeship or collegial cohesion, enables an investigation of a neglected area in the sociology of emotional labor: how it is that individuals engaged in care work occupations take care of their own emotional health. Regardless of how well doulas provide support and how well-received their efforts are perceived, childbirth can be intensely emotional and physical for these care providers; hence doulas themselves need support to do what they do (Morton 2002).

LITERATURE REVIEW

CARE WORK

First, it is important to define care work in the context of this discussion. Traditionally, social scientists have defined caring labor as those occupations that provide services for dependents – children, the sick, and the elderly. More recently, scholars have clarified terms more deliberately. In the past, “reproductive labor” had been used to describe the unpaid work women did in the home and was an essential categorization of household tasks needed to bring such invisible work into the discourse of Marxist economics (Duffy 2007). Hochschild’s (1983) study of flight attendants introduced “emotional labor,” which suggests that workers are paid to have and act out emotions

they do not really feel. Later, England (1992) created a broader category of work, referred to as “nurturant work,” to include other face-to-face service workers who also have clients or customers such as waiters and sales workers. Folbre and Weisskopf (1998) use “caring labor” to denote work that provides care services and is motivated by caring attitudes, such as a sense of affection and concern for others.

Caring is the verb to signify the act of helping (“caring about”) and being compassionate (“caring for”) that presumes an intimate relationship with another person (Zelizer 2005). I use “care work” to refer specifically to caregiving occupations dominated by women (Abel & Nelson 1990) in which all kinds of labor tasks – mental, manual, and emotional – are integrated. Traustadottir (2000) warns of the difficulties of placing boundaries and categorizing women’s caring activities because women’s work and women’s lives are fluid, complex, and constantly shifting between domains of work and family. I agree that the issues of care work are complex, but it is still important to attempt to understand and appreciate the interconnectedness of the different stages, or settings, and how women find ways to make both work. Ultimately, care work definitions are useful if only in the interest of revealing and calling attention to gender inequality and being able to categorize work to show that women do such a significant majority of paid and unpaid care work (England 2005).

Doulas’ labour support falls into the category of care work because a) doulas have individual patients, usually called clients, b) are motivated by altruism and intrinsic enjoyment (usually stated as having a passion for labour support), c) perform tasks that directly relate to reproduction and indirectly relate to historically invisible tasks that are now being commodified, d) can be unpaid (volunteer) or paid (entrepreneur or staff) or a

combination of both, and e) are subject to work structures similar to other kinds of healthcare work with the sick, such as being on-call. This research on doulas is a valuable case that combines a relevant example of care work with an analysis of the personal impacts of emotional labour and the professional impacts of the work structure.

FRONT STAGE, OFF STAGE, AND BACK STAGE

Work by sociologist Erving Goffman provides a useful framework through which to analyze how it is that doulas care for themselves while caring for others. In Goffman's *The Presentation of Self in Everyday Life* (1959), he presents an imagery of theatre to illustrate the importance of human and social action and interaction, which he called the dramaturgical model of social life. The main concepts of the framework include performance, setting, appearance (e.g. costume, uniform), manner, and script. The script is also known as the actor's front, where the performer acts a role that the audience can observe and react to such role-playing. The personal front can also include language and body language such as visual signs (e.g. sex, age, hair style, etc) and furthermore defines the situation for the observers. According to Goffman, it is central to look at how people embrace certain identities, perform certain roles, and manage themselves within circumscribed social conditions. He argues that all social situations of two or more people involve attempting to persuade others of the actor's definition of the situation. Mostly, one must know where one's identity is situated, where the self can identify with the role one is currently playing, before an interaction can occur; hence the social importance of first impressions. Goffman discerns that the performance of the actor is to "express the characteristics of the task that is performed and not the characteristics of the performer" (p.77). For him, actors providing a service act in such ways that the purpose

of the performance is to define their service or product in a way that is favorable with the audience. Thus, performing a role is foremost, rather than expressing one's personality. Additionally, actors learn to be exceptionally attuned to the audiences' reactions and can adjust their behaviors thus, whom Goffman defines as high self-monitors.

Goffman makes a distinction between front stage, off stage, and back stage. The front stage is what has already been described, where the actor adheres to conventions that have meaning to the audience, and where the stream of information is flowing from the actor to the audience. Goffman is interested in the how people, given the constraints imposed by social structures in the setting, manage to act (Fine and Sandstrom 2008). Off stage, also referred as "outside," is where actors can meet audience members independently of the team performance that happens on the front stage, and give a different performance. For doulas, the front stage is when they are with performing (providing care) for their client in a setting like the hospital, during labour and delivery. As Meltzer discusses in her dissertation on doulas a decade ago, part of the doula's role in providing mediated advocacy "is played out on the front stage as a Goffmanian performance in which doulas seek to please the physicians, the medical staff, their clients, and themselves simultaneously" (Meltzer 2004:98). The front stage could also be in settings where doulas give a presentation about their role and explain what they do to potential clients. Off stage still involves giving a performance, but where the interaction with an audience member is more private and one-on-one. For doulas, meeting with their client during prenatal visits in the client's home is an example of Goffman's off stage performance. While off stage the doula and the client can make preparations and strategies for different circumstances that may unfold on the front stage.

According to Goffman, the back stage resembles an actor's home environment where one can stretch and "be yourself" and talk about the role that was being played on stage. The audience is not present in the back stage but other performers that were on stage with the actor, whom Goffman labels team members or teammates, are present. Team collusion on stage occurs when communication between performers occurs without disrupting the illusion or giving notice to the audience. Doulas do have teammates, such as other doulas and occasionally other birth workers who understand the doula's role and support their performance. However, doulas are not usually on the front stage with other doulas; their work is performed alone. Yet, they are part of a team, even if not physically present, of other doulas and are affected by the performance of other doulas whom they may not have ever met in person. For instance, a doula may be given less trust by an audience member like a nurse or doctor if medical staff have had a performance by a different doula whom they thought overstepped the doula's role, and therefore team collusion was lacking.

Goffman states that the back stage is important for "staging talk" with teammates. During back stage this kind of talk can include discussions of how the team is going to stage the performance and can include gossip about other team members, problem-solving, revising how to act, and learning how to "talk the talk." This need for back stage camaraderie of teammates, especially, has been neglected in subsequent sociological literature. I argue that in order for doulas to endure their performances in isolation over time, it is essential that doulas have teammates with whom they can debrief back stage. As Goffman maintains:

“Whatever it is that generates the human want for social contact and for companionship, the effect seems to take two forms: a need for an audience before which to try out one’s vaunted selves, and a need for teammates with whom to enter into collusive intimacies and backstage relaxation” (Goffman 1959:206).

THE COSTS OF EMOTIONAL LABOR

Arlie Russell Hochschild, in her influential book *The Managed Heart* (1983), claims that ideology (constructed collective meaning) shapes and constrains emotions and therefore workers suffer from the challenges of care work. Wouters (1989) situates *The Managed Heart* as “a combination of Goffman’s dramaturgical perspective with an American branch of Marxism” (p.96). Hochschild (1979, 1983, 1989) looks at commercial work settings and illustrates how workers sell their smiles, moods, feelings and relationships, what she coins “the commercialization of feeling.” She suggests that those workers who are paid to have and act out emotions they do not really feel, experience more psychological distress. The literature asserts that there is a separation between emotion as displayed and emotion that is internally felt (Wharton 1999), and the management of the tension between those feelings, displaying publically only appropriate or sanctioned emotions on the job, is crucial when interacting with clients or customers (Hochschild, 1983). While Goffman does mention that actors have to realize “impression management,” Hochschild critiques Goffman for not being able to draw links “between immediate social situations and macrostructure on the one hand” (Hochschild 1979:556). She continues that Goffman’s actors “actively manage outer impressions, but they do not actively manager inner feelings” (1979:557). Her discourse focuses on uncovering “the heart of emotional labor, what it takes to do it and what it does to people” (Hochschild 1983:10).

Applying Hochschild's examination of what emotional labor does to workers, especially women, researchers have considered the costs of caring to the worker. Besides the economic costs of caring (England 1999), the noneconomic costs of the emotional work include burnout (Wharton, 1999) and other psychological suffering since care work is argued to be taxing, exploitative, and more alienating than other kinds of work. One theory as to why caregivers have an increased vulnerability to stress is because of the emotional split many workers experience internally about what they can and cannot express and the split "between being family members performing services for their families, and being professional workers performing analogous services for pay and for other" (Saraceno, 1984:15 as quoted in Abel and Nelson, 1990:24). Another noneconomic cost is the inauthenticity experienced by the worker, or what Hochschild (1983) calls emotive dissonance, which could lead to poor self-esteem, depression, cynicism, isolation and hostility at work (Wharton, 1999).

Hochschild later (1997) asks a central question: "What are the relationships between work life and family life?" How does an individual negotiate the tension between these stages (in this case, not phases of life, but Goffman's theatrical front stages of personal identity)? Hochschild found in her study when work becomes home and home becomes work that the dichotomies of work and family actually switched places, rather than integration or blurring of the lines. Current research on the psychology of work-family balance argue that the dichotomy of work and personal life has limited the ability of workers to deal effectively with the conflict between them (Rapoport et al. 2002). However, the image of "balance" may be an archaic concept. Rapoport and

colleagues (2002) show organizational examples of how personal-life considerations can be integrated, not kept separate, in the workplace.

Similar to the focusing on negative consequences of emotional labor, work-family balance has traditionally focused on the negative conflicts between the two dichotomies. For instance, the noneconomic costs of negative work-to-family spillover consists of: “withdrawal from family interaction, increased conflict in marriage, less knowledge of children’s experiences, less involvement in housework, shorter period of breast-feeding for mothers with full-time employment, depression, greater likelihood to misuse alcohol, and overall decrease in the quality of life” (Hill et al. 2001:49-50). Researchers have also found negative family-to-work spillover to include: “more pronounced psychological distress due to poor marital and parental role quality, decreased job satisfaction, decreased quality of work life, greater likelihood of leaving the company, and increased absenteeism” (Hill et al. 2001:50). While some scholars (e.g. Abel and Nelson, 1990; Traustadottir, 2000) have recommended we should be cautious not to overly emphasize the personal fulfillment women derive from providing care because it is used as a rationale to keep women in an inferior position, I also maintain that we should not overly emphasize the conflicts found in women’s work for the same reason. Doulas have a choice to perform doula work and as the findings will show, they find meaning in pursuing their passion. In order to cope with the tension between being on the front stage and the responsibilities of their families, they find strategies to help them maintain support structures in their families and back stage with colleagues that mitigate the emotional costs of caring.

SUPPORTING CARE WORKERS

Hochschild neglects the importance of the back stage collegial cohesion emphasized by Goffman. How might having one's own emotional support mitigate the negative effects of doing emotional labor? In Lundgren and Browner's (1990) study of "psych techs" in a nursing home, workers discuss openly the idea of burnout, stating that they need the physical and emotional support of their co-workers. This follows and supports my extension of Goffman's concept of teammates in the back stage, as one means through which individuals take care of their emotional needs. And it further extends the concept that burn-out has a emotional component. In more contemporary literature, the cost of caring experienced by caring professionals is characterized specifically as "compassion fatigue" (Figley 1995). This literature, mostly represented by clinicians such as mental health professionals and nurses, emphasizes the need for offsetting stressful work situations with play and rest to "remain grounded in various aspects of our complex identities" (Pearlman 1995:54).

There are concrete strategies that help workers to deal with the "split personality" issues associated with care work that can be isolating and emotionally draining. These strategies focus not on the emotional tension within the self when being on front stage, such as helping a victim of a traumatic experience, but rather on concrete activities on how to cope more effectively when off stage. Recommendations for personal self-care to mediate compassion fatigue include: 1) take time away from work for self-reflection and decompression, 2) learn how to create and maintain limits and boundaries, 3) develop a spiritual side, whatever form that takes for the individual, 4) use family and other interpersonal networks (e.g. friends, clubs, work groups, therapist, etc), 5) engage in a

creative endeavor, and 6) reconnect with another role that is played off the work stage, such as friend, parent, child, partner, sibling (Joinson 1992, Figley 1995, Pearlman 1995, Ray et al. 2013). Additionally, researchers especially emphasize that new worker training should educate care worker about how to deal with emotional information about clients, specifically that an upsetting work experience “*is and should be discussed confidentially with confidants (spouse/partner) – by following proscribed ethical procedures*” (Figley 1995:22 original emphasis).

As the following qualitative analysis on the experiences of paid and unpaid doulas will indicate, I am not persuaded that the emotional tasks required of doulas do not have the severe outcomes stated in the psychosocial consequences of emotional labor literature (Wharton, 1995, 1999; Hochschild 1983, 1997). England also critiques this view; she does not find empirical evidence for lower job satisfaction or decreased mental health in jobs requiring emotional labor, and exposes the implicit judgment that “it is not as bad to sell the use of one’s hands and head as to sell one’s heart” (England, 2005:392). Wharton (2009) similarly acknowledges that the sociological literature on emotional labor – the management of emotions by workers and the study of social relations of service jobs – has not provided much theoretical guidance for integrating the vast research since *The Managed Heart* (Wharton 2009). However, I do contend that doulas require back stage and off stage support in order to mitigate the emotional toll of their work.

This chapter is concerned with the back stage: how doulas need to take a break from their role, the support they need at home, and the need for “collusion” (a Goffman term) with other colleagues. I examine the strategies utilized by doulas to navigate the

tensions in dealing with emotional situations and having multiple (and sometimes conflicting) responsibilities. I identify the individual and cultural factors that influence how doulas are able to provide social support, while paradoxically needing similar social support themselves. First, I describe the methods used to conduct this qualitative research.

METHODS

The analyses presented here are based upon interviews with 20 women who were working as volunteer or paid birth doulas in the same mid-sized Midwestern metropolitan statistical area at the time of the interview. The director of a non-profit organization, the Volunteer Doula Program (VDP, a pseudonym), recruited 10 volunteer doulas via email through their organization e-mail list, which consisted of approximately 70 active doulas. Recruitment also included an additional 10 entrepreneurial doulas from the same geographic area through contact lists of certified DONA¹⁷ doulas retrieved from the DONA.org website, as well as independent doula's business websites who resided in the same region. Volunteer doulas contacted me directly by e-mail, while I initially contacted the entrepreneurial doulas through their listed e-mail address or business phone number. I also used the snowball method, where other study participants referred additional participants to me, for both sets of doulas. Recruitment ended once I completed ten interviews in each group.

¹⁷ DONA is a doula member organization originally named Doulas of North America. They are currently branded as DONA International, but for brevity are referred here as DONA.

I conducted interviews with volunteer doulas in June 2012 and interviews with entrepreneurial doula interviews in October 2013. This purposeful sample had a range of certified doulas: those who were certified, currently pursuing certification, or “lay” doulas who were not certified. A major strength of this qualitative data is that the two main groups (volunteers vs. entrepreneurs; certified vs. lay doulas) also covered two other dimensions: (a) range of doula experience (attended ≤ 10 births vs. > 10 births), and (b) personal birth experiences and motherhood (have given birth themselves vs. never given birth).

The average age of all participants was 33.3, with the average age of volunteer doulas at 31.1 and the average age of entrepreneurial doulas at 34.5. All participants were women. The sample was mostly white ($n=16$), with one Asian American doula, two multiracial/biracial African American/white doulas, and one multiracial/biracial Native American/white doula. While all participants had at least earned a high school diploma, one had some college, three had an associate’s degree, three were currently in college working towards a bachelor’s degree, eight had a college degree – one of which was working on a master’s degree, and three had a graduate degree (all master’s).

Only three doulas in the sample had never been married. The unmarried doulas were the three youngest of the sample – ages 20, 21, and 23 – and out of those three, one was currently living with her boyfriend, one had a boyfriend but did not live with him, and the youngest lived with her mother and brother. Additionally, two doulas were divorced. The remaining 15 doulas were married for an average of ten or more years. The 13 doulas that had children averaged just over two children per household. Of the ten doulas whom I considered certified, two had just submitted their certification

application but had not yet received an official acceptance, and the remaining had either received the DONA certification very recently (in the past year) or had been certified for at least the past five years. See Table 4a for a summary of the demographics of the doulas who participated in interviews. While there is no reason to believe that the doulas in this sample vary from the population of doulas in North America in any systematic way, there is significant variation across the US and Canada, as well as internationally, in the context in which doulas do their work. Therefore, caution ought to be utilized when generalizing from these data and is a main reason I endeavor to incorporate summaries of other qualitative findings on different samples of doulas.

Table 4a. AGGREGATED DEMOGRAPHICS OF DOULA RESEARCH PARTICIPANTS

<i>Race/Ethnicity (self-identified)</i>	Caucasian	16
	Non-Caucasian	4
<i>Age Range</i>	Min	20
	Max	60
<i>Certified by an Organization</i>	No	10
	Yes*	10
<i>Doula Experience (Total # Births Attended)</i>	3 – 10	10
	20 – 300+	10
<i>Biological Mother (Gave Birth)</i>	No	8
	Yes	12

* Certification answer “yes” includes two doulas who had submitted their certification packet/application but had not yet received an official acceptance.

Since all the volunteer doula participants shared participation in the VDP program, a baseline requirement of training and program orientation was constant. The VDP program orientation workshop consisted of approximately three hours as an extension of the DONA doula training, covering the volunteer program procedures as well as dealing with the unique needs of low-income and/or minority clients. The majority of the entrepreneurial doulas also had the same or very similar training

sponsored by DONA or the Childbirth and Postpartum Professional Association (CAPPA). Birth doula training entailed a weekend course, usually three full days, delivered by a DONA- or CAPPA-certified trainer.

I conducted interviews with the volunteer doulas in the homes of the participants and lasted approximately two hours. I conducted interviews with the volunteers using a semi-structured interview guide (see Appendix B), which I later modified and condensed when interviewing the entrepreneurs. For the entrepreneurial doulas, I conducted interviews over the phone, which lasted about one hour. During the interviews I asked participants about their demographic background, reproductive background, personal views on childbirth, becoming a doula, training, volunteering, doula practice and structure, who makes a good doula, costs and payments, with an additional open-ended question at the end.

The comparable training, education, and location of the doulas in this group are major strengths of the sample, as well as the range of doula expertise. A limitation of the sample, however, is that in order to keep the study participants confidential I was not able to ask if each individual doula knew the other doulas being interviewed. Such additional questions could have provided a picture of their informal support networks and measured how much they rely on one another for different types of social and emotional support.

I conducted an additional semi-structured interview in March 2011 with two co-founders of DONA, Penny Simkin and Anne Kennedy¹⁸ (see Appendix C for interview guide). The interview took place in Penny Simkin's home in Seattle, Washington and

¹⁸ Since both Simkin and Kennedy are associated with the founding of DONA, it would have difficult to ensure confidentiality. They both agreed to have their full names utilized for this research.

both were present at the same time. As key decision makers in the beginning development of doulas, their experiences provide a broader picture of the structure of doula training and professionalization, which in turn provide a foundation to better understand individual doulas' experiences.

The Institutional Review Board of the University of California, Merced approved this study and informed consent was obtained from all study participants. All references to individual doulas in this research are made with pseudonyms.

I transcribed interview recordings verbatim. In addition to preparing basic descriptive statistics and case reports, analysis of the qualitative data includes theme analysis (Strauss and Corbin 1990), content analysis (Miles and Huberman 1984), and life history narrative theme analysis (Luborsky 1993). For theme analysis (a.k.a. grounded-theory approach) I used the following iterative process (Bernard 2006): First, transcripts of interviews were produced and I read through a large sample of text. Second, potential themes, or analytic categories, I identified as they arose and then coded (e.g. open-coding). Third, as the themes emerged, data from those categories I pulled together and compared, making a table of summaries, by individual and group. Fourth, thinking about how the categories are linked together, I used the relations among categories to build theoretical models. I also developed closed codes from themes common within an individual interview and themes found across the pool of interviews using a pile sort method. Lastly, I present the results of the analysis by using exemplars that illuminate the themes.

For content analysis, deductive analysis of the text started with hypotheses before coding was started. Since the interviews were not so open-ended, but in fact guided by

my questions about what I thought was important from previous research (e.g. how does the doula's family show support while they are on-call), I already had theories that I wanted to test. For instance, I hypothesize that doulas cannot be successful at this work unless they have strong family support and/or strong social networks to help with the logistics of being on-call as well emotional outlets. This method creates a set of codes for variables in the theme, applies those codes systematically to the texts, creates a unit-of-analysis-by-variable matrix from the texts and codes and then analyzes that matrix (Bernard 2006). The following analysis presents the doulas' reports of their work, focusing on their emotional self-care and interactions with their own support networks and examining how their strategies for navigation emotional boundaries affect their ability to do the work.

FINDINGS

MANAGING THE PHYSICAL AND EMOTIONAL DEMANDS OF DOULA WORK

The doulas I interviewed used a variety of strategies to endure many of the hardships that come with doula work. Self-care, and especially emotional self-care, were cited continuously. They also received a surprisingly vast amount of support from their husbands and families. However, of utmost importance is having access to talk to someone "who gets it," especially right after attending a birth. Those who understand the doula's role and what goes into maintaining a particular appearance (but do not have to put on a performance for each other) are what Goffman (1959) considers "teammates." Because of their shared role, teammates have familiarity with each other even if they do not know each other as friends, and are bonded by reciprocal dependence (Goffman

1959). As the following findings will suggest, while the doulas are isolated on-stage, they still do depend on their teammates when they get a chance to go back-stage.

Self-care

The doulas talked about two different time periods in which they need to take care of themselves: 1) while they are providing labour support, and 2) immediately afterwards or in-between being called to births. For example, physical self-care is important during a long labour, and many of the doulas told stories about how they made sure to stay hydrated and eat at proper times, even “sneaking” a Power Bar or snack. Coffee was also mentioned by multiple doulas. Additionally, physical self-care after a birth includes eating and sleeping. Nancy says she tries to “frontload” sleep by sleeping well before she anticipates getting a call for a client in labour, “because if I’m well-rested, everything goes better... for myself and my ability to be on top of things for them and be sharp.” Doulas had different strategies about sleep after a birth, whether they just tried to carry on with the day even if they had not slept the night before, or if they slept for a couple of hours no matter what time they got home. Regardless, sleep is vital and often times family support cannot stop once the doula returns home because she might still need sleep, and family members need to continue to pick up the slack.

Doulas also referred to massage (e.g. a reward after a long birth), yoga, and other alternative therapies like Reiki that they receive or participate in themselves. Exercise was cited as a way to not only be physically stronger to help labouring clients, but also as a necessity to help manage stress and anxiety (Nancy). Sydney acknowledged not taking good care of herself, such as going an entire shift without going to the bathroom, or not

eating if there is work to do, and yet laughed and recognized the irony of such meager self-care.

Sometimes a break is needed; not necessarily a vacation or holiday away from home, but time off from doula work for a brief time, such as a few months. For instance, Paige, who is pregnant, has taken a break from doula work because “the physical demands of being a doula can be rather taxing. So, at this point I’m not quite feeling up to it.”

Emotional self-care

The majority of the doulas interviewed spoke about the emotional demands of providing labour support and the emotional boundaries they had to learn how to maintain. For instance, Kelly stated that as a doula “you’re always on-stage.” For some doulas, always being “on,” and as Heather puts it “a job where you have to be hyper-aware of other people,” can be emotionally taxing. It can be emotionally stressful to “hold space for people” (Melissa). Olivia described birth as a very intense situation that “does affect you.” For Olivia, she dealt with emotional intensity by “keeping my emotions in check... I do my best to put my happy face on... And then afterwards I probably cry, maybe on the way home.” Consistent with the literature, Olivia understands that there are certain social roles that are played out on the front stage, and crying would have been a discrepancy to the performance. Also consistent with Goffman’s (1959) argument that social actors maintaining a performance do not want to give a “wrong” impression while on stage, Brooke revealed that “emotionally sometimes I just have to step back and forfeit my doula role for just like a second, so I don’t totally lose it.” Here is a glimpse of

the need to have a safe back stage that the actor can retire to, even if for only a brief second.

Nancy described being at a birth as a doula like “flying solo” and how she has to deal with emotional storms by herself. For Nancy, that moment “can be intimidating sometimes, because you also have to be professional at the same time. You can’t lose it. ... So...for the moment, putting it in your back pocket, working through it, moving past it, staying professional, staying on top of your game” and then later, after the stressful moments have passed when she is not working anymore, being able to face it. In general, many of the doulas found stress management techniques helpful, such as journaling, self-reflection, meeting with a therapist, breath and body awareness, and spiritual practices such as prayer and worship.

Some of the strategies to deal with emotionally intense settings are individual, while some are social. All approaches require the skill to know what is performance and when to retreat to the back stage. Teresa described her viewpoint about the emotional tension of the doula’s role:

“You’re supposed to not care, you know? I mean, you’re supposed to – not that you’re not supposed to care – but you’re not supposed to be so invested in people’s lives. But to me you are vested in their life. You are vested in a good outcome. You are vested in what they believe they want to happen. And so, number one it’s very emotional. Birth is an emotional thing. It’s beautiful and it’s such an emotional roller coaster.” (Teresa)

This idea about not caring too much in order to do the work of a doula was also described as trying not “to take it personally” and compartmentalizing by not letting the stress “carry over” when they got home. One strategy to maintain emotional boundaries with clients is to be clear about the doula’s role. Heather said, “I’m not a therapist, I’m not.

And I'm not their best friend either. I'm not their mother. I try to give them tools, but that's about it." Danielle said she has learned how to separate her life from someone else's life. Isobel said that in her more mature phase of her life (she is 44 years old) she is now "capable of holding both sensitivity and caring with a person with a firm boundary."

On the other hand, a few of the doulas, as well as Penny Simkin, divulged that they sometimes thought they care more about the client's birth and her outcomes than the client did. Heather also echoed that "I can't care more than they do... You can't own their birth." Robin talked about the difficulties of seeing a client making choices for her birth that Robin knows statistically put the client at risk for "a long road" of medical interventions, but not being able to voice them during the front stage performance:

"And I have to keep reminding myself in those situations that my job is to support her choices and not be judgmental and to not want more for her birth than she wants for it. And doing that helps me to not taking it personally... My job is to help her to see that [whatever is happening] as the best experience possible, not to look at it as failure and not to take it as personally that I failed somehow... I did my job." (Robin)

Melissa said she negotiated the emotional stress by making sure she takes clients that she "vibes with" and does not agree to take clients that she does not "click with" because, according to her, disastrous things can happen when she does not feel the right connection to her client. Nancy thought that her experience over time gave her knowledge about how families go through labour and how their stress might manifest. This wisdom helped her to "not take it personally," which she believed could only be learned over time. Nancy's strategies for dealing with a long or difficult birth were to "check in with the world outside of that [delivery] room as long as that family's birth

allows for that.” She would ask her husband to text photos of her children so that when she quickly stepped out to eat or regroup, she would reconnect with her own children.

When asked about the stress of being around a lot of physical pain and suffering that women experience during childbirth, the doulas countered that helping women have a positive experience and having the privilege of participating in birth is what sustains them in their doula work. They are not just providing care and giving of themselves, they receive benefits as well. Brooke spoke of the “birth high” afterwards, which would remind her how much she loves her job. Angela affirmed that her doula work was “so fulfilling and rewarding, it is taking care of my needs.” Gina felt re-energized by being around babies “because they’re so adorable... when they’re giggling and happy.” Erica stated how fulfilling it is to be important enough to someone that she made a positive impact “and I didn’t even have to try that hard.” Kelly also observed that she has the closeness of the human connection in her work and that appreciation and gratitude runs both ways between her clients and herself: “They teach me a lot and are very open, vulnerable, and all those things I really appreciate a person for. They are extremely grateful for the support that I offer during the birth. ... There’s also a real sense that I’m making a difference in health for women.” Isobel stated, “I have a purpose... Like I’m fulfilling something in myself and for the world.” By having a calling to this work, the doulas feel aligned with their passion, and these transcendent rewards – like joy and gratitude and connection – allow them to withstand much of the physical and emotional hardships. In this sense, the doulas emphasized job satisfaction, improved quality of work life, and personal fulfillment – those themes that are presumed to be wanting in Hochschild’s model, which emphasizes the negative consequences of emotional labor.

When Penny Simkin and Anne Kennedy were asked what the three biggest issues they saw with the doula movement today, their reply included the doulas' relationship with their partners:

“A lot of divorces happen among doulas, you know. The doula is depending on her partner to be there when she has to go [to a birth] and very busy doulas are asking an awful lot of their partners. And sometimes the financial gain isn't [considerable] – the partner may feel really put upon and like he's supporting this woman – not the doula but the [client] who's having the doula. ... I think the domestic front is often a challenge for the doula.” (Simkin)

The marital and co-habiting status of the doulas themselves is important in terms of the support doulas receive at home. The majority of the doulas with husbands repeatedly gave positive recognition towards their husbands. This became very apparent during the interviews. A typical statement was, “I'm pretty sure I have the best husband in the world” (Sydney). Most acknowledgements came after a question about handling the emotional part of their doula work. Courtney, as well as quite a few other doulas, said their husbands support their doula work because they know she is happy doing it, and their husbands also “believes in the work and what I do” – that it makes a difference for other families. Erica said her husband “thought it was cool and different, new, and exciting. And if I could get paid for doing something that I love, he was all for it.” Erica said her husband has to have a large degree of patience as well as a sense of humor, and that her work puts “weird demands” on him professionally. Kelly, who has three young children and often takes more than one client with a due date the same week, was most articulate about the role her husband plays:

“He really does totally believe in the empowerment of family and in women. He really believes that what I do is a part of that. So, he actually finds significant meaning in making this work possible. I think he sees

himself as a 'doula husband' in the same way that in a traditional sense you have pastors and pastors' wives. I think he thinks of his role a little bit like that, like a doula husband. The doulas I know who have been in this profession for a long time have partners who think that and feel that way. The people who love the work and can't figure out how make it fit in their lives are usually the people who don't have that kind of support at home." (Kelly)

For those doulas who are not married, family support is still imperative. Heather, a single-mother, says she could not do this work if she did not live with her mother. She was very sensitive about not wanting to burn out her friends with requests for childcare. Melissa, who also lives with her mother, said she could not have quit her job and followed her dream to be a doula without the emotional and financial support of her mother.

Tangible support from family also means providing time for the doula to recover at home after a birth, especially since the structure of doula work can comprise of sleep deprivation. Kelly said her husband makes it possible for her to come home from a birth and go straight to bed and find time to recover. Nancy, a mother of two children, also mentioned negotiating with her husband to get sleep when she arrives home.

Family support also includes financial support. Many of the doulas could not commit to even intermittent doula clients without their own full-time job or spouse's full-time salary. Courtney, a volunteer doula who also has paying clients, said about her husband, "He's financially supportive. Not many people actually have the ability to go and just be like 'I'm going to try this thing that pays me by the birth and see if people will hire me.'... That shows an immense amount of support." Paige also mentioned that her husband "is not chastising me or giving me any sort of reason to feel bad about making

what I make [monetarily] now [as a doula] as opposed to what I made as a nurse. I think just accepting that... this is how I'm going to be happy and that's okay."

Having someone to talk to who gets it

The issue of having someone listen to the doula talk about the birth they just attended is crucial to their ability to manage the emotional stress of doula work. As Melissa said, "if you don't let it out somehow, that's, I think, why a lot of doulas burn out." Mainly, the doulas appreciated being able to talk to their husbands about a birth they just attended. When they arrived home from a birth, or after coming home and sleeping first, having their husband or boyfriend listen to them debrief felt extremely supportive. Olivia said, "My husband luckily has been there to support me when I do get home. ... I think good support at home too and the support of a spouse is really, you know, good." Many of them expressed gratitude for their husband's listening. Felicia said that after a birth "my husband also gets an ear full. He lets me talk it out. It is a safe outlet because he doesn't have any idea what I am saying. ... He is not involved in the birth community so I don't feel like there is a huge disclosure issue and I can talk freely with him." Robin's husband "tolerates so well my talking about birth related topics, placentas and vaginas and all of that just in every day conversation." Paige also stated, "My husband listens quite a bit, probably more than he wants to."

However, debriefing a birth with their husband has some shortcomings. Laura echoed many of the doulas, saying, "My husband is great, but he only knows so much about birth, and only cares to know so much about it." Jessica also limits her talks with her husband after a birth: "I tell him how I felt this way or that way, [but] I don't divulge everything because he's not a doula, and he's a man." Gina said that her boyfriend:

“... has really big ears who just sits and listens to me. Sometimes he has to take a lot of ear force. He’s like my support staff and if it’s too much for him to handle, I have an aunt [to talk to.] ... And like emotional baby type things... it’s like way too much for my boyfriend to handle because he’s just, you know, like a young boy. He can’t handle too much baby stuff, he might explode.” (Gina)

Likewise, Kelly said she does not debrief with her husband anymore: “He’s not the one I’m going to come home and tell about the birth. That was fun for the first year or two, but he’s sick of hearing about birth. It’s not interesting to him at all, whatsoever.”

Goffman (1959) makes a distinction that confidants, like therapists or in this case doula husbands, are persons to whom the performer details what happened during the performance. But such confidants are located “outside” and off stage, which is different than back stage. Husbands often provide important emotional support off stage. However, I argue that it is more valuable to find teammates back stage. Even if the doulas’ need to debrief is only partially met by their husbands, it is still crucial to be able to “tell people who get it” (Brooke). The doulas find it very important to be able to have doula friends and colleagues in the birth world that understand what they experience, especially since their work is independent and isolating.

Melissa stressed the importance of having a group of doula friends that she could confide in and vent with and whom she can call in the middle of the night crying if she needs to. For Melissa her support must be another doula: “Every single time I have a birth, I have to tell somebody. And at some point, it has to be a doula because no one else will completely understand.” Erica said that she needs a doula friend to be a sounding board. Jessica also said she would talk to another doula soon after a birth, in order to carefully review her feelings about it, share ideas about what she could have

done differently to help women in similar situations in the future, and process any personal lessons. Courtney emphasized that sharing after a birth is a process, but that the process has to happen. A condition of debriefing is not always an intense or difficult birth; doulas also want to share their excitement about “good” births and “tell all my doula girlfriends about the awesomeness” (Courtney).

Kelly has found other outlets to debrief besides her husband. She believes her support team can also include – besides fellow doulas – midwives and delivery nurses who understand what it’s like to be in birth work, because “whoever is willing to listen to you talk when you come home is never going to really get it [your birth experiences] in a way that helps you feel understood.” Laura appreciates that she has a group of doula friends who know when she is heading to a hospital and will check on her. Laura said she handles the stress of an intense birth better just by knowing that she will have a space of friendly doula support to vent to after.

One concern about sharing birth experiences is not disclosing any identifying client information that might violate confidentiality. Most of the doulas are aware of the confidentiality boundaries and say they reveal only what is appropriate in broad terms. Remarkably, Nancy is part of a doula collective that stipulates in their client confidentiality agreement that they can talk to colleagues about specific circumstances surrounding the client’s birth.

Anne Kennedy and Penny Simkin described their early PALS¹⁹ meetings, where they “really stumbled around trying to figure out how to support each other in ways that

¹⁹ Pacific Association of Labor Support (PALS) is a local doula membership group in Seattle, Washington, that was established in 1989 and helped launch DONA International.

were helpful.” Their meetings consisted of three components: debriefing, education, and business/administration. As Penny Simkin remembered, “the first hour was debriefing on births you’d attended, in small groups, and people would cry and they would say ‘What should I’ve done?’ And we were holding each other and helping get through that. ... They don’t do the debriefing [anymore], but we got email lists and things now...” Such a structure, of formal support groups, would be desired and preferred by the doulas interviewed in this research.

SUPPORT FOR UNPREDICTABLE WORK STRUCTURE

Being a doula is distinctive from other types of work because the nature of being on-call makes the hours very unpredictable and unscheduled (Lantz 2005). Typically a doula will start being on-call for her client two weeks before the client’s due date, and contracts to stay on-call for that client until two weeks after the client’s due date. Most babies are born within this four week timeframe. Penny Simkin, in her interview, also mentioned that one of the most important topics of doula work was “the on-call thing... how to do it right.”

Lantz and colleagues (2005) briefly mention three issues in their findings from a nation-wide survey of doulas pertaining to work-life balance: 1) balancing doula work with other jobs, 2) balancing doula work with life in general, and 3) balancing doula work with family demands and obligations. I did not ask doulas in this sample any of these topics directly; nonetheless these issues emerged organically in the interviews. The experiences of the doulas varied depending on how many clients they commit to; for instance, volunteer doulas usually only scheduled one client at a time, or one client per

month. Whereas some of the entrepreneurial doulas had up to four to six clients with due dates in the same month.

First, three doulas specifically mentioned that they have other part-time or full-time jobs primarily for financial reasons but that they have flexibility or understanding supervisors. For instance, Brooke, a college student and a nanny, provides afterschool childcare to a family that supports her doula work and understands if she has to cancel her nanny job last minute. In addition, Brooke selected other part-time contract work, which also necessitates flexibility. For Erica, who works as a shift supervisor at a coffee shop, she feels fortunate that she has an understanding boss who schedules her less hours during a week when she is on-call for a volunteer doula client. Mostly, the other doulas that have full-time positions with traditional business hours in which they would have to leave in the middle of their work day to respond to a client in labour, are volunteers who only take clients infrequently and have lenient and tolerant white-collar expectations from their directors that they can leave abruptly once in a while. For Angela, a mother of two children who works a full-time job in which she commutes to an adjacent city, explained:

“People are like, how does that work [to be on-call and have a family]? I have been really lucky. I have been working at the same job with the same boss for ten years. So I have a pretty flexible [schedule]. [My boss] is supportive. She knows that it is important to me. That is an extra sort of benefit for me.” (Angela)

On the other hand, Angela felt that to juggle scheduling of prenatal visits was most stressful because of her day job. Other doulas are not otherwise employed so that they can leave home at any time, if needed, and have financial support from their husbands.

Second, the doulas struggle with balancing doula work with normal life commitments. Teresa, one of the older doulas in the sample, had shifted her work after many years as a birth doula to be a postpartum doula, with more constant hours, mainly because of this issue of work-life balance. She clarified her choice by saying:

“I missed anniversaries and I missed birthdays and I missed holidays... I didn’t have balance and in order to be a good doula you have to have that balance. In order to be a good person you have to have balance. And when you become too absorbed... Because not only was I doing birth for my business, I was doing volunteer births and... doing different things, and it became overwhelming, I think. And as I got older it just, to me, it just became too much.” (Teresa)

Heather said she does not chaperone school field trips with her kids because of her doula schedule and she misses those types of activities with her children.

Third, the doulas make extra efforts to balance their doula work with family demands and obligations (Lantz 2005). They discussed having to speak up for their needs at home, but mostly their (wonderful) husbands increased their support when the doulas were with a client during labor. Husbands would take care of childcare, for instance, even leaving from their own work early sometimes. Danielle also spoke of her husband taking care of their two children while she was gone at a birth and resting afterwards: “... my husband is really involved with the kids, and so that really helps in terms of, ‘Dude, remember you got to do this, don’t forget to brush their teeth.’ If a husband isn’t used to the day in and day out of kids, I don’t know what I would do. I leave and I’m not worried, you know, and that’s really helpful.”

Laura, who has a husband and two children, qualified that it depended on one’s life situation how to work out attending a certain amount of births per month, for instance. For her, she could not take on several clients at once because she has “extra

worries” like little kids to get off the school bus. However, she schedules her clients so that she does not commit to any births during December, because of family birthdays and holidays. And if she knows that her family is going to take a vacation during a certain month, then “I’m going to block around that, so I don’t have to worry about [the clients] finding backup” doulas. Later, Laura indicated that one of her most favorite things about choosing to be a doula is that the scheduling is flexible, “Obviously, I don’t choose when the babies are born, but I choose timeframes to work or not work, based on my family’s needs.”

Kelly and Heather are the only doulas in the sample who work as a doula full-time while being the primary wage earner in their family. Olivia calls herself a full-time mom first, even though when pressed if she considered being a doula her primary profession, she hesitantly agreed.

Most of doulas could not or would not consider doula clients as their only income source. For instance, Felicia said, “Even if I work at my fullest capacity [as a birth doula] I would have to do something else on the side. Doulas do usually sell birth related products or things like that.” When Laura was asked if she desired to do doula work full-time she exclaimed,

“The idea of having multiple clients in labor at once is so exhaustive to me – just the thought of it – that the idea of actually doing it would be abhorrent, at least at the moment because I have two little kids [and] a husband with an inflexible job. So, you know, every time I’m on call, it’s a challenge. So, for me, I could never do this fulltime in my current situation.” (Laura)

Some of the benefits, however, of having nonstandard employment, such as an independent contractor with part-time, temporary, or short-term work, are made apparent

in the interviews with the doulas in this sample. For instance, such employment terms made it possible for Robin to “continue being a full-time mom” and gave her flexibility to provide (unpaid) dependent-care work, not just with her two young children but also for three elderly relatives over the past ten years. Robin is also a massage therapist and aspires to do more doula work and less massage work in the future because of the physical requirements of massage on her body.

However, the trade off of having work flexibility has been that Robin has many other administrative responsibilities that accompany being a business owner:

“I have to do everything from cleaning...the office to making marketing decisions to actually doing the hands on work. And I also do not have a receptionist who works for me. So, when I am called away on a birth, if it is a day that I have massage clients scheduled, it’s my responsibility to contact those clients and get them rescheduled so that I can attend the birth. So, it's a lot of juggling but it has fit well into my family life.” (Robin)

Robin also made the point that if she were to work full-time as a doula, which she defined as five to six births a month, every month, the basic necessities would include: 1) a strong support system for logistics and family obligations, and 2) a strong backup doula, at least one, preferably two. Felicia also concurred that she would like to take on more clients and if she had more clients she could build better backup relationships with other doula because it would help if they were all on-call at the same time.

DISCUSSION

This chapter examined a neglected area in the sociology of emotional labor, how it is that individual care workers take care of their own emotional health. Regardless of

how well doulas provide support and how well received their efforts are perceived; doulas themselves need support structures to do what they do.

Doula work is paradoxical much of the time. They have to leave their families in order to support other families, they need the support of their own husband just as they are teaching their client's husband how to best support his spouse, and they have to deal with extreme emotions of birth – joys, transitions, and losses. These paradoxes correspond with the experiences of many other care work professionals. For instance, Buch (2010) reported that home care workers “labored to sustain older adults’ social relations and independence even as the structural conditions of the labor threatened to support their families” (p.xvi). It is crucial to acknowledge the paradox that as care workers who provide emotional support, they also need caring in order to maintain their work.

The doulas are performing a specific role on the front stage, as evidenced by Goffmanian social rules, such as sneaking a snack while at a birth. The findings illustrate Goffman's dramaturgical model of social life by using doulas as an example. I expand Goffman's concept of teammates, who co-operate and gossip back stage, to include doulas need for such support when they are not working in order to be successful caregivers. Doulas use their teammates to confide in, vent their frustrations, problem solve difficult births, and review their feelings about what happened. Husbands are also used as confidants but the outcome is not as effective as having a colleague to talk to. Even though Goffman recognized “actors” need for back stage camaraderie of teammates, Hochschild and subsequent sociological theorists have neglected the back

stage metaphor. I find that having teammates is especially important when performing care work, because it mitigates what might be negative emotional consequences.

Doulas work independently, yet in order for the doulas to be successful on stage they need to have support from teammates back stage. Even if the doulas are not performing on the same physical stage or location, they are in effect still giving a cohesive performance. Isolation can come from the structure of the on-call schedule. Meltzer (2004), in her dissertation on doulas from multiple regions in the United States, also found that one region in particular did not have a cohesive doula community. The doulas felt like other doulas were competitors and local doula groups could not get organized. As Meltzer describes, the doulas in that region act “as if they are sole proprietors, blazing a trail on their own... Inbred fights about leadership and collective goals sabotage efforts to move forward for the greater occupational and social good” (Meltzer 2004:101-2). Isolation can also be felt if it is difficult to find other supportive colleagues. While my sample did not show such a harsh lack of cooperation or community discord in this particular Midwestern location, there was a validation that doulas need other doulas or birth colleagues to talk with, problem-solve and debrief stressful or emotional experiences.

I did not find that the care work is inherently taxing and draining, there just is usually not a sufficient amount of support structures that boosts the work of those caregivers. Hochschild (1983) contends that an emotional outward expression by the worker is performed in order to produce the proper state of mind in others, but that the worker has to induce or suppress feelings that are not a part of them. The doulas I interviewed did not say that they were personally dissatisfied with their work. Many of

the doulas who are middle-class and married have the tangible and financial support they need to buffer the stress of the unpredictable on-call structure. I also did not find any evidence in this sample of doulas that they felt what Hochschild warns as the potential for alienation because they had to embrace a role on stage that was somehow in conflict with their authentic self. The doulas did not talk about having to change an emotion to fit social guidelines; only surface examples, such as putting on a happy face and waiting to cry until they were safely back stage, emerged.

The contribution from this research is that it shows an illustration of Goffmanian front/off/back stages that produces a deeper understanding of doula work. It also demonstrates a need of care workers that has not been deliberated in established sociological paradigms, but has been discussed in more applied nursing and psychotherapy literature. For instance, I see a significant opening for professional peer groups to fulfill emotional support to each other, something that family members can do but not to the full extent needed. It is important for doulas to connect to a professional community, either by becoming a member of an international or national organization and attending conferences to meet other doulas, or by informal local networks. Literature actually suggests that an explicit formal organization will provide more social support than casual contacts, because a formal group, such as a consultation group, can be more readily mobilized when one of their members is in a time of stress (Catherall 1995). Professional peers can provide tangible support by providing childcare or back-up doula services. Peer doulas can also provide the emotional support to each other which they are trained to give to clients, such as being non-judgmental, providing information to help with decision making, reframing trauma, and being empathically attuned (Catherall

1995). Such a doula support group has already been recommended and implemented (Kane Low, Moffat, and Brennan 2006). However, the findings here confirm the necessity for a structure for teammates for doula work to be sustainable.

Further research on doulas could benefit from targeting a sub-sample of women who used to be a doula and are no longer. Women who gave up doing doula work would be better positioned to talk about the possibility of burn-out and the reasons why they did not continue this work. There was only one ex-birth-doula in this sample, the woman who had been a very experienced birth doula but moved into being a postpartum doula for scheduling reasons. This is an important point to the profession, because if those doulas who gain experience promptly leave the field, the profession will only be filled by novices. Subsequently there will not be any experienced mentors who have the capacity for self-reflection and mediating the internal tensions (Meltzer 2004) to provide support to beginning doulas. Experienced doulas learn how to maintain emotional boundaries, be responsive to other people's needs, and develop the capacity for reflection and self-care (Gilliland 2011). This emotional intelligence and skill, the crux of what doulas provide for clients that is so effective, needs to be focused on one-self and peer doulas.

Additionally, I suggest that if a comprehensive survey of doulas were commenced in the future, it would be germane to include a validated scale of self-care (e.g. Exercise of Self-Care Agency; Professional Quality of Life Revision IV [ProQOL]; the Areas of Work Life Survey; Maslach Burnout Inventory-General Survey). The use of a scale where reliability and validity are already established could provide a complementary method to identify specific coping methods used by doulas during high levels of stress. It would provide a mixed method approach to supplement the qualitative data reported here.

Additionally, a scale would provide a foundation in which to compare levels of self-care and burnout across different caregiving occupations.

CONCLUSION

In the past, research has tended to ignore the experience of care workers given that society characterizes instrumental (tangible) work as superior to emotional work and devalues the activities of women (Abel and Nelson 1990). Yet, little has been written on the rise of the doula in contemporary North America from the doula's perspective, rather than focusing on the client's satisfaction with doulas. I have begun a new discussion in the literature by highlighting the necessity of the teammates in the back stage in order for the front stage performance to be successful.

This study considers doula work as a case that illustrates care work and the negotiations between work and family, and between front stage and back stage. The research findings suggest the creation of new program structures, such as making professional doula support groups available to all doulas, that supports individual doulas (specifically) and all birth doulas (generally) in their work.

Chapter Five

CONCLUSION

The dissertation examines the social structures of doula work. It takes a mixed method approach to explain how doulas negotiate care work. Although the idea is not new that professionalization and occupational changes occur in processes which unfold over time and within each occupational group, it is rarely the case in the literature that care work and an expanding occupation are examined together. This study systematically examines how social structures among care worker actors affect the occupational legitimacy process and contributes to the sociological perspectives on work, medical sociology, and feminist theories of women's emotional labor.

Chapter Two examines ideological tensions and paradoxes of how doulas strive to establish themselves as professionals. Theoretically guided, how is doula work an example of professionalization? The demands of professionalization may contradict the very essence of doula work because it creates a paradox between striving for recognition and prestige and providing needed services to childbearing women. This creates tension between pursuing legitimacy while still desiring autonomy and self-regulation. I describe the paradoxes faced by doulas, where a condition of two seemingly opposing constructs are true at the same time, and use such paradoxes as a window into sociological problems. For instance, how do doulas provide a high level of care centered on women's values at the same time they strive for professionalism and strategies for gaining legitimacy? While autonomy as a profession is valued, such as the right to have control

over the content of training and credentialing, and discipline of incompetent members (e.g. Freidson 1970, Larson 1977), there are a few barriers faced by individual doulas that make it hard for them to participate in the overall legitimacy process. Some doulas choose doing what they think is best for the client over what might be best for the doula professional community.

I am contributing to an examination of the process of professionalization of occupations. Specifically, I use doulas as a case in which an emerging occupation has to seek occupational legitimacy for both their product and themselves as its providers, and that essentially the product they are selling is themselves (Joinson 1992). This is similar to Sherman (2010), who used the case of personal concierges to also look at occupational legitimacy. This adds to literature of the process of professionalization by considering an emic view of how individual practitioners, as well as a macro-level organization, define their work and how multiple audiences consider the work. I also improve on sociological theory on professions that study the process of occupations moving into a unique position of power, prestige, and autonomy in the labor force (Wilson and Oyola-Yemaiel 2001). Nearly all such theories assume that professionalization and legitimacy are the ultimate objective. The literature has not considered that establishing professionalism may be at odds with doing the work in the most effective and beneficial way.

In Chapter Three I analyze the effects of different types of social support on the client's delivery mode of birth. Comfort measures provided by volunteer doulas decrease the probability of having an unexpected c-section. Sociologists have been attempting to discover and understand the mechanisms that may underlie the positive relationships between social support and health outcomes (e.g. House et al. 1988, Thoits 2010). An

analytical model investigates which actions doulas take that have the biggest impact on health outcomes. This adds to a literature that has already demonstrated doulas make a difference (e.g. Hodnett 2011), by demonstrating that massage and visualization/relaxation are tasks that doulas do that are making a statistically significant effect. Previous research on separate techniques to reduce pain and stress during labour and delivery were found to be significant, such as massage (e.g. Field et al. 1997) and guided relaxation (Teixeira et al. 2005). However, there has not been a previous connection made between the benefits of doula labour support and the specific types of support they provide.

Chapter Four investigates another paradox – how doulas need support in order to give support. This is distinct from the prior chapter on social support because now it relates to the support essential to social actors in Goffman's back stage setting. Inadequate theories of worker emotion management, especially Hochschild's commercialization of feeling, provide an opening to discuss doulas' needs for peer support. I find that although doula work is mostly solo and isolating, there persists a strong need for collegiality. Doulas especially find benefits to debriefing with other doulas or birth workers when they are no longer with a client. I expand Goffman's (1959) concept of teammates, who co-operate on stage in performance and gossip back stage, to include doulas need for such support when they are not working in order to be successful caregivers.

Looking at doulas as a case of care work that has been commodified from the private sphere to the public market place, adds to the literature that critiques Parsons and other functionalists' views about work and family (e.g. Parsons and Bales 1955).

Hochschild (1983) and other researchers on psychosocial consequences of emotional labor (e.g. Wharton 1999) do not consider how back stage and off stage support can mitigate the potential negative toll of emotional labor. I concur with other care work theorists (e.g. Cancian 2000, Nelson 1999, Zelizer 2005) that functionalist theories which hold rigid dichotomous constructs between family obligations and professions are not a useful way to conceptualize different types of labor. I build upon Fisher and Tronto's (1990) argument that caring is a process, and that physical and emotional self-care must also be included. I use Goffman's (1959) dramaturgical model of social life, especially the distinctions between front stage, back stage, and off stage, to address what Hochschild (1983) and other researchers on psychosocial consequences of emotional labor (e.g. Wharton 1999) do not consider – how collegial support can mitigate the potential negative toll of emotional labor.

The emergence of doulas as a new occupation provides a fascinating opportunity to look at a profession in its formative and adolescent years, examine the strategies doulas use to set themselves up in a unique position to assist women, and scrutinize what is working and not working in the occupational structure. It also offers a valuable and important avenue for developing objective insights about women's work and how to advance professional care work.

STRENGTHS AND LIMITATIONS OF DATA

I conducted the qualitative interviews with doulas from the same geographic area in the Midwest. Half the doulas were active in the same volunteer organization, while the other half had very similar training as the volunteers (sometimes with the same instructor), were familiar with the volunteer organization or had volunteered in the past

themselves, and may have personally known other doulas from their personal network that were participating in this research. Their regional doula community may have a tighter network than other cities or regions, especially if no such key organization exists. This is a major strength of the sample. Even if the doulas' experiences from this sample may not be generalizable to all doulas in the US and Canada, the findings that doulas require peer support have important implications for areas that have less collegial cohesion.

A number of limitations need to be acknowledged. Because the quantitative data collected from the VDP surveys were not part of an experiment, there is no control group and the women who received a doula were not randomly selected. The findings from one community-based doula program may not be generalizable to all childbirthing women in the US and Canada. However, the findings strongly suggest that massage and visualization/relaxation techniques are effective on birth delivery mode. Further research on these alternative methods would be useful in confirming the degree these findings can be generalized to a larger population.

QUESTIONS FOR FUTURE RESEARCH

Based on the discoveries made in this dissertation, here is a partial list of topics and questions ready for new and continued social science and sociological investigation:

1) ***How does the concept of social entrepreneurship relate to doula ideology and work structures?*** I recommend an investigation in greater depth regarding the difference between volunteer and entrepreneurial doulas. The concept of social entrepreneurship, where entrepreneurs are more interested in creating social value and less interested in gaining personal profit (Abu-Saifan 2012), seems ripe to apply to the doulas' testimonials

of why they choose this work in the first place, and why many of them do the work for free.

2) *Are there other domains of doula care work, besides comfort measures, that are significant in making a positive difference in health outcomes?* To further expand the knowledge of the mechanisms of how social support effects health outcomes, it would be worthwhile to conduct a study to further refine and evaluate the doula tasks model I formulated in Chapter Three. While a host of clinical researchers have demonstrated that the presence of a doula makes a difference, I have attempted to disaggregate doula tasks to find which specific domains or combinations of doula care make a significant positive difference on birth experiences and outcomes. Study findings lay the foundation for future research. The real-world data collected from the VDP surveys required extensive data cleansing and had copious missing cells, but the record linkage and merging worked well between different sources (doula survey vs. client survey vs. program registration questions). The dataset just did not ask all the questions needed to test the different concepts of doula care. More experienced doulas (as operationalized as the number of previous births attended as a doula) may provide more effective support as well.

I recommend using the VDP's doula and client surveys, with some additions and revisions. Data collected should include characteristics of the doulas themselves, not just client outcomes. It is hypothesized that doulas hailing from the same communities as their clients can provide more effective support. Additionally, further data should be collected from the client's perspective. Clients should be asked how much emotional support they receive from the doula, as compared to their husband or nurses, and how effective they feel the support is to them. I hypothesize that emotional support, if

operationalized appropriately and using prior research such as Gilliland's (2011) nine different emotional support categories, is more significant when measured from the client's perspective rather than reported by the doula. Alternatively, surveys that target women who had not used a doula but would have liked to if they had known about them, as well as women who had not used a doula and would not have chosen to hire one, would also address some of the limitations to the current survey. This information would provide a better understanding of what potential clients may consider important in terms of having a "professional" doula and for whom a doula may not be desired.

3) *How do the roles of other care workers compare ideologically and occupationally with birth doulas?* To further investigate theories of care work and self-care, I suggest investigating how back stage and off stage support may be helpful and necessary to other care work occupations. How might this concept apply to any other occupation as well? Research has not considered that all types of work can be emotional taxing for workers, and that back stage and off stage social support may be necessary for many people. Expanded studies of the role of social support during other transformative life course events, such as hospice, and in a range of work settings (e.g. home, hospital, offices) may be revealing. Hospice actually has extensive research on job satisfaction, occupational stress, worker self-care, and burn-out prevention strategies. However, new research on the type of care given by home healthcare workers, for instance, who provide different types of social support that have been identified from this research, such as emotional support, education, physical comfort measures, and/or advocacy, would be innovative. This area would continue to contribute to theories about labor and how it is defined, particularly with a gender emphasis.

IN SUM

Most people have never heard of the term “doula.” As a result, doulas spend a good deal of time and effort in defining their role and explaining what services they provide. Doulas are filling an occupational niche to provide unique and specialized care for women, in addition to making a difference in health outcomes that can be understood in empirical terms. Doulas provide a rich case study for sociologists of labor, emerging occupations, gendered work, maternal and infant health, and alternative medicine. Sociological insights elucidate the local realities and lived experience of paid and volunteer birth doulas while establishing a link to larger structural occupation issues, as well as understanding how social support is something essential to give (to others) and receive (for oneself). My hope is that this research provides a better appreciation of how truly important this unique role is in supporting healthy births and specifically supporting mothers during pregnancy and delivery.

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Appendix A

Moffat's Interview Guide (Labor of Labour Support): Subject ID# _____

I. DEMOGRAPHIC BACKGROUND

1. [Sex is female unless otherwise noted here]
2. Race/Ethnicity
 - a. White (not Hispanic)
 - b. Hispanic
 - c. African-American
 - d. Asian
 - e. Arab-American
 - f. Other: _____
3. How old are you now? Age _____
4. What is your birth date? DOB _____
5. Are you a U.S. citizen? yes no
6. Are you currently:
 - a. Married
 - b. Widowed
 - c. Divorced or Separated
 - d. Never Married / Single
 - e. Long-term Partner
7. How many years have you been the above? _____
8. Who lives in your household?

II. REPRODUCTIVE BACKGROUND

9. How many times have you been pregnant? _____
10. How old were you when you were first pregnant? _____
11. Do you have any children?
 - a. _____ # of vaginal births
 - b. _____ # of cesarean births
 - c. _____ # of non-biological children (step/adopted)

12. If you have children, what are their current ages and did you breastfeed them?
- a. Child #1 _____ Breastfed? yes no If yes, how long _____
- b. Child #2 _____ Breastfed? yes no How long _____
- c. Child #3 _____ Breastfed? yes no How long _____
- d. Child #4 _____ Breastfed? yes no How long _____
13. Are / Have you been a single parent? yes no
14. Are / Have you been a teenage mother? yes no

III. BIRTH STORY NARRATIVE

[If given birth, then continue on. If not, skip to next section.]

15. Today I have several specific questions about your work as a doula, but to start, I want your story, in your own words, of the birth of your child. What happened and how do you view that birth today? [separate story for each birth]
16. If I were to make a mural or quilt or collage, something that shows your whole birth experience at one time in one picture, what different panels, scenes/themes/ideas from your birth, what should I include? [Probe: If you'd like, close your eyes and image the scenes, themes, or ideas.]
17. Was there a "turning point" in your birthing experience that changed your life?

IV. PERSONAL VIEWS

18. What is your philosophy or view of birth [in general]?
19. Do you consider yourself a religious or spiritual person?
- a. If yes, how do your beliefs affect your view of birth?

V. BECOMING A DOULA

20. When did you first hear about doulas?
21. Why did you want to become a doula? What motivated you to become a doula?

- a. Did your personal birth experience contribute to you wanting to become a doula? How?

22. When did you first call yourself a doula to others / to yourself?

23. How long have you been a doula? [date of attending first birth]

24. How long did it take from the moment you started pursuing doula work to the time of being at your first birth?

VI. TRAINING

25. What kind of doula training have you participated in?

- a. Program _____ Dates _____
- b. What did you learn?
- c. Was it what you expected?
- d. What didn't you like about the training?

26. a. Have you / Will you become certified through any organization?

- a. Why / Why not
- b. What is the hardest part of trying to get certification?

26b. What is the difference between doulas who are certified and doulas who are not certified?

27. How long do you see yourself doing this work in the future?

28. What organizations are you a member of?

- a. Have you ever attended professional Doula conferences?

29. What additional training do you have, besides being a doula? [e.g. massage, midwifery, acupuncture, homeopathy, social work, etc]

30. Do you work besides being a doula? What is your profession?

31. Are there any other professional skills you bring to your doula work that we have not already talked about?

32. What are your future aspirations? [probe that being a doula may be a stepping stone towards something else]

33. Do you think all doulas should be certified?

34. What is the highest level of education you have completed?
 a. [If college, ask for degree & subject]

- b. Do you plan any further education?

- c. What is your spouse's highest educational degree attained?

35. What did/does the people who raised you do for a living and what were their educational levels?

VII. VOLUNTEER

36. How did you hear about the VDP volunteer program?
37. How long have you been with VDP?
38. Why did you decide to become a part of the volunteer program?
39. How many births have you attended as a volunteer? Total # _____
40. How does the program work?
41. Please share 3 negative aspects of the volunteer program:
42. Please share 3 positive aspects of the volunteer program:

VIII. DOULA PRACTICE

43. How many births have you attended? _____ total
 _____ as a primary doula
44. How many births would you like to attend? [now, in the present] _____ per month
 _____ per year
45. How many births do you actually attend? _____ per month
 _____ per year
- a. [If applicable...] Why is there a difference between your preference and your actual number of clients?

46. How many births have you attended at a hospital? _____
 a. Would you prefer to perform your doula services at hospitals more, less, or the same amount?
47. How many births have you attended at a Birth Center? _____
 a. Would you prefer to perform your doula services at Birth Centers more, less, or the same amount?
48. How many births have you attended at the client's home? _____
 a. Would you prefer to perform your doula services at homes more, less, or the same amount?
49. How do you define your availability? [radius from home; #s per month]
50. How do you make yourself available to clients? [looking for mode of communication, such as pager or cell phone]
51. What are the most effective methods for finding clients? Or how do clients find you?
52. Tell me about your clients [no names]. Who are they?
 [Probes: 1st time pregnant, mother's age, race/ethnicity; language; marital status; religion; SES/class]
 a. Do these things become relevant at a birth for you? For the medical staff?
 b. Do you consider the mother the primary client, or the father as the "client" as well?
53. What do you think is the most important thing you do in your role as a doula?
54. Do you think the prenatal, labor or postpartum work with the client is the most important?
55. Tell me about what you do with your clients. What are the doula services that you provide?
 a. Prenatal [be sure to include how many visits on average]
 b. At the birth [be sure to include how long you stay with them on average]
 c. Postpartum [be sure to include how many visits on average]
56. What do you like about your role as a doula?
57. What would you change if you could?

58. What is a “good” birth? [general description]
 - a. Please give an example of a good example.
 - b. How do you feel after a good birth?
 - c. What do you do after a good birth?

59. What is a challenging or difficult birth? [general description]
 - a. Give example.
 - b. How do you feel after a difficult birth?
 - c. What do you do after a difficult birth?

60. How (do/would) you respond to a client who is unhappy about being pregnant?

61. How do you handle a “needy” client?

62. How do you distinguish/portray/introduce yourself as a doula at a hospital?
 - a. Do you think about the clothes you are wearing when you are called to a hospital?

63. Tell me about how you have worked with a variety of people:
 - a. Doctors
 - b. Nurses
 - c. Midwives
 - d. Other Doulas
 - e. Partner
 - f. Other Family Members

64. Please give me an example of a miscommunication or misunderstanding between...
 - a. ... you and your client? How was it resolved?
 - b. ... your client and her care provider or nurse? How was it resolved?
 - c. ... you and your client’s care providers? How was it resolved?

65. How do you handle the emotional part of your work?
 - a. How do you take care of yourself?

66. How do clients express their appreciation with your assistance?

67. How do clients express their dissatisfaction with your assistance?

68. How does your partner/family view your doula work?
 - a. Are they supportive? How do they show their support?

69. How do you handle the on-call nature of your doula work?

- 70. What sustains you as you do doula practice?
- 71. What has being a doula done for you, if anything?
- 72. Have you encountered any obstacles that interfere with your ability to do your job?

VII. WHO MAKES A GOOD DOULA?

- 73. What are the essential qualities a person needs to be a doula?
- 74. Do you think it is important for a doula to come from the same background or community as her client?
- 75. Do you think a man can be a doula?
- 76. Do you think it makes a difference whether a doula has not had a child of her own?
- 77. Do you think low-income women can become successful as doulas? Why/why not?

IX. COSTS AND PAYMENT

- 78. Do you have your clients sign a contract?
- 79. Do you work within a practice or partnership? If yes, How does that work?
- 80. Do you have a formal/informal backup arrangement with another doula?
 - a. How often have you had to use her?
 - b. How reliable is this arrangement?
- 81. How much do you charge per birth? (explain sliding scale policy if applicable)
- 82. When do you expect payment? Do you have a refund policy?
- 83. Have you ever bartered your services?
- 84. Have you or your clients ever been reimbursed by an insurance company?
- 85. Is your work as a doula rewarding to you on a financial level? Why/why not?

86. (Would you / Why do you) do this work for free (volunteer)?
87. Do you think your pay reflects the value of your work?
88. How much have you invested in your...
- training
 - marketing materials
 - birth bag – supplies
 - educational materials you give to clients
89. [If she has kids at home...] What arrangements do you have to make for childcare?
90. How do you use the money you make as a doula?
91. What are the major sources of your household's income?
- What is your spouse/partner's occupation?
 - What percent of your household income comes from your doula income?
92. Please look at this chart and pick the letter that most nearly describes last year's total income (before taxes) for your household. Please consider ALL sources of income.
- \$10,000 or less
 - \$10,000 - \$14,999
 - \$15,000 - \$19,999
 - \$20,000 - \$24,999
 - \$25,000 - \$29,999
 - \$30,000 - \$39,999
 - \$40,000 - \$49,999
 - \$50,000 - \$74,999
 - \$75,000 - \$99,999
 - \$100,000 or more
93. Which of the following have you or someone in your immediate family (household) experienced in the past THREE YEARS:
- Unemployment or job loss (Y / N)
 - Foreclosure of primary residence (Y / N)
 - Moving to a different home because of financial concerns (Y / N)
 - Divorce (Y / N)
 - Serious health problems (Y / N)
 - Being unable to work because of a disability (Y / N)
 - Having too little money to buy food (Y / N)
 - Having too little money to buy clothing (Y / N)

- i. Having too little money to afford health insurance for a family member (Y / N)
- j. Having too little money to buy books or supplies for school (Y / N)
- k. Homelessness (Y / N)
- l. Death (Y / N)
- m. None of these have happened to me or my family in the past 3 years (Y / N)
- n. Other (specify): _____

X. LAST QUESTION

94. Are there any other things you'd like to tell me about being a doula that I haven't asked you about?

References:

Many questions came from Morton (2002)

Appendix B

Interview Guide for open-ended interview with co-founders of DONA International

1. Why did you create and start DONA?
 - a. What was the birth “environment” at the time?
 - b. Were you the only ones training doulas at this time, or were there others in the U.S.? Did you have conversations with others, or collaborate in any way?
 - c. Why was there a need for an association?
2. Do you see any points of tension in the emerging professionalization of doula work?
 - a. Why is certification important?
 - b. How did you make decisions on what the requirements to include in the certification process?
 - c. Why do doctors and nurses have to sign off on doula evaluations, when doulas do not provide any medical care?
 - d. How does the emerging professionalization of doulas impact the doulas themselves? How do they negotiate their values and the demands of professional work, or are these two things not in conflict?
3. Is there any progress on getting health insurance to reimburse for doula services?
 - a. What have been the issues over time with health insurances?
 - b. What have been the issues over time with the medical community, like doctors and nurses?
4. What are your opinions about doulas getting paid for their time and efforts?
 - a. Are they paid what you think they are worth?
 - b. How has the labor/economic market changed over time in regards to paying doulas?
5. What do you think are the most important tasks or elements of doula work? What do they do that makes the biggest difference?
 - a. How do you think we can show that those tasks (e.g. massage) or ways of being (e.g. advocating) are what influences more positive birth experiences and outcomes? How would suggest that I operationalize those tasks?

6. What are the three biggest issues you saw/see with the doula movement...
 - a. ... in the 1990's?
 - b. ... today?

7. Have there been past surveys of doulas sponsored by DONA (or others)?
 - a. What topics or questions did it cover?
 - b. Is there any way to share that data with me?